AUDIT COMMITTEE

Tuesday 17 May 2005

Session 2

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AUDIT COMMITTEE
10th Meeting 2005, Session 2

CONVENER

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

DEPUTY CONVENER

*Mr Andrew Welsh (Angus) (SNP)

COMMITTEE MEMBERS

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

COMMITTEE SUBSTITUTES

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

*attended

THE FOLLOWING ALSO ATTENDED:

Mr Robert Black (Auditor General for Scotland)
Barbara Hurst (Audit Scotland)
Bob Leishman (Audit Scotland)

THE FOLLOWING GAVE EVIDENCE:

Mrs Pauline Ferguson (Centre for Change and Innovation)
Mr Ian G Finlay (Glasgow Royal Infirmary)
Mr Fergus Millan (Scottish Executive Health Department)
David Steel (NHS Quality Improvement Scotland)
Dr Kevin Woods (Scottish Executive Health Department and NHS Scotland)

CLERK TO THE COMMITTEE

Shelagh McKinlay

SENIOR ASSISTANT CLERK

David McLaren

ASSISTANT CLERK

Clare O'Neill

LOCATION

Committee Room 6

Scottish Parliament

Audit Committee

Tuesday 17 May 2005

[THE CONVENER *opened the meeting at 09:31*]

Items in Private

The Convener (Mr Brian Monteith): Good morning and welcome to the 10th meeting of the Scottish Parliament Audit Committee in 2005. I am pleased to welcome the Auditor General for Scotland and his team. I remind people to turn off their mobile phones and pagers—if anybody still uses pagers. We have received no apologies for absence or late arrival.

As we have quite a busy agenda today, we shall move straight to the first item, which is for the committee to consider whether to take agenda items 2, 6, 7, 8 and 9 in private. Item 2 is consideration of lines of questioning for witnesses at agenda item 5. Item 6 is to enable the committee to consider the evidence taken at agenda item 5, on the report by the Auditor General entitled "A review of bowel cancer services: An early diagnosis". Item 7 is to enable the committee to consider its approach to the report by the Auditor General entitled "Waste management in Scottish hospitals: A follow-up report". Item 8 is to enable the committee to consider its approach to the section 22 reports by the Auditor General on the 2003-04 audits of Lews Castle College, West Lothian College and Inverness College. Finally, item 9 is to enable the committee to consider a draft report on its inquiry into the report by the Auditor General entitled "Overview of the financial performance of the NHS in Scotland 2003/04". Does the committee agree to take agenda items 2, 6, 7, 8 and 9 in private?

Members *indicated agreement*.

09:33

Meeting continued in private.

09:38

Meeting continued in public.

"Waste management in Scottish hospitals"

The Convener: Item 3 is for the committee to receive a briefing from the Auditor General for Scotland on his report "Waste management in Scottish hospitals: A follow-up report". I invite the Auditor General to brief the committee.

Mr Robert Black (Auditor General for Scotland): With your agreement, convener, I shall ask Barbara Hurst to introduce the report to the committee.

The Convener: Certainly.

Barbara Hurst (Audit Scotland): The report follows up our previous baseline report, when we looked at waste management back in 2001. We kept the study fairly short and focused on those areas that we had previously identified as needing improvement. Those were issues around staff training, recycling and the sorting of domestic and clinical waste to keep them separate. Our initial decision to examine the issue was not primarily based on the expenditure, which, at £8 million a year, is a small proportion of the overall health budget. However, waste management is important for patient and staff safety and for environmental issues.

In the follow-up report, we found that progress had been made in a number of areas. The Scottish Executive Health Department made an active response to our previous report; it has provided a lot of support to boards and pursued our recommendations with them. The NHS Scotland property and environment forum has also provided support and guidance to health boards.

We found that, generally, training had improved since the previous audit. In every board area, there is now a senior person with responsibility for overseeing waste management. However, there are still a few areas in which improvements are needed.

We carried out a spot check in 53 hospitals and found that 15 had clinical waste in publicly accessible areas and nine had clinical waste bins with broken locks. Some hospitals fell into both categories. We should not make too much of the spot check, but we believe that it sends out a powerful message to senior managers that it is worth their walking the shop floor to ensure that policies are implemented in practice. We understand that, since the audit was carried out, the contractors have changed, significant progress

has been made in dealing with the problem of broken locks on bins and far more waste audits are being carried out. That is good news.

The health service is a major producer of domestic waste. In 2001, we found very little evidence of recycling by hospitals. This time, we found that there have been some improvements, although it is fair to say that those are limited. We should credit hospitals that are doing a lot of work. We know that NHS Argyll and Clyde has won a United Kingdom national award for excellence in recycling. Borders general hospital and the Edinburgh royal infirmary also have good hospital-wide policies.

However, we believe that in the remainder of hospitals more effort needs to be put into recycling. There are a number of ward-level projects, but we found that two thirds of hospitals did not have a hospital-wide paper recycling scheme, more than half did not have a cardboard recycling scheme and a quarter had neither. The issue is not simple—hospitals need to have good storage and a good infrastructure for collection. We are not saying that the problem is the fault solely of hospitals. However, we think that more could be done.

There is evidence that some domestic waste is still being disposed of in the costlier clinical waste stream. That is not a safety issue, but it is a cost issue. We think that health boards could save about £1 million if there were better separation.

All boards have local reports and action plans, so we are hopeful that progress will be made on the issues that I have identified. I am happy to respond to comments or questions from members.

Susan Deacon (Edinburgh East and Musselburgh) (Lab): I will ask two questions, but I would like to preface them with an observation with which I am sure colleagues will agree. I welcome the fact that significant progress has been made on waste management and I believe that it is important that we recognise that progress. Audit Scotland's follow-up reports on the national health service do not always indicate that progress has been made. Can you unpick some of your insights into and observations on why there has been more effective progress on waste management than on other issues? We were told that the Health Department has taken a clear lead on waste management. How significant is that? Clear leaders on the issue have been appointed in NHS boards. How big a part has that played? How significant has the role of the property and environment forum been?

My second question relates to the issue of clinical waste being left in public areas. It strikes me that the problem will not be resolved first and foremost by major top-down policies and strategies or big investment programmes and that it is very much an issue of operational practice on the ground. Can you add to what you have said about why the practice of leaving clinical waste in public areas, which is a serious issue for a number of reasons, continues to occur in some instances?

09:45

Barbara Hurst: External factors are one of the main reasons why progress has been made. A great deal of legislation and a large number of regulations are in the pipeline. There is also a clear recognition in the health service that the issue is important. In some ways, I am pleased about our previous report, which started to raise the profile of the issue. I hope that this report will continue to do that with waste managers.

You made an important point about leadership. The more that waste management is seen to be important to senior people in the health service and the more that it is linked to important initiatives on infection control, the better it is likely to be. In the report, we note some instances of clinical waste being left in corridors and outside wards. That is a real operational issue. It is fine to have policies in place and to have leadership, but we must ensure that everyone knows that they have a role to play in waste management. That is why we were careful to focus on staff awareness and training. There are likely to be local issues such as storage limitations or an insufficient number of porters to collect full bags of clinical waste. Those issues need to be addressed.

Robin Harper (Lothians) (Green): I was surprised that you did not mention St John's hospital in Livingston.

Barbara Hurst: I am sorry.

Robin Harper: I hope that shortly the hospital will be accredited at ISO 14001 level, which is an overall sustainability accreditation for energy management, as well as waste management. When producing the report, did you find evidence of other hospitals seeking accreditation?

Barbara Hurst: I cannot answer the question, because we did not put it to hospitals.

The Convener: You say in the report:

"The cost of clinical waste disposal could be reduced by £1.3 million if hospitals made sure that domestic waste is not disposed of as clinical waste."

Is that a net figure? To what extent will spending be required to achieve it? Can we estimate what hospitals might have to invest first?

Barbara Hurst: That is a difficult question to answer. Obviously, the waste must be disposed of in some way. For understandable reasons, we did not look in the clinical waste bags to see what sort

of domestic waste there was. Some of the waste might be able to be recycled, but some would have to be disposed of in landfill. It is difficult to isolate the pure costs, but clearly it would cost something to dispose of the domestic waste that is getting into the clinical waste stream.

The Convener: Thank you for the briefing. When we discuss it later in the meeting, we will consider what action, if any, we wish to take.

Section 22 Reports

09:48

The Convener: Item 4 on the agenda is a briefing from the Auditor General for Scotland on section 22 reports on the 2003-04 audit of three colleges.

Mr Black: I have made three reports under section 22 of the Public Finance and Accountability (Scotland) Act 2000. They relate to West Lothian College, Inverness College and Lews Castle College. All three colleges have experienced financial difficulties for some time. The reports relate to the 2003-04 financial year, which ended on 31 July 2004. All three colleges were the subject of reports in relation to the prior financial year, 2002-03. In no case has there been a qualification of the accounts of the colleges, but the auditors have noted some concerns about the long-term sustainability of services in all the colleges, because of the financial problems that the colleges seem to be encountering.

Back in 1999, West Lothian College agreed a private finance initiative contract for its main campus facilities. That was approved by the Scottish Office before the creation of the Scottish Further Education Funding Council. The financial case for the PFI deal involved important assumptions about the future growth of the college, in relation to student numbers and the funding that that would attract in line with policy at that time. However, the grant that relates to funding has been lower than the level assumed in the PFI model. The funding council committed itself to providing £42 million over 25 years to support the PFI contract payments. In the financial year 2003-04, that support was £2.8 million. However, the annual financial support from the funding council is likely to reduce from about 2007. The consequence is that, without a significant increase in other funding, the college will not be able to meet its financial commitments.

Inverness College has been under financial pressure for some time. It obtained additional funding in 2002-03, which it was hoped would be a basis for future financial security. The college anticipated that its deficit would be eliminated by 2009. In the financial year 2003-04, it repaid some advances that it had received from the funding council, but it experienced poor trading results. The forecast small surplus turned into a deficit of £526,000. The funding council now believes that the college will be unable to clear its deficit on its income and expenditure reserve by the anticipated year of 2009.

The cash position of Lews Castle College worsened during 2002-03 and its bankers

withdrew its overdraft facilities in December 2003. As a result, the college has had to manage its cash carefully in year. In 2003-04, the funding council gave the college a cash advance of £556,000 and the college is currently implementing and further considering a savings programme. The funding council is reviewing the funding of colleges in remote and sparsely populated areas and it has already allocated extra funds. The college is forecasting in-year surpluses in 2004-05 through to 2006-07.

I would be happy to answer any questions, with the assistance of Audit Scotland.

Robin Harper: Inverness College forecast a surplus of £94,000, but that turned into a deficit of £526,000. Could you comment further on that? Was there a weakness in its forecasting system or did something happen that it was impossible to forecast?

Mr Black: The first point to make is one that I have made before, which is that section 22 reports are on what the auditors find as a result of the audit of the accounts. They are not the result of detailed, in-depth analysis of the situation. However, as a general point, there is clearly a big difference between predicting a surplus of £94,000 and returning a deficit of £526,000. The amount is large and, therefore, of concern. I should perhaps remind the committee, however, that we are talking about a college with an income of £13.4 million and that, relative to the size of the business, the sum is comparatively small, amounting to about 4 per cent of income in the year. The deficit also includes depreciation, which is a non-cash charge on the accounts. The situation is serious, but it should be related to the size of the business, which is also significant.

Robin Harper: In a sense, then, it is the kind of difference that one might expect to arise occasionally.

Mr Black: I would not go that far. It is most unfortunate that a small surplus has been turned into a significant deficit. That should be avoidable by sound management.

George Lyon (Argyll and Bute) (LD): In respect of West Lothian College, what were the agreed assumptions about funding growth in student activity on which the PFI case was made?

Mr Black: We do not have the exact numbers, but the projections when the PFI deal was struck were based on the level of activity that the college was delivering and assumptions on growth that were in line with the ministerial policy for the sector at the time. The contract was largely negotiated before the funding council took responsibility for the sector. The funding council's view, which it expressed to us, was that, although it did not inherit any commitment to provide growth in student-related activity, it had inherited a commitment to support the PFI deal through a schedule of payments that came to £42 million over the 25-year life of the deal. That schedule provides for a sliding scale of support throughout the period, which is likely to mean that the college will hit a serious problem around 2007.

Our understanding is that the plan was extremely reliant on growth in grant-aided funding. There might well have been assumptions about extra income from tailored courses and so on; I do not know. Now, the funding council is constraining funded growth to a level below the business targets because the extra funding is being distributed across the sector as part of the Executive's policy of consolidating the size of the further education sector rather than allowing for continuing growth at a local level.

George Lyon: So the payments that the funding council has agreed for the college bear no relation to the student numbers. Were they originally linked to the student numbers? I am trying to get some clarity about what the figures are based on and how the formula for supporting the college's PFI contract is worked out.

Mr Black: I can give you a general indication of that. The committee has previously taken evidence on the concept of the weighted student unit of measurement, which is the unit on which financing is based. In 2001-02, the college generated grant-aided student activity of about 52,500 weighted SUMs. It is presently constrained to 43,800 weighted SUMs. Therefore, the college has shown that it can generate a level of grant-aided student activity that is about 20 per cent higher than that which is currently being funded by the funding council. We are advised that it has turned away many students because of the current cap on its funding and that it believes that it could continue to generate the high level of activity that it experienced in earlier years.

George Lyon: I think that that says it all.

With regard to Inverness College's failure to return a surplus in the first year of its recovery plan, you say that the college has not been able to meet its target because of poor trading results. Could you clarify what you mean by that?

Mr Black: I am not sure that we can assist the committee terribly much in that regard. The question probably needs to be posed to the board. Bob Leishman might have further information.

Bob Leishman (Audit Scotland): The auditors' report to the Auditor General signals one area of significant cost increase during the year—staff costs—but it does not go into any greater detail on that point or relate it to increases in student activity.

George Lyon: It is quite worrying that the college is as far off its target as it is, given that this is the first year of its recovery plan.

Mr Black: It is a concern.

10:00

Mrs Mary Mulligan (Linlithgow) (Lab): I was interested to hear the Auditor General say that the funding council was considering the funding of colleges in less populated areas.

I preface my comments by saying that the role that West Lothian College plays locally is significant in that it is the only further education facility in an area where there is a high percentage of young people and so is central to education there.

My questions are similar to those asked by George Lyon. The PFI settlement demanded certain results so as to enable West Lothian College to remain within budget. Because of a change of policy, the college has had to make some fairly difficult decisions over the past few years. Obviously, however, that is not bringing about a change in the financial circumstances. That change is presently being negotiated, so I was concerned to hear in the media this morning that the college was considering compulsory redundancies and had greatly increased the salary of its principal. However, I am told that none of that is correct: the college is not considering compulsory redundancies and it has not greatly increased the principal's salary. I wonder how such comments affect the sensitive negotiations that are going on around building a new financial package for the college.

When you were examining West Lothian College's settlement, Auditor General, did you have confidence in the way in which the college has progressed through a difficult period? Do you feel that the college's future is secure if it continues along the road that it has been following? Because of the way in which the policy changed, the college was always going to have to make some difficult decisions, but I think that it has done that. I do not want complications to be exacerbated by misinformation, particularly at such a sensitive time. Do you have any comments?

Mr Black: I am not sure that it would be appropriate for me to comment on the press coverage, as I am sure Mary Mulligan will understand. As I think I mentioned a moment ago, the past level of achieved activity shows that the college has been operating very successfully, as measured by the student numbers that it has attracted, and it has been constrained below that level. We have not done a full analysis of the college's business plan and its achievement, but the figures indicate that the college is thriving and has a future. However, it will have to meet the contractual commitments that it has entered into under the PFI agreement and it will have to address that with the funding council as a matter of urgency.

Mrs Mulligan: Was there anything in particular that you saw when looking at the reports that you would want to highlight for the college to address, or do you feel that that is part of the negotiating process that the college is going through at the moment?

Mr Black: The issue is primarily about the underpinning of the finance of the PFI deal going forward. Given the constrained student numbers, that is undoubtedly the biggest issue that the college faces.

The Convener: As there are no further questions, I thank the Auditor General and his team for briefing us on those section 22 reports. The committee will return to deliberate on its response to those reports later in the meeting.

"A review of bowel cancer services"

10:04

The Convener: I invite our witnesses to take their seats and welcome them to the first evidence session examining the report of the Auditor General for Scotland on bowel cancer services. Today, we shall focus on the way in which services are redesigned and on how new ways of working are being planned and introduced.

Leading the witnesses is Dr Kevin Woods, the accountable officer and head of the Scottish Executive Health Department and chief executive of NHS Scotland. To the right of Dr Woods are Dr David Steel, chief executive and accountable officer for NHS Quality Improvement Scotland; Mr Ian Finlay, a consultant surgeon at Glasgow royal infirmary; and Liz Porterfield, head of clinical strategy at the Scottish Executive Health Department's cancer branch. To the left of Dr Woods are Mrs Pauline Ferguson, programme manager for the cancer services improvement programme at the centre for change and innovation; and Fergus Millan, head of the screening and surveillance branch at the Scottish Executive. I invite Dr Woods to make an opening statement.

Dr Kevin Woods (Scottish Executive Health Department and NHS Scotland): With your permission, convener, I would like to make a few preliminary comments. First, I welcome the report, which deals with a complex subject and one that is not often talked about in public. For most people, the subject of bowel cancer is embarrassing. The symptoms of bowel cancer are not the sort of thing that people find easy to talk about, but raising awareness of bowel cancer and its symptoms is an important goal. In Scotland, the incidence of bowel cancer is rising for both men and women, and one of the most important things that we can do is raise awareness of the symptoms and ensure that people are put in touch with services quickly, as early detection of bowel cancer is an important factor in long-term outcome. It is important that the committee should discuss this valuable report. I would like to take this opportunity to emphasise the theme of early detection, to encourage wider awareness of the symptoms of bowel cancer and to encourage people to seek medical help and advice as soon as they sense that there may be a condition that needs to be investigated.

The second thing to say is that bowel cancer survival is improving in Scotland. The report makes that point and correctly says that there has been a marked improvement in bowel cancer survival in recent years. I am pleased to say that more than half of all patients will now live for more than five years after diagnosis, which is an important standard for measuring survival. What that tells us is that the actions taken by the Executive and by NHS Scotland over the past five or six years are having the desired impact. That is an important point that the Auditor General makes in his report.

I welcome the Auditor General's important observations that there are encouraging conclusions to be drawn from the report, and specifically that most bowel cancer patients in Scotland receive high-quality, well co-ordinated care.

I point out that a great many of the data used in the report are based on work and measurements that are going on in the service for the purpose of seeking further improvements. We shall no doubt talk later on in this morning's discussions about the work that is being led by Mrs Ferguson in the centre for change and innovation. A lot of what is contained in the booklet entitled "Top 20 Actions for Change: 'Making it Happen'" reflects the fact that we are working hard across Scotland to secure further improvements in the organisation of services. In that regard, I am pleased to say that all three regional cancer networks have now been accredited by NHS Quality Improvement Scotland. Mr Finlay and Dr Steel might have some more to say about that later on.

I am pleased to see in the report a recognition that there is now a clear direction for the development of bowel cancer services in Scotland, which is being led by the Health Department's bowel cancer framework group. Again, we will be happy to amplify the work that is under way in that group, which I had the pleasure of meeting fairly recently.

Having said all that, paragraph 156 of the report describes recent improvements in our performance on waiting times, but indicates that we need to accelerate those improvements. We agree with that and have already taken action to do so, in addition to the £150 million of additional investment in cancer services that has taken place since 2001. For instance, earlier this year, I took the opportunity to impress on NHS boards the need to make further improvements in waiting time performance and, at the end of this month, we will have completed a detailed action plan based upon the redesigned process that I referred to a few moments ago, which will accelerate improvements in waiting times. In addition, we are planning to train extra nurse endoscopists and provide additional training for trainers. Our intent is to optimise the use of existing endoscopy sessions that are available in the NHS. Finally, in that regard, as the minister announced in relation to "Fair to All, Personal to Each" in December last

year, new waiting time standards for diagnostic tests will be published in the near future. From that package, I hope that the committee will see that we are vigorously pursuing a full-scale improvement process, which has been under way for some time.

Lastly, I want to draw the committee's attention to the fact that we are actively preparing for the implementation of bowel cancer screening. This important programme could save 150 lives a year in Scotland. We have begun to fund the roll-out of this programme and are working through the bowel cancer framework group to produce a detailed implementation plan to ensure that the programme is successfully implemented.

The Convener: We intend to ask questions on four areas today, with different members leading the questioning on cost and performance information; driving change; capacity planning; and quality of care. I will lead on cost and performance information.

It is estimated that almost half a billion pounds is spent on cancer care annually in Scotland, £25 million of which has been ring fenced for cancer until the end of 2005-06. Although the NHS can demonstrate how that ring-fenced money has been spent, it cannot identify how the remaining £425 million or so is spent. That must limit its ability to assess value for money and monitor improvements in the use of resources. Are any steps being taken to identify a greater share of the NHS in Scotland's spend on cancer care?

Dr Woods: I think that the work to which you are referring is a study that was undertaken by a member of staff in ISD Scotland, which tried to estimate the overall cost of cancer services. The figure that the study came up with was around £450 million a year. Technically, this approach is known as programme budgeting and is usually discussed in the context of both assessing the total cost of spend and considering a complementary analysis known as marginal analysis, which is, "If you spend this amount now, what would you spend your next pound on? Where would you get the biggest effect?" At the bottom of this question, I think, is concern about programme budgeting and marginal analysis.

I had a look at Ms Graham's study. My sense was that it illustrated the complexity and difficulty of constructing programme budgets. The first question is how we should define the programme; should it be on cancer, bowel cancer or gastrointestinal disease, for example? There is then the enormous complexity of assembling data on costs for the defined programmes. If we are able to do all that, we are still left with two important questions. One, to which I have already referred, is the question of what we should spend new investment on. What do we know about the relative benefits of spending on bowel cancer screening as opposed to some form of bowel cancer prevention?

Our sense is that the second set of questions—those on the most appropriate use of any resource—is much the most important. However, we are progressively introducing a tariff system into the NHS in Scotland over the next two years. It is intended to consider critically the relative cost efficiency of different parts of the NHS so that we can get a better handle on relative efficiency. The important point about that system is that it rests on health care resource groups—HRGs—which are case-mix sensitive, so it will enable us to take a view on the relative use of resources on a disease such as bowel cancer in different parts of the NHS.

10:15

The Convener: To clarify, might bowel cancer screening, which you gave as an example, be included as a way of monitoring the success of the programme?

Dr Woods: Yes.

The Convener: There is a continuing debate on the value of targeting in the NHS. "Cancer in Scotland: Action for Change" sets a clear strategic direction but has few specific targets for improvement and does not include measures to assess the effectiveness of service changes. Possible targets include survival rates, waiting times, equity of access and patient satisfaction. What is the department's current view on employing more targets?

Dr Woods: I will make one preliminary point. I agree that more intermediate targets might be helpful, but one important target that the Auditor General's report does not mention is our overall target of reducing cancer mortality in the under-75s in Scotland by 20 per cent by 2010. I am pleased to say that we are on target to achieve that reduction—by 2003, we had achieved a reduction of 13.6 per cent. That is an important measure of whether our overall cancer programmes are headed where we would like them to be.

Survival is important. Clinical colleagues will consider that carefully in the audit that they conduct through our managed clinical networks.

We have also reached the view that it would be beneficial to introduce some intermediate milestones—that is perhaps a better way of describing them than "targets"—on progress on waiting times. That is part of our intended action plan, which I mentioned in my opening statement.

The other area in which we could usefully make more systematic measurements is patient views of

the service. There is some good material in the Auditor General's report, which is derived from a small sample of patients. Those patients are helping us with our work on bowel cancer, but it would be desirable for us to become more systematic in our measurement of their views and in feeding them into the planning process and we are reflecting on how we might do that.

The Convener: Staying with targets for the moment, I refer you to paragraph 156 and exhibit 23 on pages 38 and 39 of the Auditor General's report. Data on waiting times are collected by regional cancer advisory groups and are reported to ISD Scotland. The data show that if current trends continue, the waiting time target of two months from urgent referral to treatment will not be met for all bowel cancer patients. Interestingly, that information is not yet published, in contrast to other waiting time information, which is published quarterly. What can you tell the committee about addressing the worrying possibility that that target will not be met, and making the information more readily available?

Dr Woods: We have set a challenging target, and it is right that we should do so. It will be difficult to meet, but we remain committed to it and we will do our utmost to achieve it, which is why I was at pains to point out the work that we are doing around the waiting time action plan that we will discuss with the NHS shortly.

I would like to update the committee on the latest information on current performance in relation to bowel cancer. At the end of December we were dealing with 57 per cent of urgent referrals within two months. That is marginally below the figure for September. We are dealing with comparatively small numbers, so one would expect some fluctuation, but in general it looks as if we have plateaued in some respects and that we are sustaining that performance. However, our objective now has to be to accelerate the rate of improvement in the remaining part of the year, which is what we are committed to doing.

The Convener: I would like to clarify your answer to my first question. You talked about the key issue being the best use of additional resources. What about the best use of the current resources or the majority of the resources? How does the department hope to address that in the sense of value for money?

Dr Woods: I return to my point about the tariff, which will give us a means of examining the cost effectiveness and cost efficiency of resources. One particular area in which we need to make more rapid progress is in relation to fuller use of endoscopy sessions, which are a crucial stage in the investigation and treatment of bowel symptoms. We have some underused capacity in the system. The principal shortcoming is that we need some additional staff. We are taking steps to put in place additional training programmes, which will almost double the number of non-medical endoscopists in Scotland over the next couple of years. That will mean that we will make better use of current capacity and, as a result, will be better value for money.

The Convener: What is the expected timescale for introducing a tariff system, and what is the expected timescale for you and the management of the NHS and for Audit Scotland to receive information on value for money outcomes?

Dr Woods: We intend to progressively introduce the tariff system over this year and next year. We expect to have information of value by the end of this year.

George Lyon: I have two follow-up questions. On the last point, can you explain how tariffication will work? How do you envisage it better informing you about where extra money should be invested to ensure that you get better value for money in cancer care, particularly bowel cancer services?

Dr Woods: Currently, our cost information is at a high level; it is not—to use the jargon—case-mix sensitive. As soon as you present data on anything in the health service, whether on costs or activity, people ask, "Have you adjusted the data to take account of the types of patients that you treat, because they are different from the patients down the road?" The tariff system introduces a common vocabulary to the conversation by using a technique known as health care resource groups. HRGs are widely used internationally; they are accepted as a sensible basis on which to consider variations in case mix. HRGs will allow us to consider how we deploy resources to comparable groups of patients in different places. When you do that, you can consider variation and the appropriate level of spend, which may not be the lowest level, the middle level or the highest level, but it will be somewhere on the spectrum. If data are presented under the tariff system, we will be able to ask the sorts of questions that we have always asked but we will no longer get the answer, "Well, you're not comparing apples with apples because you haven't standardised for the case mix."

George Lyon: In Scotland, health boards are both commissioners and providers; there is no separate commissioning role. How will tariffication actually work?

Dr Woods: I think that you are alluding to the fact that, in England, data from HRGs are used as part of the payment-by-results system. That is one use for the data, but we are using them in two different ways: we can analyse data from HRGs at almost any level, for the purposes that I have just described; and we can adjust financial flows

across health board boundaries. There are a lot of flows between health boards and, hitherto, they have not been addressed in a way that is case-mix sensitive.

George Lyon: I would like to ask a follow-up question on waiting times. In his report, the Auditor General highlighted four reasons for delays between the initial diagnosis and the start of treatment. Those reasons included

"the continued reliance upon paper-based referral systems … 'named' referrals to individual consultants"

and

"unclear referral information from GPs".

What action are you taking to tackle the blockages that the Auditor General has identified?

Dr Woods: I hope that you will not feel that I am labouring the point, but we think that the answers for each stage of the patient journey are set out in "Top 20 Actions for Change". The booklet is the result of work with patients, the public and clinical teams throughout Scotland. The booklet contains lessons that have been learned, and the waiting time action plan that I referred to is intended to ensure that those lessons are applied throughout Scotland. There are examples of good practice such as referral from primary care and risk stratification. We are determined that good practice from the booklet should be systematically applied. We have to ensure that any blockages are removed.

I agree very much with what has been said on the need for electronic referrals. If we had an electronic patient record, it would help enormously. That is why we are committed to implementing such a record as fast as we can. On behalf of the minister, I chair a group that is leading the work on that.

Once a person is in the system, there are good models in which clinical nurse specialists consider referrals. They decide how urgently somebody should receive a diagnostic test and what the most appropriate diagnostic test is. We also want those clinical nurse specialists to be able at that point to book patients in for subsequent stages of treatment. We are clear about what we need to do. In some places, that is already happening, but we want to make that standard practice throughout Scotland. I am sure that my colleagues could tell you more about that.

The key stage in the patient journey lies after the diagnostic test has been undertaken—I referred to work that we are doing in relation to endoscopy—when a multidisciplinary team assessment takes place. That stage in treatment is most important. It involves bringing together all the professionals to decide with a patient the best course of action for that patient. I am pleased with the progress that we have made on establishing multidisciplinary teams.

That is the flow. We know the components that we must get right and we are working hard to put such arrangements in place systematically throughout Scotland. I am sorry if my answer was lengthy.

10:30

The Convener: Members generally do not recall seeing the document that you have shown us. Apart from making it available to committee members for our deliberations, sending it to all members might also be worth while, so that they are aware of the work.

Dr Woods: I am happy to do that. I am showing you an expanded version of exhibit 29 in Audit Scotland's report. We have just made the exhibit larger for display in public and included details of some projects that are under way in parts of Scotland.

Mrs Mulligan: I agree with the convener that it would be useful to have a copy of the diagram.

I will press you briefly on identifying spend and being able to judge outcomes. You made interesting points about how the spend overlaps in areas such as treatment and screening, but you also mentioned prevention, which I will use as an example. How do you identify the investment that you make in prevention, which is wide ranging? How do you show the outcomes, to justify reinvestment? Without that, I am not sure whether we will have useful investment in tasks such as prevention, particularly of a condition such as bowel cancer.

Dr Woods: We could give a reasonable account of the overall resource that is committed nationally through some of the widely publicised initiatives that we are undertaking, but in general you are right. The same argument applies to what goes on in primary care. How do we attribute a fraction of total activity to individual programmes? Much of our prevention work is aimed at diet and exercise, both of which are important in bowel cancer but are also important in relation to heart disease. The technical problem is how to divide the total spend to show what we spend on activity to prevent bowel cancer rather than heart disease. The Graham study could not do that because the data did not exist.

I am sorry to reiterate it, but the question to which we return is: what should we make additional investment in? The decisions that have been made in Scotland are right. For instance, fundamental capacity problems needed to be put right in radiotherapy, on which we have spent £33 million in recent years, to ensure that people have

state-of-the-art linear accelerators. That investment decision was right. When we made those choices, we were still pursuing prevention by funding a pilot project on bowel cancer screening. From that, we now know enough to judge that it is wise to invest in bowel cancer screening programmes. That is the kind of dialogue that needs to be had. Simply assembling overall spending into a programme does not, of itself, help with such decisions, which must rest on what is known about the relative effectiveness of different interventions.

Mrs Mulligan: As you have outlined, identifying which investments specifically target different conditions is complicated. The fear is that if the results of such investments are unclear, we might not be able to justify investment in future. I am interested to know how the service gathers figures to support its arguments for providing such investment in future.

Dr Woods: Ultimately, the test is the trajectory of survival rates, which is what really matters.

Mrs Mulligan: Rather than survival rates, would not the test be the rate of identification of the disease? For example, as a result of investment in prevention, should the number of people presenting with bowel cancer not drop?

Dr Woods: Obviously, preventing the disease from occurring is highly desirable, but if we can detect more cases earlier, that is also highly desirable.

Mrs Mulligan: So both measurements are important.

Dr Woods: Yes. However, early detection of the disease is particularly important for long-term survival. Therefore, the overall measure of whether our investment in bowel cancer is paying dividends should be survival rates. Our survival rates are going very much in the right direction as a consequence of the actions that have been taken.

Mr Andrew Welsh (Angus) (SNP): One of our difficulties is that we can get lost in the jargon and in the mass of statistics. Unless I picked him up wrongly, Dr Woods said that current performance on waiting times meant that, as at September, 57 per cent of urgent referrals were being seen within two months. That sounds impressive, but given the simple truth that cancer can spread if it is not treated quickly, it is of the utmost importance that diagnostic waiting times are kept to a minimum.

To my mind, the waiting times situation is much worse than is presented in the report. If we deconstruct the numbers on page 41 to factor in the statistic that only 35 to 40 per cent of all those who are admitted for diagnosis are urgent referrals, the new numbers reveal the creation of a two-tier service, in which urgent cases are seen rapidly but significant numbers of non-urgent cancer cases face unacceptable waiting times. Surely the key to fighting cancer is detection as early as possible. By grouping urgent and non-urgent referrals together, does not the report hide the true waiting times that many potential cancer sufferers faced? The report says that 50 per cent of patients were treated within two months, but that 50 per cent includes the 35 to 40 per cent of all cases that were classed as urgent referrals.

Dr Woods: We share the ambition of meeting the overall target that has been set. I will not repeat what I said earlier, but the target is challenging. However, we remain committed to it and we are determined to achieve it.

The presentation of bowel cancer involves particular issues that it might be useful to outline. Patients may be unaware of the symptoms of the disease and they may present at hospital as an emergency case with some form of bowel obstruction. It might be helpful to clarify for the committee how measurements in those cases are included in the data. The presentation of bowel cancer is rather different from that of, say, breast cancer, for which referrals are largely elective and are easier to track. Mr Finlay can enlighten the committee with a clinical point of view.

Mr Ian G Finlay (Glasgow Royal Infirmary): Without getting into the medical detail, if one is to understand the report, one must understand a little about the problems that the disease presents both to us as clinicians and, in turn, to the Executive. As has been said, bowel cancer is a common cancer. The problem is that, unlike breast cancer patients, who present with only one symptom—a lump—bowel cancer patients present with non-descript, ill-defined symptoms that are very common, such as bleeding from the bowel and changes in bowel habit. According to the study that has just come from Glasgow, that means that of 100 patients who present with symptoms, only three will prove to have the disease. That is our problem in trying to tackle the situation in one big bite. We have an enormous number of patients who do not have the disease—the so-called worried well—who must be processed through the system to identify the 3 per cent who do have the disease.

Added to that, we are pushing back the tape for achievement because we are shaking the trees and telling people properly about cancer to make them more aware. We have run campaigns to make them aware of the symptoms, which in turn has caused the problem to escalate. We have been faced with an overwhelming tide of patients with symptoms. It is important to consider the waiting list targets and the problem of urgent and non-urgent referrals in that light.

In an attempt to solve that problem, in England and Wales it was stated that all urgent referrals from general practitioners had to be seen in two weeks. We know now from that data that if one is as prescriptive as that, the tail that Mr Welsh described of patients who are non-urgent but have the disease, becomes longer and so the overall waiting time is longer.

We try to have a reasonable waiting time target for urgent patients while carrying along the body of patients who have symptoms. That has been the problem and it is worth laying that out.

Susan Deacon: I ask for additional information on precisely what you have just explained to us. Will you give us a sense of the proportion of people with symptoms who are referred for diagnostic tests? You gave us the percentage of people who are subsequently diagnosed with bowel cancer, but roughly what proportion of them go on to be diagnosed with some other form of bowel disease that requires treatment and intervention, such as diverticulitis?

Mr Finlay: About 20 per cent, but many of those diseases are relatively trivial.

Mr Welsh: I understand the complexity of the situation, but I have difficulty when phrases such as trajectory of survival rates are used. What it really boils down to is: do you cure people?

We asked you the simple question: do you know what you are spending money on and what effect it is having? Of course, if one asks a question that is impossible to answer, one will not get an answer. The programming, planning and budgetary systems of the 1960s produced just that—no real answer. Now we are being told about programming and budgeting, marginal analysis, the introduction of a tariff system, relative cost efficiency and health resource groups. We tend to get lost in such jargon. The question is: are you confident that you know what you are spending money on and what the effects are?

Dr Woods: We are confident about where we have been spending the additional money that we have received and we are clear about where we think we should spend more of that money to remove bottlenecks. We are clear about the importance of spending money on bowel cancer screening and we are introducing methods that should enable us to understand better whether we are getting value for money from the existing spend. I hear what you say, but I believe strongly that the introduction of the tariff system will help us to understand rather better the pattern of spend in different parts of NHS Scotland.

Mr Welsh: I hear the word "should" coming into what you say, but if the systems work, you will know what you are spending money on.

Dr Woods: I say "should" only on the basis that we are in the process of introducing the system over the next two years.

Mr Welsh: We will check against delivery.

Dr Woods: I am sure of it.

The Convener: I ask Margaret Jamieson to take us on to questions about driving change.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): A number of my questions are directed to the representative of the centre for change and innovation, so I ask Dr Woods to feel free to butt in if he feels that to be appropriate.

My first question relates to the existing bowel cancer framework, which is not explicit about the scale of change that is required. How does the centre for change and innovation prioritise services for change and how is change delivered and measured?

10:45

Dr Woods: If I may, I will butt in before my colleagues have even spoken. Since I arrived in my post in January, I have been reflecting on how we organise ourselves to support the delivery of key objectives. I do not wish to anticipate where I might ultimately conclude that we should go, but it is increasingly clear that we need to align better on our delivery objectives and on the detailed work that the centre for change and innovation is undertaking. The benefits of doing so become obvious when one considers the work that has been done on bowel cancer screening—we get a focused effort and we can drive the programme throughout Scotland. With that preliminary comment, I invite Mrs Ferguson to say a bit more about the specific programme.

Mrs Pauline Ferguson (Centre for Change and Innovation): I can speak specifically about the cancer service improvement programme, but not the bowel cancer screening programme—Fergus Millan knows about that.

Margaret Jamieson: I am not too bothered who answers, as long as we get an answer.

Mrs Ferguson: The early part of the cancer service improvement programme, which started in 2003, was about our team of seven people engaging with staff and helping them to understand the problems and bottlenecks in the system and processes, which are outlined in the Audit Scotland report. Much of the work in the first year was done with clinical teams, although we also actively sought the views of patients and families and fed them back in quickly, instead of waiting months to do so. That was an exciting start to the programme.

In the second year, we moved quickly on to testing out changes that the staff came up with—we supported their ideas. A facilitation skill was required, as well as expertise in tools and techniques that can be used. Through that process, more than 500 changes were tried and tested throughout Scotland—not all of them related to the bowel cancer service, although many did. We also worked closely with the cancer networks. That work led to successful improvements, which is really where the top 20 actions for change came from. We distilled the improvements down to the 20 that we thought would make the most impact.

The changes are generic and can be applied to any cancer and any service. They are mostly about removing bottlenecks through simple process changes. However, we need to monitor how the service takes up the changes. We have a simple way of doing that and we will feed information back to the Health Department's national waiting times and performance management units. As Dr Woods said, the information has been used to help to form a national action plan. The focus for this year is to drive that work forward.

Margaret Jamieson: Was the work undertaken in isolation from the bowel cancer framework?

Mrs Ferguson: No. Obviously, the centre for change and innovation is closely aligned with the Health Department's cancer branch. Mrs Porterfield can say more about the bowel cancer framework, but we are informed about and kept up to date on progress and any implications that there might be for us.

Dr Woods: It is important to point out that we are talking about a cancer service improvement programme; it is not limited to bowel cancer, but applies more generally.

Margaret Jamieson: Mrs Ferguson has identified a link with Liz Porterfield and her branch, but there are many other branches in the Health Department, as well as colleagues in NHS Quality Improvement Scotland, the regional cancer advisory groups, the health boards and individual hospitals. How can you be sure that they are all following the same model, that you have removed all the barriers—professional or otherwise—and that we, the public, can be confident that whatever hospital or general practice we attend, we are getting best practice?

Mrs Ferguson: That is an important question and that is exactly where we are in the programme. Research shows that it can take improvement programmes quite a number of years to achieve sustained change, but we have achieved sustained change in some areas of Scotland during the past year. It is worth while to note that. We need to build on that. It has already been mentioned this morning that we want to roll out the programme and make standard the changes that have worked, in particular the top 20 actions for change.

Margaret Jamieson: You indicated that you have evidence that that best practice is absolutely the best in some areas of Scotland. How do you ensure that that best practice is delivered elsewhere?

Dr Woods: That is a really important question and I agree that we must get better at ensuring that the solutions to problems that we find in one place are available to and implemented in others. That is the department's performance management function, and that is what I was alluding to when I talked about the need to ensure that we align the objectives that we are pursuing with the work of the CCI within the department and that the intelligence that we get from our performance management processes feeds back as part of the process. As I said, I have been considering that since I arrived because we can do better on some of that than we might have done hitherto.

Margaret Jamieson: I take some comfort from that.

We are all aware that NHS boards are accountable to the minister and to you, Dr Woods. Given that we have regional cancer advisory groups and managed clinical networks making decisions for more than one board, how can we be sure that those organisations are truly accountable and that their decisions are applied equitably across the regions? As I come from the west of Scotland, I know that decisions that affect Glasgow also affect Ayrshire, Lanarkshire and Dumfries and Galloway. How is that accountability charted? I do not think that service delivery for Ayrshire cancer patients should be part of the accountability process of greater Glasgow.

Dr Woods: I think that you are referring to the diagram at exhibit 7 in the Auditor General's report.

Margaret Jamieson: Yes.

Dr Woods: I had a look at that so I will venture an explanation. On the face of it, it looks complex but I hope that when I have explained it, it will not appear to be quite so complicated.

The Health Department has overall responsibility for policy, strategy and performance. To help us with that, we formed the Scottish cancer group, which brings together a range of people from across Scotland. However, given the nature of cancer and the fact that patients often require highly specialised services that cannot be provided everywhere, we decided that it would be

a good idea to bring NHS boards together for planning purposes in the form of regional cancer advisory groups—or RCAGs as they are described. They have a planning function but, in 1999, on the back of an acute services review, we decided also to create managed clinical networks to bring together clinicians and management to work on the problem of improving quality and services throughout Scotland. It is important to note that the managed clinical networks are essentially the agents of the boards—they exist to progress work that an individual board could not complete successfully on its own. The boards are accountable to the department and the networks are agents of the boards, in that they work on their behalf to find solutions to bottlenecks, planning problems and so on.

One of the great benefits of working in that way is that it has ensured that improvement in service quality has occurred across regions, rather than being confined to a particular centre of excellence. That was a key objective of managed clinical networks. It is fair to say that we must be careful that we get the management connection between the networks and the boards right because the boards retain responsibility and accountability for resources. I fully accept that, given that the networks are the agents of the boards, we must ensure that there is proper connection and that through other management relationships we are able to turn the conclusions of the networks and the issues that they identify into change on the ground.

I started by saying that the situation that exhibit 7 illustrates was complicated, but that is the way in which things are formally structured. If the committee wishes, I am sure that Mr Finlay would be happy to elaborate on how the west of Scotland clinical network has been operating.

Mr Finlay: It is worth saying a little more on the subject. In 1999, Scotland, like most other countries in Europe, including England and Wales, had very little idea about the specifics of cancer care, especially quality issues. As a result of the 1999 review, the managed clinical network idea was spawned. It was a clever idea that was designed to address your point, which is that to achieve quality throughout Scotland, it is necessary to work across several boards, otherwise each board would get lost in its own agenda and proper comparisons between boards would not be made.

We started an audit and we asked all the clinicians to come together to agree to go to multidisciplinary meetings. Such a national agreement was unique in Europe. In addition, we were working to the standards of the Clinical Standards Board for Scotland and we asked the managed networks to produce quality to those standards. That was very clever indeed because it got us away from league tabling, whereby although there was perhaps a minor difference between hospital 1 and hospital 23, all the hospitals were basically the same. That enables us to say that all our service is getting over the hurdle of meeting that standard.

In 2002, we produced our first report. The data that we collected to identify the required change form the meat of Audit Scotland's report. It was only in 2002 that the managed networks knew what was happening on the ground.

Dr Woods: Mr Finlay spoke about working with the CSBS, as it was then. It is important that the managed networks meet the accreditation standards of QIS; as I said in my opening statement, the three regional networks now meet those accreditation standards. That is vital to ensuring the quality of care that patients receive, wherever they are in Scotland.

Margaret Jamieson: On that point about quality of care, staff have recently raised concerns about the diagnostic equipment that is used for cancer patients, especially in the west of Scotland. Is that a failure of the membership of the regional cancer advisory groups? Is it down to one group making a decision in isolation from others or is it about planning and procurement procedures that do not include front-line staff?

11:00

Dr Woods: I take it that you are referring to the scanner in Glasgow royal infirmary.

Margaret Jamieson: It was the Western infirmary.

Dr Woods: Thank you for correcting me. There are so many scanners that I cannot remember where they all are. You might be interested to know the number of magnetic resonance imaging scanners and computed tomography scanners in Scotland. I have the figure somewhere, so I can tell you later.

The main point about the Western infirmary scanner was that the clinical director for radiology in north Glasgow said that patient care was in no way compromised by the age of the scanner. Greater Glasgow NHS Board is meeting today to formalise the replacement of the scanner. It is one of two scanners that were identified for replacement; the other, at Stobhill, was replaced last year, but the scanner at the Western had a comprehensive maintenance contract and it was judged that it could continue to work satisfactorily until this financial year. It will almost certainly be confirmed today that, as the minister indicated fairly recently, the new scanner should be on site and working within three months.

We also have to remember that there are a number of other scanners in the west of Scotland. There is new state-of-the-art equipment at the Beatson oncology centre, which includes a new CT scanner that was commissioned last year. We have to view this in context. We are of course spending £87 million to rebuild the Beatson oncology centre. Over the next three years, we will spend something like £125 million on replacement medical and diagnostic equipment. I was hoping that while I was telling you that I could remember the total number of CT and MRI scanners in Scotland. We have 42 CT scanners.

Margaret Jamieson: I return to the point that I was trying to make, which I obviously did not make very well: staff who are delivering the service have not been fully involved in the decision-making process. I accept the logic that you have just outlined; a decision had to be made that the equipment at Stobhill needed to be replaced much quicker than did the equipment at the Western. The individual who went public was not involved in the round of information and some of us might say that they were shroud waving. We all know that cancer is an emotive subject. Is there an issue about the dissemination of information throughout the area?

Dr Woods: I do not want to comment on what the individual concerned may or may not have known when they made their comments, because I am not sure about that. In general it is correct to say that we would expect staff who were working closely with such equipment to be fully involved in a dialogue about its replacement. I expect that that has been the case as capital programmes have been established. I do not know whether Mr Finlay can shed more light on that.

Mr Finlay: I do not know the detail of the specific case that Margaret Jamieson raises. In general, there is difficulty with huge capital expenditure on the replacement of equipment when it is not specific to cancer but runs across disciplines and hospitals and involves several referral areas. I do not think that I could answer the question with reference to cancer, which is my remit today.

Margaret Jamieson: I have been told that my time is up.

The Convener: It would not be the first time, Margaret.

We move on to the next section, on capacity planning, which will be led by Andrew Welsh.

Mr Welsh: The report states that

"Few endoscopy suites are working to full capacity"

and that there is "wide variation" in their use. Do you accept that the availability of qualified staff is a major constraint in endoscopy activity?

Dr Woods: We believe that we need to increase the number of endoscopists to utilise all the slots that we have and to accommodate the expected increase in demand for colonoscopy that will arise from the bowel cancer screening programme. That is why we have put in place plans to review the capacity in endoscopy and the number of people in training. As I mentioned earlier, we expect to announce soon the outcome of consideration of a business case that we have had prepared on the matter. The key components are that, as well as training endoscopists, we need to train trainers and to make provision for additional training of medical staff.

Mr Welsh: What is the current shortfall in the number of staff?

Dr Woods: Perhaps I can express that by saying that we need to increase the number of nurse endoscopists by 25 during the next two years. I think that the current number is 29 with seven in training, so we are planning almost to double the number. That will go a long way towards fully utilising the sessions that we have and it will put us in a good position to cope with the expected increase in demand for colonoscopy that will arise from the bowel cancer screening programme.

Mr Welsh: Which areas of Scotland are most affected by the shortfall?

Dr Woods: A diagram in the Auditor General's report indicates where we have unused capacity. Not everywhere has unused capacity, although I am sure that everywhere would benefit from having additional nurse endoscopists. Where we have sessions that are unused, it would obviously be desirable to bring that capacity into use first.

Mr Welsh: I am just trying to establish where the shortfalls are.

Dr Woods: Exhibits 30, 31 and 32 in the report give the details.

Mr Welsh: Is anywhere up to full complement?

Dr Woods: Yes. I was at Stobhill hospital last week to talk to staff about their bowel cancer services and my understanding is that all their available slots are filled. They would like to increase their number of sessions—that is their biggest problem, rather than a shortage of endoscopists to fill the sessions.

Mr Welsh: You said that there will soon be a business case on the issue and that you need to train trainers. How soon is soon?

Dr Woods: We have just received the business case and we are considering it. If I did say that, I should clarify it by saying that we will soon decide on the outcome, following our consideration.

Mr Welsh: In England, more than £8 million has been allocated to three regional endoscopy training centres but, apart from a course for nurses at Glasgow Caledonian University, no such training exists in Scotland. How do you plan to meet future need, let alone current need, without such trained staff?

Dr Woods: Our plan is, as you say, to increase the amount of training that is undertaken at Glasgow Caledonian University. In addition, we intend to utilise the Cuschieri skills centre in Dundee to provide training for trainers and for doctors. There is a need to be more systematic and to quality assure the training for doctors, and the Cuschieri skills centre will allow us to do that. We will have a centre of training expertise in Dundee and we will have an increased number of students in training at Glasgow Caledonian University.

Mr Welsh: Mr Finlay mentioned an "overwhelming tide of patients". How will you cope with the results of the bowel cancer screening programme if it is the success that we all hope that it will be? I know that you are discussing the business case. How and when will all the endoscopy training be implemented? You have given us some idea of numbers and location, but what is the timescale?

Dr Woods: The increase in the number of people in training will be delivered over 2005-06. I think that there will be an additional intake in January next year to boost the numbers. Of course, the arrangements that are being put in place in Dundee will continue thereafter. In having the business case prepared, we have obviously taken into account what we expect the impact of bowel cancer screening to be on the number of patients who come forward for colonoscopy.

Mr Welsh: We accept that staff training and the provision of trained staff will be an essential part of tackling the whole problem. I hope that the shortfall will be eliminated as quickly as possible.

Three out of the four reasons for the discrepancy between capacity and usage that are listed in paragraph 193 on page 48 of the report relate to poor management skills and leadership. How are you eliminating poor management and improving leadership skills?

Dr Woods: That essentially boils down to the way in which services are organised and planned locally. It is usual in our hospitals to have services under the direction of a clinical director, a business manager and people like that. What the Auditor General is referring to in that paragraph is the need to ensure that those functions are discharged effectively. If there is "inflexible skill-mixing", as the report says there is, it may well be that having additional nurse endoscopists will provide additional flexibility. It may also be that we can operate with more flexible working hours in some of these services. Fundamentally, this is about the quality of operational management. We must continue to ensure that we have high-quality operational management that can arrange and deliver services that patients require.

Mr Welsh: What are you doing now to eliminate poor management, improve leadership skills and ensure that procedures are put in place and followed by front-line staff?

Dr Woods: Part of the solution lies in the systematic application of some of the change processes that are described in the report. Our plan on waiting times is very much focused on trying to achieve that. More generally, the minister has announced that we will publish a leadership and management development strategy for NHS Scotland. That is almost complete and it will come out shortly. You are quite right to say that leadership and management of clinical services are extremely important to effective delivery. We have taken the opportunity to work with the service to come forward with some new proposals on that. Those proposals will be on the streets, as they say, before too long.

Mr Finlay: I point out that it is really a discrepancy between demand and capacity, which is partly to do with our geographical problem of meeting the needs of small communities in distant areas. Although some of the hospitals in exhibit 30 are not working at full capacity and the graph shows apparent capacity, patients would have to travel quite long distances to have a test in those hospitals, so it is not quite as simple as saying that the facility is not being used.

11:15

Mr Welsh: Have you considered how other countries that have public health services address such issues? If so, which countries have you considered?

Dr Woods: We are most familiar with the work that has been done on diagnostic services and endoscopy redesign in England. Much of what we are doing parallels the work that is being done in England, which offers the nearest, most useful comparator.

Mr Welsh: Are the recruitment and retention of key staff a problem?

Dr Woods: We have difficulty recruiting in some areas, such as radiography, but in general we are making considerable progress in relation to staffing numbers in bowel cancer services. For instance, although there are vacancies in radiography, there has been an 18 per cent increase in the number of radiographers in

Scotland since 1997. This year there will be 100 graduates in the discipline and the number will rise to 139 next year. Since 1997, there has been a 35 per cent increase in oncologists, who are key members of the team, and we will have 19 more oncologists over the next three years. There has been an 18 per cent increase in radiologists since 1997 and we expect 28 radiologists to complete their specialist training during the next three years. In general, those staffing increases will put us in a reasonable position in relation to supply and demand in those specialties.

Mr Welsh: Are retention and turnover of staff a problem?

Dr Woods: Yes, but the modelling that I described factors that in. We anticipate that by 2006-07 many of the disciplines that I mentioned will be broadly in balance in Scotland.

Mr Welsh: What is the retention problem?

Dr Woods: Do you mean the level of retention?

Mr Welsh: What are the causes of the problem?

Dr Woods: They could be many and varied. It could be to do with personal circumstances; someone might want to pursue a career elsewhere. I do not want to speculate much beyond that. Multiple factors affect decisions that people make about pursuing their careers.

Mr Welsh: The report suggested that the recruitment and retention of key staff are problems. Will the measures that you mentioned address the problems?

Dr Woods: They will go a long way towards doing so.

Mr Welsh: Who is responsible for workforce planning for bowel cancer services?

Dr Woods: The responsibility is part of the broader responsibility for workforce planning, which takes place at a variety of levels. Locally, of course, workforce planning is the responsibility of NHS boards, but nationally we take a close interest in the matter and work closely with NHS Education for Scotland, which is responsible for the postgraduate training of doctors and dentists. The Health Department works on workforce planning for nursing. We will soon produce important papers on workforce planning for NHS Scotland; much work has been done under the auspices of our national workforce committee, which leads that work. We should see the fruits of that labour during the summer.

Mr Welsh: The service has suffered from staffing problems and the lack of training of key staff. There is to be a national bowel cancer screening programme. It is estimated that screening the 50 to 69 age group could save 150 lives each year, which would be great. However, can the system cope with the increased workload?

Dr Woods: As I have said, we are actively planning for the implementation of bowel cancer screening. We cannot simply bolt on bowel cancer screening to the existing services; they need to be expanded and developed. That is why we have been looking—in particular, but not only—at the issue of using non-medical endoscopists. It is a critical point in the training pathway. The bowel cancer framework group that we have established within the department has brought together all the interests in the matter to ensure that we have a comprehensive plan that enables us to roll out bowel cancer screening.

Part of that work has been to identify what additional resources we believe will be required for that. We have already committed £2 million of capital to expand the laboratory in King's Cross, in Dundee, and to equip it with the necessary systems. That process is under way now. We estimate that it will cost about another £2.7 million to run the call and recall system for bowel cancer screening and that the additional treatment and investigation costs will come to about £6.1 million across Scotland. We are factoring all that into our forward plans to ensure that we have the necessary capacity in place.

Susan Deacon: I have a couple of brief follow-up questions on the proposed screening programme, on which I would welcome some additional information. There are UK bodies that are charged with looking into screening programmes and the like. Are we in Scotland going in a distinctive direction in this area or at different pace from other parts of the UK, or is this development part of a UK-wide move?

Dr Woods: I will invite Mr Millan to speak in a moment. My sense is that we are going in broadly the same direction as the rest of the UK, as what we are doing rests on the same evidence. One would be wary of departing from that. There is some debate about what the age range should be for screening, and I think that we plan to aim it at a wider age range than might be the case elsewhere. However, I am ready to stand corrected.

Mr Fergus Millan (Scottish Executive Health Department): That is essentially correct. The NHS in England is undertaking its own planning and announced last year that its screening programme will roll out from 2006. It faces the same issues that we face, concerning capacity and how the programme can be built into its existing services. However, it has not yet announced details of the number of screening centres or the age range. As Dr Woods said, we are considering an extended age range. The proposed programme in Scotland is essentially comparable, but we are perhaps in a

slightly more advanced position on it than the NHS in England.

Susan Deacon: Thank you. I have a second point for clarification. Can you give us a sense—even in broad-brush terms—of how the proposed bowel cancer screening programme may compare with other national screening programmes, regarding the outcomes that you expect? You have said that 150 lives might be saved by the proposed screening programme. I know that detailed information is available on that but, broadly, how might that outcome compare with those of screening programmes for breast cancer, cervical cancer, and so on?

Dr Woods: From memory, I think that the proposed screening programme will save significantly more lives than the programme for cervical cancer screening. Mr Millan has the data.

Mr Millan: The screening programme for breast cancer is expected to save about 40 lives a year, and the screening programme for cervical cancer is expected to save about 26 lives a year.

Dr Woods: That is why we think that investing in the proposed bowel cancer screening programme is one of the most important things that we can do.

Mr Welsh: For clarification, I have a couple of specific questions. How can you ensure that all hospitals in Scotland that will provide bowel cancer services will use risk-based diagnosis measures instead of the clinics' or GPs' own preferences?

Dr Woods: That is being discussed by the bowel cancer framework group. I was at its meeting a couple of weeks ago, when that matter was discussed. We have built the need to achieve that into our waiting times action plan for bowel cancer, and we will pursue that with some energy over the next few months.

Mr Welsh: Thank you. The report suggests that certain terms lack definition, the most important of which are "urgent" and "specialist". What plans are in place to define those two terms precisely, and what criteria will be used to define them?

Dr Woods: Urgency is a clinical decision that is made by a general practitioner in the light of the medical history of the patient and the symptoms that they are presenting with. To that extent, urgency is defined by a GP, who comes to a view on a patient. The bowel cancer framework group is working on a referral protocol that will give more detailed guidance to GPs to help them with those difficult decisions. As Mr Finlay said—and I think that it is also in the report—there are a large number of people with symptoms, but only a small number of them will go on to develop bowel cancer. That is why the adoption of risk stratification in primary care and in hospitals, when people get to see a clinical nurse specialist, is important.

Mr Finlay: We are working hard to produce a robust mechanism for defining urgent and non-urgent patients, bearing in mind the need to treat all patients. For two or three years, guidelines have been in place that define urgent and non-urgent cases. GPs are aware that a third of patients are in the non-urgent group, but because they are the patients' advocates, they quite properly tend to tick the "urgent" box first, especially if waiting times are a bit long. That is understandable. It is what I would want, myself.

Mr Welsh: We all understand the importance of being labelled as an urgent case, as evidence indicates that there is a clear advantage in a speedy diagnosis because it results in higher survival rates; that is why I am asking the question.

Are there any plans to reduce the number of appointments that have to be marked "did not attend"?

Dr Woods: Yes. Clearly, one needs to do all that one can to reduce the number of appointments that people do not attend. The note of caution that you hear in my voice relates to the fact that we need to understand why people did not attend an appointment. It might be that the service has not organised itself as effectively as it might have in terms of making it easy for people to attend or it might be that the patient finds that particular circumstances arise on a particular day. Equally, however, it could be to do with the fact that people do not take the opportunities that are afforded to them. We have to be careful to understand the causes of missed appointments and allow that to guide the actions that we take.

Mr Welsh: Do you plan to increase the co-ordination between waiting lists in order to reduce the discrepancy in waiting lists? For example, are there any plans to eliminate the procedure of named referrals and replace it with some sort of centrally controlled register of appointments?

Dr Woods: Many hospitals are considering a common receipt of referrals. Last week, in Stobhill, I heard about clinical nurse specialists reviewing referrals. That is a useful way of managing referrals as it ensures that patients are differentiated according to urgency and diagnostic modality. Again, we know what we need to do; our task is to ensure that we do it across the piece. However, there will always be reasons why a GP will want to refer a patient to a particular consultant and we need to respect that.

Mr Finlay: I agree that there has been a move away from named referrals. However, patient choice is important and some patients want to see a particular doctor. That is why we want to ensure

that patients continue to have a right to see the doctor of their choice.

The Convener: Susan Deacon will lead the questions on the quality of care, with a focus on the patient's experience.

11:30

Susan Deacon: As many of the responses that we have heard today have already touched on this area, I will endeavour to go forward, not back, as the saying goes.

Mr Finlay, you helpfully outlined some of the developments in Scotland that have enabled cancer clinicians to improve the quality of care that is offered to patients. In particular, you highlighted the managed clinical networks and other developments that arose from the acute services review in 1998-99. You also highlighted the fact that the regional cancer networks played a positive part in that. However, our efforts to develop the associated machinery have not stopped there. I am struck that exhibit 7 is, in a sense, a snapshot of the world in which you live and of the plethora of individuals and bodies that come to you, ask you many questions and make many demands of you on a fairly regular basis. Will you share with the committee your experience and view of the efforts and scrutiny that add greatest value to the work that you and your team do and what gets in the way?

Mr Finlay: Thank you very much. I will attempt to answer that question.

Susan Deacon: You may plead the fifth amendment.

Mr Finlay: I turn to the report first. I welcome the report, which is balanced and beautifully written, but I felt that I had been shot with my own gun when I first read it. Back in 1999, nothing was in place. Clinicians worked in isolation and we knew very little about the process. We set up the managed networks, got clinicians to work together across regions, collected the data and got our first data snapshot in 2002, which forms the substance of the report. At that time, we compared our performance against the standards of the Clinical Standards Board for Scotland. The aim of the process was to pick up good quality, which we knew existed in certain areas, so that all hospitals in Scotland would be on a level playing field. Last Friday we reviewed the data on important clinical outcome measures—such as whether a tumour had been completely removed, which is obviously critical to a patient's outcome—and all our networks throughout Scotland now meet those standards. In 2002, however, some of those standards were not met. I think that it is that process of clinicians working together from the bottom up that has driven quality up. That was not to please the Executive—I am not here as an apologist for the Executive—but because everyone wanted to do their best to fight the disease. We have harnessed people's enthusiasm.

The first priority was getting right the simple things, such as the quality of surgery and ensuring that specialist surgeons see patients and that all patients see oncologists. I suggest that we are well on the way to achieving that, if we have not already done so. If we break the data down by individual hospitals, we perhaps still have some way to go to nudge everyone up, but we are going in the right direction. Waiting times are disappointingly stubborn simply because we are overwhelmed by demand, and the more programmes we seem to run, the more patients come to us as a result of the success of the various programmes. That could never have been anticipated.

We should not lose sight of the fact that, over the past decade to 15 years, we have improved survival of the disease in Scotland by around 15 per cent, which is a higher rate than anywhere else in Europe. Cynics will say that that is because we started from such a low ebb and that we could go nowhere else but up, but that is incorrect. Our data were examined by the European cancer institute, which attributed what has happened to many of the measures that we have taken on sub-specialisation, the network processes and so on. There is much to be upbeat and positive about and I hope that the report is not interpreted as a negative document—it simply picked up our attempt to improve the lot of patients who have the disease. There have been further improvements since the data were compiled, which I hope that we will be able to share with the committee in due course.

Susan Deacon: I am grateful for your answer, which reinforces my long-held opinion that doctors are more effective politicians than politicians are. Your answer is genuinely informative and terribly diplomatic, which I appreciate. However, I want to press you a little further. You talked about the importance of achieving change from the bottom up and the practical things that make a difference to the patient's experience. I want to return to the range of activities that are taking place.

We have at this meeting representatives of two Scottish Executive branches—NHS QIS and the centre for change and innovation—the Scottish Executive Health Department in a broader sense and of course the committee and all that goes with that process of accountability. In practical terms, what would you like more of from any or all of these organisations—or from us—to enable you and your team to focus on taking forward the necessary practical improvements and on building

on the good practice and successes that have developed over the years?

Mr Finlay: I could flippantly say, "More of everything", but I will not. I am mindful that the cake is of a certain size and that if colorectal cancer takes more, someone will have to get less. That is always a danger and it is also the danger of targets: we can meet any target by just moving the resources from somewhere else into a target-driven process.

We have to be realistic about how much resource we devote to this disease and there are discrepancies in how much resource is available. We put a lot into breast cancer—which is good—but less into other cancers. We probably need a little more resource in bowel cancer as a share of resources in order to achieve some of the things that we want. Mr Welsh was right to ask what would happen to symptomatic patients if we roll out screening. One of our challenges is to solve the symptomatic patients before we roll out screening. We must do that.

It would be helpful if the Executive were to give direction that would encourage primary and secondary care to work together to implement the guidelines. Although we work by consensus, we need to direct some of the guidelines. We have to encourage the process and keep going. We also have to encourage the people who are producing good work on the ground to keep doing so. We need to work with them to improve the service. A lot can be improved just by encouragement and reorganisation—and with some money; there will need to be some money.

Susan Deacon: Thank you very much. I am grateful for that answer. If I may, I will maintain the same line of questioning for David Steel. I am conscious that, although the clinical standards board as was, and QIS as is, has been referred to on a number of occasions this morning, we have heard relatively little of your view about how the process of improving the quality of care can be driven forward. You have a number of years' experience under your belt, as does the organisation that you represent. What does that experience tell you about how best this can be done? Reflecting on this morning's discussion, how can the process of improvement be driven forward?

David Steel (NHS Quality Improvement Scotland): I will follow on from Mr Finlay's comments. Our role—in the past as the clinical standards board, and now as NHS QIS—is to set standards, monitor the performance of the service against those standards and make recommendations in the light of what we find. We then look to NHS boards and, in this case, the networks to implement our recommendations. We do that partly for the reason of ownership that Mr Finlay mentioned. Although some things are done most effectively from the centre, other things are done much better if they are taken forward locally with help from the centre. That is where the centre for change and innovation comes in as well. We also look to the Health Department, through its performance management arrangements, to ensure that that is happening. As the committee heard earlier, boards are accountable to the department and ministers and not to NHS QIS. We have a role in helping with implementation: for example, one part of the organisation is responsible for producing best practice statements. A couple of statements have been produced in relation to different aspects of cancer treatment.

We also have a role in following up on the action that has been taken as a result of our reports. For example, on health care associated infection, we have undertaken four reviews to see what progress has been made in the light of the earlier reports that we produced on the subject. There are various ways in which we ensure that the recommendations that we produce are implemented. As you can imagine, one of the very good pieces of news that I have heard in the past few days was about the meeting of the regional cancer networks that was held last Friday to look at the latest audit data, which show that all the key clinical standards are now being met. That is a good example of how the combined effort of all the people who are represented at this end of the table can lead the service in the right direction.

Susan Deacon: The report identifies that some of your organisation's standards have not kept pace with clinical practice and need to be revised. Can you tell us specifically what stage you are at in doing that and, more generally, how you ensure that the standards that you set do keep pace with change so that the right things are being measured and change is driven in the right direction?

David Steel: The answer to your specific question is that we have embarked upon the process of updating those standards. We deliberately waited until the Audit Scotland report was available, but that process has now started. An important part of that is ensuring that the standards that are developed for the screening service are consistent where they overlap with those for the symptomatic service, for the very reasons that were mentioned earlier.

As you say, it is important that we keep our standards up to date, but there are two other factors that we must take into account. First, if we change the standards too frequently, we create instability by constantly moving the goalposts. A degree of stability is needed so that the service can address the issues that arise from the

standards and ensure that we get improvement. The message that we get from the service is, "Don't do this too often."

Secondly, returning to a point that Mr Finlay made earlier, there is the question of how much effort we put into the areas that we have already examined, as opposed to the large number of services where we have not yet set standards or undertaken equivalent work. It is a balance of judgment for us. The four sets of cancer standards that we have relating to the four major tumour sites were among the first standards that we developed in 2000-01 and we felt that now was the time to tweak them. I do not think that it is more than tweaking. The Audit Scotland report rightly identifies a number of areas where there is new evidence or where new techniques and procedures are now available, but there will not be a radical change in the standards. They seem to have stood the test of time reasonably well.

Susan Deacon: I want to ask about the implementation of standards. At various points in the discussion, all the witnesses have identified where different responsibilities lie, but I would like you to explain one specific area a little further. Frequent reference has been made to GP referrals. That is one area in which, as I understand it, good practice guidance exists. Whose job is it to ensure that that guidance is followed?

Dr Woods: Ours, I believe, in the sense that when people have discovered solutions to problems, we must ensure that we can generalise their implementation. That relates to our performance management function. The tension is the extent to which one can embrace almost every possible issue that arises in the health service and incorporate it into that function.

We have an important role in that area, but I would also like to make a more general comment. It struck me that you were interested in a more general point, which seemed to be about the role of scrutiny and challenge in performance improvement and whether the landscape was getting a bit crowded. I read the comments that you made in the previous meeting. Those processes are undoubtedly vital to the process of improvement, but a lot of what is described in the report has been achieved by highly motivated staff wanting to come together, to work together and to apply lessons, whether those lessons are about GP referral or other matters. They devote a lot of time and energy to the process of improvement.

We need to ensure that we always leave space and time for people to be enterprising and innovative at local level. I fully support the important role of scrutiny and challenge, whether it is performed by Audit Scotland, this committee, us as a department or QIS, but we need to ensure that people are encouraged to come together locally and discover the solutions to the problems. That is what has been going on in the service.

11:45

Susan Deacon: I am grateful for your answer; you read between my lines correctly. However, the overarching concern for us all—certainly for this committee—is seeing improvement happen.

My time is running out, but I would like you to respond on one final issue that I do not wish to lose. GP referral guidelines are a good example of guidance existing and there is no dispute about how such referral should be done, yet the Audit Scotland report refers to it repeatedly as simply not happening. I do not want to protract this line of questioning, but there is a sense in the committee, and perhaps elsewhere, that we keep making the same observations. I acknowledge that the department has accepted responsibility candidly, but the key question remains. How can we see improvement, rather than continue to finesse the guidance and standards?

Dr Woods: For the reasons that you describe, GP referral and the implementation of the protocols are almost number 1 on our action plan, and we will pursue them over the next few months. I am in danger of repeating myself, which I do not want to do, but we recognise the point and are determined to pursue it with vigour.

Susan Deacon: The final issue that I want to ask about is information for patients. First, could you say a little more—briefly, please—about how awareness will be raised?

Secondly, I refer to paragraph 108 of the Audit Scotland report, which sets out a positive picture of patient information. I note the input of voluntary organisations and charities such as Colon Cancer Concern, CancerBACUP and Macmillan Cancer Relief. We should recognise that improvements have taken place. In the minus two minutes that are left, could you give us a sense of how that translates in practical terms to the kind of information that patients are receiving on, for example, the prospect of having a colonoscopy or a sigmoidoscopy and subsequent surgery, and what that might mean for them physically and mentally? How are you spreading the good practice that has been developed in cancer care to other areas of the service to improve the information that patients receive?

Dr Woods: I will deal with the question on awareness. In anticipation of such a question, I brought with me an example of the kind of material that is now available. It comes from a project in the Forth valley on bowel cancer awareness, which I think was funded by the New Opportunities Fund. The material is excellent. Other such projects are

going on throughout Scotland. I would like to bring an exhibition of awareness-raising material to the Parliament. When we get into bowel cancer screening in a more widespread way, we will need to do more awareness raising. Perhaps Mr Finlay could comment on the information that is given to patients at the time of diagnosis.

Mr Finlay: Much has happened in the past few years. The networks have generated their own documentation, which they hand to patients. The keystone in the process of helping patients with information and taking them through the difficulties has been the development of nurse specialists, who have the time to speak to patients and their families. The report is full of examples of patients who talk about their relationship with nurse specialists. Inevitably, the doctor is too busy, is not good at communicating or has other things on his mind, but the nurses are particularly skilled at such activity. That cornerstone of patient information and support is in place in most units throughout Scotland.

David Steel: During the six years that we have been in operation, there has been a sea change in the information that is available and the use that the health service has made of it. One of the roles of the new Scottish health council is to share expertise in that area with boards and to ensure that that continues to happen.

The Convener: What happens to boards that do not comply with clinical standards?

David Steel: First, we would look to the local board and its clinical governance committee to take the appropriate action. For that, they are accountable to the Scottish Executive through the accountability review process.

Mrs Mulligan: On improving information for and communication with patients, Dr Woods suggested that information on patient experience could be gathered from the patients themselves and used to develop systems. Will you expand briefly on that point?

Dr Woods: I invite Mrs Ferguson to say a little bit about this matter, because the top 20 tips that we have been discussing have been informed by that process of dialogue with patients.

Mrs Ferguson: From the very beginning, we have sought the views and experiences of patients and their family members. First, we enlisted the help of people who had been through the Royal College of Nursing leadership course and had been trained in conducting one-to-one interviews. In the second year, we invited patients to contribute to the mapping that we carried out with service staff, but they were a little inhibited by that. We learned from that experience and now engage them very successfully in one-to-one interviews in which they tell us their experiences at the different stages of their journey. Family members can add quite a bit to that process. After all, they can sometimes feel left out of things.

The important lesson that we learned was that we needed not only to ask about patients' concerns, but to find out what was good about the service. Patients felt that there were many good things about the service, and we fed that information back to the service staff.

We were reassured to find out that patients raised similar concerns, which centred on certain bottlenecks, reporting back on results and communication. They said that although communication had improved, it could sometimes be a little better. We quickly fed back that information to service staff and were quite reassured by the speed with which changes were made in the service. We continue to share that learning throughout Scotland; in fact, next week, we are holding an event on spread and share, at which some patients want to set up a poster board. That is very encouraging.

Mrs Mulligan: Who takes responsibility for responding to patients' issues?

Mrs Ferguson: It has to be the clinical staff who deal with the patients.

Mrs Mulligan: But who takes responsibility in NHS Scotland?

Dr Woods: I think that you are asking whether we could be more systematic in this regard. The answer is yes. We have a number of well-validated instruments such as questionnaires that allow us to measure patients' experience of the health service. As I said, we are examining the matter to make it more systematic and to ensure that it informs the management process.

George Lyon: When taking evidence on the health service and the productivity of the system during the past 12 months, the committee was concerned that there is a sense that productivity is declining in the national health service in Scotland. In answer to an earlier question, Ian Finlay said that the service was overwhelmed by demand and that it could not have predicted that. What do you mean when you say that you are overwhelmed by demand? What are the underlying causes? Why could not the demand have been predicted? How is the service responding to the challenge?

Mr Finlay: I am talking specifically about bowel cancer, not about demand in general. There have been some high-profile cases of patients who died of bowel cancer and that caught the public's eye. In particular, Bobby Moore, the England football captain, died of bowel cancer in the late 1990s and that received a lot of publicity.

Before that, patients had very little awareness of bowel cancer and what the symptoms are. As

recently as four years ago when the west of Scotland cancer awareness programme asked the public what they understood about bowel cancer, relatively few patients understood what the disease is and what the symptoms are. There has been a rise in public awareness through all sectors of the media, including magazines and a variety of other sources, which has caused everyone who sees a spot of blood to believe that they might have bowel cancer. I suggest that we might have overdone it, but that is what has caused the sudden increase in demand and I do not think that we could have anticipated that.

George Lyon: Do you mean an increase in demand for diagnosis rather than an increase in the number of people who have the disease, or have all the numbers increased?

Mr Finlay: There is demand everywhere. The numbers have increased enormously because people did not present to the service before. Increased awareness has caused demand to run through primary care, through general practice, and into secondary care. General practitioners are very worried that they will miss a cancer, although the likelihood of that happening is extremely small. The whole thing has cascaded during the past five to eight years.

Dr Woods: We return to the importance of establishing the evidence-based referral guidelines in general practice so that we can ensure that people raise their concerns with their family doctor. If patients can be managed in that context, they should be; they can then be referred on. That is what we are trying to achieve at the moment.

The Convener: I thank Dr Woods and all the members of his team. The oral evidence has been very useful and informative for us. We will probably seek to clarify a number of further points once we have read through the *Official Report* of today's meeting. We will write to you to ask for those clarifications and any further written evidence that might help.

11:58

Meeting suspended until 12:11 and thereafter continued in private until 12:38.

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