AUDIT COMMITTEE

Tuesday 5 February 2002
(*Afternoon*)

Session 1

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AUDIT COMMITTEE
3rd Meeting 2002, Session 1

CONVENER

*Mr Andrew Welsh (Angus) (SNP)

DEPUTY CONVENER

*Mr David Davidson (North-East Scotland) (Con)

COMMITTEE MEMBERS

*Scott Barrie (Dunfermline West) (Lab)
*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
Paul Martin (Glasgow Springburn) (Lab)
*Mr Lloyd Quinan (West of Scotland) (SNP)
*Mr Keith Raffan (Mid Scotland and Fife) (LD)

*attended

WITNESSES

Mr Neil Campbell (Grampian NHS Board)
Mr Alec Cumming (Grampian University Hospitals NHS Trust)
Mr Neil McConachie (Argyll and Clyde NHS Board)
Mr David Sillito (Argyll and Clyde Acute Hospitals NHS Trust)

CLERK TO THE COMMITTEE

David McGill

SENIOR ASSISTANT CLERK

Ruth Cooper

ASSISTANT CLERK

Seán Wixted

LOCATION

Committee Room 2

Scottish Parliament

Audit Committee

Tuesday 5 February 2002

(*Afternoon*)

[THE CONVENER *opened the meeting in private at 14:01*]

14:13

Meeting continued in public.

The Convener (Mr Andrew Welsh): I welcome everyone to the third meeting of the Audit Committee in 2002. I ask members of the public and everyone involved to ensure that pagers and mobile phones are turned off.

I have received apologies from Paul Martin, who cannot be with us because of his duties on the Justice 1 Committee.

Scottish Environment Protection Agency

The Convener: Agenda item 2 relates to performance measures in the Scottish Environment Protection Agency. Further to an initial response that the committee considered in May 2001, members have received an interim progress report from SEPA. The report is in response to recommendations contained in the Auditor General for Scotland's report "A measure of protection: A baseline report on performance measurement in the Scottish Environment Protection Agency", and sets out its detailed progress on the implementation of the Auditor General's recommendations.

We have received an assurance that the agency will provide a final report in June 2002. Furthermore, the Auditor General will undertake a follow-up report in the autumn. As a result, I recommend to the committee that we take no further action at this point as we shall return to the matter. Are members agreed?

Members *indicated agreement*.

"Overview of the National Health Service in Scotland 2000/01"

The Convener: Item 3 is our consideration of the Auditor General's report "Overview of the National Health Service in Scotland 2000/01". Before I welcome today's witnesses, I want to put on record a letter that I have received from Mr John Aldridge, director of finance at the Scottish Executive health department. In relation to a comment that he made at our previous meeting, Mr Aldridge states:

> "The relevant section appears in column 954 of the official report where, in response to a question from Mr Quinan, I stated that I thought he was correct in saying that in 1999-2000, Argyll and Clyde Acute Hospitals NHS Trust was given the right to sell a piece of land and retain the receipt of £1.5million to offset its deficit. I regret that I was wrong to confirm Mr Quinan's understanding without offering some qualification. The Trust was given permission to sell a piece of land and retain the receipt, to be used for specific identified purposes. But, in the event, I understand that the piece of land was not sold, and therefore the question of retention of the receipt, or its use, either to offset the deficit or for any other purpose, did not arise."

I am happy to read that statement into the *Official Report*.

14:15

I welcome to the committee Mr Neil Campbell, chief executive of Grampian NHS Board; Mr Alec Cumming, chief executive of Grampian University Hospitals NHS trust; Mr Neil McConachie, chief executive of Argyll and Clyde NHS Board; and Mr David Sillito, chief executive of Argyll and Clyde Acute Hospitals NHS Trust. This is the second evidence-taking session for our inquiry into the Auditor General's NHS overview report. Two weeks ago, we took evidence from the chief executive of the NHS in Scotland, Mr Trevor Jones, and the director of finance for the Scottish Executive health department, Mr John Aldridge.

We will follow similar lines of questioning to establish how matters raised in the Auditor General's report impact at a local level within Argyll and Clyde and within Grampian, particularly in relation to acute hospitals trusts, which appear to be under the greatest financial pressure. We will examine three main areas: first, the financial performance of acute NHS trusts; secondly, the impact on acute trusts of the £90 million additional funding for the NHS that the Minister for Health and Community Care announced in September 2001; and thirdly, the steps that are being taken to secure a more comprehensive picture of the financial position in the new NHS board areas.

I will open this session by asking the health board chief executives, Mr McConachie and Mr Campbell, about their respective areas. Mr

McConachie, this is the Auditor General's second overview report on the NHS in Scotland. How satisfied are you with the NHS's overall financial performance in the area for which you are responsible?

Mr Neil McConachie (Argyll and Clyde NHS Board): As far as satisfaction is concerned, the most important aspect is how closely we are working together. Our responsibility is to deliver financial balance and improvements in services. As a result, NHS Argyll and Clyde has developed a comprehensive health improvement programme and has a collective vision for a financial plan to underpin that programme. At the moment, I am happy that NHS Argyll and Clyde is working collectively towards delivering its financial and health improvement targets.

The Convener: Thank you. Mr Campbell, will you describe the picture in Grampian?

Mr Neil Campbell (Grampian NHS Board): It is very much the same as the picture that Mr McConachie described. Perhaps the important issue for the committee should be the way we are working jointly in Grampian to tackle some significant management issues. Managing within our resources is our particular area of pressure. We have a joint plan, agreed across NHS Grampian, for dealing with those management challenges. The issue represents somewhere in the region of 1 per cent of the money that is spent in Grampian.

The Convener: In other words, you are responsible for balancing annual finance and for improving services. How typical is your authority? Is it atypical?

Mr Campbell: NHS Grampian is typical of boards in Scotland. It has particular issues that make it different—it is a teaching board, it is a tertiary centre, and it covers a significantly rural area with a large landmass. It is not different entirely from the rest of Scotland, but it is different from some other conurbations and cities.

The Convener: And your board, Mr McConachie?

Mr McConachie: I am not really sure how to answer that question, except to say that because the Clyde area has quite a large urban population and Argyll has a spread-out rural population, the area is like Scotland in microcosm. If you sat where Trevor Jones sits and looked across the patch, the area would look typical, as it has every variation that you could name. Of course, we do not have a teaching hospital, but we do teach medical students in some of our hospitals, and we are proximate to Glasgow, which is another factor. We are probably typical of Scotland as a whole, but we may not look quite the same as some of the other geographical patches in Scotland.

The Convener: So one area is typical and one is not so typical. Would the trusts like to comment? Are you satisfied with the overall financial performance in your areas?

Mr Alec Cumming (Grampian University Hospitals NHS Trust): Although we have had deficits, our outcomes over the years have been in line with the plans that we set and agreed with our health board. The audit of our accounts has been consistently positive. Appropriate controls are in place. The overspends that we have experienced resulted from pressures that no doubt you will wish to explore in due course, but I am satisfied that we have appropriate control mechanisms in place.

The Convener: Do you agree, Mr Sillito?

Mr David Sillito (Argyll and Clyde Acute Hospitals NHS Trust): Yes, I do. There is good evidence to say that things are reasonably well managed. We have certainly settled down following the change in the health service. My trust was made out of five other trusts, so there was quite a lot of work to be done in the early years and our focus was on that. After the first 12 or 18 months, we began to get into more of the detail about control. Things seem to be going reasonably well.

The Convener: We will now get down to the proof of the pudding, and look at the detail. Scott Barrie will examine whether NHS trusts are continuing to experience difficulties in achieving financial targets.

Scott Barrie (Dunfermline West) (Lab): I will start with Mr Sillito. The Auditor General's report identifies Argyll and Clyde Acute Hospitals NHS Trust as one of eight trusts that did not break even in the financial year to 2001. Could you explain the main reasons why your trust was unable to break even, and highlight specifically the difficulties that you encounter as an acute hospitals trust?

Mr Sillito: At the end of the year in question we had a deficit of something like £3 million. At the end of the previous year, we had a deficit of £3.5 million, so we managed to make a small contribution to reducing our deficit. Taking one year with the other we did not break even, but for the year in question we did break even. We had not planned to be able to make the repayment we did last year. In discussion with the Scottish Executive, we had planned repayment for a number of years in the future, but our plans were superseded by the £90 million that was handed out.

The day-to-day pressures that we face are similar to those that are outlined in the Auditor General's report. Junior doctors have been a particular issue—I could elaborate on that. Other issues are beginning to come along that affect us in common with other parts of Scotland, such as

the European working time directive and the general drive to raise clinical standards, which imposes a range of cost pressures. That is not unique to us but is common across the whole patch. I could go on to talk about the issues, but I will pause to see if there are any further questions.

Scott Barrie: You have highlighted a number of issues that you said were common across Scotland. What were the specific reasons for Argyll and Clyde being unable to meet its financial targets? I presume that other trusts had the same problems, but they were able to meet their targets.

Mr Sillito: I mentioned that Argyll and Clyde Acute Hospitals NHS Trust represents the bringing-together of five trusts. When the five trusts were brought together, there were lingering deficits and some levels of non-recurring funding from the earlier years of those five trusts. That was part of the reason for our first-year deficit.

Mr Lloyd Quinan (West of Scotland) (SNP): Mr Sillito, you have said that, to a degree, you suffer the same pressures that other parts of Scotland suffer, and Mr McConachie has pointed out that Argyll and Clyde is a microcosm of Scotland. To what extent does the geography of the area that you cover impinge on your ability to meet targets? How many financial pressures arise directly from, for example, the poor communications infrastructure on the north side of the river?

Mr Sillito: The geography adds a dimension that not everybody else enjoys or endures. We struggle with a range of tensions. We would like to provide local access for our communities. We have a large community in the Paisley conurbation, and smaller communities in the Greenock conurbation, in your area, Mr Quinan, and in Oban. It would be easier if we provided services in just one location, but we cannot do that. We have constantly to judge what level of services we can push out to peripheral areas, bearing in mind the fact that, in general, it costs more to provide services in four areas than it costs to provide services in one. However, although the geography adds a pressure, the challenge is to manage that as effectively as possible without going overboard.

Mr Quinan: I fully appreciate what you say and I understand that the pressures are greater when you have several different sites. Is it possible to identify the additional costs? Doing so might allow you to secure funding in a different way. Would it be useful to you, and to the Auditor General, if geography, different sites and the lack of communications infrastructure, especially on the north side of the river, were taken into account?

Mr Sillito: A fair stab has already been made at that by the Arbuthnott review. That review considered a range of major cost drivers such as deprivation and population. Furthermore, I think that I am right in saying that rurality was included in the equation for the first time. As a result, Argyll and Clyde has had an increase for rurality, whereas funding for a number of boards will have gone the other way. In another respect, funding for Argyll and Clyde itself has gone the other way, because its population has been falling. However, we received some compensation because of our remote areas.

Mr Quinan: You referred to the use of non-recurring funding by the previous trusts. Do you plan to make use of non-recurring funding? Is it an avenue for you to deal with the current deficit?

Mr Sillito: The problem with using non-recurring funding is when it becomes the norm. If one continues to use the same non-recurring funding, or if one allows it to grow ad infinitum, there comes a stage when the merry-go-round has to stop.

We always try to provide the maximum amount of services as soon as possible. It is legitimate to use a modest level of non-recurring funding if there is the prospect of recovering from that position. In other words, if we have some spare cash now, and if we know that full-time funding is coming in future, we would rather provide the services now—although such a decision requires judgment.

Mr Quinan: So you have plans to use non-recurring funding.

Mr Sillito: We use it as a matter of course, at a certain level.

The Convener: I have difficulty coming to terms with non-recurring funding becoming the norm. What percentage of your overall deficit is non-recurring funding? You said that non-recurring funding was a problem and was one element of your deficit at changeover. How big a part of your overall deficit was it then and is it now?

Mr Sillito: When we brought all the trusts together, our non-recurring deficit was about £3 million.

The Convener: What was the overall deficit?

14:30

Mr Sillito: The overall deficit was £3.5 million that year. However, with the health board, we augmented our funding to recover from that position, so we had a clean sheet during and at the end of that year. The amount of non-recurring funding that we might be using just now is not more than about 0.5 per cent.

The Convener: How much is that?

Mr Sillito: Our total budget is about £150 million.

The Convener: Is it satisfactory that non-recurring funding remains part of the budget?

Mr Sillito: I tried to explain why I thought that using such funding might be legitimate. If, for instance, we knew that additional money was to be provided next year for cancer services and we had some cash this year, we might start those services sooner, because full-time funding was to be provided next year.

Mr Keith Raffan (Mid Scotland and Fife) (LD): Is the use of agency as opposed to bank nurses a continuing problem?

Mr Sillito: Yes.

Mr Raffan: Roughly how major is the cost?

Mr Sillito: The biggest hits that we have taken this year from single items have been in medical and nursing staffing. I am not sure whether I can give the absolute split, but the big drivers are the use of agency nurses for nursing staff and the use of locums for medical staff.

Mr Raffan: That brings me neatly on to the next point. Forth Valley NHS Board, which is in my constituency, has no teaching hospital and has told me about problems, which may not be problems that teaching hospitals have, of filling consultant positions and of having to use locum consultants—which I understand can be very expensive.

Mr Sillito: It is.

Mr Raffan: Another problem is consultants' overtime at weekends, which can sometimes be a huge amount that goes into four figures. Are they major issues for you too?

Mr Sillito: Overtime is not a major issue for us. It happens, but only episodically. The big problem is consultant staff in some of our hospitals or in some specialties. More remote hospitals tend to use locums, but not continually. They may not have consultants in the same specialties all the time, but usually one or two are around all the time. Bigger hospitals tend to use locums in specialties that may have a shortage, such as anaesthetics or obstetrics.

Mr Raffan: As it sometimes takes much longer to fill a consultant position in a trust such as yours, which has no teaching hospital—perhaps we will hear about Mr Cumming's trust later—is the locum situation different in trusts that have a teaching hospital?

Mr Sillito: I am sure that it is. We did not quite cross swords, but Alec Cumming and I both interviewed the same person and the chap went to Grampian for some reason.

The Convener: We have a fair number of detailed questions.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): You mentioned how, under the Arbuthnott funding formula, NHS Argyll and Clyde had received extra money in consideration of rurality. Has that process been applied below the board level?

Mr Sillito: Not by us. Neil McConachie may know about that. The process was not designed to be broken down below the macro level.

Margaret Jamieson: That leads to a question to Mr McConachie. Given the great deal of time and effort that individuals spent on devising the Arbuthnott formula and that parliamentary committees spent on it, how can we be assured that funding is being delivered where we want it to be?

Mr McConachie: I will answer in two parts. First, as I understand it, there was no initiative to apply the Arbuthnott formula below health board level. In that sense, Arbuthnott is being applied in the distribution to the various NHS board areas. Having said that, it is obvious that we should look at application below health board level, although that has not taken place yet. We have started the process of applying Arbuthnott and of examining what it looks like. That work is under way, but it is far from being concluded.

We have set up a group to take forward the initial view—to ask what questions Arbuthnott funding raises. Someone who works on health economics at the University of Glasgow is on that group and there is representation from the various trusts. We will continue to examine the situation by taking figures for a two or three-year period and assessing the variations. There might be explanations for why a particular area seems to be an outlier. If there are no such explanations, it would be legitimate to ask questions. At that point, it would be up to NHS Argyll and Clyde to consider what has been raised by the examination exercise that will take place over the next few months and to ask whether we should do anything about it. Ultimately, it is up to the NHS unified board to make a decision about where it spends its money.

We are looking at what the variation below health board level might be in various communities. The nature of the Argyll and Clyde area means that communities are quite dispersed. We will consider what questions any variations raise, what the answers are and what we need to do about the situation, if anything. Those sorts of options would go the NHS unified board.

The Convener: Scott Barrie wants to examine the situation in Grampian.

Scott Barrie: Mr Cumming, your trust has failed to break even in the past two financial years. It is running a cumulative deficit of around £5 million. We have heard from Mr Sillito about some of the

difficulties that face acute trusts. What extra difficulties does your trust face, given its status as a teaching hospital trust? Do you agree with the reasons that Mr Sillito gave?

Mr Cumming: All the issues that David Sillito raised are relevant to us. Some other general issues would apply to many trusts. We have experienced significant increases in the costs of treating patients with cancer over the past few years. Cancer drugs, in particular, have increased in cost.

There has been a substantial increase in the level of emergency medical receiving—it has been well above the level that we would expect from growth in population, particularly the elderly population. We do not understand the reasons for that, but it has been a major cost pressure for us.

There has been a substantial escalation in demand for laboratory services, mainly from GPs. That is probably a result of the pressures of clinical governance that David Sillito referred to and of the need to be certain that the care that is offered is based on good evidence.

We have had substantially higher use of our intensive therapy department, which is partly because people who are in hospital are more ill—the hospital is becoming better at treating very ill patients. That requires high-tech facilities. Clinical governance reasons—being absolutely sure that patients are given every chance—are another factor in higher use of intensive therapy.

Please excuse me. I have a frog in my throat.

The Convener: Do you need some water?

Mr Cumming: I need more than water, unfortunately. I need a good doctor.

I will deal with particular factors for Grampian. Our cost base—the average cost per patient—is very low. It is 10.6 per cent below the Scottish average. That is a major issue. In any specialty area, our costs of keeping patients in hospital are well below the Scottish average. As a result, any pressures that arise have an immediate effect on us. The fact that we start from a low cost base makes life quite difficult. That is simply a challenge that we have to face.

In common with all other teaching areas, we like to stay at the forefront of medicine. We believe that it is right that Scottish patients have the opportunity to access the latest developments in medicine. We like to play our part in that, but there is a cost attached. There are many examples of that, such as the issues around cancer treatment, which I mentioned earlier. We have also been particularly innovative in some orthopaedic techniques locally.

The availability of those techniques will spread across the rest of the NHS in due course, but it is one of the functions of a teaching hospital to encourage its staff to be at the leading edge and to ensure that we provide care comparable to that provided in the rest of Europe and North America. That is part of our function and it adds to our cost pressures.

The Convener: If the pressures will not go away—indeed, you describe increasing pressures—why should the deficits?

Mr Cumming: The deficits must go away because we know that we have to live within the level of resources available to us. That is a matter for joint planning between the trust and NHS Grampian. We must consider the way in which money is spent across Grampian and the level of services that we offer.

In Arbuthnott terms, Grampian should have a lower level of requirement for services, yet we provide services at an average level for Scotland. There is a challenge for us there. We must provide services that fit with the funding available to us and that are appropriate for the level of health of our population. We are considering that jointly with NHS Grampian. It will lead to some reshaping of service and moving of expenditure in order to address the issues that I have outlined.

The Convener: In spite of junior doctors, clinical standards and everything else, are you confident that you can get rid of the deficits and improve services?

Mr Cumming: It is part of our job. We are employed and paid to tackle those issues and to make the best possible use of such resource as it is determined to be available to us. We must ensure that we use the resource in the most effective way for the care of patients. That is at the core of my job.

Mr David Davidson (North-East Scotland) (Con): Good afternoon, Mr Cumming. This afternoon you began by talking about overspends as a result of pressures. Within those pressures, do you feel that being a teaching facility adds to your cost base? You said that the cost base is 10.6 per cent below the Scottish average.

Mr Cumming: It undoubtedly costs more to be a teaching centre. There are direct costs involved in teaching and there are indirect costs, such as being at the leading edge. There are also differences in practice in terms of the involvement of consultants in teaching and contact with patients. Those direct and indirect costs are compensated for in the additional contribution for teaching—ACT—funding, which is made available to all the teaching trusts.

Whether the ACT funding is adequate to deal with the direct and indirect costs is a difficult

question to answer. That is being examined on a national basis—a group is considering whether the level of ACT funding is appropriate. There is a school of thought, particularly among non-teaching trusts, that it is too big. Those in teaching trusts feel that it should be larger.

Mr Davidson: Does your trust have any input to the ACT exercise?

Mr Cumming: Our trust has no input as such, but a distinguished colleague from Grampian is part of the review group.

Mr Davidson: I have a little local knowledge, as Mr Cumming will appreciate. You stated that you would seek to live within your means, provide value for money and deliver service. Is it fair then for me to ask you whether you feel the addressing of deficits and the cutting the cloth to fit will lead to a deterioration in service delivery appropriate to the demand laid upon it?

Mr Cumming: We have given a commitment that we will provide services in accordance with the needs of the population of Grampian. There is an issue for us in that the population of Grampian is 10.3 per cent of that of Scotland, whereas the funding available to Grampian is roughly 9 per cent of the Scottish share and declining. That is for the very good reason that the average health level in Grampian is higher than the Scottish average. We provide services at average level. That obviously provides a challenge for us, and we have to consider how to provide an appropriate level of service.

We have made it clear that we do not intend that any individual service should deteriorate. When we were in difficulty this year, we made it clear that our priorities were patient and staff safety; achieving the waiting list targets that have been set for us; and achieving the financial targets that we have agreed. We believe that we will meet all three targets, but we have made it quite clear that they are in that order. The preservation of safety and quality of service are crucial.

Mr Davidson: I have a final point on something you said about drug costs. Do you feel that you have a disproportionately high demand for high-cost drugs in the north-east when it is set against the Scottish average?

Mr Cumming: I can only speak for acute services and the answer is no, except for the special factors that I identified as arising out of the development of services as a teaching hospital. There is nothing to indicate that the general hospital population requires a higher level of drug usage. I cannot answer for primary care.

14:45

The Convener: We will now move to considering how you are going to square the financial circle.

Scott Barrie: From our earlier inquiries into health service issues, we know that trusts facing financial difficulties are required to prepare recovery plans that aim to achieve financial balance. As the chief executive, Mr Sillito, what steps do you take to ensure that the financial recovery plans are robust and achievable? To what extent does your trust liaise with the health board and the health department on the financial position and the discussed recovery plan?

Mr Sillito: I will take your last point first. There is quite comprehensive liaison. We would not produce a plan that we had not discussed with the health board in the first place. Latterly, we have been in the practice of submitting jointly the plans to the Scottish Executive if it requires them. We produced a recovery plan at the end of the first year when we were heading for a £3.5 million deficit.

In our recovery plan, we used some of the large indicators that are published, such as lengths of stay in hospital, number of blocked beds and the proportion of our budget that was spent in particular service areas. We fashioned our recovery plan around those indicators and then monitored progress.

I have to say that we have not been entirely successful in all areas. The question of blocked beds has proved to be particularly difficult. We have enjoyed a higher level of blocked beds than almost any other part of the country. Up to now, that burden has ended up on the acute sector and that will continue until we resolve some of the other issues that lead to that problem.

Scott Barrie: Last year, we took evidence from Trevor Jones. In that evidence, we heard that Argyll and Clyde Acute Hospitals NHS Trust was performing in line with its recovery plan and, on the basis of the latest monitoring returns, was set to achieve its break-even target. However, by the end of the financial year, the deficit was approximately £3 million.

Mr Sillito: I am not sure if I have the right years. In the first year—the year ending in 2000—we had a deficit of £3.5 million. For the year ending in 2001, we had clawed back £0.5 million. That was better than we had planned. We had not planned to be making a contribution to the deficit. For our second year, therefore, we did slightly better than breaking even.

The Convener: We are getting a rosy picture here. Everything is under control. Services and costs are going up but, not to worry, the trust is going to break even. Trevor Jones, the chief executive of the NHS in Scotland, gave us a rosy picture and told us that everything was under

control. Now you are telling us the same thing. The reality is that there is a £3 million deficit. That does not seem to me to be under control. In your robust recovery plan, when will you balance the finances as well as providing the services?

Mr Sillito: I did not mean to imply that everything is rosy. Things are difficult. If you have a deficit, you have to repay it. We did not increase our deficit in our second year; we made it slightly smaller. That was the point that I was trying to make.

The Convener: Yes, but in his evidence Trevor Jones said that there would be break-even. Are your recovery plans really that robust or are they just mind games? Can you deliver on your recovery plans and balance the books as well as provide services? That has clearly not happened so far.

Mr Sillito: As you know, the £3 million that we were carrying forward has been written off by our proportion of the £90 million that was issued by the Scottish Executive at the tail-end of last year. Argyll and Clyde got £4.5 million, which comprised £1.5 million for Renfrewshire and Inverclyde Primary Care NHS Trust and £3 million for ourselves. In a sense, the slate has been wiped clean.

The Convener: So if the slate has been wiped clean, will the books now balance?

Mr Sillito: I do not know exactly how NHS Argyll and Clyde will end up this year. It looks as though collectively we will come in with a small deficit, certainly smaller than £3 million. It will probably be about half of that.

The Convener: But therefore you will have to go back to central Government to wipe the slate clean again. Where does this cycle end?

Mr Sillito: I am not sure that we would be well received if we went back and asked for another £1.5 million. We are planning to find ways to claw that back in future years. Our spend is—

The Convener: When will this cycle end? You are in charge, and you have these massive problems to contend with. When will the books be balanced and services provided, which is what the people want?

Mr Sillito: The £1.5 million has to be seen in the context of a budget for Argyll and Clyde of something in excess of £400 million, so it is a relatively small amount of money by comparison.

The Convener: But it is a deficit, and deficits can accumulate.

Mr Sillito: They can accumulate. So far we have managed to reduce one deficit, so we have demonstrated in some way that we can take action. In common with lots of other acute trusts we are struggling with the tensions of providing the sorts of measures that we have talked about—measures to do with the working time directive, junior doctors, drug costs and blocked beds—at the same time as developing and delivering services. On this occasion we have gone slightly over budget.

The Convener: I know that it is not easy, but when will you balance the books? That is what we would all like to know.

Mr Sillito: We hope that next year we will break even. That is our plan for this year, and that is what we are working on.

The Convener: Break-even was talked about by the head of the NHS last year, but we are still waiting for it. Is your recovery plan robust enough to deliver break-even?

Mr Sillito: The big difference between the way it was a couple of years ago and the way it is now is that in the forthcoming year NHS Argyll and Clyde is going to examine its books as an entity, and not simply the acute trust.

The Convener: You are saying that there will be deficits and that there will be mounting pressures for more expenditure, for the reasons that you outlined earlier, so you cannot see break-even.

Mr Sillito: No, I am saying that at the moment our worst scenario for this year is a small deficit. As I said, we are talking about £1.5 million out of £400-odd million. We have been asked by the Scottish Executive to produce plans before the end of this financial year that demonstrate that we will be able to break even next year. That is what we are working on.

The Convener: Breaking even is one of the duties that is laid upon you. You will not achieve it this year, but you think that you will next year.

Mr Sillito: Correct.

The Convener: Does that include getting rid of this year's deficit?

Mr Sillito: That is what we are working on.

Mr Quinan: I have two or three questions. First, is it not true that you have been given funding to address the measures in the working time directive? The directive has absolutely nothing to do with the deficit, because the changes that have resulted from it have already been dealt with in the finance that you were given for this year.

Mr Sillito: The European working time directive hits us in a number of ways. It is often used as a catch-all for a range of pressures. We have been given some—

Mr Quinan: There are those here who would say that it is regularly used as a red herring.

Mr Sillito: I can give you an example of where it hits us. The best way of explaining it is to consider maternity services and obstetrics. Obstetrics is almost a unique service, in that consultants are expected to be there at 3 o'clock in the morning. In the past, by and large junior doctors would look after deliveries at 3 o'clock in the morning. For a couple of reasons those juniors are not available: either there are fewer of them or they are less well qualified because of the changing training routine.

Increased standards and the risk of litigation means that, increasingly, the consultant staff have to be in. If the consultant staff are in at 3 o'clock in the morning, you do not want them to be operating at 10 o'clock in the morning. There is a professional pressure there. The working time directive starts to bite. We estimate that to achieve harmony with both the working time directive and clinical standards we need something like 11 additional obstetricians. We are going to try to find ways of mitigating that situation.

Mr Quinan: I accept what you are saying, which impacts on another issue that I want to ask you about. What about junior doctors' hours? That is not the same issue as the working time directive.

Mr Sillito: No, it is not.

Mr Quinan: Are junior doctors' salaries financed?

Mr Sillito: In part. I do not mean to be derogatory, but the junior doctors are more junior in that they are less capable than the previous generation of junior doctors. If we accept that they can do less and that they work fewer hours, we have to replace their manpower and inputs by bringing in staff grades such as qualified doctors or by enhancing the training for nurses. We are paying more for the pay rise for junior doctors. They are less skilled—

Mr Quinan: The money for that pay rise was included in your annual funding. It does not relate to the deficit or the projected deficit.

Mr Sillito: It does, because additional costs fall from it. For example, we have to fill the hole caused by lower skill levels and lack of numbers by augmenting the medical staff. Those costs start to bite. Although the junior doctors' salaries have been covered, the implications have not been. Our funding contains a contribution towards that, but it is not sufficient.

Mr Quinan: I appreciate that. In response to Mr Raffan, you said that a financial pressure arose from the use of locums. Your description of consultants not being able to pass work on to junior doctors at 3 o'clock in the morning suggests that that is an area where locums could be used. The use of locums is a serious pressure in your area because of the working time directive, the use of what you described as junior junior doctors who are not of the same standard as junior doctors were some years ago and the fact that, as a result, you have had to increase training in other areas. Does that mean that the trust's inability to attract and retain staff—partly because of geographical reasons—is an on-going, year-on-year financial pressure on the trust and the health board? If so, do you agree that such pressure will continue until we apply the principles of a rural weighting to match, for example, the principles of weighting that apply in London? The witnesses from Grampian indicated that they have a similar problem in bringing people to outlying areas.

Mr Sillito: I do not know the extent to which Grampian suffers from the locum problem.

Mr Quinan: Let us talk about Argyll and Clyde, then.

Mr Sillito: The use of locums has been an issue. As I said, the use of locums is a way of life in, for example, our Oban hospital. On the other hand, it has been less of a way of life in Vale of Leven hospital. Although we have found it particularly difficult to recruit for some posts in that hospital, I do not think that that is just because of rurality or the hospital's remoteness. Other factors have to be taken into account.

Mr Quinan: However, as such factors clearly affect service delivery, they have to be brought into the equation to ensure that you address the financial pressures. For example, I have asked about the geography of your health board area. Those factors are all aspects of how the committee and others assess the financial needs of your area and address the issues that will allow you to reduce the pressures on your deficit.

You said that you expect the projected deficit for this year to be £1.5 million. Trevor Jones was informed by a report that you would break even; at least, he told the committee that, based on information that he had received from you, he believed that you would reach a break-even point. You have said that you will effectively halve the deficit. Will you use non-recurring funding to do so?

Mr Sillito: I am not sure that I fully understand your question.

Mr Quinan: Okay. Your current deficit is £3 million. You have said that you expect the deficit to be £1.5 million by the end of this year—

Mr Sillito: No. Our current deficit is gone; it has been wiped by the Scottish Executive. Of the £90 million that was distributed, part was for winter and part was for deficits.

Mr Quinan: Is it fair to say that that is non-recurring funding?

Mr Sillito: Yes.

Mr Quinan: If all the pressures that led you into the £3 million deficit are not removed and the contribution from the £90 million is a single one-off payment of non-recurring funding, the situation for creating a deficit has not altered.

Mr Sillito: Some alterations have been made. In our discussions with the health board and our other colleagues in the primary care trust, we decided to alter our funding at the end of the first year, so that several inevitable pressures that we had picked up were addressed.

Mr McConachie: I will pick up on what Trevor Jones may or may not have said. To be fair to him, we met him last week as NHS Argyll and Clyde, after—

The Convener: We have the record of what he said.

15:00

Mr McConachie: However, since you met him, we met as NHS Argyll and Clyde and gave him an updated financial status report, so he is aware that, two months from the end of the financial year, NHS Argyll and Clyde projects a deficit of £1.5 million for the total system. We have a commitment to drive that out of the system as best we can by the end of the year. Trevor Jones would have been made aware of that projection last Thursday.

Mr Quinan: The £3 million from last year has been wiped out, so you start from zero. However, at the end of this financial year in two months, NHS Argyll and Clyde will have a deficit of £1.5 million. That makes £4.5 million in reality. If the £3 million had not been wiped out, the deficit would have increased by 50 per cent.

Gentlemen, I genuinely believe that you are massively underfunded for several reasons and that non-recurring funding is not the way of addressing that. We must find ways of removing the pressures on you. The real situation is that you had a deficit of £3 million, which was wiped out, but since then you have accumulated another deficit of £1.5 million. If you have accumulated that amount, surely in another six months—

The Convener: We should let the witnesses respond.

Mr Quinan: Sorry.

Mr Sillito: I suggested that part of the first year's deficit concerned what had gone on before and related to a complete adding-up of the books. Our funding has increased every year since then and part of that increase has been used to address underlying pressures. In our second year, we did not operate at a deficit; all that we owed was the £3 million, which was wiped out. In our second year, the area did pretty well and broke even. We are now into our third year and we are back in the position of dealing with a deficit—£1.5 million. All those matters are separate—one is not a function of another. The developments are not linked.

Mr Raffan: I would like to put the situation into context—my position differs slightly from that of the previous questioner. We can get hung up on figures. Mr Sillito said it in passing, but I would like it to be clear in the *Official Report* that £1.5 million is about 0.4 per cent of the entire budget. Even £4.5 million would be just over 1 per cent. Some might wish that national Government could be as good as that, but I will not tempt the witnesses in that direction. Is the percentage very low?

Mr Sillito *indicated agreement*.

Mr Raffan: My second point concerns junior hospital doctors' pay, which creates a double whammy. I would like to emphasise the point—or perhaps you could emphasise it for me—that the issue is not just those doctors' pay, but their limited hours and the resulting staff shortages. Is that correct?

The Convener: Mr Raffan, I think that we are meant to ask questions rather than make statements.

Mr Raffan: I just asked whether my assumption was correct.

Mr McConachie: The percentage is correct. I make the point—I think that Mr Cumming referred to it—that there is a responsibility to manage that percentage, albeit small, because it represents a sum of money that we do not want to have to find.

Before the idea of a £1.5 million deficit catches on, I emphasise that two months of the financial year are left. A £1.5 million deficit is our projection at the moment. We are being prudent in saying, "This is the figure that we are committed to." We must continue to work to manage the deficit out of the system. That is the commitment that we have given.

At the moment, the £1.5 million is a projection; it is not a year-end actual. The two must be taken together. Argyll and Clyde is still committed to working at the deficit and to managing it to produce a better result. There is a difference between that approach and making a commitment at any one stage on what we will do.

The Convener: We will leave the fine area of Argyll and Clyde and focus on Grampian.

Scott Barrie: Following on from the comments of Mr Sillito and Mr McConachie, I ask Mr Cumming to comment on the position of Grampian University Hospitals NHS Trust in the current financial year and on what progress the trust is

making with its recovery plan.

Mr Cumming: We agreed before the beginning of the financial year that we would have a deficit of £6 million in the current year. During the year, the position worsened and we were overspending beyond that £6 million level. We took corrective measures in August and through the autumn of last year and we now expect to end the year exactly on target. In fact, the cumulative deficit at the end of the year will be £5.4 million, because we will have written off the carried-forward deficits and a small part of this year's deficit by the use of our share of the £90 million. The £5.4 million deficit is exactly in line with what has been agreed with the Scottish Executive.

I will put the expected deficit in context. It is a reasonably limited figure in relation to the £450 million of funding in Grampian. However, it is a substantial issue for us—I will not duck that. In Grampian, the board and the trust agreed with the Executive that a deficit was unavoidable for the reasons that I have identified: an underlying efficient cost base and a level of service above that that we are, in effect, funded to provide. We have argued that we need time to carry out structural reorganisation in our area to get the level of services in line with the funding that we have. We have a three-year forward plan at the end of which we will break even. We have forecast a deficit for this year and next year and we have forecast that we will achieve balance the year after.

Mr Davidson: You finished by saying that you were adjusting the services to bring them into line with the funding. Does that mean any cuts in service?

Mr Cumming: Neil Campbell may be better placed to comment on that, because we are not talking about acute services alone; we are talking about the range of services throughout Grampian.

Adjusting the services means that there will be difficult issues for us. For example, as is well known publicly, we have proposed to close Tor-Na-Dee hospital. We believe that, if we are to make the best use of the resources that are available to us, we must tackle difficult issues such as the services that are currently at Tor-Na-Dee. There may be a number of other such issues.

We also need to co-operate with our colleagues in general practice to ensure that the demand that we experience in the acute hospitals in Grampian is in line with what the Arbuthnott report says that we should experience. At the moment, there is a discrepancy. We are therefore co-operating with general practitioners and examining patterns of demand, which vary greatly from practice to practice, to see whether we can find a way of reducing the overall demand. That will require restructuring in Grampian as a whole. Given that the issue is Grampian-wide, it may be more appropriate for Neil Campbell to comment.

The Convener: Would Neil Campbell like to comment?

Mr Davidson: Can I finish with Mr Cumming before I go to Mr Campbell?

The Convener: That sounds ominous, but go ahead.

Mr Davidson: Some of Mr Cumming's comments lead to further questions. We are considering a particular situation in the trust.

Mr Cumming, you talked about the proposal to close Tor-Na-Dee hospital. That is a realignment of service provision, which I understand. However, once the service is withdrawn and the site is disposed of, that presumably counts as another non-recurring input of resource. Will that take place within Grampian University Hospitals NHS Trust or Grampian NHS Board?

Mr Cumming: It will take place within NHS Grampian. We cannot dispose of the site. It is shared by Tor-Na-Dee hospital and Roxburghe House, the cancer hospice. Roxburghe House will be replaced, but that will not happen for about two and a half years.

Mr Davidson: So service at Roxburghe House will continue.

Mr Cumming: Yes, the site is required.

Mr Davidson: So that is not an immediate concern.

Mr Cumming: No. The closure of Tor-Na-Dee hospital will make available to us a substantial amount of recurring funding to help us to address the issues. We believe that the services that we will offer in place of Tor-Na-Dee are an improvement on the services that we currently offer at Tor-Na-Dee. This is a win-win situation, although it is not easy to persuade our population of the merits of the case.

Mr Davidson: I am aware of the argument and have sympathy with what you are trying to do.

You said that, this year, the agreed deficit will be £5.4 million. What is an agreed structural deficit? The chief executive of the NHS in Scotland ducked that question a little in his evidence. You cannot currently exist without having an agreed deficit in place—in accountancy terms, that is a structural deficit. Presumably, you are saying that you hope annually to break even with your cash flow, but the deficit that you are accumulating and that was reduced in the past is rolling forward in one form or another, because your service structure does not allow you to get rid of it. Is that a fair analysis?

Mr Cumming: That is quite fair. We need three years to engineer the structural change that is necessary to bring us into recurring balance in Grampian.

The Convener: In those three years, what costs will come? You have said that various pressures, many of which are outwith your control, may add to the deficit. Just when you look as though you are heading towards breaking even—the task with which you are charged—you may find that other on-going pressures will drag you back into deficit. How do you cope with that?

Mr Cumming: We know of some of the pressures. We know that we will have to meet certain compliance dates—and not just those relating to junior doctors. We also know that existing cost pressures will continue.

There is no easy answer, but our job is to control those pressures. Recently we agreed a protocol for the control of drugs, which exerts rigorous control over the development of new drugs for cancer care, ensuring that we proceed only when we are satisfied that there is evidence of benefit to patients. That is difficult for clinicians and for patients, but we believe that it is part of the challenge to which people such as me must face up.

I hope that we have predicted most of the pressures in our forecast. There may be others, but our job must be to manage within the resources that are made available to us.

Mr Davidson: I have two quick questions for Mr Campbell. First, from your position on the board, which is currently in surplus—we will come to that eventually—what action can you take to help the trust? What plans do you have to help the trust to deal with the difficulty that it claims will take three years to resolve? Do you have a game plan for that? Secondly, what are you doing about the demand exercise that is coming from the primary care sector, through GPs?

Mr Campbell: Those are two difficult questions.

The plan for Grampian is an NHS Grampian plan. It does not sit solely with the acute trust. The deficit is generated from the activity of the acute trust, but it is not an acute trust deficit—it is an NHS Grampian deficit. The three-year plan aims to rebalance the work that we do in Grampian, to enable us to make best use of our resources. That rebalancing of work and services seeks to address services as they have developed over many years. All health systems face that situation. The plan applies throughout the health system in Grampian—in primary, secondary and tertiary care. We are moving forward on that basis. That is how Grampian NHS Board will support the changes that are necessary in acute and primary care services; that is how I will support Mr Cumming. Our approach relates very much to the whole of NHS Grampian.

Our approach to primary care services recognises where innovation and the opportunities for service redesign lie. That is the way in which primary care services need to develop. In Grampian we have an unprecedented opportunity to change primary care services, because historically we have developed 20 community hospitals—the largest number of community hospitals in any health board area. We have the opportunity to examine how those community hospitals are used, to maximise their use and to make an impact on what happens in the acute sector. That is also part of the plan to recover the financial position.

The most complex piece of work that one can do in the health service is to remodel services between secondary and primary care and to remodel the whole health system. That is why we have sought to do it over a three-year period and why we have tried to address the financial pressures over a three-year period rather than pretending that it is possible to do that within a year. Mr Cumming has made it clear exactly how complex that management process is. It involves not only what one has to do daily within a set plan, but the pressures that come from either side of the plan—the pressures that the committee has suggested that we do not know about yet. The managerial challenge for us is to be aware that we could be knocked off course, so we must have contingencies in place to deal with such possibilities. Our plan tries to do that.

The Convener: A credibility gap is opening up. I hear you using phrases such as “best use of our resources”, “restructuring service provision” and “remodelling services”, but you are chasing a £5.4 million deficit. How are you going to turn what have been called unavoidable deficits into avoided deficits? It seems that you are chasing an ever-moving target that is getting more costly.

15:15

Mr Campbell: I do not think that the target is moving. We were very clear about the target that we were aiming for at this year-end.

The Convener: I meant the new costs that are being built into the system.

Mr Campbell: There are at least two streams of on-going work. We have made assumptions based on the growth that NHS Grampian will achieve over the next couple of years because of financial allocations from the centre. We know what those allocations will be for the next two years and we knew in advance of this year what they would be for this year. We can build robust plans based on the amount of money that we know we will be

receiving. We can also build robust plans based on the resources that we can generate within NHS Grampian itself by doing things differently.

Mr Cumming mentioned Tor-Na-Dee hospital, where an historic service that serves the needs of a specific group of people has been transformed. We can reprovide that service in a more appropriate model for the 21st century for an extended client group and for half as much as we are currently spending on it. We will therefore be putting in place a service that is as good as, if not better than, the existing service and that meets the needs of a wider group of people. That is excellent. We will also make a saving of something in the region of £500,000, which we can put back into our plan for addressing the deficits in the region.

The task is complex and difficult task to pursue, but it is our duty to pursue it. We do not have the option of continuing to overspend or of looking for more money from the Executive. Our job is quite clear. We have to manage within the available resources and must provide the highest-quality services possible.

Mr Cumming: I would like to add two points. First, we need to remember that the levels of uplift being given to the NHS are bigger in real terms than ever before. I know that because I have worked in the NHS for 26 years. That uplift obviously helps us to deal with some of the issues.

Secondly, I realise that, when presented in general terms, the plan that we described sounds aspirational. Our job is to turn it into nuts and bolts. I do not think that the committee would want to go through the nuts and bolts, but we would certainly be happy to provide details of the year 1 elements of that nuts-and-bolts work. We are doing real work on issues that we have identified where we know that we can make savings with either no impact or a minimal impact on service. Our aim is to spread that process through years 2 and 3 and to break even. It is not aspirational. The issue comes down to nuts and bolts and to real things that you can touch and see.

The Convener: I am sure that the committee wishes you every success in that task. We have heard the theory, but the real test will be next year's overview, to which we shall return.

Mr Raffan: There are two brief points on which I would like clarification. The current deficit is £5.4 million and you are talking about a three-year plan to break even. Is that correct?

Mr Campbell: That is correct.

Mr Raffan: What about the accumulated deficit during that three-year period? Will it be wiped out at the end of the three-year period or will it still exist?

Mr Campbell: We will have an accumulated deficit at the end of three years of £12.4 million, but we will be in an in-year break-even position at the beginning of that year in 2004.

Mr Raffan: I do not want to pursue that point now—

The Convener: Sorry. Mr Campbell is saying that at the end of the period there will be a £12.4 million deficit. Does that mean that it is a structural deficit?

Mr Campbell: We will have adjusted our cost base within Grampian NHS Board so that, year on year, we are able to live within the allocation that is available to us. The deficit that we will have accumulated—which will be £12.4 million—is the year-on-year effect of overspending over the time that it takes to adjust the structural deficit, as Mr Raffan described it.

The Convener: You will have to do more than live within your means at the end of that period—you will have to get rid of the accumulated deficit.

Mr Raffan: Are you looking to the Executive to get rid of that deficit for you?

Mr Campbell: We do not have a plan in place to address the accumulated deficit, which will sit on our books at the end of year three.

Mr Raffan: I would like a minor point—compared with that bombshell—to be clarified. Does the very tight drug protocol that is being imposed on consultants, which Mr Cumming talked about, exist in addition to protocols that are imposed by the Health Technology Board for Scotland? Does Grampian have a drugs protocol that is tighter than protocols in other areas? That would mean that drugs—for example, for cancer—are available in other health board areas but not in Grampian.

Mr Cumming: No. The protocol is consistent with national guidelines that help us to ensure that controls that are in place locally are in line with national guidelines. As I said, as a teaching trust area we tend to be at the forefront of developing new drugs. The protocol exists to help us with new drugs as they appear and to ensure that those drugs are not used in an uncontrolled way.

The Convener: I get the impression that I am listening to conscientious people who are running to stand still.

Margaret Jamieson: The Auditor General's report mentioned matters that he considers will constitute additional pressures on the NHS in future. Some of those have been alluded to, such as junior doctors and employee costs that will result from working time directives. We have not heard about other pressures that you think might cause you difficulty in meeting your financial

targets, or about how you will deal with them. The pressures might just hit you over the head, as they did in my health board area when junior doctors made false claims that they had poor accommodation. That is something that will face every one of you. I was in a fortunate position, because the accommodation in question was perhaps the best in Scotland.

Mr Sillito: I could add a long list of pressures that we might expect to face. One pressure that will probably be worse in our area than it will be elsewhere is harmonisation of rates of pay. As I said, we used to be five organisations so we have, at the very least, five rates of pay for the same job.

Margaret Jamieson might be aware of the recent settlement—more or less throughout the country—in relation to medical secretaries. That will have excited other groups of staff to consider their positions. Other groups of staff are saying that it is time for harmonisation and grading issues to be sorted out. Given our geography and organisational history, I expect that that will be a particular pressure for us.

Blocked beds have been "mentioned"—I am sorry to use a euphemism, but the word comes out rather too easily. Bedblocking is a continuing pressure in our part of the world. It is fortunate that our quarterly moving average has come down. I think that that has happened because of all the work that we have put in.

Drug costs continue to creep up and quality is another big area. Medical standards are improving and we know some of the reasons why. More consultants are on hand than in the past; we have talked about the cost of that.

Those are one or two pressures to start with—I could go on.

Margaret Jamieson: Can Mr Cumming tell us about any pressures that loom large?

Mr Cumming: David Sillito has covered the issues of which we are aware. I have nothing to add to the list. Our difficulty is in dealing with the unknown. We have listed the pressures about which we know.

Margaret Jamieson: Are those all the pressures that you know about? What about hospital-acquired infections, infection control and the need for cleaner hospitals? A significant number of the recommendations in the documents that the Auditor General has published are still to be implemented. We have not heard about how those—

Mr Cumming: The Auditor General mentioned decontamination. I am sorry, but I assumed that you used the Auditor General's list as a starting point. Decontamination is certainly a major issue for us. As it happens, the cleaning standards in the hospitals for which we are responsible are high and were acknowledged as such in the Auditor General's report.

Decontamination is a different issue. For a variety of reasons—CJD among others—we must achieve ever-higher standards of decontamination. That requires substantial investment in equipment and a fair amount of investment in kit that is used as a one-off. We are examining the cost of that and although we do not have a final figure, the Auditor General has identified it as a major cost.

Mr McConachie: We are focusing on the pressures that will come in and it is right that we do so. It is probable that we do not know about many of the pressures that will come. The Auditor General has also produced reports on day-case rates, which could produce efficiencies to provide a counterbalance. He has also produced reports on prescribing. Significant amounts have been invested by primary care trusts to ensure effective prescribing. It is the responsibility of the service to take those points on board and to create a balance with some of the factors that will push costs the other way. In response to the convener's comment that it sounds as if everything is rosy, I say that, of course, everything is not rosy. The situation is complex, but it is not all one-way traffic. We must, through managerial effort and managerial focus, use some of the issues that the Auditor General has highlighted to create a balance.

Margaret Jamieson: We are looking for a balance. Mr Cumming indicated that there have been significant increases in spending on health year on year. The inputs are being made, but it is difficult to see the outputs. We cannot continue to pour money in while getting very little out. Obviously you are there to consider how the service is delivered and whether it is delivered in a way that meets patients' ever-increasing expectations of the health service. There is no way in which we can measure it but—believe me—those expectations increase daily. Unfortunately, we are not meeting them.

Mr McConachie: You can take it for granted that we are aware of the level of expectation. Some of the matters that I mentioned—such as more effective prescribing and patients' becoming day cases, which patients might prefer to spending a few days in hospital—are about outputs. The Clinical Standards Board for Scotland recently reported on cardiovascular outputs and quality. There has been an extremely positive response In Argyll and Clyde. We might not be making enough of some important clinical outputs. We must ensure that they are more visible, because they are positive.

The Convener: You are grappling with major current problems in trying to break even, but all

that is overshadowed by accumulated deficits. You are trying to balance two major forces. I wish you well.

Mr Quinan: Mr Sillito has referred on several occasions to bedblocking being a major problem in your area in future. Is that an expression of the area's changing demography? Is it related directly to the high levels of deprivation in Argyll and Clyde and to a failure in the interface with the social work departments and local authorities?

Mr McConachie: I do not want to make a generalised response. I will give an example of why that is not the case. In west Dunbartonshire, there are—as you are aware—high levels of deprivation. However, delayed discharges are relatively low there compared to other areas that have high levels of deprivation. If we were to make a generalised statement based on deprivation, that could lead us to a false analysis. We must examine the issue area by area.

One of the most important steps that have been taken in the past few years is undoubtedly the interface with local authorities. We have for two or three years held meetings between leaders and chief executives of our five councils and chief executives and chairs of the NHS organisation. That stopped a lot of the "It's your fault" finger-pointing that used to go on, which was leading us nowhere. We are now getting into a much more constructive analysis.

The problem in Renfrewshire is that there are no nursing home beds. Although the number of nursing home beds that is available is undoubtedly an element of the solution to that problem, it is not the whole answer. In some senses, it is a question not of resources to pay for beds, but of re-examining how those services can be provided and restructuring accordingly. One cannot go from area to area attributing problems only to deprivation. I suspect that an element of deprivation is involved in relation to how people handle their relatives and others for whom they want to care; however, it would be too simplistic to say that that is the only issue.

15:30

Mr Quinan: The broader demographic picture shows that we have an aging population. There are a number of issues that can create pressures that have not arisen, but of which I am aware through my involvement in a report by another committee. For example, pressures are created by high levels of chaotic substance abuse. That occurs in many areas, but is a particular problem in the Argyll and Clyde NHS Board area. Mr Cumming mentioned the pressures on accident and emergency services in Grampian; those pressures are partly a result of chaotic substance abuse. Do you find that that is a direct additional financial pressure?

Mr McConachie: Forgive me if I get my figures wrong, but they will not be so far wrong that they will not illustrate the point.

The Convener: You can adjust the figures later. Please carry on.

Mr McConachie: In some senses, members will find that the adjustment is not too important. A recent study showed that about 19 per cent of acute medical admissions in Argyll and Clyde were related to alcohol misuse. Substance misuse—in this case, alcohol—therefore has a clear impact on services in the NHS. If the health system addresses only acute medical admissions without going further back and trying to understand society's alcohol habits, 19, 20 or 25 per cent—whatever the exact number is—of admissions to acute medical units will continue to be because of alcohol abuse. Health systems must do something about that.

A national report on alcohol was published recently. A great deal of effort is being made in local health areas to address alcohol problems. A unified board, involving local authorities and people in the health system, can do fundamental work to address that. We must examine the underlying causes, but there is certainly a direct link between substance abuse and use of the health service. That link exists now and will for some time. In an ideal world, it would not be there.

Mr Raffan: Mr Cumming might want to answer this question. It was said that the Grampian NHS Board area and the Argyll and Clyde NHS Board area have a common drug abuse problem. The highest percentage of heroin use in Scotland is in Fraserburgh. Does that have a major impact on the service that you provide?

Mr Cumming: Neil Campbell might be better placed than I to comment on that. The biggest impact of drug abuse is on primary care, although there is an impact on secondary care and we see the effects in our accident and emergency departments. It is sad that drug abuse also has a significant effect on our maternity services, for the mothers and their partners and sometimes also for drug-dependent babies.

Mr Raffan: I might be moving on to questions that have already been asked, but I would like to develop some points. Returning to Grampian's deficit, I would like to ask about your £6.5 million share of the £90 million that was allocated. Was it all used to clear past deficits?

Mr Campbell: It was not all used to clear past deficits. Our deficit as set out in the Auditor General's report was £4.9 million—the accumulated deficit for 1999-2000 and 2000-01.

Our allocation for deficit clearing was £5.5 million. The balance of £600,000 will offset some of our accumulated deficit for this year.

Mr Raffan: Will that be put towards the deficit or additional services?

The Convener: Before Mr Campbell answers that question, we will move to the next section of questions. David Davidson is next.

Mr Raffan: I am sorry—I thought that you wanted to move on to the next section.

The Convener: No, David Davidson is asking the question.

Mr Davidson: Which section do you mean?

The Convener: I was talking about the impact of the £90 million—

Mr Davidson: That was Mr Raffan's question in section C.

Mr Raffan: Shall I carry on?

The Convener: I beg your pardon. Carry on.

Mr Raffan: We have given you a breather. Do you want to add anything to what you said?

Mr Campbell: I have forgotten what I said. The bottom line is that we were able to use £600,000 of the £5.5 million against this year's accumulated deficits. None of it was used for service development. It was used for clearing accumulated deficits.

Mr Raffan: Do you monitor that closely to ensure that that happens?

Mr Campbell: There is no problem in understanding that part of the equation.

Mr Raffan: The additional funding was used to clear the £4.9 million deficit and the balance was meant to leave you with a clean sheet. However, as we have discovered, you have £5.4 million in the current year, which will rise to £12.4 million at the end of three years. The money has not achieved its purpose of giving you a clean sheet, has it? You are still heavily in deficit.

Mr Campbell: The money gave us a clean sheet with which to start the NHS board's term. The system needed to be adjusted in order for us to achieve financial balance year on year. That will take three years, during which we will accumulate a deficit year on year, which will be the cumulative deficit of £12.4 million to which we referred earlier.

Mr Raffan: Of the £6.5 million, you have several hundred thousand pounds left to go towards the £5.4 million this year, but you will still be left with a huge accumulated deficit. How will you clear that?

Mr Campbell: We have not yet agreed with the Executive a plan for clearing the accumulated deficit. We have, however, agreed what is probably the hardest task, which is a plan to get back into recurring financial balance. That is challenging enough from a management perspective, given all the scenarios that we discussed.

Mr Raffan: Reading between the lines, you are saying that it will be a challenge to break even at the end of three years, so you will be looking to the Executive to help you with that.

Mr Campbell: I will want to discuss with the Executive how we will deal with the accumulated deficit together.

Mr Raffan: When will that happen?

Mr Campbell: The Executive will require us to demonstrate that we have the managerial ability and the capacity to get back into recurring balance before it will be prepared to discuss clearing the accumulated deficit. Discussions are continuing. I suspect that there will be no agreement on clearing the accumulated deficit until we, as an NHS system in Grampian, have demonstrated that we are able to get back into balance.

Mr Quinan: It is clear that the position in Argyll and Clyde is different. However, the health board, the acute trust and one of the two primary care trusts had accumulated deficits at the end of 2000-01 of £7.2 million, £3 million and £1 million respectively. In the light of those figures, what do you regard as the true overall financial position of the NHS in Argyll and Clyde? Will the proposed changes in accounting facilitate the overall management of finances in the board's area?

Mr McConachie: Did you mention the £7 million deficit in the then Argyll and Clyde Health Board, which is mentioned in the Auditor General's report?

Mr Quinan: Yes. I mentioned £7.2 million in relation to the health board, £3 million in relation to the acute trust and £1 million in relation to one of the primary care trusts.

Mr McConachie: As I understand it, the figures are measured differently, so I will deal with the health board first. The £7 million is not expenditure that we had to make. It is predominantly made up of provision that we have taken on to our books for future years, for example for clinical negligence and injury compensation benefit. We did not spend the money, but it shows up as a deficit on the books. The same applies to a change in our carry-forward, which went down from £3 million to approximately £1 million. Apparently, that is accounted for as another £2 million deficit, which means that, altogether, the deficit ends up as £7 million. Therefore, the £7 million is slightly different from the operating deficits that can be seen on the trust's side.

I have indicated that, as of last Thursday, we are projecting a £1.5 million deficit—actually, it is £1.6 million—across the system in Argyll and Clyde, to close out the year. I re-emphasise that a management responsibility in the final two months will be to do whatever is possible to close that down.

The deficit has different components but, since 1 October and the change to the unified board system, we must address it as a whole. We have done that by considering the money situation from a health board perspective. Our first interest, of course, is how to spend the money on a population basis. We have to consider which communities, as opposed to which organisations, we should put money into. We need to get a handle on that. Having done that, we will need to understand the split between primary care and the acute trust. We will also need to understand the split between primary care and community care, because resource transfer funding to support and work with local authorities is well into double figures.

What I have said about considering that split is not in any way unusual. From time to time, we have to check whether the balance is right. A large part of what we do in health systems is to deal with the pressures that we are talking about today. We have to determine whether those pressures have shifted the balance. The balance may be right or changes may be required to get the balance back. At the moment, we are trying to understand the balance.

We have a policy—which has a great deal of logic behind it—of wanting to spend more and offer more opportunities for patients in primary and community care. The paradox is that, although people love our hospitals, they do not want to be in them—they would rather be treated at home or closer to home. We have moved in that direction. It is important to stop every now and then, whether we are in balance or not, and ask whether we are spending money in the right areas on the services that we want to provide. In Argyll and Clyde, we are undertaking that exercise to assess future needs. I am sure that we are no different from anywhere else in doing that.

Mr Quinan: I want to go back to the provision that has been set aside for the future. Your projection for this year is a £1.6 million deficit. Is there any deficit other than the £1.6 million, which takes that provision into account?

Mr McConachie: No. The £1.6 million is income and expenditure. I would have to come back to you on other provisions and other health board figures, which are in some senses technical. I would have to get the finance people to give me the breakdown. What I have been describing is purely and simply income and expenditure across the system.

Mr Quinan: Can we get the other figures from you?

Mr McConachie: Absolutely, I will get the left-hand column of appendix A updated for you as best I can.

Mr Quinan: Thank you.

I have a final question for Mr Sillito. Mr McConachie referred to this, but how do you expect the new unified board structure to assist the acute trust to achieve break-even as quickly as possible?

Mr Sillito: Much as Mr Cumming outlined, I think that acute trusts take what is thrown at them and we must try to resolve the problems. Working closely with primary care trusts and the health board, there is an incentive for us to work with GPs to determine what is or is not an appropriate referral. We must also determine what diseases can be dealt with more effectively in the community. For example, a huge number of people who have coronary heart disease go to hospital, although they could be dealt with in a suitably equipped primary care setting.

We have also talked about blocked beds and delayed discharge. Now that the local authority has members on the NHS boards, there is a greater understanding of the importance of that issue and the authority has greater influence in bringing pressure to bear to resolve it. That is an example of an area in which the acute sector—which often feels as though it is where the pressure ends up—may get help from elsewhere.

15:45

Mr Quinan: Will the creation of the unified board allow you to streamline administration and other services? If so, what would be the financial fallout of, for example, potential redundancies or the non-filling of posts?

Mr Sillito: We started work on streamlining in a number of areas prior to the idea of the unified NHS board—in human resources, for example. We have three HR directors in our patch. They determined that each would deal with a specific issue. For instance, one writes policies on certain issues for all trusts. We also have an area information management and technology group. Each organisation has members on the group and it is chaired centrally. That will help us with contracts for telecoms, for instance. A review is currently being undertaken of all the support services, which encompasses HR, finance, estates and so on. The review will consider whether we can do things more effectively. There may be a financial benefit, but I do not think that it will be huge.

Mr Quinan: Do you believe that there will be reductions in staff in non-clinical areas?

Mr Sillito: I do not think that the reductions would be significant.

Mr McConachie: I want to build on that. I shall take up the last point and add others. There is an area partnership forum and a great deal of discussion takes place with it about potential changes, so that staff are involved at the earliest opportunity and understand what the implications may be. The groundwork that has been undertaken in the past couple of years in initiatives such as the area partnership forum will undoubtedly pay dividends as we go forward and consider how any changes can be made constructively, through staff and management working together.

On the same theme, I want to go back to whether the balance of expenditure in any one area—be it a geographical area, a community or an area such as primary care or acute care—is right. Some of the things that are helping us to get the balance right in communities are things that did not exist before, such as local health care co-operatives, which represent communities' points of view. We now have an area clinical forum—a sub-committee of the board whose chair is on the board—which adds a clinical dimension. There is a monthly meeting of what we call the health improvement forum. Last Wednesday, it met to consider our local health plan. Around the table were two lay members of social inclusion partnerships, the chief executive of a social inclusion partnership, two local authority chief executives, a director of social work from a local authority, two GPs, medical directors of the trusts and chief executives of the trusts. The forum is not a decision-making body, but the mix of people who are considering the balance and advising the unified board whether it is right, as part of the unified board's decision making, has changed beyond recognition in the past three or four years. The board has also approved a public involvement strategy to take that a stage further.

It would worry me if the committee asked me, "Is the balance right?" It would be too narrow to ask me alone. The whole point is that we are moving to an entirely different way of assessing the balance between each of the spending areas, to make the best and most effective use of the money. The unified board will become comfortable with that.

On whether we have got the balance right at the moment, the answer, of course, is no, because we are only two or three years down the road. The process is evolving. I hope that in three or five years' time the decision-making process will have become much more open, transparent and robust than it is today.

The Convener: This committee will not move into the policy area, which is the job of other committees. Obtaining simplicity out of complexity is what this committee likes to do, but that is difficult in the health service, given the different accounting bases that are involved. We also examine the progress that is being made and the steps that are being taken to secure a more comprehensive picture of the financial position in the new NHS board areas and the NHS in Scotland overall.

Mr Davidson: This question is directed at Mr Campbell. In the Auditor General's report, and in particular in appendix A, which has been referred to this afternoon, we note that while the acute trust had a deficit of approximately £5 million, the primary care trust had a surplus of about £2.8 million in the year ending 2001. At the end of the accounting period in 2001, the health board had a surplus of £3.8 million. Given that the health board had that pot of gold, which it could divide, it seems strange that we ended up with a deficit in one trust and a surplus in another.

As the convener said, we are simplistic people here—

The Convener: No, I did not say that. I said that we seek to obtain simplicity out of complexity so that everyone can understand.

Mr Davidson: At least, by saying that, I checked that my colleagues were awake.

Did the surplus in the primary care trust accumulate as a result of a lack of service or unfilled posts, which could have impacted on the acute trust and its having to pick up the damage that ensued, or was the surplus a form of reserve?

Mr Campbell: I will write to you with the detail of my answer. For now, I will keep it simple, because I am also a very simple man in terms of understanding the detail of your question.

In simple terms, my understanding is that the primary care trust's surplus is mainly to do with asset sales. The positive financial balance sheets of the primary care trust and the health board are to do with resources that we are holding and that are committed, but which have yet to be spent. It is a technical bonus rather than an actual bonus. It is not money that we can spend twice; it is already committed, therefore it is spent. We cannot spend it again to cover a deficit elsewhere in the system. It has just not been given out yet.

Mr Davidson: So basically it is end-year flexibility, in parliamentary finance terms.

Mr Campbell: Yes.

Mr Davidson: The resources were fully committed, so there was no opportunity to subsidise or support the financial position of the

acute trust.

Mr Campbell: There was no uncommitted money within the system, either in the primary care trust or in the health board, that could have been used to cover deficits elsewhere in the system. The surplus was money that was committed and earmarked, but which had yet to be used to pay the bill.

Mr Davidson: Why did we not know about that? Why the information appeared in the form that it did is possibly a question for the Auditor General—a standardised format is usually used—but why, in all the discussions that we had, was that money not labelled clearly as end-year flexibility funding? If the resources were discounted as reserved items in the accounts, which I presume is how they have been treated, the health board would technically be in deficit. Is that what you are saying?

Mr Campbell: No. If we were to spend the money twice, the health board would be in deficit. The money that is shown on the balance sheet is money that is committed. It has yet to leave our bank account—I am keeping the explanation in simple terms—and go to the bank account from which it will be spent. We cannot spend it again and cover a deficit elsewhere. I do not know why that information was not available to the committee. It was a matter of open reporting within the then health board, and now the NHS board. As part of the financial reporting regime, the position in relation to committed and uncommitted money is reported at each health board meeting.

Mr Davidson: You have dealt with my next point, which was about the imbalance in financial labelling across the trust.

If I may, I will broaden the issue slightly. As Mr McConachie mentioned, we are moving to a standardised new global trust. How will we see where the funding tensions lie? In the future, a potential accumulated deficit of £12.4 million that arises from difficulties in the hospital trust will appear as a health board deficit, unless you can offset that deficit in the other parts of the operation.

Mr Campbell: It is important to understand the total picture of an NHS system. My chief executive colleagues and I are interested in the financial state of the NHS system in Grampian. Within that, we must understand exactly what happens in each part of the system. That information will be collected and will be available. As I understand it, the information must be reported through the Executive's monitoring of the NHS system. The Executive will want to know which parts of the system run in balance and which parts run in deficit. It will also want to know the overall position of the NHS in Grampian. Grampian NHS Board also wants to have information on the balance of each part of the system and the balance of the whole system.

Mr Davidson: You said that a three-year deficit accumulation will be attached to the acute trust. What will the outturns be for the primary care trust and the Grampian NHS Board?

Mr Campbell: The primary care trust and the board should break even.

Mr Davidson: Is that for the following three years?

Mr Campbell: Yes. Would it be useful if I read out the figures for each year?

Mr Davidson: It would be helpful if you supplied them in writing.

Mr Campbell: We will provide them.

Mr Raffan: Mr Campbell mentioned the network of 20 community hospitals. Is that network a way of relieving pressure on bedblocking and the acute services at the Foresterhill site? Is that part of the overall game plan?

Mr Campbell: The network of community hospitals is one of Grampian's most important resources, but we do not utilise it fully. That does not mean that the beds are empty—the beds are well used for the purpose for which they were intended—but that the models of care and service in the community hospitals are probably not the most effective for the 21st century. Many of those establishments were built at the turn of the 20th century; they predate the NHS. The model of service has changed, but it does not reflect the sort of services that we must provide in the NHS in Grampian.

Mr Cumming mentioned that we are funded for a level of acute activity that is substantially lower—nearly 2 per cent—than the level of acute activity that exists. We deal with that by using community and primary care services to change the shape of the secondary care services. That is why we must examine the community hospitals. They are a tremendous asset, but they must be used appropriately.

Mr Davidson: In recent communication from Mr Cumming, I discovered that, because of pressures on some of his consultant staff, particularly in the ear, nose and throat sector, there is an inability to provide clinics in community hospitals in rural areas. If Grampian University Hospitals NHS Trust has difficulty in funding additional time for consultants in those hospitals, will it seek the funding from the primary care funding stream?

Mr Cumming: We are committed to the general principle of keeping those clinics going in peripheral areas. However, the clinics are not logically organised and should be reformed so that

they provide a service that is appropriate to the population distribution in Grampian. The historical pattern must be considered.

The specific issue of the ENT sector is not financial, but a result of our inability to recruit somebody. For a short period we will have to retrench some work. The aim is to continue to provide out-patient services at appropriate community hospitals for the population in Aberdeenshire and Morayshire.

Mr Davidson: My question still stands for Mr Campbell. Is there an intention to use primary care funding to provide those services for communities, even though they are sourced from the acute trust?

Mr Campbell: We must think about the whole system in Grampian. We must maximise the use of all parts of the health care system. At the end of last week, I spent two days with general practitioners and surgeons, who talked about a process of investment in primary care to change the way in which they provide a range of surgical services. They mentioned flexible endoscopies; I will not go into detail, but the suggestion is that GPs could do that work in primary care resource centres in the community. That would transform the way in which surgeons work in the acute sector and would mean an investment in primary care at the expense of investing further in acute services. To address the problems, we must take a whole-system approach and consider the way in which we invest resources in the coming years.

We are managing a deficit in the system, which means that we must consider carefully how we commit resources. The smallest possible margin of resources is involved. According to our predictions of growth for the health service in Grampian, by the end of the three-year programme of change, we will spend somewhere in the region of £550 million a year on health services. Over that three-year period, we must address the deficit, which is around £6 million. Although the change programme that we must initiate is a big challenge, it is at the margins of what we are doing. The issue of investment is much bigger. The big decisions are about how we commit new resources, how we change the shape of services and which services we must change.

The Convener: This market day is wearing late. I think that that was your final statement. I thank the witnesses for their attendance and participation.

16:01

Meeting continued in private until 16:29.

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