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Pàrlamaid na h-Alba

Official Report

PUBLIC AUDIT COMMITTEE

Wednesday 14 April 2010

Session 3

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PUBLIC AUDIT COMMITTEE
7th Meeting 2010, Session 3

CONVENER

*Hugh Henry (Paisley South) (Lab)

DEPUTY CONVENER

*Murdo Fraser (Mid Scotland and Fife) (Con)

COMMITTEE MEMBERS

*Willie Coffey (Kilmarnock and Loudoun) (SNP)
*Cathie Craigie (Cumbernauld and Kilsyth) (Lab)
*George Foulkes (Lothians) (Lab)
*Bill Kidd (Glasgow) (SNP)
*Anne McLaughlin (Glasgow) (SNP)
*Nicol Stephen (Aberdeen South) (LD)

COMMITTEE SUBSTITUTES

Derek Brownlee (South of Scotland) (Con)
Linda Fabiani (Central Scotland) (SNP)
James Kelly (Glasgow Rutherglen) (Lab)
John Farquhar Munro (Ross, Skye and Inverness West) (LD)

*attended

THE FOLLOWING ALSO ATTENDED:

Mr Robert Black (Auditor General for Scotland)
Caroline Gardner (Audit Scotland)
Jillian Matthew (Audit Scotland)
Claire Sweeney (Audit Scotland)

CLERK TO THE COMMITTEE

Jane Williams

LOCATION

Committee Room 1

Scottish Parliament

Public Audit Committee

Wednesday 14 April 2010

[The Convener *opened the meeting at 10:00*]

Decision on Taking Business in Private

The Convener (Hugh Henry): I convene the Public Audit Committee's seventh meeting in 2010, to which I welcome members, Audit Scotland colleagues and any members of the public or press who are here. I remind everyone to switch off all electronic devices, so that they do not interfere with the recording equipment.

Before we consider the agenda, I will take the opportunity to comment on the 10th anniversary of Audit Scotland, which was one of the first institutions to be created following the Scottish Parliament's establishment. The contribution that Audit Scotland and its staff have made to Scottish public life is remarkable.

It is a credit to the organisation that, whenever anything controversial that relates to money crops up in the public sector, the first port of call for politicians of all parties is to call for Audit Scotland to conduct an inquiry. Recently, people who are not politicians have referred themselves or others to Audit Scotland. People have the confidence to do that because everyone values Audit Scotland's integrity and the quality of its work. They know that the issues will receive fair, objective and thorough scrutiny.

At times, it must be difficult for you, Auditor General, and your staff to stay above the party-political fray, particularly when we politicians try to score points by involving people from outside the political arena, such as Audit Scotland. To your credit, you do that task exceptionally well. The quality of your work is valued by members of not only the committee but the Parliament and by everyone in the public and private sectors.

Since I became the committee's convener, I have realised even more the significance and the high standards of Audit Scotland's work. All committee members have valued the reports that you have produced and their depth, clarity and impact. That can be seen in how the media report not just the committee's work but what you do as an organisation.

Audit Scotland has had 10 years of success and of making a high-level contribution to the quality of life in Scotland. I hope that recommendations by Audit Scotland and its staff—whether on education, health or the environment—have led to improvements in how we use our public resources and in how we deliver our services.

As an aside, it is a happy coincidence that Audit Scotland has just been included in *The Sunday Times*'s list of the 75 best places to work in the United Kingdom's public sector, so I congratulate it on that.

On behalf of the committee and all members of the Scottish Parliament, I congratulate Audit Scotland on a remarkable success story.

Members: Hear, hear.

Mr Robert Black (Auditor General for Scotland): Thank you very much indeed for your extremely generous remarks, convener. As I have said to the committee before, all the work that comes before you is down to the hard work of Audit Scotland, and it will be a real pleasure to relay your kind remarks to the staff—that will give them a real fillip. For me, Caroline Gardner and her colleagues, it was a privilege to start from a clean sheet of paper 10 years ago. Working with the committee, we have realised a vision for the role that public audit and scrutiny can play in a modern democracy. It is a great tribute to the committee that it has given us the support that we need to perform our role effectively. As I have said on many occasions, we can take the work only so far. We can do our best to present good, robust analysis and the key findings in our reports, but devolution has helped enormously in that the missing link has been provided by the committee, which receives our reports and, when appropriate, asks questions of accountable officers, chief executives and occasionally ministers to conclude the process of holding to account. That helps enormously. It means that, out there in the public sector, people take our work seriously because they recognise the accountability process that is associated with it. I therefore thank the committee for its support.

It is interesting that there is such a wide interest in our work outside Scotland. The committee will recall that we get lots of visitors from other countries, and a limited amount of our work is involved in developing institutions of government and audit in other countries. That is down to the model that was designed by the Scottish Parliament at the outset, which has been a great success. The robust democratic scrutiny system that came with devolution is one of the successes of the Scottish Parliament and, ultimately, although it may not be talked about terribly much, it is valued by the people of Scotland. It ensures that, when things go significantly off the rails, something can be done. Also, when things are going well, that is recorded, although such things tend not to come before the committee.

Thank you for your kind remarks. We look forward to relaying them to the staff, who will appreciate them.

The Convener: Thank you. We now turn to the formal agenda. Are we agreed to take item 4 in private?

Members *indicated agreement.*

Section 23 Reports

"Review of orthopaedic services"

10:08

The Convener: Item 2 is a section 23 report entitled "Review of orthopaedic services". I invite the Auditor General to brief the committee on the report.

Mr Black: I invite the deputy Auditor General, Caroline Gardner, to introduce the report.

Caroline Gardner (Audit Scotland): Orthopaedics is a national health service speciality that matters. Back pain, hip problems and other orthopaedic conditions seriously impair people's mobility and their quality of life. Orthopaedic services treat a high and increasing number of patients every year—there are around 76,000 in-patients, 24,000 day cases and more than 500,000 out-patient appointments every year, at the last count. The service costs about £370 million a year, making it the third biggest after general medicine and general surgery.

I will pull out four key messages in the report, to set the discussion in context. First, orthopaedics is a success story. Waiting times have fallen significantly in recent years and, by 2008, 95 per cent of in-patient and day-case orthopaedic patients were being seen within the target time of 26 weeks from referral. That is a success story, and we know that maintaining that progress will be difficult. A new target of 18 weeks from referral to treatment is due to come in from next March, and increasing financial pressures in the health service will make it more difficult to maintain the momentum in the future.

Secondly, the efficiency of orthopaedic services varies a good deal throughout Scotland. That is not fully explained by the resources that are available or by the type of procedures that are carried out in different places. Over the past 10 years, the funding for orthopaedics has risen by 68 per cent in real terms and the number of consultants has risen by 50 per cent, yet activity has increased by just 12 per cent, so there is a gap in the productivity increase over the period. There are gaps in the available data from which we can draw firm conclusions about productivity, but we know that orthopaedic consultant teams are carrying out fewer procedures than they did 10 years ago—and that that varies across Scotland.

It appears that the NHS boards that manage their emergency work separately from their planned orthopaedic work have higher consultant activity levels and lower unit costs. There is an important clue there on how to increase

productivity and bring it up to the average level for Scotland.

We identified from the data that, if NHS boards with lower activity levels could reach the average for Scotland, an extra 3,700 patients could be treated within the resources that are currently available. That is significant in the context of an ageing population and rising expectations for a pain-free life.

The third key area that I wish to highlight is other opportunities for improving efficiency, which is particularly important in the current climate. We think that there are opportunities to do that in a number of ways: by standardising the type of implants that are used for joint replacements, mainly hip and knee replacements; by reducing longer lengths of stay down towards the Scottish average; and by continuing the shift from in-patient treatment to day-case treatment for the most suitable patients.

Our report shows that, for most procedures, Scotland as a whole is still a long way behind the target for orthopaedic procedures. Some boards are doing much better than others, and there is scope for greater efficiency and for a better quality of care for day-case patients for whom that type of care is suitable.

Fourthly, on quality, there is a lack of information about the outcomes for patients, but it is clear that NHS boards are generally doing well against the available quality measures. Members will find some information about that in our report.

I will leave it there, but my colleagues and I will do our best to answer your questions.

The Convener: Thank you very much. A couple of the things that you said intrigue me. You mentioned that the number of consultants has increased by 50 per cent, but that activity has increased by only 12 per cent. Exhibit 3 on page 6 of the "Key messages" document shows that total activity is lagging behind total spend. That is worrying.

You also said that there are fewer procedures than were carried out 10 years ago. For some reason, we are not seeing the results that we might expect from the significant extra investment. Is there any explanation for that? Has there been any attempt to explain why activity and number of procedures have lagged behind investment?

Caroline Gardner: It is a complicated picture, and the ability to draw firm conclusions is limited by gaps in the data. The number of procedures has significantly increased over those 10 years, but the number of procedures per consultant team has gone down. That is explained by the increase in the number of consultants of about 50 per cent over the period.

There is a different case mix now, with more complex hip and knee replacements being done, but the overall picture shows a reduction in productivity. We are not entirely sure why, and it seems a fruitful area for the committee to explore further. I will ask Claire Sweeney to add to that, as she is much closer to the data than I am.

Claire Sweeney (Audit Scotland): The picture is indeed slightly more complex, given the procedures that are technically possible now. That change, which has taken place over time, will account for some of the difference. There is also a link to cost—some more expensive procedures are now being carried out.

It is worth mentioning the big focus around improving waiting times for patients, which has led to money being spent on additional work during evenings and at weekends. That, too, might account for some of the difference, although it increases both costs and activity. The explanation largely relates to the more complex procedures that are now being carried out. However, the limitations in the data mean that it is difficult to be clear about it.

The Convener: There is an argument that a reduction in the number of procedures per consultant team might be a good thing, either because too many operations were previously being carried out in too much of a hurry because of understaffing—which would clearly be a worry—or because more complex operations are being done that take more time, as you say. Is there a way of telling whether we have a welcome trend and a reduction for the right reasons, rather than an unwelcome trend as a result of investment not giving the proper returns?

10:15

Claire Sweeney: It is probably important to mention the changes in contracts, particularly for medical staff, which we think will have an influence. We could not go into a great deal of detail on that, as the report examined published and available national information. However, from other projects in which we have carried out work in more detail on the issues around the consultant contract and the impact of the European working time directive, with changes to the way in which junior doctors are trained, we know that, potentially, the amount of what we might call medical hours is reduced at the same time as there is a greater focus on more complex cases. All that needs to be taken into consideration in the round. We could not give hard-and-fast numbers on what that means for consultant hours on the ground, but it is certainly a factor that boards should consider in more detail.

The Convener: Paragraph 25 in the key messages report talks about the variation in Scotland. It states:

"In 2008/09, there were around 7,200 arthroscopies of the knee and the percentage carried out by mainland boards as same day surgery ranged from 75 per cent in NHS Dumfries and Galloway to 92 per cent in NHS Forth Valley."

There are similar reports of variations with other procedures. Why is that?

Caroline Gardner: We have examined day surgery several times in the past 10 years. The picture for orthopaedics is similar to that for specialties as a whole. We have found a wide variation in the percentage of procedures that are carried out as day cases. Exhibit 12 in the main report shows, for six procedures, the Scotland average, the target and the performance of the boards for which data are available. For example, for cruciate ligament reconstruction, the rates range from 2 per cent in Grampian up to 62 per cent in Lothian. That is an extreme range of variation, although it is not outstandingly extreme.

We have found that we cannot explain that with reference to the type of patients being treated, the facilities that are available or the way in which the work is organised. The most important determinant seems to be consultants' preferences and the way in which they prefer to organise their work. That has important consequences for the quality of care that patients receive and the costs that the health service incurs. That is an important indicator of the different levels of activity and costs that are being incurred in providing orthopaedic services.

The Convener: The issue of consultant preferences is interesting. On the one hand, the variation could show that consultants are showing initiative, working at the top of their game and delivering excellent results. On the other hand, the worry is that NHS Scotland is not considering best practice and asking why others are failing to deliver similarly. Has there been any response from NHS Scotland on what it is doing to improve performance and standards throughout Scotland?

Caroline Gardner: We have not had a response on that recently. The committee has considered the issue a couple of times and took evidence from the then Health Department. There is activity going on. The challenge comes at the interface between the consultant's clinical judgment, which must absolutely be sacrosanct, and the ability of a board to challenge that by using data about what other consultants and boards are achieving for similar patients and similar types of care. There is not a single right answer for any individual patient. As auditors, we certainly cannot identify what that might be. However, those are proper questions for health boards to ask and for the committee to understand better, too.

The Convener: Are there any issues to do with availability of resources? We know about some of the challenges that Greater Glasgow and Clyde NHS Board has faced. Although it is not hugely behind health boards in other parts of Scotland on carpal tunnel release, it is significantly behind on other procedures. Is that to do with investment of money?

Caroline Gardner: When we have looked at the issue in detail in the past, it has been clear that doing same-day surgery rather than in-patient surgery has an effect on cost, depending on how things are organised. If patients are treated as day cases in an ordinary in-patient ward, not much money is saved—the ward will still have to be staffed 24 hours a day and the same levels of cover will be needed. It is much cheaper to treat patients as day cases in a day-case unit that closes overnight, where work is planned in that way. Most health boards now have such units available for most specialties.

We have not looked at that issue specifically for this piece of work, but we know that it is not primarily about the availability of day-case units, in which there has been a lot of investment. There may be a question about whether the health board has the right balance of day-case beds and in-patient wards, which gives rise to a broader question about how it manages its pattern of clinical activity and what consultants do. The fact that it should be cheaper to treat patients as day cases rather than as in-patients should push the trend in that direction.

The Convener: We will hear from Bob Doris then George Foulkes—I am sorry; I meant Bill Kidd, not Bob Doris. I passed Bob Doris in the corridor earlier on. Sorry about that—it was a senior moment.

Bill Kidd (Glasgow) (SNP): I am not going to say anything about that. [*Laughter*.]

The reduction in the number of in-patient beds, with treatment in the community or on a day-case basis, brings down the overall spend and therefore provides a better use of resource. Is the difference in performance a result of consultants in some health boards deciding that they would prefer patients to spend longer in hospital because they believe that that will deliver a better recovery than would be the case if those patients received community health and social care services outside hospital? Is that why some health boards do not invest in treatment outside hospital? Are they the ones that are lagging behind in the amount of money that they are spending on same-day surgery?

Caroline Gardner: For suitable patients, most of the procedures in question do not require much in the way of health and social care after discharge. All the evidence is that if the treatment is got right on the day and people are discharged with proper pain relief and instructions on how to get help if they need it, the quality is just as high as it would be with in-patient care.

It is clear that there are some patients for whom that is not the case, and that is taken account of in the same-day surgery targets in the top line of exhibit 12, which are not 100 per cent. Some surgeons are more experienced, more comfortable and more confident than others when it comes to working in that way, but all the work that we have done over quite a long period suggests that the variation between health board areas cannot be explained by the availability of facilities or by how rural or remote a health board area is. It is to do with the things that a consultant chooses to do, based on his or her clinical judgment.

Bill Kidd: Paragraph 29 in the "Key messages" document says that the average length of stay in hospital following an orthopaedic procedure is 5.2 days for patients in Glasgow, whereas for patients in the Western Isles it is 15.5 days. That is a considerable difference, notwithstanding the fact that Western Isles NHS Board will have a smaller consultant team, which will have a different view about how to treat patients. It may be more difficult to deliver community health care in a more spread-out area such as the Western Isles than it is in Glasgow, but that seems to be an issue that we should look at, with a view to drawing the two treatment methods closer together.

Caroline Gardner: You are quite right. We cannot explain the range of variation in length of stay for in-patients. That is worthy of further exploration.

George Foulkes (Lothians) (Lab): This excellent report illustrates the convener's general comment about the high quality of the reports that we get from Audit Scotland, which is extremely helpful.

The two issues that I am pleased about are the great success of the Golden Jubilee hospital, which is extremely encouraging, and the phasing out of Netcare. The taking over of the Netcare-run facility by NHS Tayside has meant that the amount of work that is done in the private sector has decreased.

The report states that the Scottish Government health directorates are

"encouraging boards to phase out their use of the private sector".

The thing that worries me—the report highlights the gap, although that is not the fault of the people who wrote it—is explained in paragraph 36, which states:

"it is not known how many patients NHS boards refer to the private sector for treatment."

It seems strange that boards do not keep a note of that. I am a little suspicious about it, because I still get anecdotal evidence, as I am sure other members do, that consultants are saying, "You might have to wait 10 weeks before you get this treatment, but if you want to go privately I can do it tomorrow." That is still happening.

What more can be done to determine what is happening? I do not think that the boards are exerting pressure; it is the consultants who are exerting pressure on people to have more treatment in the private sector. How can that be assessed? How can we get the figures on that?

Caroline Gardner: I ask Claire Sweeney to answer that initially.

Claire Sweeney: The message that we found through the work that we did is that information on that is not collected consistently at a national level. Doubtless, the boards have some of the information at a local level, but there are issues about how consistently it is recorded and reported. We cannot say how many people throughout Scotland are referred in that way because the information is simply not available.

George Foulkes: Would each individual board would have the information?

Claire Sweeney: The boards would have some information around the issue, but we have questions about how easy it would be to draw comparisons and how consistently and routinely the information is recorded. We certainly cannot give a picture for the whole of Scotland.

George Foulkes: The boards might not know. The consultants might not be too keen on the information being available because they get a lot of extra money by referring people to the Murrayfield hospital or a private insurance company hospital somewhere. They might not want it to be known.

Caroline Gardner: There are two separate issues and it is worth while to distinguish clearly between them. In the report, we are talking about patients who are referred to private facilities by their NHS board and whose treatment there is paid for by the board, mainly to meet waiting time targets. Separately, some individuals choose to pay for private treatment, either under insurance schemes or by paying as they go. The boards certainly have information on the first category although, as Claire Sweeney said, it is not recorded consistently. The boards might not—they probably will not—have information on the second category, although there is some published data

that we could pull together for the committee if that would be useful.

George Foulkes: I think that it would be helpful to have that information. I do not know about other members, convener, but I would certainly like to have it. It would be unfortunate if people were being pushed into the private sector unnecessarily when they could get perfectly good treatment within a reasonable time in the NHS.

Murdo Fraser (Mid Scotland and Fife) (Con): I have a couple of questions on the cost of treatment. I read with interest paragraph 92 of the report, which illustrates the striking variations in the cost of certain procedures. It states:

"The average cost of a hip implant varies from £858 in NHS Lothian to £1,832 in NHS Forth Valley."

That is a striking difference. The two boards are geographically close to each other, but the cost in one is more than double the cost in the other. There are similar differences in the cost of knee implants. The report states that work is being done to try to reduce the cost of implants and standardise training. Given the scale of the figures, that work is essential. If all health boards performed at the level of the most efficient, substantial savings would be made.

Related to that, tariffs are covered in exhibit 21 on page 33, which states that tariffs have been developed to a much greater extent in England than in Scotland. Does Audit Scotland have a view on whether the further development of tariffs in Scotland would help to improve efficiency?

10:30

Claire Sweeney: We are not aware of any work that has been undertaken nationally on standardising the cost of implants, although we say in the report that such work should be carried out. There is certainly scope for boards to make savings and secure value for money from the implants that are purchased; for example, as our work shows, there are differences in consultant preferences. We discussed the issue in great detail with NHS Scotland Procurement, which has more detailed information on the matter.

Caroline Gardner: On tariffs—

The Convener: Just before you go on to that, I would like to follow up that response to Murdo Fraser's question. Essentially, you are saying that the cost differential is down to consultant preference. I presume that we are talking not about inferior products or products that are less likely to provide a satisfactory outcome but about products that are proven and reliable. Frankly, if that is the case, I find it unacceptable that consultant preference should be costing the NHS so much. It might be happening because consultants are not aware of what else is available, in which case NHS Scotland should be taking urgent steps to ensure that everyone is aware of the most cost-effective units. On the other hand, consultants could be left open to accusations that they have chosen more expensive products for some other reason. That would be unfortunate but, whatever the reason is, there appears to be no justification for continued expenditure on what appear to be overpriced products.

Claire Sweeney: The report highlights a range of issues where we found quite a lot of variation in cost and activity; indeed, it usefully demonstrates such differences. When we examined certain variations and areas where savings could be made, we heard no particularly reasonable explanations as to why these variations existed. As I said, it is another area in the report where there appears to be scope to save money by making things more consistent. You might be right in suggesting that this information has not been drawn together in a consistent way before, and there might need to be a more co-ordinated approach in that respect.

The Convener: We will return to the issue later.

Caroline Gardner: Audit Scotland does not have a view on the use of tariffs. In England, they underpin the payment system for NHS work; that is not the case in Scotland, but that policy decision is outwith the remit of our interest.

However, our strong view is that the quality of cost information underpinning the tariff system in Scotland is not yet good enough. That is an important consideration. Because tariffs are not used for real in the way that they are in England, the importance of understanding what drives costs and explains difference has not gone as far as it needs to go. In the current financial climate, having a strong understanding of why costs vary and where there might be room to take out costs without affecting the quality or level of activity is central for the health service.

Murdo Fraser: I have a related question on the cost of procedures that brings us back to George Foulkes's point about the Netcare contract at Stracathro hospital, which falls within my parliamentary region. I was a bit surprised to hear him say—if I remember it correctly—that he was pleased that it had gone back into the NHS, given that it was his colleague Mr Andy Kerr who, as Minister for Health and Community Care at the time, pioneered the project.

In summer 2008, PricewaterhouseCoopers published its 10-month review on the Netcare project. I do not have that report with me but, if I remember correctly, the project got a glowing bill of health, with sky-high patient satisfaction levels

and not a single case of hospital-acquired infection. It was also delivering very good value for money to the NHS. Of course, the project has now been brought to an end and, according to the report, PwC is doing a further piece of work on it, which we will be interested in seeing. Is Audit Scotland aware of any figures that show the cost of treatments under Netcare at Stracathro compared with costs in the NHS as a whole?

Caroline Gardner: I will pass that on to Claire Sweeney.

Claire Sweeney: And I will pass it on to Jillian Matthew.

The Convener: It must be a hard one.

Jillian Matthew (Audit Scotland): We did not consider prices of individual procedures at the treatment centre, but exhibit 7 shows the overall costs. You will see the costs that were agreed. The costs were rearranged slightly after the inception of the contract. At the time, the issue of potential overpayments for treatments that had not been done attracted quite a lot of attention. The centre took quite a bit longer to set up than anticipated. It could not receive patients or perform major procedures as quickly as it could have so it had to renegotiate the contract. NHS Tayside has provided us with figures and we are happy that the board has kept with the contract, that satisfactory payments have been made and that it has not paid for anything that has not been done.

Murdo Fraser: Will the final PwC report provide us with a comparison between the costs of the Netcare project and costs within the NHS more broadly?

Jillian Matthew: We have been trying to get those details, but we are unable to get any information until PwC publishes the final figures. I am not sure about the level of detail that the report will get down to, but we have asked to be sent a copy once it has been finalised.

Murdo Fraser: When is the report due to come out?

Jillian Matthew: Any time now. I can chase that up.

The Convener: This is an important issue. If you are comparing the two methods of service delivery, and you are assessing the best use of public funds, you need to know whether providing services through Netcare was more expensive or less efficient than doing it through the NHS, or vice versa. Otherwise, we will not know whether the decision to set up Netcare was right or the decision to disband it was wrong. We have no way of knowing if we do not have that information.

Jillian Matthew: We may have some figures on the prices that were set for procedures. We need to go back and check. I cannot remember whether that was based on the tariff costs that have been set for some of the procedures. However, we could look at that and see whether we can compare.

The Convener: It would be useful if you were able to give us information that would tell us whether what was being delivered by Netcare was more expensive or less efficient than the NHS.

George Foulkes: The information would need to be strictly comparable. My recollection, which I think is confirmed in exhibit 7, is that Netcare took only the quick and easy jobs—the ones that it could make money on quickly—and that difficult and dangerous ones were sent back to the health boards to be done under the NHS. I do not know that the two will be strictly comparable.

By the way, just for the record, that is not the first time that I have disagreed with Andy Kerr.

The Convener: George Foulkes is right. However, you would be able to compare the cost of similar procedures.

Jillian Matthew: There is an issue with the procedures that the treatment centre was able to do because of its location and medical back-up. For example, it could not take complex procedures or procedures involving certain conditions among elderly people. It had to do fairly straightforward procedures because it did not have medical back-up if things got complicated. It would not have the same case mix as boards, for instance.

Willie Coffey (Kilmarnock and Loudoun) (SNP): I return to the convener's opening question on exhibit 3 and the divergence between spend and activity. I would like some clarification on that issue. It is a bit difficult to understand how there can be spend without related activity at least matching it. The report talks about some £32 million that was spent on reducing waiting times. Does that count as activity?

Caroline Gardner: Yes. The activity that was done specifically to reduce waiting times will have increased both activity rates and cost. In many boards, cost will have increased more than activity increased because the work was done at weekends or out of hours and through other providers or in different ways. That activity will have increased both cost and activity rates while decreasing productivity, because cost went up faster than activity did.

I will just check with Claire Sweeney that I have not misled anyone there.

Claire Sweeney: That is right. Both are included.

Willie Coffey: What explains the growing divergence between the activity and the spend

that is put into the system? What explains that growing gap?

Claire Sweeney: In part, as I said before, that might be due to the fact that it is now possible to carry out more complex and costly procedures that could not be carried out before. Another issue is the increased cost of medical cover, as the cost of buying a given number of hours of a consultant's time is different under the new consultant contract from what it was under the previous arrangements. The introduction of the European working time directive has also had an impact on the training arrangements for junior doctors, which means that the medical workforce has a very different feel to it from what was the case a few years ago. All those things will make a big difference to productivity.

We have consciously presented the issue in the way that we have in the report because it is very hard to dig underneath some of those issues. Further investigation at a much more local level would be required to see what the increase in funding has translated to in each of the hospitals in Scotland.

Willie Coffey: Exhibit 3 certainly shows an interesting indicator. If that divergence continues, committees of the Parliament might begin to think that we are not getting benefit from the extra money that is being spent, especially when we see such gaps emerging. However, I do not think that that is the picture that is emerging from Audit Scotland's explanation, which suggests that activity has also increased along with spend. Nevertheless, people looking at that graph might conclude that, if the gap widens, we are not getting value for money. However, that might not be the message that exhibit 3 is telling us.

Claire Sweeney: I should also emphasise that, as we mention in the report, that picture can be seen across the whole of the NHS. We looked at how the performance of orthopaedics was placed to check whether there were problems in orthopaedics that were not being seen across the rest of the NHS, but there is a standard picture. That perhaps emphasises the point that the issue is probably due to staffing being more expensive and to procedures being more complex. There is a consistent message across the picture.

The Convener: That comes back to the point that I made at the beginning. If the gap is because more complex procedures are being carried out than was the case previously, we need to be prepared to accept that. If the gap is because procedures—whether routine or otherwise—were previously rushed and staff were overworked, we should also be prepared to accept that gap. However, if the gap is simply due to costs going up without any other explanation along the lines that I have suggested, that would be a worry. The gap might be due to a mixture of those issues. We might need to look at the matter further to find out exactly why that gap has emerged. Indeed, from what has been said, the issue applies not just to orthopaedics, so it might well come up again elsewhere.

Anne McLaughlin (Glasgow) (SNP): A number of people have mentioned the issue of sharing best practice. Paragraph 96 states:

> "Rates of surgical site infections for hip replacements are low and the average for Scotland has gradually reduced from 2.1 per cent ... to 0.8 per cent".

I assume that best practice was shared there. However, the same paragraph refers to the variation in readmission rates. In exhibit 25, the chart for "Emergency readmission rates following a hip fracture, 2008/09" shows a range from 5 per cent in NHS Borders to 15 per cent in NHS Greater Glasgow and Clyde. Similarly, the chart for "Emergency readmission rates following an orthopaedic procedure, 2008/09" shows a range from 2.5 per cent for NHS Fife to 6 per cent for NHS Greater Glasgow and Clyde. Obviously, there is still a need to share best practice. Was there any indication as to why there is such a big gap between different health board areas, particularly for hip fracture readmissions, which range from 5 per cent in one area to 15 per cent in another?

Caroline Gardner: We know quite a lot about hip fracture, because there is a long-standing hip fracture audit that was first set up in Scotland and is a real Scottish success. It has looked at good practice on everything, such as what should happen to somebody when they are admitted to hospital with a hip fracture, how quickly they should be operated on, and antibiotic and anti-blood clot treatment. A lot of work has gone on to ensure that that good practice is applied throughout the system.

We know that people's home circumstances have an impact on emergency readmission rates, among other things, so it is not surprising that Greater Glasgow and Clyde might be more likely to have a higher readmission rate than the Borders. However, I do not think that it is possible to put our finger on the nub of exactly what is driving the pattern at that level. We need to get under the surface to look at the results of the individual hip fracture audits and how good practice is being applied. Claire Sweeney might want to add to that.

Claire Sweeney: Although the review was a look at the national information, we did some detailed work at board level to do a sense check and get a feel for whether there are any trends. One of the big messages that came through was that people are often unable to explain some of the variation. That is why we have not presented

you with concrete answers for why some of the information looks the way that it does. That suggests that there is a need for boards to look in more detail at why there is variation, and there are some issues with case mix that might have an impact. That information has come out from the local work.

Anne McLaughlin: Can you give me an example of what you mean when you say that people's home circumstances might lead to an increase in readmission rates?

Caroline Gardner: I was referring to the general point that we know that ill health is associated with deprivation and that the more deprivation that there is in an area—in Greater Glasgow and Clyde, for example—the more likely it is that people are in poor health generally and may not cope as well at home after a major operation such as a hip or knee replacement. They may not have as much family support around them and their housing may not be as suitable—a whole range of things comes into play that may make it more likely that they do not do as well after an operation as someone who lives in a bungalow with easy access to a telephone and neighbours who are willing and able to help out. It is the broad set of circumstances around deprivation that we think comes into play.

Anne McLaughlin: So it is not a specific problem with hip fractures; it relates to any operation.

Caroline Gardner: That is right.

The Convener: However, there is an issue about quality and procedures, which I know about from personal experience, when my father fell and broke his hip. The ability to get patients into rehabilitation and doing the proper exercises immediately is an important facet of recovery from a hip fracture, but I know that in some hospitals that does not happen as it should. That will impact not only on the length of stay in hospital but on the ability of the person who receives treatment to live successfully in their own home. Frankly, some hospitals are still not meeting acceptable standards.

Caroline Gardner: The report looks at exactly that question of rehabilitation in hospital and once people have been discharged. Claire might want to say a bit about it.

Claire Sweeney: We did not look in great detail at the rehabilitation side; we were very focused on looking for potential efficiencies and at the acute care that was provided—surgery, in particular. However, we touch on the issue in the final paragraph of the report—paragraph 103. We found that, as you say, convener, there is variation in the rehabilitation services that are available, particularly for older people. That will obviously have an knock-on impact on the length of time that people need to stay in hospital and the procedures that can be carried out as day cases. You are right: rehabilitation has a set of impacts on how other services are developed. It is not something that we looked at in detail, but we certainly touched on it and took account of it in the report.

The Convener: Thank you again for a good and comprehensive report. I am sure that we will follow up on it.

"Protecting and improving Scotland's environment"

10:50

The Convener: Committee members have before them a response from the accountable officer. Are there any comments or thoughts on that response? It covered many of the issues that we raised. There might well be matters of interest to the Transport, Infrastructure and Climate Change Committee but I am not sure that we need to do anything further. Are members content to note the report and refer it to our colleagues on that committee?

Members *indicated agreement.*

The Convener: Just before we turn to item 4, which is to be taken in private, I will comment on changes in the committee, which it was remiss of me not to note at the beginning of the meeting when I referred to Audit Scotland. Members will have noticed that Tracey White has now left the committee to go to the Parliament's legislation team. She is replaced by Jane Williams, who is now in place as our committee clerk—welcome, Jane.

There is another imminent change. Joanna Hardy, who has been with the committee for a considerable time, is moving to what is colloquially referred to as the enterprise committee. I am sure that she will enjoy the fresh challenge there.

I record our thanks, not only to Tracey, but to Joanna, who has been a real asset to the committee. We have produced some difficult reports and she has been stalwart in helping us to meet the challenges of producing them. I thank her very much for her work, and wish her good luck in her new committee. I am sure that Jane Williams will carry on that successful record of support to the committee.

We now move into private session.

10:52

Meeting continued in private until 11:40.

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