AUDIT COMMITTEE

Tuesday 21 December 2004

Session 2

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AUDIT COMMITTEE
† 24th Meeting 2004, Session 2

CONVENER

*Mr Brian Monteith (Mid Scotland and Fife) (Con)

DEPUTY CONVENER

*Mr Andrew Welsh (Angus) (SNP)

COMMITTEE MEMBERS

*Susan Deacon (Edinburgh East and Musselburgh) (Lab)
*Robin Harper (Lothians) (Green)
*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
*George Lyon (Argyll and Bute) (LD)
*Mrs Mary Mulligan (Linlithgow) (Lab)

COMMITTEE SUBSTITUTES

Chris Ballance (South of Scotland) (Green)
Mr Ted Brocklebank (Mid Scotland and Fife) (Con)
Marlyn Glen (North East Scotland) (Lab)
Mr John Swinney (North Tayside) (SNP)

*attended

THE FOLLOWING ALSO ATTENDED:

Mr Robert Black (Auditor General for Scotland)
Mr Duncan McNeil (Greenock and Inverclyde) (Lab)

THE FOLLOWING GAVE EVIDENCE:

Mr Neil Campbell (NHS Argyll and Clyde)
Mr James Hobson (NHS Argyll and Clyde)
Mr David Meikle (NHS Argyll and Clyde)

CLERK TO THE COMMITTEE

Shelagh McKinlay

SENIOR ASSISTANT CLERK

David McLaren

ASSISTANT CLERK

Clare O'Neill

LOCATION

Committee Room 5

† 23rd Meeting 2004, Session 2—held in private.

Scottish Parliament

Audit Committee

Tuesday 21 December 2004

[THE CONVENER *opened the meeting at 10:02*]

Items in Private

The Convener (Mr Brian Monteith): I welcome members of the committee, the Audit Scotland team and the public and press to the 24th meeting of the Audit Committee in 2004.

We have a busy agenda today. Under agenda item 1, I must seek the committee's approval to take in private items 5, 6 and 7. Item 5 relates to our approach to the section 22 report by the Auditor General for Scotland, which we will hear more about soon, entitled "The 2003/04 Audit of Historic Scotland". Item 6 relates to our consideration of the payment of witness expenses in relation to our inquiry into the section 22 report by the Auditor General entitled "The 2003/04 Audit of Argyll and Clyde Health Board". Item 7 relates to a consideration of the evidence that we will take during item 4, which relates to the section 22 report by the Auditor General entitled "The 2003/04 Audit of Argyll and Clyde Health Board". Those items are all of the sort that we would normally take in private. Does the committee agree to take them in private?

Members *indicated agreement.*

The Convener: Do members also agree that our consideration of lines of questioning in relation to our inquiry into "The 2003/04 Audit of Argyll and Clyde Health Board" should also be taken in private on 11 January?

Members *indicated agreement.*

"Overview of the financial performance of the NHS in Scotland 2003/04"

10:05

The Convener: Under item 2, the Auditor General will report to us on the "Overview of the financial performance of the NHS in Scotland 2003/04", which was published yesterday.

Mr Robert Black (Auditor General for Scotland): This document is the overview of the financial performance of the national health service in Scotland for the financial year 2003-04. It complements my performance overview report, which came out in August. In this financial overview, I comment on the overall financial performance of the NHS in Scotland during 2003-04. As in previous years, I have identified the factors that seem likely to affect future performance.

Most NHS bodies achieved their financial targets in that year. However, four boards finished the year in deficit: Argyll and Clyde, Lanarkshire, Grampian, and Western Isles. Although Argyll and Clyde and Lanarkshire have large deficits, the overall deficit for the NHS in Scotland is small in comparison with the amount of money that is spent.

The in-year projections of three boards for this year are anticipating deficits in 2004-05. Those boards are Argyll and Clyde, Grampian, and Greater Glasgow. In addition, some boards have identified funding gaps for 2004-05. Although the boards in question have financial recovery plans in place, some of the plans include savings targets that are quite challenging. On pages 22 and 23 of my report, you will find exhibits outlining the savings plans in place for Argyll and Clyde, Lothian and Greater Glasgow.

In the report, I have summarised the factors that might affect future financial performance. I draw three main sets of factors to the committee's attention. The first relates to the financial strategies that are being used by some NHS bodies to achieve financial balance. Because about 80 per cent of boards' budgets are committed to staffing, property and family health services, boards find it difficult to free up resources to redesign services or meet budget constraints. As a result, some boards are continuing to rely on non-recurring funding to a significant degree. The problem with using one-off resources such as those is that they do not address the underlying cost pressures. Boards have generally found it difficult to find genuine year-on-year savings that would reduce costs and free up resources for service improvements.

The use of non-recurring funding for the past year is summarised in exhibit 6 on page 19 of the report. We estimated that it amounted to more than £370 million. The largest single item—some £218 million—came from ring-fenced money. Although that is money that is designed for specific purposes, it is being spent in order to enable the boards to achieve balance. In some boards, the amounts involved can be significant. For example, Lothian relied on one-off funding of more than £44 million in 2003-04 and it is likely that it will need nearly £40 million from one-off resources in 2004-05.

The second set of factors relates to a number of cost pressures that the NHS is facing, including pay modernisation. Of course, that is a matter that the committee has considered in the past and was described in a performance report that you saw earlier in the year. I have provided updated figures from the Scottish Executive Health Department for the various agreements, which are estimated to total between £234 million and £364 million for 2004-05. Details of that can be found in exhibit 7 on page 24.

We asked individual NHS bodies to provide their local estimates for each of the pay modernisation agreements, as that would give us the local perspective. However, we were unable to obtain estimates from every board. Although it is not clear whether all boards used the same assumptions, their estimates were generally higher than those that we received from the Health Department. I have included the estimates in my report. That was particularly true of the new general medical services contract.

There is a significant risk in financial planning in the NHS in Scotland if health boards and the department calculate cost pressures differently. I therefore wrote to the acting head of the Health Department to ask for an explanation of the differences.

A third factor relates to pension costs in the health service. As of 1 April 2000, the employer contribution to the NHS pension scheme increased from 5.5 to 14 per cent. The increase was needed to address a shortfall of some £934 million as against known liabilities. The additional cost to NHS bodies of the increase in the employer contribution is at least £226 million. The Health Department will meet the cost as part of the general uplift in funding. However, the requirement is another source of financial pressure on NHS resources as a whole over future years.

We are happy to answer any questions that the committee may have.

The Convener: Thank you. As the committee knows, we are scheduled to receive a further briefing on the report on 11 January. More significant questions can be put to the Auditor General at that time. Indeed, we are scheduled to take evidence from the Health Department's accountable officer on 25 January.

Although our agenda today is busy, we felt that, given the publication of the report this week, it was important that the Auditor General should be allowed time to report on the document today. We thought that it would also be helpful in the context of our agenda item today on the audit of the Argyll and Clyde NHS Board accounts. Members can put questions on the report today, but they should bear in mind that full answers may not be forthcoming. We will go into more depth on the report on 11 January.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): I have a question on the use of ring-fenced moneys. If a ring-fenced allocation is made, are terms and conditions associated with the spending of that money?

Mr Black: The short answer is that if money is allocated for a specific purpose, a memorandum is sent by the department in which it intimates the resource allocation and the purpose for which it is to be used. We have commented elsewhere in the report on the matter by saying that the accounts that are subject to audit do not make transparent those additional allocations. However, there will be documentary evidence that the allocation is for a particular purpose.

Margaret Jamieson: Does the department follow through on the memoranda that it sends out? Does it sign off the fact that the money has been spent on the purpose for which it was intended?

Mr Black: I am sorry, but we cannot give you a definitive answer to that question. I suggest that the information should be sought from the department.

Susan Deacon (Edinburgh East and Musselburgh) (Lab): I welcome the change to the format of the report, which is explained in paragraph 14. I found the new format helpful and wanted to say so by way of feedback.

Although I have identified a number of points and queries, as the convener said, I do not expect to get answers today. However, I will put those points on the record and flag them up as areas for further examination in our sessions in the new year. I am sure that the Auditor General can respond directly to some of the issues that I raise, and I hope that that might be the case with my first question.

Exhibit 7 on page 24 indicates that the estimates are "revised" Health Department estimates for the costs of pay modernisation. Can the Auditor General tell the committee how those estimates contrast with the previous ones?

10:15

Mr Black: Exhibit 7 contains the Health Department's revised estimates for the single year 2004-05. In the report that I published in the summer, we estimated future cost pressures on a cumulative basis through 2005-06. The short answer to Susan Deacon's question is that exhibit 7 shows that the cost of the consultant contract that has been given for the year 2004-05 is the same as that in my earlier report. The figure for agenda for change, which is £130 million to £160 million, is new because the negotiations have been concluded since the previous report. The figure for the cost of the GMS contract for 2004-05, including out-of-hours work, is £82 million, which has risen by £29 million since the previous report was given to the committee. That is how we get the total cost of between £234 million and £264 million.

Susan Deacon: I am grateful for that clarification. The Health Department's estimate of the cost of implementing the new GMS contract, which has risen by £29 million, is the main area of disagreement with the service because the service says that the cost will be greater. Given that, can you tell us what the higher figure is? What is the service's estimate of the cost of implementing the contract?

Mr Black: The short answer is that I am unable to give the committee that information. There seems to be agreement between health boards and the department on the cost of the consultant contract. The figure for the cost of agenda for change is entirely new and it is presented as a range, or as the department's best estimate of the cost. Susan Deacon is correct that we have evidence that the boards' estimates of the costs of the GMS contract seem to be higher than the department's estimates are, which is why I have written to the department to ask it to help to clarify the extent of the difference and the reasons for it. The problem was that information from some boards indicated that the costs might be relatively high, but we did not have a return from all the boards and we could not be wholly satisfied that the terms in which the numbers were calculated were similar in all boards. More work will need to be done on those matters, but there is clearly a risk that the cost of the GMS contract may be higher than the figure that the department has provided.

Susan Deacon: Paragraph 74 of the report stresses the need to ensure that

"current financial management arrangements are sound"

and that the Health Department and NHS bodies

"have sufficiently skilled staff and appropriate systems in place to enable them to meet future challenges."

I am sure that we will want to explore that wide issue when we have the chance in the new year. However, for now, given the concerns that the committee has expressed about the reliability of performance data that the Health Department produces, will the Auditor General say whether we should have similar concerns about the financial data that the department produces?

In the same part of the report, the Auditor General talks about the impact of late allocations of money to the service. Can he make available additional detail on that in advance of our sessions in the new year to inform our examination of that specific point?

Paragraph 19 of the report explains the balance of health service spending in Scotland. It states that, of the £7.5 billion that was spent in 2003-04, £7 billion was allocated to the service and £0.5 billion was used by the Health Department. Can the Auditor General provide us with additional information on how the £0.5 billion is utilised by the Health Department? I appreciate that other sources for that information are available. Has the Auditor General considered how decisions are taken about the use of that centrally managed expenditure?

Mr Black: In response to your first question about the quality of financial data and whether the committee could receive an assurance about the financial reporting, I can provide that assurance. This year, there were no qualifications on the accounts of any NHS body in Scotland. In general, the health service is good at coming close to or hitting the revenue resource limit and its other targets every year and the position with what might be called in-year financial management and control and financial reporting is sound.

I am concerned more about the forward financial management of the health service and the extent to which NHS boards rely on one-off funding to balance the books. The problem is that such a reliance might not address the underlying cost pressures that continue while new financial burdens are imposed.

As far as late and in-year changes are concerned, I draw the committee's attention to paragraphs 44 and 45 on page 11 of the report, where we have itemised the number of changes that some health boards have had to cope with. In the case of Tayside, which is one of the more extreme examples, there were some 100 changes to the revenue resource limit during 2003-04. Such a situation must make financial management that bit more difficult, not least because some of the changes are notified after the financial year has ended.

It is absolutely appropriate to acknowledge that changes will be made during the financial year as resources become available and special needs arise. For example, health boards can be under a

lot of pressure during the winter. Nevertheless, such significant changes to the financial target of the revenue resource limit over a financial year—and indeed after the end of a financial year—somewhat obscure and devalue it. I should also record that the Health Department recognises that there is an issue to address and is committed to reducing the number of such changes that it pushes through.

On the question about the £0.5 billion balance of funding, if the committee agrees, I will consider the matter and provide an answer at a future meeting.

The Convener: I am sure that that would be acceptable.

Mr Andrew Welsh (Angus) (SNP): I thank Audit Scotland for the report's clarity. The Auditor General said that the problem does not really lie with the reporting mechanism. However, I wonder whether it is a budgeting problem. Even at first glance, the situation is quite alarming. Sound finance is crucial to good service planning, but the overview highlights an air of unrealism within boards and in the department. After all, when is a balanced budget not a balanced budget? I suggest that that is when it uses ring-fenced, non-recurring expenditure; when it does not achieve savings; and when it does not make adequate resources available to tackle cost pressures. I find it alarming that the department and the health boards differ over the estimates of costs. If the reporting is good, which is an essential element, are we looking at problems of budgeting and allocation?

Mr Black: It would be reasonable to say that the department and the health boards converge on the estimate of future cost pressures. However, there is still some way to go, not least with regard to the GMS contract.

The somewhat challenging savings plans that health boards are having to introduce to meet future financial targets must also be a matter of concern. Pages 22 and 23 of the report set out three case studies of the current savings plans for Argyll and Clyde, Lothian and Greater Glasgow. Committee members will see that, in each case, it will be quite a challenge to achieve those savings and that a number of health boards face some real risks with financial and resource management. That applies not just to the three, quite large boards that we picked out as examples but more generally in the health service.

Mr Welsh: It bothers me that budget manipulations and strategies that appear to achieve an annual balance can hide or appear to overcome fundamental problems that are accumulating. We must address that.

The Convener: I think that that was a statement, rather than a question, which is fine.

George Lyon (Argyll and Bute) (LD): Will the Auditor General comment on the emerging trends in the boards that seem to be most under pressure? We are trying to drill down to ascertain whether the root cause is bad management or structural underfunding in relation to the money that the Scottish Executive makes available to boards. Is a pattern starting to emerge in which certain boards struggle to meet pay modernisation costs and to address the other factors that are driving increased costs in the health service in Scotland?

Mr Black: The financial recovery plans of six boards are based on savings to their cost base. In three cases—Argyll and Clyde, Greater Glasgow and Lanarkshire—the savings are substantial. The other boards that have put in place savings plans are Borders, Forth Valley and Orkney. The extent of the pressure varies, but each of those boards has put savings plans in place. In a number of cases, the plans will be challenging, as I think that the boards' managers themselves recognise.

George Lyon: Are there common denominators that indicate why the emerging cost pressures are so acute in those boards, especially in the three boards that you mentioned first—apart from the fact that they are all in or near Glasgow?

Mr Black: On the basis of our analysis, it is not possible to pull out generalities. Members of the committee will be aware that every board faces similar pressures, but there might well be local factors that circumscribe the amount of savings that boards must seek.

The Convener: If there are no further questions for the Auditor General, I thank him for answering those points. The scope of the questions indicates that that was a useful agenda item and the committee will return to the matter on 11 January. Before we move on, I welcome Duncan McNeil, whose constituency is in Argyll and Clyde NHS Board's area. He was courteous enough to let the committee know that he wanted to attend today's meeting.

"The 2003/04 Audit of Historic Scotland"

10:27

The Convener: Agenda item 3 is a briefing from the Auditor General for Scotland on his report under section 22 of the Public Finance and Accountability (Scotland) Act 2000, on the 2003-04 audit of Historic Scotland. Before we hear from the Auditor General, I mention to members that the report makes reference to a fraud case, in relation to which legal proceedings are active, so questions to the Auditor General must be on the broader issues that arise from the briefing. I will rule out of order questions on the specifics of the case.

Mr Black: The report is on the accounts of Historic Scotland for the 2003-04 financial year. It brings to the Parliament's attention an allegation of a sizeable fraud, which resulted in the suspension of a member of staff of Historic Scotland. A police investigation is currently going on. Historic Scotland considers that the suspected fraud might have been going on since 2001 and estimates the value at £112,000.

I am pleased to report that Historic Scotland appears to have taken prompt action in response to the fraud. An internal investigation uncovered a number of control weaknesses, which are being addressed. I expect the appointed auditor to monitor the action that has been taken, as part of the audit of the current year.

I am also able to say that the Scottish Executive has required all its executive agencies to examine their controls regarding such things as the segregation of duties and the use of the Government procurement card, which is also involved. That analysis and tightening of control are on-going.

As the convener indicated, there is a live court case and I will not be able to discuss in detail how the alleged fraud might have occurred, in light of the fact that a criminal prosecution might be considered at some stage.

10:30

Mr Welsh: The report states:

"Historic Scotland and the Scottish Executive have taken a number of steps to learn lessons and prevent recurrence."

Surely that means that the lessons learned in one area should be applied and tested throughout the Scottish Government system and assurances sought that effective financial checks and balances are in place throughout the system. What advice can you give us about ensuring that such lessons are being or will be applied throughout the system?

Mr Black: That is really a matter for the Scottish Executive. As I indicated, it has responded by taking a corporate initiative across the whole of the Scottish Executive. The auditors will be monitoring that and reporting as necessary.

The Convener: If there are no further questions, that is item 3 covered. We will consider the section 22 report on Historic Scotland in private later in the meeting.

"The 2003/04 Audit of Argyll and Clyde Health Board"

10:31

The Convener: Under agenda item 4, we will hear evidence relating to the committee's report in response to the Auditor General for Scotland's section 22 report on Argyll and Clyde NHS Board's accounts.

I invite the witnesses to take their seats and I welcome them to the Audit Committee. The representatives of NHS Argyll and Clyde are Mr Neil Campbell, who is chief executive; Mr James Hobson, who is director of finance; and Mr David Meikle, who is a divisional director. Before I ask them to give a brief opening statement, I thank NHS Argyll and Clyde for providing written evidence in advance of the meeting; it has been useful to the committee.

For the benefit of the public, the press and fellow MSPs who are not members of the committee I will set out clearly the focus of our evidence session today. The Audit Committee considers and reports on a variety of financial documents, including reports from the Auditor General for Scotland. That remit carves out a distinctive role for the committee, which is quite different from that of other committees, in that we hold to account those who spend public funds to ensure that they do so effectively and efficiently. In this instance, the committee is to examine the financial and wider management practice at NHS Argyll and Clyde and the way in which the Scottish Executive Health Department supports and monitors the performance of that health board.

It is useful to emphasise the fact that the remit of the Audit Committee is to examine financial not policy issues. We must make that clear distinction. That means that the committee will take evidence on the board's financial position, not on how its services are provided or on the changes proposed under its clinical strategy. I ask members to bear that in mind and I give fair warning that questions that, in my view, fall outwith that remit will be ruled out of order.

Therefore, our questions today will focus on the board's current financial position and on how that arose, and on its medium-term financial forecast. It is intended that the meeting will, if necessary, continue into the afternoon. We plan to break at 12 noon for a short lunch and will reconvene at 12.30 for further evidence. The committee may continue until no later than 2 o'clock, because members have commitments with other parliamentary committees. Because we have other agenda items to consider later, we look to finish taking evidence at 1.30.

I invite Neil Campbell to make his opening statement before we move on to questions.

Mr Neil Campbell (NHS Argyll and Clyde): I welcome the opportunity to make an opening statement. I hope that it will be useful if I take the opportunity briefly to set the context of the past two years in Argyll and Clyde.

It is two years and three months since the Minister for Health and Community Care intervened in Argyll and Clyde by forming a small task team, which comprised Peter Bates, who chaired the team and is chairman of NHS Tayside; Cameron Revie, who is a director with PricewaterhouseCoopers; and me. The outcome of that intervention was that the four chief executives who were responsible for NHS Argyll and Clyde at the time stepped down from their posts.

It is two years this week since the interim management team took over responsibility at NHS Argyll and Clyde. The opportunity today to meet the Audit Committee is a welcome part of the scrutiny of what has happened since then. During the past two years, a new senior management team has been appointed and one thing that each member of that team has in common is an absolute commitment to try to effect change in health services in Argyll and Clyde in the right way to bring the results that the population expects. That has required some significant and tough decisions to be taken.

The underpinning principle that the new senior management team works towards is that we do what needs to be done in an open and transparent way—in other words, with no smoke and mirrors. That is important, given the history of NHS Argyll and Clyde. Many of the problems that have dogged it for the past seven or eight years have been clouded in a degree of mystery and have not been open to the level of scrutiny that we, as the senior management team, believe is necessary.

The basis on which we have worked during the past few years follows closely the four key areas of work that the ministerial intervention team advised in its report to the Minister for Health and Community Care. Those four straightforward areas have formed what we call our road map for action in the past four years.

The first one is about achieving financial balance in NHS Argyll and Clyde. The advice that we were given, which went to the minister at the time, was that financial balance should be recovered over a period of five years, to ensure that the difficult action that would be necessary did not result in a catastrophic effect on services. The five-year recovery programme recognises the consequences of the accumulated deficit, and I am sure that that will be an area of discussion today.

Linked to that financial recovery is the second area that was advised to us: the modernisation of clinical services and the need to tackle the organisation and distribution of services, which were—and still are, to some extent—fragile, facing risk of collapse in some areas and in need of modernisation to bring them up to 21st century standards. That links into the financial strategy.

The third area is the development of a new corporate organisation and structure. Historically, one of the challenges that NHS Argyll and Clyde faced was a lack of coherent, corporate action to deal with problems.

The fourth area underpins the other three: the intervention team's most sensible and straightforward proposal was that, during all the change and difficult decisions, the show must be kept on the road, things must continue to move and progress must not be blocked. We must not be constrained in continuing to provide high-quality, appropriate services to our population.

I will outline briefly what we have done. We have certainly kept the show on the road. Over the past two years, we have avoided the service collapses that were likely in surgery—people are still receiving a surgical service throughout Argyll and Clyde—maternity services, gynaecology, anaesthetics and laboratory services. Not only are all those services still functioning well in Argyll and Clyde, but our performance against the national targets on waiting and access is as good as any in Scotland. That has been the case for the past two years, and I am sure that we can talk about that later. Waiting is one of the main judgments in that area, and we can talk about that, but we have also made two years of progress on tackling delayed discharge, which had been an endemic problem in Argyll and Clyde. The committee should remember that the background to that is that the delayed discharge position in other health board areas in Scotland has deteriorated; however, with partners, Argyll and Clyde has made significant progress.

On moving towards a more corporate team, we have a strong corporate organisation in Argyll and Clyde, where there is no inconsistency between policy decisions of the board and implementation. We have produced a clinical framework for major service reorganisation in Argyll and Clyde. The first part of that has been submitted to the Minister for Health and Community Care for his consideration and further work will be submitted to him in due course. There has been good progress on that, and there is a tremendous amount of clinical support for the proposed radical change.

Against a difficult background, we have had two years of steady progress on our financial balance and savings plans, which, I appreciate, are of major interest to the committee. We have had two years of real, on-the-ground savings. In year 1, we saved £13.5 million—we will talk about the detail of that later—and this year we are on target to achieve £14 million-worth of real savings.

The management team has had a huge amount of support during the past two years. That support has come principally from Argyll and Clyde NHS Board, which has a membership of 26, which consists of people drawn from a variety of groups within Argyll and Clyde—such as the clinical staff side and local authorities—and other members appointed by the minister. They have given us tremendous support for the difficult decisions that we have had to pursue over the past two years.

We have also had a lot of real support from our local MSPs. That has not been universal 100 per cent of the time, but we have received a tremendous amount of support from them and from councillors throughout Argyll and Clyde. I do not want the committee to think that it has all been sweetness and light and roses, because there has been a significant amount of challenge in that support, but it has been there for us.

Over the two years, we also received a huge amount of support from the former Minister for Health and Community Care, Malcolm Chisholm, for the work that we were undertaking on the four areas that I outlined, which had been reported to him a little over two years ago.

The Convener: Thank you, Mr Campbell. We will look into two spheres, namely the current financial position and the medium-term financial forecast. I invite George Lyon to start us off on the current financial position and its background.

George Lyon: I will start by trying to establish the background to the current financial position. As you are no doubt aware, Argyll and Clyde's overspend is the worst of all the board overspends in Scotland and predictions are that, over the next two or three years, the accumulated deficit will rise to £100 million—that is the figure that is bandied around. Will you outline for the committee what the board's financial position was when you took over in December 2002?

Mr Campbell: I will ask my director of finance to answer that question.

10:45

Mr James Hobson (NHS Argyll and Clyde): The ministerial support group was appointed in December 2002, in financial year 2002-03. At that point, it was being reported to the NHS board that there would be an in-year deficit of £9.6 million—that was the forecast for that year. The ministerial support group established that the underlying position was significantly worse. It is fair to say that there was a history of financial difficulties

within NHS Argyll and Clyde leading up to that point.

The actual outturn for the year was £9.6 million—that is what was reported in the audited accounts—but that was underpinned by more than £20 million of non-recurring income. When that was stripped away, the true position was in the order of £31.4 million.

The ministerial support group had estimated that the figure was between £25 million and £30 million and made a recommendation that that needed to be validated. The difference between the in-year reported figure in the accounts and the underlying position was largely made up of two elements of non-recurring money. One was about £8 million of what I would call normal non-recurring actions related to deferment of expenditure and so on. The balance was about £14 million of capital-based non-recurring income. It was a mixture of virement from capital to revenue and the proceeds of land disposal.

That was the position when Neil Campbell and I took over as part of the interim management team. We moved into 2003-04. I took on the ministerial support group's recommendation and identified that the opening position was of the order of £35 million.

George Lyon: Why had the board got itself into that position? What were the underlying causes? In which areas were the deficits being accumulated? Information has been supplied by the Health Department about the situation in NHS Argyll and Clyde. The overall surplus/deficit summary as at 31 October 2001 shows that the acute sector accounted for much of the forecast deficit of £6.5 million: it accounted for £4.263 million. In the primary care sector, each of the primary care trusts accounted for about £1 million. Can you go into the background of why NHS Argyll and Clyde got into that situation and how it camouflaged it in the outturn figures?

Mr Hobson: I have not looked back in a great deal of detail—that would be an interesting exercise—but it is clear from doing so that at that point, in 2001-02, there was probably a systemic recurring deficit of between £10 million and £15 million. It is fair to say that Argyll and Clyde Acute Hospitals NHS Trust probably had a deficit of about £4 million. It had also incurred an income-and-expenditure deficit in that year. Many of the underlying difficulties of NHS Argyll and Clyde as a system are a result of historical and geographical factors. There are many reasons why NHS Argyll and Clyde got into the position it did.

Mr David Meikle (NHS Argyll and Clyde): Over the period, in its financial management and financial planning, NHS Argyll and Clyde looked to develop services based on a range of efficiency savings and cost-reduction measures that it looked to reinvest in services. However, there was a double whammy, as the savings were not achieved and the developments that were introduced cost more than had been planned. Those two elements had a cumulative effect. That is part of the historical nature of developments in NHS Argyll and Clyde.

George Lyon: Can you give us some examples of what you mean by that? What investments took place that came in over budget and what cost savings were put in place that did not materialise?

Mr Meikle: I can give you some detail on the development of the renal service at Inverclyde, for example. The original assumption was that income could be clawed back from NHS Greater Glasgow when we introduced a satellite renal service at Inverclyde royal hospital, but that did not materialise, because additional patients were referred from other parts of Argyll and Clyde to Glasgow. A range of efficiency savings relating to prescribing at that time were heroic, but did not materialise because we did not put in the support structure to make them happen. That structure is there now, as you can see from some of the savings that we are making this year on prescribing.

Mr Campbell: I will relate the circumstances that have just been described back to what the support group found when it went into Argyll and Clyde. Although clearly defined savings plans were in place in the former trusts in the health board and there was evidence that savings were being made against them, at the same time other budgets were being overrun, which either completely absorbed the savings or, in the worst circumstances, were greater than the savings. We saw plans to save £1 million or £2 million through efficiencies in support services, but budgets in other areas, which were probably directly related to that, for overtime for ancillary staff, were overshot and would negate the savings plans. A number of things happened historically. Heroic savings plans were delivering savings, but without the management control on the other side of the house to hold budgets in line.

In the past two years, we have tried to demonstrate openly that savings have been made in identified areas and that we have held the budgets in other areas that it has been within our control to hold. I described the commitment of senior managers to having no smoke and mirrors. One of the things that we have tried to avoid doing—the previous regime fell into this trap—is to identify heroic cost reductions based on non-recurring money in the system. A land-sale receipt worth £5 million or £10 million would be identified as part of an in-year saving alongside another £5

million to £10 million of other savings. When the other savings did not materialise, we did not want to say, "We have already saved £10 million, but we have missed the other £5 million." If the £10 million was non-recurring funding, the perception of making savings was completely false. There was a degree of smoke and mirrors in the two or three years leading up to the intervention.

The problems in the system can accumulate in two ways. First, they create a deficit that has to be managed. Secondly, they completely change the perceptions of the people working in the system who are responsible for the savings. They feel as if they are doing their best and achieving what everyone else is achieving, but because of the smoke and mirrors, it is not real, and when we dig to find the savings, they are not there. If budgets are not held and savings are not delivered, there is a culture in which people believe that they are doing their best, but they are not achieving what they set out to do, and in which developments take place that are not fully funded. Then we end up with the kind of deficits that we are seeing in Argyll and Clyde now, which have to be managed out. Of course managing out the deficits is far more painful three years on than it would have been if they had been tackled at the time.

George Lyon: I seek clarification on one further point before I move on to the actions that you took to address the financial position. Is it true to say that most of the overspend was in the acute sector or in the primary sector? The figures that we have seem to indicate that it was mostly in the acute sector. Was the acute trust severely out of control?

Mr Hobson: The acute trust had the recorded income-and-expenditure deficit and so probably had the greatest financial pressure. It is fair to say that the acute trust had a significant deficit of probably £4 million to £5 million. Renfrewshire and Inverclyde Primary Care NHS Trust probably had a similar underlying deficit. Broadly speaking, I think that Lomond and Argyll Primary Care NHS Trust was fairly close to financial balance. The health board part of the system had a significant reliance on non-recurring income, so that would have been a component of the deficit.

At that time, the system reported as four discrete organisations, so it was difficult to pick up where exactly the deficit lay. The ministerial support group's report, which was latterly validated by the interim management team, was the first time that anyone had examined the issue on a system-wide basis. Indeed, part of the problem was that deficits were not being examined or reported on a system-wide basis. For example, under the former regime, the health board could rightly report a position of balance even when a trust had an underlying deficit.

Mr Campbell: As with all such things, the issue is much more complicated, as it was not simply about where the budget deficit lay. A perhaps more useful perspective is to examine the level of resources that Argyll and Clyde NHS Board receives from the Scottish Executive's health vote. In terms of population, Argyll and Clyde is funded at around—or just marginally above—the Scottish average. As I said in my opening comments, over the past two years, Argyll and Clyde NHS Board has successfully provided acute services with funding that is broadly in line with the Scottish average. It would appear from that argument that, taking into account our population, we are funding acute services at or about the level that is appropriate to the resources that we receive.

However, over those past two years, we have paid substantially above the Scottish average for many of our priority services, such as mental health, learning disability, older people and maternity services. The most extreme difference is in mental health services, for which we pay something like £17 million or £18 million more than the Scottish average. For maternity services, we pay £5 million more than the Scottish average. For services for older people, we pay about £3 million or £4 million more. I think that all the figures are in the evidence that we submitted.

Although one reading of the report is that acute services did not perform within their budgets, acute services were by and large funded at a lower level by, or received less income from, the then health board than the pro rata level that went into priority services. The adjustment that we are trying to achieve, which is linked to our clinical strategy, will adjust our overall spend to a level that allows us to support all the services within the health board area within a more equitable framework. That does not mean that all services will be funded at the Scottish average, because we need to take account of geography and of particular initiatives, such as delivery targets, that are required of us. However, we need to get much closer to an equitable level of funding than has historically been the case. Therefore, it is not simply a matter of saying that the deficit related to acute services. It is not accurate to look at the matter in that way.

George Lyon: What actions have you taken to stabilise the financial position since you joined the board two years ago? Clearly, one of the fundamental challenges must have been that there was no set of accounts to demonstrate the financial position of Arygll and Clyde NHS Board.

Mr Hobson: From a financial perspective, the first thing that I did as a member of the interim management team was to assess the opening position. As I said, we established that the system faced a potential shortfall of £35.5 million for 2003-04.

George Lyon: When exactly did you establish that figure?

Mr Hobson: I will explain how I established the figure. I examined the baselines for all the component parts of the system; it was really the first time that had been done on a whole-system basis to try to capture the total income and expenditure of the system. Under the health board-and-trust regime, there was a lot of inter-company trading and so on, so it was a question of stripping that out and looking at the whole picture of what the system faced. Establishing the baseline was the first issue.

11:00

Mr Campbell: If I can interrupt at that point, it is important to emphasise the context. There were four distinct organisations in Argyll and Clyde and, although that might be a description of many parts of Scotland before the health plan began to address that problem, the distinctness was pronounced in Argyll and Clyde. The three trusts and the health board behaved as if they did not have a relationship with each other, so it was quite normal for the board to say, "Well, we're in a balanced financial position. Here's our year-end and our income and expenditure match. The acute trust's £4 million problem is for the acute trust to sort out, and the problem in the primary care trust is theirs." The same views would be exchanged between the trusts, which was a completely unrealistic position.

Because we have created single systems throughout Scotland during the past two years, we now look on that kind of behaviour as being completely bizarre, but that was how business was transacted. Not only was there that level of complete disregard for the success of the whole system based on people working together, but the situation was valued. People said, "It's not our problem—it's someone else's." It seems ridiculous and bizarre that that is how people behaved, but I am afraid that that is how it was. Argyll and Clyde was an extreme case, but it probably was not as extreme as some parts of Scotland.

Mr Hobson: I left off when I was talking about establishing the baseline that was rolling into my first year. The next part was to consider what was going to add to that baseline. We considered potential cost pressures and assessed inflation and other factors and commitments that had already been entered into. For example, in 2003-04, there was the impact of national insurance, the low pay deal, and the new deal. We tried to get all those planning estimates for that year so that we could put together a robust financial plan or projection.

In the history of financial plans and projections that were submitted by NHS Argyll and Clyde, it is fair to say that the financial planning mechanisms that were in place were not particularly robust. We therefore wanted a robust plan and projection that used the assumptions that were in place at the appropriate time.

Obviously we had—as part of the interim management team—committed to putting together a programme for how to recover the position. We used the intelligence that we had at the time to draft an outline of how to get the system back in balance, which meant applying a savings target within that financial plan to recover, over three years, the deficit that was forecast at the time. In effect, that meant that we applied a savings target of £13.2 million for that year, followed by two similar savings targets. The world has moved on since then; I am sure we will talk about the changes at some point. So, our initial action was to validate the baseline, look realistically at what was going to add to it, ensure that there would be no unjustified or unnecessary addition to the cost base, and apply a more robust savings programme than had previously been applied. It is important to say that there was an emphasis on trying to achieve recurrent savings; previous savings programmes had been largely non-recurrent in 2001-02 and earlier years.

Mr Campbell: We would not want the committee to think that there was anything particularly strategic about what happened in 2002-03. We hit the ground not running, but stuck in the mud. It is not possible to walk into an organisation that has been decapitated and expect it still to function. We were dealing with a non-functioning organisation at the beginning of 2002-03. We had to build capacity and try to achieve a position in which we could take the organisation forward. We did not start from a comfortable position; there had been a systematic service collapse in Argyll and Clyde, particularly north of the River Clyde and around the Lomond area, where we were losing major services. We had to dig ourselves out of the mud before we could do anything.

In year 1, which was 2002-03—one year ago—we set out to try to save £13.2 million, of which as much as possible was to be saved on a recurring basis. We looked across the system and went into areas where we thought we could find savings. There was nothing particularly strategic about that; we took the sort of action that is taken every day in Scotland—not just in the health service, but throughout the public sector—to be efficient and effective and to continue to deliver services. When we expanded budgets, we tried to make savings elsewhere to match that expansion. Although our saving by the end of year 1 was £13.5 million—of which about £7 million was recurrent—we incurred other significant costs in that year, some of which we managed in-year and on a recurring basis, and

some of which added to our cost base in subsequent years, particularly in relation to sustaining, for example, surgical services.

Mr Hobson: To complete the picture, in 2003-04 we established the baseline and savings targets and aimed to achieve a planned in-year deficit of £22.3 million. In the event, the Treasury accounting rules changed and £9.6 million from the previous year had to be added. However, if we stick to the in-year position against the allocation, our planned position was a deficit of £22.3 million. In the event, the outturn was £25.8 million. Obviously, there were overspends and underspends against that, but the main components of the position were the change in Treasury rules, which limited our capacity to vire from capital to revenue against our original planning assumptions and created a £1.3 million pressure, and the excess against the original planning assumption for the cost of the consultant contract. As I said, compared with the assumption in the plan at the time—which was adopted throughout the health service—the actual outturn was higher, so the accrual for back pay was in excess of the original planning assumption.

Broadly speaking, in our first year we delivered the baseline budgets that we set at the start of the year, which was quite a good performance. We applied quite a hard culture in managing the position, because our commitment was to minimise the deficit. We achieved the savings target that we set in our first outturn year, albeit that it was not all on a recurring basis.

George Lyon: Did you say that the change in Treasury rules meant that the deficit had to be carried forward?

Mr Hobson: Yes. Previously, if a system incurred a deficit, it could be offset against surpluses within the system and the Health Department could offset it against other Scottish Executive budgets.

George Lyon: Does that mean that the deficit would be written off at the end of each year?

Mr Hobson: In effect, yes. Under the old regime, the deficit was written off at the end of the year. Under the new rules, that capacity no longer exists for the Health Department, so an adjustment is made. The £9.6 million from the previous year was therefore added to our planned deficit of £22.3 million, so our in-year deficit was the cumulative deficit. The same situation will apply in the current year, because a similar adjustment will be made. The deficit that is reported in the in-year income and expenditure account is the accumulated deficit. However, a large proportion of that is historical.

George Lyon: What impact does that deficit have on your cash position for the next financial year? Does it simply sit on Argyll and Clyde's books as an accounting entry or does it impact on the following year's spend?

Mr Hobson: The deficit is largely an accounting entry, so it sort of sits on our books. Our understanding with the Health Department is that we can draw down cash as required, so it does not restrict our ability to access cash or impact on our liquidity or cash flow.

George Lyon: So, you are still able to spend the full uplift and baseline budget that the Executive allocates at the start of each financial year.

Mr Hobson: We receive the baseline budget allocation, which is what we manage our finances against. However, that allocation is adjusted to include payback of any deficits that have been incurred in the previous year.

Mr Campbell: The question is really important—

George Lyon: I am simply trying to get to the bottom of the impact of the deficit.

Mr Campbell: Each year I am, as Argyll and Clyde NHS Board's accountable officer, in breach of the memorandum of accountability because we set out to spend more than we receive in income. That is simply the position that we find ourselves in. It is not a pleasant choice; we did not sit down and think that it would be a good idea. Because of the change in the Treasury rules, we will spend in excess of our income each year, even when we are back in in-year financial balance. In other words, our books will show the accumulated deficit as an in-year deficit even when we are back in in-year balance because each overspend is deducted from our allocation during the year in which the allocation is made.

The £9.6 million accumulated deficit for 2002-03 was deducted from the board in that year, which meant that at the end of the year our books showed an in-year deficit and the accumulated deficit. Our in-year deficit was £25 million which, when the accumulated deficit of £9.6 million was taken into account, took us to £35 million. This year, after saving £14 million, we will have an in-year deficit of about £25 million, added to which will be the £35 million that we built up last year and the £9.7 million deficit that was built up before the interim management team was brought in. As a result, as the accountable officer, I am in effect committing £60 million that we do not have.

The issue comes down to the technicalities of bookkeeping. We have been put in the extremely serious position of having to plan outside the rules of accountability. The situation also seriously impacts on our attempts to have meaningful discussions about major service reform with the various stakeholders throughout Argyll and Clyde, because they see reform as being driven by our

financial problems. Although it is a component of the reforms, it is not the main driver.

Our position also impacts on our attempts to give a public account of our performance. Although I know that we are making progress with an enormously challenging agenda, it does not look as though we are. Indeed, with headlines in the media about £100 million black holes, it is certainly not made to look that way. I can demonstrate that we are starting to come out of the black hole and that over the next few years our in-year financial performance will be as good as anyone else's in Scotland. If we continue to perform as well in the other three key areas that I identified—I believe that we can—we will be performing alongside the best. However, it will not look like that.

George Lyon: I think that everyone is clear about that.

The Convener: Before we go on, I point out that although it is now 11.14 we have completed only the first of the 14 groups of questions. I am concerned about time, so I ask members to roll their questions together where appropriate. Given that we now have a good contextual background, I ask witnesses to send us written evidence, if they wish to give context to their figures. That would be easier and would speed things up.

11:15

George Lyon: Contextual questions are always going to be important.

The Convener: Indeed. I appreciate that.

George Lyon: Let us turn to the present. You have given us the background on what you inherited and what actions you took. What is the current financial position and what is the projected year-end position?

Mr Hobson: Our planned position for this year is to have an in-year deficit of £25.4 million, compared to an in-year deficit of £25.8 million last year, after applying a savings target of £14 million. We are reasonably confident that we will meet that in-year target.

George Lyon: I seek clarification on the Scottish Executive's role in helping you over the past two years. Two letters on the accountability review were sent by the Scottish Executive to John Mullin, the chairman of Argyll and Clyde NHS Board. Both the August 2003 letter and the August 2004 letter mention the need for a recovery plan. Was it the same recovery plan or different recovery plans the Executive was asking for? Perhaps you can explain what that is all about and what support you are getting from the Health Department, given the difficult position that you inherited and the way in which you are trying to recover the position. What assistance is the Executive providing? For some of the changes that you are making there might be one-off bridging costs, the cost of doubling-running services and so on.

Mr Campbell: It is a very complex area that you ask about, so I will try to keep my answer simple. The requirement two years ago was for us to submit a financial recovery plan. We have repeatedly submitted the same financial recovery plan, taking account of a range of challenges that have been given to us by the Health Department to provide clarity around the plan. What we have not been prepared to do—it would be inappropriate—is to change the basis on which the recovery plan was designed.

George Lyon: There are other more detailed questions coming up. Could you please clarify whether it is the same cost recovery plan that is referred to both times? That is all I want to know.

Mr Campbell: Yes—it is the same plan. We have not been asked for a different one.

Mr Welsh: You said earlier that you want to get closer to an equitable level of funding. How much do you mean by that?

Mr Campbell: How much?

Mr Welsh: Yes. What would be an equitable level of funding?

Mr Campbell: Let me clarify what I meant. Across Argyll and Clyde, we have an amount of money allocated to us on the basis of our population. We are funded marginally above the Scottish average, based on the Scottish vote formula. We need to commit that resource more equitably within Argyll and Clyde than we currently commit it across the range of services. It is inappropriate for us to spend far above the Scottish average on one basket of services and far under or just at the Scottish average on other baskets of services. We need to get nearer to a balance.

In mental health services, for example, we are spending £17 million or £18 million a year more than the Scottish average. We do not have the best mental health services in Scotland, yet we are spending that much more. We are spending just about the Scottish average on acute services. We need to get our spending on mental health services nearer to the Scottish average, rather than far above it. That is what I meant when I talked about equitable spend.

Mr Welsh: Yes, but you said that it was inevitable that your expenditure would be greater than your income. You also said that you want to get closer to an equitable level of funding. Again, I ask: what figure do you have in mind?

Mr Campbell: I was not suggesting that the level of income that we have is not equitable.

Mr Welsh: On Treasury rules, you say that it is inevitable that spending will exceed income. What do you have in mind as an equitable expenditure level for NHS Argyll and Clyde?

Mr Campbell: The level of funding that we commit should be that which we are allocated by the Health Department as our fair share of the Scottish vote. That is the equitable level of funding that we should spend in Argyll and Clyde. However, spending must be equitably distributed. We cannot spend substantially more than the Scottish average when we are funded on a weighted basis at the Scottish average. We should not spend substantially more on any of our services. There will be differences in how we spend money because of local prioritisation, but not to the extent of the current extremes. The areas that make the greatest contributions to our getting back into balance will be the areas in which we are spending most above the Scottish average, rather than those in which we are spending least.

Mr Welsh: Are you saying that your present level of funding is adequate and that you want to rebalance expenditure within the overall total?

Mr Campbell: I am saying that the amount is formula based. As the accountable officer, I am responsible for ensuring that we spend only within the formula allocation that has been made to us. I want to ensure that there is more equitable distribution of the money across the services that we provide in Argyll and Clyde.

Mr Welsh: I move on to the "smoke and mirrors" that you mentioned and the use of non-recurring funding in annual budgets. How much non-recurring funding has been used in your budgeting in recent years?

Mr Hobson: There is about £20 million of non-recurring funding in our financial plan for this year. We have an in-year outturn of £25 million, which is supported by about £20 million of non-recurring funding.

Mr Welsh: What would have been the effect on your 2003-04 budget of not using non-recurring funding?

Mr Hobson: The outturn would have been about £46 million.

Mr Welsh: That bothers me, because on 12 February 2002 the Scottish Executive warned you that there was no

"comprehensive and clear view of the individual and collective deficit positions"

and that there was reliance on

"non-recurring income and capital receipts to achieve financial balance in 02/03 and 03/04."

I believe that the planned deficit for 2003-04 was £22.3 million. In reality, the deficit was £35.4 million, but if ring-fenced and non-recurring funding had been stripped out the operational deficit would have been £50 million. I have heard the figure of £35.4 million being agreed to. Do you accept that, if we had stripped out ring-fenced and non-recurring funding, the deficit would have been £50 million?

Mr Hobson: The deficit would have approached £50 million.

Mr Welsh: If the substantial recurring costs must be removed from your operational base budget at the same time as you are absorbing organisational change and pay rises, how and when will you do that?

Mr Campbell: The fees to which you refer are outlined in detail in our financial recovery plan. The year in which we will return to in-year balance is 2007-08. That will be underpinned annually by continued use of some non-recurring money in NHS Argyll and Clyde. There is nothing wrong with our using non-recurring money on an annual basis. The major danger against which all health systems need to guard is large-scale use of that money. In 2007-08, when we will be back in recurring balance, we plan to use about £5 million or £6 million of non-recurring money, compared with £20 million this year. We are trying to get the right balance between recurring and non-recurring funding. It is planned that we will be back in in-year recurring balance from 2007-08. The non-recurring moneys that will be used will amount to about 1 per cent of our income.

Mr Welsh: The problem with non-recurring funds is that they must be replaced. The financial juggling that has taken place from year to year seems to have served only to disguise the real deficit and to create a cumulative real deficit. That must store up present and future problems. In other words, there is a projected £100 million of cumulative deficit by 2007-08. How will you cure that, or will you just ignore it?

Mr Hobson: I refer to the accountability review letter. The context is that the historical financial plans for Argyll and Clyde relied heavily on non-recurrent funding. Our current financial plans also rely on non-recurring funding of the same magnitude. That is not necessarily a bad thing, because it minimises the gravity of the in-year situation, which is quite important. A balanced financial system can use non-recurring funding to invest or to use as transitional finance. A system such as ours relies on it to minimise the deficit position.

In the forward financial plan that we have prepared, our aim is to reduce reliance on non-recurring funding. The only way we can do that is

to generate recurring savings and erode our current cost base. That is the basis of our forward financial plan, which basically involves pulling—we have still to pull about £35 million out of our cost base recurrently. That is the planned action over the recovery period.

We have not built heavy reliance on non-recurring funding into our financial plan. If we can generate more non-recurring funding we will do, because that is good management and will give us that wee bit of headroom that we do not currently have. That would also have the impact of reducing any in-year—and therefore accumulated—deficit.

Mr Welsh: There are problems both with on-going and with cumulative finance. If there is a cumulative deficit of about £100 million, do you have any plans to get rid of that accumulated deficit?

Mr Campbell: We expect the cumulative deficit at the end of our plan to be about £73 million. It will peak at £77 million or £78 million and will end up at about £73 million.

Mr Welsh: What do you expect to do with the deficit?

Mr Campbell: We cannot within the Argyll and Clyde NHS system recover that accumulated deficit. It is beyond the means of the system to generate a non-recurring resource of the magnitude of £73 million. From the very beginning of the debate around the challenges in Argyll and Clyde and intervention there, it has always been a clear part of the discussion that there would be an accumulation of deficit by the end of the process of recovery, because it takes five years to recover from financial problems of the magnitude that exist in Argyll and Clyde.

The problem is an accumulated one. The changes that have taken place in the Treasury rules as the process has gone on have meant that, instead of there being a back-office accumulation, the accumulation has been very much to the fore: it is seen annually, which makes the problem more stark. The problem has always been there, however. If a recovery programme is run over a number of years, there is a generation of accumulated deficit. We have no ability to repay the accumulated element of the deficit in Argyll and Clyde.

We have—this requirement was placed on the interim team and on the current team at Argyll and Clyde—focused on managing the finances in-year and getting them back to a balanced position where we are in control of the finances and are making decisions based on realistic resources coming into the board.

We will take any opportunities to minimise the accumulated deficit by using non-recurring moneys, but the predicted £73 million—with the peak being at £78 million—is beyond our ability, as a single system, to repay.

Mr Welsh: Forgive me for saying this but, in normal finances, running at an annual loss and simply piling that up is a cumulative loss and would seem to be the road to financial perdition. If you end up with a cumulative deficit of about £75 million in 2007-08, who will pay for it? Will it just be written off?

Mr Campbell: We are not really in a position to say what will happen to it. I suspect that other witnesses whom the committee will call in due course will be able to describe better how the deficit will be paid for. The approach at Argyll and Clyde—with the clear accountability that we have undertaken to maintain—is to restore financial control within the system and to have a clear plan for achieving the necessary savings to get back into that situation of financial control. The ability to repay an accumulated deficit of £73 million is certainly outside the scope of any health board in Scotland.

Mr Welsh: You have just said that you want to restore the financial situation. There is evidence of turmoil within the finance system in respect of

"a significant number of presentational adjustments … difficulties in extracting financial information … in the form required by the new manual"—

that is, your uniform board accounts manual—in respect of "late changes" in property revaluation, a disjointed management structure and the lack of a settled risk management strategy.

Furthermore,

"performance management reporting is still being developed"

and

"a strategic Information Management and Technology (IM&T) plan is not yet in place."

Do you believe that your system is suitable to achieve accurate financial budgeting?

11:30

Mr Campbell: Much of your description relates to the previous regime. I assure the committee that the evidence is that our organisation is stable and well structured. We can give a clear account of commitments and resources and we have appropriate management structures in place to bring about savings, which we have demonstrated in the past two years.

Mr Hobson: One of the biggest advantages of the single system is that we can unify financial processes—we now operate with one ledger, not four. The finance functions have been reorganised and we have changed roles and responsibilities.

Our actions in the past two years demonstrate that we have a much better budgetary control system, although it is still not perfect and we will continue to develop it. We have more accurate forecasting information and a better idea of the way forward. We are evolving, but our control is significantly stronger than it was when I arrived as part of the interim management team.

Mr Meikle: I can reinforce that from the operational perspective. In the past two years, we have got financial control of NHS Argyll and Clyde. Local managers and clinicians understand the financial difficulties and challenges and we are going forward together. The build-up of cost pressures in the system is not the same as it was; pressures still exist, but we are managing them within the budgetary control system, which is integrated and unified within NHS Argyll and Clyde.

Mr Hobson: I return to the point about the changes to the accounts manuals and to the revenue resource limit. All the NHS systems in Scotland face those issues, as they face, for example, the late finalisation of the valuation. Like every other system, we have had to cope with those changes.

Mr Welsh: I am bearing in mind the convener's strictures, but I ask the witnesses to clarify what sources of non-recurrent funding are now used.

Mr Hobson: In the current year, we have assumed approximately £20 million of non-recurrent funding, which can be split into two components. On income, we will vire £5 million from our capital allocation to our revenue allocation. We will generate around £10 million from two principal sources—either from additional non-recurring allocations that we will receive in the year or from deferred expenditure, such as slippage against ring-fenced income. That is part of normal financial management practice. The other non-recurring support that we have in-year is from any non-recurring savings that we generate. Obviously, that supports the bottom line; if you like, it is income in reverse so it contributes to the non-recurring support in the system.

Mr Welsh: Can you assure us that those measures—deferred expenditure, for example—have no effect on services?

Mr Hobson: When we are allocated funding for a specific purpose, we honour the purpose for which it is intended, as far as possible. When we get an allocation for something, it often takes time before the infrastructure and the service can be initiated, which provides a benefit at that time. However, we ensure that any funding that we get is used for the purpose for which it is intended. As part of the openness in our financial position, we carry such allocations forward in our financial plans so that they are absolutely visible to people. If we have an allocation of £300,000 for audiology, we show the non-recurring impact of not spending it, but the money sits in the financial plan for future use when it is required.

George Lyon: I move to the underlying cost pressures in 2003-04 and prior years. I want to get to the bottom of the main financial pressures that affect your ability to sustain current service levels. What are the main challenges that you have to meet at present?

Mr Hobson: Over the past two years, many of our main financial challenges have been around the pay modernisation agenda, of which there are a number of elements. The consultant contract, the GMS contract and the agenda for change—which is currently being implemented—are probably three of the main financial pressures and will probably add around £20 million to our recurring cost base over a two-year period. We have had other pressures this year—they apply to every board in Scotland, although they apply more to some boards than to others—including the revaluation of the NHS estate. We were one of the significant losers in that exercise, which has placed an additional pressure of £3.7 million this year.

George Lyon: Are all the cost pressures from pay modernisation initiatives fully funded in your allocation from the Health Department? If not, how will you fund them?

Mr Hobson: They are not specifically funded in the allocation from the Health Department. In general, our allocation uplift is meant to include all pay and price inflation, so, by definition, any shortfall against that uplift is not fully funded.

George Lyon: How is the calculation done at departmental level? From what the Auditor General said earlier—which you might have heard—there seems to be an argument about what the boards are reporting as the costs of the GMS contract, for example. Given that you employ the doctors, one would think that you should know about that and about the allocations. Can you explain how the calculations are done at a national level? Are they done through Arbuthnott?

Mr Hobson: I cannot comment on how the calculations are done at the national level.

Mr Campbell: I am sure that the committee will want to debate the issue with other witnesses in due course, but we can try to give the consultant contract some context—it is important to add context. Our financial plan is based on our allocation. As we receive our allocation, assumptions are made that are based on our population. We received our allocation and then planned for meeting the costs of the consultant contract. The plan that we set included a 7 per

cost for implementing the consultant contract. We based our assumptions on that figure; we also assumed that the resource that we received would match that cost. However, although we based our plan on the figure of 7 per cent, by the time that implementation was completed, the figure was 24 per cent.

George Lyon: What was there a 24 per cent increase in?

Mr Campbell: There was a 24 per cent increase in the payroll costs of consultants.

George Lyon: So that was a 24 per cent increase in consultants' pay.

Mr Campbell: There was a 24 per cent payroll increase. The difference is that that figure does not relate to individuals—the increase might have been greater for some and less for others.

George Lyon: Right—but that is the average pay increase.

Mr Campbell: We assumed a figure of 7 per cent and our assumption about our allocation was that there would be funding of 7 per cent to meet that cost. An additional allocation was then made towards the difference between the two figures. The bottom line of our starting point for last year was that, if we took our total uplift for Argyll and Clyde against the known costs, we were looking at around a 120 per cent commitment to meet extra costs within the system at the beginning of the year.

The expectation of every health system is that there is a local prioritisation and efficiency process that balances the difference between uplift and the actual costs in the system. That is a reasonable expectation most of the time. We must work to become more efficient and to revisit practice and resource commitments. The double problem in Argyll and Clyde is that we are starting from a position of being financially challenged. We have major financial pressures. We must deal with that whammy in managing additional costs.

The second significant pressure that we must think about is that, once we produce financial plans to make savings in order to develop services or to reach a financial balance and those plans are set, we have to revisit the plans if there are changes to the external parameters around them, which can have a major impact on how we deliver our targets. That was why, in 2002-03, although we assumed that a £13.2 million saving would bring us into a £22.3 million year-end position, we ended up being in a £25.8 million year-end position.

George Lyon: Because of the extra costs of the consultant contract.

Mr Campbell: Because of the extra costs and the changes to the rules. That is where the consultant contract gives Argyll and Clyde a particular problem, because everything is open and in the public domain. Perhaps that is where things should be, but it makes management very difficult.

George Lyon: I want to move on to deal with the cost pressures of the GMS contract and how that is impacting on your bottom line, but I have one final point on the consultant contract. The basic idea behind the consultant contract is that it will raise the amount of time that consultants commit to the NHS from 20 hours to 30 hours. How many consultants in Argyll and Clyde were working below the 30-hour threshold that is specified in the new contract?

Mr Campbell: It might be better if I were to provide a written answer on that, but from anecdotal evidence, my view is that not more than a handful of consultants in Argyll and Clyde, if any, were working for less than 30 hours.

George Lyon: So the consultant contract has produced no increase in activity.

Mr Campbell: I could not demonstrate that we had an increase in activity as a result of the consultant contract. If it would be helpful, we could submit some written detail on that, so that you have the facts rather than my speculation.

George Lyon: In other words, consultants have had a straight pay increase; no extra performance or activity has resulted from the contract.

Mr Campbell: That would appear to be the case.

George Lyon: Can you explain what the financial impact of the GMS contract for general practitioners has been? Has it been fully funded?

Mr Hobson: Two main pressures have affected the impact of the GMS contract this year. The first is the additional cost of out-of-hours provision. Our estimate of the in-year effect of that for this year is £3 million, which is not funded. That will rise to a full-year impact of £5 million, because the out-of-hours service started only part of the way through the year.

The second pressure comes from the quality and outcomes framework. We are funded on the assumption that practices will achieve a certain percentage of the points that are available under that framework. At this stage, it is likely that they will underachieve against that assumption, but we will not know what the final figure is until the end of the financial year. We face a potential shortfall of £600,000, so the in-year impact on our funding of GMS is that it will present a challenge of about £3.6 million this year. That will rise when the full-year impact is felt.

Mr Campbell: I appreciate that, as members of the Audit Committee, you are interested in the financial flows and that your questions on the

GMS contract and the consultant contract will relate directly to that. However, there is much more to both the modernisation programmes in question than just pay rises and the number of hours of availability. With the contracts, we are investing in the future. I genuinely believe that they represent important policy decisions in that they will allow practice to be reformed in the future and will encourage recruitment and retention. There is much more to the modernisation programmes than simply the number of hours of staff availability in which they result and the amount of money that we pay for them. Although I accept that it is important to make judgments on those matters, I would not want to give the committee the impression that we were not committed to, or interested in, the modernisation opportunities that the contracts present. We will pursue that agenda over the coming years and we will obtain substantial gain from the contracts in due course.

George Lyon: The committee's role is to explore economic performance issues. In relation to the GMS contract, Mr Hobson mentioned figures for the extra cost of £3 million and £5 million. Did you say that that extra cost was funded or was not funded?

Mr Hobson: That would be the additional cost that we would expect—

George Lyon: And the uplift figures cover that?

Mr Hobson: No. From our submission, you will see that, if that is factored into the uplift table, a sort of shortfall against the uplift of £6.8 million results. Although the cost is built in, because there is no specific earmarked stream in our allocation for GMS funding, it is not possible to identify it. If we look at the totality, the cost is not fully funded.

11:45

Mr Campbell: Again, it is important that we do not leave the committee with the impression that we think our problems are simply to do with the uplifts around those contracts. Although they are a contributing factor in terms of trying to achieve financial balance, if we were an organisation that had begun from a position of financial strength, it would not be so difficult to manage the level of financial pressure that results from them within an income of £585 million; in fact, the task would be more straightforward. However, as I have said, we started from a position of having an in-built financial problem.

George Lyon: I will move on to address the problems that you face. In recent years, other NHS boards have faced similar financial pressures—they have the same costs and so forth as you have. Why has the failure to manage the finances been so much worse in Argyll and Clyde than elsewhere? Is it just the historical situation that you inherited or is there something inherently wrong in the uplift calculations? I note from your earlier evidence that you think that the Arbuthnott formula is okay.

Mr Campbell: That was not quite what I said.

George Lyon: We would like to hear your view on the matter.

Mr Campbell: A number of issues are involved and I will try to make some sense of them. We are in a really difficult position because of the point at which we started. When I say "we", I am talking about the current management team that has been in place for two years and which started from a particularly difficult base.

Those two years have been particularly difficult years for the NHS in Scotland. In fact, the Auditor General's latest overview report indicates that the past year has been a really challenging year for Scotland in terms of performance and finances. We had a very bad starting position—indeed, no one would have wanted to start from that point. That is the first bit of the story.

On the formula and our allocation, I said that we receive our fair share based on the formula. The formula applies equally across Scotland and the amount that we receive is proportionate to the Scottish Executive's vote for health. It is fair in that context.

We have a particularly challenging environment in Argyll and Clyde. I suspect that almost any other board would give the committee the same sob story, but I will describe ours. We have 26 inhabited islands, a geography that takes in 2,500 square miles, significant rurality—although it is not that different from other rurality—and the added factor of remoteness. Our population is clumped in groups around our major conurbations, which is where some significant social deprivation is to be found. In some of those areas, our social deprivation factors are as bad as the worst in Scotland.

Argyll and Clyde has a dreadfully poor communications infrastructure in terms of its road, rail and air links. The distribution of the population is sparse in our rural areas. When historical factors are added, one finds that to serve a population of 400,000 we have four district general hospitals that are solely Argyll and Clyde hospitals: three of them have been full-blown district general hospitals and the hospital in Oban is, in all senses bar size, a district general hospital. However, in addition, we are supporting the infrastructure costs of another district general hospital in Glasgow. We spend £57 million in Glasgow. Instead of our allocation going to support our infrastructure in Argyll and Clyde alone, we also have to support part of the infrastructure in Glasgow, because of the amount

of activity that goes into that city. Such infrastructure cannot easily be sustained. In fact, it is entirely impossible to support it, which is why are going down the route of developing a vision for clinical services.

The answer to your question is complex. However, we are funded fairly on the basis of the Scottish vote, which is significant. Members will be well aware of how the allocation has increased. However, we face the particular pressures that I have outlined. Whether the formula fully takes account of them is a debate that probably needs to take place elsewhere.

George Lyon: You touched on the levels of cross-boundary financial flows, particularly those to NHS Greater Glasgow. You outlined one figure, but can you give us more detailed figures for cross-boundary flows both ways? I take it that there is a little cross-boundary flow back the way.

Mr Campbell: I will give you an overview and James Hobson will pick up on the detail. We will spend £57 million in the current year with NHS Greater Glasgow, which is split about 50:50 between spending on what we would call bog-standard district general hospital services—I probably should not use that term—that could be provided within Argyll and Clyde but which, by choice or referral, are provided in Glasgow, and spending on tertiary services that can be provided only in Glasgow.

Within that £57 million, Glasgow also provides a number of waiting list initiatives on our behalf. We will continue to debate the cost of those with NHS Greater Glasgow. In addition, an exercise is going on in the west of Scotland that is looking at Glasgow's wish to re-base the costs. Glasgow's view is that west of Scotland boards do not pay enough for the services that it provides for their residents. The figures for cross-boundary flows into Argyll and Clyde are marginal and insignificant.

George Lyon: So you are saying that, at the beginning of each year, about 12 or 13 per cent of your budget is automatically chopped off and regarded as part of Glasgow's budget.

Mr Campbell: Yes. We work on the assumption that around 15 per cent of our budget is tied up in consumables.

Mr Meikle: We work on the basis of 60 per cent pay costs, 15 per cent supply costs, 15 per cent site-sustaining costs and 10 per cent going into NHS Greater Glasgow. That amounts to roughly 100 per cent of our allocation.

Margaret Jamieson: Two years ago, Mr Campbell, you moved from the task force to an appointment as chief executive of NHS Argyll and Clyde. What support did you and your new management team receive from the Health Department?

Mr Campbell: It has been a difficult two years in terms of trying to build and develop a relationship with the Health Department. Why that has been challenging for all parties is understandable. The most important thing at the outset was to establish the single system and to get corporate behaviour established in NHS Argyll and Clyde. Doing that required a major consultation and the involvement of all Argyll and Clyde staff and, to a lesser extent, the stakeholders.

We received significant support and help from the Health Department, particularly from staff in the performance management division, in preparing our submissions and plotting the single system entity, which we moved into before the partnership for care legislation—the National Health Service Reform (Scotland) Bill—was published. We have also received help in managing our waiting times over the past two years and we are doing as well as the best in Scotland on all fronts in that area. I would argue that we are probably one of the best boards in Scotland on waiting times and the significant support that we have received from the waiting times unit has helped us to maintain our position.

We have also had a great deal of support from the performance management team in our consultation work on our clinical strategy, in which we have been able to gain direct access to MSPs and the minister for discussions on the due process for the development of the strategy.

The area in which we have needed the greatest amount of support has been around our financial plan, which has probably been the most difficult area. We began this discussion earlier, when I was asked about signing off our financial plan. It has taken us two years of discussion to get to the point at which we have still not signed off our financial plan. We have had two years of progress in terms of delivering targets that are our targets. The support that we require relates to our need to have a clear accountability framework that is understood by all parties in terms of our financial plan, but that does not exist. When I say "all parties," I should say that the board, my management team and I are absolutely clear about our accountability in delivering against our financial plan. However, that accountability runs two ways. It has to run between the department and ourselves and between ourselves and the department. Without that established framework, we are working in a vacuum. I will give you an example of the nature of that vacuum, the implications that it has and the reason why support is important in this area.

We are under significant scrutiny. Because of that scrutiny, every decision that the board wants to take has to be debated. That is right and proper

because it involves people fulfilling their duty. My example is this: we have no choice but to develop one of our local health centres; if we do not, it will cease to be available to the public and a big proportion of our urban population will not have access to primary care. That is not the sort of choice that we want to be faced with but it is one that we have to make. We have to invest in that health centre. However, we cannot move ahead with that investment because it will have a financial impact on us in 2006-07 of half a million pounds. In terms of the money that Argyll and Clyde NHS Board spends, that is right at the margins, but it is half a million pounds that we do not have and is not built into our financial plan. Even if we build it into our financial plan, that is only Argyll and Clyde's financial plan; it is not a financial plan that is jointly agreed or for which there is joint accountability. We have worked to have that agreement in place for the past two years, although it has been difficult.

I feel that that is an area in relation to which support has not been forthcoming. I appreciate the difficulties that the department has in explicitly supporting us in that area but, equally, Argyll and Clyde is unique in its circumstances and position. People in Argyll and Clyde NHS Board are clear about their accountabilities and are not responsible for the poor financial situation. They are responsible for the actions that they are taking and support for their current responsibilities is what is needed more than anything else. However, there is a deficit of support around that area.

Margaret Jamieson: Do you believe that a line should have been drawn under the financial problems in Argyll and Clyde in order to enable you and your management team to move forward and develop services for the people in the area?

Mr Campbell: That question relates to a complex area. If we are to make meaningful progress in Argyll and Clyde, we need to be clear about what is expected of us as a management team, based on realistic assumptions of what can be done. We think that we have set that out in our financial plan. Asking us to run faster, work harder and save a little bit more when we are talking about an unrecoverable accumulated deficit of £73 million in a single system would be to start a fruitless discussion. The discussion needs to be about what can be done by the organisation itself and clear accountability has to be established in that regard. Changes in parameters around that need to be taken into consideration but we need to lay down the rules for those changes before they are made. There is nowhere for us to hide in Argyll in Clyde and we will be held accountable for what it is possible to hold us accountable for. On that basis, we would like to be supported in relation to the tough decisions that we have to make over the coming years.

12:00

Margaret Jamieson: May I take you back to the accountability letters that you have provided to inform us for today's meeting? In particular, I note the accountability review letter dated August 2003, which indicates that the then head of the Scottish Executive Health Department said that more robust savings plans would have to be provided and that you would have to show financial balance in your current plan. He went on to indicate that he would expect a revised five-year financial plan, which would be developed with clinicians and staff, to be produced by 1 October 2003.

Being a simple individual, I would expect that the 2004 accountability letter would chart the progress that was requested in the previous letter, but I found something totally different. Is that the level of support and understanding by the department of the problems that you and your colleagues face? There seems to be no looking back, only looking forward, in one particular area.

Mr Campbell: As I keep saying, the situation is always complex. We began the process as an interim management team and then became the management team, forming the initial financial plan, which was in place right at the beginning of the financial year 2003-04 in a very sketchy form. The plan was then developed during the early part of that year. Over the two years and 22 meetings, we have gone through a cycle of discussions, which began by a lack of agreement about the starting position for Argyll and Clyde. That was unacceptable, in my view, simply because the starting position was established in broad terms by an independent team that intervened in Argyll and Clyde. The position for 2003-04 was set by people who had no vested interest—an interim management team, in which James Hobson and I, along with others, were involved.

The starting position was the starting position and we have never moved from that—we have been absolutely clear that we are not prepared to move from that. We began with a non-acceptance of the starting position and we then moved into the initial discussions about how the plan could be delivered more quickly. In our initial plans, we built contingencies of about £5 million into each of the early years. Those contingencies were identified in our plan for developments. We knew that, during the normal course of running a health service in a local area, things would happen that would require us to spend money. The debate at that point was about whether we could take out the contingencies and reduce the overall deficit, so that the recovery period could be shortened from five years to three years. We had some significant debate about that at our first accountability review in August 2003. Following on from that, we took out those contingencies and we obviously then reduced the

deficit so that we were able, theoretically, to recover more quickly.

In that year and the year that followed, the financial hits that we experienced were the consultant contract, the GMS contract, agenda for change, revaluation of the estate and so on, as we have outlined before. The £5 million would have contributed to that, so what effectively took place was that, after we had taken out the contingency, the hits happened and we had to expand the plan back to five years, with the same level of accumulated deficit as was in our first plan.

We then moved on from that to a debate that was not so much about not agreeing a starting position or taking out contingencies as about the fact that £13.2 million or £13.5 million of savings is not enough and that we needed to make a bigger saving, because the accumulated deficit was too great. That was a legitimate position for the Health Department to take; we cannot overspend by that level. The reality is that real savings of £13.5 million—a mixture of recurring and non-recurring savings—where that money is coming out of the system, is significant for a health system. That is a major challenge.

We could have identified smoke-and-mirrors savings of £30 million to £40 million if we had wanted. The smoke and mirrors would have been about our identifying non-committed health plan expenditure as a saving, which it would not have been—it would have been a deferral of spending. We could have identified a whole range of other initiatives, in theory, but they would not have been about real cost reduction. We identified those things without putting them in as cost reduction. So we identified £13.5 million of savings, which, we contended, was a significant amount. We argued about that for some time. Our view was that, if we made those savings and demonstrated our ability to save, that would put us in a strong position in year 2.

Moving into year 2, the Executive said that it was arguing not with the fact that our in-year plan was a good one—we were making the savings and it could see that we had saved £13.5 million—but that the plan was not a strategic plan. Apart from the fact that that was unfair, the situation became demoralising for staff. The plan was clearly not a strategic plan—we had hit the ground standing rather than running and had to build up to a more strategic approach. The strategic approach has come as we have developed our clinical strategy. Much of what we are doing in year 2 is more focused on where we are going with the changes to services.

The whole debate has now moved on to the nature of the accumulated deficit—the fact that it is too big and needs to be managed down—and our not being able to write it off. That demonstrates a loss of support for us, given the fact that, when the discussions began two years ago, they were predicated not on a year's recovery, which would have meant that there would not have been an accumulated deficit, but on a five-year recovery. There was a good reason for that. Given the fragility of the health services in Argyll and Clyde, if we tried to recover a deficit of the magnitude of that in Argyll and Clyde NHS Board's system within anything less than five years, those services would collapse.

We tried to get an agreed position on a financial plan over two accountability reviews. As I say, we had 22 meetings. The commitment from my team has been 100 per cent. We have attended all those meetings—I have attended 10 of them. Of the remaining meetings, one was an accountability review, which the former chief executive attended, and one was a meeting with the former chief executive, which I requested to try to bottom out matters in advance of the accountability review. It has felt as though we have been on our own and that the response has been, "The problem's yours now. Deal with it." I do not believe that it is possible for us to dig our way out of the financial challenge that we have on that basis. There has to be a partnership approach.

You have the latest accountability review letter. A paragraph in the financial section talks about signing off a financial plan on the basis of a partnership agreement. I raised that matter at the accountability review meeting and I had further discussions to ensure that the point was made in the accountability review letter. It remains the most important part of the support that Argyll and Clyde NHS Board needs. We are not looking for a handout to get us out of our financial problem; we have to dig ourselves out.

Yes, we need a Scotland-wide solution to the accumulated deficit, as it is beyond our ability to deal with it—anybody can see that. However, there must be local accountability in dealing with the problems and making the tough decisions. As I said earlier, the board is committed to doing that, as is the management team. By and large, across the political spectrum in Argyll and Clyde, among MSPs and local councillors, there is an understanding and support for our making the necessary tough decisions. Everybody recognises that we cannot improve services while we suffer from a lack of financial headroom that is underpinned by our financial problems.

Margaret Jamieson: I think that you have answered my next question. What you have said demonstrates the fact that the Health Department has not been too smart in trying to provide support; rather, it has hung you out to dry for the previous difficulties, of which it was aware. Looking back at the performance assessment

framework, the letters on the accountability review talk about things needing to be done to address the finances, but there appears to have been no follow-up. The committee should raise that matter when the former chief executive of the NHS in Scotland appears before us next year.

The Convener: We are running 10 minutes late on the clock—how late we are running in our questions is another matter. I have been keen not to intervene to try to speed up your answers because it is important for you to feel that you have had your hearing and been able to put your case. Also, it often happens that, in answering a question, a witness provides us with further information that we were not expecting. That is why we have run the meeting as we have.

I now suspend the meeting for lunch. Members should be back here by 12.40 pm.

12:11

Meeting suspended.

12:44

On resuming—

The Convener: We have landed. We can now ask our witnesses further questions on the audited accounts for 2003-04 of Argyll and Clyde NHS Board. In this session, we will consider the medium-term financial forecast, how it will be achieved and the impact on service provision. The committee has gone through the questions that we anticipated asking and we will leave out those that have already been answered.

Robin Harper (Lothians) (Green): I think that we have a picture of your financial forecast, but does it assume any changes to current services? If so, what are they?

Mr Hobson: Our forecast assumes that we need to recover £35 million recurrently from our system during the recovery period. In order to effect a change of that magnitude, we will have fundamentally to review the mode of service provision within NHS Argyll and Clyde. That takes us back to the comments that Neil Campbell made earlier about aligning our financial plan with our strategy.

On how we propose to get into financial recovery, we estimate that about £25 million of the £35 million needs to be recovered through strategic change. That is necessary to deliver a change of that magnitude and it involves implementing some of the proposals in our clinical strategy. We have been out to consultation on those proposals, which have been put to the minister for approval. They involve the modernisation of priority services, such as services for older people and people with learning disabilities, and mental health services. That will start to tackle some of the areas on which Argyll and Clyde traditionally spends more per head of population than comparable health boards. Implementation of those changes will take place during the next few years. That is not the whole answer, but it is a key component of our getting back into financial balance.

Mr Meikle: The clinical strategy has three themes. First, it takes forward community care implementation and, as James Hobson indicated, the modernisation of mental health, learning disability and older people's services. Secondly, it involves the development of primary care. We heard earlier about the cost of the new GMS contract, but as we go forward we need to work out how we can maximise the benefits that it offers us and indeed the further modernisation of primary care services. That is about facilitating and working with primary care providers so that they can work differently.

The third strand of the clinical strategy involves examining the detailed options that are available to us on acute services. On that, we need to work with the national advisory group and Professor Kerr and to link with NHS Greater Glasgow and NHS Ayrshire and Arran. There is a fourth theme, which has a longer timeframe: the community development model and the future of community hospitals in Argyll. In the medium term, we plan to reduce the costs of those four themes in our financial plan by £25 million.

Robin Harper: May I press you a little on that? In my experience over the years, there has been a perception that mental health services are the poor relation in the national health service. You spend more on mental health services than other boards do, but some people would say that that is a good thing. I invite you to comment on that.

Mr Campbell: My clinical background is in mental health services—I trained as a psychiatric nurse. I have given many years of service to mental health services in various jobs and I would certainly not seek to do anything to damage them in my current role. The reality is that Argyll and Clyde's mental health services are early 20th century services. That comment is not a criticism of the good, committed staff whom we have; it is based on the model of service that we have. We have an institution that still has several hundred patients—it has 180 patients, in any case—and was built 125 years ago. We have another hospital that was built more recently than that—in the 1960s, I think—which is absolutely appalling. We are trying to provide 21st century services in accommodation that is many years past its sell-by date on a model that no planned service would have in place in the 21st century.

We must adjust that model. While we are providing services in the facilities that we have, we are spending a huge amount to support bricks and mortar that nobody wants and a model that does not serve our population's needs well. If we can liberate the staff and resources associated with the services, we can do better with less. You might ask me how I know that. We are spending above the Scottish average on mental health services—the figures are in the information that we have provided. We spend £18 million more than would be spent on a similar service somewhere else in Scotland. Surely we can do better than that and take some of the costs out.

None of our plans proposes to take £18 million out; rather, we propose to save something between £7 million and £9 million as we change the shape of the services. We will be able to adjust the balance over the period of change and, if we have the balance about right, we will still be spending about £8 million or £9 million more than the Scottish average, probably as a way of dealing with our rurality issues—we will certainly be providing more local services in the rural and remote areas—and we will be able to stand up and be respected for, rather than be ashamed of, the quality of our in-patient care.

Robin Harper: Thank you. There is an inexorable logic in that.

Susan Deacon: I will move on to service redesign and, in particular, the clinical strategy, which has already been referred to on a number of occasions. I reiterate the convener's point that the committee's job is to consider not the substance of the proposed changes but the process and, in particular, how that links to the board's plans for financial recovery. As a preface to my question in that context, I ask you to clarify for the avoidance of doubt precisely where in the decision-making process the clinical strategy now is. What stage is it at?

Mr Campbell: The NHS board met in November and decided to support the proposals in the clinical strategy for the transformation of services for mental health, learning disabilities and older people and the development of primary care, to initiate a programme of community development in Argyll, so that we can come to some conclusions about what we do with many of the challenges that we face in Argyll, and to recommend those proposals to the minister on the basis that they are the proposals on which we consulted—there is some marginal change, but, basically, the proposals are the same as those on which we consulted.

For the acute services, the board agreed to recognise the challenges that we face in trying to sustain a number and variety of hospital sites. Those challenges are not simply financial—although finance is a challenge—but relate to clinical sustainability and safety. The board also agreed to acknowledge that we will need to consolidate acute services, but only on the basis of having reached the maximum provision that can be provided locally. It also agreed to ask for further work to be done over the months to early summer as the first part of the debate to demonstrate what can be provided locally and, only after we have concluded that, to decide what must be centralised on the best evidence and taking account of national work. When we have completed that work in early summer, the board will meet and make final recommendations to the minister about acute services. The other recommendations have already gone forward for approval.

Susan Deacon: Is it your understanding that a decision could be taken in the near future on the recommendations that have gone forward for approval and that that is not dependent on the outcome of Professor Kerr's work, for example?

Mr Campbell: We indicated to the board that the other services that we described are non-contentious—that is to say, they are associated with developing primary care—or are subject to a national framework and Scottish Executive policy. I refer to mental health services, services for people with learning disabilities and services for older people. That is the basis on which we have asked the minister to make a decision. There are other considerations that the minister will have to take into account, but a national framework is already in place and we believe that there is broad support for the proposals that we have submitted.

Susan Deacon: In a moment, I will ask more about the potential cost and funding of service changes. However, I would like for a minute or two to pursue the issue of timing. In which financial years do you expect the two aspects of the clinical strategy that you have described to have an impact on your financial planning? You said that the first element might be subject to a relatively early decision. When do you expect the financial implications of the changes to feed through?

Mr Hobson: Some of the work—for example, on the financial planning around learning disabilities—is already well under way and can be implemented relatively quickly. Merchiston hospital, which is our learning disabilities hospital, is scheduled to close in December 2005, although it may continue to operate for a little longer. However, the hospital will be closed within 18 months. Other work—for example, on the redesign of mental health services—is not quite so advanced. It is unlikely that those changes will feed into our financial plan for the next financial year, but they will start to feed through in subsequent years.

As we said in answer to an earlier question, we have tried to make our financial recovery plans

less ad hoc and more strategic. In other words, we have tried to look in the direction in which we are going. Our plans for this financial year and, to some extent, for the next financial year have started to pick up the fact that we are doing work on the early part of mental health services redesign. The process will be phased. The identification and implementation of changes to acute services is likely to be longer term.

Mr Campbell: It is important that I add a rider to what James Hobson has said. I will give the committee two examples. We are asking the minister to make a decision on services for people with learning disabilities, which will allow us to conclude the process by closing Merchiston hospital. Ministerial approval has already been given to the decision to provide the service elsewhere. While we await the ministerial decision on the hospital closure, we are examining what action we can take in advance of it to reduce the cost of actions around learning disabilities. I refer to the double running costs of £3 million a year. We will not cut across the ministerial decision, but there may be action sooner rather than later.

There is already a commitment in Scotland—certainly in Argyll and Clyde—to move away from institutional care for older people. Because we have done well in tackling delayed discharges and have built up a much stronger relationship with local authorities, we have been able to push harder to close beds that are currently occupied by patients whose discharge to an appropriate care setting has been delayed. I know that "delayed discharge" is a pejorative term. However, we have been able to act more rapidly to move to the right type of accommodation patients who are in hospital only because the local authority has not yet placed them. They happen to be occupying some hospital beds whose closure we have recommended to the minister. If we can move that process forward more rapidly, it will give us the capacity to consolidate wards. We hope that, while we await the ministerial decision—and without pre-empting it—we can achieve some financial gain in the next financial year on that basis. That is the way in which we will try to manage the process.

13:00

Susan Deacon: To what extent have the various aspects of the clinical strategy been costed explicitly?

Mr Hobson: They have been costed only in outline form at this point, because until the provided services in the community are fully identified and planned it is not possible to cost them. The same applies to changes in acute services. We have carried out a scoping exercise—that is the best way to describe it—considering the costs in the hospitals that are scheduled to close and what might be realisable, using realistic planning assumptions. We need to do a lot more work over the next six to eight months to validate that and to have the definitive financial plans so that we can identify how to make the change happen.

Mr Meikle: This feeds into the culture that we are promoting within Argyll and Clyde. In the discussions that we had with the clinicians about the clinical strategy, the clinicians were looking for us to define the financial parameters. That is what we are trying to do, without getting into the detailed costing of the service. We are defining the financial parameters within which the clinicians can look to redesign the new service. Clinicians have been stung in the past with regard to the historical management of NHS Argyll and Clyde, so they are keen that we define at the outset the financial parameters within which they can work.

Susan Deacon: I am conscious that there are all sorts of chicken-and-egg issues. How are you going to address the situation? I note, for example, the clear statement in the Audit Scotland report:

"Implementation of an agreed clinical strategy will be critical to the development and sustainability of modernised health services in NHS Argyll and Clyde."

How are you going to get agreement on the development of that strategy? In Andrew Walker's recently published review of your clinical strategy, he expresses concern that

"One of the problems with this is that you end up discussing options that you do not know if you can afford. I recommend that your proposals, including the options for acute care, need to be linked to your financial strategy at the earliest opportunity so that affordability can be clearly judged."

The second question is, who pays for these things? There are interesting issues around running costs, to which I will come. What are you doing to put pound signs against the proposals and have a joined-up discussion that addresses change within the context of affordability?

Mr Meikle: You are right about the chicken-and-egg analogy. By defining the financial parameters we can work with the clinicians and the community to consider what services can be provided. We then have a process of consolidation. To make that happen and take forward the four work streams that I spoke about, we disaggregate things, get the involvement and buy-in and work at as low a level as we can. We begin to build up what services look like for general surgery, for mental health, for Inverclyde royal and for the Royal Alexandra hospital. We build up a matrix and in doing so we come up against the affordability question. The process is iterative. We say, "That may be how we would like things to be in blue-sky thinking or without financial parameters." However, we have to work within the

reality of our financial allocation and infrastructure. Having done the initial work with clinicians and the community, we have made people aware of that.

Mr Campbell: I want to intervene on that. Susan Deacon's question raises a much more philosophical point than some of the other questions—at least I think that is true. As we redesign acute services we can do what David Meikle described and say, "That's the pot of money available to do that." There will be 101 competing ways of spending that money. Good managers and leaders involved in the process will be able to play around with the various parameters that we have in the acute service and come to a prioritisation conclusion.

We cannot do everything, but we can play around with the parameters. For example, as we consider how we redesign the breast screening service, we can ask various questions. How much wasted effort and cost can we design out? Given that we are proposing to expand the service by adding a couple of consultants, what will we get if we commit to that expansion? How will we reach a conclusion? Do we redesign the way in which women enter the service or the way in which women who are in the system are recalled for out-patient appointment after out-patient appointment? Can we take wasted effort out of the service? Such debates are going on. When we know what extra the redesign might offer, we must consider whether we want that extra. We must then examine the national parameters to do with one-stop clinics and access within a defined amount of time and we must consider how far we are from being able to achieve those aims. We might well then conclude that we want the extra that the redesign would bring. That might mean that the savings that the redesign generates are ploughed back into something that we want to achieve. We are assuming up front that our allocation in 2008-09, 2009-10 and beyond is already being committed on the basis of the redesign, because we need to work towards that activity.

Equally, in another area of endeavour, for example dermatology, we might acknowledge how we could make the service better for patients, but although we aspired to a redesign we might not commit to it up front. Maybe in 2007-08 or beyond we might make that step change, but we would not design for it now. We might design the basis on which we could make the change, but we would not necessarily make the change.

That approach must apply to all our services, but we are at a very early stage. We have consulted on proposals and we have made the case for change. On a range of areas that we described we have a large degree of clinical support and varying degrees of support from elsewhere—we also face a lot of opposition. We are moving into the next stage, which is much more local, as David Meikle described, and in which we begin to gather people together to get to the heart of the redesign. We have a very high-level strategy and when we get into the detail of that we must match up all the forces and drivers with the money. The process will require an enormous amount of management over the next few years. The opportunities are limited, because unlike other health systems that are in redesign, we cannot spend what we currently spend, because that would be more than our allocation. That is a constraining factor. Can it be squared? We have given a commitment to ourselves and to the people around us that we will work towards squaring it. We have not got an awful lot of choice.

Susan Deacon: Let us consider how you will take such changes forward. You talked about the impact of double-running costs and it is worth noting that the matter is mentioned in the Auditor General's report "Overview of the financial performance of the NHS in Scotland 2003-04", which we discussed earlier. Should the Scottish Executive take further steps to support boards to take forward such changes, for example in the management of double-running costs?

Mr Campbell: There is not a yes or no answer to your question. In some circumstances, of course the Executive should take such steps, because change cannot happen in any other way. In other circumstances, change can be generated locally. We are seeking agreement on our finance plan and from this stage, at which we can see the future around our clinical strategy, we have built into the discussion components about effecting and resourcing change, because NHS Argyll and Clyde has no headroom. If we want to get ourselves out of a hole, where can we find the money to mobilise change? We have asked the Scottish Executive Health Department to support us up front with the costs of change up to an agreed limit. We would work towards that limit in a carefully controlled and managed way, so that money could not be misused by our or any future team, which might say, "It's a bit of bridging, we'll stick it in here and it'll cover the deficit." The money would have to be identified and used for the specific purpose and paid back. We have suggested that we could pay the money back, not between now and 2007-08, but beyond 2007-08. We have suggested that we use the 0.5 per cent that is allocated within our general allocation for redesign. We could pay the money back using that allocation. For us, 0.5 per cent is £2.5 million a year. We think that we probably need somewhere in the region of £10 million to £20 million for double-running costs. That is an estimate; we will not know the figure until this work is finished. We could pay the money back at that level over between five and 10 years—eight years might be

a reasonable period of time. That money was specifically allocated for redesign. That is the right purpose for which to use it and that is what we would be doing with it.

We can manage the double-running costs, but the bottom line is that we need to reach agreement on the financial strategy. We are not asking for something for nothing. We are prepared to commit to repaying the money on the basis of a budget allocation that is for that purpose. The bridging finance would bring with it substantial benefit for patients and also unlock our ability to release the resources that are necessary to get us back into the initial balanced position. That is the theory of it all.

Susan Deacon: Are you saying that any decision about, for example, bridging finance, would depend on the outcome of the on-going discussion about the financial strategy?

Mr Campbell: It all has to be linked together. Our financial strategy has to sort out our in-year position properly. There can be no smoke and mirrors. We have to be clear about the use of non-recurring money to reduce the accumulated deficit. We must do things in-year with non-recurring money—whether that is from land sales or anything else—to keep our accumulated deficit down to £73 million. The strategy must include information on how we will effect change, so we must be able to talk about bridging within it. All those things are included.

In due course, the point will come when we are in a position to describe the new infrastructure—buildings—and we need to be able to move to the next phase of our financial strategy, which is about how on earth we will service a capital debt. We have made some assumptions in our plan about making savings in acute services of about £10 million. We recognise that about £5 million would have to go back in to service the debt. Those are currently high-level figures, so we must get into the detail. The figures might be greater than that. We are at an early stage and it is a chicken-and-egg situation. All those things need to be in the plan.

Susan Deacon: All roads seem to lead us back to the plan—you are talking about the financial plan. Following on from Margaret Jamieson's questions before lunch time, can I try to bottom out once and for all why it is proving so difficult to achieve agreement—a partnership agreement was the phrase used—on a financial plan? That seems to stand in the way of many things moving forward. Perhaps you feel that you can add nothing further to your earlier comments. We have come back full circle to where we were before lunch time.

Mr Campbell: The financial plan is the single most important thing for success in Argyll and Clyde, because everything else relates to it. It is not the single most important thing because money is the most important thing; it is the single most important thing because it is the enabler of all the other things that we want to achieve. The fact that there is not an agreed plan with accountability on both sides means that we cannot move forward in the coherent way that is expected of us.

My frustration about that one issue is off the scale. If we can move forward on that it would free up the opportunities around everything else and it would make the debate entirely different. Instead of having a public debate about the level of our growing deficit, we could have a debate about how we are moving forward with the service changes. It is very important that we reach a conclusion on the plan as it would change the whole complexion of the discussion.

Susan Deacon: Thank you. You have given us a very clear message on that.

You touched on this issue in an earlier answer, but, for the record, could you tell us a little more about what you are doing to work with neighbouring boards to plan and resource changes? That is a specific point, but I also want to give you the opportunity to add anything further to the question of implementing change that you might not have said already. I am struck that Neil Campbell said a moment ago that the planning is at a very early stage. Frankly, the observer could be forgiven for thinking that the situation had been going on for years and years. Somehow, somewhere conclusions must be reached and there must be some clarity about where health services in Argyll and Clyde are going. Is there anything further that you would like to share with the committee about what the Health Department or this committee could be doing to aid the process?

13:15

Mr Campbell: I will start with your final point, then David Meikle will talk about the regional planning discussions that we are having.

I talked about the road map that was given to us by the intervention team—I also take responsibility for that because I was part of that process. It required the creation of a clinical strategy so that we could describe the future of services. That was so important because Argyll and Clyde was one of those board areas that had hundreds of strategies and no vision. There was no collective understanding of how it was all strung together to make that real difference to services on the ground.

As well as doing formal consultation, we have spent the past 12 months developing and

describing that vision for services in Argyll and Clyde, and producing robust evidence of why change has to happen, which is for the variety of reasons that have been described elsewhere in sufficient detail. We have been laying out a compelling vision for services in Argyll and Clyde and why change has to happen. Underpinning that is a decision on some very specific changes that will enable the delivery of that vision.

We now need to move into the detailed planning for the delivery of that vision, which is underpinned by the financial framework, by the solutions to the workforce challenges that we face, by the physical infrastructure, and by the challenges that are caused by the physical infrastructure such as finding the capital to spend on such projects. That is the detailed work that we are now moving on to do.

A huge amount of planning has gone on in the past two years, as well as engagement, discussion, deliberation and, I hope, education. A vision has been created from all that. Even those who are strongly opposed to the proposals that went to the board in November would say that there is a compelling vision for services in Argyll and Clyde. They might be opposed to that vision, and have an alternative, but they would say that the vision is very clear and that it is underpinned by the simple development of local services—given that things cannot stay the same—and by consolidation for excellence. That generally feels as if the vision should be for acute services, but it is not just for that; it is for the whole range of services that we provide. That is the compelling vision. It needs to be fleshed out, but we have to work on the detail of the implementation. That is what the rest of the planning is for.

Mr Meikle: During the past couple of years, we have worked on building on the relationships and planning contacts with our neighbouring health boards, particularly Glasgow. Some of that has been ad hoc and has been dealing with contingencies. So we have examined pressures on vascular services with the Southern general hospital, for example. We are also examining pressures on mental health services in Lomond. We have also worked with Glasgow in considering what options could be available.

As we go into the detailed planning phase that Neil Campbell talks about, we have to take that planning work to a different level and ensure that our planning mechanisms link in with Greater Glasgow NHS Board and Ayrshire and Arran NHS Board for those elements that affect those boards. I have had discussions with the planning directors and divisional chief executives in Glasgow and in Ayrshire, and we have our programme architecture. We are going to take our programme forward within the next seven months.

We are linking our architecture to that of the other two health boards. We sit down and explicitly work through our planning assumptions and some of the issues that face Glasgow, Ayrshire and Arran and Argyll and Clyde health boards, as well as the interfaces. We do that explicitly; we communicate the outcomes and publicise the debate so that everybody can follow the considerations as we go along. We envisage the three health systems continuing to work together in the next seven months.

The Convener: I have a rough rule of thumb of allowing four minutes for each question, but we are already 15 minutes over my projections. If members ask questions additional to those that we have agreed to put, we will run further beyond the projected time. I ask for succinct questions and answers. If members feel, as they hear the answers, that they no longer need to ask questions, or if they feel that answers could be put in writing, that would be helpful for the meeting's progress. Notwithstanding that, we want to get to the root of the problems.

George Lyon: To be brief and helpful, I will ask three questions together. I ask the witnesses to respond reasonably briefly, if they can. First, are you confident that the executive team has sufficient capacity and resources to deliver the recovery plan and are the right middle managers in place to support the executive team in delivering the huge changes that confront you? Secondly, to what extent have clinicians been involved in developing the financial recovery plan? Thirdly, you have given us comparative information on the numbers of management and administrative staff, but how do your management costs compare with those of other health boards? That is linked to the question of how you are going to achieve the reduction of 180 administrative and management posts to give a saving of £4.5 million. That plan seems to indicate that you have too many middle managers in the first place.

Mr Campbell: I have absolute confidence in the executive team. They are a committed group of people. They make mistakes from time to time, as we all do—I certainly do—but they are a committed group of competent managers. However, they are only as effective as the people who support them.

George Lyon: That is the question.

Mr Campbell: Any big, complex system presents competence and capacity challenges in relation to people. For two years, we have tried to establish a way of working in NHS Argyll and Clyde that gets the best out of people. We have not centralised the way in which we manage; we have tried to decentralise it. We have helped people to feel empowered to take action and make things happen. Our success in the past two years

in achieving financial savings—I nearly said recovery—and in the complex work on the clinical strategy has demonstrated that we have a large number of highly competent middle managers who are doing their best in difficult circumstances. It will continue to be a challenge for us to sustain their efforts and to help them deliver the best that they can. By and large, we have the right middle management support.

In the next 12 months, as we consolidate structures through the move to community health partnerships, we will undoubtedly need to consolidate some of the corporate management functions to be able to devolve further to CHPs. Consolidation means bringing together and it will achieve two results. First and foremost, it will enable us to rationalise support functions. That is where we think that we will find the £4.5 million of savings in management and administrative costs and bureaucratic transactional processes. We have done quite a bit of detailed planning on that and we believe that the savings are deliverable.

George Lyon: Does that mean a change from the old system of three or four finance divisions, as well as a human resources division?

Mr Campbell: Yes. Human resources and finance are two big areas, but we can also look at how we organise public health and health promotion. We are examining opportunities to share some of those functions across boards.

The other thing that we will be doing more of—and it is something that the health service has been poor at—is buying in expert knowledge on an ad hoc basis. We just do not make enough use of that, maybe because consultancy is frowned upon. We need specialist skills to do key pieces of work, but we do not need them in the organisation all the time. If we were to bring them in all the time, they would not be expert for long. For our land transactions and our business case, we aim to bring people in to do a discrete piece of work and at that point—

George Lyon: Disregard what is going on around us. The blinds are being lowered.

The Convener: I assure you that we are not under nuclear attack. Please carry on.

Mr Campbell: The management issue is doable, but it is complex. Remember, we propose to proceed on a managed basis. We are not saying, "We are going to make all these people redundant tomorrow." We are actually offering a process that will change the shape of our workforce, in partnership with the staff side, and that will allow voluntary redundancy, but also allow us to pick and choose and put the right people in the right place.

Your second question was on clinical involvement and support around the financial strategy. For the first time in my career, I have experienced clinicians—two in particular—standing up in front of other clinicians, particularly consultants, and delivering a presentation to them that I would be happy to deliver on how we need to balance the books in order for them to be able to achieve what they want to achieve.

I do not pretend that we have complete clinical sign-up to all the rigours of saving the sorts of sums that we are talking about in Argyll and Clyde. However, for two years clinicians have resisted submitting business cases for more and more, and have accepted the fact that things have to change. For two years they have worked with us on the development of the clinical strategy, pretty well universally throughout Argyll and Clyde, even where there has been opposition to some of the conclusions.

That leads us to a different kind of infrastructure, which will be smaller and tighter. For example, on mental health, the psychiatrists are keen to start the process of redesign. They are waiting for us to define for them the parameters within which they can work, particularly the money. There has been a lot of clinical commitment, but I do not want to over-egg it. It will be difficult to implement, because tough decisions will have to be taken. There will be winners and losers, which will cause some friction and that will have to be managed.

George Lyon: I have questions, which I suspect you can answer in writing, on the number of senior managers you have on secondment. How many are on secondment? What are the terms of those secondments? You say that the posts are surplus to requirement. How will money be saved when the secondments end? A written answer would do.

I have other questions on community health partnerships. How will your move to community health partnerships streamline processes and simplify structures? Will setting up community health partnerships have any impact on the bottom line, in terms of savings? That is a big question, in some ways.

Mr Campbell: We will commit to a national policy with vigour, as with any other policy. It will mean something slightly different in Argyll and Clyde. Unlike every other health system in Scotland, which attempted to move to a single system without restructuring, Argyll and Clyde was in a different position in that, following the intervention, there was no choice but to restructure. We went for a radical solution, which was to create divisional organisations that integrated primary and secondary care, rather than primary care and acute trusts.

We did that, first because it would enable us to do the redesign that we would need in future. Secondly, the divisions were coterminous with local authorities, because we thought that that was

a valuable component in future joint working. Thirdly, it allowed proper integration of behaviour between primary and secondary care clinicians. Fourthly, instead of sustaining the NHS board as a health board and having all the planning and HR functions and everything else at the centre, we devolved them out to the divisions. We have a slim, stand-alone corporate function, but the corporate function is actually in the divisions.

Moving to CHPs means that we must revisit that approach. I do not mean the principles that underpin it around the relationship with local authorities, corporate behaviour and so on, but some of the structures. We can just about manage with three CHPs, but if we try to replicate things with five CHPs, the resource will become too thin to be effective. We would have to increase the resource, which we cannot afford to do. So the opportunity that we will seize from CHPs—or the opportunity that has been thrust on us, let us say—is that we will centralise or consolidate some of the corporate functions.

We cannot afford to lose the gains that we have made from people being prepared to work together in a corporate way by disaggregating them. Therefore, as we centralise some corporate functions, we will require a particular type of behaviour that is about supporting outwards. So there will be opportunities for us to make cost savings. On the basis of the work that we have done in changing behaviours, perhaps we will keep other cultures in place, but it is going to be hard work.

13:30

George Lyon: Could we have information in writing on how much of your cost base is fixed for salaries and buildings?

Mr Hobson: I can give the committee that information. I will provide an analysis of our cost base in writing.

George Lyon: I have a brief final question, which takes us back to what Susan Deacon asked about. I am confused about the standing of the cost recovery plan. The Auditor General's report states:

"The auditor's opinion is not qualified because the Accountable Officer has provided the auditor with assurance that the Scottish Executive Health Department will ensure that the Board has access to cash throughout the period 2004 to 2008, which will enable the Board to meet its liabilities as and when they fall due."

Will you explain that position? That seems to contradict completely what you said about there being no acceptance of the cost recovery plan. Both statements cannot be true.

Mr Campbell: I hope that they are true.

George Lyon: You cannot have access to unlimited cash while not accepting the cost recovery plan at the same time.

Mr Campbell: There is a real world out there. I do not personally pay people's salaries—I do not write the cheques—but salaries are paid by my order to all our staff on a monthly basis, and all the bills that come in are paid by my order each month. People go away and spend that money in the shops or wherever. I am talking about real money flowing through the system—that is what happens in the real world out there.

I will add to that real picture. We do not have money for probably the last month of the year—£60 million is probably a month's worth of our expenditure; it is not quite that amount, but let us assume that it is. I still draw down cheques and have them written. They are paid because the bank happens to be the Scottish Executive. The Health Department has a budget. Cheques are paid and people are paid. That is the real world.

George Lyon: The question is, is the cheque a blank cheque?

Mr Campbell: No. The challenge comes in accountability. That is why the recovery plan, as a signed-off, jointly agreed and jointly accountable document is so important. As things stand at the moment, I just write cheques.

George Lyon: So there is a blank cheque.

Mr Campbell: I have a plan that sets out what we will save and how we will recover over five years, which is noted by the department. The plan is not approved. That is an unsatisfactory position. Where is the accountability in that? There is no question at all in my mind that I want to be clear about what things I and my team will be held accountable for and what we can do.

Of course, the other side of the issue is Health Department accountability. Where there is a variation, a judgment must be made about my performance and the department's performance. That is why a written plan is necessary. At the moment, I order cheques to be signed because they have to be signed. That is how services are provided. The Health Department is left saying, "This isn't right. They are committing money that they haven't got." Those are the two sides of the story. We must have that plan in place.

George Lyon: The circumstances that you describe are utterly bizarre.

Mr Campbell: I want to move away from that position, so I do not disagree with you.

George Lyon: I understand that, but I am saying that the current position is bizarre. Basically, you have a blank cheque.

Margaret Jamieson: I have a brief question about your plan and your identifying the need to

reduce the number of management and administration posts by 180. Do you have plans that would affect other staff groups?

Mr Campbell: The clinical strategy will mean a complete change of services. If it is delivered on the basis on which we consulted, we are talking about a reduction of more than 500 hospital beds. The strategy will have a major transformational effect on all our staff in Argyll and Clyde.

In terms of submitting the strategy for consultation, we have agreed that it will all be managed within the organisational change process, which is a partnership agreement in Scotland. In Argyll and Clyde, we have supplemented the process with local arrangements. The strategy will have an effect on staff and the process will need to be managed over a period of at least five years.

Margaret Jamieson: Some individuals will be qualified only in one specific area. Do you have the capacity to take their raw skills and retrain them to deliver something different somewhere else?

Mr Campbell: We have some capacity to do that, but it will be enormously challenging. That said, we are not embarking on anything that others have not done before us. The level of change in Argyll and Clyde is nothing compared with the level that Glasgow achieved simply by closing two of its learning disability institutions. However, despite the huge experience and number of examples on which we can draw, the process will be difficult and we will have to handle it sensitively.

Susan Deacon: Like other members, I will hone down my questions to focus on a couple of areas, the first of which is information. Over a considerable period, the committee has expressed significant concern about the lack of good management information in the health service in Scotland. What information is most important to enable you to undertake your work? To what extent do you have access to information that is fit for purpose?

Mr Hobson: From our point of view, the key component of information is financial information—given that I am the director of finance, members might expect me to say that. We need to have good, reliable financial information on income and expenditure and how we make use of our funds. As I said, we are developing that area and will continue to do so. Generally, the NHS has good financial information that it can use on an accounting basis.

We probably do not have sufficient information in the area of costing; we lack information on comparison or benchmarking. There is a lack of joined-up information across the service. I am thinking, for example, of how our management costs compare with those of other health boards. We have done some analysis on that, but there is no national standard benchmark for management costs or for a number of other areas.

In addition, we need better and more joined-up information in relation to the workforce. Many of the changes that we have to make are around the area of workforce planning. Through the workforce planning agenda, we must get the right resources to resource the services that we will provide in the future. That is an issue not only for our NHS board, but for the NHS in general in Scotland. There is a bit of a dearth of information in that area.

Mr Campbell: James Hobson has picked up on most of the areas, but I have two points to add.

First, we talked about our assumptions in relation to the pay modernisation agenda—the costs for implementation and the reality of those costs—which is one of my anxieties. I hope that the fact that I have raised that matter will prompt the committee to question other witnesses on the subject. For people in my position, who do long-term planning on the basis of nationally provided information, the important thing is that when the process reaches a conclusion, the figure is within a ball park. The difference between 7 and 24 per cent does not represent a ball park that anyone can play in.

If agenda for change is out by 1 per cent in Argyll and Clyde, the impact would be—

Mr Hobson: It would be £2.5 million in year; the full-year impact would be twice that.

Mr Campbell: So, a 1 per cent variation would lead to an impact of £4 million to £5 million. At this point, we do not know what the fallout will be. National information must be as good as it can be in the circumstances. We must acknowledge that the information that we have is not always perfect.

My second point is about changes to activity that result from important policy pledges. An analysis should be done of the impact that those policies will have on the cost to the service, its capacity and its workforce. A debate that changes the ratio of out-patient activity to in-patient activity must be translated into cost, workforce and capacity. If there is a move of half a dozen weeks on out-patient activity, there will be an enormous impact on in-patients because of the 80 per cent conversion rate of out-patients. If in-patient delivery is moved by a few weeks or months at the same time, which is important, it is crucial to people like me that a proper analysis has been done of that so that we can understand the impact nationally and apply the parameters locally. That way, we will be able to plan properly for the long term.

Those are the two issues on information that I think are important.

The Convener: Do any members have a final question that they feel they would benefit from asking our witnesses now, while they are here?

George Lyon: There is a point that I want to clarify on information. Are you saying that the Health Department does no modelling work on the impact that the pay modernisation deals and the decisions on waiting times, for example, will have on service delivery? The majority of the pay modernisation deals are about a reduction in activity as well as increases in financial rewards. A reduction in activity will have a huge impact on service delivery. Is no attempt made to model the effects of such measures or to discuss their impact on the finances and manpower of the service in three, four and five years? Is none of that work done?

Mr Campbell: I am not saying that such work is not done; I am saying that when it is done, it needs to be accurate and it needs to support people like me in carrying out our role of planning for the long term. It is an area on which I and colleague chief executives challenge the Executive, because it relates directly to our performance and that of our organisations. At the end of the day, we recognise that we are accountable on the funding of the consultants contract. If we are to be accountable in a meaningful way, we need to start off by having the right parameters. That is the point that I am making.

Mrs Mary Mulligan (Linlithgow) (Lab): Your answers to us have been helpful and comprehensive. I want to give you the opportunity to offer your view of the work that you are doing to develop a new clinical strategy, make huge changes in workforce planning and deal with all the other challenging changes that you face. Are there any issues that you would like to flag up as central to making those changes and bringing about financial stability in Argyll and Clyde? What could put those changes at risk? Do you have plans to deal specifically with those risks or are you not thinking about that at this stage?

13:45

Mr Campbell: The killer question always comes at the end. There are a number of points that I would highlight to the committee. I have talked at huge length about the need to have a signed-off financial strategy. The process of producing that strategy needs to include discussion of how we in the NHS deal with the accumulated deficit problem and who is accountable for what. That cannot wait.

We need a framework that allows people like me to make difficult decisions and an environment that encourages that. I say that to the Audit Committee rather than the Health Committee simply because we are talking about difficult decisions that will lead to financial balance, which, in turn, will lead to improvements to services. People like me need cover to do the things that will, in due course, bring about tremendous improvements for the people of Scotland. However, that framework is lacking. One has only to pick up the papers to see that—tomorrow's reporting of this committee meeting will be interesting reading.

There are huge risks associated with all the actions that we are taking, which we have described to you today. They include whether we can achieve the desired results, whether we can get the money out, and whether the proposals around the clinical strategy will release the savings that we have described. One manages risks not with a written plan but through people, and those people have to be alive and alert to the risks. We are alive and alert to them.

One of the things that is missing from the debate about our clinical strategy and our financial plan is our ability to have a strong enough relationship with the Health Department so that it is alive to the risks in the same way as we are. We can manage a degree of risk ourselves by taking different courses of action as things unravel, but we need the kind of relationship that allows a two-party process. A bit of ducking and diving is necessary when one is dealing with the level of risk that we are dealing with, and that requires mutual trust and support.

Mrs Mulligan: That is helpful.

The Convener: It falls to me to thank all three of you for your help today as witnesses. My apologies for the windows of mass disruption—despite them, you have been particularly eloquent and detailed in your answers and you have given the committee a clear picture of the problems that you face, the way in which you are dealing with them, and the questions that we need to put to the witnesses from the Health Department who will be here in the future. Thank you for your time. Your evidence has been most useful.

We move into private session for items 5 to 7.

13:47

Meeting suspended until 13:49 and thereafter continued in private until 14:03.

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