House of Commons

Committee of Public Accounts

Managing high value capital equipment in the NHS in England

Fifty-third Report of Session 2010–12

Report, together with formal minutes, oral and written evidence

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Committee of Public Accounts

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The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the internet at www.parliament.uk/pac. A list of Reports of the Committee in the present Parliament is at the back of this volume.

Additional written evidence may be published on the internet only.

Committee staff

The current staff of the Committee is Philip Aylett (Clerk), Lori Verwaerde (Senior Committee Assistant), Ian Blair and Michelle Garratty (Committee Assistants) and Alex Paterson (Media Officer).

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Summary

In the past three years, NHS trusts in England have spent around £50 million annually on buying three specific types of high value capital equipment – Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) scanners, used mainly for diagnosis, and Linear Accelerator (Linac) machines for cancer treatment. The current value of these three types of machines in the NHS is around £1 billion. Patient demand for services from these machines has increased significantly in the last decade and continues to grow.

Since 2007, the Department of Health (the Department) has devolved responsibility for procuring and managing these machines to individual trusts but this structure is not conducive to delivering value for money. Each trust makes its own assessment of demand, buys specific machines through the route of its choosing and operates the equipment as it sees fit. As we have heard before, despite having no control over the actions of individual trusts, the Department remains accountable for value for money across the NHS system. We continue to question whether the system provides value for money when Foundation Trusts act independently with no explicit incentive to adopt best practice nor to work together to achieve economies of scale. We are concerned that the NHS is failing to optimise its purchasing power, crucial at this time when £20 billion of savings in the NHS are required by 2015.

The NHS currently has inadequate information to assess cost, performance and capacity across the system as a whole. Commissioners and trusts have no mechanism to understand the reasons for large variations that persist in the use of MRI and CT machines, as they are unable to compare their performance with other trusts. The NHS needs to make high quality, comparable data available on machine use and cost. We welcome the Department's plan to require all trusts to produce data on MRI and CT scan use. A standardised, national dataset would help trusts to compare unit costs and benchmark their performance. It would also enable commissioners to identify the large variations in utilisation across trusts and take appropriate action.

The procurement and management of high value equipment is fragmented and uncoordinated, leading to wasted resources and variable standards of services. Trusts have three main ways to purchase high value equipment: by dealing directly with suppliers; through framework agreements, managed by NHS Supply Chain; or by joining up with other trusts in collaborative purchasing arrangements. We were told that framework agreements are generally a more efficient way to purchase one-off equipment orders yet one in five of these machines are bought outside framework agreements and the Department has no power to mandate trusts to use them.

Even within the framework agreement there remains much greater scope to save money by bundling orders together across trusts, as the Department showed through its Cancer Equipment Programmes of 2000-2007 which delivered savings of around £38 million through aggregating demand. NHS Supply Chain has, however, so far placed no bulk orders for any of these three types of machine we looked at, despite now purchasing over 80% of such machines for the NHS. All orders have been placed individually with no aggregation to larger volumes. This is a lost opportunity to use collective buying power to

get lower prices and we expect NHS Supply Chain and other collaborative procurement bodies to work with trusts to share plans on future needs and get better prices and value for money by exploiting the joint buying power.

Trusts vary in the effectiveness with which they use their machines, as demonstrated by differences in the number of scans per machine, opening hours and waiting times. For example, the average number of scans per CT machine varied from around 7,800 to almost 22,000 per year and opening hours ranged from 40 to over 100 hours per week. There are also unacceptable response times for certain conditions, for example, 50% of people who have a stroke are not getting a scan within 24 hours. Furthermore, an estimated 13% of cancer patients are not getting access to radiotherapy when it could prolong their lives. Trusts therefore need to increase the flexibility with which they manage and use equipment.

Half of the machines in use will need replacing over the next 3 years, at a cost of £460 million. The Department has not assessed whether existing machines could be used more efficiently to meet rising demand to make better use of scarce financial resources at a time when the NHS needs to find £20 billion of efficiency savings.

On the basis of a report by the Comptroller and Auditor General,[1] we took evidence from the Department, NHS Supply Chain and University College London Hospitals NHS Foundation Trust on managing high value capital equipment in the NHS in England.

1 C&AG's Report, *Managing high value capital equipment in the NHS in England*, HC (2010-11) 822.

Conclusions and recommendations

1. **The Department is not achieving best value for money when it purchases high value equipment and there is no clear accountability for maximising value in the purchase and use of such equipment.** We have previously raised concerns about how accountability will work in a devolved structure and in this case, find again there is no overarching accountability arrangement in place. The Department is responsible for securing value for money in health spending but cannot require Foundation Trusts to work together to exploit their buying power or to match capacity and demand across the NHS. At present the systems for buying and managing high value equipment are fragmented, with resources being wasted. The Department should clarify who will be accountable to the Committee for ensuring value for money in the purchase and use of high value equipment in the NHS.

2. **The NHS lacks adequate information on MRI and CT activity to compare performance between trusts and to drive improvements in efficiency**. Large variations persist in machine use, waiting times, opening hours and access to scans. Neither trusts nor commissioners are able to compare the throughput and efficiency of their MRI or CT machines because there is no central repository of data. This compares unfavourably to radiotherapy where, since 2009, trusts have been required to contribute to a national dataset on levels of machine use. The Department has pledged to produce a dataset by April 2012 covering the use of MRI and CT machines by trusts, and we welcome this. From 2012-13 onwards, the NHS Commissioning Board should ensure that this dataset enables local clinical commissioning groups to hold trusts to account for their performance, and to drive improvements in efficiency.

3. **Some trusts are not using framework agreements which would allow them to buy the same machines more cheaply.** NHS Supply Chain told us that it had operated framework agreements for MRI and CT since 2007 and Linac machines since 2008, but that 20% of these machines were still bought through other routes. Some trusts remain unaware, or sceptical, of the benefits of buying through framework agreements and may choose more expensive procurement routes. The NHS Commissioning Board should require commissioners to use 'comply or explain' clauses in contracts with trusts to encourage purchasing through framework agreements unless they can articulate a clear reason to take a different approach. NHS Supply Chain must gather, quantify and promote evidence on the cost effectiveness of its framework agreements.

4. **The NHS is not taking advantage of bulk buying to achieve discounts, which is a missed opportunity to contribute towards £20 billion efficiency savings.** Trusts largely base procurement decisions on their immediate requirements and do not coordinate planning with other trusts across the NHS. The Department concedes it has not done enough to get trusts to work together. NHS Supply Chain has so far placed no bulk orders for MRI, CT or Linac machines, despite having achieved volume discounts on other types of machines for example, digital mammography and ultrasound. NHS Supply Chain currently lacks information on what equipment

trusts plan to buy so is unable to plan ahead to identify opportunities to bundle orders. Commissioners should require trusts to share their plans for the replacement of high value equipment with NHS Supply Chain and/or other collaborative procurement bodies. This would enable NHS Supply Chain and others to aggregate orders across trusts to secure better prices.

5. **NHS Supply Chain's objective to save the NHS money is at odds with how it is paid**. Surprisingly, the Department's contract with Supply Chain allows it to charge trusts a percentage of the equipment purchase price, which provides little incentive to negotiate lower prices with suppliers. The Department should consider how its contract with NHS Supply Chain might be changed so that NHS Supply Chain is financially rewarded for negotiating lower prices and generating savings.

6. **It is unclear if the NHS can meet growing patient demand for scans and radiotherapy services at the same time as having to deliver substantial financial savings.** Trusts may need to spend £460 million within the next three years to replace worn-out machines. The Department has not assessed whether existing and new machines can be used more efficiently to meet rising demand to avoid unnecessary expenditure on under-utilised equipment at a time when substantial wider savings are needed across the NHS. At a national level the Department, and in future the NHS Commissioning Board, should put in place the means to gauge whether capacity accurately matches needs. This should take into account the savings that could be made if machines were used more efficiently. At a local level, commissioners should secure the right capacity in the right places to meet the needs of their populations.

1 Improving the management and use of high value equipment

1. The NHS spent around £50 million a year in 2009 and 2010 purchasing CT, MRI and Linac machines.[2] The average price paid for these machines ranges from £580,000 for a CT scanner, £900,000 for an MRI, to £1.4 million for a Linac machine. Across the NHS as a whole, there were around 976 machines of these three types at the end of 2010.[3]

2. Since 2007, the Department has devolved responsibility for procuring and managing these machines to individual trusts. The Department told us that it had limited powers to influence how trusts buy and manage high value equipment, but it did have responsibility for value for money of the system as a whole and recognised the need to benefit from potential economies of scale.[4] Foundation Trusts, which now account for 58%[5] of hospital trusts, are independent of the Department's control and have freedom to manage their operations with minimal intervention or direction. The intention is for all hospital trusts to become Foundation Trusts.

3. In the future, the NHS Commissioning Board will be responsible for setting out the likely demand for services and its expectations for the service standards to be achieved. However individual trusts would decide what machines they need and how to purchase them.[6] In this decentralised system, the absence of central coordination makes it difficult to ensure money is not wasted locally and that best value is achieved in buying and using equipment across all areas and in all settings.

4. As it cannot force individual trusts to act collectively, the Department's approach is to provide information and make tools available to Foundation Trusts to encourage appropriate behaviour.[7] However, not all trusts are using these tools and adopting good practices such as using central framework agreements to purchase equipment (see part 2). The Department admitted that progress has been 'frustrating'.[8]

5. The Department's main levers to improve performance and consistency are contract terms and payment mechanisms between commissioners and trusts. It admitted that commissioners could do better by using their powers more effectively, for example, by identifying performance standards and applying financial penalties to those trusts that fail to meet them.[9] We also heard about using a 'comply or explain' approach in

2 Q88

3 C&AG's Report, Figure 1

4 Qq 1-4, 98

5 Ev 15

6 Qq 5-6

7 Qq 8-10,114

8 Qq 71-72, 98

9 Qq 114-118, 122

commissioning contracts whereby trusts would be expected to follow guidance and best practice unless they could provide a strong reason for not doing so.[10]

6. The report by the National Audit Office showed that trusts vary in their capacity and approach to managing and using their high value equipment. Trusts vary in the number of scans per machine, opening hours and waiting times, for example, the average number of scans per CT machine varied from around 7,800 to almost 22,000 per year. Opening hours also ranged from 40 to over 100 hours per week.[11] Unit costs also vary significantly across trusts for the same service. [12]

7. Furthermore, it is unacceptable that for some services, there are still access problems, with 50% of people who have a stroke not getting a scan within 24 hours and an estimated 13% of cancer patients, whose life could be prolonged, not getting access to radiotherapy.[13]

8. Since 2009, trusts have been required to contribute to a national dataset on radiotherapy machine use and the Department has recently published its first annual set of radiotherapy data.[14] The Department and the NHS can use such data to understand the reasons behind large variations and then work with trusts to resolve issues that are leading to low or unsustainably high performance.[15] By contrast, there is no systematic means to enable trusts to assess how efficiently they are using their MRI and CT scanning machines as there is no national repository of comparable data. The Department told us it intends to start a national and trust level diagnostic imaging dataset for CT and MRI machines in 2012 to enable organisations to benchmark themselves and tackle variations in performance.[16]

10 Q99

11 Q114, C&AG's Report, paragraphs 3.8, 14

12 Q8, C&AG's report, paragraphs 3.10 - 3.12

13 Qq 54, 109, C&AG's Report, paragraph 3.4

14 Q86, C&AG's Report, paragraph 18

15 Q119

16 Qq 86, 123

2 Improving procurement of high value equipment

9. Patient demand for scanning services continues to grow. There are risks as the NHS has to meet this rising demand with an ageing machine stock whilst also delivering £20 billion of financial savings. Trusts need to spend an estimated £460 million within the next three years to replace worn-out machines.[17] The Department was confident that there was sufficient capital to fund replacement yet it had not assessed whether trusts could afford to replace all machines when needed. Nor has it assessed whether NHS capacity is appropriate for the population now and in the future.[18]

10. With devolved responsibility for procuring and managing high value equipment, each trust makes its own assessment of demand, buys machines through the route of its choosing and operates the equipment as it sees fit. Trusts can purchase high value equipment by: dealing directly with suppliers; through framework agreements managed by NHS Supply Chain; or by joining up with other trusts in collaborative purchasing arrangements for particular localities or types of supplies.[19]

11. Framework agreements cover the procurement of a particular type of good or service from pre-approved suppliers over a fixed time period. NHS Supply Chain has had framework agreements in place for MRIs and CTs since 2007, and for Linacs since 2008.[20]

12. NHS Supply Chain is operated by the private distribution company DHL under a 10-year contract with the Department of Health.[21] It told us that its primary objective was to deliver savings for the NHS. However, we question the incentive mechanism in place supporting this objective, given NHS Supply Chain is not directly rewarded for its savings performance but takes a 2% management fee on the value of a capital equipment purchase. It would appear that NHS Supply Chain would benefit from higher prices and has little incentive to negotiate lower prices with suppliers on behalf of the NHS.[22]

13. Notwithstanding the contractual arrangements, framework agreements are generally a more efficient way to purchase high value equipment as they save trusts from lengthy and expensive European Union procedures.[23] Despite the advantages of framework agreements, we heard that about 20% of machines were being bought outside framework agreements.[24] Decisions to buy in another way may be justified but we were surprised that more trusts were not using these national agreements.[25] Witnesses told us that trusts were sceptical of

17 Qq 9, 51,54

18 Qq 51-55

19 Q94

20 Qq 22, 24, 73

21 Q33

22 Qq 34-43

23 Q70

24 Qq 17-19

25 Q69

the potential savings. The Department and NHS Supply Chain also lack management information on what trusts pay for equipment bought outside framework agreements, so are unable to evaluate and quantify either the extent of any savings made, or potential future savings.[26]

14. The price of a machine is affected by its specification. Individual hospitals may require different specifications depending on their medical specialisms. For example, neurological and cardiac services may need CT and MRI scanners with higher specification. The Department and in future, the Commissioning Board, can advise trusts on when specialised and cutting-edge machines are needed, or when the standard models will suffice, but have no way of ensuring the advice is accepted. In the majority of cases, standard machines are appropriate. [27]

15. The Department's own 2000-2007 Cancer Equipment programmes showed how aggregating demand could deliver lower prices and achieve savings of around £38 million on a £407 million procurement programme for CT, MRI and Linac machines.[28] The NHS is, however, not taking advantage of its bulk purchasing power. Even when trusts use current framework agreements, machines are bought as one-offs, with no price discounts for greater numbers purchased.[29] Having already received discounts for committed volumes of ultrasound and mammography equipment, NHS Supply Chain has yet to do so for MRI, CT or Linac machines.[30] Witnesses told us this was primarily because of the complexity of the machines and limited planning information from trusts on what was needed and when.[31] NHS Supply Chain and the Department recognise that aggregating orders in larger volumes will lead to lower prices.[32]

16. In order to aggregate orders into higher volumes, NHS Supply Chain relies on information from trusts' capital equipment plans, including the age of machines and when they might need replacing as well as identifying future demand for new machines. However, only 40 trusts shared their 2010-11 capital equipment plans with NHS Supply Chain and in 2011-12, only 30 have done so.[33]

26 Qq 70, 83, 98

27 Qq 100-101

28 C&AG's Report, paragraph 2.3

29 Qq 11

30 Qq 20, 25-26, 32, 77

31 Q27

32 Qq 77-79

33 Qq 47, 62

Formal Minutes

Wednesday 12 October 2011

Rt Hon Margaret Hodge, in the Chair

Mr Richard Bacon	Austin Mitchell
Mr Stephen Barclay	Nick Smith
Dr. Stella Creasy	Ian Swales
Matthew Hancock	James Wharton
Jo Johnson	

Draft Report (*Managing high value capital equipment)* proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 16 read and agreed to.

Conclusions and recommendations 1 to 6 read and agreed to.

Summary read and agreed to.

Resolved, That the Report be the Fifty-third Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for placing in the Library and Parliamentary Archives.

[Adjourned till Monday 17 October at 3.00pm

Witnesses

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Oral evidence

Taken before the Committee of Public Accounts

on Wednesday 7 September 2011

Members present:

Margaret Hodge (Chair)

Mr Richard Bacon	Joseph Johnson
Stella Creasy	Austin Mitchell
Matthew Hancock	Ian Swales

Amyas Morse, Comptroller and Auditor General, **Robert Prideaux**, Director, NAO, **Mark Davies**, Director, NAO, **Marius Gallaher**, Alternate Treasury Officer of Accounts, HM Treasury were in attendance.

MANAGING HIGH VALUE EQUIPMENT IN ENGLAND AND WALES

Examination of Witnesses

Witnesses: **Andy Brown**, Managing Director, Diagnostics, NHS Supply Chain, **Sir Robert Naylor**, Chief Executive, University College London Hospitals NHS Foundation Trust, **Sir David Nicholson**, Chief Executive of the NHS, and **Professor Sir Mike Richards**, National Cancer Director, Department of Health, gave evidence.

Q1 Chair: Welcome to you all. It is good to see you again,
Sir David, at your regular appearance. Welcome to other members of the panel. I shall start with you, Sir David, and it is the usual problem that arises from the Report on "Managing high value capital equipment in the NHS in England". Within your devolved structure, who will be accountable for ensuring value for money in the acquisition of high value equipment?
Sir David Nicholson: This is in the structure post-2013?
Chair: Yes.
Sir David Nicholson: Accountability for management of assets—replacement of assets—within the foundation trust will be the responsibility of the chief executive of the trust and his accounting officers, and as individual accounting officers they will be brought to account by you. In terms of the NHS trusts that are left, the permanent secretary of the Department of Health will have a body that has been described as the NHS Trust Development Authority, and when the SHAs are abolished, it will be responsible for managing all the remaining NHS trusts post-2013.

Q2 Chair: So value for money in the acquisition of this expensive equipment lies with whom?
Sir David Nicholson: With the chief executives of the foundation trusts, and with the permanent secretary of the Department of Health.

Q3 Chair: But with whom? It can't be dual.
Sir David Nicholson: The reason why it is dual is that the accountability framework is different for the foundation trusts and the remaining NHS trusts before they become foundation trusts.

Q4 Chair: So once all the others become foundation trusts, it will rest only with foundation trusts.
Sir David Nicholson: Yes.

Q5 Chair: That leaves you with a number of problems, and I will take you through them one by one. One is, if we are to get best value, particularly with your £20 billion savings and so on, and increased demand, who will be responsible for identifying demand?
Sir David Nicholson: Demand for diagnostics and other services in future will be the responsibility of the clinical commissioners and the commissioning board, but the clinical commissioners are accountable to the commissioning board, so overall it will be the responsibility of the NHS commissioning board.

Q6 Chair: So it will be your responsibility to say, "We need x MRI scanners."
Sir David Nicholson: No, we will set out what we think the demand for service will be. We will set out what our expectations are in terms of the quality and nature of the kit that is required, but individual organisations will decide whether they have them or not, and how they purchase them.

Q7 Chair: This sounds like a heck of a mess. Let me take you a little further. You will settle service levels, so if you've got to have an MRI scanner—we will come back to how you're performing at the moment—within, for argument's sake, two weeks, you'll set that service level, but five hospitals in a region or eight hospitals in a region will compete with one another to decide how to deliver that, and will individually determine whether to buy an MRI scanner themselves.
Sir David Nicholson: No, we will not just say, "That's the demand for MRI scans". We will have a whole set of other service specifications that are required. It is not just direct access to MRI. For example, if we wanted to commission orthopaedic services, we would expect them to have an MRI scanner to enable them to do that. If we commissioned cancer services, we would expect them to have CT and MRI.

Q8 Chair: So, by commissioning the service, you implicitly expect them to buy the equipment. The Report shows that there is a massive variation—surprise, surprise—in unit cost because at the moment there is no co-ordinating of either purchasing or sharing of information on best practice on usage. How, in your commissioning, will you drive the system so that we do not waste money on equipment and we get the best value in the usage of the equipment?

Sir David Nicholson: We will set a series of expectations for individual hospitals that will include, I think, the age of your machine. There is a direct connection between the age of your machine and your ability to provide uninterrupted services, so we would do that hospital by hospital.

Q9 Chair: But how will you ensure best price and best usage?

Sir David Nicholson: How they buy it is a matter for them. But we can help, support and provide tools to enable them to do it, and we can encourage them to use things like Supply Chain, which most of them do now in order to buy them.

Q10 Chair: But we have this massive variation. The National Audit Office has identified a potential for at least a 10% saving in this area, and has put it together with the consumables. Basically, the NAO is saying to you, "Cut 10% off all your acquisitions, whether consumables or high value equipment". I don't feel this is driving. I shall come to Mike Richards in a minute because he runs the centralised system. I am trying to work out in my brain—and I don't get it yet—how, in a decentralised system, you will actually eke out best price and ensure best usage, and your tariff—if you are going to tell me that—always drives you to the average. It doesn't actually drive you to best price and best usage.

Sir David Nicholson: We want to encourage people to work together to buy the machines.

Q11 Chair: That's not good enough.

Sir David Nicholson: We have had some progress in this area around the machines. More than 70% of them now are bought through the framework agreement, using Supply Chain. That is significant progress and, over the past three years, it has got more and more. In fact, virtually all of them now are using Supply Chain to buy this type of equipment. What we are not getting at the moment is the benefit of scale because they are buying them off the framework contract one by one. But Supply Chain is working with them to get to that place so that we can reach a position where people can predict their individual purchase; they can work with Supply Chain. I think that we can both benefit from that. I don't think that it is just a matter of the tariff.

Q12 Chair: You don't think that it is a matter of the tariff. Well, Mike Richards has been running a centralised system on the radiography equipment. The Report again demonstrates, Mike, that, up until 2007, you achieved a 10% lower price in the cost of the equipment that you purchased.

Professor Sir Mike Richards: Yes.

Q13 Chair: Just for this high value equipment—this is pricey stuff—what is your view on encouragement, support, blah, blah, blah frameworks as opposed to actually making this in the tight-loose system a tight way of ensuring best value for the NHS?

Professor Sir Mike Richards: We started a central programme back in 2000. Incidentally, that was both for the radiotherapy equipment and for CT and MRI scanners at that point because we were way off the pace then. There is no doubt at all that we needed capacity and we needed it quickly, and we had a central programme in which we were working with the NHS and saying, "You need an extra CT scanner, you need an extra MRI scanner". I think that that was right for the time, and it came to an end in 2006–07.

We are in a much more mature situation now. We have far more information, information that can help benchmark. We are in a position where we can still give advice. I think that central advice which, in the case of radiotherapy, is given through not only the National Radiotherapy Advisory Group and the National Radiotherapy Implementation Group, but the equivalent group for imaging, remains important. But at the same time, we have better data coming through so that we really know what is going on in the hospitals. No doubt, we can come back to this, but the radiotherapy data set is a very important example of that.

We are seeing the capacity go up, but we have also—most importantly—seen that the waiting times have come down. The waiting times for radiotherapy were very, very bad. Back in 2003, 70% of radiotherapy patients waited more than four weeks for treatment. That came down to 50%, then 30% and now it's down to about 2%.

Q14 Chair: I shall just stop you. The Report says that waiting times came down for everything, right. It came down for everything because we bought more because we had that capital investment. I accept that, but what is striking with the radiotherapy in this much more centralised system that you had, is that it was cheaper. It was cheaper so we got better value. Now you are fragmenting and letting it go out to the trust. It just strikes me that this ought to be a tight rather than a loose part of the settlement.

Professor Sir Mike Richards: We are giving the responsibility more locally, but at the same time we have set up the NHS Supply Chain. That is in a position where it can negotiate much better prices than the individual trusts would do—that is already happening—so the trust can go to the supply chain and ask it to work with it. It is quite a good combination because it doesn't restrict flexibility. If a trust wants a particular sort of machine, it can ask Supply Chain about that and Supply Chain is working with all the manufacturers. I am confident that this system can actually benefit the trusts and can benefit the health service as a whole by giving us good prices. I do think that there is more we can do for trusts, and when three or four of them want the same bit of equipment, we ought to be able to do even better. That is where we can make further progress.

Q15 Austin Mitchell: Supply Chain does not get any provision on getting the price knocked down. If you have an advisory role now and are telling them about equipment, you are not telling them where to get the best price, what the best price is or that if they haggle, they will get a lower price.
Professor Sir Mike Richards: The very fact that almost all the trusts are now working with Supply Chain tells me that they are finding this an advantage.

Q16 Austin Mitchell: It might be to get the centralised buying, but they don't all work with Supply Chain, and there is no indication that Supply Chain is actually haggling about best price.
Professor Sir Mike Richards: I could leave that to people from Supply Chain to answer. Andy Brown.

Q17 Chair: According to the Report, 75% are working with Supply Chain. That means that 25% aren't.
Andy Brown: No, over the past three and a half years more than 75% of this equipment—CT, MR or on linacs has been bought by our framework contracts. That market share has increased over the past three years so I would say that it is in the high 80s now.

Q18 Chair: So you disagree with the facts in the Report.
Andy Brown: No, I don't disagree with the facts.

Q19 Chair: But it says 75%.
Amyas Morse: Just to be clear. I thought that Sir David's comments were very valuable, so if he would just ponder for a second. We don't disagree at all with going through the Supply Chain. The crucial point is the one that you touched on, Sir David, about using the volume. It is a high measure of convenience to trust using Supply chain in terms of speed of ordering. Nobody is arguing with that either. We do not criticise that in the Report, but the question is how long will it be before you are getting the volume discounts you should be getting from the bulk of purchasers going through? That's the bit that we are really very interested in. You mentioned that they were working towards it. If you will forgive me, that is a bit of a general phrase. Our point is that, given that such a large amount of money is going out there, if you can get some agreement that is effected through the Supply Chain, we are not against that. We are simply making the point that a lot of value is going begging at the moment.
Sir David Nicholson: Absolutely. I think we share that view with you. There are two ways that you can do it: one way is that we are consistently working with trusts across the whole country to talk about the benefits of Supply Chain. We recently held a workshop with people from across the country to enable us to do that. We are pushing it from our end to encourage people to do it. I have written to all chairs of organisations to do that. At the other end, via the Department, Andy is getting lots more information about the sort of things that are in here, so, as you know, we can tell you the age of virtually all the machines, and where the trusts are; and connecting those things together is the way—

Q20 Mr Bacon: That is all very well, but if you look at the last five years, the purchasing that has taken place has dropped like a stone, if you compare 2010 with 2005 or 2006, and getting the information now may be a little late in the day. Mr Brown, I would like to know how many deals you have done with manufacturers of linear accelerators when you have said, "I can guarantee you a volume order" of 10, 12, 15 or whatever the number is in return for a discount? How many?
Andy Brown: None.

Q21 Mr Bacon: Okay. If you look at this chart, the yellow part at the top is linear accelerators. That is by no means all of them, because there are quite a few purchases in the preceding years. However, if you take 2006, 2007, 2008 and 2009—unfortunately it is one of those charts where you have to look across at the index—it seems that there are 33 or 35 in each of the first couple of years, 20 or so in the next couple of years and perhaps 10 or so in the final year. There are about 100 or 105 linear accelerators.
The Report says at page 5 that they cost £1.4 million each, so one presumes that the NHS was spending between £100 million and £150 million on linear accelerators over that period, buying roughly 100 linear accelerators. Even though those orders were coming through and even though some of them are now apparently coming through the supply chain, it seems that at no point were you in a position to say to the manufacturers, "Over the next three to five years we will have orders for 100 accelerators. Let's get a good price." You did not do that. Was the information coming too late, or what?
Andy Brown: Let me explain some of the facts and the context. We did not have a contract for linear accelerators until mid-2008.

Q22 Mr Bacon: You mean a framework?
Andy Brown: A framework, yes. We started our first capital contract in November 2007, and that was for medical imaging. We did a contract for linear accelerators a year later. In that time, we were letting NHS trusts know that we had a contract, and we were building up awareness and confidence that we could do those things. More and more demand has come via our contracts for those three modalities.

Q23 Mr Bacon: In English?
Andy Brown: CT/MR and linear accelerators. I think that we can go further in terms of being able bulk purchase, but we need to plan better. We now have good traction—

Q24 Chair: Hold on a minute. This is since 2008.
Mr Bacon: Most of this purchasing has happened.
One of you was saying earlier that there was a lack of investment in 2003 and subsequently, but judging by the graphs for all three it seems that a lot of the purchasing has already happened, and that it has now dropped off significantly. I happened to take linear accelerators because it was at the top of the three-coloured bar chart, but I could have made the same point about MRI or CT scanners. Had I asked that question about volume commitments for the other two

items, am I right in supposing that the answer would still have been none?
Andy Brown: We have certainly talked about volume commitments.

Q25 Mr Bacon: In terms of signing deals with volume commitments, would the answer for those two items—MRI and CT scanners—also have been none?
Andy Brown: For those modalities, yes; but we have done significant volume deals on other modalities when we had the information.

Q26 Mr Bacon: You mean machines other than those three?
Andy Brown: Yes; for digital mammography, ultrasound and flexible endoscopy.

Q27 Mr Bacon: What is the difficulty about doing that for scanners?
Andy Brown: One of the difficulties is that they are high-spec machines, and trusts do not replace them lightly. The decision to replace them is usually subject to an internal business case within the trust. Some trusts work with us from an early stage of procurement, and some do not. Some do a local evaluation, decide which machine they want and then come to us to use the framework contract. So ostensibly what we have is a lack of visibility. I would like to get more visibility. When we have worked with trusts to get more visibility, we have done good deals à la digital mammography, flexible endoscopy and ultrasound. There is no reason why we cannot do the deals in the same way, but we need to plan it better. When I say "we", it is working with the NHS—

Q28 Chair: Mr Brown, you did not set up these deals until 2008, but as I understand it, you set up your framework agreements in 2007–08, which basically means you do not have to do the EU procurement stuff, as far as I can tell. What have you been doing? Why are you still planning? Here we are, coming towards the end of 2011—three years on—and you have not got beyond planning.
Andy Brown: I think we have got beyond planning. It is getting NHS trusts to understand that planning is important.

Q29 Chair: Sir David, we have had three years. With a bit of luck, they may do one deal next year. Can you afford that when you are looking for £20 billion?
Sir David Nicholson: Clearly we need to get value for money out of all of these issues. We have been operating in the way that we have. Interestingly, the way that Mike described it, at a national level. This was doing it in a national way, not just a local way.

Q30 Chair: So you are not happy with this?
Sir David Nicholson: Absolutely. We need to do better. There is no doubt in my mind about that. I think it is pretty clear from the conversation that we need to accelerate this process.

Q31 Austin Mitchell: Is not your position made worse by the fact that we are now having a patchwork quilt of foundation trusts independently making decisions? On a priori grounds, it must be cheaper if you use muscle in centralised buying and you can cut deals. We need so many of these machines; give us a three for the price of two offer, like Waterstone's.
Sir David Nicholson: That is fine, but we need to give the trusts the machines that they need to deliver the services that they need to deliver.

Q32 Austin Mitchell: Yes, and centralised buying allows you to aggregate that demand.
Sir David Nicholson: The aggregation of buying is absolutely the way that we need to go, and I think Andy has described that we need to do that. We just need to accelerate that. I am not pretending to you that we have done it.

Q33 Ian Swales: Mr Brown, you run the Supply Chain. You are the managing director. Supply Chain is a DHL organisation, so you work for DHL.
Andy Brown: I work for DHL. It is a 10-year contract with the Department of Health to run the Supply Chain for the NHS.

Q34 Ian Swales: DHL is a private company with shareholders and so on. Can you explain what your incentives are as the managing director of a private sector company with regard to Supply Chain? What makes you do a good deal for your shareholders—or not, as the case may be?
Andy Brown: First of all, I am the managing director of the diagnostics division within NHS Supply Chain. I am not managing director of the whole NHS Supply Chain. In terms of what my incentives are as a function of my team, first of all the primary objective of the contract is to save money over the life of the contract for the NHS. That is our primary objective. We are allowed to make a profit, and that profit is capped. We cannot make any supernormal profit in any one year. We would have to give that back through pricing to the NHS. I believe it is in the long-term interests of DHL shareholders that NHS Supply Chain is successful beyond the life of a 10-year contract. Therefore, delivering the savings is the primary objective.

Q35 Ian Swales: So just to be clear, how do you make a profit? Do you get fees or do you put a percentage on each thing you buy before it is passed through?
Andy Brown: We take a management fee on the value of the transaction.

Q36 Ian Swales: On the value of the transaction. So you have an incentive.
Andy Brown: I will give you some facts and figures by way of explanation. We take a small percentage fee on the value of the transaction. You may say, "Well, it is not in your interests to see prices come down." It is very much in our interests to see prices come down. As I explained before, the savings for the NHS on that contract are our primary KPI—our primary objective.

Q37 Matthew Hancock: It may be a key performance indicator, but what is your financial interest?

Andy Brown: If we are not delivering a good job for the NHS, trusts will not use us; trusts are not mandated to use our contracts.

Q38 Mr Bacon: Is there a direct link between your visibly having achieved a particular key performance indicator like that and some extra financial reward that you get?
Andy Brown: No.

Q39 Mr Bacon: It is just this fee? Does the percentage fee vary with the size of the transaction?
Andy Brown: A little, yes.

Q40 Mr Bacon: So a high value transaction will have a smaller percentage.
Andy Brown: It will.

Q41 Mr Bacon: What would the percentage range be?
Andy Brown: In terms of difference or percentage?

Q42 Mr Bacon: What is the percentage fee that you charge for a large item, such as a linear accelerator, and for a smaller item, such as a surgical glove or a PC?
Andy Brown: Surgical gloves are consumables that are supplied through a wholesale route, which is a different economic model. On the capital equipment, 2% is our standard.

Q43 Austin Mitchell: But that means that the more you are paying the more you are getting.
Andy Brown: No.
Ian Swales: Can I keep on this trail for a moment? I assume that DHL has no other arrangements with e-suppliers, such as Toshiba, Siemens and so on, with end-of-year volume rebates for instance. It would be quite normal in business to do so.
Andy Brown: When you say DHL, it is NHS Supply Chain. When we negotiate a rebate based on volume, we typically pass that on to trusts through pricing.
If I can come to the point about our incentivising—

Q44 Ian Swales: Before we leave this, would you describe your relationship with the NHS as an open or a closed-book relationship?
Andy Brown: It is not an open-book relationship in that we do not share our total prices, costs and so on.

Q45 Ian Swales: So it does not know what you actually paid to Toshiba, Siemens or whoever.
Andy Brown: It does, because for this equipment it is a direct contract. So the purchase order goes from the trust to the supplier—the trust knows exactly what it is paying.
Can I make a point about pricing? Prices have come down over the past three and a half years on the machines. Not only has the high-specification pricing come down, but the lower-end specs have come down too. We can demonstrate pretty good saving.

Q46 Chair: Have they come down because of your methodology, or simply because they have come down?
Andy Brown: No, they have come down because of the methodology. On our savings to income ratio, in 2008, we saved 13 times more than we earned; in 2009, it was 8.5 times more; in 2010, it was 12 times more; and this year it has been 25 times more .

Q47 Ian Swales: I have one last question, again for Mr Brown. A few minutes ago, Professor Richards said that if three or four trusts worked together, we could do better. How do you interpret that comment in the context of what you do?
Andy Brown: The term "collaboration" in the NHS—indeed, within the NAO report—is something of a misnomer. To expect trust A and trust B, which are right next to one another, to work together is sometimes difficult. However, we might get visibility of the demand through seeing their capital equipment plans and their raised asset plans. We are getting that now—more than 40 trusts gave us their capital equipment plans last year and 30-odd have done it this year. We are looking at those capital equipment plans and saying, "Right, there is demand for x in Gravesend, Plymouth, Gateshead—in x, y and z." We can then start to aggregate that, which is what we are doing.

Q48 Ian Swales: Did you say that fewer trusts gave you their plans this year than last?
Andy Brown: Yes, but I don't know what to read into that.

Q49 Ian Swales: If it was so good, you would think that the trend would be in the opposite direction, wouldn't you?
Andy Brown: Certainly we are getting much higher quality plans this year. You need good quality information on which to base good commercial decisions, which is what we are working towards.

Q50 Stella Creasy: Obviously, these are challenging financial times, but many machines need replacing. Surely if Mr Brown says that it is really difficult to get people to work together, there is a high cost to us in your not getting them to purchase collaboratively. Have you carried out an assessment of the cost to the NHS of continuing to use machines that are out of date, that break down and that cannot do as many scans as you want? I note that the report says that 13% of the linac machines are already out of date.
Sir David Nicholson: We do not do that for the NHS as a whole. We have not done that calculation for the NHS as a whole.

Q51 Stella Creasy: So you have not made an assessment of the cost to you?
Sir David Nicholson: We have made an assessment of the broad cost of replacing the machines as per their lifespan and when that ends. We have done all of that, and the NAO says it will cost us £460 million over the next period to enable us to do it, so we know that. We know that through depreciation means, in the way that the resources are allocated through the tariffs with the pricing mechanism, that trusts will have £2.1 billion-worth of depreciation. We know for the next four years that the Department is allocating over £17

billion-worth of capital. So we think that the amount of capital in the system is there, and that the amount of depreciation in the pricing system is there as well.

Q52 Stella Creasy: So all that money is there. You have a challenging financial target to meet in terms of the NHS budget, and yet you cannot get people to work together to help you get lower prices. Is that a fair assessment of the situation? At the moment you have to coax them into it rather than—
Sir David Nicholson: No, the figure that Andy—

Q53 Stella Creasy: If you were able to negotiate the lower prices, who gets the money back, because you will have to get people to work together, won't you?
Sir David Nicholson: The individual trusts get the money back.

Q54 Chair: Can I just challenge you on your availability? You have cut capital by 17%. The central capital pot has gone. You look at those rather scary figures in the report about replacement. I cannot remember them: 50% in three years or something like that, and 80% in six or whatever it is. And you look at this absolutely exponential growth in demand, for all sorts of perfectly good reasons. Then you look at the fact, which is probably the final thing in this little scenario, that only 50% of people who have a stroke have a scan within 24 hours—scandalous; and 15% of cancer patients, whose life could be prolonged, do not get access to radiotherapy—scandalous. You are being a bit complacent, if I may say so.
Sir David Nicholson: I do not think we are being complacent. It seems to me that over £17 billion-worth of capital and £2.1 billion-worth of depreciation resources is a significant amount of investment (written evidence from the Chief Executive of the NHS).

Q55 Chair: A 17% cut and central funding gone. And £20 billion—
Sir David Nicholson: If you think about the amount of capital that has been invested in the NHS over the past five or six years in particular, it seems to me that there is more than enough capital in the pot to be able to deal with these issues.

Q56 Stella Creasy: But you are basing that on the prices that you have now, aren't you? One issue we are talking about today is that you could have a better price, and therefore save more money, if you could get central purchasing to work.
Sir David Nicholson: Yes, there is no doubt in our mind. The benefit of the NAO Report in the way that it is set out is that it says to us that whatever we have done so far has not been enough in terms of getting people together to aggregate that purchasing.

Q57 Stella Creasy: But the new system is going to make that harder, not easier, because the central stick that you need to help Mr Brown with his getting the trusts that are next door to each other to work with each other is not going to be there, is it?
Sir David Nicholson: But I have not got it now. There is no difference in the new system from the old system from that perspective, because the majority of trusts that have CT and MRI scanners and radiotherapy machines are foundation trusts now. Most of them have been for the past two or three years.

Q58 Stella Creasy: So we are going to continue struggling to get this right.
Sir David Nicholson: No. Robert might want to say something about his experience of running a foundation trust in London. I have to say that I did not know the figure that Andy talked about of the reduction in the number of trusts that were giving him their full capital plan; I am not quite sure why that is. But all the evidence we have around is that—

Q59 Stella Creasy: But shouldn't you know that, Sir David? As I say, isn't there a massive financial interest for us to get this right?
Sir David Nicholson: Yes, there is.

Q60 Stella Creasy: So if Andy needs those data, even if you are not going to set up a central unit to do this, why aren't you saying, "Everyone's got to give their data over to help do this"?
Sir David Nicholson: Well, we can encourage people to do that, and we are doing it.

Q61 Chair: Robert, are you happy that you have enough capital around the system—in your budget—to do it on your tod and get enough MRI scans, CT scans and radiotherapy equipment to meet the growing demand and have a good-quality service?
Sir Robert Naylor: Yes, I am. My trust was one of the first-wave foundation trusts, and we have been a foundation trust for about six years. Our systems for asset management and the utilisation of depreciation to purchase equipment are well in advance of much of the rest of the NHS. That is one of the tricks we had to learn when we became a foundation trust. Prior to becoming a foundation trust, you effectively queued up for funding from the centre for such equipment, so there was no real incentive for you to look after your assets, as there is nowadays. Now that we get paid depreciation in the contracts for the treatment of patients in the trust, it is up to us to manage that depreciation and to ensure that there is sufficient money in the pot from that depreciation to pay for capital equipment in the future.
I can show you my plans for the placement of my asset base over the next 10 years. At the moment my asset base, in terms of equipment, totals some £76 million, about a third of which is the equipment about which we are talking today. We have a very high proportion of very high-tech equipment because we are a very highly specialised organisation. I can show you my plans going forward 10 years for how much depreciation we are putting aside each year to pay for the next year's capital programme. We are in a new world; we never used to have to do that in the old world of the NHS. These are the new disciplines that have come about from becoming a foundation trust.

Q62 Mr Bacon: That is extremely interesting. I am not asking Sir Robert to speak on behalf of other trusts, so perhaps Mr Brown may want to comment

on this. You said that you have to have high quality information to make good decisions. Is part of the problem that many trusts are simply not in a position to give you detailed capital plans for the next 10 years, as Sir Robert is? Is part of the problem that, basically, they haven't learned the trick yet?
Andy Brown: It is certainly part of the problem. It is important to look at this in terms of asset management. All of these assets have a life, which is typically between seven and 10 years. So it should be possible to predict the end of an asset's working life. There is no use buying an asset well if you maintain or finance it badly. Asset management is something that NHS trusts have to learn to do better.

Q63 Chair: Do you want to purchase yourself? You are in a slightly specialist role, but do you think it is better being done by you—is it a loose thing?—or should it be done centrally, as the cancer equipment was?
Sir Robert Naylor: No, it absolutely has to be through a national framework contract. I can give you an assurance that we would automatically go to the framework agreement for every major item of equipment that we buy. The only time that we might not go to that agreement is when we are buying an extremely specialised piece of equipment at the leading edge of research and development. For example, we are in the process of installing the first PET-MRI scanner in the UK, which is a brand new modality in cancer treatment. So, of course, there is no framework agreement for that, because it is the first one. We will have to negotiate that directly, with the support of NHS Supply Chain, but for all other items of major equipment we would automatically go to NHS Supply Chain, because we realise it is in a better position to negotiate such contracts than we are.
If I may return to the earlier question about trusts not working together, I do not believe that it is the case. We see tremendous advantage in working with our colleague trusts. About three years ago, we were established as one of the first five academic health science centres in the UK. Although it started off as research and development and basic science, and translating that into new treatments for patients, a consequence of the development of that system has been that trusts in north central London are now working much more closely together than they ever did before. One of the projects on which we are currently working is procurement. We are now working much more closely together across a whole range of things: the provision of pathology services; back office functions, such as finance, payroll and HR; and procurement. We see the benefit of working with other trusts to aggregate our purchases so that we can get discounts on volume purchases.

Q64 Matthew Hancock: Following on from that point, I want to bring it to the wider question across all trusts. How many trusts are there?
Sir David Nicholson: Acute trusts in this environment?
Matthew Hancock: Yes.
Sir David Nicholson: About 168 (see written evidence from the chief executive of the NHS).

Q65 Matthew Hancock: And what proportion of those don't work generally through the framework agreement?
Andy Brown: I would say a handful.
Sir David Nicholson: Yes, I was going to say that.

Q66 Chair: According to the Report, the figure is 75%.
Sir David Nicholson: It's slightly better than that now according to the latest records we have. You're in the mid 80s, aren't you?
Andy Brown: We shouldn't confuse the number of MR, CT and linacs machines with the number of trusts that are buying—not every trust buys a CT, MR or linac every year. I would say that the number of trusts that are using us is higher than the number of machines bought in any one year.

Q67 Matthew Hancock: When you say, "a handful", what does that mean?
Andy Brown: Less than 10 around the country are—

Q68 Matthew Hancock: Less than 10% or less than 10?
Andy Brown: Less than 10.

Q69 Matthew Hancock: Less than 10 are not. Why would they not?
Andy Brown: Some use us for other modalities and some may not buy CT or MR through us. There are several reasons: some have what are called "managed equipment services", which is where they've contracted out their entire radiology equipment service to the likes of Siemens, Philips or an independent; some are part of a PFI deal and there are about 30 PFI MESs around the country—
Chair: But 30 leaves you with 70.
Andy Brown: And some are, let's face it, for relationship and political reasons—people are people.

Q70 Matthew Hancock: If they don't go through you, what do you think is the impact on the cost of the machines they buy?
Andy Brown: For them or for us?
Matthew Hancock: For them. I'm not that bothered about you.
Andy Brown: I think it's impossible to say because I don't see what they pay. What I can be assured of is that they've had to go through a full OJEU process, and that in itself is expensive, so they've incurred that cost over and above what they pay for the machine.

Q71 Matthew Hancock: Sir David, there must be a reason why you do not mandate this but allow trusts to choose whether to use NHS Supply Chain. Could you explain?
Sir David Nicholson: Well, I can't. With Foundation Trusts, I can't manage—

Q72 Matthew Hancock: Because you legally can't.
Sir David Nicholson: Yes. Legally can't.

Q73 Matthew Hancock: And if we look back, when was the framework that you now use put in place?
Andy Brown: November 2007.

Q74 Matthew Hancock: If we look at chart 5 on page 16 of the Report, we can see that November 2007, according to my lay reading, is after the big bulge. What are the savings per unit, or however it is best expressed, from having the framework?
Andy Brown: Not all trusts in that large bulge you refer to got an MR or CT, so about 25% of trusts didn't get a CT or MR in that wave. From the benchmarking we did in setting up our contracts, we are confident that there is a 12% to 15% difference in prices paid by trusts prior to using our framework.

Q75 Matthew Hancock: Would it be inaccurate to characterise this as, when the MRI, CT and linacs machines were being bought, which was mostly before the framework was put in place, they were bought at a higher cost than could have been achieved if that framework had been put in place at the start of the very sharp increase in purchases?
Andy Brown: I think that is very difficult for me to say because that was before my time—before NHS Supply Chain.

Q76 Matthew Hancock: But you managed to reduce the cost and what we've been challenging today is why that hasn't been driven further.
Andy Brown: What also has to be brought into context is that the specification of these machines is complex, so in that—

Q77 Chair: May I interrupt this a minute, Matt, just for clarity? A framework contract is not necessarily about the cost of the machine. What the framework contract allows you to do is not go through the OGC procedures. The cost of the machine comes out of bulk buying. Tell me if I'm wrong, Amyas, but that's my understanding.
Amyas Morse: I think we'd all agree with that. Can I just ensure that I have this straight just to inform what you're asking? There is no doubt that there is a significant convenience to the trust of having the framework agreement. We agree. We're not challenging that. No doubt, if you are able to talk about the forward plans, even though that is not the same as a contract, it is persuasive to negotiating some discounts, but, you would agree, not the same level of discount you would get if you were able to say, "I've got committed numbers".
Andy Brown: If we had committed numbers, we would be able to get better pricing.
Amyas Morse: I am only just showing you that there is a scale. I am not blaming you, or trying to suggest that you should be doing something differently. You are doing whatever you can do in the parameters. But if it were possible to get more trusts to be in a position to commit, the prices would be lower.

Q78 Matthew Hancock: But they can't do that because of the legal framework. Is that correct?
Andy Brown: No, they can commit.

Q79 Matthew Hancock: They could commit, but you can't commit. My final question on this line of questioning: if trusts commit, then you could make savings, because you would be able to plan better in your business.
Andy Brown: Yes.

Q80 Matthew Hancock: Do you offer passing some of those savings through to the trusts?
Andy Brown: We pass the vast majority of those savings through to the trusts.

Q81 Matthew Hancock: So why don't trusts pre-commit and therefore get better value for money?
Andy Brown: For various reasons. I think a lot of trusts commit to working with us.

Q82 Matthew Hancock: Yes, but as you said that is not enough.
Andy Brown: Let me finish. A lot of trusts commit to working with us. What stops them committing a machine at a point in time is a degree of uncertainty around perhaps their services, perhaps their finances, perhaps the probability of "something will happen". That does, in the real world, vary for all sorts of reasons.

Q83 Ian Swales: May I just ask one final question in this area? Clearly, some trusts are going it alone. You have said that. It surely cannot be that difficult to take an equivalent machine that a trust has bought alone and look at the framework agreement. You are going to find one of two things. Either they paid less, in which case there is a lot to learn about how the supply chain is working, or they paid more, in which case they have got a lot to learn. Given the amounts of money we are talking about here per machine, do you invest any effort in that kind of management information sharing across?
Sir David Nicholson: No.
Mr Bacon: Well you should, it seems to me.

Q84 Joseph Johnson: I am very concerned about your ability to save £1.2 billion on the procurement budget and I am really worried about the loss of economies of scale. I really struggle to see, with the current structure, how the framework agreement is going to help much when you are just talking about aggregating piecemeal scanners here and there.
Looking at the NAO Report, the issue is not just about replacing the existing stock of ageing machines, it is also about, presumably, continuing to catch up with the OECD average for the number of these machines that are in circulation in other countries. Looking at the Report, the figures are quite stark. You have got a stock of 976 of these machines currently in use in the country and 6 MRIs per million in the NHS in England against Japan's 43 per million. Japan does seem to be something of an outlier and perhaps you might explain why the discrepancy exists there. But even in other countries which are closer to the UK, geographically at least, there are 19 per million in Greece, 11 per million in the Netherlands, and much the same can be said about the prevalence of CT machines and linac machines. What is your ambition, not just for replacing the existing stock, but actually continuing to bridge the gap that you started on? And why does this gap persist to the extent that it does?

Sir David Nicholson: There is no doubt we started at a very, very, very low base. That was why we allocated the resources nationally to drive it forward. If you look at the figures, I do not think we want to be hidebound to a kind of target of numbers per million population, largely because every health care system is different. But also, we do more scans per machine than some other countries. It is the scans per machine and access that are the critical thing for us. So, waiting lists have come down significantly. We do lots and lots scans through our scanners, so we do not want to be hidebound to a number for the future.

Q85 Joseph Johnson: So you have no objective of reaching at least the OECD average for number of machines.
Sir David Nicholson: Not for the number of scanners.
Professor Sir Mike Richards: When we started out on this, the only figure we had was the number of scanners per million population, so we had to work with that. That was the only thing and we were way behind. We have moved forward and they have moved forward. We have also looked very carefully at the CT and MRI scanning rates reported by the OECD, and in general, we probably get more scans out of our machines than they do. Having said that, we are still doing fewer scans per million population than other countries. I think the demand will go up in this country, because the range of indications for doing such scans is broadening all the time. Partly, it is broadening as the scanners get better, so there are more things that you can now do and see with the scanners. The demand will undoubtedly go up, and we need to ensure that we respond to that.

Q86 Chair: How, in the current climate, with a non-centralised approach?
Professor Sir Mike Richards: One thing that we really can do is provide information, which is part of the answer to that. If we are providing trusts and commissioners, too, with high-quality information on what they get—for example, we can look at the number of scans per 100,000 population. If we can provide that information to every part of the country, they will see that they are relatively lower or higher than the average. We cannot yet do that. From next year, when we hope to have the diagnostic imaging data set in place, we will be able to do that.
We can do it now for radiotherapy; only last month, we published the first full annual report from the radiotherapy data set. We will publish the second report a whole lot quicker than that, hopefully by about the end of this year, because we have now got the methodology sorted out. In that report, we will be focusing on inequalities of a variety of sorts. So, I think we will give really high-quality information to the NHS—plus, we also have the information on waiting times. We have combined those two, which I think really does help.

Q87 Joseph Johnson: I just wanted to get a quick sense of why there is this massive dispersion of the number of machines per million of population, and why the UK seems to be lagging so far behind on that measure.
Professor Sir Mike Richards: I think it is historical; it goes back to pre-2000, in fact, and we have been playing a long game of catch-up. You will see that we did a considerable catch-up from 2001 to 2007. The NAO chart shows that we expanded a lot the numbers of machines going in, and we have seen—again, the NAO Report shows—that our number of scans over a decade has gone up almost threefold, so we are doing better on that. I am not complacent at all. I know we need more scans.

Q88 Joseph Johnson: We are now spending £50 million a year on these machines, rather than £80 million a year between 2001 and 2007. Do you expect the gap to widen or narrow over the next three to five years?
Professor Sir Mike Richards: My view is that, first of all, the NAO Report shines a helpful spotlight on this, which we can make use of. Secondly, we can now work with trusts—my team is already doing that—and we can feed back to them exactly what is going on there. We can ensure that they are able to prepare, and then I would expect them to work with the supply chain.

Q89 Joseph Johnson: But, will this gap on machine per million of population widen or narrow over the next three to five years?
Sir Mike Richards: Because I don't think the machine per million of population is—

Q90 Joseph Johnson: Okay, scans per million.
Professor Sir Mike Richards: I would be confident that the number of scans will go up, and we will at least be going up in parallel. I hope it would narrow.

Q91 Stella Creasy: My main questions are about the issue of data, but I just want to clarify something with Sir Robert. Earlier, it seemed that you were saying that you do purchasing through the supply chain process, but that you also work with other foundation trusts on procurement—is that right?
Sir Robert Naylor: Yes, that is right.

Q92 Stella Creasy: Have you found that you are able to negotiate as groups? How do you discover the other foundation trusts to do that? Are you setting up competing groups of people going to manufacturers and saying, "A group of us want to buy; what discount can you give us?" Are you bulk buying and using your bargaining power separately to the supply chain process?
Sir Robert Naylor: Yes, we are. The choices that foundation trusts have about where they buy things is completely up to foundation trusts. However, I think a foundation trust would be pretty foolish if it went out to do its buying on its own, because it does not have the expertise or the aggregation of purchasing power. So, most trusts—certainly my trust is part of a collaboration of procurement, which isn't just in north-central London; it extends across to the west midlands and beyond. There is a group of hospitals—

Q93 Chair: How many trusts?

Sir Robert Naylor: In total, I would guess that there are probably about 35 trusts working together. This is based upon an organisation called HPC that was set up in the west midlands, and when I was a chief executive of a trust there many years ago I was part of its setting up. It was set up to try to get the benefit of aggregated procurement, so all orders would come in to a central place and then that organisation would purchase on behalf of these hospitals. We managed to achieve huge savings in those days; I'm going back 15 years or so.

Q94 Stella Creasy: Could you quantify the sort of savings that you are achieving when you work in that way as opposed to through Supply Chain? Could you put a figure on it at all?
Sir Robert Naylor: We have a choice of purchasing through this collaborative consortium, going to Supply Chain or going to buy something directly ourselves if we want to, but the majority of our purchases are bought together in the consortium, and Supply Chain is an obvious place to which we might go to get the best prices. So, if Supply Chain offers the best prices for a commodity we will go there; if we could get a better price by going directly to a manufacturer—

Q95 Stella Creasy: But what you are saying is that you are exercising bargaining power independently of the supply chain process at some point. Do you have a figure or an example in your head of the kinds of savings you are able to make when you are using your bargaining power in that way?
Sir Robert Naylor: It would be impossible to give a figure overall, because we buy thousands of different lines of commodities. Pretty much everything that is manufactured out there in commerce is used in a hospital somewhere, so the range of commodities that we buy is enormous.

Q96 Stella Creasy: I appreciate that, but obviously one of the concerns we have here is about the ability of the NHS to exercise its bargaining power. What you are telling us is that foundation trusts have already got on and tried to do some of this stuff, and you are telling us where the benefits have come from that collaboration, which tells a slightly different story from what Mr Brown is saying about the difficulties of getting people to work together. So, it is clearly possible in some instances, but it is not happening in others.
Sir Robert Naylor: Well, of course it isn't because of foundation trusts. As I said, this collaborative procurement arrangement was established 15 or 16 years ago, because trusts even in those days realised the benefit of working together. Rather than duplicating the purchasing departments, the receipt departments and the paying of invoices, there was benefit in coming together. But I think that there is much more incentive to do that nowadays because foundation trusts have the freedom to do it, and obviously if we save money through purchasing through a consortium or through NHS Supply Chain we can retain that money, and that money is then the resource that we have to buy the equipment we are talking about today.
Stella Creasy: I appreciate that but—

Q97 Ian Swales: May I ask a question, Stella, just to help you here? You say you can buy at three levels, in effect. Have you tested that on any specific item of equipment that is the subject of this report?
Sir Robert Naylor: We haven't done in recent years because, as Mike said, from 2000 to 2007 most of the new equipment was purchased through a nationally negotiated set of contracts organised by the Department of Health. Then the framework agreement came along, as Andy has described, so we haven't gone off either of those two purchasing mechanisms for this equipment for at least the past decade.

Q98 ***Amyas Morse:*** I just wanted to turn, Sir David, if I may, to the subject of accountability, and not yours actually. You were saying to us that we need to try harder to persuade trusts, that we need to get them to listen to us, and I hear an unspoken, "We really want them to do more of this and we are trying to persuade them to do it." Would you recommend to the Committee that it appropriately consider the accountability of the individual accounting officers who are running the trusts, if they are getting a lot of good practice recommended to them and for some not terribly clear reasons are not taking up on it? Is that something that the Committee should be taking account of? In other words, apart from your persuading and communicating and your wooing of them, which I gather all of you are trying very hard to do, isn't there some element of duty involved that we might give consideration to as well?
Sir David Nicholson: There are a whole lot of issues in there, aren't there?
Chair: Don't evade it in your answer. It's quite a good question.
Sir David Nicholson: I wasn't proposing to evade it; I couldn't possibly do that. It is frustrating on a number of areas that we cannot make more progress in this area. Part of it is because there is a lack of information, so it is quite difficult to get anything. You get a group of trust chief executives together to try to explain to them the benefits of the supply chain and bulk purchasing, and they all sit there and say, "Actually, I can get a better deal myself directly with the company, thank you very much." But you never really know, because of the problem we have with information, whether that is true or not. As we heard at a previous hearing, we are doing a lot of work to get that information transparent and open so that everyone publishes and everyone has to do that.

Q99 Mr Bacon: It sounds like you could do with some assistance from an auditor going in and checking the actual prices that are being paid.
Sir David Nicholson: But this is a broader issue than just this. Information is the issue. If you are looking at what extra you would ask, I think the kind of approach of comply or explain is a better approach to do that—a more transparent approach and one more likely to get people, I think, on board and make it happen. That seems to be the issue.

Amyas Morse: I find that a very helpful phrase. I take it from what you are suggesting that that would be a reasonable basis to approach the question of accountability of those who are running the class, to say, "If you've got a very good reason why you're not doing it, okay, I can understand that, but if there isn't a very good reason, we are entitled to expect that you can demonstrate that you have used best practice."
Sir David Nicholson: I think that is right.
Sir Robert Naylor: If I could add a comment, as a provider my job is to run my trust and provide the best care I can for my patients in the most efficient and effective way, but I do that in the context of a contract with a commissioner. I see no reason why, through commissioning, there cannot be requirements placed in contracts to say there was an expectation to do these things and if these things are not done there is a need to explain that. That is exactly the kind of relationship that foundation trusts have with Monitor. We have lots of guidance—very few instructions, but lots of guidance—but if we do not follow the guidance, the onus is on me as the accountable officer to explain why we have not been following that guidance. That seems to me to be quite a strong lever over an organisation like mine to actually comply or then to have to go to all the trouble of having to explain why we are not complying.

Q100 Mr Bacon: I want to ask about the question of specification, which Mr Brown touched on very briefly, although I suspect it is a clinical question to some extent. At least in the first instance, I would like to direct it to Sir Mike Richards. Plainly, one of the things that might inhibit a trust from going into a central purchasing arrangement is that it will want to be sure that, at the precise moment it decides to replace a machine, it gets the newest, best machine available—perhaps not the very newest, because it will want to be sure that it is tested and works. You can see that that might be a problem.
The second issue is that I suppose you might have—whether they are radiologists or consultant oncologists inside a hospital—different views on which bell and whistle of the machine is absolutely essential and whether it is okay to have the Volvo, whether some people will even be arguing for the Mini, or whether you absolutely have to have the Rolls-Royce. Views about that will differ inside different foundation trusts. In so far as there is such a thing as a bog standard MRI machine—you said that these machines are getting better—how difficult a problem is the spec and how it is changing to surmount and overcome the difficulties in getting better prices through central purchasing? Are we wrong to suppose that there would be considerable gains from—I know this is a crude phrase—obtaining large purchases of a bog standard MRI machine, if there is such a thing, which are still not being obtained, not for reasons of spec, but just for reasons of lack of co-ordination?
Amyas Morse: To add to that, 84% of MRI machines are in fact standard. That is the information in the report.

Q101 Mr Bacon: I take Sir Robert's point that there is always going to be a leading edge. Presumably, Sir Robert's point is going to affect decisions later, because somebody else in a hospital in a different part of the country will hear what Sir Robert's hospital has been doing and will say two or three years down the road, "I want a bit of that." You have to control that, don't you? But let's get back to the original question.
Professor Sir Mike Richards: The specifications that individual hospitals will need will differ. There is the leading-edge question and I welcome the fact that PET-MRI, as an example, is beginning to come into this country, and I welcome the fact that it will be happening at Sir Robert's trust. That's fine. There will then be highly specialised trusts, such as neurological or cardiac services, that may need the high end of a CT scanner, for example, for heart services, and MRI scanning for brain and neurological services.
There will be differences between trusts, but there will be workhorses as well. What we can do is provide advice on when the leading edge and the highly specialised ones are needed and when the standard ones are completely okay. If we can provide that advice—I think we have the clinical experts, the physicists and others who can help us provide it—and we can also say that we now think the indications for a particular form of radiotherapy, such as stereotactic body radiotherapy, or whatever, are this, you will only need one of those machines per five million people, because only a narrow group of patients will need it. That is what I think we can do.
It may well be—Sir David may want to comment on this—that the commissioning board can do that in the future. It is a potential role for it. We can give that advice so that when a trust is making up its mind, it can determine that for the indications of what it will need, it seems the right sort of machine. It can then go to the supply chain to get the best deal.

Q102 Mr Bacon: But it is one thing for you to offer the guidance and the advice, but it is another for the trusts to listen in the conversations that they are having with Mr Brown. Mr Brown, do you think that trusts use spec as an excuse for not engaging, or is this not a problem?
Andy Brown: No, not at all. Our framework deals cover all specs. There may well be one or two brand new modalities, like PET-MR, which were not around four years ago when we did the framework in 2007. We are doing another framework now, which will be launched in November, because they are four years long. That framework will take account of any technological changes in that period of time. We will have the latest technology on there as well. Furthermore, we future-proof our contracts, to ensure that should a supplier bring out a new technological change in the contract period, that automatically gets on to the framework.

Q103 Chair: How many suppliers have you got framework agreements with?
Andy Brown: For this level of machines there are four manufacturers. It is pretty much four worldwide.

Q104 Mr Bacon: Can you just remind us who they are?

Andy Brown: Siemens, Philips, Toshiba and GE. For linear accelerators, there are three manufacturers: Elekta, Varian and Siemens.

Q105 Austin Mitchell: I just want to move the discussion on from the prices paid for the stuff to the use of it. First, I was struck by something issued by the Department of Health since the report came out about waiting times for scans. I want to ask you, Sir David, why, apart from the election of a Conservative Government, the waiting time for scans has got longer since 2010?

Sir David Nicholson: The waiting times generally across the whole board are relatively stable, but they go up and down during any year or any seasonal arrangement. There is a great danger in people picking out particular months and particular years and trying to compare them against each other. It is almost limitless what you can do in that environment. We think that they are low and stable. If you look at them, the average is still some 1.8 weeks for MRI. There is stability.

Q106 Chair: Some 1.8 weeks. The NAO is always a little bit out of date, so what is your latest data on waiting times?

Sir Mike Richards: The median wait for CT scans is 1.4 weeks. For MRI scans, the wait is 1.8 weeks. Those are stable.

Q107 Chair: What were they a year ago?

Professor *Sir Mike Richards:* I haven't got the figures for a year ago, but I can tell you what they were four years ago, when they were three times as long for MRI, and for CT scans they were about twice as long.

Q108 Chair: Can you let us have a note as to what they were?

Sir David Nicholson: They were broadly the same this time last year, but that is against a background of an increase in activity of nearly 5% over the year.

Q109 Chair: So these terrible stats in here, which I did find a bit shocking, that 50% of people who have a stroke do not get a scan within 24 hours, has that changed?

Professor Sir Mike Richards: That is an area that, undoubtedly, we still need to do work on. We are monitoring that, and there is the stroke audit that gives us the figures. There is variation between trusts. At the highest end it is 97% of patients that are being scanned within 24 hours and at the other end it is about 28%, so there is variation. We have to work on that, but that is not, of course, just about machines; that is also about the work force. It is about seven-day working, and, as you are probably aware, there is a lot of effort going into looking at how we can get hospitals in general to move towards seven-day working.

Q110 Chair: Is it also true that 15% of cancer patients who would benefit from radiotherapy do not have access to that therapy?

Professor Sir Mike Richards: Can I explain those figures? There were some international figures that suggested that over half of all cancer patients would require radiotherapy—about 52%—and we are currently somewhere nearer to the 37% mark. There are concerns about whether that international benchmark is right, and we are doing further work with our experts, which we expect to publish later this year, on what the demand really is. I am sure that we will need more patients being treated with radiotherapy. The next question is where are they and why are they? It is not that they are being denied radiotherapy now. I personally think that a proportion of this is due to the fact that we still have a problem with late diagnosis in the NHS. We have made no pretence about that. It is a major part of the cancer strategy that we want to reduce the problem of late diagnosis. The main thing being that if these patients are diagnosed late, they are no longer suitable for curative radiotherapy.

Q111 Chair: I understand that, but what the Report actually says is that 15% of patients, presumably those who have been diagnosed with cancer and for whom radiotherapy might prolong their life, are not accessing that therapy.

Professor Sir Mike Richards: I think that is based on the figures that 37% are currently getting it and this international figure of 52%.

Q112 Chair: When are you publishing this research?

Professor Sir Mike Richards: I believe that the new demand figures for radiotherapy are going to be published in November or December.

Q113 Mr Bacon: You mentioned that there is still a lot of further work to do. You will know that this Committee has twice looked at stroke, and this, I suppose, is really a question for Sir David, because I would like to know how much more work there is to do. You have quoted 90%, down to sort of 20-odd per cent.

Professor Sir Mike Richards: 28%.

Mr Bacon: One of the things that was very clear from the National Audit Office work on stroke five years ago—we have looked at it again more recently than that following the progress report that they did—is that, because the costs of treatment after a stroke for those who survive are so huge—higher than cardiac I seem to remember—the mantra "always scan" actually saves you money. Yet, five years later, we are still talking about having a lot more work to do. When will we get to the point when the work is done?

Sir David Nicholson: It will never be done in the sense that new arrangements will come into place and new techniques and new technology will allow us to do even better, so it not something that you ever reach, but we have a stroke improvement strategy, we have a plan, we have a whole set of people out there working on improving stroke services as we sit here today. When we came last time, we said that, over the next three years, we would expect to hit most of those issues that we identified in that strategy, and we are continuing to do that work.

Professor Sir Mike Richards: As an onlooker, stroke is not my area of responsibility, but there is absolutely no doubt that progress is being made in that area. Having a stroke strategy, and what has happened since then, really is making a difference. That does not mean that we do not have a lot more to do, and both Sir David and I would agree on that.

Q114 Austin Mitchell: You have bought this expensive equipment and part 3 of the Report reveals some worrying discrepancies about its use. Figure 12 shows wide variations in the "Average number of fractions per machine". Figure 13, "Opening hours", shows surprising variations. They are like pubs. Figure 14, "The percentage of people in each trust waiting under two weeks", shows fairly steep variations. Figure 15, "The percentage of people in each trust waiting under two weeks from referral to a CT scan" also shows variations. The Comptroller and Auditor General's Report states: "From our visits we found variations in the average number of scans per CT machine per trust varied from around 7,800 to almost 23,000 in 2009–10." What are you doing centrally to ensure more consistent usage across the NHS? How will that be ensured once the independent foundation trusts each start playing their own game?
Sir David Nicholson: We publish information nationally and individual organisations benchmark themselves against it. We provide support and advice.

Q115 Austin Mitchell: Is that a name and shame strategy?
Sir David Nicholson: Yes. And there is a series of tools that we use to help them manage their demand and the way they use their machines. We provide all that.

Q116 Chair: I know that we are going over old ground, but you provide information. The idea is competition, but the good burghers of Barking and Dagenham do not have that choice. If they do not have a car, they have to go to the local hospital and the waiting list may be long. The PCT now suggests reducing the extended hours of opening to meet the financial system. There is no choice. The information does not drive better services for the individual—unless, like you and me, they are middle class and can wander across the capital or the country.
Professor Sir Mike Richards: You are talking about information being given to patients, which I fully support, but information being given to commissioners—

Q117 Chair: That does not help. If our commissioners in Barking and Dagenham buy services from Sir Robert's hospital in the centre of London, my guys will not go because they cannot afford to travel there.
Professor Sir Mike Richards: That is not the point that I was trying to make. I was saying that your commissioners can then really work with the local provider, if they were not at the most efficient end of the scale, because they would have that benchmarking information.

Chair: "Work with" is just not tough enough. Jo is not here, but you have the two with the worst hospitals—we go over this time and again—and you have been working with them since I became MP there in 1994. I have not seen any substantial improvement. What I get as a resident and a citizen in London is unfair, given what my constituents get.

Q118 Austin Mitchell: That would apply in Grimsby as well. What powers do you have, apart from collecting information—presumably naming and shaming—and pushing up the performance averages to some kind of decent consistent average? How will those powers operate when they are all foundation trusts?
Sir David Nicholson: The major way in which we do that is through the contractual arrangements and the payment system that we have in the NHS. We have a national contract with a series of incentives and penalties, and we have a payment system.

Q119 Austin Mitchell: If that works, why are the variations still there?
Sir David Nicholson: First, there will always be variation. Indeed, variation can be a good thing; that is how you get innovation and the leading edge. You don't want everyone to be exactly the same; you want people such as Robert's organisation to get ahead.
Austin Mitchell: It is also how you get dead people.
Sir David Nicholson: What you tend to find in these graphs—they are very interesting—if you look at the top and the bottom, which is what we tend to do, we would say, "Who are the two or three at the bottom, and what are the factors that affect them?" You tend to find that they are normally special cases, that particular things have happened in those environments. You should look at the totality of this. I know that you have taken some 5% off each end; nevertheless, the variation is not quite as big as it appears when you quote the worst and the best, because there are often separate and different issues there.
Professor Sir Mike Richards: May I say what my team and I do with this data? We do follow it, and we know exactly which trust is which. For the radiotherapy centres in figure 12, we know exactly which ones are where, and there are usually reasons for why they are at the lower end of the scale. For example, one of those at the lower end of the scale is a radiotherapy centre that had only just got going during this period, so it was perhaps not surprising. It was still building up its work load, but that radiotherapy centre means that patients have to travel a whole lot less across Somerset in that particular case. That is one reason. We identified work force issues in another case. We are now working with that trust and it is working on resolving them.
Equally, at the top end there are unsustainable services where they are putting too many patients through those machines, and that is not desirable either. The benchmarking enables us to say, "Those are the places that probably also need an extra machine to be able to give a sustainable service and they should then be working with NHS Supply Chain."

Q120 Ian Swales: You have twice mentioned work force issues. We sat in this Committee a few months ago and heard about £50 million fighter planes that were on the ground because they didn't have pilots. That seems a crazy way of running the economy of the RAF. Is the real situation with the scanners that aren't used as much that they are actually short of people and that we are trying to save money on people while staring at expensive machines that aren't used?
Professor Sir Mike Richards: You have to take each hospital and trust on its own. In one case, it is work force for radiotherapy. In many others, it is not. We have done a great deal to expand the work force on the diagnostic side and on the treatment side—the radiotherapy side. Does that mean we have gone far enough? Have we all the numbers we need? No, we haven't. But we have seen a steady increase. One of the things that we did several years ago was to double the number of therapy radiographers in training because we knew that we needed that. In fact, it was not until they came out of training that we could start seeing some of the benefits.

Q121 Chair: The attrition rate is shocking.
Professor Sir Mike Richards: This is partly why we have had to create more training places. I am not in any way complacent about that either.

Q122 Ian Swales: My question is around the point that Sir Robert raised earlier. You may not have the power to demand various things of trusts, but you do have a lot of power as a commissioner. To what extent can you set performance standards and so on as part of the commissioning process? You may not be able to demand that they do certain things, but you can demand outcomes. You can demand what the figures should be, surely. In terms of accessibility to scanners, for example, can't you do more in mandating that as part of your commissioning process?
Sir David Nicholson: I am sure that we can do better. We can identify performance standards and we can put financial penalties against people who don't deliver them. Mike and his team are working on that. We have improved the contract every year so far. We've got better at doing that, and will undoubtedly get better in the future. Commissioning can do that.

Q123 Ian Swales: Sir Robert's point was a good one as well. At that point, he was talking about data. You quite often sit in front of this Committee saying you are not that happy about the data you've got. Well, can't you just decide what you need and then get it as part of the commissioning process?
Sir David Nicholson: We can. There is a process for us to go through. We are going through a process in relation to the data set for diagnostics at the moment because we don't believe we have the data available. There is, of course, a whole set of other people who say to us that these are unreasonable demands on front-line organisations to create more and more data. There is a process that we have to go through, which we are going through at the moment. We have to define the data very carefully. It is a very complex thing. You are absolutely right. Over the next few years, you will see an explosion of data in this regard.
Mark Davies: Since 2009, the national radiotherapy data set has been a mandatory requirement, so better data is now emerging on radiotherapy. There is still some distance to go in scanning data, in terms of utilisation.
Professor Sir Mike Richards: Can I tell you what we are doing? I agree with that comment, which is why we are establishing a diagnostic imaging data set. It is about 19 separate items of information. We are trying to simplify for the NHS how we collect the data.
An awful lot of this data is collected in so-called radiology information systems in individual hospitals. Our approach is to say, "Can we extract from those existing IT systems and pool it nationally so that we can give a national picture and feed it back to people and can look at the variations?" That is the work that we are doing at the moment. I am leading on that work, and we are hopeful that we will get all the permission through so that we can start collecting the information from next April.
Sir David Nicholson: Then we can mandate that to individual organisations.
Amyas Morse: So we are not actually publishing that data right now. That is something you are developing.
Professor Sir Mike Richards: We haven't got it yet, but we will.
Amyas Morse: On the whole subject of interpretation of information and the discussion that we have just had about outlying factors, it is interesting to know what you think meaningful ranges are. We produced this information, but you are constantly looking at the information. Of course, we could produce examples of things with good reason why this and that was starting up or whatever, but what is interesting is whether you think the range is acceptable at the moment or not. What is your opinion on it?
Professor Sir Mike Richards: I think we need to look separately at the extremes, for which there are sometimes good reason and sometimes not, and the variation of what you might call the "middle section". I have looked at lots and lots of these figures over the years with respect to cancer, and I tend to look at the 90th centile and the 10th centile. A working rule is that, if the ratio between those is more than two, I really need to look into it.
For example, without opening up a whole other can of worms, in the past we have looked at cancer drugs and we have seen those variations. What we have seen over time is that, every time we measure it, the variation gets less. But, to begin with, that variation was considerably more than two and really meant an unacceptable variation to me. I do have that metric in my own mind, which I personally think is quite a useful one. It seems to apply whatever you look at.

Q124 Chair: Thank you very much indeed. That was a useful exchange. We look forward to coming back to this and other issues. No doubt you are coming to us next week again on something else.
Sir David Nicholson: I think that the foundation trusts is my next visit.
Chair: I'm looking forward to that.

Written evidence from the Chief Executive of the NHS

MANAGING HIGH VALUE CAPITAL EQUIPMENT IN THE NHS IN ENGLAND

At the Public Accounts hearing on 7 September, Committee members asked for a note from the Department of Health on diagnostic waiting times. This note sets out my response to this request and also provides some points of clarification that I would like to make having read the transcript of the hearing:

IMAGING WAITS (Q108)

The Committee asked what the median waiting times were for CT and MRI scans a year ago. These figures are set out in the table below:

	Median waiting times	
	CT scans	*MRI scans*
July 2011	1.4 weeks	1.8 weeks
July 2010	1.3 weeks	1.8 weeks

CAPITAL (Q54)

To clarify my statement in response to Q54, over the next four years, the Department's capital settlement is £17.9 billion (£4.4 billion per year for the first three years and £4.6 billion in the final year—difference in total is due to rounding). This includes £2.1 billion of depreciation resources in each of these four years.

ACUTE TRUSTS (Q64)

There are 168 acute trusts, of which 97 are foundation trusts and 71 are non-foundation trusts.

I trust that the information on waiting times and the points of clarification will be helpful to Committee members.

In addition, there are a small number of minor changes that I would like to suggest are made to the transcript for accuracy. These are shown in track changes on the attachment. I hope that these will be acceptable to the Committee.

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