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Pàrlamaid na h-Alba

Official Report

PUBLIC AUDIT COMMITTEE

Wednesday 9 June 2010

Session 3

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PUBLIC AUDIT COMMITTEE
11th 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)
Russell Frith (Audit Scotland)

THE FOLLOWING GAVE EVIDENCE:

George Brechin (NHS Fife)
Ben Clift (NHS Tayside)
Colin Howie (Scottish Committee for Orthopaedics and Trauma)
Andrew Kinninmonth (NHS National Waiting Times Centre)
Dr Brian Montgomery (NHS Fife)
Audrey Warden (NHS Tayside)
Jill Young (NHS National Waiting Times Centre)

CLERK TO THE COMMITTEE

Jane Williams

LOCATION

Committee Room 4

Scottish Parliament

Public Audit Committee

Wednesday 9 June 2010

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

Decision on Taking Business in Private

The Convener (Hugh Henry): I welcome everyone to the 11th meeting in 2010 of the Public Audit Committee. I remind members and others to ensure that all electronic devices are switched off so that there is no interference with the recording equipment. Anne McLaughlin has sent her apologies, as she will be slightly late. I also welcome Audit Scotland staff and members of the public to the meeting.

The first item on our agenda is a decision on taking business in private. Do members agree to take items 5 and 6 in private?

Members *indicated agreement.*

Section 23 Report

"Review of orthopaedic services"

10:00

The Convener: The second item on our agenda is consideration of the "Review of orthopaedic services". The committee heard from the Auditor General for Scotland on the issue and decided to invite a number of witnesses to the meeting. I welcome to the committee and to the Scottish Parliament a veritable cast of thousands. We are joined by a substantial number of people from different areas with an interest in orthopaedic services: Jill Young, chief executive, and Andrew Kinninmonth, clinical director for orthopaedics, from the NHS national waiting times centre at the Golden Jubilee national hospital; Colin Howie, the chair of the Scottish committee for orthopaedics and trauma; George Brechin, chief executive, and Dr Brian Montgomery, medical director, from NHS Fife; and Audrey Warden, general manager, surgical directorate, and Ben Clift, consultant orthopaedic surgeon and clinical lead, from NHS Tayside.

Rather than invite all of you to make an opening statement, I suggest that we move straight to questions. If any of you have a particular item to raise, feel free to do so.

I will begin with a general question, which is perhaps for Colin Howie, who I realise has a wider role as well as a specific one. The evidence that we have heard points to a considerable increase in expenditure on orthopaedic services, but it seems that activity has not kept pace with that—perhaps you can give us evidence to the contrary. For example, the consultant workforce has increased by almost 50 per cent, whereas activity has increased by only 12 per cent. I would be interested in your views on that.

Colin Howie (Scottish Committee for Orthopaedics and Trauma): Thanks very much. I should perhaps mention that I was on the advisory committee for the report.

The answer comes in many parts, as you might guess. First, as well as being partly related to waiting times, the increase in consultant numbers is partly related to changes in work practices in the health service generally. We raised the issue of whether we could benchmark by looking at other specialties to find out whether what we were seeing was specifically about waiting times or was to do with the change in how the health service is disponed, an example of which is the reduction in junior doctors' hours. About half the appointments have been made to change how the health service works so that more patients see more consultants

and fewer junior doctors, who are not allowed to work as hard. That is part of the issue. There are probably another 23 reasons that I could go into, but you will not want to hear all of them.

The other part relates to waiting times. As part of the process of looking at what we do and focusing on getting waiting times down, we were asked to rule out things that we felt it was unnecessary for a consultant to see. For example, patients with nondescript medial joint line knee pain, which is almost universal over the age of 40, are now more appropriately seen by a physiotherapist. Good examples in the Auditor General's report are the back services in Lanarkshire and Glasgow, where patients are diverted away from orthopaedics into other specialties.

Consultant activity has to be monitored nationally, in the same way as it is monitored in England. A combination of finished consultant episodes is looked at, which is made up of three parts: out-patient events, in-patient events and day-case events.

On out-patient events, there has been a change so that more non-doctors see patients. Their activity does not count towards consultant activity. On in-patient events, there has been a concentration on hip and knee replacements, because that is where we get the best bang for the buck. Those procedures are second and third on the list of cost-effective options for health care provision; pacemakers are number one. The health service has quite rightly concentrated on reducing the waiting times for those procedures. That is the expensive end of the spectrum. For day-case procedures, we have examined—and continue to examine—what we do critically. The number of day-case procedures that were done in the past and for which there is no real evidence base—such as epidural injections for back pain—has gone up and down over the period.

The work has involved a combination of things. We have moved to increase the number of major surgeries and we have changed the way in which the health service works in general because of changes in junior doctors' hours, which have affected all specialties in general medicine and general surgery.

Because orthopaedics has been under pressure, we have concentrated on what we do well and ruled out the things that we did not do so well. We are not there yet—there is still room for improvement, which is probably your next question.

The Convener: It is partly on that, but before I go there, I am intrigued that you say that there are a number of procedures—I am not sure if I would call them operations—through which support is given to patients in different ways, and yet that does not seem to be recorded. You talk about work that consultants have done and that others are now doing instead of consultants. Surely if the net outcome—the benefit to the patient—is the same, you should be recording the work that is done. Why is it separated out in that way, instead of being viewed as a general benefit from orthopaedic support, albeit not by using a consultant?

Colin Howie: At this point I direct some sympathy towards the Auditor General. It is very difficult to gather consistent data in the same way over a 10-year period from which to draw any firm conclusions.

There is a division between secondary health care services, which our service is regarded as being, and primary health care services. In reality, in both those areas, and certainly in orthopaedics, a lot of the patients we see need not surgery, but reassurance that they have a benign self-limiting condition that would not benefit from surgery at this time. That represents good health care delivery. The difficulty is how we deliver that health care and measure it.

One could argue that it should be done in the community. I return to my point about the Lanarkshire back-care model that we are rolling out, in which physiotherapists are coming back to co-ordinate health care in the community. However, there is an argument over whether that counts towards community delivery or secondary health care delivery, and over who gets the salary, who controls the individual and where they go.

You are right—it probably does not matter. It probably makes sense if there is a unified system that crosses both boundaries. The committee might want to talk to some of the people who are more involved with the politics of health care delivery than I am. I think it would be much better if the physiotherapists worked with the orthopaedic surgeons, as they do in other models.

The Convener: Any of the panellists should feel free to join in.

How do we know that we are having the desired effect that you seem to suggest there is if it is not being recorded and the information and data are not available? Is it a best guess, or an assumption? If the evidence is there, why can we not see it?

Audrey Warden (NHS Tayside): That is a major concern. I am speaking on behalf of NHS Tayside and no other board, but the Audit Scotland report has helped us to go back and investigate where we are capturing robust data that demonstrate clinical outcomes, and where we are not capturing data in areas that we believe are making a valuable contribution to patient care. We

are considering where we can enhance practitioners in community and secondary care settings, and administer and get involved in the patient care pathway for the benefit of patients. We are looking at where and how we record that in a robust way throughout Scotland, so that we can have measurable outcomes and comparisons for all boards.

The Convener: But if you are doing that now in Tayside, it raises the question why it has not been done previously. Is it also being done in other health board areas or has it been left to each individual health board to do it, with no central influence or exhortation? I find it astonishing that we can invest such substantial amounts in the health service—I would argue that we have seen benefits; I suggested last week that my own constituency case load reflects the improvements that we have seen, as there are far fewer complaints about the health service than there were six, seven or eight years ago—without having such information. All this money is going in, but if we do not have the information, how can we justify the record levels of expenditure, particularly when we are entering a period when we know that money will be tight and that there will be competition from other areas of the public sector? The question is perhaps not for you but for the accountable officer and the Scottish Government, but if there is no requirement for consistent recording, how will we know whether the money has been well used?

Dr Brian Montgomery (NHS Fife): One of the problems that we have—I say this on the back of what Colin Howie said—is that the way in which we now record and capture data has not kept pace with changes in clinical practice and clinical models. Whereas, before, we had the medical model and the surgical model, now a much greater range of professionals contribute to the overall picture in both secondary and primary care. A major and urgent bit of work needs to be done to modify how we code things and capture them in a way that not only is applicable locally but allows us to make the national comparisons that you are talking about.

Ben Clift (NHS Tayside): I think that your question perhaps refers to patients with musculo-skeletal conditions who are not being treated within the specialty of orthopaedics. Is that what you are asking about?

The Convener: Partly. Colin Howie suggested that some people were being treated but not necessarily by consultants. There were desired outcomes, but we were not able to record the achievement of them. If we are achieving the same impact, surely we should be able to record it, whether it is being done by a consultant or by somebody else. The fact seems to be that we do not know how many people are being treated, how well it is being done and whether it is working, yet there have been huge increases in the money going in.

George Brechin (NHS Fife): The first point is that there is and has been for some time an issue about how outcomes as opposed to processes are measured. We are quite good at counting the processes, but we count them almost in the silos in which we have always counted them. We are trying, as all health boards are, to look at what we would describe in our jargon as the musculo-skeletal pathway—that is, when someone approaches their general practitioner saying, “My back isn’t great,” or, “My knee isn’t great,” an outcome of which can be an orthopaedic procedure, physiotherapy or whatever. Measuring on that pathway is tricky, but it is sensible if you are interested in the orthopaedic pathway. However, if we then want to look at how community health partnerships use their physiotherapy budget, we might want a different cut of the data, which are around not pathways but service delivery.

One of the challenges for the NHS, ISD Scotland—the national data collection people—and Audit Scotland is to ensure that we collect data consistently throughout Scotland in ways that fit changing clinical practice. We want the consistency and rigour that ISD applies, arguably to a set of definitions that fitted the way in which we practised some years ago, but also a recognition that we will always want to cut the data in a number of ways.

10:15

Jill Young (NHS National Waiting Times Centre): I can perhaps give a different view. As you know, we are a national hospital and we do not have direct responsibility for primary or community care services. I go back to your original point about increased investment without the equivalent increase in activity. One example is the redesign work that we have been involved in for many years. Previously, when a patient attended an out-patient appointment, it would be counted as one visit at the hospital. They would reattend some weeks later for an X-ray or some other test, such as a blood test or a heart test, and return for their admission. We would count it as three separate activities in the national recording system. We have redesigned that for many of our patients into one stop, so that if they attend for one visit, we count it as one visit only, and they receive that whole pathway of care. However, it is not just the same pathway of care. We have received investment for a magnetic resonance imaging scanner for our orthopaedic patients. Although such a procedure costs much more, it has a much

better quality of outcome for the patient. While there has been huge investment, the count of patients attending the hospital is much reduced. Overall, the quality has vastly improved, resulting in the much reduced length of stay that members saw in our report.

The Convener: With regard to Jill Young's point, can each of you say whether the increased investment in each of your health board areas has improved the quality of care for patients?

Dr Montgomery: One important aspect of that relates to Colin Howie's point about the difference in the way in which training-grade doctors work. One of the benefits of the increased investment in consultants is that surgical procedures for the vast majority of patients are being undertaken by consultants. Unsupervised juniors no longer operate as they used to. However, in the past that was all counted in the overall activity, so that is probably one of the reasons why we get that apparent disproportionate investment in consultant time without the same benefit to activity levels. The quality of the activity has gone up because most of it is now delivered by consultants.

The Convener: The point about junior doctors is valid and understandable. It is an issue that had to be addressed legally, but even professionally it should have been addressed much earlier. However, all the investment that has gone in has not been to address the issue of junior doctors. You all seem to assent to the view that the quality of care has improved following the investment. Can you prove that? How do you demonstrate that?

Jill Young: Certainly, our indicators prove the quality of care. We have one of the lowest lengths of stay for hip and knee replacements; one of the lowest infection rates for patients; and the lowest readmission rates—patients being readmitted to hospital with complications. In the orthopaedic unit that Andy Kinninmonth leads, we have one of the highest patient satisfaction outcomes, according to our regular surveys of patients. There is a list of patient indicators that we monitor on a monthly basis.

The Convener: What about the other health boards?

Ben Clift: It is the same thing. We have the national audits that primarily consider joint replacement, but most areas have fairly robust local audits looking at specific things, whether it is complications or scoring, in an effort to quantify the success of procedures and so on. That is a considerable investment in itself. It requires trained staff, but you need to be able to say what your results are. Certainly in Tayside—I think that it is true throughout Scotland—people are now in a much stronger position to be able to say what their results are. That often relates to the individual consultants. I cannot emphasise enough the point that, whether it is due to obvious factors such as the European working time directive, the new deal for junior doctors, or other issues such as patient expectations, by and large orthopaedic care in Scotland is consultant delivered, in a way that it was not 10 years ago.

The other side of that coin—which is not primarily the topic here but is exceptionally relevant—is trauma care, which benefits from the same input and is, of course, pretty labour intensive. The quality indicators are there in orthopaedics, whether at the national level, which Colin Howie has led on, and in quite a lot of local audits. Everyone needs to be able to prove their work now.

Audrey Warden: As far as quality is concerned, the patient experience is of critical importance. Picking up on what Jill Young said, I think that most boards are redesigning their end-to-end orthopaedic pathway, and they can demonstrate evidence, by using improvement tools, that the patient's experience has improved through the eradication of non-added-value steps for that patient journey, as Jill was explaining. That means taking out clinic appointments and introducing one-stop clinic appointments. We need to focus on that as the added dimension of quality for patients.

George Foulkes (Lothians) (Lab): I have not understood much of what you have said so far, because of the jargon that you use. I wonder if you could try to cut down on the jargon, such as the "musculo-skeletal pathway" and how you "record and capture data". There are easier ways of saying that, in plain English.

The total increase in orthopaedic activity is just under 12 per cent, which is lower than the rate of increase in other high-volume specialisms. You have not explained why that is the case. Could you try to do that, in simple English?

Colin Howie: Yes. First, you are right. The report says:

> "activity in ... general surgery increased by only six per cent".

The highest increase is in dermatology. That is what we would expect, as dermatology is an out-patient-based specialty. An out-patient consultation does not take very long, even in dermatology, whereas a hip replacement can mean someone standing there for two and a half hours, during which time a dermatologist can see nine or 10 patients. The activity throughput for a dermatologist will be higher than that for an orthopaedic surgeon.

The waiting times were five years for a hip replacement. To an extent, we are trying to get rid of a backlog in waiting times, so we have purchased more activity.

George Foulkes: So, once we get rid of the backlog, some of the consultants will no longer be required.

Colin Howie: That is not the case in Scotland. We are now getting into the difference between reducing waiting times, which is about backlog, and dealing with incoming activity. The national waiting times unit can show a 4.3 per cent year-on-year increase in referrals from GPs for orthopaedics, despite what we have put into the community. We have never really been staffed up to a level at which we can cope with the incoming activity. We are now beginning to get close to what we need.

In the recent past, we have had to buy additional activity for waiting times initiatives in other areas, and we have undoubtedly paid through the nose for that.

George Foulkes: I do not think that you have yet answered the convener's simple, valid question, which taxpayers want to know about. You have 50 per cent more consultants, but only a 12 per cent increase in output. That is a huge difference. That is very difficult to justify—all the money that the previous Government put into the health service has not resulted, apparently, in an equivalent increase in output by consultants.

Colin Howie: It depends what output you are interested in. The Auditor General had to use a definition of "consultant throughput" from 10 years ago, expressed consistently throughout the period of 10 years.

George Foulkes: Do you think he is wrong? Is his analysis—

Colin Howie: Do I think that the Auditor General is wrong? I would never say that.

George Foulkes: Well, other people have said it in the past. They might not have lived long afterwards, but they have said it.

Colin Howie: He is on the other side of the table.

George Foulkes: But seriously.

Colin Howie: He has been hamstrung by the data as they were collected over the years. If I wanted to make my specialty look fantastic, I would tell people to see large numbers of patients who did not need surgery. If they were going to do operations, they should do operations taking only two minutes that did not cost a lot of money. That would improve their activity and throughput and make them look very effective.

Unfortunately, for the general population, orthopaedics deals well with fractures and joint replacements. Those are perhaps the two most effective therapeutic interventions that can be done. It was illogical to limit access to those by having long waiting lists and, rightly, people decided to bring waiting times for those down.

George Foulkes: Do any of those contribute to the lack of progress from the increased expenditure? Does it ever happen that things are set up for an operation—let us say, a hip replacement—and one of the key people in the team does not turn up, meaning that the whole thing must be abandoned? How frequently does that happen?

Colin Howie: We have a national theatre benchmarking group. The answer is that, yes, it happens. Does it happen frequently? Less than 1 per cent of the time does a procedure not occur because an implant, a consultant or an anaesthetist is missing or because staff do not turn up. When the volcanic ash cloud was a problem, we had all sorts of people in the wrong places. When there was snow over Christmas and the new year, over a three-week period we had to deal with nearly three times as many trauma patients as normal; therefore, we had to switch from treating elective cases to treating trauma cases.

George Foulkes: What about inefficient and almost incompetent consultants? We had one in Ayrshire a few years ago who had to retire early. What do you do if a consultant is not up to the mark and is not producing the goods at the right level?

Colin Howie: What do I do about it?

George Foulkes: What is done?

Colin Howie: I should leave that to the medical directors. Nationally, the orthopaedic community started off by looking at joint replacements. Since 1999, each consultant in Scotland has had a personal report that is available on the web and can be accessed on the arthroplasty project website not by consultant name, but by hospital, which shows the readmission rates for deep vein thrombosis, infection, dislocation and things such as that. That has made a big difference to outcomes and we have had a measurable reduction in the dislocation rate. Where people have been seen to be performing abnormally, we, as a profession, have sent them letters and have asked them to respond, which has been hugely unsettling for all of us—even for those of us who have sent the letters. That has had an effect and people now look at what they are doing.

There are more than 240 consultants in Scotland, and somebody will be performing in a way that might be regarded as unacceptable.

What happens to them depends on why they are not performing. Some people do not perform because they are medically unfit, in which case there is a route for medical directors to take to deal with that. Some people do not perform because their technique is not up to scratch, and that is much more difficult to handle. We have to get information and data on that, and people are generally unwilling to come forward with that at an early stage; nevertheless, we have done that.

George Foulkes: What about the third reason—the fact that a consultant is spending a lot of time doing private work?

Colin Howie: That irritates me intensely. A lot of consultants spend a lot of time on the golf course as well, but what people do in their spare time is up to them. The new consultants contract is structured in such a way that what you suggest should be got rid of. There are ample controls and checks in the system to ensure that that does not happen. There was a concern that people were manipulating waiting lists to send patients to the private sector. It should be recorded that the orthopaedic community in Scotland sees the best way of saving money for the health service as being to stop sending the short-term waiting list team to the private sector, bring it back into the NHS and build it up. That would be cheaper and more effective, and it would avoid our being criticised in that way.

George Foulkes: I still have not got to the bottom of the increase in orthopaedic activity.

Ben Clift: I can answer that. It goes back to trauma. Most of the appointments involved in that increase in consultant activity are for trauma cases. Trauma input—in which I include out-of-hours input, input at weekends and in the middle of the night and all that—is now far more consultant based than it was before. There are a number of reasons for that, including technical reasons and the inexperience of junior staff where they are available. Also, since 2003 we have had a time-sensitive contract. It may not have been intentional, but when people revealed their diaries, that demonstrated that they were working more than the maximum number of hours in the time-sensitive contract. People are still working longer than they are technically getting paid for—that is evident in the job-planning process that we go through each year.

Trauma is a big part of the issue. Most, but not all, consultants in Scotland deal with both trauma and elective orthopaedics. From the audit, it is evident that in most areas trauma accounts for between 30 and 50 per cent of the workload at any one time. It is also a demanding part of the workload. That is one of the explanations for why people work for longer than they get paid for. It is in the nature of the specialty that trauma will always be a big part of it. I second what was said earlier. We are victims of having a successful operation for a non-life-threatening condition—joint replacement—that takes a bit of time to perform. There is a limit to how many procedures can be carried out in one day, and demand for the procedure is rising. The situation has been made worse by the fact that the operation is now being offered not just to elderly patients but to younger patients, for various technical reasons. There is a lot more on our plates.

10:30

George Foulkes: If the consultant workforce were reduced by 50 per cent—because the current Government wants to save money, for example—would output decrease by only 12 per cent?

Colin Howie: No, elective output would almost certainly stop completely. We cannot stop people falling over, so we would have to address such cases first. Therefore, I do not think that knee arthroscopies or hip replacements would be done on the NHS.

The Convener: I return to a point that Colin Howie made. It is not about what consultants or medical staff do but about how the system is managed and how things are recorded—the processes. Have those who manage the system at the Scottish level failed adequately to plan, record, monitor and analyse? Have they failed to ensure that there is consistency across the country and that data are both robust and relevant?

George Brechin: No. The data are collected robustly. That applies to both ISD data and the kind of audit data that the arthroscopy audit generates. The data are consistent, and much effort goes into ensuring that that is the case.

In a system as complex as the NHS, we will always want to examine the route that a patient takes—the pathway of care—or the way in which a specialty, a health board or part of a health board, such as a community health partnership, works. We are always seeking some sort of compromise, because the data are drawn up in one way, which is historically consistent but does not necessarily match the way in which people want to analyse the data now. When we have the all-singing, all-dancing electronic patient records, we will be able to analyse them and we may get to the position of being able to cut the data vertically as well as horizontally. At the moment, what we do effectively and consistently is record in ISD definitions one way of looking at activity, but not necessarily all of the ways that people want.

The Convener: You say that the data are both robust and consistent, but earlier we heard that, in many respects, we do not have the data and

information that are needed. If we do not have them, how can they be consistent and robust?

Jill Young: I am equally sure that the central department has not failed in collecting data, but there is no doubt that data could be improved. If we had stopped innovation and research into new techniques, the output from the Golden Jubilee would never have happened. We need to have the freedom to develop new techniques, such as our CALEDonian technique, which extends the skills of nurses, physiotherapists and pharmacists, whose input is not counted consistently. We must have the flexibility and freedom to develop innovations and new techniques to improve quality. Once they are proven and we get the research or trial outcomes, we can roll them out throughout the country. That is when ISD and others should step in to ensure that the data are consistent.

Dr Montgomery: I want to build on my earlier point about the difficulty that we have had in ensuring that the way in which we collect data keeps pace with clinical change and different models. George Brechin is right to say that we collect the data, but the problem is that we do not do so in a way that allows us to make comparisons over the years, which is one of the explanations for the apparent lack of return on the investment. Given how we collect data, it would be difficult to compare a cohort of 100 patients who were treated in the system as it was 10 years ago with the same cohort treated in the system as it is today.

Ben Clift: On the data, we all accept that the ISD exists. Locally, we know that we submit such data. When we try to validate the information that goes in, we know that it is not as accurate as we would like it to be, given that we are subject to scrutiny. On joint replacements, we fall short by perhaps 10 percentage points—we want to examine that. That is a problem for us locally, but it means that the position is not entirely accurate.

Another relevant example concerns people such as extended scope practitioners—physios or whatever. In some areas, their work has historically been included under a consultant's name when a clinic with a consultant is nearby. Such data might still be collected in that way. When we compare boards, I am not—no one is—in a position to say how much activity falls within that welcome aspect of clinical work and how much is done by a consultant. Unless we set out basic rules for prospective data collection, we will always be stuck with that problem.

The report refers to difficulties in being sure of consistency when direct costing is undertaken, hence the productivity arguments. We know of that problem. We do much data collection, but issues will remain with local cost levels and with comparing boards' costs. When we compare boards, we do not know whether we always compare like with like—in some areas we do, but in some areas we certainly do not.

The Convener: That is a neat introduction to variation in activity throughout Scotland and comparisons of activity.

Murdo Fraser (Mid Scotland and Fife) (Con): I do not know whether the witnesses have copies of the report with them—it might be useful to refer to it. Exhibit 18 on page 30 shows wide variation between health boards in orthopaedic consultant day-case activity. As representatives of NHS Fife and NHS Tayside are here, it might be interesting to probe those variations. Exhibit 18 shows that the number of episodes per consultant in Fife is more or less double that in Tayside, yet the direct day-case cost per patient in Fife is substantially lower than that in Tayside—perhaps as low as half that in Tayside. The Auditor General and the committee are interested in why activity and costs vary so much between two health boards whose areas are geographically close and whose populations do not differ substantially. Will NHS Tayside and/or NHS Fife comment on that?

George Brechin: I will pick up an issue that Ben Clift mentioned. We are fortunate to be able to separate trauma from elective cases, which certainly makes our lives easier. We have the trauma service at Queen Margaret hospital and the elective service at the Victoria hospital. Those services are separate and there is no—interference is the wrong word—knock-on impact from one on the other. My orthopaedic colleagues have spent much time on developing that system.

George Foulkes: Are trauma cases people who come into hospital through accident and emergency?

George Brechin: Yes—I apologise for not explaining that.

George Foulkes: That contrasts with people who are sent for care by their GPs.

George Brechin: Elective cases involve people who are referred because they are thought to need an intervention. Trauma cases come through accident and emergency and certainly need an intervention. The separation that I have described has a substantial benefit. I do not know whether my Tayside colleagues want to comment.

Audrey Warden: I think that it is common knowledge that Tayside's day-case performance has been less favourable right across all the specialties. We acknowledged that last year. The improvement support team is helping to give us an outside view on how we can change our service model to improve our day-case performance, and that is reflected in orthopaedics.

The second issue for Tayside was the impact of the SRTC. We certainly sent a significant amount of minor activity to the SRTC as part of the contract, for the benefit of patients, to manage additional capacity.

The Convener: Will you clarify for the record what the SRTC is?

Audrey Warden: It is the Scottish regional treatment centre, which started up towards the end of 2006 and had a three-year contract. Tayside took full advantage of that additional capacity within the system to meet waiting times. On that model, we sent a significant number of patients who required minor procedures to that facility. We still have to bottom out how much impact that had on the remaining activity that we undertook within Tayside. There are complexities in that.

Murdo Fraser: I understand that. From my knowledge of the SRTC, I think that NHS Grampian and, to an extent, NHS Fife also sent patients there, so that has to be factored in.

Given the great discrepancy between Fife and Tayside, we want to be sure that Tayside is taking the issue seriously and is looking at how the costs in comparison with those for other health boards can be driven down. I see that Mr Clift is keen to come in.

Ben Clift: We have fallen down in that area across all the specialties. Part of it is about the use of dedicated day surgery facilities, which is a challenge for us and is being improved upon.

I wish to discuss some of the cost figures separately with the audit team, because, as you have pointed out, there is a significant discrepancy. We have looked at the figures and we cannot entirely explain some aspects of them. However, I accept your point.

The other factor is the quality of our data input in relation to coding, to which I referred earlier. We think that we are underreporting what is, if you like, out-patient activity that is being reported in some of the other boards. Looking at the figures, I think that there is something in that—some out-patient activity just does not get logged as a procedure. We have probably underrecorded the amount of day-case activity within the board.

The Convener: To some extent, does that not bring us back to what we discussed earlier: there is no robust and consistent information? We were told that there is robust and consistent information, but now you are telling the committee that some information is not being recorded. There is clearly an issue in Tayside in that information is neither robust nor consistent. That may be the case elsewhere, too.

Ben Clift: Consistency refers to what is happening across Scotland.

The Convener: It also applies to what is happening within a board. Clearly, there is not consistency across Scotland if information is not being recorded in at least one board.

Ben Clift: There are issues with some of the data input. We have underreported in the specific area of day cases. On joint replacement and so on, the data are much easier to pick out.

Murdo Fraser: I have another question on a related matter: the average length of stay in hospital for orthopaedic patients, which is picked up in paragraph 47 on page 19 of the report. The average length of stay for orthopaedic patients in NHS Greater Glasgow and Clyde is 5.2 days, which compares favourably with some of the other health boards. Surely if NHS Greater Glasgow and Clyde can deliver that average, and it is desirable from everyone's point of view—from the point of view of the NHS saving money and, presumably, from the point of view of patients—to have the lowest possible safe period in hospital after an operation, why are other health boards not able to achieve that?

Ben Clift: The audit team might be able to tell us whether they included everything in getting that average. We are in a peculiar position in Tayside, because 12 beds in our orthopaedic bed complement are dedicated to amputation rehabilitation. The average length of stay following amputation is probably about six weeks, so that makes a difference to the Tayside figure.

I believe that it is better to look at issues in terms of specific procedures. The main factor is the average length of stay for hip and knee replacements, and in that example you will find that all the boards are coming down to significantly less than one week. The average length of stay might just include too much.

10:45

Murdo Fraser: Does anyone else want to comment?

Colin Howie: That takes us back to what was said about day-case procedures. Again, it comes down to how services are set up. In Lothian, for example, most of the hand services are provided by plastic surgery, so the day cases that relate to that, which represent 10 per cent of the orthopaedic workload, are recorded against plastic surgery. How the service is set out governs how it goes.

It is much the same with the length of stay issue—it depends on what we look at. Again, I will speak about Lothian, although I am not supposed to, because I am not representing NHS Lothian.

Our length of stay is heavily influenced by the prolonged length of time that it takes us to get people with fractured necks of femur home again after they come in with a hip fracture. To a certain extent, I cannot influence that, because getting the patient home again is a community rehabilitation issue. All that I can do is shout on the ward—just the usual Lancelot Spratt stuff.

The good thing about the report is that it asks more questions. The danger is that people will look at exhibit 18 in isolation and say, "This is an important question." We should also look at some of the other exhibits. For example, exhibit 11, which is probably more robust than exhibit 18, shows the number of patients per head of population who have an operation and it shows that there are substantial differences. There is a difference of a third between the area with the highest number and the area with the lowest—if we ignore the Highland health boards, which are exceptional, although it was very nice in Orkney yesterday.

There are questions about the rates per head of population. Exactly what that means and whether we should be targeting the rates per head of population in certain areas—in other words, whether we should go further—is covered in the report and has been looked at by the health care delivery team. That takes us back to the point about the robustness of the data. Because of the way in which the report is structured, we are looking at data that were agreed 10 years ago. We now realise that the data might not be robust enough to represent the change, as Brian Montgomery said earlier.

One good example is that, if we look at the ISD definition of an associated health care professional who works outwith their normal role, such as a physiotherapist who sees orthopaedic patients or assists in theatre, there are now 186 different definitions. Trying to keep tabs on those is difficult in a changing environment, so the question is almost more important than the answer.

Andrew Kinninmonth (NHS National Waiting Times Centre): I have a comment on value for money versus length of stay as outcome measures. In many reports, length of stay is equated with value for money, which might be reasonable, but until recently we did not have robust data on whether that equates to quality of outcome. There is a perception that someone who is in for a shorter time must have had better quality care, but that is not strictly true. The worry for us in the orthopaedic community is that, if we send someone home at three days rather than seven days, they might deteriorate before they come in for a review to check whether all is well. That can be the case in certain circumstances.

In our system, we look at length of stay and then at the quality of outcome at six or eight weeks. We have found that, in the main, patients have a similar result to the one on the day when they left hospital. We are beginning to get some robust data about outcomes and quality versus value for money—that is, short stays in hospital. It is important to dissect that and ensure that we do not assume that, because someone is in for a short time, they get quality care and a better result. We now believe that they get the same result from being in for a shorter time, but a certain investment in out-patient services is required to ensure that that is the case. That is where some of our money has gone.

The Convener: We are back to the same issue again. There appears to be a contradiction, because you said that information was not available until recently, and then you said that we are beginning to get information. It is clear that there have been problems in identifying the relevant data, information and statistics. Perhaps it has miraculously been sorted out in the past couple of months. I am critical not of the medical staff but of those who manage at health board and Scottish levels. We need information, but we do not want a bureaucracy that prevents those who are charged with providing care from doing their work—there must be some kind of balance.

Andrew Kinninmonth: It is a difficult issue. The ISD statistics on length of stay are used nationally to assess value for money. However, we produce outcome measures as part of our department's internal audit process. That practice is probably now common all around the country. At one stage, orthopaedics did not look at their patients, but now they do. We are now getting much more robust data, but they are coming from an internal audit that we do of our out-patient service, which is not necessarily currently available to the national ISD.

Bill Kidd (Glasgow) (SNP): Thanks very much for the information so far. Paragraph 50 on page 20 of the report states:

> "It might be expected that NHS boards with a shorter length of stay would be at risk of higher readmission and complication rates, but the available information does not show this to be the case ... There is scope to save an additional 20,600 bed days if the NHS boards with a longer length of stay for knee replacement, hip replacement and hip fracture can reduce their average length of stay to the national average ... with appropriate community health and social services in place."

Does that suggest that people are being kept in by at least some health boards, and perhaps the majority, because they cannot ensure that community health and social care services will be in place for patients if they are released earlier?

Colin Howie: I will take that question because it is my pet subject. The length of stay in hospital

has been an interest of mine for many years. When I started doing orthopaedics, patients stayed in for three weeks for a hip replacement, but we are now down to an average length of stay of about six days. That is partly because of expectation and partly because of what we do around the table here. From reviewing all our patients, we know that about 20 per cent of patient satisfaction—which is what we are all interested in ultimately—is down to what they expect. If they expect to come into hospital for 10 days, it is actually very difficult to get them out in anything less than that, so we must change what the public expect when they come into hospital. Managing expectation is a key part of the process.

On social support, we often identify unmet need when patients come into hospital. When somebody, particularly an elderly person, comes in and it is their first interface with health care services, we assess them and they see an occupational therapist. At that point, we might identify unmet need in the community, because people in the lower socioeconomic groups in particular do not access health care appropriately, for one reason or another—there is an argument about whether they can do it or whether they do not do it.

However, there is an issue about how we get those patients back into the community. In general, in moving from stays of three weeks to stays of six days, we have not involved social workers in health care, certainly for elective services. On the other hand, there has been a major issue with regard to trauma services. A previous financial crisis 10 years ago resulted in rehabilitation beds in our area being cut, which immediately increased the average length of stay for hip fractures by two days. We are probably about to do the same again, because we rely heavily on social care services taking our patients out again.

It is interesting that paragraph 101 of the report states:

> "There is no relationship between the level of intensive homecare available in each NHS board with either hospital length of stay or readmission rates for orthopaedic services."

That is true, but it may go back to the fact that we cannot accurately measure what is going in to give us the results. In addition, only a small number of people actually need that care, but a lot of people believe that they need it. There is a difference between the two, and it is again about expectation.

Bill Kidd: At the stage of referral to hospital, or at least at the stage when patients are seen prior to admission, is it clearly explained to them how long they are expected to remain in hospital if they do not have complications? I presume that that is the case. On a slightly different but linked question, is it the case that people who live in more rural areas spend longer in hospital, because there is less sufficient support for them when they are released?

Colin Howie: Most major hospitals have a pre-admission area and go for day-of-surgery admission, so people are seen beforehand. As part of that process, they will be assessed if necessary. For example, people who have hip replacements often need to be seen by an occupational therapist and have a collection of bits that need to go home with them, whereas those who have knee replacements do not need those bits and are often assessed differently. Most big units will have that in place, and most smaller hospitals will, too. We have no data to prove it, but that must be done to reduce the length of stay. In most areas, people will be pre-assessed and, where appropriate, they will be seen by an OT before they come into hospital. A problem arises if a patient has parental abuse—we had such a case recently—or something else that comes to the fore only once they are in hospital. Then the patient stays a long time.

I was a consultant in Inverness for five years. Patients in rural communities and those who have high social needs before they go into hospital often go home quickly, because they are already well set up at home and the social care services are extant.

Ben Clift: I pretty much agree with Colin Howie. The broad answer to the question is yes, for trauma cases. With elective cases, by using the CALEDonian technique, which was developed at Andy Kinninmonth's hospital and which quite a number of people have taken up, a hospital can get people out the next day, although that is with selected people with the right expectations, as has been pointed out. The optimal length of stay for an average hip or knee replacement is never likely to drop below four-ish days. That is just my guess, as there is no consensus on that. Americans who have been working on the issue for a long time feel that patients do not want to stay in for fewer than three days.

On the trauma side, people come in as they were the moment they broke whatever. They are often in a precarious social situation anyway, so we are reliant on people from outwith our specialty. It is worth mentioning that that is where we interface with other specialties within boards, particularly medicine for the elderly. The more back-up that we get on a formal basis from those involved in medicine for the elderly, who could in effect take over the care of patients and get them home more quickly because that is their area of expertise, the quicker there will be a reduction in the length of stay for that group of patients, particularly the single biggest group, which is

those with hip fractures. That is a well-recognised model, but we cannot bring it about easily by bringing specialties together, although it is an aspiration of many health boards that deal with large numbers of hip fractures.

As I said, the average length of stay in orthopaedics in general is clouded by amputations. We have to separate the elective cases from the other groups.

Cathie Craigie (Cumbernauld and Kilsyth) (Lab): I want a bit more information on exhibit 11, which Colin Howie mentioned. From the graph, Fife seems to have a much more balanced approach. Is it correct to assume that planned day cases will reduce the number of emergency admissions? Fife seems to have a balance there. Am I right to think that? What is the opinion of people from other parts of Scotland? Mr Brechin told us earlier that Fife has the planned and—what was it called?

George Brechin: We have separated out planned, or elective, and emergency cases.

11:00

Cathie Craigie: Could you say a wee bit more about that?

George Brechin: I would like to separate the question that we have already touched on, which is the use of day procedures in the context of elective care, from the basic workload of emergency care, which is by its nature unpredictable—people fall over, break legs and arrive at the trauma department.

One of the most challenging things for Audit Scotland in drawing up the report was the boundary, or in some senses the lack of boundary, in north-east Fife between the service that comes to the Queen Margaret hospital and the service that goes to Ninewells or, potentially, Perth royal infirmary. There is no fixed catchment boundary between Fife services and Tayside services. It varies and will depend to a certain extent on the judgment of the ambulance team as to which unit is nearest given the traffic conditions. There is a separate set of issues around general practitioner preference for elective activity.

We were struck in exhibit 11 by the relatively low level of emergency in-patient care in NHS Fife. We do not think that there is a magic wand that touches somebody as they cross the Forth or Tay and means that they are less likely to fall over. Although we have not discussed the point in detail with Audit Scotland or our Tayside colleagues, we suspect that it is possibly an artefact of the report having to pick a population of 50,000 from the whole population of Fife to use for the graph. I would love to be able to say that the population of Fife is less likely to break things, but I do not think that that is true. I think that it is just an artefact of how the population has been divided. We do day cases differently from in-patients—we touched on that—but I do not think that the emergency load is different. It has just been counted differently because of the population issue.

Cathie Craigie: I am interested in separating the planned and elective work from the emergency work. Looking at exhibit 11, I think that perhaps NHS Fife has it right with the Queen Margaret and—what was the other hospital?

George Brechin: The Victoria hospital in Kirkcaldy.

Cathie Craigie: So one receives emergencies while the other takes people from Fife who are in for planned orthopaedic—

George Brechin: Planned care, but for one or two exceptions, is done at the Victoria hospital in Kirkcaldy; trauma cases are seen at the Queen Margaret. As Mr Clift was saying, that protects us from the impact on and disruption to planned activity of an extra emergency load, which can happen if the same theatres are used for both types of care. Comment is made in the report that three boards have the benefit of being able to separate planned activity from trauma activity, and the performance figures look different partly because of that.

The point that I was responding to earlier is that I do not think that the relatively low level of emergency in-patients shown in exhibit 11 is actually true. I think that it is based on the report having to create a population and assume that such-and-such of the population of Fife counts in the Tayside figures. If a different population level had been put in, there would have been a different answer.

Dr Montgomery: I can illustrate what George Brechin has said about the difficulties of comparability with a specific example, which is also a reflection of different methods of practice.

As Colin Howie said earlier, if we were in Lothian we would look at hand traumas as a problem for plastic surgery, whereas in Fife we have a great deal of hand trauma dealt with through orthopaedics. A lot of that work accounts for our very high day-case rate. Furthermore, even in emergency work, if someone appears at night with a hand injury that can be stabilised, they may be sent home to come in the next day to have it dealt with as an urgent planned procedure. Again, those cases are labelled differently for the purposes of data collection. I would defend our practice, but it probably favours us when it comes to presenting statistics such as those in exhibit 11.

Willie Coffey (Kilmarnock and Loudoun) (SNP): I will continue on the theme of variations across the boards. The Auditor General's report shows on pages 28 and 29 that there is a significant difference in the number of orthopaedic in-patient day cases carried out by consultant teams. It ranges from 458 in NHS Dumfries and Galloway all the way up to 739 in NHS Forth Valley. If you have a quick look across the page at the estimated cost for that, you can see that there is a broad correlation between the level of activity and the cost per case. Can anyone offer an explanation of why there is such a variation in terms of consultant time per case? Is there any move towards trying to make that consistent so that, ultimately, we can bring down costs, which the public expects us to do?

Colin Howie: Are you talking about exhibit 17?

Willie Coffey: Exhibit 16 and exhibit 17.

Ben Clift: I am not clear about how cost per case is calculated. Bed numbers might sound easy to count but, in Ninewells and Perth royal infirmary, depending on when you are counting them and what you include within orthopaedics, there are either 97 or 79 beds, once you have knocked off bed closures due to flexible work at weekends—in other words, efficient use of beds, which is one of the themes that we are discussing. Likewise, on staff costs, it might not be sensible to include all your consultants, as some of them might be doing only hand surgery and so on. The breakdown can be an issue.

I am not questioning the figures, as such, but I am not sure how they were arrived at, and there is some detail, particularly around bed numbers and so on, that would merit a conversation with the audit team.

Colin Howie: On exhibit 16, the big difference between our situation and the situation south of the border—we should not make that comparison, of course—is that, south of the border, roughly a third of the health care episodes are delivered by non-consultant career grade doctors. In Scotland, we have regarded them as being slightly variable. Although the individuals who are currently in post are regarded as being very good, which is the basis on which they were employed, it is not a pattern of health care that we feel is a good method of delivery, as it can be a bit inconsistent. The number of non-consultant career grade doctors delivering front-line care is limited, although those who are in post are doing a valuable job, and have been personally selected.

Earlier, it was stated that the numbers of day-case activity procedures were heavily influenced by the case mix—in other words, the presence or absence of a hand service. How the hand service is provided is important. For example, do you deal with most of your wrist fractures by sending people home and having them come back another day? That is what happens in Edinburgh, Fife and Tayside. Such factors skew the figures a little bit.

If you take a figure that is heavily influenced by case mix and marry it to another figure, such as the consultant numbers in your area, the information that can be gleaned becomes less secure. That is not to say that that should not be done. As I said before, the question is quite important. When someone asks why the figures are like that, I will go away and compare my figures with those of other boards to see whether I can learn any lessons about how to shift things forward. For me, that is the greatest learning point of the exercise.

My specialty is the first that has been involved in a report such as this. A large number of questions have been raised, which means that the exercise was worth while. The sort of information that we are talking about is available in relation to no other specialty, and it might be worth conducting similar exercises in other specialties, as the experience has been good, and has raised many useful questions.

Willie Coffey: But there is such a variation. The performance of NHS Forth Valley is almost double that of NHS Dumfries and Galloway. When people without specialisms, such as we who sit on the Public Audit Committee, see figures such as those, we do not think that they can be attributable to minor changes at the margins and gradings and so on. There seems to be something significant going on that we cannot quite put our finger on. Can anyone else throw any light on the matter?

Ben Clift: On exhibit 17, the difference between, say, Forth Valley NHS Board's and Tayside NHS Board's in-patient episodes per consultant per year is around 150, or roughly three patients a week. I think that that is correct. If trauma cases are included, things will depend on, for example, how many individuals in the health boards look after trauma patients. There could be a perfectly straightforward explanation. Obviously, how the trauma service is staffed is one issue. When it comes to value for money, productivity on elective work is probably more controllable and of more concern to the taxpayer.

There may simply be variations in trauma cases because of the number of people who fall over, the number of staff with an interest in trauma, and how trauma services are staffed. The last point could account for the whole figure—I do not know whether anyone wants to agree or disagree, but it is plausible.

George Brechin: I back up what both my orthopaedic colleagues said. In exhibit 16, three of the four boards on the right side of the graph have

separated out elective cases from emergencies. It is clear that that will contribute to the ease of work.

As Mr Howie said, both the surgical community and management in general welcome the report because it gives us a better overview of the comparative position than we have had. There are quite a lot of indicators in which Fife does reasonably well in the rankings. That does not mean that we have just picked up the report, thrown it in the bin and said, "Right. We're doing okay. We'll move on." It is a prompt to all of us to think about what we are doing, and it raises many questions. Tied in to the audit work that is done both nationally and by all the teams, it helps us to think about how to use our resources in moving towards the achievement of the 18-week target.

The Convener: Before I bring in George Foulkes, I would like to clarify something about exhibit 16. Some boards choose to use only consultants, whereas others choose to use consultants and career grade staff. There are two bars for Dumfries and Galloway NHS Board. What is the relevant total figure? Is it the higher bar or an aggregate of both bars?

Colin Howie: We pondered that graph at length. Basically, the light blue lines are for the total number of episodes per consultant. The dark blue lines are for exactly the same total number, but the career grade staff are supposed to contribute to dealing with the throughput in an unsupervised way. The consultants are assisted by somebody whom they do not supervise as closely.

The Convener: So the episodes in Dumfries and Galloway would be no more than 450.

Colin Howie: That is by consultant. However, there are two career grade doctors there, so there were 350 episodes per permanent member of staff in orthopaedics.

The Convener: Right. That includes both.

Colin Howie: Yes. That is the dark line.

The Convener: Consultants and career grade staff are used in Fife, but only consultants are used in Tayside.

Ben Clift: Yes.

The Convener: Colin Howie cast some doubt on what was happening in England and Wales and did not want to use the model in which career grade staff are used. Why is that appropriate in Fife, but not in Tayside?

11:15

Dr Montgomery: In making the comparison between NHS Fife and NHS Tayside, I think that it is important to note the distinction that, whereas we are predominantly a district general hospital environment, NHS Tayside has a full-blown teaching environment to contend with as well. One of the other reasons why we have a number of non-consultant career grades is that that is a way of addressing some of the challenges that we face through the reduction in the number of training grades. We are filling that gap in the middle, between what would formerly have been provided by training-grade doctors and what still needs to be provided by doctors but perhaps not by full-blown consultants.

The Convener: You do not think that that is necessary in Tayside.

Ben Clift: It is a fait accompli, really. We must deliver services, so we have permanent staff who do that—not at the level of consultant, most of the time, but at that level some of the time because they act with a degree of independence. We benefit from being a centre for training in that we have a significant number of trainees; however, their service commitment is overestimated. They do not help with operations; they are there to be trained. Nevertheless, there is some benefit to fracture clinics and return clinics in service terms. In those areas—it is probably true of all of them—where there are no consultant grades, staff grades or whatever, there is a consultant-based service pretty much across the board. We have not had to go down that line to deliver service.

My experience from elsewhere is that it is difficult for that post to be satisfying and that the consultant post or the training post is the better option for most doctors. However, with the reduction in training numbers, we are heading for a situation in which all boards will have to re-examine the non-consultant grade and the number of those may increase. In NHS Tayside, we will probably do that out of necessity at some point.

George Foulkes: I have a slightly tangential point. Several witnesses have questioned the methodology of the report and the accuracy of some of the figures, yet Mr Howie was a member of the project advisory committee. Did any of those concerns or reservations come up in meetings of that committee?

Colin Howie: Inevitably, and there were some heated debates. It is the Auditor General's report, and we were told that; nevertheless, we highlighted some issues around the way in which the data were gathered. Equally, we must accept that, although there are different data sets, those data sets are incomplete in some areas—they do not compare across board areas and we cannot follow them through. The Auditor General has a set route that he goes down—that is what auditing is all about, I suspect—which fixes what data are available and what we can do with them. The difficulty is in our trying to overinterpret the data

that we have. We anticipated that I would be in this position when the report came out.

George Foulkes: Scotland is a relatively small country and we have relatively few health boards compared with England. Do the boards receive any guidance from the Scottish Government health department about the collection and compilation of statistics or about making comparisons between boards so that proper analysis can be carried out of the differences between boards and the reasons for them?

Colin Howie: The answer is, again, in two parts. First, ISD gives us clear guidance on how things are coded, but the coding guidance changes over time with new procedures such as resurfacing arthroplasty of the hip and unicompartmental arthroplasty of the knee. There is always a process of catch-up on such things.

Secondly, a lot of health intelligence—if that is the right phrase—has been put into the 18-week programme to bring waiting times down. That is a separate, short-term data set. A lot of information is now gathered centrally on waiting times, the patient's journey and some specific procedures.

George Foulkes: But it is not rocket science, is it? We have a chief medical officer for Scotland, a chief executive of the health service in Scotland and a whole panoply of support. Surely, they could give you some guidance on how you can compare the outputs of consultants and different things. Are there groups working out how you can do that, so that you do not have to criticise the Auditor General for not understanding?

Colin Howie: I am not criticising the Auditor General. There are groups sitting down. The value of the report is the fact that it is the first up and out of the box. A lot of the questions that you are asking are important questions that nobody has asked before because we have not had the information before.

George Foulkes: Well, now that we have the report—you have said how valuable it is—what are you doing systematically to follow it up?

Colin Howie: What I am doing?

George Foulkes: Well, you know—

Colin Howie: Orthopaedics is co-operating with the 18-week pathway group and, in the past six months, a slew of data on waiting times has come out because we knew that this was coming. For example, we know that there are fluctuations in emergency admissions and if you do any queue analysis you know that you have to staff up for 80 per cent capacity to deal with fluctuations due to trauma. However, we have just discovered that the variations and fluctuations associated with elective referrals to orthopaedics are even greater than those for emergency referrals and generally happen during the summer, because the general public—and, indeed, GPs—go on holiday and come along to the orthopaedic clinic at certain times. That is why at certain times of the year we achieve our targets and why, at others, we all get kicked for not achieving them.

George Foulkes: But people have been going on holiday for decades, although they might now be going to Majorca instead of Blackpool.

You are chair of the Scottish committee on orthopaedics and trauma. Are you sitting down with Trevor Jones—

Colin Howie: Trevor Jones?

George Foulkes: Who is the accountable officer for health? I have forgotten who it is now. Anyway, are you sitting down with those people and going through all this systematically to see what can be done about it?

Colin Howie: Yes.

George Foulkes: Right. Good.

Ben Clift: I should add that we are not criticising the auditors at all. Although we have supplied the data, we nevertheless have concerns about some of them. However, that is the nature of the process.

Our take in NHS Tayside is that this has been an opportunity to pick up certain things and work out why such-and-such a figure has come up. It might be data related or related to a fault, poor delivery or whatever; I accept that and what I have said is in no way a criticism of the report or the auditors. The report is really just a starting point. As Colin Howie pointed out, we are the first specialty into the process and we are certainly learning a lot from it.

Nicol Stephen (Aberdeen South) (LD): Following up on George Foulkes's questions, I have to say that this happens a lot in the private sector. Big organisations look at regional variations—and indeed international organisations look at national variations—in their operations and, it is fair to say, in many instances the local or regional organisation tries to explain away the differences or to give good reasons why their region or country is different. Often the centre is a bit cynical about and reluctant to accept such regional explanations, because it very often feels that audit data contain profound, substantial and important issues that need to be addressed. Does the Audit Scotland report highlight some profound and important issues that you will be required to address?

George Brechin: Yes, because one of the strands of the quality strategy that we are all taking forward is about addressing variability and variation. It is important that one understands the

variation that you have mentioned, and I think that the NHS has a track record of exploring variation to understand and do something about it instead of exploring it to excuse it and hopefully leave it behind. I think that that is what we are doing. For example, we are looking at this issue in the context not just of the move to 18 weeks but of the new configuration that we will have when we open the new building at Victoria hospital. We are now looking at how we redesign services in advance of the move; after all, you cannot redesign services after you move into a new building, and the report forms part of the information that we will be using. We also discuss these issues with the Scottish Government health directorates' delivery unit—I think that that is the correct name, but I apologise to my colleagues if I have got the nomenclature wrong—in reviews of our performance. As far as explaining our performance is concerned, this is all grist to the mill. We all want to get to better. There is no point in being complacent and saying, "We've got on top of this issue—let's move on."

Nicol Stephen: That leads me to the second part of my question. In many organisations, this sort of report would be delivered by internal not external auditors. You have said that this is the first specialty in the NHS that has had—I was almost going to say "suffered"—this sort of analysis. Still, you know what I mean. You have had this document forced on you. You did not choose to produce this document internally—Audit Scotland produced it. Why is that and why are you not doing this sort of analysis internally? In addition, to follow up on George Foulkes's question, do you see yourselves doing this sort of internal assessment and carrying it forward, learning the lessons and changing how you operate as a consequence of the Audit Scotland report?

George Brechin: I would say that this is the first report that has come from Audit Scotland in this form. Other reports and activities have worked on cross-board comparison for a number of years. We have touched on the arthroscopy audit, which is publicly available on the website. I am not sure—my orthopaedic colleagues will know better than I do—but I think that it is possible to look back over 10 years of comparative data, which we use. We can also look at something called the surgical profiles, which were produced by NHS Quality Improvement Scotland and for which Fife was one of the pilots. Those data look at how people work across the boards in surgery. However, I do not think that we should not welcome Audit Scotland's move into that kind of cross-board comparison. If my internal or external auditors or my quality lead wanted to do something about that, they would have to talk to the other boards. The person who is best placed to deal with that is the Auditor General. It is right that we add this to the armoury of cross-board comparisons.

Nicol Stephen: Is it reasonable for us to challenge you or request that you and the Scottish Government collectively give us a much better understanding of how you will deliver on the core recommendations and other obvious areas not only in this report but in subsequent ones? We are asking for half a day today what we believe are important questions, but we are getting no great sense that there will be a comprehensive change in the way in which the system operates as a consequence. Is it reasonable for us to request that there will be such a response from the minister down?

George Brechin: I cannot speak for the minister, but what I can say—I suspect that I speak for my board colleagues—is that all health boards have processes in place that ensure that we take reports and recommendations from our Audit Scotland colleagues, work through them and report to our audit committees on how we are doing that. We take all of them seriously. You are asking—I understand why—for a collective NHS Scotland response.

Nicol Stephen: An integrated response.

George Brechin: We would have to defer to Kevin Woods, the chief executive, on that and, if need be, to the minister.

Nicol Stephen: But you would welcome that.

George Brechin: Absolutely.

The Convener: We will move on, because time is pressing.

Cathie Craigie: I, too, welcome this study and the work of the Auditor General. However, I would have hoped that a study such as this one would let us see where best practice is operating, whether things are done differently in Fife, for example, and whether that is the way to go, and what effect having the national centre has had on the way in which orthopaedic services are delivered. Although this morning's evidence has clarified the position a bit, there is uncertainty about how the figures have been measured, because we are not measuring like with like. Until we agree the figures, it will be quite difficult to use this report to move forward and deliver orthopaedics in a way that is modern and responsive to the patients. Do the panel members agree with that, or have I been too pessimistic?

Audrey Warden: I can speak for Tayside. I think that the report gives us the opportunity at a high level to look at local investigations and see where the opportunities to change service delivery lie. From Tayside's perspective, we welcome the report. We were also using other data fairly intelligently and we have recently been in

discussion with CHKS Ltd, which is a company that takes data and makes peer comparison, not only within but outwith Scotland. It gives us back data about our performance against a comparable peer. We certainly use those data from both a clinical and a managerial perspective to develop workable solutions for our services in Tayside.

11:30

George Brechin: I reassure the convener and the panel that I am certain—not least because I have just confirmed with Mr Howie that this is the case—that the professional groups will consider the report and that it will be discussed not just by managers such as me but by consultants. I assure you, because I have sat in on some of them, that debates among consultants about performance can at times be quite brutal and frank. You can be reassured not only that the report will be taken forward through the formal processes but that it will be used by informal professional groupings in a process of internal challenge.

The Convener: We move on to the next section of questioning. Reference has been made to the purchase of surgical implants, which Anne McLaughlin will ask about.

Anne McLaughlin (Glasgow) (SNP): Oh!

Bill Kidd: I will ask the first question.

I think that I am correct in saying that the statement was made—I cannot remember by whom—that over recent years there has been an increase in the number of joint replacement operations. If that is correct, it is a very good thing, as it benefits a large number of people in society and returns their lives to them.

However, in paragraphs 91 and 92 on page 32, the report raises the issue of the cost of the surgical implants. The average cost of a hip implant in Scotland varies from £858 in Lothian to more than £1,800 in Forth Valley, and the average cost of a knee implant varies from between £1,100 and £1,200 at the Golden Jubilee hospital to around £2,000 in Forth Valley and the Western Isles. Those are big variations.

Given that more joint replacements are being carried out in a time of budgetary pressures, what are your thoughts on how boards should procure implants and how they should decide which implants to use? Are criteria such as clinical effectiveness and cost used to choose implants? Are individual consultants allowed to choose implants or is the process co-ordinated centrally by each board?

Jill Young: Ninety per cent of all the Golden Jubilee's supplies, including implants, have been rationalised to the extent that they are provided by two suppliers. The remaining 10 per cent of supplies are provided by four other suppliers. That is purely because of patients' specific requirements or because of research or trials of new ways of doing operations.

We are part of the national procurement exercise, so we benefit from the cost reductions that it provides. In addition, because we have only two suppliers of prostheses for hip and knee replacements, we can negotiate an even better deal. The contract is due for renewal in August and we plan to achieve a further significant reduction in cost, certainly for the amount that we use.

The Convener: Bill Kidd mentioned the pressures. Despite that rationalisation, your cost for a hip implant is £1,202, whereas NHS Lothian's cost is £858. Your cost is almost 50 per cent higher. Why cannot you go the extra mile to achieve the same purchasing figures that NHS Lothian achieves?

Andrew Kinninmonth: I do not know how NHS Lothian produced its figures, but I have in front of me our figures, which one of my colleagues produced extremely carefully—almost obsessively, in fact. He came up with the number in the document, which includes some of the add-ons. The cost of the implant—the metalwork and the plastic—is about £800 to £900; it is £828, to be precise. He included in the total price the additional items that are used during the procedure, such as those that are needed for cementing the prosthesis, which is the way that we stick it to the bone, and some of the other bits and pieces that we require, which put it up to the £1,200 mark.

The Convener: So we might not be comparing like with like.

Andrew Kinninmonth: Correct.

The Convener: Either there is a flaw in the way in which Audit Scotland has carried out the work, or there is a flaw in the information that Audit Scotland has been given. It is just absurd that we cannot make a comparison. I do not know whether Colin Howie is able to comment on the Lothian figures.

Colin Howie: I do not want to comment on the Lothian figures. 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 for implant purchase and we are going to a separate EUCOMED contract, as we can get a better price independently. That is the great danger with the point that you have just made.

There are a number of variables within the costs, which are difficult for anybody to capture. A

modern hip replacement that in theory has a better long-term result, such as ceramic on ceramic bearings—a harder bearing, with less wear—is much more expensive. If either the surgeon or, increasingly, the patient believes that they should have that implant, it will push up the costs.

If you ask me, as a scientist looking at the figures, whether there is any direct benefit from that approach in the long term, I would say that there is no evidence of a direct benefit. However, there is an expectation on the part of the public and, indeed, on the part of some MSPs, who write letters on the subject of bearing surfaces and expensive implants, that we should provide that service. When we try to resist that, we sometimes get told that we should not. There is an expectation for patients to have the latest, superwhizzy, all-singing, all-dancing implant. Those are at the more expensive end of the spectrum. The question that we really need to address is whether we should be doing that for everybody and whether we should be considering implant cost.

That goes back to the report, which asked a question on the matter. There are many issues with the information that we have received back, but the knowledge that some people can have a general hip replacement for a bit over £800—we put one in for that—is important.

NHS Fife has been speaking to us about its contract costs for knee replacements, which were not high enough to be cited, but they were a lot higher than ours. We have been sharing that information—perhaps illegally—so that costs can be brought down.

George Brechin: I am not sure I should comment. [*Laughter*.]

The Convener: You cannot comment on Lothian, but Fife is represented here, and the figure for Fife is 20 per cent lower. On the other hand, the figure that is quoted for knee implants is £1,166 at the Golden Jubilee hospital, £1,407 in Tayside and £1,674 in Fife. You cannot comment on Lothian, but the figure for one procedure is 20 per cent lower in Fife than it is at the Golden Jubilee, whereas it is substantially higher for another procedure. What is the explanation?

George Brechin: I will start to explain—and this builds on the original question. A number of years ago, the choice of prosthesis would be down to the individual consultant surgeon. Theatres and orthopaedic teams would have to cope with a number of different replacements, possibly using a number of instrument sets to fit them. Now, we are working with the teams in coming down to a single choice. In Fife, we use one knee replacement, which has been agreed by all consultants. That introduces benefits for safety in theatre and for confidence—everybody knows what they are doing and, if there is not a choice, the right instruments are used. That in itself is a major benefit. Costs have been brought down, and we have been able to use the accompanying purchasing leverage.

We are using an agreed standardised hip implant, as far as we can—although, as my orthopaedic colleagues will point out, the range of issues that might need to be coped with now is broader, so a broader range of prostheses could be required. As you have heard, we are using information to leverage further gains in purchasing. The most important thing has been to secure agreement among those in the surgical community that they wish to use the same implants, or a much more restricted range of implants than they had a few years ago.

The Convener: You mentioned knee implants. Will what you are now doing in Fife ensure that, in future, your costs for knee implants will no longer be 40 per cent or so higher than those of the Golden Jubilee, and that the figures that we are discussing are historical?

George Brechin: No.

The Convener: Your costs will still be higher.

George Brechin: The implants must be the ones that the surgical teams are comfortable with and confident about using. Even if we could make a transition to something else, there could be costs in the transition.

The Convener: So if we had the team from Golden Jubilee, who are comfortable with that, they could achieve a significant saving.

Jill Young: You need to be careful, because changing one part of the equipment has a knock-on effect. With some knee and hip prostheses, the joint requires specialist trays of instruments in theatres. As soon as you change one part of the chain, you must change the sterilising department and the equipment through which the instruments must be put.

The Convener: So all the figures are meaningless.

Ben Clift: The saving is not as big as those that come from salaries and workforce costs, so I do not want to overcook it. National procurement has been in place, but it is not really national procurement, as we are not paying one price for Scotland. I do not really see why we are paying 14 different prices, or different prices for however many health boards there are, given that Scotland's population is not that big compared with the population of an English health board.

Surgeon preference is not a negligible issue, but surgeons can easily learn new techniques if they

have to. If we set a ceiling in broad categories such as cementless hip replacements and cemented hip replacements, and invite companies to reach that point, we would solve the whole problem. I do not see why we are negotiating as umpteen individual health boards, even though, in theory, there is national procurement. We have made the system unnecessarily complicated. Although NHS Tayside has done pretty well in some negotiations, the discrepancies are probably not especially justified.

Bill Kidd: NHS national procurement was set up in November 2005. Paragraph 92 on page 32 of the report states:

"NHS National Procurement estimates that £2 million would be saved each year if NHS boards were able to standardise their purchasing of hip and knee implants."

Many hip and knee implants could be procured and many operations could be carried out for £2 million; obviously, the costs of each procedure vary.

I still find it difficult to imagine that consultant orthopaedic surgeons do not want to move from the procedures and implants that they have always used to something else because they are not comfortable with that. As Mr Clift said, someone in that position should be able to vary their techniques and to be comfortable with a different type of implant after a short period. I do not know whether some people like what they consider to be the gold standard but, in these times of budgetary pressures on the NHS, as much as anything else, we should seek the best value that we can find—that does not mean the cheapest solution—that will deal with the vast majority of knee and hip implant replacements.

Andrew Kinninmonth: I agree entirely. I have been using the same hip implant for 25 years, and it is arguably one of the cheapest.

The Convener: Not exactly the same one for everyone.

Andrew Kinninmonth: I wash it in between. I have been using the same type of implant for 25 years. It is one of the cheapest and has the best record of longevity and quality outcomes. None of the others that are currently available can compare with that. Honestly, I do not see why anyone should use any other kind, but that is open to debate.

11:45

The Convener: It certainly is.

Ben Clift: Other implants can equal that record, although they cannot better it. Many implants have similar outcomes and similar safety profiles. If their prices are similar, that is no problem. A problem arises when somebody says, "I must use this one," just because they want to use it, and it costs £1,000 more.

Colin Howie referred to ceramic hips and so on. More complexity is involved now. However, surgeons can agree in broad groups on a reasonable upper limit. It is up to companies to fight for their market share. However, I do not think that that should be negotiated at health board level.

The Convener: Do the figures not show that a problem exists?

Colin Howie: As a professional, I use the same hip implant as Andy Kinninmonth, because we were brought up together.

George Foulkes: They are joined at the hip.

Colin Howie: However, I disagree slightly with Andy Kinninmonth. The main aim is to do what NHS Fife has done—to ensure that all the surgeons in a group use the same implant. After that, we must consider an implant's long-term outcome—we have 10-year results for hip and knee replacements. That is what we do for hip and knee replacements. We then consider cost. We are high-volume users and the designs are old, which brings down costs. We need to do those tasks to deal with costs.

We deserve criticism for the profligate use in some areas of multiple types of implants without clear guidelines and without control. As a profession, we must take that on the chin. However, telling us all to use the same implant is a mistake. Good examples of why that is the case come from elsewhere in the United Kingdom. The capital hip, which was a look-alike version that 3M produced of a successful hip, produced disastrous results after two to three years. Companies withdrew from the market and the Government was left to pick up a huge problem. That happened when waiting lists came in and somebody somewhere said, "You will use this implant."

A group of surgeons in Southampton who were told to use a specific implant used it badly. As a result, more than 70 patients are now suing the health board in Southampton. A similar story relates to knee replacements in Weston-Super-Mare.

We as consultants need to show rectitude. We all need to use the same implant in the same hospital. We need to consider the cost of implants. As a profession, we need to produce guidelines on expensive implants—we have not done that to date.

Equally, choices are often driven by marketing. We are trying to run an egalitarian system in a capitalist society. I say with all due respect to people around the table that we receive letters that say, "Why isn't this available on the NHS? So-and-

so can have it done privately—you're clearly limiting access to health care." We must recognise that that drives some of our costs.

Anne McLaughlin: My question might have been answered—if I missed that, it is because I was slightly distracted by George Foulkes saying that you and Andrew Kinninmonth were joined at the hip, if you were brought up together.

I understand what Andrew Kinninmonth said about the figures not being exactly the same—he said that the cost per actual implant in NHS Lothian might not be £858 and that the other figures might include elements such as cement. However, the difference between the costs in NHS Forth Valley and in NHS Lothian, for example, is huge. The cost is £1,832 in NHS Forth Valley and £858 in NHS Lothian, which is a difference of just under £1,000. That cannot be accounted for by saying that the figures are on slightly different bases. Do we have information on the longevity of implants? I do not know the other criteria—do they include comfort for the patient?

I accept what Mr Howie says about politicians writing to say that it is unfair that people are not receiving some implants, but we understand that we face additional financial pressures now and that we must all take a sensible approach. It would therefore be useful to know whether you have information—I do not know whether you have talked about it—that allows you to say, "Look—there is absolutely no evidence that this implant will last longer, be more comfortable or be better on any criterion than that implant." Is evidence on the costs available for us to consider?

Colin Howie: Yes—

Anne McLaughlin: I will just ask one more question so that I do not need to speak again. Does Ben Clift suggest that the best way forward is for all negotiating on the cost of implants to be done nationally rather than by each health board individually?

Ben Clift: Well, I answered—

The Convener: Colin Howie can go first, and we will come back to Ben Clift.

Colin Howie: The answer is yes. For hips, there is a group in England called the orthopaedic data evaluation panel, which is supported by the British Orthopaedic Association and the British Hip Society, and sponsored by the Medicines and Healthcare products Regulatory Agency. It produces a list of implants and gives them an ODEP rating. For example, an implant can get a three, five or 10-year ODEP rating, depending on what the long-term results are—that is the length of time for the follow up.

Implants are also defined as being A, B or C; those are the originators. If I designed a hip, it would do well in the long term, but whether Andy Kinninmonth could replicate my results in the long term is a different question. If he could do so, the implant would get an ODEP 10A rating.

Unfortunately, the same system is not available for knee replacements. We can apply the same rules, but the MHRA has not done the same thing in that field. Perhaps somebody at Government level could push the MHRA to do that, because we, as a group of orthopaedic surgeons, think that it would be a good thing to do.

Ben Clift: From the published literature, it appears that there are now a lot of implants with comparable results. We would like one that is definitely better than all the rest, over the short and long term and for all patients, but it is more complex than that. There is not a huge safety issue, but the safety profile and the outcomes are important.

My point—and I am here to be educated on this—is that I do not see why we are negotiating in each different health board, depending on local volumes and so on, for what is basically the same procedure, especially given that some of the boards cover pretty small populations. The industry feeds on that. If it was told that it was supplying for Scotland and implants had to come in at a certain price, excluding those for which there are any doubts about the track record, that would satisfy surgeons and I am sure that there would still be a significant variety of implants to meet personal preferences. That would be a way of dealing with the costs.

We spend a lot of time speaking to people about whether we are going to use certain implants in Tayside. Our rules are that they cannot be any more expensive than what we already have and that we need to see the outcomes. I do not see why there is a big difference. There is custom and practice, but that does not benefit the NHS financially—we can see that it does not.

Anne McLaughlin: It is definitely worth looking into that. To come back to Colin Howie's answer on ODEP ratings, I point out that in NHS Forth Valley each implant costs £1,000 extra in comparison with the costs to NHS Lothian. NHS Forth Valley is not coming back to us to say that an implant has a much higher ODEP rating and will last twice as long, and that the board is trying to save costs in the future.

Would you expect—I appreciate that you do not know for sure—such a wide gap in the ODEP rating to justify that difference?

Colin Howie: No.

George Foulkes: I do not want the witnesses to go away with the thought that we are trying to push them into getting the cheapest possible hip.

An old lady came to see me—I had better not be ageist—

The Convener: Older than you.

George Foulkes: She was a lady of advancing years. She said that she had had three hip replacements, and it was clear that she had only two legs, so I thought that that was very strange. One was a replacement for a previous hip replacement—she had to have a new one because the old one had worn out.

We need to ensure that, as I think one of the witnesses said, people can get just as good a hip replacement under the NHS as they can if they go private, if that is possible. It is not just about how much it costs to have a replacement done, but—as Anne McLaughlin said—how long the implant will last. It is more difficult to put in a replacement for a 90-year-old; it would be better if one that is put in when she is 80 can last until she passes away.

Colin Howie: I can tell you the statistics on that. If you have a hip replacement at 80, you are more likely to get splattered by a bus than you are to have your hip revised. On average, 90 per cent of hip replacements last for 10 years, and 70 per cent last for 20 years. We have not followed them up for 30 years, but I revised a hip that was done 41 years ago because it had worn out. That is a success, not a failure.

George Foulkes: Excellent—that is what we want.

The Convener: Before I move on—

Andrew Kinninmonth: May I just make one riposte to Mr Foulkes? He suggested that people get a better hip replacement in the private sector—

George Foulkes: No, I said that someone else suggested that.

The Convener: It is worth putting on record that George Foulkes would not have said that.

George Brechin: It is unlikely that anyone on this side of the table would have suggested it either.

The Convener: Before I move on to the use of the private sector, I want to go back to what Colin Howie said in response to Bill Kidd's question on NHS national procurement and the suggestion in paragraph 91 of the report that £2 million a year could be saved through the standardisation of surgical implants. Did Colin Howie say that NHS Lothian is thinking about withdrawing from the national procurement arrangements?

Colin Howie: Not only are we thinking about doing that, but we have already done it. NHS Greater Glasgow and Clyde has also just withdrawn from those arrangements. In fact, the pattern was set by major health boards in England, where large providers have withdrawn from procurement systems because they can obtain better costs by doing so. Because the contracts that are set up at national level need to represent the demands of all the different hospitals, the way in which the contracts are set up generally does not suit large-volume users such as NHS Lothian and NHS Greater Glasgow and Clyde. For example, the NHS bodies in Leeds and Nottingham have both pulled out of national procurement for exactly that reason.

The Convener: Clearly, the £2 million saving that is suggested in the report will not be achieved if the major players such as NHS Greater Glasgow and Clyde and NHS Lothian withdraw from the national procurement arrangements. Does that not raise the question about what point there is in having national procurement arrangements if boards withdraw from them?

Colin Howie: Possibly. However, there is a definite benefit from standardising, if not nationally at least within a hospital, as that provides enormous purchasing power. That is the learning point. For the most part, the hospitals with the lowest fixed costs for implants use the same implant for the majority of implants in the hospital. That is the important message.

The Convener: Clearly, we will not get to the bottom of that issue today, but that perhaps opens up a different line of inquiry. If a significant national initiative that was supposed to save the NHS money is being opted out of by the major health boards and that trend is likely to continue, we need to find out what exactly NHS Scotland's national procurement is doing, how it will deliver those savings, whether it has a future and why it cannot do what NHS Lothian and NHS Greater Glasgow and Clyde are doing. We will leave that one sticking for the purposes of today's discussion, but we probably need to delve into it.

George Brechin: Convener, may I say a word in favour of national procurement?

The Convener: Can you explain precisely why national procurement cannot do what NHS Lothian and NHS Greater Glasgow and Clyde are doing?

George Brechin: Where the volumes involved are relatively small, there are attractions for commercial companies in offering just one or two points of supply at a cheaper price than their standard price, which might cover one case a year in Inverness and 10 cases a year in the royal infirmary. For high and medium-sized volumes, national procurement is beneficial. The issue arises when there is a cost to supplying the national level. The procurement people would be able to explain that in more detail, but I do not

wish to give the impression that health boards do not believe in national procurement.

The Convener: Clearly, what the Audit Scotland report says at paragraph 91 will not be achieved, so we need to get to the bottom of that. However, let us leave that one sticking just now, as we are a bit pressed for time.

Willie Coffey will move us on to the use of the private sector.

Willie Coffey: Yes, that discussion brings us quite neatly on to how the NHS uses and commissions the private sector for services. The Audit Scotland report found that national information on how many patients are referred to the private sector for orthopaedic treatment is limited. The obvious question is why. Do we monitor that? Do we know the cost of such services in the private sector? Where are there opportunities to yield savings for the public purse?

In addition, perhaps Mr Howie can clarify what he said earlier about the potential manipulation of waiting lists to send patients to the private sector. Did he mean just to throw that comment on the table? It would be helpful if he could clarify that when responding to the questions.

12:00

Colin Howie: The comment came up in the *Official Report* of the previous committee meeting.

We know exactly how much we spend on the private sector, because we have to pay for that, and we know exactly who goes, because we have to send them. It is an expensive way to deliver health care and it is an option that has been used in the short term to increase capacity, rather than increasing the size of the hospital, changing functions or altering the way in which patients are managed through the hospital. As a professional group, both down in England and north of the border, we are keen for that practice to disappear, because we believe that the service can be delivered more cost effectively within the health care environment by increasing the capacity of existing health care systems. It is a relatively easy calculation to do, and I think it is true to say that a number of the health boards have already done it.

George Brechin: The Fife perspective is that we do not use, and have not used, the private sector, save that one or two individuals have been referred by us to Lothian—I know that this is true for Lothian and it may be true for Tayside—and through that referral route have gone into the private sector. Certainly in the past three or perhaps four years, we have not used the private sector directly.

Ben Clift: Apart from the Netcare experiment—it is a private company but it is not quite the same as the private sector—the situation has been entirely driven by the political targets, to be honest. Nobody wants to send patients down the road for something more expensive. It opens up the specialty to accusations of profiteering—that was mentioned in the previous summary document when the issue was raised. None of us is really for it, to be honest; it has been driven by the targets, and we are playing catch-up with the targets, which are now pretty onerous.

Willie Coffey: I will come back on that, if I may. Paragraph 36 on page 15 of the Auditor General's report states clearly that

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

Mr Howie said the opposite, as he said that that is known.

Colin Howie: It is not—

The Deputy Convener (Murdo Fraser): I shall let Mr Howie in on this subject, but Jill Young wants to come in shortly.

Colin Howie: It is not known nationally how many patients go to the private sector. It also depends on the question that is asked. Do they go to the Golden Jubilee or do they go to Stracathro? Are they dealt with in-house by waiting list initiatives, under which people are paid additional amounts of money to work outwith their normal job plans, or do they physically go to the private hospital and have their operation there? That information is being gathered as part of the 18-week pathway to try to get a handle on how many patients are going elsewhere. The patterns of health care delivery are different in different health boards, but substantial numbers of patients are going elsewhere in all of them. The figures are not collected nationally, so the Auditor General could not get them, which is why they are not in the report, but if you know where to ask, you can get the data.

The Deputy Convener: Jill Young is anxious to comment.

Jill Young: I will pick up on Willie Coffey's point about opportunities to take other approaches rather than use the private sector, because clearly we do not use it at all and have no need for it. We have huge opportunities. We have doubled our orthopaedic performance over the past two to three years and we can do more. We have shared that with boards. This year, we are looking to increase again by another 25 per cent, although we will not be able to bring that into effect until the third and fourth quarter of this year, because of late requests.

We can still do more beyond that, so, from our point of view, there should be no need for people to go to the private sector. However, referrals

cannot be only for one-off backlog clearing of waiting list problems, because for us to do more we have to employ more theatre staff, so we need the assurance that the referrals will continue to come for at least two to three years to allow us to forward plan.

Willie Coffey: I will come back very briefly to Mr Howie. If I was to ask your good self how much NHS Scotland spends on private orthopaedic services, what would the answer be?

Colin Howie: I would not know for NHS Scotland.

Willie Coffey: Who would I ask? Would I ask individual boards and just add it up myself?

Colin Howie: Correct.

The Convener: The committee can possibly do that. As no one else wants to come in on the private sector, we will move on to the role of other services.

Anne McLaughlin: The report considered the variations in access to rehabilitation and particular issues for older people who might need additional medical care. Paragraph 103 states:

"NHS boards should review the provision of rehabilitation services to ensure the needs of orthopaedic patients are met and patients discharged to care homes receive sufficient support."

Seeing as a representative of NHS Fife is here, I also quote paragraph 103:

"For example, in NHS Fife a geriatric orthopaedic rehabilitation unit is only accessible to patients living in east Fife and patients in west Fife receive rehabilitation in the orthopaedic ward which may affect the length of stay for these patients."

Perhaps NHS Fife can talk about that. What provision do health boards generally make for the rehabilitation of older orthopaedic patients? Are you satisfied that, when those patients are discharged, they receive the right level of rehabilitative support?

Dr Montgomery: The rehabilitation that is made available in Fife is consistent; what is not consistent is where it is delivered. That reflects the way in which community health partnerships differ across Fife, particularly in relation to the role of community hospitals and what they are able to offer. Community hospitals are unevenly dispersed across Fife geographically, so although a patient would get the same treatment, they might get it delivered in a different place and perhaps in a different way depending on the local service configuration.

Anne McLaughlin: I do not want to dwell on this, but the report says that receiving rehab in an orthopaedic ward may affect a patient's length of stay.

Dr Montgomery: I will explain why that is an issue. As people cross the interfaces—for example, when a patient is transferred from an acute hospital bed to a community hospital—that, unfortunately, usually generates an extension to their stay. It is about hand-offs and interfaces. It is something that we are conscious of and working very hard on. The treatment that was offered would be the same, but the length of time that it would take would be subject to some variation.

George Foulkes: Sorry, but can I jump back a bit? I should have asked about this under the use of the private sector. George Brechin said that Fife does not refer anyone to the private sector. However, if someone in Fife was in BUPA, they could go to a private hospital without your ever knowing anything about it—is that correct?

George Brechin: Absolutely.

Dr Montgomery: Patients can initiate that themselves, or it can occasionally be done through their general practitioner. However, patients who have been referred to the orthopaedic service in Fife would not be referred on to the private sector.

George Foulkes: So you have no information on that, although there could be lots of people taking that route, and we do not know the figure for Scotland as a whole.

George Brechin: Absolutely. The point that the Auditor General made was that the data on when the NHS pays for access to the private sector are not available. Over the past three or four years, we have not used that route, so the figure for our board is zero. However, there is no national collection of data on when the NHS pays for such services.

George Foulkes: So, a number of patients from Fife could be getting orthopaedic services from private hospitals but you would not know anything about it. Would you know if your consultants were doing the work in the private sector?

George Brechin: I can tell you that, with the exception of one individual who is about to start, or who may just have started, to undertake private practice, the consultants in NHS Fife have not undertaken private practice.

George Foulkes: What about NHS Lothian?

Colin Howie: Are you asking whether our consultants undertake private practice or whether we know the figures?

George Foulkes: Do you know the figures?

Colin Howie: No. A lot of patients come for treatment from Fife, the Borders, the Highlands and other places.

George Foulkes: To that hospital—what is it called? The Murrayfield hospital?

Colin Howie: Yes. The consultants in Edinburgh undertake private practice. However, under the new consultant contract, their time for such work is limited.

George Foulkes: You do not know anything about that work.

Colin Howie: No. It is a bit of a saw that I tend to grind that the private hospitals in general have not contributed to any national data set for the arthroplasty project, for example. We do not know the quality of care in the private sector—there is a vacuum. We do not produce data on the private sector, although we produce data on the NHS.

George Foulkes: What sort of salary does a full-time consultant orthopaedic surgeon in NHS Lothian get paid?

Colin Howie: The same salary as any other full-time consultant on the salary scale.

George Foulkes: What is that?

Colin Howie: Goodness knows—£70,000 rising to £110,000 over their working career.

Nicol Stephen: Plus merit awards.

George Foulkes: Plus merit awards. In their spare time, they could be working in private hospitals.

Colin Howie: Or playing golf.

George Foulkes: Yes indeed.

Colin Howie: I should point out that, historically, those in orthopaedics do not get merit awards or distinction awards to the same degree as those in other specialties.

Anne McLaughlin: Given that Audit Scotland is saying that NHS boards should review rehabilitation services, I wanted to ask specifically about older people who come out of a care home, are treated in hospital and then go back into the care home. Is there a general acceptance that follow-up and rehabilitation services need to be reviewed, particularly for older people?

Colin Howie: The problem is with the definition of a care home. If it is a nursing home where there are nurses, it is expected that the patient will receive nursing care and rehabilitation services, because that is what nursing homes get paid for—nursing homes are paid more per head. There is no such expectation with a care home, and no automatic discharge there, because care homes have no nursing facilities. Most hospitals should be aware of that. There are considerable differences around the country in relation to access to support facilities in the community. Care in the community in Forth Valley, for example, is very good—my sister is in charge of it—but there is considerable difference around the country.

The other problem that we have is the silo mentality. Someone who is 65 will go into orthogeriatric rehab, but someone who is 64, has had a stroke and has a broken hip may not access that same rehab pathway, even though they have the same needs. Someone who is 40 and is crippled with polyarticular rheumatoid arthritis certainly will not have access to that kind of facility. Silos tend to be based on age, which is inappropriate, rather than on need or disease, which would be more appropriate. For many of our patients, fractured neck of femur is almost an end-of-life event. If the patients come from a nursing home, 50 per cent of them will be dead in six months, yet we cannot access terminal care for them, because they do not have cancer.

Ben Clift: I take the point about need. With reference to the remit of this committee in relation to lengths of stay, value for money and so on, most orthopaedic areas would appreciate enhanced input from medicine for the elderly. There are pressures to do with falls clinics and outcome measures, but in terms of hospital management, the needs of a large number of our patients are best met not by us as orthopaedic surgeons but by another specialty. That is an inevitable conclusion of scrutinising the way that these patients are cared for.

The Convener: There is an issue in relation to the elderly. I speak from personal experience. When my father fell and broke his hip on Christmas eve, the operation was carried out on Christmas day—it was instantaneous, which was superb. The problem was with mobilisation immediately afterwards, and with rehabilitation, which did not happen. Because of the lack of follow-up services, my father went from being a relatively fit and active man in his 80s to being virtually chair-bound. I could not complain, nor could the family, about the surgical work that was done. However, crucial follow-up services are often lacking and there is poor planning and delivery. It happened to my father, so clearly it is happening to others.

Ben Clift: There is good evidence that other specialities should be involved at the stage that you describe. Within our specialty, we do not have control over bringing that sort of thing in. There are services in Tayside and elsewhere. That is a fundamental part of the care of those patients that impinges on what we are discussing today.

12:15

The Convener: Absolutely. If it is not done, it just negates the value of the work that you and your colleagues do.

Ben Clift: It does, to an extent.

The Convener: My final question is about prevention. This morning we have discussed the consequences of fractures, accidents and so on. Clearly, it is in everyone's interests to ensure that we avoid where possible incidents or processes that can lead to such injuries. Accidents will always happen—people will always have falls in bad weather—but has there been any research on the impact on the backs and hips of children and adolescents of carrying loads to and from school? I know that, after discussions with the Communication Workers Union, Royal Mail put limits on the weight that postal staff can carry and the distance that they can carry them because of worries about the impact on backs, hips and knees.

Ben Clift: I am not aware of any such research.

Colin Howie: There is research, but not of the kind that the convener is thinking about. There is a direct relationship between knee arthritis and long-term obesity. When you rise from a sitting position, roughly seven times your body weight goes through your kneecap; in other words, if you are a stone overweight, every time you get up the equivalent of 7 stone of potatoes goes through it. That simply wears out the kneecap. The major issue about weight is actually long-term obesity.

There was a theory that carrying a satchel caused scoliosis, but the evidence for that is slim to non-existent. In general, though, any heavy weight will increase load on joints and therefore increase wear. For example, international rugby players have only a 50:50 chance of getting to 50 without needing a knee replacement because of the trauma caused to their knees.

Dr Montgomery: Just to further emphasise Colin Howie's point, I think that the biggest two issues that we face are the epidemic of obesity and the relative immobility of younger people. A lot of what orthopaedic colleagues are picking up now are the sequelae of people living longer but not having particularly healthy bones. Bone health is about diet, exercise, weight and a number of other issues.

The Convener: On behalf of the committee, I thank you for your time and your contribution to what has been a long but very informative evidence session. A number of issues have been addressed and you have left us with a number of other questions that we will need to pursue further.

I suspend the meeting for a couple of minutes.

12:18

Meeting suspended.

12:22

On resuming—

"National Fraud Initiative in Scotland"

The Convener: Item 3 on the agenda is on the report "National Fraud Initiative in Scotland". I invite the Auditor General to brief us on the report.

Mr Robert Black (Auditor General for Scotland): I invite Russell Frith, who is our director of audit strategy and who had led on the project, to brief the committee.

Russell Frith (Audit Scotland): Thank you for the opportunity to brief the committee on the report. One of the key messages in it is that attempted fraud is likely to increase during times of financial hardship, so public bodies need to remain vigilant. Giving exposure to reports on anti-fraud exercises through Parliament and the media can only help to increase the deterrent effect that such exercises have.

The national fraud initiative is a data-matching exercise that Audit Scotland carries out to help our audited bodies to detect fraud and error. It matches a number of data sets, such as payroll, housing and council tax benefit records and student, pensioner and deceased persons records across a range of public bodies to identify matches that require further investigation by the public bodies. Just because something appears on one of the match lists, it does not automatically mean that it is a fraud or an error. All matches require further investigation to clarify the circumstances.

We conduct the exercise jointly with the Audit Commission in England, which takes the lead on procuring the company that carries out the matching and on providing the secure website. That is, in a small way, an example of a shared service that really works—it would be much more expensive for us to try to do the exercise alone. We operate to very high security standards. Data can now be submitted to the exercise only electronically and matches are provided back to the participating bodies via a secure website. There is no physical transmission of data.

The outcomes from the exercise have been valued at just over £21 million, which is the highest so far of the three full exercises that we have carried out. That does not necessarily mean that fraud and error are increasing, because the amount includes a fairly large amount that has come through from the previous exercise since we last reported two years ago, and it also reflects a

widening of the scope of the exercise, particularly the introduction of looking for invalid single person discounts in council tax.

Examples of the outcomes from the exercise include 179 occupational pensions that have been stopped because they were being paid to deceased persons and about 1,600 housing benefit payments to public sector employees, pensioners or students that have been reduced or stopped.

We have included a number of case studies covering some of the more interesting matches in the report, such as a salaried professional who was paid by two councils for nearly two years. That is a good, simple example of something that the NFI can pick up on because we have taken the payrolls from all the councils and have run them together and can see whether someone appears on more than one, in which case a question arises.

A new area of work this time has been to match electoral roles to council tax records to identify possible cases where single-person discounts have been invalidly deducted. Our work led to some 4,300 discounts being withdrawn across a number of councils. Further, the fact that NFI was doing that prompted other councils to employ a private sector credit reference agency to carry out similar work, which identified many more invalid discounts. We regard that as a success, because NFI has prompted councils to take controls in this area much more seriously, which has resulted in them gaining big cash rewards.

Similarly, in the years between NFI exercises, the Scottish Public Pensions Agency now matches its records to data on deceased persons, which are provided by the general registrar. That results in a good increase in the control environment.

This report has followed up a number of the case studies from the previous report to indicate the range of sanctions that are being imposed, which range from fines through to community service orders to a small number of jail terms. We now know that 190 cases from the last exercise have been referred to the procurator fiscal and that there have been about 80 successful prosecutions, with another 48 or so in the pipeline.

When I briefed the committee on the last report in 2008, I said that our sister organisations in the rest of the UK had been given explicit powers to conduct these exercises, and that we hoped to obtain similar clarification of our powers in Scotland, to enable us to increase the range of bodies taking part and to enable cross-border matching to take place. At the moment, if someone lives on one side of the border and works on the other side of the border, we cannot include those matches. The committee was supportive of that, and the new powers are contained in the Criminal Justice and Licensing (Scotland) Bill that is before the Parliament and will proceed to stage 3 in the next couple of weeks. We intend, assuming that the bill is passed, to widen the scope of the next exercise, which starts in October, to include the larger central government bodies. That will give us a pretty full coverage of the public sector in Scotland.

The Convener: You mentioned that one employee had been paid by two councils for almost two years. Apart from the fraud, does not that say something about the council that continued to pay a salary and about the incompetence of the managers who failed to check their own budgets, which would have shown that that person was still receiving a salary? The fraud has been dealt with, which is commendable, but has the council taken any steps to deal with the incompetence of its staff and their failure to deal with the situation?

12:30

Russell Frith: Yes. The council has looked into why the case happened and it appears that there were some unusual circumstances around the employee who left. The person was, in effect, on an internal secondment to another bit of the council and left from that secondment rather than returning to their substantive post. I fully agree with the point that you make, but the council, having looked into the matter, believes that it was a fairly unusual set of circumstances.

The Convener: Your report states that some councils that declined to take part

"had reservations about providing the electoral register to Audit Scotland for legal reasons."

I realise that it is possible to have a redacted electoral register, but my understanding is that, as elected members, we have access to the full register.

Nicol Stephen: It is provided to commercial organisations.

The Convener: The redacted register is provided to commercial organisations, but I am not sure that the full register is.

Russell Frith: Specific legal measures apply to the provision of full electronic copies of the register. Theoretically, we could access a written copy of the register and try to scan the whole thing, but there are specific provisions on access to full electronic copies. We hope that the new powers will resolve any remaining grey areas.

Nicol Stephen: Convener, what is the redaction?

The Convener: Any one of us can apply to the electoral registration office to have our details withheld from the information that is given to commercial companies.

Nicol Stephen: So it is like the telephone preference service.

The Convener: Yes.

Bill Kidd: My question is on similar lines to the convener's first question. In paragraph 58 on page 15, you state:

"The NFI matches council tax records with the electoral register".

However, I presume that the council already holds both pieces of information, so should it not be able to do the work itself?

Russell Frith: Technically, the registers are generally held by joint valuation boards, which carry out the electoral registration work, rather than by councils.

George Foulkes: The report makes an interesting point about blue badges. I find it particularly annoying that many able-bodied people park in disabled parking spaces and use them illegally. Paragraph 67 states:

"Perth & Kinross and Fife Councils each corrected more than a thousand records."

Given that the total number of corrections in Scotland was only 4,340, that suggests that other councils are not making corrections as efficiently and effectively as Perth and Kinross Council and Fife Council are, because I do not think that there are more law breakers in those areas than there are in Edinburgh, Glasgow, Dundee or Aberdeen. What can we do to get the other councils to follow the examples of Perth and Kinross and Fife?

Russell Frith: I do not think that that is quite the right position. For example, Glasgow took part in the previous cycle as a pilot exercise—it is the largest council to have been involved—therefore we would not expect it to have a significant number of corrections again. Also, the numbers depend on the steps that councils had already taken and the efficiency with which relatives or others returned badges in the past. Nevertheless, we encourage all councils to take part in the work.

George Foulkes: Who is encouraging councils to do that? Is it Audit Scotland, the Government or the Convention of Scottish Local Authorities?

Russell Frith: Our auditors having got the results this time, we encourage the individual external auditors to talk to the councils about specific data sets and how they handle them.

George Foulkes: Good. Thank you.

Willie Coffey: Exhibit 5 on page 12 shows the range of offences. The figures add up to about 10,000 offences. You said earlier that they were not all crimes, because some cases were due to errors. For example, housing benefit overpayments can be simple errors. However, there is an incredibly low number of referrals to the Procurator Fiscal Service. An incredibly low number of proceedings were taken up compared with the tally in the report. Are we to conclude that the vast majority of cases were payments that were made in error rather than crimes that were deliberately committed to defraud the state of funds?

Russell Frith: It is difficult to say how many were crimes. For example, one of the biggest numbers relates to blue badges. It is quite possible that a significant number of badges were simply left in a drawer when the person died—they were not sent back but nor were they used fraudulently. We are unable to tell from this exercise the degree to which that happened.

In a number of cases, particularly ones that deal with pensioners, the bodies concerned are less likely to refer cases for prosecution. They would rather just sort them out and make any recoveries that they can. It is quite rare for cases involving pensioners to be referred to the procurator fiscal. The exception would be if the case were serious.

Willie Coffey: In my experience, when local authorities deal with housing benefit overpayments, they do not tend to prosecute anyone. However, a proportion of authorities must have determined that there was a deliberate act rather than a simple error, misunderstanding or delay in submitting forms and receipts. There seem to have been few proceedings in which it was shown that there was a deliberate attempt to defraud. Is there a move to strengthen the process so that we can bring down some of the numbers?

Russell Frith: We can certainly consider that more closely during the next cycle.

Anne McLaughlin: I found the report utterly fascinating. I have decided that if I am not re-elected, I will indulge my inner Miss Marple and ask for a job with the national fraud initiative. It is amazing how things are worked out. However, I wondered about the single person's council tax discount, and matching it with the electoral register. What would be the point of doing that in Glasgow? Most of the city is tenements, and the electoral register does not include flat positions. Paragraph 60 says that Glasgow City Council

"prefers to use a credit reference agency"

to do that work because of the additional data from that source. Is that correct?

Russell Frith: That is one of the reasons why councils tend to use credit reference agencies. The data sets are different. I will not sit here and

say that matching with the electoral roll is the only way of obtaining the information because, as you know, the electoral roll is not necessarily complete. We used that example because it is a good starting point, using the data sets that are available to us.

Anne McLaughlin: I advise anyone who is planning to commit fraud to read the report first.

The Convener: I have two questions on the Student Awards Agency for Scotland. The first is on an issue that you refer to in case study 8. It is all very well identifying people who are not entitled to be in the UK and taking action against them, but the case study raises the question why they were given the money in the first place if they were not entitled to be in the UK. Are no basic checks done by the SAAS?

Russell Frith: I cannot answer that question. I do not know.

The Convener: Would it be possible to find out? Why is a public agency paying out money to people who are not entitled to be in this country? It is fine for the SAAS to identify such students and tell the Home Office their whereabouts, but it beggars belief that it pays out money in the first place.

Secondly, if a student knowingly provides false information to the SAAS in order to claim additional income, the agency will clearly seek to recover that money if it becomes aware of the situation. However, that is a fraudulent act on the part of the student. To take Willie Coffey's point, does that render the person who makes the claim liable to prosecution for knowingly giving false information?

Russell Frith: I would have thought so, yes.

The Convener: Does the SAAS carry out any basic checks, or does it just take everything that is sent to it at face value?

Russell Frith: We will find out and come back to you.

The Convener: Okay.

My next question is on something completely different. I had a meeting this week with a number of nursery and out-of-school care providers in my area. They raised an issue with me that I find truly staggering. It started off with a case reported in the local papers of a group of people acting in a criminal way. They were charged and prosecuted for making fraudulent claims for, I think, working family tax credits—they were claiming that money was being paid for out-of-school and nursery care.

It turns out that there was a well-organised scam. One of the nursery providers—who were not involved in any way; it was just that their name was used—told me that they had a 48-place nursery at the time but that, if the number of people in the town who said that they were paying money for their child to be placed at the nursery had been aggregated, it would have come to something like 350. The nursery provider suggested that the fraud was happening not only locally but nationally and indeed internationally, and they gave me the example of people abroad making claims from the child tax credit system.

If that small snapshot is anything to go by, we are talking about multimillion-pound—maybe even billion-pound—fraud in benefit, with no apparent checks being done until after the event. Is that something that the national fraud initiative can look at, or is it simply the case that, if people have suspicions, they must report them to the police? That is not always the easiest thing to do, as the police have other issues that they need to respond to.

Russell Frith: It is highly likely that it would not be open to the NFI to look at that issue. The law on all data relating to taxation is extremely strict and predates the NFI. It has always been the case that information held by Her Majesty's Revenue and Customs is subject to far greater confidentiality requirements than information held by some others. If HMRC data were needed as the source, I doubt that we would be able to bring them in under the present law.

The Convener: So if people have identified loopholes in the system and are organised with criminal intent, there is virtually no way of identifying that other than by waiting for someone to be reported, charged and prosecuted and for an investigation to be carried out.

Russell Frith: I cannot see immediately how we would be able to address it through the NFI, although obviously HM Revenue and Customs has its own data analysis sections.

Nicol Stephen: You could draw it to the attention of HMRC, and if it could link the issue to an individual provider—an individual nursery—it could find out what is happening.

The Convener: That is part of the problem. In the case that I mentioned, that happened and the police investigated, but it has been said to me that scams are going on all over the country—

Nicol Stephen: And it is not happening in other cases.

The Convener: That is right—and we are talking about major amounts of money.

Okay, I will take up that issue separately.

Section 23 Report (Response)

"Improving public sector efficiency"

12:44

The Convener: Under item 4, we have a response from the accountable officer to our investigation into improving public sector efficiency. Are there any comments?

Willie Coffey: I do not know how much further we can pursue the response about how particular suppliers get on to the approved list, as Ms Manzie has given us a reasonable explanation. However, I am always interested in whether qualitative assessments are carried out on potential suppliers or whether the companies that get on the list tend to be bigger and able to offer economies of scale.

I am always keen to find out whether smaller companies, businesses and operations can find their way into procurement frameworks—not just in this issue but across the board. It is not clear to me that that is the case, and I sometimes worry that we have systems in place that favour larger companies and enterprises that can make economies of scale. Perhaps that is the ultimate point—to drive down costs—but there has to be a way in which smaller businesses can participate in the procurement process.

The Convener: Okay. Other than that comment, shall we just note the response?

Nicol Stephen: I have a separate point about national procurement from the earlier evidence—although we are perhaps coming on to that.

The Convener: Yes, we will deal with that when we come to consideration of that evidence.

Nicol Stephen: Okay.

The Convener: With that, we move into private session.

12:46

Meeting continued in private until 13:01.

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