AUDIT COMMITTEE

Tuesday 25 May 2004
(*Morning*)

Session 2

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AUDIT COMMITTEE
11th Meeting 2004, Session 2

CONVENER

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

DEPUTY CONVENER

*Mr Kenny MacAskill (Lothians) (SNP)

COMMITTEE MEMBERS

*Rhona Brankin (Midlothian) (Lab)
*Susan Deacon (Edinburgh East and Musselburgh) (Lab)
*Robin Harper (Lothians) (Green)
*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
*George Lyon (Argyll and Bute) (LD)

COMMITTEE SUBSTITUTES

Chris Ballance (South of Scotland) (Green)
Mr Ted Brocklebank (Mid Scotland and Fife) (Con)
Marlyn Glen (North East Scotland) (Lab)
Mr Andrew Welsh (Angus) (SNP)

*attended

THE FOLLOWING GAVE EVIDENCE:

Dr Peter Collings (Scottish Executive Health Department)
Mr Trevor Jones (Scottish Executive Health Department and NHS Scotland)
Gerry Marr (NHS Tayside)

CLERK TO THE COMMITTEE

Shelagh McKinlay

SENIOR ASSISTANT CLERK

Joanna Hardy

ASSISTANT CLERK

Christine Lambourne

LOCATION

Committee Room 2

Scottish Parliament

Audit Committee

Tuesday 25 May 2004

(*Morning*)

[THE CONVENER *opened the meeting in private at 10:05*]

10:20

Meeting continued in public.

Items in Private

The Convener (Mr Brian Monteith): We move to the public part of the 11th meeting in 2004 of the Audit Committee. I remind members of the press and public to check that their mobile phones and pagers are turned off.

Item 2 is to seek the agreement of the committee to take items 4, 5 and 6 in private. Item 4 is to enable the committee to discuss key issues that arise from the evidence taken on the committee's inquiry into the "Overview of the NHS in Scotland 2002/03", on which we have a draft paper.

Item 5 is to enable the committee to consider the evidence to be taken this morning on the Auditor General for Scotland's report on managing medical equipment.

Item 6 is to enable the committee to consider a draft report on the Scottish Parliamentary Corporate Body's accounts for 2002-03.

Do members agree to take agenda items 4, 5 and 6 in private?

Members *indicated agreement*.

"Better equipped to care?"

10:21

The Convener: I welcome Trevor Jones and his team, Peter Collings and Gerry Marr, to the committee. I understand that Mr Jones does not wish to make an opening statement, but I give him the opportunity to introduce his team before we move on to questions.

Mr Trevor Jones (Scottish Executive Health Department and NHS Scotland): On my right are Dr Peter Collings, who is director of finance and performance management in the Scottish Executive Health Department, and Gerry Marr, who is the chief executive of NHS Tayside acute services division.

The Convener: Very good. We will be looking at two issues in the Audit Scotland report "Better equipped to care? Follow-up report on managing medical equipment". The first is the Health Department's leadership role and the second is information to support performance management and accountability for medical equipment.

Mr Kenny MacAskill (Lothians) (SNP): Mr Jones, will you describe your role in the provision of medical equipment and all that relates thereto? What is your department's responsibility for planning replacement programmes at all tiers and levels in the national health service? What is your remit for funding and purchasing substantial items of equipment of direct relevance to national strategies, such as linear accelerators?

Mr Jones: First, the department has the role of setting broad policy direction for NHS services. Secondly, we ensure that NHS boards have systems in place to deliver those strategies and to provide safe and high-quality care. Thirdly, we allocate resources to boards to allow them to implement their local strategies. We take a strategic role in the direction of the NHS and we ensure that services and ministerial priorities are delivered.

What was the second part of your question?

Mr MacAskill: What are your responsibilities for planning replacement programmes at all levels?

Mr Jones: At a strategic level, we would not expect to take a major role in the replacement of routine medical equipment. We have 15 territorial boards in Scotland, each of which has a multimillion-pound budget. Our clear policy is to devolve decision making down to the most appropriate level. We want to push decision making down through the NHS boards and divisions to local operational units. We do not want to drag decision making up into the centre, where

it would be inappropriate for us to try to second-guess what people know is local good practice.

We need to ensure that the systems are in place to enable sound and effective programmes for the replacement of routine medical equipment to be followed. Our role is much more about ensuring that processes and procedures are in place than it is about agreeing replacement programmes.

We take a much more active approach to high-cost items of equipment for use in national priority strategies, such as cancer and heart disease. The national replacement programme for linear accelerators is not prepared by staff in the department; it is prepared by NHS physicists and clinical staff in cancer services who assess priorities and agree a sensible replacement programme.

The linear accelerator programme is one of our cancer strategy successes. We have been replacing outdated equipment and we now have state-of-the-art equipment throughout Scotland. When we complete the current phase of replacement, we will have 24 linear accelerators in Scotland. That meets the target set by the Royal College of Radiologists to have five accelerators for every million people.

Mr MacAskill: I appreciate what you said about leaving decision making to local areas. If we leave aside the linear accelerators, which come from a different direction to some extent, what is the interaction between rolling out and funding national strategies, and decentralisation and local management?

Mr Jones: It is by exception that we would have centralised funds. We try to get as much of the NHS resources to NHS boards to let them decide on local priorities.

If we take the cancer example, we fund the capital cost of linear accelerators, but the responsibility to fund the revenue cost of the linear accelerator programme lies with local NHS boards. We have debated in the committee several times whether it is better to have earmarked funds at the centre or to allocate resources based on the need of the population of NHS board areas and allow local decisions to be made. I am firmly in the camp that says that it is good to get as much cash as possible out to local NHS boards for them to manage the resources locally. Otherwise, if we retained a lot of cash at the centre, we would have to second-guess what might be right in a local situation. We provide capital for major capital equipment, but we do not fund the revenue consequences because that is for local determination.

Rhona Brankin (Midlothian) (Lab): There has been a lot of recent publicity about long waiting times for magnetic resonance imaging scans. How do you assess how many MRI scanners are needed and is existing provision adequate and equitable in terms of access for patients throughout Scotland? A third of MRI scanners in the NHS in Scotland have either reached their standard life or are older than the standard life. What is the Health Department doing to address that situation? MRI scanners are used to diagnose a wide range of conditions. How does that fit in with your approach of concentrating on medical equipment in policy areas such as cancer?

Mr Jones: We do not fund MRI scanners from a central pot. MRI is funded by local health boards and it is now part of the general diagnostic kit that is available to clinicians throughout Scotland. Decisions about whether and how to purchase are taken by NHS boards. Perhaps Gerry Marr will explain how NHS Tayside handles that situation.

We do not see MRI as something special that has to be funded from the centre, although we could if a business case were made against any of our central programmes. If someone in a particular board identified a major step forward in cancer treatment, they could make proposals for central funding but, generally, MRI is regarded as part of the routine NHS kit, although the equipment is expensive.

Gerry Marr (NHS Tayside): I am happy to comment on what we do locally. As Trevor Jones said, MRI is now a standard diagnostic tool that is used for many reasons. Our preference is to move away from purchasing to leasing equipment because we think that that achieves two things. First, it allows us to build the maintenance costs into the leasing agreement. Secondly, it avoids the problem of the equipment going beyond its active life, as the leasing agreement allows us to replace the equipment on a five-year basis.

By coincidence, NHS Tayside allocated £4 million in revenue last month to go to contract leasing for all our major radiological equipment at Ninewells hospital. That is the strategic way to deal with big items of equipment. We have two MRI scanners that are within their working life, but we have one that is 10 years old and it is expensive to maintain. The shift from purchasing to leasing is sensible. About £7 million-worth of our major equipment is now under leasing arrangements.

10:30

The Convener: Does that show up as a shift that might be interpreted as less capital spending?

Gerry Marr: In accounting terms, that is correct. The shift affects the accounting treatment of the situation and changes what might be declared as the asset base. However, that is an accounting issue. Leasing is certainly the best way of

managing equipment in the longer term to prevent big pieces of equipment from ending their working lives after five years.

The Convener: That may be an accounting matter, but it is the sort of issue that politicians pick up on.

Rhona Brankin: I will probe a little further. At the centre, how do you judge the adequacy of provision throughout Scotland? That is key. The Health Department's role is to ensure that patients gain access to what has been described as a standard diagnostic tool. If an MRI scanner is such a tool, some patients seem to have an awful lot more access to one than others do. The department has a clear role of ensuring that that diagnostic tool is available to everybody in Scotland.

Mr Jones: It is worth repeating that the department should have a strategic role in health service provision generally. It would not be sensible for the department to assess every detail of the quantity and quality of every piece of kit in every health board area in Scotland. That is why we have NHS boards. The aim is devolved management. I keep stressing that we should not pull all decision making to the centre.

We would identify gaps in provision from a range of matters, the most obvious of which is waiting times. We have an overview of waiting times. If the waiting times for any service were increasing, we would debate the cause with the NHS board concerned. One cause of increasing waiting times could be a shortage of capacity in staff or equipment. We would debate with a board how it would reduce waiting times. There are different ways to solve problems, which might not involve simply medical equipment. In the first instance, we would talk generally about the outcome for patients, rather than monitoring the input of the resource that a board spent.

Rhona Brankin: My second question was about scanners that have reached the end of their standard life or are older than their standard life. What can you do to ensure that such machines are up to date and safe?

Mr Jones: When I was asked what the department's role was in relation to medical equipment, I should have said that we have a safety role. We advise NHS boards on safety issues. NHS Scotland also has a centralised process that the NHS procurement organisation runs. That organisation is examining adverse incidents that involve medical equipment so that information can be fed throughout the service. The chief medical officer provides the service with safety advice about medical equipment and the procurement organisation reports on adverse incidents.

An interesting debate concerns whether any equipment—not just medical equipment—should be replaced when it reaches the end of its standard life. We all go through that every day and we all make different choices about when equipment will be replaced. No great logic says that as soon as equipment reaches the end of the manufacturer's recommended standard life, it should be changed. Gerry Marr's point about examining the efficiency of a piece of equipment is important. A piece of equipment may well last significantly longer than its standard life and continue to be cost effective, whereas another piece of equipment may reach the end of its economic life before the end of its standard life, because of the work that it does. We must consider individual pieces of equipment and form a view about the appropriate replacement time. No great logic says that if a manufacturer says that a standard life is five years, the equipment must be replaced after four years and 364 days. We must consider whether a piece of equipment works well and is safe and state of the art. Just because equipment is five years old, that does not mean that it is out of date.

Gerry Marr: In local systems, the medical physics department in each hospital has a leading role in and absolute responsibility for maintaining the medical equipment register and maintaining safety. The Audit Scotland report comments on the adequacy of registers and the role of medical physics departments. The medical physics department in my hospital is responsible for saying that although a machine has gone beyond its working life, it is safe and effective and can be maintained for the next two years. If that department told the board that a piece of equipment had no useful life, it would have to be taken out of service.

Rhona Brankin: Will you describe how information from the adverse incidents reporting scheme is fed into the system and how it informs decisions?

Mr Jones: NHS boards should report adverse incidents involving equipment to the central procurement organisation—Scottish healthcare supplies. If that organisation identifies a problem that could reoccur elsewhere in the NHS, it will notify the service of that. I do not know the detail of how that system works, but I would be happy to circulate that information to the committee, if that would be helpful. I would rather send the committee chapter and verse on that information than guess at it.

The Convener: That would be helpful.

Susan Deacon (Edinburgh East and Musselburgh) (Lab): I will return to Gerry Marr's comments about leasing arrangements. You were clearly enthusiastic about how effectively they deal

with MRI scanners and, I presume, with other equipment. In simple terms, are you saying that such an arrangement takes care of replacement, because that is built into the leasing agreement? That is a rolling approach that is different from the traditional idea of having a list of equipment with dates when replacement is planned.

How widely is that approach used? Do you plan to extend it? Can that approach be applied to lower-cost items? I would be interested to know from Trevor Jones whether that practice is more widespread in other boards throughout Scotland. If it works effectively in some areas, is it being encouraged elsewhere?

Gerry Marr: In Tayside, we lease £7 million-worth of radiology equipment against an asset base of £44 million. The transition is quite difficult, because it involves moving from capital to revenue. As members know from other discussions, revenue is relatively tight. However, we are still travelling in the right direction.

No hard-and-fast rule exists, but when we have tested the marketplace, it has been suggested that leasing equipment whose value is under £250,000 for anything less than five years will probably not be attractive to the market. We are talking about five-year lease arrangements for items of equipment whose value is above £250,000. However, that depends on how the market reacts to leasing arrangements.

Susan Deacon: Will you give the committee a flavour of what those items might be?

Gerry Marr: At last month's board meeting, we assigned £4 million to the radiology department at Ninewells hospital. That is for MRI scanners, computed tomography scanners and X-ray equipment—all the big pieces of kit that a normal, functioning radiology department uses for routine diagnostic work. The items range from MRI scanners and big plain X-ray machines to CT scanners and other equipment.

Mr Jones: We would encourage boards to lease if the economic case was that leasing was better than capital purchase. There is a range of boards that have examined leasing and do lease equipment. I can easily supply the committee with details of who does and does not do that. For instance, when the new Edinburgh royal infirmary was being constructed, a decision was taken that medical equipment there should be leased and that, essentially, a private finance initiative contract should be used for that equipment. I am not up to date with how that has developed since my days in Lothian, but we can obtain those details.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): I would like to pick up on the point that Rhona Brankin made about provision being patchy across Scotland. We are obviously trying to get quality indicators for provision, particularly of diagnostic equipment. Is there no strategic role for the department to say, dependent on the size of the health board area, how many MRI scanners a health board should have or how it can assist other health board areas? In my area, the health board has just commissioned two brand new MRI scanners, but in six months' time they will be out of date because that piece of kit is changing. The difference between the equipment that we had and what we have replaced it with is immense in terms of patient care. Is that not the tack that you should be taking as the chief executive of the NHS in Scotland? Should you not be out there to get the best for the people of Scotland?

Mr Jones: The tack that I should be taking is to ensure that patients in Scotland receive the best type of health care. I do not think that it would be the right tack to prescribe input requirements for the number of staff who will be employed on every ward or for the number of MRI scanners, computed tomography scanners or X-ray machines that should be in use. That is why we expect the NHS to solve those issues locally, and boards need to do that by looking at local clinical practice, because different clinical practices will have a different range of demands for medical equipment.

What we should be doing is ensuring that boards work together across boundaries and that they use medical equipment to best effect. Two weeks ago, we had discussions with NHS chief executives and chairs about how to use some spare imaging capacity in the Golden Jubilee hospital and how to ensure that that spare capacity in one hospital can be used to benefit people not only in the west of Scotland but anywhere in Scotland. We have a responsibility to ensure that boards work together and we are currently placing great emphasis on the need to break down the historic boundaries that have existed between health boards. We want boards to plan across their own boundaries through the new regional planning structure. If boards are thinking about major capital investment in equipment, they should be working with coterminous boards to develop joint plans, and we would want to see regional planning taking effect around that.

Margaret Jamieson: So what you are saying is that it is nothing to do with the department.

Mr Jones: No, I was not saying that.

Margaret Jamieson: You seem to be saying that those are local decisions. I am concerned that there is a heck of a lot that gets passed down to local level. Whether someone gets access to a scanner is just luck; it depends on which health board area they live in.

Mr Jones: I did not say that it was nothing to do with the department. I said that the style of management is about having devolved decision making, with decisions being taken at the right level. It would not be sensible to suck decision making up into St Andrew's House. My experience of the NHS tells me that remote decision making would not lead to the best outcome for patients. There must be decision making at the right level in the service and, wherever possible, it should be close to the patient.

Gerry Marr: I would like to make a distinction between existing modalities and new modalities. I have been a member of the positron emission tomography scanner project, which is a positive development because, in the past, boards acquired new modalities in an unregulated way. The PET scanner is an extraordinary new modality for the treatment of cancers. The expert working group has met and its recommendations have been referred to the cancer networks under the new regional arrangements. I think that the cancer networks have been a success anyway, but we are now seeing a much more co-ordinated and sensible approach to new modalities, as opposed to what might be described as standard diagnostic kit. That is a good process and we will commission it, and PET will be introduced in a way that is equitable for the population across the NHS.

Rhona Brankin: Mr Jones, it is your role, at the centre, to ensure that standards are met across health boards in Scotland. You said that you would know when there was a problem with lack of patient access to MRI scanning because the waiting time would increase. Could you tell the committee what you consider to be an acceptable waiting time for a cancer patient to have access to an MRI scan and which health boards are not meeting those standards for cancer patients?

Mr Jones: It would not be a case of looking at waiting times for MRI scans; you would need to look at the individual clinical conditions, but I can certainly supply you with information on waiting times. I do not carry the waiting times for 20-odd hospitals in my head, and you would not expect me to, but I can certainly provide you with that information.

10:45

Rhona Brankin: What I am really interested in finding out is what standards you are applying with regard to patients' entitlement to MRI scans.

Mr Jones: We would use a range of different standards. As you know, the organisation that sets standards for the NHS is NHS Quality Improvement Scotland, which will review specific clinical procedures and set a range of standards, including waiting times for diagnosis. That would be one type of standard.

We also consider recommendations from the royal colleges. For example, the Royal College of Radiologists set a population target for linear accelerators, which we will achieve in the fourth wave of the linear accelerator programme. That is another standard.

We also set local Scottish targets for waiting times for specific treatments. Different types of standards apply and we keep an eye on all of them. If we were concerned, we would raise a detail with an individual NHS board. If the concern was serious enough, it would be raised formally at the accountability review.

Rhona Brankin: Do you see the need for MRI scanners as sitting within your priority of treatment for cancer?

Mr Jones: We would now expect patients to have access to MRI scanning routinely. As we have said, it is not new technology that only a few can have. It is part of the basic kit now.

Margaret Jamieson: The department appears not to focus on the low-cost, high-volume equipment—such as intravenous systems and respiratory equipment—that is often bought using revenue funds. Yet the Medicines and Healthcare products Regulatory Agency indicates that patients are at high risk from such equipment if it is not used properly. How do you currently monitor how well local health care systems are managing risks associated with using low-cost, high-volume equipment, and how do you ensure that the health service learns from incidents resulting either from human error or from faulty equipment?

Mr Jones: In talking about low-cost, high-volume equipment, you are probably moving towards what we call medical devices. There is a UK-wide agency that monitors the safety of medical devices, and the chief medical officer communicates information on good practice from the Medical Devices Agency out to the service.

On measuring incidents, it might be useful if Gerry Marr were to talk about the practicalities of managing an adverse incident that could affect patients.

Gerry Marr: We can deal with the issue under three headings: training, tracking and product rationalisation. Those are the three things that we must ensure are in place if we are to avoid incidents, and you will appreciate that that is our intention.

I can talk only about my own organisation, NHS Tayside, where there is a specific risk-management procedure. If there is an adverse incident, it has to be reported through the risk-management system, on what we call an IR1

incident report form. There is a procedure that then takes the matter through different levels of intervention. We have a red and amber system of reporting, not just on medical equipment but on any adverse incident that might have had an effect on the patient.

We have a highly developed risk-assessment process. We have been awarded accreditation under the clinical negligence and other risk indemnity scheme in the past year and a half, and part of the risk assessment for that revolves around medical equipment. Our procedure is a way of managing the system locally. CNORIS does not deal with medical equipment very effectively, so I would not characterise our procedure as being within the CNORIS system. It really sits within our IR1 reporting system.

Mr Jones: Peter Collings can take us through some of the details of that clinical management system, if that would be helpful.

Dr Peter Collings (Scottish Executive Health Department): CNORIS is a risk-management scheme within the NHS. One part of it is almost a self-insurance scheme: boards pay into a pool so that, when they subsequently make claims, those claims can be paid out of the pool. We have built a set of risk-management standards into that, which is what Gerry Marr was referring to. If a board's risk-management processes meet the standards, it will make a lower contribution to the pool. That is an incentive for boards. The arrangement is similar to the way in which people with certain driving certificates will pay less for their car insurance. Boards, and divisions within boards, are working on their risk-management processes and have a positive financial incentive to do so.

Margaret Jamieson: How does that affect my hobby-horse—the performance assessment framework?

Dr Collings: I cannot remember whether there is an indicator but, in accountability reviews, we certainly consider the level of CNORIS that individual organisations have achieved in their risk-management processes. They will then be congratulated, or not, on that level.

Mr Jones: We should remind ourselves what the performance assessment framework is. It is a tool to allow us to take a strategic view of the performance of organisations; it is not a means of checking every piece of business that goes on in an NHS board. I remember being at this committee recently when you were discussing such matters with some NHS boards. The committee expressed concern that the number of PAF indicators might be rising too high, resulting in people being bogged down in detail.

PAF is not about monitoring everything. One of the biggest problems that the Health Department has is to discourage people from adding indicators to the framework. Some people want every subject to have an indicator, but we do not see it that way. We simply want to get a high-level view of an NHS board's performance; we do not want to check the detail of every issue that that board may face.

Margaret Jamieson: It seems from the Auditor General's report that the department takes a hands-off approach to medical equipment in the NHS. There seem to be huge discrepancies between acute care and primary care and between east, west, north and south. It seems that no indicators are applied.

Mr Jones: You would expect to see significant variations between acute care and primary care, because you would expect heavy investment in medical equipment in acute care but not so much in primary care.

Do we take a hands-off approach? We are very rarely accused by the NHS of being hands-off. Our role has to be strategic. As I have said, whenever possible, we should concentrate more on clinical outcomes and less on the inputs that lead to those outcomes. I think that our involvement in medical equipment is appropriate. For example, we are involved in the very expensive equipment for national programmes—equipment such as linear accelerators, which have been a huge success. We also expect boards to have in place proper monitoring systems and replacement programmes for medical equipment, and we give advice on safety that we expect boards to follow.

Could we do more? Yes, we obviously could. We have sought comments on the Auditor General's report from all the boards and we have received replies from them all. We are reviewing those replies at the moment. Boards have indicated how they feel they should respond to the report.

One idea in the report that is particularly interesting is that of having more detail in the control assurance statement on the management of medical equipment. I see value in that and we should explore it.

Susan Deacon: Margaret Jamieson has indicated the particular patient risk that could be associated with some of the lower-cost, smaller items of medical equipment. Many of those items are out in the community, either in primary care facilities or in people's homes, on loan from the hospital. Especially in the latter case, issues of wear and tear and usage must arise, which will be important when considering replacement of the items and risk and safety. It is one thing to monitor equipment in the controlled environment of a hospital, but how do you monitor it elsewhere?

Gerry Marr: It is more difficult. I cannot comment on primary care because I have no

experience of that. However, in acute care we increasingly find that we have to deliver packages of care at home. At the moment, we are in the middle of setting up an elaborate package of care for a child who has a rare condition. All of the equipment required will be risk assessed before it goes into the child's home and there will be clear training for the nurses and the parents. Often these days, parents will help with the care of their children at home—using ventilation equipment, for example—and that carries risks.

As I say, I cannot comment on primary care, but in the few instances in which it is necessary in acute care, medical equipment is risk assessed and training is given. Product rationalisation is also important. Part of the problem in hospitals is the plethora of different models of the same equipment, which is a result of aggressive marketing by companies in the marketplace, in which a lot of money is involved. However, we try to ensure that risk assessment is adequate.

Susan Deacon: You have talked about what happens when a package of care is put in place—for example, when respiratory equipment goes into a patient's home—but how would equipment be monitored over time? What happens if it needs to be replaced? What are the arrangements for checks and maintenance? I appreciate that every case is different, but what general systems do you have in place to check and maintain equipment in a patient's home?

Gerry Marr: Our systems, which are the responsibility of the medical physics departments, are not perfect by any means. The departments should register and label each piece of equipment, giving information on when it has been inspected and approved. I am not saying that there always is, but there should be a process in place for using that register and ensuring that equipment is maintained. The Auditor General's report points out that the systems have to be worked on and I accept that. We can always do better as we try to minimise risks.

Susan Deacon: In its discussions with boards, is it part of the department's strategic role to consider equipment that is out in the community? Does the department seek to ensure that the boards have systems in place to deal with such equipment, as well as with larger, hospital-based equipment?

Mr Jones: That is right. As Gerry Marr said, much more care is required when equipment is not in a central spot. Systems for checking equipment have to be more rigorous. We have to move away from the old idea of equipment having to come back to the institution; if a medical physics technician has to see equipment, he should be able to go out into the community and see it. We need to move services out into the community, and we need to be able to check and ensure the safety of those services out in the community. We have to get the systems, the processes and the procedures right.

Rhona Brankin: I want to ask Dr Collings about the procedures for risk management. I understand that health boards have three different levels of risk management. What are they and how are health boards doing in attaining them?

11:00

Dr Collings: The CNORIS standards are divided into levels 1, 2 and 3, which are reflected in reductions in CNORIS risk-pooling contributions of 10 per cent, 15 cent and 20 per cent. I do not have statistics to hand on the levels that boards have reached. The lowest level is commonplace: it is the norm for boards to achieve at least level 1. Boards are still working towards achieving the higher levels. Gerry Marr might tell you more about the process, because he has been through it, whereas my knowledge is purely theoretical.

Gerry Marr: We are at level 1 and we are working towards level 2. The standards at levels 2 and 3 are demanding—and so they should be. As I said, CNORIS does not deal specifically with medical equipment and we might have to consider that—I think that Audit Scotland's report makes that point.

We have published a risk-assessment strategy and we must demonstrate that we have assessed risk and that the risks in different parts of the organisation are owned by a named manager. For example, I own a number of risks in the system. We have developed software in Tayside that enables my computer automatically to remind me when I come into the office on a Monday morning that a risk assessment is due and that I have ownership of it and must update the risk register—that is not just about medical equipment but about a range of corporate responsibility for reputation, balance, investment and so on. We have developed a sophisticated risk-assessment tool in Tayside, which is characterised by proper, formal risk assessment and managerial ownership of every risk that the organisation has identified on the CNORIS register.

Rhona Brankin: I was trying to ascertain the levels that health boards have achieved and are expected to achieve. What timescale and targets are set for health boards to achieve the desired level?

Dr Collings: As far as I am aware, most boards are at level 1 and are working towards level 2. I can write to the committee with details of the levels that boards are at.

Rhona Brankin: Does the Scottish Executive Health Department have an overview of the levels that boards should achieve and the timescale for achieving them?

Dr Collings: We do not set specific targets for boards; we simply monitor their progress and if a board is not making visible progress we ask it why that is.

Gerry Marr: For information, the process has been affected—delayed is not the right word—because I understand that CNORIS and NHS QIS are in dialogue about merging the two schemes.

Robin Harper (Lothians) (Green): The baseline report, "Equipped to care: Managing medical equipment in the NHS in Scotland", was published in March 2001. Paragraph 1.6 of the follow-up report, "Better equipped to care?", which was published in February 2004, says:

"Our baseline study was carried out at local level on behalf of the Accounts Commission and so the national position, including the SEHD role, was outwith its scope. Although not all trusts, health boards and the SEHD were included in this audit,"—

this is the important bit—

"our key findings and recommendations were for all those with a role in ensuring good planning and management of NHSScotland medical equipment."

Will you summarise the problems that you have encountered that account for the relatively poor rate of progress in implementing the recommendations of the baseline report?

Mr Jones: I am not convinced that the rate of progress has been particularly slow. The question is: what is the appropriate level for intervention on medical equipment? In that context, I perhaps disagree with Audit Scotland's conclusion that there should be greater strategic involvement—there is strategic involvement. Perhaps we disagree about what we mean by that and by the management of medical equipment.

The baseline report was issued to all NHS boards and they have developed action plans and are working to address the issues that the report raised. I think that the latest report says that Audit Scotland is satisfied with the progress that has been made on the operational implementation of the report by NHS trusts in Scotland. The latest report concentrates on strategic management and I have described what I think is the appropriate level of strategic management with respect to medical equipment.

Robin Harper: So you are saying that an appropriate rate of progress has been made so far; however, the Auditor General's report says that the rate of progress is slow, so it is difficult to begin to address the issue. At the current pace of progress, how long will it take to reach the point at which you and the Auditor General are satisfied with the rate of progress? How many more years will that take?

Mr Jones: That question is impossible to answer. The Auditor General and I would have to sit down and agree a clear target for the appropriate management arrangements for medical equipment and we have not yet done so, so I would not suggest a timescale. As I have said, the latest report has been issued to the service, we have responses from all NHS boards and we are currently reviewing them. The sensible next step would be to agree how we should manage things with the service and the Auditor General and agree an implementation plan from there.

Robin Harper: So you think that it would be appropriate eventually to set targets.

Mr Jones: We routinely agree an action plan for all audit reports. The difficulty is in using the word slow. What is slow to some people is very fast to other people. Specific, jointly agreed actions with clear dates attached to them are needed. When one has those, one can be clear about whether or not one has delivered.

Gerry Marr: There are different levels of progress. In our report, there are things that we should do relatively quickly—the auditors made points about reconciliation of asset registers, better, more systematic training and recording of training. All such matters should be progressed fairly rapidly and they will be dealt with through our local audit committee, which will ensure that progress is timelined.

The balance between the life of medical equipment and the investment strategy is among the more challenging matters to which the report refers. I could not sensibly put a timeline on how we should continue to move towards leasing. Locally, if we want to do things over a two-year period, £9 million investment year on year would be required over the next two to three years to reconcile equipment that no longer has a working life in terms of its book value. Therefore, there are different levels of challenge. Some challenges should be progressed quickly and there should be no excuse not to do so, but the on-going process of prioritising capital to invest in medical equipment is more challenging.

Robin Harper: Do you have plans to raise the profile of general maintenance of medical equipment as an issue in the health service?

Gerry Marr: In our local strategy, our view is that, because of new technologies and new information pathways, there must be more investment in information technology than in bricks and mortar. Solutions are becoming available to us. That is why, in Angus for example, we have built an MRI and radiology department that uses

digital technology to link with the main centre. We have been able to repatriate 40,000 episodes of care back to Angus by investing in technology as opposed to simply in bricks and mortar.

Mr Jones: As a result of the report, we are having debates across the service about the profile of medical equipment replacement; part of our discussions with boards relates to ensuring that the right governance systems are in place to ensure that that profile exists. Therefore, we are doing what the member suggests.

Susan Deacon: I listened carefully to the answers that you have just given. They touched on the issue that I want to raise, but nonetheless, I would like you to focus on two specific recommendations in the Auditor General's report about strengthening the national strategic role on medical equipment. One recommendation suggests that the Health Department should introduce

"a specific medical equipment management standard to provide assurance that proper strategic and operational practices are in place."

Do you intend to do that?

The second recommendation is that the Health Department

"should improve governance and accountability for medical equipment by using performance information to inform Accountability Reviews."

Do you plan to do that?

Mr Jones: I have already said that I am interested in the introduction of a standard through the controls assurance process. We need to investigate that matter after having regard to the responses that we receive from the service, but I suspect that we will move in that direction.

We should not have specific performance indicators that are discussed at every accountability review. The accountability reviews are used to address significant issues with NHS boards; we do not have a standard checklist of issues to discuss during the process. The performance assessment framework gives us a high-level overview of performance and reveals the areas on which we need detailed discussions with boards. However, I would not want to have a standard item on medical equipment in the accountability reviews; I can think of 200 or 300 similar issues, and if we applied the same logic to them, we would lose the emphasis of the accountability review process. If we were concerned about medical equipment in a board area, we would raise the issue, but it should not be a standard item on the agenda.

Susan Deacon: How do you intend to ensure that proper accountability is achieved?

Mr Jones: We will do that by having in place proper governance arrangements and by assessing board performance through our normal process. If that assessment shows that there is a weakness with medical equipment, we will raise the matter. However, we will not do that routinely in an accountability review.

Susan Deacon: Comparisons with other parts of the UK are not always appropriate or helpful, but I understand that the approach in England is more akin to that which was recommended by the Auditor General.

Mr Jones: England uses the controls assurance process, which is what I suggest we should do.

Susan Deacon: So you do not think that the way forward that you propose is materially different from the situation in England.

Mr Jones: I expect that the two will be similar.

The Convener: The next section is about information to support performance management and accountability in relation to medical equipment. We have a number of concerns about the information that is available to help administrators with their task.

George Lyon (Argyll and Bute) (LD): The witnesses have argued strongly that the Health Department has a strategic role and that it considers outputs, not inputs. Mr Jones has suggested that he expects boards to have in place proper monitoring systems and proper replacement policies with minimum standards. However, the department cannot monitor that at present because it lacks even basic performance information that would allow it to find out whether the aims are being achieved. Why is the information to support the management of medical equipment so poor and what are you doing about that?

Mr Jones: As a consequence of the report, we have raised the issue with boards and we are now reviewing the boards' proposals to address the issue. Exhibit 13 in the report, which sets out the access to information, shows that the lowest return is 87 per cent—I think that the data are for trusts rather than boards. I am not sure that the figures are "so poor", although they could be improved. We can see where we have gaps in information and we need to have discussions with the organisations that are highlighted about how they aim to address those gaps.

11:15

George Lyon: The Auditor General's point is that he had to collect the information because your department and, in some cases, boards were unable to supply it. The fundamental issue is that you have to develop systems to provide

information so that you can hold boards to account.

Mr Jones: We have to ensure that the appropriate information is collected. I would have to debate with the service whether the information in the report is the information that is required to manage medical equipment. Audit Scotland requested that information for the report, but the question whether all of it is key information for managing medical equipment is a debate that we need to have with the service. If the information is key and there are gaps, we will need to fix that.

George Lyon: So you accept the criticism that there is not enough management information.

Mr Jones: I absolutely accept that we can improve the information.

George Lyon: My next question leads on from that. Are you concerned that 11 trusts could not provide even basic information about the replacement value of equipment that had been purchased from capital? Do you agree that such information should be held?

Mr Jones: That is an interesting question, given Mr Marr's points about whether capital replacement or leasing is more appropriate. A view certainly needs to be taken about what the standard of medical equipment is and whether it is working effectively and safely. We also need to take a view on whether the equipment is working efficiently or whether it is so expensive to maintain that it should be replaced. We certainly need to get into that exercise and start generating that information routinely.

George Lyon: Our recent discussion of the "Overview of the National Health Service in Scotland 2002/03" highlighted a range of cost pressures such as pay modernisation and prescribing costs. Medical equipment could be another cost pressure. The amount of equipment in use that is beyond its standard expected life could indicate that there is a risk of underinvestment. How are levels of investment in medical equipment monitored at present? Are you concerned that, according to the Auditor General's report, two thirds of trusts cannot show that their investment programmes are based on realistic forward planning for medical equipment?

Mr Jones: I am concerned if we do not have forward plans for the replacement of medical equipment. The solution may be to move into leasing rather than reinvesting in new equipment, but we should certainly have plans. I am concerned about that.

George Lyon: How long will it take to develop basic information systems and plans? Are discussions on-going? What progress is being made?

Mr Jones: Discussion is on-going. As I said, we are having that debate with the service about its response to the report.

George Lyon: When can we expect progress with which the Auditor General will be satisfied?

Mr Jones: I will be disappointed if we do not have an agreed position with the service within three or four months' time.

George Lyon: So we can expect progress on those issues in the next three to four months.

Mr Jones: Most of the responses that we have received from boards have been quite positive about the recommendations that systems need to be put in place.

The Convener: Paragraphs 4.11 and 4.12 and the performance indicators in exhibits 17 to 21 suggest that there are significant and substantial variations among trusts. The report suggests that, as a minimum, aspects such as the age profile of equipment, the level of equipment that is available and the spending on maintenance should be benchmarked to provide useful information. In response to George Lyon, you said that efforts were being made to begin that process. Once the data issues have been identified, will that be enough to allow you to discharge your role of holding NHS boards to account? Until the data issues have been identified, are you unable to hold boards to account?

Mr Jones: We can hold boards to account, but what we have to consider is the level of central control that the department should exercise over NHS boards and at what point issues should be managed by Greater Glasgow NHS Board—an organisation that spends £1 billion a year—rather than them being managed from Edinburgh. The key issue is deciding on the right level of central intervention. As I have said several times, that is the issue on which I have some concerns about the report's conclusion because it could drag the department into micromanaging mature and large organisations. We must ensure that we do not get to that point.

We do not do benchmarking very well in the NHS in Scotland. We are in the process of commissioning a major exercise to benchmark NHS Scotland against other UK and European countries and to benchmark organisations within NHS Scotland. The exercise, which will examine both the efficiency of the service and access to services, will become a powerful tool as it is developed. Its results will enable us to examine the comparative performance of the national service and organisations within it.

George Lyon: I seek clarification on a point that Susan Deacon raised. The Department of Health in England and Wales has introduced a specific

standard for managing medical devices as part of the controls assurance requirements. Why did the Scottish Executive Health Department take the decision not to go down that road in Scotland?

Mr Jones: I think that we have answered that question. We have not taken that decision. We have just had a debate during which I have said that that is the direction in which we should be moving.

George Lyon: Okay. For how long has the Department of Health in England and Wales had the system in place?

Mr Jones: I do not know.

Susan Deacon: I have a practical question that I hope will develop our understanding of the matter. For the moment, at least, let us accept the level of involvement and intervention by the Scottish Executive Health Department that you have described and argued strongly for this morning.

How do you test—for want of a better word—how effectively the boards have put the systems in place? You mentioned indicators such as waiting times. If you see your job as ensuring that boards develop the systems, practices and procedures that attend to the issue, how do you test that the boards have done that? Is it a case of Gerry Marr walking into the accountability review and giving you assurances, or does anyone from the department see, feel and touch the practices in the service? Does the answer lie somewhere in between?

Mr Jones: It is a mixture of all that. We need to ensure that clear advice is given on the safety of medical equipment and we must satisfy ourselves that people follow that guidance, so we set the framework. We have data, which we review, from the financial accounts about how boards spend their cash. We have discussions with clinical staff and from those discussions we get a strong feel for what the issues are in a board. Members of the Health Department are active in that regard every day. We have meetings with NHS staff about general issues and we get feedback from those meetings. The department uses a range of tools to form a view about how a service performs.

Gerry Marr: I reassure the committee that the controls assurance strategy is a major issue for health care systems at the end of the financial year; it forms a great part of the review of our performance in preparing our accounts and controls assurance for the auditors.

I run and manage the service, so I do not want the Health Department to run the medical equipment; I know that Trevor Jones does not want that either. However, there is an issue about local systems being held to account on the basis of adverse audit or audit reports. NHS Tayside's audit committee must take ownership of that and the controls assurance mechanisms mean that we must be able to get the controls assurance statement at the end of the financial year.

There are checks and balances in the system. I expect to be held to account by my audit committee if I do not deliver, on a specific timeline, the recommendations in my local reports. Mention has been made of asset registers, but we must remember that there are thousands of pieces of equipment worth under £5,000 in our hospitals and in clinics in our communities; those pieces of equipment are a revenue charge and are therefore part of a different process and procedure. The Audit Scotland report makes the point that we must also improve on that aspect of risk assessment. It is about striking a balance between working strategically with the department and being held to account for our performance locally through audit.

The Convener: There are no further questions. I thank the chief executive of NHS Scotland and his team—Dr Peter Collings and Gerry Marr—for joining us and answering questions about the report. I wish them all a safe journey.

We now move into private session for the remaining items on the agenda.

11:25

Meeting suspended until 11:52 and thereafter continued in private until 12:39.

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