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Pàrlamaid na h-Alba

Official Report

PUBLIC AUDIT COMMITTEE

Wednesday 8 September 2010

Session 3

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PUBLIC AUDIT COMMITTEE
13th 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)
*George Foulkes (Lothians) (Lab)
*Bill Kidd (Glasgow) (SNP)
*Mr Frank McAveety (Glasgow Shettleston) (Lab)
*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)
Nick Hex (Audit Scotland)
Kirsty Whyte (Audit Scotland)

THE FOLLOWING GAVE EVIDENCE:

Dr Harry Burns (Chief Medical Officer for Scotland)
John Connaghan (Scottish Government Health Delivery Directorate)
Stephen Gallagher (Scottish Government Health Delivery Directorate)
Colin Sinclair (NHS National Services Scotland)

CLERK TO THE COMMITTEE

Jane Williams

LOCATION

Committee Room 4

Scottish Parliament

Public Audit Committee

Wednesday 8 September 2010

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

Interests

The Convener (Hugh Henry): Good morning and welcome to the 13th meeting in 2010 of the Public Audit Committee. I remind members and others attending to switch off all electronic devices so that they do not interfere with the recording system. I welcome members of Audit Scotland and members of the public to the meeting.

The first item on our agenda is a declaration of interests. Members will know that Cathie Craigie has left the committee. I am sure that we are sorry to see her go, but I welcome Frank McAveety—who is well known to us—to the committee. I invite Frank to declare any relevant interests.

Mr Frank McAveety (Glasgow Shettleston) (Lab): I have nothing to declare, other than what is already in the register of members' interests.

Decision on Taking Business in Private

10:01

The Convener: We move on to item 2. Can we agree to take items 5, 6 and 7 in private?

Members *indicated agreement.*

Section 23 Reports

"Review of orthopaedic services"

10:01

The Convener: We now come to item 3. We have been dealing with the section 23 report on orthopaedic services in Scotland. We have heard from a number of witnesses and this is a further evidence session. I welcome John Connaghan, director of health delivery; Dr Harry Burns, the chief medical officer for Scotland; Stephen Gallagher, the depute director of health delivery; and Colin Sinclair, the director of national procurement for the national health service in Scotland. Kevin Woods has sent us his apologies and has asked John Connaghan to take his place today. Is there anything that you would like to say by way of introduction?

John Connaghan (Scottish Government Health Delivery Directorate): Yes. Thank you, convener. I will make a brief opening statement.

We welcome the publication of the report. In fact, it is an area of work that we suggested to Audit Scotland and we are glad that it undertook the study. The main messages about eliminating waste and variation are at the heart of what we are doing in the Scottish Government's NHS Scotland efficiency and productivity programme. The recommendations are appropriate and complement our thinking. We fully accept the challenge to implement meaningfully the recommendations within the shortest possible timescale.

This is the first report of its kind. We have some minor observations to make on the methodology, which we can make later to Audit Scotland, and we can use those to inform future work along these lines. I look forward to the publication of future reports like this one.

Finally, although we acknowledge that the report points us to some productive and quality opportunities, I am glad that it highlights many of the positive developments that have taken place, not least the significant reduction in waiting times and the many improvements in quality that have been made over the past few years.

The Convener: Thank you. Can you perhaps tell us exactly the remit of the director of health delivery?

John Connaghan: There are six main areas. The principal one is performance management of the NHS and, in that respect, providing assurance to ministers that all key Government health targets are being delivered. Another area is oversight of the health improvement, efficiency, access and

treatment—HEAT—targets system, which is where we set targets for the NHS. Another one is efficiency and productivity: we co-ordinate the national efficiency and productivity programme. Through the improvement support team, which is headed up by Stephen Gallagher, we also deal with the modernisation of the NHS, spreading best practice, introducing new techniques and encouraging innovation. Last but not least, a big area of our work for the past five years has been co-ordinating efforts on the reduction in waiting times.

George Foulkes (Lothians) (Lab): Can Mr Connaghan explain how his responsibilities link in with those of the chief medical officer?

John Connaghan: We are part of the health management board. The chief medical officer provides advice to the board, and to me today, on any clinical or medical aspects. Harry Burns can perhaps say a word or two more about that.

Dr Harry Burns (Chief Medical Officer for Scotland): I am here to answer the clinical questions—why one prosthesis is chosen over another and so on. I try to keep myself to clinical matters; management matters rest more properly with John Connaghan.

George Foulkes: Are you ever conscious of the fact that the administration of the health service in Scotland may be just a little top heavy?

John Connaghan: The issue is under constant evaluation by boards. Each board has its own savings programme. This year boards are targeting in the order of £275 million of savings.

George Foulkes: I meant centrally—at Scotland level, rather than at board level.

John Connaghan: That issue is also under review. There is a shaping-up review across the Scottish Government. For the past year and a half, all posts have been under scrutiny. Replacements are very carefully considered, and central Government has its own savings programme.

The Convener: No doubt we will return to the matter at another time. I want to respond to the comments that Dr Burns and John Connaghan have just made, specifically in relation to orthopaedic services. Dr Burns, what input do you have to discussions? Later, my colleagues will ask about purchasing of implants and so on, and about issues relating to investment and outputs. What comments are you invited to make from a medical perspective about whether orthopaedic services are working efficiently and effectively—whether they are using the right implants and so on? Do you have a role in that process?

Dr Burns: I meet regularly the Scottish Committee for Orthopaedics and Trauma, which has an opportunity to raise with me any clinical concerns that it has. I transmit those concerns to Kevin Woods, the chief executive of the health service, and to colleagues and to ministers, where appropriate. Similarly, it is my role to go back to clinical groups such as SCOT to explain to them Government policy in a variety of areas. I act as a conduit and interpreter of clinical advice. We are all aware of the fact that, when you get 10 senior doctors in a room, you may end up with 11 different opinions on various issues. Part of my role is to interpret the evidence that I get in the light of my clinical experience and to distil out the important issues.

The Convener: Are you classified as a civil servant?

Dr Burns: Yes.

The Convener: Are you bound by the same rules in relation to involvement in political issues and so on?

Dr Burns: Absolutely.

The Convener: Although you are a medical professional, you are nevertheless a civil servant.

Dr Burns: Yes. My colleagues will correct me if I am wrong but, by custom and practice, chief medical officers are allowed to comment publicly on issues of concern to public health. At times, they are allowed rather more latitude than conventional civil servants on such matters of public interest. For example, the previous chief medical officer in England made comments about pricing of alcohol and tobacco control that, at times, drew adverse political comment from ministers, although it would be too strong to say that there was a falling out. It is chief medical officers' role to push the boundaries in the interests of public health.

The Convener: Nevertheless, everything that you say is said within the context of the civil service rules.

Dr Burns: If I am to be effective, I must be able to challenge Government policy in a sensible way. My main concern is to work with ministers to make change. It is only prudent for me to do so.

The Convener: I do not know whether what I am leading on to is so much a medical issue or an issue for Mr Connaghan. What we come across consistently—we have seen it here, in orthopaedic services—is that there is often a problem with data collection and the comparing of information that is brought in from different health boards. Indeed, we sometimes find that the information is either not recorded or is not accurate.

For example, we have just received a letter from you about a comment that was made by Grampian NHS Board, which claimed that a significant number of schoolchildren were being brought in

suffering from the effects of alcohol. Your letter says that that is not the case and that the health board was wrong, but senior people from the health board can say on the record, in public, that that is a worrying and alarming issue. That suggests to me that the collection of data in the health service leaves a lot to be desired. From a medical practitioner's perspective, surely you cannot make informed comment when you are being fed rubbish by the people who collect the data.

Dr Burns: In some circumstances, it is perhaps not the data collection that is the problem so much as the interpretation of the data. In that particular instance, the question that was asked of the data system was about how many children were brought in with the word "drunk" on the data collection form. Some of the children—in fact, the majority—had drunk things that did not contain alcohol. It is a question of the insight that was used to interrogate the data systems.

The Convener: Forgive me, but this applies not just to orthopaedics, but to everything else. You have information coming in and intelligent, well-educated and—I know that this is George Foulkes's hobby-horse—very well-paid people analysing it, but they do not have the ability to interrogate the information to distinguish between young children who have drunk whatever liquid and young children who have drunk alcohol; therefore, they come and tell us that all the children were suffering from the effects of alcohol. If the people who give you the information are not able to interpret it, how can we know—for example, in talking about productivity in orthopaedics—that anything that we are hearing is actually true?

Dr Burns: If I had been trying to find the number of children under the age of 15 who had been admitted to hospital as a result of drinking alcohol, I would not have asked the question: the people from whom I would have sought that advice would have asked the question appropriately.

In Scotland, we have an information system, particularly around acute events, that has been in place for the past 30 years. It is significantly better than most information systems in Europe and allows us to link events in the acute sector, in particular, that are not linkable in England. Over the past few years, we have used the community health index to begin to link all sorts of other events that are not associated with acute admissions, such as X-rays, prescriptions in pharmacy and so on. One of the reasons why Scotland is of such interest to the pharmaceutical industry, for example, when it is carrying out clinical trials of new drugs is the fact that our information systems are better than most information systems anywhere else in the world. The question is about how the information system is interrogated. That requires a level of skill, and we have very skilled people in the Information Services Division Scotland who do that. However, it is not perfect.

It is relevant to the report that, over the past 10 years, during which trends and so on have been evaluated, definitional issues have changed. Often, it is necessary to use the definitions and systems that were in place 10 years ago to get comparable data over the decade because we have moved on and are using better, more specific information systems now. It is a changing area. However, I want to leave the committee in no doubt that the Scottish information systems are in the top 10 in the world.

The Convener: Mr Connaghan, how good is the collection of information in orthopaedics? Are you satisfied that you have all the relevant information and that it is accurate?

10:15

John Connaghan: Let us examine the information that we have on efficiency and productivity. Over the past few years, we have developed a number of benchmark indicators; there are now more than 80 that we can look at. Not all of them were examined in the Audit Scotland report, but a fair few were. Some of them are really quite important to us and are in common use throughout Scotland for comparing productivity. I will mention a few. Average length of stay, day-case rates, occupancy, new-to-return ratios and theatre utilisation are all in common use within boards and among boards in comparing performance.

On developing that work—we can perhaps talk about this later—the Information Services Division of the NHS in Scotland and the Scottish Government are embarking on a revision to the Government's health information strategy between now and the end of the year to cover the five-year period 2011 to 2016, which will refresh the strategy for our information systems. However, I am pretty satisfied with where we are right now.

The Convener: So, the information that is collected by every health board in Scotland is completely comparable and there are no discrepancies. The boards all include out-patient and community activity and all the information is recorded in the same way.

John Connaghan: You have raised an issue of different definitions. Although we have good information systems, we also need to be careful about changes in clinical practice, as Dr Burns said. That is why ISD Scotland has a system whereby it constantly revises the definitions that

are attached to some of the activity. You asked whether all the information that is gathered throughout Scotland is directly comparable. That is clearly not the case, because boards do different things. Teaching boards have specialist services, there are island boards, some boards have single-site orthopaedics and others have two sites for orthopaedics. I would like to give you the impression that, although we can have some broad surveillance of activity and the efficiency and productivity indicators throughout Scotland, we need to be careful about the interpretation and to look behind the statistics, as Dr Burns said. However, that is not to say that the statistics that we have are of no use.

The Convener: We are not able to make that direct comparison, however. It is necessary to be an expert and to understand all the differences to get behind the figures. In a small country such as Scotland, why cannot we collect figures that make comparison easy?

John Connaghan: We do, and we set national indicators for them. We have a range of efficiency and productivity indicators in our HEAT targets, and boards have been working to those. I have already mentioned some of them, such as average length of stay, day-case rates—

The Convener: You have mentioned some of them, but you are still indicating that there is a range of things in which the statistics are not directly comparable. You told us that we have to be careful.

John Connaghan: Indeed.

The Convener: So why, in a small country such as Scotland, cannot we just sort it out and get statistics that we know are comparable so that we can show that there is consistency? Why do we need to be experts to be able to understand the figures?

John Connaghan: I have already explained that, in addition to ISD Scotland's continuing work on statistics and their definitions, we are engaging with it on a relatively wide exercise between now and the end of the year to take a look at the forward five-year strategy. Things change. The pattern and configuration of services change, and so does clinical practice as clinicians move into new techniques. It is important that we keep abreast of that and that our information systems are capable of gathering those changes.

Dr Burns: I will give a personal example of a problem in information collection that I was involved with some years ago. It is part of the continuing refinement in increasing accuracy—it is a dynamic situation.

I used to work in the kidney transplant team in the Western infirmary. None of the surgeons who did transplants was ever credited with any of them, because the patients were admitted to a renal unit that was supervised by a physician. They came to us to have the kidney transplant, then went back to the renal unit, so all the coding showed that the physician did all the surgery, and none of the surgeons ever got credited for the time that they spent doing renal transplants. When we realised that that was happening, we changed it. Where a patient goes into ward A for a particular treatment, the coder might put down the consultant in charge of that ward, rather than the surgeon, as the person who did the surgery. There will be examples of that all along. Without a bit of local knowledge and activity, we do not get such kinks ironed out. That is why we are always conscious that we have to investigate things a wee bit further to ensure that there is not some structural reason for a difference. The situation is dynamic; things improve all the time.

The Convener: I am sure that things are improving all the time, but the problem is that, in relation to the NHS, this committee consistently hears from Audit Scotland that there are problems with data collection and problems of consistency, which makes it difficult for ministers to make the right decision and difficult for us and the committee to exercise scrutiny—indeed, it makes it difficult for Audit Scotland to say whether public money is being well used. For example, our briefing states:

> "Audit Scotland were unable to make a clear judgement on levels of productivity in orthopaedic services due to: widespread concerns about cost data; inaccuracies in staffing data; limited measures of quality; and the impact of other factors".

Things might be improving, but why is Audit Scotland not able to make a clear judgment because of the data problems?

John Connaghan: I said earlier that this was the first study of its kind. Audit Scotland worked with us to take a look at the data during production of the report, which in itself is quite interesting. Since we got the report, we have had the luxury of a little time to digest the information in it and to work with the NHS boards, particularly looking at the long-term productivity trends that NHS Scotland identified. Perhaps we will come to this later, but when we get beneath the surface of that it is interesting to see what emerges in terms of productivity comparisons of how we have been doing in orthopaedics over the past 10 years. We have done quite a bit of work with boards since the report was published. I need to link that to the fact that the ISD and the Scottish Government are embarking on another five-year refresh of our information strategy.

Dr Burns: I agree with you, convener, about the outcome data. I have been banging on about

outcomes for 20 years—it started out with cancer and so on. Orthopaedics is particularly interesting because the outcome that we want is fit people who are walking around pain free, in control of their lives and independent. That is a particularly hard outcome to get a clear definition of and because those people are not in the system, it is very hard to collect those data. However, I think that we should pursue that. We should try to get some sort of system that measures wellbeing in the community. However, no one can do it, apart from some very highly defined and very expensive American health insurance systems—there are some niche markets in the United States. You are right, convener, but if we want comparisons between the effectiveness of different hip prostheses and so on, we need 10 or 15-year follow-ups.

The Convener: I do not dispute what you are saying, Dr Burns, but that does not disguise the fact that, on other aspects that are easier to measure, such as cost data, there are significant concerns that have not been sorted out. There are inaccuracies in staffing data, which have nothing to do with measuring wellbeing. If we do not know the facts about staff, I do not see how we can properly manage. However, I do not want to hog the whole of the questioning. Does anyone else want to come in on this section before I move on to variation in activity?

George Foulkes: We are on national data collection—is that right?

The Convener: Yes.

George Foulkes: I will follow up on what the convener was asking. Under national data collection, you start off by saying that

"NHS Scotland has robust data on clinical services."

Dr Burns says that the information system is one of the 10 best in the world, which is a bold claim.

Dr Burns: It is maybe even the best.

Mr McAveety: That is even bolder. [*Laughter*.]

Dr Burns: I do not hang back.

George Foulkes: The Auditor General's report states on paragraph 36:

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

Why is that the case if you have such a robust, top-class system?

John Connaghan: That point has been the subject of reports from the Auditor General, and we have now taken steps to capture that information. It is necessary to differentiate between activity and cost. Each board knows exactly what it spends with each supplier, particularly in the private sector. That information is captured as part of its general ledger, so we can have a very accurate picture year on year of costs and what we spend. However, I fully accept that in previous years the recording to split out the activity that had been undertaken either in whole or in part by the private sector was not, perhaps, up to the mark. For example, all the activity may have been recorded under the health board name rather than part of it being recorded under a private sector name. However, we have taken steps to address that since 2007-08, and we now think that our data for the latest year are much more robust, with actual numbers on activity.

George Foulkes: But—

John Connaghan: Can I say one other thing on that? We do not want to ensure just that data come into us on a once-a-year basis, because that does not allow us to get a good management picture. Therefore, we have recently set up a quarterly management report to tell us about activity and cost, and we are in the process of considering writing to boards to say that, before they pay an invoice to the private sector, they need to have the record located. That will give us extra insurance in the issue.

I recognise that there has been a problem in the past, but we think that we have now taken sufficient steps to sort it out.

George Foulkes: What are the figures?

John Connaghan: Our estimate of activity is in the region of 2,500 discharges—that was contained in a recent note that I sent to the convener with the answer to a parliamentary question. Our estimate of spend in 2008-09 is in the region of £10 million, which is a little drop on the previous spend four or five years back when we allocated £15 million centrally and ring fenced it for use in the private sector.

The Convener: I was going to ask about this later on, but as you referred to that PQ we are as well doing it now. The letter that you sent referred to an answer to a PQ that was asked by Mary Scanlon. You mentioned a reduction in expenditure in the private health sector from £15 million to £10 million. However, activity seems almost to have doubled. Is that because the system is now more efficient, or are we talking about simpler procedures? We are spending £5 million less—a third less—but we have doubled the number of discharges.

John Connaghan: This answer goes back to my previous answer. We accepted the criticism that prior to 2007-08 our recording of the number that should be allocated against the private sector was not up to the mark. As I have explained, we have taken steps since then, particularly from 2009 onwards, to have a much more robust data collection system among boards for the ISD. The

increase in the discharge figures is simply a reflection of the better data collection system, which is more accurate. As I said, that system will be supplemented by quarterly reports linking activity to the payment of invoices.

The Convener: Thanks for that. We will move on to variation in activity.

10:30

Willie Coffey (Kilmarnock and Loudoun) (SNP): I want to follow on briefly from that discussion. Over many months, the Public Audit Committee has looked at various sections of the public sector and come up with similar comments, particularly about data collection and management. It appears that validating the data is a consistent issue. Often it is dangerous to present statistics as read, as though they are correct and accurate.

To illustrate the point, the convener gave the example of statistics on the drinking of noxious substances, which were interpreted to give the impression that the people concerned were drunk on alcohol. The data were probably technically accurate and correct, but their validation was not. In this case, the data that were collected appear to have been accurate in the first place, but it is pleasing to hear Mr Connaghan say that you are trying to eliminate validation issues.

I turn to the issue of variation in performance across Scotland. Mr Connaghan opened his remarks with a commitment to eliminate waste and variation, which naturally leads on to my questions. For the benefit of the committee and those listening, I will share with you and ask you to comment on four examples in the Auditor General's report. First, the percentage of arthroscopies of the knee that mainland boards carried out as same-day surgery ranged from a low of 75 per cent in Dumfries and Galloway to a high of 92 per cent in Forth valley. Secondly, the length of patient stay in hospital ranged from an average of five days in Glasgow to one of 15 days in the Western Isles. Thirdly, the number of orthopaedic in-patient and day cases dealt with by consultant teams ranged from about 450 in Dumfries and Galloway to about 739 in Forth valley. Last but not least, the emergency readmission rate varied from about 5 per cent in Borders to about 14 per in Greater Glasgow and Clyde.

It is the Public Audit Committee's role to ask what the variations mean—whether there is any clinical reason for them or whether they relate to the gathering of data and statistics. Can you explain the broad variations that I have described and their implications?

John Connaghan: I will start with the issue of day-case surgery. My colleague Stephen Gallagher will comment from his perspective.

Stephen Gallagher (Scottish Government Health Delivery Directorate): We accept that there is variation in the rate of same-day surgery across boards. There could be multiple reasons for that. It could be related to the availability of a day-case unit or to whether pre-operative assessment is routinely in place. There could be a technical reason: someone is listed as an in-patient, but the procedure is carried out as same-day surgery. Patients may have been admitted the day before surgery—an issue that must be linked to the availability of pre-operative assessment. There is a range of reasons for variation in the level of same-day surgery.

I guess that you are more interested in what we are doing about variation. We have done a number of things in relation to same-day surgery. First, we have set up a relationship with the British Association of Day Surgery and are using its directory, which sets out aspirational best practice—best practice in the UK and internationally—and suggests challenging aspirational targets for same-day surgery. We are working with the association and have set a performance target that is based on making progress against the directory. We have set a HEAT target that is due for delivery in March 2011 and are increasingly confident of the progress that boards are making towards that.

We have also established a delivery group to drive delivery of the target and of targets relating to admission before the date of surgery, because we believe that those are interrelated. The group is chaired by Jane Burns, who is a consultant anaesthetist with NHS Lanarkshire. Where we have noticed that there is variation in performance among boards, we have established a specific performance support team, much as we did for cancer a few years ago, when we had difficulty delivering the cancer target across Scotland. Over the past six months, the team has been working with Greater Glasgow and Clyde, Tayside and Lothian. We are pleased to report informally that there is good progress in those boards, which will eventually show in the validated management information that comes before the committee. We have an active strategy to address variation in same-day surgery.

Willie Coffey: What about the other examples that I cited? You said that the reasons for variation "could be" such and such. Do we know that those were the reasons for variation in the particular cases that have been mentioned?

Stephen Gallagher: Yes, but I am saying that the reasons will be different in different boards, depending on the physical infrastructure, such as

whether there is a dedicated day-surgery unit or an established pattern of pre-operative assessment. The work that we are doing in detail with the boards in performance support allows us to get to that level of detail about specific issues in specific boards, and we make recommendations for improvement based on those specific issues.

Willie Coffey: What about some of the other examples, such as the average number of days spent in hospital and the number of consultant team day cases? Clearly, those lead directly to additional costs.

John Connaghan: Earlier, you mentioned the NHS Forth Valley example. At the outset, I should say that we fully accept that variation exists in performance across Scotland. That is why we have established the procedures that we are discussing. Mr Gallagher outlined what we intend to do about that. There are efficiency savings to be made; we cannot pretend otherwise.

Earlier, I mentioned that, since the Audit Scotland report was published, we have had a chance to get behind some of the figures. With regard to the Forth valley example, it is interesting to note that Forth valley has nine consultants, but it also has a teaching element. It has another 11 career grades and trainees, making 20 doctors in total. The Audit Scotland analysis is carried out on consultants, which is quite right, as that is in itself a valuable indicator. However, looking beyond that, we also need to consider the output that is provided by junior doctors. Dumfries and Galloway does not have such a big teaching component—I think that it has four extra people in that regard. When you factor in the output from those junior doctors, who do a bit of work, the variation is not as marked. However, there is still variation, and we need to determine whether we can reduce that and effect a productivity improvement.

Willie Coffey: That tells me that the indicators are not the same across the board. If Forth valley has a training element that the others do not, that does not allow us to make correct comparisons, which might lead us to make inaccurate assessments of variations.

John Connaghan: It is fine to consider one indicator in isolation, but you should be careful about drawing absolute conclusions from that indicator. We tend to consider a range of indicators because we need to understand how the system is set up, what the contributions are of other members of staff and so on. We need to consider that, for example, one board has a series of one-stop out-patient clinics where a patient is seen by a number of professionals, whereas another does not have that sort of productive and efficient system. That is the sort of thing that leads to variation. It is crucial for us to be aware of the variation that exists, but we need to get behind it and tailor the response from each board in order to achieve a better way of working. That is part of what we do in the efficiency and productivity programme.

Willie Coffey: What explains the difference between the average length of hospital stay in Glasgow, where it is five days, and in the Western Isles, where it is 15? How can you possibly explain that?

John Connaghan: One aspect of life in the Western Isles is that, because there is only one hospital and people are scattered throughout the islands, people might not have the capability to simply step on the number 64 bus and get home.

We also have to look behind some of the Glasgow figures. I have not examined the statistic for Glasgow that you mention. Harry Burns, who has worked in Glasgow, might be able to say a bit more about it. However, quite often, boards split treatment between an acute phase, in which the acute problem is fixed, and a stay in a rehabilitation facility or whatever. Moving patients to a rehabilitation facility is probably why the figures for the average hospital stay in Glasgow are shorter—that might mask the real situation.

It might be more valuable in providing you with a direct answer to look at the length of stay by procedure rather than just by patient. The results of doing so are interesting. From what I recall of the average length of stay for a hip or a knee operation, although there is some variation across Scotland, it is not as big as the variation that is recorded in the report between the Western Isles and Glasgow for a general stay. Harry Burns might want to say a bit more about variation.

Dr Burns: I have nothing to add directly to what John Connaghan has said, beyond saying that I think that we are on the verge of future challenges in getting the length of stay down even further. Colleagues of mine recently visited an institute in Denmark where people get out of bed on the same day that they have had a total hip replacement and are walked up and down the stairs.

Some of the anaesthetists at the Golden Jubilee have been working on that process in tandem with the anaesthetists at the centre in Denmark for some years. They are applying not just to orthopaedics but to general surgery a number of techniques that manipulate the body's response to surgery in a way that allows patients to recover astonishingly quickly. Such work is still highly experimental, but it is not inconceivable that we might be moving towards, at best, an average stay of three days for such procedures in coming years. It is a changing field. Those centres that have active researchers who are involved with international networks and so on will be at the

forefront and so will tend to move a bit more quickly.

The Convener: I would like to question you a bit further on that. Correct me if I am wrong, but my understanding is that when someone has had a hip replacement, early mobility rehabilitation is critical to improvement.

Dr Burns: Yes—depending on their general state of fitness.

The Convener: Yes but, generally speaking, the more quickly a patient can be mobilised, the better. Conversely, the longer a patient is left without mobility rehabilitation, the less favourable that is for their long-term improvement.

Dr Burns: In general, yes.

The Convener: If someone breaks their hip on Christmas eve, which coincides with public holidays, and the operation is carried out on Christmas day, will the necessary rehabilitation services be provided to ensure that that person is encouraged to be mobile, or is someone who breaks their hip and has to have an operation during a holiday period taking their chances?

Dr Burns: No. As a point of principle, people should get the treatment that they need when they need it, regardless of external circumstances. I would be disappointed if that was not happening.

The Convener: I know for a fact that it does not happen, but we can converse about that separately.

In response to Willie Coffey, John Connaghan gave a broad description and then he said that a stay in a rehabilitation facility "might mask" the actual length of hospital stays. We are back to "might" again. Do you know for a fact whether such masking takes place? When you responded to Willie Coffey's questions, why could you not say with certainty what is happening?

John Connaghan: My colleague Stephen Gallagher has outlined that when we run into a difficulty in truly understanding variation in driving better board performance, we go to another level of support for boards. That involves the establishment of an expert team that takes apart that system, its statistics and working practices, and reassembles them. When we did that for cancer, we saw a remarkable improvement in cancer performance, and we are doing it now for quite a number of acute services and in orthopaedics. We get to the bottom of such issues.

There is another issue that I would like to raise in relation to the previous conversation. I have a bit more information to provide about rehabilitation, which I think is of interest to the committee. There was an issue with hip fracture to do with the speed of treatment that patients were getting. When we talk about speed of treatment, we look to have a hip fixed within 24 hours of the patient's admission to an appropriate unit.

You might be aware of the study that was published last week that compared performance in other parts of the United Kingdom. In Scotland, we recognised that there was an issue about four or five years ago and set a HEAT target. Now, 98 per cent of hip fracture operations take place within 24 hours of admission to an appropriate unit, which is the clinical target. That HEAT target was successfully delivered, but it was recognised as part of that that we need to follow up on rehabilitation. We established a national strategy for rehabilitation and funded it. We are nearly at the point of having recruited to a post in every health board a rehabilitation co-ordinator to monitor the quality of rehabilitation, the provision of the service and the delivery of the strategy. That is now in existence—the recruitment has nearly been done. As you say, rehabilitation is important.

10:45

The Convener: Is it not a sad reflection on the bureaucracy that is the NHS that the solution in local areas is yet another co-ordinator? Rather than get a manager who is well paid to manage the service, we need yet another bureaucrat to co-ordinate at a time when the number of front-line staff is being reduced. The whole thing becomes absurd.

John Connaghan: You assume that there is no clinical input.

The Convener: Sorry, but you did not say that it was a clinician; you said that it was a co-ordinator.

John Connaghan: I take that point, but I make the point that a co-ordinator works across agencies. It is not only the health service that is involved. The process is about ensuring that the patient has enough support when they leave and that community services, as well as acute hospital services, are co-ordinated effectively.

The Convener: We know for a fact that the number of nurses in the health service will be reduced, but you are saying that there will be more co-ordinators.

John Connaghan: In this case, we think that one co-ordinator for every health board is a wise investment.

Anne McLaughlin (Glasgow) (SNP): One of the significant issues in the report was the variation between health boards in the cost of surgical implants for hips and knees. You say in your letter that you have saved £1.2 million so far through the new contract. Will you clarify the period over which that saving has been made? Is the figure based on a like-for-like comparison? We

could save £1.2 million by buying fewer surgical implants, so is the figure an actual saving?

How do you establish value for money? During the previous evidence session on the issue, we talked about Orthopaedic Data Evaluation Panel ratings. I would like a little further explanation of how those ratings establish value. I believe that ODEP ratings apply only to hip replacements and not to knee replacements, but I think that Colin Howie said in that previous meeting that it would be a good idea for somebody at Government level to consider whether we could have ODEP ratings for knee implants. What are your thoughts on that? What would be the difficulties in doing that and why do we not already do it? Will you explain a little more about the ODEP ratings and how they establish value for money?

John Connaghan: I ask my colleague Colin Sinclair to address those questions directly and to say a little about our strategy on the issue, because you will want to know where we are going on it.

Colin Sinclair (NHS National Services Scotland): There was a huge variation in orthopaedic procurement across the service. Historically, each health board built up different local clinical practice for, principally, hips, knees and trauma. Until the first contract came in—the one that has saved £1.2 million—it was predominantly individual boards and in some cases individual hospitals that procured for their own use based on local clinical practice.

We have set up a strategy with three phases. The first phase, which involved the contract that expired at the end of last month, was about capturing all the expenditure in the health service around the three main areas of trauma, hips and knees. The first stage in any procurement exercise is understanding what is spent. By capturing all that, we managed to identify where there were trends. We negotiated a price reduction in principle with suppliers at a national level, which was based on benchmark price levels so that if boards bought a certain amount, they got a certain price.

Under the contract that delivered savings of £1.2 million, we did not ask boards to change very much in the way of local practice. Some did but, principally, boards could carry on doing the same thing. As we now had a national umbrella and pricing that was based on boards' commitment to the products that they bought, the £1.2 million savings were delivered. That was benchmarked against previous price and uptake information from suppliers, so that we could understand the usage, look at the price and calculate the benefit. I am confident that the £1.2 million savings have been delivered—we have validated that with the health boards involved.

NHS Greater Glasgow and Clyde decided to use a mechanism called a mini-competition, which is an integral part of the process when there is no joined-up view of what needs to be purchased, a disparate amount of product is being bought and there is a disparate supply market.

NHS Greater Glasgow and Clyde made the most of that opportunity: it took the board more than a year to co-ordinate and understand what its spend was and to define what the local clinical practice was going to be. That allowed it to go ahead with a clear view of what it wanted to purchase, undertake the mini-competition and make the deal that it did.

It has been put across previously that NHS Greater Glasgow and Clyde somehow stepped off the national framework, but it did not—it very much used that framework. Because it could sort its local clinical practice—in the area of trauma, for instance—it was able to go down to a single supplier and drive benefit. That is an on-going process for NHS Greater Glasgow and Clyde. The exercise also conditioned the supply market with regard to the fact that Scotland was now serious about orthopaedics, was pulling information together and was taking a more co-ordinated approach to examining it.

The second phase, which is the contract that started on 1 September this year, aims to collate that spend to provide detailed information to health boards. That information will allow boards to look at their local clinical practice by giving them good, solid data so that they can compare and contrast. The clinicians who work with the procurement people can then review practice and decide whether it is undertaken in the most appropriate way, whether it provides value for money and how it links in with the other issues of clinical effectiveness and patient outcomes.

It is safe to say that, as a result of being able to provide that information, all boards are now engaged at different levels in the process of examining their local clinical practice to see whether there is an opportunity to drive better deals. The contract is structured so that there are different purchasing layers—if a board buys more than 100, it gets one price, and if it buys more than 300, it gets another price. Each board can see very clearly which price it will pay.

We expect that there will be savings of around £800,000 a year—simply on pricing—once that contract is fully implemented. The Glasgow mini-competition and the co-ordination of NHS National Procurement has driven suppliers to make price reductions, and we reckon that another £1.2 million can be saved by driving further reductions in local clinical practice and moving towards greater standardisation. That process is already happening.

Anne McLaughlin: I was going to ask you about the NHS Greater Glasgow and Clyde mini-competition. I thought that NHS Lothian was opting out of the national framework. Does that have a negative impact on the NHS National Procurement contract?

Colin Sinclair: No, the Glasgow decision was very much allowed for. We were to some degree hoping for it, under the conditions of the first framework—the contract allowed people to go down that route if they felt that they could drive value, which is what NHS Greater Glasgow and Clyde did. It took a while for the board to pull that together, but it managed to do so about three or four months ago.

NHS Lothian has never withdrawn from the national contract nor set up a mini-competition; it is involved in the national contract. I am not sure why it has been suggested otherwise.

Anne McLaughlin: What about the issue of an ODEP rating for knees in addition to the ODEP rating for hips?

Colin Sinclair: I will probably have to refer that issue to Dr Burns.

When we procure, we have what is called a commodity advisory panel, which is a group of experts in the particular commodity that we are buying. It meets the procurement people and they agree what needs to be bought and what criteria need to be used, such as price and quality, and factors such as the ODEP rating might well be taken into account at that stage. There is a process that defines the minimum quality standards along with a range of other criteria that have to be met before the supplier can be accepted.

Anne McLaughlin: John Connaghan said in his letter, and you have also said, that the national procurement contract had to be phased in—you referred to phases 1, 2 and 3—because

"procurement in orthopaedics is complex, due to the diversity of the suppliers, the wide range of products and the difference in clinical preferences."

With particular emphasis on clinical preference, how will the NHS address those issues?

John Connaghan: I will turn to Dr Burns on clinical preference.

On changing prostheses, we must also have an eye on clinical safety, particularly as changing prostheses means that we have to change other things around them, such as the instruments, and training will need to be given if it is a particularly different type of prosthesis. We also need to take into account patient safety when clinicians move from one practice to another—if they are to use a different joint, for example. Dr Burns is much more of an expert on the issue than I am.

Dr Burns: Clinical preference is really interesting and there is an issue to explored. Part of the problem is that different prostheses are likely to wear out at different rates. For example, metal on plastic wears out faster than metal on metal, but metal on metal might have some complications associated with it. It takes 10 to 15 years of use to work out those different factors. In the process, clinicians will be influenced by papers that are published. Sometimes, papers are published without declarations of interest—they may be funded by the manufacturers and so on, and they could well cloud clinical preference inappropriately. It is not as straightforward as comparing drug A with drug B, with hard, randomised control trials taking place within a definable timescale. There will always be debates between clinicians about a certain prosthesis being safer in certain circumstances and so on.

In the Glasgow negotiation, the clinical director debated with his colleagues, telling them, "Right, we are going to have three here. Which are they to be, guys?" Hard, clinical management was therefore at work there. That lesson can and should be learned elsewhere. It is certainly one that Stephen Gallagher's team is looking at. It is largely about shared learning: they did this in Glasgow, so why can it not be done elsewhere?

The other point about the variation in the number of prostheses is that there is an after-sales service issue. It is not just a matter of saying that we will all jump with that one manufacturer and that will be it. A hospital may not carry in its inventory very small sizes, so if it has a very small person who needs a particular prosthesis, that has to be ordered separately.

There are supply-chain issues. I understand that some parts of England ran out of certain prostheses when air freight was disrupted by the volcano. The implication is that, if prostheses run out, it might be prudent to deal with two or three different manufacturers so that at least we have something that we can fall back on. We have learnt a lot from the Glasgow exercise.

The Convener: We will have questions from Murdo Fraser, Bill Kidd and then George Foulkes.

George Foulkes: I wanted to come back in on an issue that was raised earlier, which is why I was trying to get in before Anne McLaughlin.

The Convener: Murdo Fraser wants to raise an issue that arises from something that has been said, so I will bring him in.

Murdo Fraser (Mid Scotland and Fife) (Con): Thank you. I will follow up on a point that Mr Sinclair made about the national procurement

contract and the position of NHS Lothian. I was checking the evidence that we took on 9 June from Colin Howie, who is the chair of the Scottish Committee for Orthopaedics and Trauma. I will quote what he said in the *Official Report* when we asked him about the national procurement contract—I believe that he is associated with NHS Lothian. He said:

"The national procurement contract that we went on to four years ago actually increased our costs by 10 per cent, because of how it was set up. We are stepping out of the national procurement contract now and we are going to a separate contract, as we can get a better price independently."—[*Official Report, Public Audit Committee,* 9 June 2010; c 1754.]

That seems to contradict what you have just told us.

11:00

Colin Sinclair: I was aware of that. In principle, where I believe we are would contradict what Mr Howie said. Similar to NHS Greater Glasgow and Clyde, NHS Lothian, at some point earlier this year, thought about going down the mini-competition route, but did not think that it would be able to go quickly enough through the necessary discussions that Dr Burns has outlined. There are savings validated with NHS Lothian from the contract that started in 2008; however, I do not think that there was a national contract arrangement in place through NHS National Procurement prior to 2008. There might have been other local arrangements, but there was no national arrangement before February 2008. When I consulted procurement colleagues in NHS Lothian, they did not understand either that point about NHS Lothian withdrawing and believing that it could get better local pricing.

There is perhaps some misunderstanding about the way in which the contract is structured. The previous contract allowed boards to buy what they required; it did not demand that they make changes. It was also a banded structure whereby, if they bought a certain amount, they got a certain price, and there is still price variation across NHS Scotland. I am not sure whether that has led to misunderstanding about how the procurement process has worked.

My procurement colleagues who deal with orthopaedics specifically are attending SCOT and are engaging with local consultants, partly to understand where that point of view came from and to ensure that the correct position is known.

Murdo Fraser: Thank you for that. It would be helpful for us to have some clarity on the matter. When the committee is trying to understand the position, it is not helpful to have witnesses coming here and giving widely disparate views on it. It seemed to be Mr Howie's belief that NHS Lothian's costs went up as a result of national procurement. If you are able to provide further clarity to the committee on that, that would be extremely helpful.

Colin Sinclair: I will do that.

The Convener: George, do you want to follow up on something that has been said?

George Foulkes: I did not quite understand the reply to the convener's question about the co-ordinators who will be appointed for each board area. What will their role be?

John Connaghan: An example is an allied health professional consultant-level appointment who works with the Scottish Commission for the Regulation of Care. Their particular role is to support staff in care homes for older people in implementing a systematic, person-centred approach to falls prevention, and in implementing management that is based on best practice and the current evidence base. Other co-ordinators will develop a resource to support the provision of prevention training for—

George Foulkes: Is that specifically for orthopaedics?

John Connaghan: It is specifically for musculoskeletal rehabilitation, which Dr Burns will confirm is mainly in the area of orthopaedics.

George Foulkes: There will be one co-ordinator for each health board. Are they new appointments?

John Connaghan: They are new appointments. There may already have been a similar function of sorts within each health board. I do not have the detail behind each of the health board appointments with me today, but I can give you some further advice on that.

George Foulkes: What sort of salary level are the appointments going to be at?

John Connaghan: I do not have that detail with me.

The Convener: Perhaps you could write to us with the detail about how many appointments there will be, where they will be located and what their salary level will be.

John Connaghan: I will, indeed.

George Foulkes: I am just a bit concerned that your solution to the problem of variation is to appoint, as the convener said, bureaucrats to deal with it.

Dr Burns: Can I—

George Foulkes: I am going to ask you a question, Dr Burns. We are not talking about rocket science in most orthopaedic procedures.

We know that they are best delivered by having good, well-resourced and well-supported front-line health teams of doctors, nurses and health support workers—that is nothing new.

Apparently we are going to appoint 50 new co-ordinators. At its last meeting with Lothian region MSPs, NHS Lothian said that it is going to reduce the number of nurses in Lothian by 333. How are those co-ordinators going to improve the service for people who need orthopaedic treatment and rehabilitation?

Dr Burns: I would be surprised if the work of those individuals was not carried out by physiotherapists and nurses who are already in the system. For a number of years, we have been working hard on falls prevention. Health boards hold a considerable body of knowledge about how, using a number of techniques, to stop old people falling and breaking their hips, so that will be achieved through focusing on existing staff. The co-ordinators will not be bureaucrats and probably will not be new appointments.

George Foulkes: There is a disjunction between what you are all saying today and what is actually happening on the ground. At our meeting, NHS Lothian said that Lothian alone is going to lose 333 nurses: that is just nurses. It is going to have to cut back on all sorts of other staff as well. How is it going to be able to deliver services in orthopaedics, rehabilitation and other areas with fewer people on the front line?

John Connaghan: The committee needs to understand that from Dr Burns's account of why this is important. I might come back to the wider issue of other staff in a minute. Some studies have been published about older people and their risk of falls. It is the primary cause of hip fracture. If the work of the co-ordinators on falls prevention in hospitals, care homes and elsewhere reduces that risk, there will be a benefit to the NHS downstream in terms of the amount of resource it uses.

Bill Kidd (Glasgow) (SNP): From what has been said, I am a wee touch unsure about how hands-on or hands-off NHS National Procurement is in setting parameters for the health boards to make savings and ensure best service delivery. I wonder about the fact that the most populous health board area is undertaking a mini-tender because it seems to think that it can get a better deal, and that Lothian, which is probably the second most populous health board area, might also do that. Does that put the national procurement programme at a disadvantage in making the best possible deals to purchase equipment and knee and hip replacement therapies?

Colin Sinclair: I do not believe so, in that case. When we started in 2007-08, the problem was that each health board had its own local clinical practice and purchased its own hips and knees, depending on its policies, what its clinicians needed and so on. The phase 1 option of drawing all that together immediately drove a benefit in the region of £1.2 million.

The mini-competition is not used a lot in procurement, but if it is felt that a department can get together quickly and understand what and how much it wants to buy, it can make a separate arrangement that allows it to move forward more quickly than the rest of the organisation, but it works within the realm of a national framework that has been set up. Because NHS Greater Glasgow and Clyde sorted its local clinical practice, it was able to do that, although it still works under the framework of the overall national contract. The Glasgow initiative co-ordinated with, and received support from, NHS National Procurement; it did not do anything separately. We believe that that case started to tee up the supply market because it understood that health boards in Scotland had co-ordinated their approaches and were going to co-ordinate them much more in the future, and that helped to drive better pricing for phase 2.

In effect, when the phase 2 pricing came in, we could clearly see that it had been influenced by the moves that had been made through the Glasgow mini-competition. Because of the way that the phase 2 contract is now set up—it is in this banded structure—we believe that no health board should now need to go down that mini-competition route. It is available to them if they choose to do so but, given the way that the contract is structured, we do not believe that that is required. We have heard nothing from Lothian to suggest that it is going to go down that route, because the way that the contract is structured means that it can drive maximum benefit without having to do a mini-competition. That is an example of where a mini-competition has added to the process, rather than taken away from it. Mini-competitions happen, but they are not a frequently used process in the procurement system.

Bill Kidd: Is national procurement being rolled out across all the other health sectors in Scotland?

Colin Sinclair: Very much so. The figure moves around, but there are roughly 182 national contracts in place, which cover about £700 million of NHS Scotland spend. There are other national frameworks in different areas, which takes the overall spend, under a national overview, up to about £1 billion. The strategy is very much about how we roll that out further, particularly given the current financial climate, to leverage more benefit from suppliers when we are buying the same or similar products and services across the whole service. The national procurement agenda, which

was underwritten by the McClelland report, is very much the direction that we need to take, given the financial climate that we are in.

Nicol Stephen (Aberdeen South) (LD): We were given a very different picture at the previous evidence session. You heard from Murdo Fraser about some of the things that were said to us on the record. There is clearly a culture in some of the health boards whereby they like to keep open the opportunity of going for a mini-tender or something outside the national procurement process. Are they permitted to do so?

Colin Sinclair: The expectation is that health boards will engage fully in national contracts. If they have a specific local need where the national contract cannot provide that cover, they can make local arrangements. There are occasions when they feel that they can get a better price through a local arrangement than through a national arrangement.

Nicol Stephen: I am just trying to press you as to how and when Glasgow, Lothian or whoever can step away from the national arrangements. Are you saying that that is now no longer permitted, or would it be permitted only in exceptional or local circumstances?

Colin Sinclair: Nothing has been absolutely laid down that says that health boards must use national contracts. There is a general push in support, through the chief executives group, to which I report on occasion, of national contracts being used. Given the nature of the health service and how it has come to the position that it is in, with a lot of local activity and authority, there are still occasions when boards will buy things outwith a national contract. However, in principle, all health boards work to national contracts. We have very good implementation and take-up rates of national contracts.

Nicol Stephen: I presume that the health minister, who is ultimately responsible for all the health boards, could detail these requirements and could set a requirement that would prevent the hiving off of individual health boards and the sort of confusion that we saw just a few months ago when we took evidence previously.

Colin Sinclair: Yes. That would clearly be within the minister's power. From a procurement point of view, I would say "yes", but I want the health boards to work with NHS National Procurement because we deliver service and value and savings, not because they are forced to do so. I very much want it to be a partnership arrangement whereby we understand the boards' requirements, the boards see the benefit that we can deliver and jointly we drive forward value. The orthopaedic contracting process is a very good example. It is coming across a wee bit as though mini-competition is a problem: it is not actually a problem—it is a legitimate tool in the procurement armoury to try to drive value and it is being used.

I take the point that was made earlier about clarifying where Mr Howie's perception came from and ensuring that it is reconciled, but in principle the process has been a good example because it has all been about collaborating on spend and then trying to drive out variation and maximise leverage while still taking account of patient and clinical requirements.

11:15

Anne McLaughlin: I have two quick questions, but first I should say that I am sure that, when Colin Howie was here last time, he was representing an orthopaedic association and was not speaking on behalf of NHS Lothian.

The first of my two questions is for Dr Burns. How significant is the ODEP rating in assessing value for money? I know that you talked about all the other things that we need to look at. If it is significant, is there a reason why it cannot apply to replacement knees as well?

Dr Burns: My understanding is that one of the main drivers of the ODEP rating is the expected length of life of the prosthesis. There are possibly other issues with knees, which are a different kind of joint because they are ball-and-socket on one side and much more surface-to-surface on the other. There are more technical issues involved in the failure of knee joints such as different stresses and so on.

That is a roundabout way of saying that I do not know, but I suspect that it would be more complicated to apply an ODEP-type rating to knees. However, there is no reason why we should not pursue the matter and suggest to the medical devices agencies and so on that they should be looking at something like that. The difficulty is that, in general, we need to wait a long time to evaluate the long-term cost effectiveness of prostheses.

Anne McLaughlin: When you say that

"there is no reason why we should not pursue"

it, does that mean that you will pursue it?

Dr Burns: I will certainly ask the question.

Anne McLaughlin: Excellent.

Dr Burns: I will do it today.

Anne McLaughlin: I do not know who my other question should be directed to. I think that it was Dr Burns who said that NHS Greater Glasgow and Clyde had a proper clinical debate about the use of surgical implants. That sounds extremely sensible to me. You have to include clinicians in

such discussions because there are all sorts of reasons why the cheapest is not necessarily the best. Can you or anyone else do anything to encourage or compel other health boards to do the same thing?

Dr Burns: I believe so.

John Connaghan: Colin Sinclair outlined the fact that there are three phases to the strategy. We have had phase 1, which realised some savings. We are just about to embark on phase 2, which is, by and large, the clinical debate that you describe. It will take into account in the round the efficacy of the use of particular implants. That is scheduled to happen for the next couple of years as part of phase 2. I ask Colin Sinclair to say a little about the long-term plan after that, or phase 3.

Colin Sinclair: Phase 3 is to drive more standardisation when each health board has been through the process that was described for Glasgow. I have a list of five health boards in which procurement staff are engaging with clinicians in exactly that kind of debate. I know that they have already started the discussion on whether we should have two knee manufacturers and two for hips and are actively engaging in that. If we can standardise things more in phase 3, we can go back to the market again in two years—that is our first option, but we can extend it if we want to—with much reduced variation and try again to drive better pricing.

There is an issue about not driving to only one manufacturer, because of commercial and availability issues. We need to keep a fluid supplier market and also to allow innovation. Phase 3, then, will use the pricing data but also the quality and clinical data on hips and knees to see whether we can help the whole productivity process from start to finish. That will tie in with the work that Stephen Gallagher's team is doing on productivity and will help to address the situation. An uncemented hip might be more expensive, but if it reduces theatre time it will be a more cost-effective solution overall. In discussing that, we get into a much more sophisticated debate about the total cost of the operation from end to end.

The Convener: Anne, do you want to ask anything about the purchasing of surgical implants that has not already been asked?

Anne McLaughlin: I do not think so.

The Convener: As there are no further questions, I thank our panel for their attendance. This has been a fairly lively session. We look forward to receiving further information from Mr Sinclair about NHS Lothian, from Mr Connaghan about the co-ordinators and from Harry Burns about Anne McLaughlin's questions.

I recognise that, as Dr Burns and Mr Connaghan said, we are making progress and things are getting better. However, where there are inefficiencies and inconsistencies, we need to address them.

"Using locum doctors in hospitals"

The Convener: I invite the Auditor General to brief us on the report, "Using locum doctors in hospitals".

Mr Robert Black (Auditor General for Scotland): I will introduce the report briefly, as I am conscious of the pressures on your time this morning. As ever, I will rely heavily on the Audit Scotland team to answer any questions that you might have.

This report on locum doctors was published on 17 June, just before the parliamentary recess. We undertook the work because, clearly, locum doctors have an important role to play in ensuring that hospitals are adequately staffed and can provide patient care around the clock.

I will highlight three sets of issues in the report. First, the spend on locum doctors and opportunities to get some efficiency savings out of that spend; secondly, managing the demand for locums; and, thirdly, the important issue of ensuring patient safety.

Over the past decade, expenditure on locum doctors has more than doubled in real terms. It rose from around £17 million in 1996-97 to at least £47 million in 2008-09. Around three fifths of the spend was on agency locums, and the balance was spent on internal locums who were employees of the NHS.

Exhibit 1, on page 6 of the report, shows that six boards reduced their expenditure while seven others, plus the Golden Jubilee hospital, increased their spend. NHS Highland is not included because it could provide expenditure data for 2008-09 only.

In 2004, NHS National Procurement set up a national contract for agency locums. In 2006, the Scottish Executive instructed health boards to use only the agencies that are included in that contract. However, relative spend on non-contract agencies has not gone down; in fact, it has increased marginally over the past three years, from 31 per cent to 33 per cent.

The national contract lapsed in May 2009 and was not replaced until June 2010, which led to the boards negotiating their own hourly rates with agencies, with some boards paying higher rates than they had been paying during the contract period.

The team thinks that the health service could save around £6 million a year if it used locum doctors more efficiently.

Exhibit 2, on page 7, shows a wide variation in spend on locums as a percentage of total spend on medical staffing. The percentage ranges from 2.4 per cent in NHS Greater Glasgow and Clyde to 11.4 per cent in Orkney, with NHS Dumfries and Galloway being the highest mainland board, with a percentage spend of 11.2 per cent. NHS Western Isles is an extreme outlier at 36 per cent, which reflects the difficulties in recruiting permanent staff to that island board.

We recognise that some boards will find it difficult to reduce spend without more significant changes in the way in which health services are delivered, but we think that all boards should be able to make some savings by improving their procurement procedures and by making improvements to their workforce planning.

The second set of issues is on managing demand. Demand for locum doctors in hospitals has increased in the past three years. Seven boards were able to provide us with information and we found from those data that the number of requests for locum doctors almost doubled between 2006-07 and 2008-09. It is impossible to quantify fully the levels of demand, as not all boards hold or can access easily information on requests for agency and internal locums. However, we know that there are wider workforce issues affecting the demand for locums, which include difficulties in filling vacancies, the full implementation of the 48-hour week under the European working time directive and changes to junior doctors' training. At the same time as those pressures were arising, the agencies were finding it more difficult to meet the requests for locums. Their ability to meet requests fell from 83 per cent in 2006-07 to 71 per cent in 2008-09.

The final set of issues relates to patient safety, which clearly remains paramount. The team examined how that is safeguarded by health boards when employing locum doctors. We must recognise that locum doctors help NHS boards to maintain appropriate staffing levels so, in that way, they contribute significantly to safe and appropriate care for patients. We should bear that in mind when we take account of the potential risks to patient safety, particularly where locums are unfamiliar with the department or hospital in which they are hired to work.

Exhibit 15 on page 24 highlights the three key stages at which risks occur. The first is appointment, the second is induction and supervision and the final one is performance management. All health boards have a checklist that sets out the documents that they should receive when employing locum doctors, but only half the boards formally set out who is responsible for each element of the appointment process in their locum procurement policy. That means that there is a risk that not all checks will be completed properly. For example, that could happen if the arrangements for hiring a locum doctor are made out of hours when the staff who are normally responsible for those checks are not available.

Few health boards have corporate induction and supervision policies relating to locum doctors, and performance management arrangements for locums are not well developed. Most of the feedback tends to be informal, which means that there are no formal mechanisms for sharing information about the performance of individual locum doctors among health boards.

That is a brief outline of the report. As ever, there is a lot more in the report than I have been able to cover, but the team will be happy to answer questions.

The Convener: Thank you for that. You have identified that the demand for locums has increased since 2006-07, but the ability of agencies to meet the requests has fallen. Has that affected the price that agencies charge? In other words, if there is a scarce resource, can agencies push up the fees? Does it cost the health service more because the demand cannot be met?

Mr Black: There is some evidence of that. I invite the team to give you the details.

Nick Hex (Audit Scotland): It is fair to say that it is very much a supply-and-demand issue. If supply of locum doctors decreases, generally, there is an issue of increased cost. However, it is hard to quantify that. We found that we cannot necessarily quantify exactly how much the costs go up by, because that depends on the individual doctor and circumstances and, obviously, the post to which they are appointed.

The Convener: Do you have an idea of how much more expensive it is to employ a locum doctor than it is to have someone on the payroll?

Kirsty Whyte (Audit Scotland): Exhibit 6 on page 11 gives an indication of the different types of pay rates at April last year when the national contract for locum doctors was still in place. For internal locums, there are nationally set pay rates and then there are national contract rates, which were in place until May 2009 last year, until when the national contract ran. Then there are costs for locums from agencies that were outwith the national contract. As you can see from the exhibit, the pay rates for external locums, particularly non-contract locums, were much higher than those for internal locums.

The Convener: You refer to NHS internal locums. Does that mean that the NHS already has

its own system to plug gaps but that it is not sufficient to do everything?

11:30

Nick Hex: By internal locums, we mean staff who are already substantively employed in the NHS, who may either fill gaps in service where there is a requirement, or work at a different hospital or for a different board. There is no specific system yet, but we make the point in the report that the Government is considering the establishment of locum banks.

Mr Black: For a few years, the NHS has been running nurse banks of direct employees. The intention is to see whether the model can be developed and implemented effectively for doctors, too.

Nick Hex: That is correct.

Bill Kidd: Is there concern that the limits that are set by the working time directive will be exceeded if, as well as doing their own jobs, people are taken on as locums, through internal banks?

Mr Black: Yes, we identify that risk in the report. It is up to individual doctors to behave in a professionally responsible way, but there is nothing to prevent a doctor from doing locum work in a health board other than the board of their main employment. It is appropriate to ensure that people who do that do not work excessive hours.

The Convener: That is an important point. So, there is no way of checking how many hours a doctor is working if they work as a locum in different areas.

Nick Hex: That is correct. Health boards ensure that the staff whom they employ do not breach the terms of the working time directive, but if a doctor chooses to work additional hours elsewhere, there is currently no mechanism to monitor that.

Mr Black: It is possible that people will be in the position of working excessive hours, but we do not highlight that as a major risk in the report.

The Convener: Should the board that takes on a locum require them to sign a document indicating how many hours they have worked in the current period, or a declaration that they have not worked excessive hours? Surely boards should seek guarantees from those whom they employ when they take them on.

Mr Black: The question is probably best addressed to the health directorates.

Nick Hex: Boards must undertake pre-employment checks on locums whom they intend to use. Currently, they are not required to check the number of hours that a locum has worked. The development of locum banks will help to address the matter, because a centralised system will make it possible to monitor such issues much more closely.

Murdo Fraser: My question relates to another issue of patient safety. From time to time, we hear—at least anecdotally—concerns about the employment of locum doctors from foreign countries, whose command of English may not be particularly strong. There are concerns that such doctors may have difficulty communicating with patients or other NHS workers. Have you identified that as a risk in your report?

Mr Black: We did not have that information; I am not sure how we could get it. However, as Nick Hex said, health boards are required to carry out pre-employment checks, which should provide some kind of safeguard. At UK level, arrangements for employing in the NHS overseas doctors from outwith the European Union have been tightened up.

Kirsty Whyte: Doctors from outwith the EU are required to undertake a proficiency in language test by the General Medical Council when they come into the country, but doctors from other countries in the EU are not required to do that. The issue has been in the media recently, and I know that earlier in the summer, the UK Government said that it would look into it, with a view to tightening up the system.

Nicol Stephen: I have a general question to ask in the context of the Auditor General's report. Is it his experience that the information that is available to the NHS in Scotland, which is both critical to and criticised in many of his reports on the NHS, is the best in the world?

Mr Black: The short and not very helpful answer is that I am the Auditor General only in respect of Scotland and not the rest of the globe.

Murdo Fraser: That is a good answer.

Nicol Stephen: Taking a wider view—

Mr Black: A more helpful answer might be to remind the committee that late last year, we presented a report on the management of information in the NHS, which it is fair to say presented a very mixed picture of progress in developing information systems that are fit for purpose. We recognise that a lot of effort is being put into that, as we heard this morning. Given the urgency of the issue in Scotland, the pace of that work continues to be extremely important.

Willie Coffey: On the point about excessive working hours, would not that be revealed through the pay-as-you-earn tax system? Notwithstanding the recent problems with the tax system, surely it would pinpoint the fact that a person had worked in excess of 48 hours.

Mr Black: That is an interesting question, but it is well outside the scope of the report, as you might imagine. We all know that HM Revenue and Customs is extremely careful about data protection issues and about releasing anything to do with the financial circumstances of people who pay tax. I do not imagine that there would be any realistic prospect of getting access to those data for such a purpose.

The Convener: If there is nothing else, I thank the Auditor General and his team for their report.

We now move on to item 5, which we will take in private.

11:37

Meeting continued in private until 12:26.

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