House of Commons

Committee of Public Accounts

Hip replacements: an update

Seventeenth Report of Session 2003–04

Report, together with formal minutes, oral and written evidence

Ordered by The House of Commons to be printed 29 March 2004

HC 40
Published on 5 May 2004
by authority of the House of Commons
London: The Stationery Office Limited
£10.00

The Committee of Public Accounts

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Summary

Hip replacements are one of the most common and most effective major surgical procedures performed in the NHS. Over 43,000 are carried out each year, bringing mobility and relief from pain. The way in which the hip replacement pathway of care for patients is managed and organised—from initial GP consultation through to operation and discharge from hospital—has implications for the economic, efficient and effective use of the resources of NHS acute trusts, and above all for the quality of care provided to the patient.

In April 2000 the Comptroller and Auditor General reported on elective hip replacements.[1] His report highlighted areas where there was scope to improve the efficiency and effectiveness of hip replacement procedures as well as the quality of patient care. We subsequently made a number of recommendations for improvements.[2] Since then there have been a number of key developments including the launch of a National Joint Registry, and the publication of guidelines by the National Institute for Clinical Excellence (NICE) on the evidence of effectiveness required for hip prostheses used in the NHS.

On the basis of a further Report by the Comptroller and Auditor General,[3] we looked again at elective hip replacement in the NHS, including the progress made in the last three years in implementing our previous recommendations.

1 C&AG's Report, *Hip replacements: Getting it right first time* (HC 417, Session 1999–2000)

2 43rd Report from the Committee of Public Accounts, *NHS Executive: Hip Replacements—Getting it right first time* (HC 513, Session 1999–2000)

3 C&AG's Report, *Hip replacements: an update* (HC 956, Session 2002–03)

Conclusions and recommendations

1. **Around 1 in 10 of consultants use hip prostheses for which there is inadequate evidence of effectiveness.** Innovation can bring benefits for patients, but there need to be strict safeguards for new models with little or no track record. The NHS Purchasing & Supply Agency should issue a full list of prostheses which meet the NICE standard as soon as possible.

2. **To get the most value from the new National Joint Registry, it needs to be comprehensive.** Currently only around half of NHS hip and knee replacement operations are recorded. The Department should identify the best means of encouraging wider participation, which might involve making data submission by NHS trusts mandatory, and implement it without delay.

3. **Around 40% of trusts are offered incentives to introduce new prostheses, and around 1 in 10 of consultants had accepted incentives from hip prosthesis manufacturers.** Departmental guidance sets out rules to ensure that incentives are transparent, properly authorised and do not impact adversely on patient care. Such incentives have the potential to distort clinical judgement and to prejudice the value for money of procurement decisions. The Department should explore with suppliers how these incentives might be phased out.

4. **Patients should receive their hip replacement from a surgeon who has the experience and knowledge gained by carrying out the operation frequently.** About half of consultants undertaking primary hip replacements do so less than the equivalent of once a week, and a significant proportion may gain insufficient experience to maximise their skills and knowledge. We recommend that the Department of Health considers as a matter of urgency advising patients as to the advantages of seeking a surgeon who regularly undertakes a number of operations a week.

5. **The Department should obtain a good understanding of the relationship between numbers of operations carried out by individual surgeons and their outcomes.** It should then set minimum annual numbers of primary and revision hip replacements to be undertaken by surgeons who work in the NHS.

6. **Too many referrals from General Practitioners for hip replacement turn out to be inappropriate.** Trusts should give feedback to individual GPs on their referral patterns.

7. **Primary hip replacements cost from £2,266 to £7,456.** The Department should establish the reasons for the wide variation in costs, including whether costs are recorded accurately, and the scope for greater efficiencies.

8. **The roll-out of Treatment Centres risks a mismatch between the need for and provision of additional capacity in the NHS.** To mitigate that risk, the Department should take stock of the establishment of Treatment Centres to date, and apply the lessons in rolling out the next tranche.

9. **Despite our predecessors' recommendation that standards should be set for follow up of hip patients after surgery, such standards are still not in place.** The Department should implement that recommendation and agree standards with the British Orthopaedic Association without further delay.

10. **Although use of care pathways brings significant benefits for patients, only 50% of trusts use them for hip replacement cases.** Use of care pathways by trusts, general practitioners and others involved in patient care should be universal for routine hip replacement work and pathways should be based on established templates to ensure consistency of good practice.

1 The effectiveness of hip prostheses

1. There are some 64 hip prostheses on the UK market. In our previous report we noted that some 14% of consultants had limited evidence of the effectiveness of the prostheses they used routinely. In April 2000 guidance by the National Institute of Clinical Excellence (NICE) set out the standard that hip prostheses used in the NHS should meet. The NHS Purchasing and Supply Agency has not yet drawn up a planned list of those prostheses which meet the NICE standard, but we would have expected that by now most consultants would be using such prostheses. 13% of consultants use prostheses that do not or may not do so however, and 11% of consultants still use prostheses for which they have no published evidence of effectiveness.[4]

2. The Department agreed that it was unacceptable for consultants to use routinely prostheses which did not meet the NICE guidelines. It intends to ensure that primary care trusts—who commission orthopaedic services from acute trusts—insist that all prostheses used meet the NICE guidelines or are part of a clinical trial, and for the patient to have that information.[5]

3. The National Joint Registry, covering hip and knee replacements and recommended by us in our previous report, was launched on 1 April 2003. The contract to run the Registry expires on 31 March 2005 when the arrangements will be re-evaluated. After six months of operation there were 30,000 entries on the Registry, and all hip and knee prosthesis manufacturers were complying with it. To be fully effective the Registry needs to capture information from all consultants and all trusts involved in hip replacement surgery. It is disappointing therefore that it only records around 50% of hip and knee replacements carried out in the NHS.[6] The value of the Registry may be compromised if compliance is not significantly increased.

4. Both NHS trusts and individual consultants are offered incentives by hip prosthesis manufacturers to trial their prostheses. The Comptroller and Auditor General found that nearly half of trusts are offered incentives to introduce hip prostheses they would otherwise not purchase; and nearly 10% of consultants had accepted incentives from manufacturers, mainly in the form of international travel for training purposes.[7]

5. The Department's guidance provides that incentives should be transparent, publicly declared, and should not impact on patient care. Two thirds of incentives accepted by consultants were not properly recorded, however, and most free or subsidised international travel was not appropriately approved.[8] The acceptance of incentives is therefore not being properly monitored and controlled.

4 C&AG's Report, paras 7, 2.1, 2.3, 2.5

5 Qq 8–10, 88–90, 93–94

6 Qq 7–8, 71–81

7 C&AG's Report, paras 2.18, 2.20

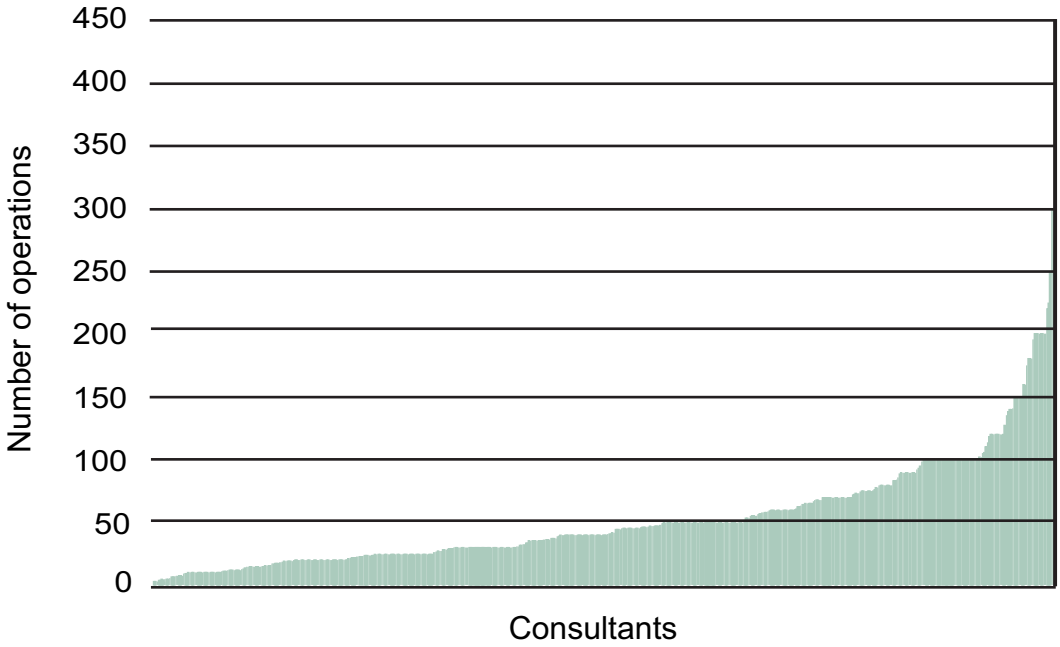
8 *ibid*, paras 2.19–2.20 and Figure 5

2 Improving patient care

6. There is increasing evidence of a direct relationship between the number of hip replacements carried out by individual consultants and outcomes. In particular, studies in the US have shown a significant relationship between low work volumes and poorer outcomes.[9]

7. **Figure 1** illustrates the volume of hip replacement operations performed by 650 consultants, and shows that many consultants are doing less than one primary hip operation per week.[10] It is questionable whether low volumes of surgery are sufficient to maximise patient outcomes, and there are moves within the private sector to introduce minimum volume levels for their hip replacement consultants.

Figure 1: Number of primary hip operations performed by consultants in England in 2001–02



8. The Department told us that Figure 1 covered a variety of different practices and different groups of patients, but expected intuitively that there was a relationship between volume of work and clinical outcomes. In this context, the Department expected individual trusts to manage the potential risks of those surgeons doing relatively few operations, for example, by undertaking clinical audits.[11] Such measures have a role to play, but they do not substitute fully for a better understanding of the link between volume of work carried out and its quality. Information from the National Joint registry is to be used to look at the issue more closely, and a working group including the British Orthopaedic Association will provide advice to the Department in summer 2004 on the impact of surgeon volumes on clinical outcomes.[12]

9 C&AG's Report, para 3.10

10 *ibid*, Figure 10

11 Qq 15, 26–27, 36–64, 83, 95–101, 108–111

12 Ev 16 (ref Qq 108–110)

9. The Comptroller and Auditor General found that 10% of consultants mainly prioritise their patients on the need to meet waiting time targets. A survey by the British Orthopaedic Association in 2001 found also that over half of trust orthopaedic units had been asked to operate on long waiting patients at the expense of more clinically urgent patients.[13] The Department agreed that distorting clinical priorities to meet waiting time targets was unacceptable, and that any examples of inappropriate prioritisation should be investigated by the trust Chief Executive and acted on. The underlying principle was that all clinically urgent patients must be treated first in order of priority, with routine patients being treated in chronological order.[14]

10. **Figure 2** shows the average wait as at October 2002 for an outpatient and inpatient appointment for each consultant undertaking hip replacement surgery. The average waiting time for hip replacement is the same as it was in 1999, and the average total wait, from GP referral to surgery is nearly 12 months.[15] The Department explained that waiting time for the longest waiting patients had reduced, with the maximum wait down from 18 months to 12 months. Current average waiting times were influenced by increasing demand for hip replacements, but progress was being made.[16]

13 C&AG's Report, para 3.5

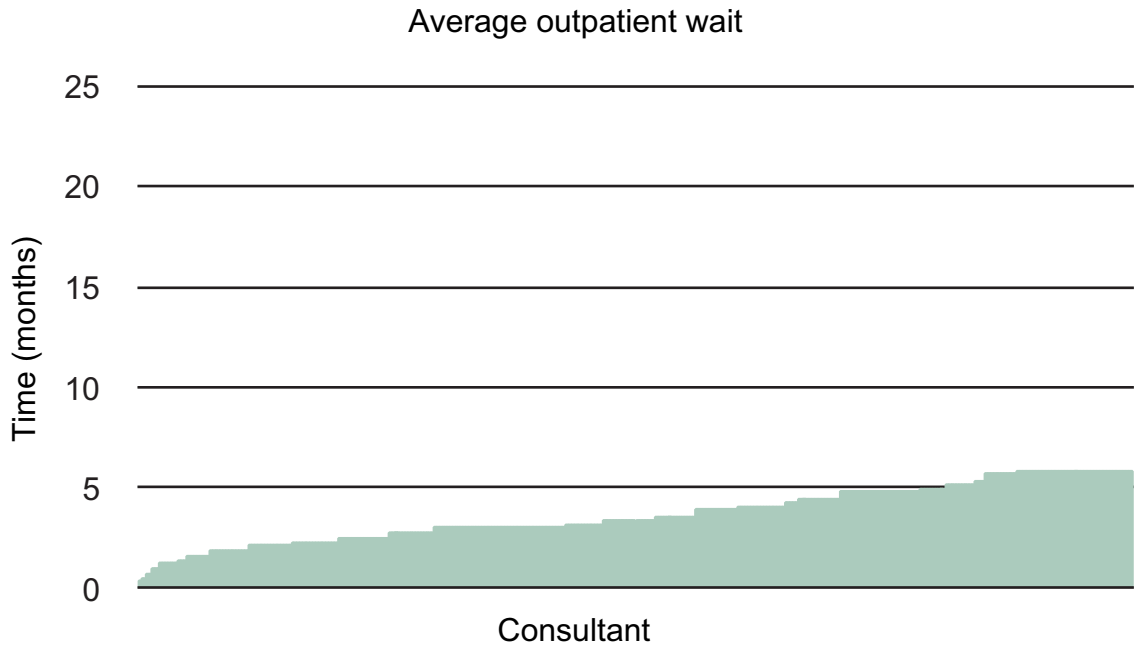
14 Qq 122–124, 127–130

15 C&AG's Report, para 3.4 and Figure 6

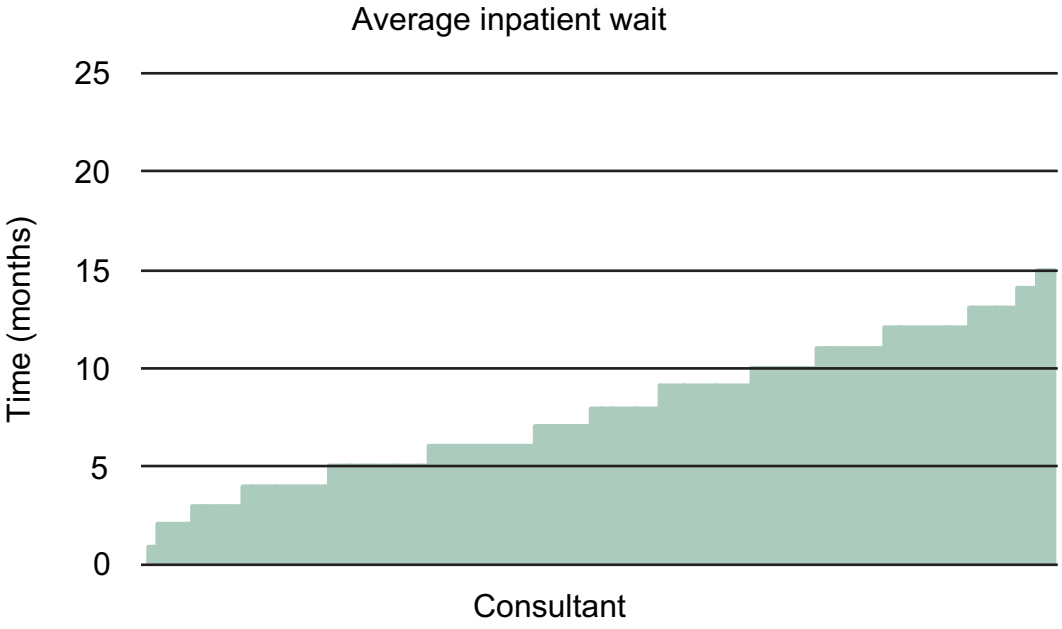
16 Qq 11–14

Figure 2: Average wait for an appointment as at October 2002

(a) Average outpatient wait in England



(b) Average inpatient wait in England



11. The Department of Health has launched a major programme to create a number of Treatment Centres which will provide fast treatment for patients in specialties with long waiting times, such as orthopaedics. They will handle only elective treatment, with emergency cases being dealt with in NHS trusts. The first Centres opened in 2002.[17] We recently visited the Ravenscourt Park Treatment Centre in West London and were impressed by the facility, which specialises in orthopaedic work.

17 C&AG's Report, paras 5.1–5.3

12. There are currently 47 Treatment Centre schemes of which 11 are fully open and 24 are partly open,[18] which together will deliver an extra 144,000 operations a year by the end of 2005.[19] The number and location of the Treatment Centres is based on plans submitted by all Primary Care Trusts in 2002, derived from the estimated capacity needed to meet the inpatient waiting times of six months for 2005.[20] Where capacity was not available through the NHS or it seemed better to do so, the private sector was invited to tender to run Treatment Centres, getting a subsidy to do so and, if necessary, bringing in doctors from abroad.[21] Whilst the five London Strategic Health Authorities worked together to plan for the needs of London,[22] in some cases private sector Treatment Centres are being sited close to those run by the NHS, and will be in direct competition with them, particularly as more capacity comes on-stream.[23]

13. While demand is increasing, and waiting times remain high, Treatment Centres can offer considerable advantages to patients in terms of reducing their waiting time for surgery. As waiting times are reduced, however, there may be a question of over-capacity in the future, especially within specific localities, and it is important that there should be fair competition between NHS and private sector Treatment Centres.[24]

18 Q 68

19 Ev 15 (ref Q 19)

20 *ibid*

21 Qq 69, 126

22 Ev 15 (ref Q 22)

23 Qq 21–22, 68–70

24 Qq 3–5, 19–25, 65–70, 126

3 Improving value for money in hip replacement

14. The previous Report on hip replacements by the Comptroller and Auditor General[25] highlighted aspects of hip replacement procedures where there were opportunities to improve value for money. Areas identified included GP referral practices, the cost of hip replacement, lost theatre time, follow up of patients, and length of patient stay.

15. Over the last three years the number of consultants who said that a quarter or more of referrals to them was inappropriate has increased from 6% to nearly 10%. This is equivalent to nearly 15,000 hours of consultant time wasted each year. Inappropriate referrals not only waste valuable consultant time, but may also not be in the best interest of the patient.[26]

16. The Department was unable to say why this increase in inappropriate referrals had occurred. A number of referral centres had been set up to which GPs initially referred, which then decided whether and to whom to refer those patients. GPs were also being encouraged to train and develop their special interests and expertise,[27] which should impact on their referral practices and better educate them as to treatment options and their impact on patients.

17. The Comptroller and Auditor General's Report notes that the average cost of a primary hip replacement operation recorded by Trusts in 2002 was £4,274, with a range from £2,266 to £7,456.[28] This is an unacceptably wide range, and the Department was concerned about it. The Department noted that the range was reducing year by year, and suggested that figures at the lower end of the range may not have included all relevant costs.[29] The Department expect that the introduction of a national tariff, which becomes fully operational in 2005–2006, will drive down cost differences.[30]

18. The average avoidable delay in starting hip replacement operations is around two and a half hours a week in each trust, representing about 19,500 lost theatre hours each year across England, compared to about 10,000 hours lost in 1999.[31] This major loss of operating time in 2002 amounted to some 500 surgeon weeks. The Department told us that this reflected the need to handle emergency work, and was partly due to staff shortages. Other factors included a shortage of beds and patients being medically unfit for surgery. The Department was looking at ensuring good practice in operating theatres and a properly planned service.[32] The implementation of guidelines from December 2002 for

25 C&AG's Report, *Hip replacements: Getting it right first time* (HC 417, Session 1999–00)

26 C&AG's Report, para 4.3

27 Qq 17, 106

28 C&AG's Report, para 4.5

29 Qq 105, 115–117

30 Ev 16 (ref Q 117)

31 C&AG's Reports, *Hip replacements: Getting it right first time* (HC 417, Session 1999–00) para 3.9 and *Hip replacements: an update* (HC 956, Session 2002–03) para 4.7

32 Qq 107, 111–113

improving operating theatre performance provided an opportunity to achieve a reduction in lost theatre time in the near future.

19. Follow up of patients after hip surgery is essential to allow consultants to identify the need for revision surgery at an early stage if needed. Our previous Report on Hip Replacement work recommended the setting of standards for follow up.[33] Such standards have not been introduced. The majority of consultants follow up patients for as long and as often as they think necessary, but over 20% do not, mainly because of shortage of time or pressure to meet waiting time targets.[34] The Department acknowledged that there was scope for further improvement, and that there was a need to do more follow up of hip replacement patients.[35]

20. In recent years there has been some success in reducing length of stay in hospital, which has declined from 11 days in 1999 to 8 days in 2002 for primary hip replacement; and from 16 days to 11.5 days for revision surgery. Many consultants consider that length of stay can be reduced further, though in doing so the needs of patients who have been operated on must be the most important consideration. When justified, earlier discharge means resources are freed up for new patients. **Figure 3** illustrates how trusts can treat more patients by reducing length of stay.[36]

Figure 3: Treating more patients by reducing length of stay

	Number of beds in hospital		
	40	**60**	**80**
Reduction in length of stay (from an average length of stay of 8 days)	Number of additional patients that can be treated in one year		
1 day	**146**	**219**	**291**
2 days	**340**	**510**	**680**
3 days	**612**	**918**	**1224**

21. The use of an integrated care pathway for hip replacement is one way in which to reduce length of stay while also achieving equal or better clinical outcomes. Around half of trusts now use or are developing such a pathway,[37] but our earlier recommendation that all trusts should use them is still far from being met.

33 43rd Report from the Committee of Public Accounts, *NHS Executive: Hip Replacements—Getting it right first time* (HC 513, Session 1999–2000)

34 C&AG's Report, para 3.18

35 Qq 102–104

36 C&AG's Report, paras 4.10–4.12 and Figure 14

37 *ibid*, para 3.9

Formal minutes

Monday 29 March 2004

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Allan	Mr Brian Jenkins
Mr Richard Bacon	Mr George Osborne
Mrs Angela Browning	Jon Trickett
Mr Frank Field	Mr Alan Williams

The Committee deliberated.

Draft Report (Hip replacements: an update), proposed by the Chairman, brought up and read.

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

Paragraphs 1 to 21 read and agreed to.

Conclusions and recommendations read and agreed to.

Summary read and agreed to.

Resolved, That the Report be the Seventeenth Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

Ordered, That the provisions of Standing Order No. 134 (Select Committees (Reports)) be applied to the Report.

Adjourned until Wednesday 31 March at 3.30 pm

Witnesses

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Oral evidence

Taken before the Committee of Public Accounts

on Wednesday 26 November 2003

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Allan
Jon Cruddas
Mr Brian Jenkins
Mr Alan Williams

Sir John Bourn KCB, Comptroller and Auditor General, further examined, and **Mr James Robertson,** National Audit Office, examined.

Mr Rob Molan, Second Treasury Officer of Accounts, HM Treasury, further examined.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL:

Hip replacements: an update (HC 956)

Witnesses: **Sir Nigel Crisp KCB,** Permanent Secretary/NHS Chief Executive and **Ms Margaret Edwards,** Director of Access, Department of Health, examined.

Q1 Chairman: Good afternoon, welcome to the Committee of Public Accounts where, this afternoon, we are looking at the progress of hip replacements, dealing with the Report by the Comptroller and Auditor General on that subject, and we welcome back, after a very brief absence, Sir Nigel Crisp.
Sir Nigel Crisp: Thank you.

Q2 Chairman: I hope you feel refreshed after your last appearance in front of us. Could you please introduce your colleague?
Sir Nigel Crisp: I am joined by Margaret Edwards, who is our Director of Access.

Q3 Chairman: Thank you very much. May I say that some Members of the Committee visited Ravenscourt Park Hospital yesterday, Nigel, and we were very impressed with what we saw.
Sir Nigel Crisp: Good.

Q4 Chairman: We were very impressed by this facility, which is a dedicated facility for hip replacements, where consultants and doctors are able to concentrate on a very narrow range of hospitals. There is nothing more I need to say on that but it may be that other Members who attended our visit may have some questions for you on that sort of subject. Do you want to comment, by the way, on these dedicated centres, like Ravenscourt Park Hospital? It does seem to be a way forward.
Sir Nigel Crisp: Yes, I think it will be for more areas of elective surgery, and in London I think we are going to have three or four (I cannot quite remember)—one in south west London, which is a co-operation between four hospitals there, which will actually be based in Epsom. I think this separation of planned elective surgery away from emergency surgery will be the way to go in a lot of different cases.

Q5 Chairman: A point they put to us is that when you arrive at a district hospital for your hip replacement—which may have been planned months before and maybe you are a very busy person—often you are pushed out of the slot by fallers coming in, and increasingly consultants are telling us that they get fed up with the National Health Service having to say sorry to people the whole time—"I'm sorry, we cannot do your operation"—whereas at the Ravenscourt Park they virtually never have to say sorry, everything is planned in advance and people know they are going to get their hip and they are going to be out in five or six days.
Sir Nigel Crisp: We do have a number of these now for different specialities around the country, and I am sure we will see many more. That is certainly our intention.

Q6 Chairman: If we look at the Report we will see that progress, I am afraid, contrary to the picture that we saw at Ravenscourt Park Hospital (which, of course, is a sort of beacon model) has been mixed. If you look—and I think Members may want to come back to this again—at Figure 1 on pages 11 and 12, you will see, Sir Nigel, that some things have actually got worse since our last hearing. This hearing is, of course, an update. You will see there that the PAC recommendations in the left-hand column, which are laid out, are the ones we made in December 2000. Can you just tell us, at the start of this hearing, why there has been such mixed progress since our previous report?

Sir Nigel Crisp: I think the answers, in part, are down here. There are a large number of areas where we have actually moved forward really quite considerably. We have now got the registry up and operating and I am pleased to say that since April, when it started—

Q7 Chairman: Just on that point, we see later in the Report that Sweden has had a Joint Registry for 20 years, so it does seem that in some areas we are still behind the field.
Sir Nigel Crisp: In some areas we are behind where other countries are and in some areas we are well ahead.

Q8 Chairman: OK. I am sorry to have interrupted. Please carry on.
Sir Nigel Crisp: If you take that one, which is one of the particularly important points that was drawn out here, that registry started on April 1 and we have now got 30,000 entries on it, which is more than half of all hip and knee replacement operations carried out this year in the NHS, and we have got 70% of trusts and all private hospitals using it. Australia, incidentally, are up to 95% after four years, and we are up to 50% after, whatever this is—six months. So it has started and it is running. There is also a series of other points here where important progress has been made. There are some disappointments and ones which we need to follow up. The particular one that I am concerned about, which I cannot immediately see here, at the moment, is surgeons not using the prostheses under the NICE guidelines. That is one of the areas.

Q9 Chairman: Yes, 13% of consultants use a prosthesis which may not meet the NICE guideline.
Sir Nigel Crisp: That is right. That is somewhere here.

Q10 Chairman: Do you have any comment on that?
Sir Nigel Crisp: Well, that is not acceptable. We have looked at this since this Report came out and indeed yesterday I discussed it with the Council of the British Orthopaedic Association as to what we needed to do. It needs to be picked up both through audit internally within the hospital, but we will actually now look at whether when PCTs commission services from hospitals they insist on any prostheses that are used either being the subject of a clinical trial properly organised in that way, or that they have got a NICE certificate, as it were, of validity. What is more, that information should be given to patients. That we think will plug that gap.

Q11 Chairman: Let us look at progress. If you look at paragraph 3.4 on page 22, you will see that average waiting times for hip replacement is the same as it was in 1999. Why is this? This is the key point, is it not? This is what people are looking for.
Sir Nigel Crisp: The position here is that what we have done over the last three years is to bring down the very long waits, so that we have actually got waiting times down to within 12 months, whereas in 2000 the longest waits were 18 months.

Q12 Chairman: Can I stop you there? Do you accept that the average waiting time for hip replacement is the same as it was in 1999?
Sir Nigel Crisp: It has actually shifted during the course of this year but I think it is the same. These figures are the same—for the average wait.

Q13 Chairman: Is that not rather an indictment of what you have managed to achieve over the last—
Sir Nigel Crisp: No. The very long waits have come down; we have now got down to below 12 months and, as I say, at that point the very long waits were 18 months. At that point there was no maximum wait, as I recall it, for out-patients' appointments, and those are now within six months. So we are making progress. There is a long way to go—a long way to go.

Q14 Chairman: Why have the average waiting times not improved when there are more orthopaedic surgeons available than there were before? There are, are there not?
Sir Nigel Crisp: And they are doing a lot more work as well. The figures for the additional hip replacements—again, which are somewhere in this document—show that we have seen considerable increases including very big increases in the last year. There is more demand in this speciality, unlike in some other specialities.

Q15 Chairman: If you go back to Figure 1 on pages 11 and 12, one of the criticisms there made of your work is that there was poor monitoring of hip prosthesis, and some consultants doing few operations. When will our recommendations on these matters be fully implemented?
Sir Nigel Crisp: There was a study done which looked at whether or not the volumes of operations that a surgeon did actually affected the quality of outcomes, and it was inconclusive; it did not show that that was a problem. We are going to look at that again because intuitively you would think it was, but there was absolutely no evidence that it is at the moment. So we will be able to look at that much more clearly when we have got the registry in place because we will be able to follow it through on a national basis and not just locally.

Q16 Chairman: If you look at paragraph 2.18 on page 19 now, you will see that trusts and consultants are offered incentives by manufacturers. Do you think that these incentives affect their clinical judgment?
Sir Nigel Crisp: I believe they do not. We have got a very clear policy which we have reiterated since the publication of this Report to everyone in the NHS about engagement with commercial organisations. In every case people need to declare that interest and make sure that the Chief Executive of the organisation itself has signed it off to say that "This is not affecting"—

Q17 Chairman: Other colleagues may want to come back on that. Just in general, if you look at part four of the Report, it talks about inappropriate GP

referrals, lost theatre time and hip work that has actually increased. Why is the situation in these areas worse than it was three years ago, when we last reported?
Sir Nigel Crisp: This is paragraph 4.3, is it not? The short answer to that is that I do not know that there is a clear answer to that, but this is something which we now need to deal with. There are a number of projects around the country to deal with this, which are the areas where GP referrals are going to referral centres, where they are then scrutinised and then they are passed on to the hospital, if that is the appropriate place for them to go, or they are passed on to the physiotherapist. So we are putting in a mechanism to stop this happening.

Q18 Chairman: Can I ask you now a wrap-up question. If we return to the subject in three years' time, what will the situation look like in terms of outcomes, waiting times and other things I have been questioning you about?
Sir Nigel Crisp: In three years' time the maximum wait will be under six months; the maximum wait for out-patients will be under three months and the average wait, I have no doubt, will by then have come down because we will be eating into the maximum numbers. Length of stay went from 11.5 to 8 days, I think, during this period, which is actually a big drop in a three-year period. I would expect our length of stay in three years' time to be much more nearer 5, which some people think is the benchmark which we are using for this. I think we will see improvements against all of those three factors and we will also see this Joint Registry being fully utilised, and we will also see the NICE guidelines being fully implemented.
Chairman: Thank you, Sir Nigel.

Q19 Jon Cruddas: Can I touch on the Diagnostic and Treatment Centres first? Do you anticipate throughput, in terms of the number of hip replacements?
Sir Nigel Crisp: Yes, we do. I cannot give you that number right now but we can certainly provide that.[1]

Q20 Jon Cruddas: So you do not know the working capacity, for example? You do know, but you have not got it.
Ms Edwards: I cannot recall the figure off the top of my head, but for every single one there is a business case that we assess them against; we assess how many procedures they would do. So that has been signed off for each one per year.
Sir Nigel Crisp: We do have figures, but I am afraid I cannot produce them now.

Q21 Jon Cruddas: The next question is the likely effect of them on the scale of waiting lists.
Sir Nigel Crisp: Can I take the question slightly further back, which is why we are putting in the treatment centres? We actually asked all health authorities and PCTs to plan in the autumn of last year to hit the six-month waiting time, and to say "What capacity do you need to do that?" As a result of looking at those plans we have decided which DTCs to put in place in order to achieve those numbers. So they are based on what people believe the volumes need to be. It is a pretty significant increase. The programme will deliver an additional 157,000 admissions in 2005. Those are not all orthopaedic, though. I cannot give you the breakdown on the orthopaedic, but it will be another 157,000 by that date.

Q22 Jon Cruddas: Can I ask about—which is a subject you have just touched on—the geographical planning of the centres? One of the issues that came up in our discussions yesterday was that a private sector Diagnostic and Treatment Centre was going to be built within two miles of the one we visited yesterday.[2] What consultations do you have with the private sector about whether their geographical locations fit into this overall map of yours?
Sir Nigel Crisp: I think it is worth saying that there are some other DTCs in London that are also not far away, including the original one at Central Middlesex Hospital. Two miles in London embraces a big population. The process we went through is that the five health authorities in London said what capacity they needed; was it available through the NHS and, where it was not available through the NHS or it seemed better to go to the private sector for whatever reason, they then went out to tender and asked the private sector to put in proposals for DTCs. So in London, in particular, which is easier to plan for than most of the rest of the country, this is a planned process.

Q23 Jon Cruddas: So you do not see any problems about local over-capacity within parts of, say, London or other major cities?
Sir Nigel Crisp: Well, the point I make is that our current target is six-months' waiting time, but we are trying to actually get rid of waiting times.

Q24 Jon Cruddas: Presumably, if you are getting rid of waiting times then that implies that when the waiting times have been got rid of you will have over-capacity to deal with the sort of normal flow of referrals.
Sir Nigel Crisp: Frankly, the conversation we would have had a year ago is "Isn't the NHS vastly under-capacity?" We have now put in about 27,000 more operations, in NHS treatment centres since April 2003, so it is not yet over capacity, and I do not believe it will be over capacity in two years' time.

Q25 Jon Cruddas: Do you recognise that there is a possible tension down the road here? I thought the facilities were fantastic yesterday, but just through some of the discussions there, there was this issue of possible over-capacity. I think they were talking about 3,000 or 4,000 throughput at the moment per year and it would have a capacity of 10,000. There were some problems about gearing up to that. But

[1] Ev 15.

[2] Ev 15.

they were concerned about the local location of the private sector, and they were concerned about whether once you get over, if you like, the hill of the waiting lists, then there is subsequent rational planning in terms of the capacity of the system versus the sort of normal distribution.
Sir Nigel Crisp: I do understand that. Can I just draw out two variables? There are certain procedures where activity is going down—and they are things like ear, nose and throat surgery, for example—and there are some procedures like orthopaedics where activity is going up. We are all being more active, we are all living longer and the number of hip replacements and referral rates and so on are all going up. So we can see there is a growing increase for certain types of surgery. We do not believe we are yet at the point where, to keep our waiting lists going down and meet anticipated future demand, we have enough capacity; we need some more. However, having said that, I absolutely take the point that that particular facility is not yet working at full capacity, and they have got another ward opening in January, I seem to remember. What we have said to the NHS locally is "You must make sure you use that capacity". So I actually had a conversation with the five health authorities from London and the surrounding areas, in fact, last week about saying "Make sure you use that capacity in the short term because we do not want any NHS capacity left idle, particularly if, in some cases, we may be going and buying some additional work in the private sector. So let us make sure we use it". The other point—and your comments here are a very good advertisement for Ravenscourt—is that as we move into the process of giving patients choice about where they go, if they believe that they can go to Ravenscourt quickly and it is a high-quality facility and they may have to wait longer, even if it is some way out of town, then they may desire to come to Ravenscourt. I think that will help fill capacity. We are not at over-capacity.

Q26 Jon Cruddas: Can I just ask one final question which is the point you were making when responding to the Chairman's point. At paragraph 3.10, page 22 of the Report here, it says that there is evidence that there is a relationship between surgeons who do little hip surgery and poor outcomes. Did you say in some of your earlier comments that there was not a relationship between outcomes and volume?
Sir Nigel Crisp: There was a British study as well, was there not?
Ms Edwards: Yes, the Royal College.
Sir Nigel Crisp: The Royal College of Surgeons did a study on this which did not demonstrate that relationship, so we need to come back to it.

Q27 Jon Cruddas: So, as it stands, you do not see a case for a minimum number of operations per consultant?
Sir Nigel Crisp: Not yet, but if the case is proven, then we will get to that, and intuitively I suspect we will get to that.
Chairman: Thank you very much. Mr Alan Williams?

Q28 Mr Williams: To the C&AG, in paragraph 2.18, you tell us, "Nearly half of trusts told us that manufacturers offer them incentives". Does that mean that the other half told you that they did not or did the other half simply not reply?
Mr Robertson: Essentially the answers would have been no, although there obviously were some trusts that did not respond as well.

Q29 Mr Williams: How many did not reply?
Mr Robertson: I do not have that figure immediately to hand.

Q30 Mr Williams: Well, it is of some relevance because we would assume that those who did not reply probably did not want you to know.
Mr Robertson: From memory, it was a minority of the trusts that did not reply.

Q31 Mr Williams: I know it is a minority because over half did reply, but what I am trying to get at is how many did not reply.
Mr Robertson: I cannot give you that figure at this point.

Q32 Mr Williams: Well, I would like to have that as it is of considerable relevance. Sir Nigel, unless I misunderstood your answer to the Chairman when he was talking about incentives and offers to the trusts and to the consultants, you said that you did not feel that it influenced decisions.
Sir Nigel Crisp: I did say that and I was wrong to say that because this clearly says that a third thought they did.

Q33 Mr Williams: Are you going to apologise to the Chairman?
Sir Nigel Crisp: I do apologise and I accept that. That was how I remembered this and I was not looking at that line at the time, but that is how I understood it and I am sorry to mislead you.

Q34 Mr Williams: Well, that is of some importance again if you do not understand that that is happening. That should be a fact that you are aware of, should it not? You may not be aware of the figures and I would accept that, but the fact that you are not aware and you would actually say to this Committee that it obviously definitely did not influence decisions does suggest to me that you are not quite on top of this area.
Sir Nigel Crisp: I accept the criticism, but the concern that I had with these paragraphs was a slightly different one, paragraph 2 further on, where people are not following our guidance.

Q35 Mr Williams: You signed up to this Report in which it was accepted that a high proportion of trusts indicated that it did influence decisions and yet apparently it is so unimportant that it is not within your recall and even the proportion, which I can understand, was not within your recall.
Sir Nigel Crisp: I accept your criticism. I got it wrong.

Q36 Mr Williams: If we look at diagram 10 on page 24, my colleague Mr Cruddas, who just questioned you, referred to the United States' study in 1997, a relatively recent study.
Sir Nigel Crisp: Yes.

Q37 Mr Williams: It showed a relationship between low volume of hip work and poorer outcomes. Now, surely it is a matter of common sense that there must be some relationship. For example, someone who is only doing one a year must be somewhat out of practice. Would that not be self-evident?
Sir Nigel Crisp: As I said earlier, intuitively you would expect that to be the case.

Q38 Mr Williams: Yes, intuitively, but what you are doing is you are fencing on the basis of the US study and you tell us about something that is going on elsewhere, but—
Sir Nigel Crisp: Within the United Kingdom, yes.

Q39 Mr Williams: Where is it?
Sir Nigel Crisp: Again I will try and find it. Let me just find the details of that. It is here somewhere. I do not know if any of my colleagues can draw it out for me.

Q40 Mr Williams: I hope that the clock is put on pause, Chairman! Would you like an adjournment for a spell to see if you can find it?
Sir Nigel Crisp: Can I ask if my colleagues can try and find it while you ask me another question?

Q41 Mr Williams: Of course. May I say something to you that I say to any witness. I do not care who answers the question, but all I want is the answer to the question. There is nothing wrong with admitting that you do not know as long as someone else does.
Sir Nigel Crisp: I have not actually got this here.

Q42 Mr Williams: Well, did you not think that we might touch on this US study? Did it not dawn on you? We have had three questioners and two have directed attention to this study. It was obvious we were going to talk about it surely and you have come unprepared for it.
Sir Nigel Crisp: Well, I am sorry, but in the briefing I actually had seen something on this, but I was going on my memory without actually looking at the piece of paper. Can I come back to you on this one?

Q43 Mr Williams: Well, yes, but you are having to come back to us on the only two areas on which I have asked you questions. It does not exactly fill the Committee with confidence, does it?
Sir Nigel Crisp: I understand that, yes.

Q44 Mr Williams: But you accept the basic proposition that common sense intuitively tells you that there must be some threshold which is the level of competence?
Sir Nigel Crisp: And that it may vary between individuals, but yes.

Q45 Mr Williams: It may vary, but within parameters, and there must be some such information, but you are not aware of what it is. Well, we know that you are not because I am going back over old ground. We will look at table 10. Does that not petrify you? You look at that graph there which shows how many consultants are doing less than one operation per week, less than one per week.
Sir Nigel Crisp: Yes.

Q46 Mr Williams: Indeed the median figure is only doing two per week. Can I ask the C&AG this: how many consultants does this graph cover?
Mr Robertson: It covers 650.

Q47 Mr Williams: Well, looking at it, it would seem to me that something like three-quarters of them are performing below the median level. That is just a visual impression, but I think it is probably not all that far off, and the median level is only two per week.
Sir Nigel Crisp: Yes.

Q48 Mr Williams: But you do not know the level, how low it has to go before competency is put at risk, but looking at that graph it would suggest to me that in a large number of hospitals, there are a large number of consultants who are carrying out far too few operations in order to be able to maintain clinical standards. Does that not seem self-evident?
Sir Nigel Crisp: Yes, it does, it does.

Q49 Mr Williams: It does?
Sir Nigel Crisp: I am sorry that what I am saying is intuitive, but if I just refer you to the recommendation here, the recommendation from this Report was to evaluate the risks involved with consultants who carry out few hip replacements and put in place procedures to manage such risks. It is not actually saying that we should stop people doing them at a particular threshold, but that we should consider the risk.

Q50 Mr Williams: That actually has no relevance to the question I just asked you. What alarms me is that you, who are in charge of one of the most important areas of failure in the Health Service, are not aware of what is the minimum level of competence for operations. You cannot explain why so many have so few and whether they have maintained their competence. Let's take it a stage further—
Sir Nigel Crisp: I am perfectly aware about the minimum level of competence which actually means skilled and trained surgeons. I think you are talking to me about the number of operations that are taking place.

Q51 Mr Williams: No, no
Sir Nigel Crisp: I am sorry, I misunderstood.

Q52 Mr Williams: Listen again because I do not want to fluster you, so let's start again. You accepted intuitively that there is a minimum number of

operations below which you are in danger of losing your clinical competence. You accepted that intuitively.
Sir Nigel Crisp: I think in terms of that, that is the case, but as with all these things, I then look for evidence because sometimes intuition is wrong, is it not?

Q53 Mr Williams: Yes, but you have not been looking very hard for the evidence. How long have hip operations been going on in this country? Did they only start a year or 18 months ago?
Sir Nigel Crisp: They started in 1962.

Q54 Mr Williams: Well, we have had a year or two to work out what might be the minimum level of competence. Recently in a case in Wales I could be shown national figures of what is the minimum number, for example, of infantile neurosurgery operations required to keep a level of competence. These figures must be available somewhere.
Sir Nigel Crisp: No, actually they are not in this particular area. In certain very highly specialised areas, such as the one you are talking about, specialist expert bodies come up with recommendations, which is what you will have seen in Wales. Those recommendations may sometimes be contested by other professional bodies. There is not a clear demarcation and I think that is where the National Audit Office did not actually say that there should be a minimum number, but that the risks of those surgeons who do a small number should actually be evaluated and managed properly.

Q55 Mr Williams: Well, let's approach it from another angle then as we cannot get anywhere. We are not doing very well today.
Sir Nigel Crisp: Thank you!

Q56 Mr Williams: Let's take that same table. Now, what is the annual cost represented there of the number of operations that are carried out?
Sir Nigel Crisp: Well, I am not sure again I can actually give you a specific number.

Q57 Mr Williams: Just ballpark figures.
Sir Nigel Crisp: Well, the average cost is somewhere in the order of £5,000 to £6,000, is it not, and there are 44,000 operations.

Q58 Mr Williams: It ranges from £2,000 to over £7,000 in there.
Sir Nigel Crisp: Okay.

Q59 Mr Williams: And there are 650 consultants.
Sir Nigel Crisp: The figure for last year was that there were 44,000 elective hip operations, just under 44,000, and, as you say, the range would give you an average of somewhere around about £4,500 per operation.

Q60 Mr Williams: Just go back to your intuition for a moment again and we will talk intuitively since it is impossible to talk statistically because there are not any. When you look at figure 10, does it not give you a feeling that throughout most of the country, hip operations are grossly under-managed and under-performed?
Sir Nigel Crisp: Can I say that on this particular list here, what we need to know is why those people are doing so few operations and what the reason is—

Q61 Mr Williams: Yes, we look for the information.
Sir Nigel Crisp: Actually some of these are specialists in children, for example, who will do typically a lot fewer operations and so some of these are specialists in particular areas and doing fewer operations, so the issue here is that this graph not only reveals a huge variety in volumes of surgery, but what it hides though is the variety of different practices and different groups of patients and you need to get underneath that.

Q62 Mr Williams: Yes, it suggests that, but it also suggests, I think intuitively to me and I suspect to other members of the Committee, that we are getting appallingly bad value for money out of this area of medicine and that what you describe as structural factors amongst them, and since the structural factors cannot be changed as they apply at the moment, is it not time, therefore, to consider revising the structure under which you provide this service as, for example, in the hospital we saw yesterday?
Sir Nigel Crisp: Let's be clear that we are going some way in that direction.

Q63 Mr Williams: Some way beyond what? I am glad to hear that, but tell me what.
Sir Nigel Crisp: Let's take what one might guess about the orthopaedic surgeons who are doing very few hip operations and you want to ask what they are doing the rest of the time. Are they actually primarily people who are doing knee operations? Are they primarily people who are working with children? What is the reason why we are actually doing a smaller amount? Now, if we end up doing more of what you saw yesterday at Ravenscourt or indeed what you would see at Epsom in January, you will see specialist centres that are only doing joint replacements, then that means that we will see fewer surgeons doing more joint replacements. That is not the same thing though as saying that a children's surgeon should not do ten or 15 or 20 operations a year.

Q64 Mr Williams: Of course, but does that not, therefore, suggest that that must be the way forward perhaps?
Sir Nigel Crisp: I am sorry, but I think that is what I said earlier actually, that we want to separate out the elective from the trauma much more so, but the difference between you and me is that I am not saying—

Q65 Mr Williams: So you want to do it. You have now accepted that it needs to be done, so what have you done to achieve that?
Sir Nigel Crisp: Well, we have set up the Diagnostic Treatment Centre Programme.

Q66 Mr Williams: How far has that got?
Sir Nigel Crisp: Well, there are something in the order of 47 schemes in the programme.

Q67 Mr Williams: How many of them are operational, if you will excuse the phrase?
Sir Nigel Crisp: At this moment, 11.

Q68 Mr Williams: So basically we have got 11 and after all these years and after all this evidence, the system is not working. People are waiting unnecessarily long and suffering for unnecessarily long periods and suffering disadvantage for unnecessarily long periods. We have got as far as 11 at the moment. You have mentioned the size of the programme, but what proportion of the yearly demand is represented in this graph? Will that just scratch the surface or will it make a significant contribution?
Sir Nigel Crisp: It will make a significant contribution. Let me just give you a few of the figures, if you would like. Of the 47 schemes, 24 are partly open, 11 are fully open. The total schemes will actually deliver an extra 157,000 admissions, as I said earlier. That is orthopaedics as well as other specialities, some of these are dedicated hip centres like the one in Epsom and some are others, at the moment we have 47,000 hip operations a year and something like 42,000 knee operations carried out in the NHS annually. Those are the sort of volumes, going up about 10% a year.

Q69 Mr Williams: I have overrun my time and there are so many other things I would like to ask, but what you have just said puts an additionally questioning perspective on something we were told yesterday, that it is costing more than average to deal with the hip operations, but it is doing them on a significant scale and it is achieving what you have admitted we need to achieve and replicate more widely around the country. However, they were able to tell us that the Government, the Health Service, is about to give subsidy rates to a private hospital to open up within an arm's length of this one, not in the areas where it is needed, not in the areas where there is a lack of this specialist provision, but right alongside the one unit you have got providing it. Does that not sound crazy?
Sir Nigel Crisp: Well, two miles, as I said earlier, is actually quite a long way in London.

Q70 Mr Williams: Well, they come from Bath and from Portsmouth to go to the unit we were looking at yesterday, so two miles is not that far in London, with respect.
Sir Nigel Crisp: But if people are coming from Bath and from elsewhere, the point that I made at the beginning is that this is actually a planned process, that we talked to the health authorities and asked the health authorities to plan how much capacity they needed, and this is based on those plans about how much capacity they need to provide for local patients. Now, if there is a bit of spare capacity over, as there happens to be in the short term in Ravenscourt, they are using it for patients from Bath and elsewhere, but this programme of 47 schemes, which are designated as treatment centres, and there are other areas where they do things very similar which are not designated, covers the whole country.
Mr Williams: Perhaps you can put a note in to us on that.[3]
Chairman: Well, thank you very much for that; it was a very interesting series of questions. Richard Allan?

Q71 Mr Allan: The registry seems to be put forward as the key to filling in some of the information gaps which my colleague Mr Williams has highlighted about performance and I want to ask a few questions about that. Was it proposed before this Report coming forward? It seems that other countries have had such registries for a long period of time. Did the NHS universally look at registries throughout the history of hip replacements, which we have heard have been going on for 40 years or did it take the NAO Report for this to come forward?
Sir Nigel Crisp: I am not sure. We actually consulted on it within the NHS in 2000, which was the date of the last Report, but I do not know what consultation or discussion there was before that.[4]

Q72 Mr Allan: I think it was suggested at the beginning that 70% of trusts are now working with it and that 50% of all replacements that have taken place are now registered with it. How many of the manufacturers are complying with it, and is there a differential between different kinds of manufacturers, for example between UK manufacturers and non-UK manufacturers?
Sir Nigel Crisp: I do not know. I may be about to get the answer from behind.
Ms Edwards: All manufacturers.

Q73 Mr Allan: They are all working with it?
Ms Edwards: Yes.

Q74 Mr Allan: Did we get any answer on the history coming forward in the note as well?
Sir Nigel Crisp: I do not know about considerations beforehand.

Q75 Mr Allan: Can I ask about the model that you have chosen for implementing the registry as it does appear rather expensive. Was any cost comparison done between the model in the UK and some of the international registries that we have that are in place, or was it purely between different options that you could have done in the UK?
Sir Nigel Crisp: I know that it was the latter. There was a tendering exercise over how we should do it, but I do not know if we looked at other models to see how they were funded in Sweden or Australia for instance. I assume that we did but I do not know and will check.

Q76 Mr Allan: It might be helpful to know if there was an intention to do that. We have adopted one kind of model and it would help us to know whether

[3] Ev 15.
[4] Ev 15 and 16.

you have compared that with some of these other models that certainly look as though they may be cheaper than the one we have chosen.
Sir Nigel Crisp: We certainly considered whether to go via the manufacturers or via the trusts, as it says in the Report.

Q77 Mr Allan: The route you have chosen leaves us with a £2.50 admin fee to the manufacturers for passing on the £25 registry fee and questions have been raised by some of the manufacturers around that. Can you tell us now whether any further consideration has been given to altering that fee either up or down?
Sir Nigel Crisp: The fee comes down to £1.70, as I think this Report says. It will be reviewed again, but at the moment we have set out the tender and the process has only just started.

Q78 Mr Allan: And as far as you are aware that £2.50 is what we can expect to see and all the manufacturers are happy with that, they are content?
Sir Nigel Crisp: Yes. It seems to be working at this stage. This is early days.

Q79 Mr Allan: Can I ask what happens after the two years is up because I understand this contract runs to 2005? Are you free to re-tender?
Sir Nigel Crisp: There is no reason at all why we should not. We will obviously evaluate before we re-tender.

Q80 Mr Allan: The system as such, intellectual property if you like, is owned by the NHS rather than the company that is running it, is it not?
Ms Edwards: Yes, that is the case.

Q81 Mr Allan: So you would just be re-tendering for somebody to operate your register rather than tendering for the whole package?
Sir Nigel Crisp: Yes.

Q82 Mr Allan: Can I ask about the use of the register because having it is one thing but it is the use that is all-important. Will there be a charge to the various bodies for access to the data held within it, to researchers, to trusts or indeed manufacturers, or is there going to be open access to the data that is going to be held within it?
Sir Nigel Crisp: No, there should not be a charge.

Q83 Mr Allan: What is the relationship between the outcome of that research and the policies in the trusts? This is going to be critical for manufacturers. This is a point where we could get there and we could be told by the trusts that they have a policy on how many operations per year their consultants should be carrying out using this prosthesis and not that prosthesis. How is that going to work?
Sir Nigel Crisp: This provides us with information that we have not known about before, which actually is a series of information including, perhaps as importantly as anything else, how soon and how often revisions need to be done, in other words if the joint has failed, whether you need to use another one and whether that is related to individual surgeons, whether it is related to the particular prosthesis that is being used and so on, it is that level of information and this is going to take some time to get to and to see the outcomes will take some time. I do not know that that will tell us the definitive answer to the question I think Mr Williams was asking, which was whether there is a bottom limit to this particular set of procedures.

Q84 Mr Allan: It should start to give us some idea.
Sir Nigel Crisp: It should indeed, and is therefore potentially highly sensitive in that it affects both the economic future of manufacturers on the performance of the devices side and the future of individual consultants on the performance of the consultants' side and whether we should organise having a smaller number of people doing a larger number of operations.

Q85 Mr Allan: But the intention will be to be as open as possible with that data?
Sir Nigel Crisp: That is right. We would intend to have that data available to people.

Q86 Mr Allan: Do you know whether it will be available to patients, which would be the other sensitive area? Will patients be able to find out that this particular device fails in so many instances as opposed to that device?
Sir Nigel Crisp: Where we are moving to as a wider issue is to give people much more information about their operation across the board. We have actually got a scheme at the moment, which I do not know if Margaret Edwards could tell you a little bit about, called an "Owner's Manual" for a prosthesis.
Ms Edwards: The idea here is that we will give patients information about the prosthesis they have been given, some history about it like you would with any other product, you will get your own manual and information about it and we are piloting that at the moment and doing some evaluations of that not just for hips but across a number of surgical procedures. It is all part of a culture of giving patients more information and the information is appropriate for those patients. We are doing quite a bit of testing on that at the moment.

Q87 Mr Allan: You can see the next logical step is an individual who has done the research turning up and saying to their consultant, who may have had incentives from a manufacturer to use one particular one, "I don't want that one, I want this one because I have done the research and it's the better option." Can you envisage some difficulties in that kind of situation?
Sir Nigel Crisp: If I can generalise that, that is starting to happen on different therapies anyway in terms of drugs and so on and that is the world that we are moving into. We want to make sure that patients have as much information as possible about the prosthesis, about the results of the prosthesis, about the surgeon and so on, that is the world we are going into. The National Joint Registry will have an

annual report which will pick out the big themes, but going beyond that, individual patients will do that kind of research and that is why you need an informal discussion with the surgeon.

Q88 Mr Allan: You said earlier about the fact that some trusts are not using NICE approved prostheses and you are suggesting how that might be overcome is for PCTs to say, "We'll only place our contract with you if you deliver it that way". How realistic do you think it is, given that most PCTs have a hell of a job getting any orthopaedic service for their patients, for a PCT to come in with muscle and say "I'm not going to deal with you" and the consultant saying "Fine"?
Sir Nigel Crisp: I discussed this with the Council of the British Orthopaedic Association yesterday and they, like all of us, agree that surgeons should only use prostheses that comply with the NICE guidelines or that they are part of a proper clinical trial. Ultimately we want to make sure that the patient knows that piece of information and the patient knows whether or not they are getting an approved prosthesis or they are part of a clinical trial. The step towards that is to have the PCTs insisting that prostheses have to fall into those two categories and I think that is quite realistic.

Q89 Mr Allan: You think that insistence is stronger than any motivation that an individual consultant may have to be using a different one, maybe where they have got some motivation and they would use their clinical judgment as to why they have chosen one?
Sir Nigel Crisp: The Report said there were a number of surgeons who did not know the NICE guidelines. We need to get it out there and to make it clear through the British Orthopaedic Association and the Department of Health that you are going to do that, but what is the fail-safe position is through the process and through the patient wanting to know if it is approved.

Q90 Mr Allan: And it will come with an owner's manual.
Sir Nigel Crisp: Exactly. That is where we need to go.
Chairman: Thank you very much. Mr Brian Jenkins.

Q91 Mr Jenkins: Sir Nigel, coming so far down the list you will appreciate that most of the points I wanted to raise have been brought up, but I do want to nail something down now. Thankfully not many of the public read these reports like you do. I know you read this Report and you gained a lot from this Report, yes?
Sir Nigel Crisp: Yes.

Q92 Mr Jenkins: You have passed on some guidelines arising from this Report because what came up in this Report was news to you.
Sir Nigel Crisp: Some things in the Report were news, yes, the one that we have just been talking about.

Q93 Mr Jenkins: That is why they are produced. I want to dictate a scenario for you now and I want you to nail something down. Someone walks into my surgery and sits down and says, "Mr MP, I have just been told by my doctor that I have to have a new hip. I want you to ask some questions," and I say, "I'm going to see Sir Nigel and I will ask him the questions then." He then says, "What am I going to get? Am I going to get the hip that is right for me, am I going to get the hip that the consultant is pushing because he has got some foreign or international travel off that company providing the hip, am I going to get the hip that the PCT is pushing because they have got a financial inducement off the company that is producing that, or am I going to get the hip that is right for me?" Tell me, which one is he going to get?
Sir Nigel Crisp: The answer to that is he is going to get a hip that meets the NICE guidelines or that is approved for the NICE guidelines. In 13% of cases that is not the case, that is what this has revealed and that is why we have got to be very tough with that. If you like this is a kite-marked hip. You might well ask why they use this particular manufacturer's version of that as opposed to another and there may be lots of reasons for that. It may be that they are influenced by the fact that they have gone on a training programme run by one of the manufacturers and I would expect them to say something like, "This is the hip that I am accustomed to using, I have had good results with it over the years with my patients," or, "There is a choice of these two". That is what I would expect to have happened and this is why, as the consultant that is having this discussion with you as a patient, I believe this is the right one for you.

Q94 Mr Jenkins: And as the head of the NHS you can categorically put your hand on the table and say you will be getting the hip that is right for you?
Sir Nigel Crisp: When we get it nailed down—and patients should not be getting hips that are not part of a proper trial or that do not meet the NICE guidelines—

Q95 Mr Jenkins: I am glad you used the term "when we get it nailed down" because I did want to ask about the amount of operations the surgeon performs because as it says on page 24, paragraph 3.12, in 1999 this Committee brought this to your attention and it goes on to explain the relationship between the number of operations and the outcome. That was four years ago and we have not got that nailed down yet. Although the Royal College of Orthopaedic Surgeons did a report—
Sir Nigel Crisp: It was the Royal College of Surgeons.

Q96 Mr Jenkins: They are the providers. Are they the manufacturers in that respect or are they the people that provide this stuff? Do you have an independent report? Do you have an outcomes report, a report of how many patients were involved because we have not got a register? We are going to

get a register under the voluntary sector and that is going to plough information in and we are going to get that data on the outcomes eventually.
Sir Nigel Crisp: The Royal College of Surgeons is the body who is responsible for setting standards in surgery, they are the body that is responsible for doing the training in surgery and that is the body that we have and therefore we would call on them from time to time to do investigations to look to see whether or not the patient is getting the right treatment in today's knowledge of what the right treatment is.

Q97 Mr Jenkins: I want to know when we do an independent survey on how well they have performed for the patient, not for surgeon and I want an independent review and hopefully this data collection will give us that. In 3.14 it says, ". . . whilst the evidence is unclear, trusts need to be aware of the potential risks and manage them accordingly."
Sir Nigel Crisp: This is the recommendation which the NAO make, which is that we do not know whether there are a minimum number of operations that a doctor should do in hip replacement. We believe there is in certain specialities and particularly the subspecialties which Mr Williams talked about. It may be that we will never get a very fixed view on that as to whether the number is X or Y. Where there is a small number of operations carried out, intuitively, as I said before, you would expect there to be a higher risk and you would want to know and that is why the NAO Report says that people need to look at the potential risks with people who are doing relatively few operations.

Q98 Mr Jenkins: And the trust needs to manage it accordingly.
Sir Nigel Crisp: Absolutely, yes.

Q99 Mr Jenkins: Can you tell us, as somebody who oversees these trusts, how you are going to implement that? How is a trust going to manage this accordingly?
Sir Nigel Crisp: One of the things that they might do is look at the particular surgeon's report of operating over the years—and you will notice again in here that there is a survey being done on infection, so infection rates is a complication that might be associated with it, revision is another complication—and see if there are any grounds for worry in terms of what a patient is experiencing.

Q100 Mr Jenkins: So the trust is going to do this as an individual trust?
Sir Nigel Crisp: As again I am sure you know, the way we try to manage quality in individual organisations is through clinical audits locally, it is through peers looking at what is happening within the system. As again you know, we have just put in an appraisal system for doctors so that people's track records in terms of performance will actually be looked at in that appraisal system and all of that is about trying to make sure that we do not have any doctors who are performing as outliers within the system and to reassure you and your patients that we have got people operating against common standards and achieving higher standards of performance. That is what all of that system is there to do.

Q101 Mr Jenkins: My only concern is that you were asked to assess the risk accordingly and now we are four or five years down the line from when this Committee recommended this. Would you say that this lacks some sense of urgency somewhere along the line?
Sir Nigel Crisp: Over this period you will have seen a big increase in the amount of audit that has gone on, you will have seen the introduction of clinical governance in this period, which means that we are going through quality information in each individual trust, we are putting in systems to do that, that has all been happening in parallel to this set of processes, so for orthopaedic surgeons and every other area we should have better quality controls now than we had three years ago.

Q102 Mr Jenkins: As part of the process the follow-up care and reporting back on the follow-up care would have been logged into the system to show us how successful the outcome has been, yes?
Sir Nigel Crisp: Locally, yes.

Q103 Mr Jenkins: The Report says the follow-up care has diminished over the last few years because surgeons do not have the time as they are meeting targets.
Ms Edwards: I think there is a slight difference between the number of follow-up outpatients' appointments and the number of patients who have had an operation.

Q104 Mr Jenkins: I do follow-up as a matter of feedback to see how effective it has been and to see if anything can be done better and that gets fed back into the operational process as quickly as possible and that is where we require the follow-up care for checks, is that right?
Sir Nigel Crisp: It actually says in 3.18 that ". . . there have been increases in the frequency and length of time over which follow up is carried out since our original report, there is clearly scope for further improvement" and I think that is absolutely right. It says 20% continue not to follow it up mainly because of shortage of time or pressure. I agree with the point and that is why we agreed this recommendation that we do need more follow-up.

Q105 Mr Jenkins: I noticed that the range of costs for hip replacement has gone from £2,000 to £7,400. You must admit that that is an unacceptable range of costs. Why are you not concerned about the spread of costs?
Sir Nigel Crisp: We are indeed. I also suspect those in the bottom range have not included everything in their costs given that the joint itself costs something of the order of £1,300 in the bottom case. I think there is some costing error in that.

Q106 Mr Jenkins: In the Report it says that 15,000 hours of consultants' time is used inappropriately because referrals by GPs are sent onto them, effectively because GPs are not acting as the gatekeeper. Maybe people are now much more vocal and demanding when they want to see a consultant, so they are passed on and we are using consultants' time which is totally inappropriate. What are you doing to alter that?
Sir Nigel Crisp: Two things. The first one is the continuation of a programme of GPs with a special interest which you probably know about in other specialities. You train up the GPs more so that they know how to do it, and, secondly, we are putting in place these referral centres so the GP refers to the referral centre and the referral centre takes a view as to whether they need to go to physiotherapy.

Q107 Mr Jenkins: One last question. I notice in the Report that it says that we lost 19,500 hours. That is a big increase. Why have we got this massive loss of operating time, a scarce resource in the NHS?
Sir Nigel Crisp: A series of reasons. The answers to it are in part what earlier your colleagues were talking about, which is to have dedicated time to plan theatre so that you do not have interruptions from emergency theatre. Part of it is also about the fact that we are expanding very fast and, again, if you had gone to Ravenscourt yesterday you would have known that they have had some difficulty building up their staffing levels. Again, that needs tackling. The only other point I would make is that this Report is going to the next council meeting of the British Orthopaedic Association, who are the leaders within the profession. I went through it in some detail with them yesterday. They too learnt stuff from this, which is the first point that you made. They too recognise the criticisms here and we need to sit down together to make sure that the profession itself as well as the Department of Health is making sure that we make the progress that I said we intend to make in the next three years.

Q108 Chairman: Now, May I return to a subject which Mr Alan Williams was questioning you on quite closely? If you recall, he was questioning you on page 22, paragraph 3.10, which says: "In 1997 the results of a US study showed a significant relationship between a low volume of hip work carried out by individual surgeons and poorer outcomes". Paragraph 3.10 simply confirms what we said in a previous report in April 2000. For instance, on page 9 we said, "The NHS Executive, in consultation with the National Institute of Clinical Excellence and the British Orthopaedic Association, should explore whether a consultant should perform a minimum number of primary and revision hip replacements to maintain their expertise, and consider issuing guidance. They should also consider the merits of further development of centres of excellence to undertake, in particular, revision hip replacements." If one goes to page 37, paragraph 3.23,—and this is not the present Report but one which is already three or four years old—we said then: "Low numbers of procedures performed are not a reflection of the workload of consultants. Many perform a wide range of other surgical procedures, including trauma work and other joint work. However, consultants who perform a small number of hip replacements each year may not build up sufficient expertise to maximise successful outcomes, particularly in the more complex revision cases and younger age group. Many of the consultants who responded to our survey commented that the numbers being performed are, in many cases, insufficient to ensure that skill and experience levels are such as to maximise the chances of a successful outcome for the patient." Here we were, saying all this in 2000, and it was not intuition; it is a matter of fact based on US studies. It was heavily underlined in our 2000 report. I am sure you will gather that our feeling is that you have not reacted with sufficient vigour to what we said to you in 2000.
Sir Nigel Crisp: I think what I need to do is to give you a proper written response to that because I can see that it is a very fair question as to what we have done during that period to assess the evidence that has been put forward from your earlier comments but also from the US report and why we agree with the recommendation in this Report, which is that you should manage the risks properly where somebody is doing a small number of cases rather than set a minimum standard.[5]

Q109 Chairman: I know it is all very well, but this is more important. This is a public broadcast hearing and notes are often a convenient way of things being forgotten. The fact is that we now know that one in ten consultants does ten or less primary hip replacements a year. If I was watching this on television and I knew that I was about to go under the knife I would be rather worried about this. Would you not be rather worried about it?
Sir Nigel Crisp: I would hope that patients would have the sort of conversation that some of your colleagues have been asking about, such as, "What prosthesis are you using? Why is this the right one for me?", as Mr Jenkins put it. I would expect that to happen. I am sorry that I am not equipped to sit here and give you the answer to the very fair question that you have asked me.

Q110 Chairman: Do you not think that you really should give urgent consideration to introducing a minimum volume of work for NHS surgeons in regard to operations? Do you not think that this should be an urgent matter for consideration by you?
Sir Nigel Crisp: I will come back to you as soon as I can, having consulted with some colleagues centrally.[6] As you know, we do that in a number of highly specialised procedures. We do not do that in general for relatively common procedures. What I will report back to you is why we do not do that or what consideration we have given to doing that or not.

[5] Ev 16.
[6] Ev 16.

Q111 Mr Williams: Can I make one further comment on that? You have referred to "What prosthesis?". That is not the issue. That is irrelevant. The issue is, no matter how good the prosthesis that is used, what is the competence of the doctor to use it properly? That is what we want the answer to, and what we want to know from you is exactly what you did in the last three years after you had the NAO Report, months before you came before the PAC to get a grilling here, or rather your predecessor, in fairness to you. We want a full explanation and I think I can safely talk on behalf of the whole Committee when I say that when we have seen that note we reserve the right to call you back to face questioning on the contents of that note. Can I turn to the question of delay? We are told in the Report that avoidable theatre delay is running at two and a half hours a week, whereas previously it was only one hour per week. Why have things got 150% worse instead of getting better?
Sir Nigel Crisp: As I said earlier in response to this, I do not think there is any one particular answer to this. Like most of the rest of the discussion we are having at the moment, this is about how do we turn this into a properly planned service with all the elements of care lined up in the right way. As it says in the next paragraph to that, we have been looking at how we can make sure that people are following good practice in managing operating theatres, so I think it is a range of different issues. It says the delays are mainly due to shortage of beds or to patients being medically unfit, so it is a number of different things.

Q112 Mr Williams: That sounds fine, but it has gone in the opposite direction, has it not?
Sir Nigel Crisp: I agree.

Q113 Mr Williams: We were not happy with one hour, but you can say, "Okay, we can put it down to exigencies and so on". Now it has got worse and all you are saying is that it needs better management. Can we spell this out in surgeon time? We are told that the avoidable delay amounts in total to 19,500 hours of theatre time. That is equivalent to 500 surgeon weeks or over ten surgeon years being completely wasted by avoidable delay.
Sir Nigel Crisp: I agree with you. The point that you also need to see alongside that is the number of operations has gone up very significantly over this period, so more patients are being treated, and you also note that, as we have noticed that this is happening, as we have got concerned about operating time usage, we have put in place a programme for improving the management of the operating theatres in order to tackle this issue.

Q114 Mr Williams: Then we also find that there is almost an equivalent amount of time, 15,000 hours a year, wasted because of inappropriate referrals from GPs. This was something we were told about yesterday. This is not in the control of hospitals; I understand that. It is quite the opposite. People are slapped on the list for a hip operation but when they get to see a consultant they may have a heart condition that makes them inoperable upon, certainly until that can be dealt with. I recognise that this is a much more difficult problem for you to try and control because it goes to all the GPs. Is strong guidance given to GPs on the need to ensure that they do not put people on waiting lists who could not have the operation if they got to the stage of seeing a consultant and possibly being offered a date?
Sir Nigel Crisp: I do not think we give guidance specifically on that point, but what we do, and again you will have seen the big increase reported in this document of care pathways for orthopaedic care, is that there is a lot more done about explaining to GPs the criteria that they should use for referring people into the service and that now has gone up to 50%, has it not, of places that have got that sort of process in place. It is more than just whether or not people are medically fit. Sometimes that may not be apparent until the day. It is about getting the right criteria. To tackle this point, which is an important point, we are putting in place the referral centres we talked about in some places, we are putting in place GPs with special interest and we are putting in place these care pathways so that it is very clear to the GP what criteria the consultants would expect them to use in making those referrals, and that will include some issues about medical co-morbidity as well as about the condition of the hip itself.

Q115 Mr Williams: Can we switch to page 28 and the cost of hip operations and the incredibly wide range of that. For primary hip operations we are given figures of £2,266 to £7,456. The dearest is three times dearer than the cheapest. We recognise that there must be variations in the nature of the operation, but how is it that the range is as wide as it is?
Sir Nigel Crisp: The point that the NAO make is the one that you have just made, but the second point is that when we have looked at what we believe is the hospital which is recording the lowest figure, £2,266, we think they are calculating their costs wrongly because the prosthesis, in other words the hip itself, is a very significant part of that cost, so I think the range is smaller but, even so, there is a range. What again I am sure you know is that we are moving towards a national tariff for all common procedures in the first place which would include primary hip replacement and each year, as we move towards that tariff, we are seeing the range of costs reported by trusts reducing.

Q116 Mr Williams: It refers here to a National Schedule to Reference Costs. That is what you mean, is it?
Sir Nigel Crisp: Yes, that is right.

Q117 Mr Williams: How long has that been in existence?
Sir Nigel Crisp: I cannot remember if this is the second or the third year. It is something like two or three years. I cannot remember the exact date. We will be producing the next one, I think, in the next month.

Mr Williams: Perhaps you could also give us a note on what it has achieved so far in terms of the narrowing of ranges and also in the work it has actually done. Let us know what it has been doing since it started and let us see what effect it has had, if any. A note will do for that.[7]

Q118 Mr Allan: When my colleagues raised the question of the small number of operations I cast my mind back to the debate we recently had in Sheffield about the future of heart and lung transplants where the service cut a unit precisely on the basis that the small number of operations carried out each year meant that consultants would not be good enough effectively to do it. Whilst I understand that that is more of a speciality, I guess the concern remains that for a service like that, where the NHS wanted to cut the service, they had the figures to hand and they said, "Instead of too few operations per year we will go ahead and cut it". For a service like this, where there is clearly huge pressure and you want to keep as many orthopaedic surgeons in the field as possible, there may be less of an incentive for you to tackle this. Can you give us an assurance that that is not the case?
Sir Nigel Crisp: I understand why you are saying that, but the difference with the sort of case you are talking about in Sheffield is that it is much more of a team operation because this was a heart transplant. You need the scientists, you need the intensive care unit, you need everything lined up around that. It is a much more complex set of operations. Part of the argument, as I recall it, that they had was about the competence, the skill, the experience of everybody in that system and the continuation of working together, whereas any hip operation is a relatively simple operation within the system. There is a difference between the two things for that reason.

Q119 Mr Allan: But the public understood it primarily in terms of the surgeon skills.
Sir Nigel Crisp: But it is the surgeon and team even more so in the case of heart transplant.

Q120 Mr Allan: But if we were to find similar results,—and they were, as the Chairman pointed out, highlighted some years ago—and if you were, through this exercise and in your note, able to deliver us a programme to say, "On such and such a date we will be able to tell you fairly definitively and give you the results fairly definitively of our research into these people who are only carrying out a small number of operations a year", would you be happy to do that and would you act upon it?
Sir Nigel Crisp: The answer is yes, but, if you remember the Sheffield case, the research was pretty good and it was not accepted by everyone as being adequate research, was it? There was continuing argument about whether or not—

Q121 Mr Allan: I think I was on that side of the argument.

Sir Nigel Crisp: I suspect you may have been on that side of the argument about tackling the research, which does demonstrate how difficult it is to be definitive here. And people on your side of the argument would no doubt have been saying, "These are experienced surgeons, they have been doing it for some years, look at their track record. Even if they are only doing three a year, they have all gone well, so why are you criticising these surgeons?".

Q122 Mr Allan: Touché there. In paragraph 16 on page 3 of the Report it says, "We found that 10% of orthopaedic consultants surveyed prioritise their patients mainly on the basis of the need to meet waiting time targets rather than in terms of clinical priority. The British Orthopaedic Association found that in March 2001, 52 out of 100 orthopaedic units that responded to a survey had been asked to operate on long waiting time patients at the expense of more clinically urgent cases". We are all aware of the pressure on orthopaedics more than anything else. As the Chief Executive of your organisation with responsibility both for meeting targets and for the quality of the service, how do you react to that and do you think it is acceptable?
Sir Nigel Crisp: No, we do not think it is acceptable. We have got a very clear policy which is that it is clinical need and then, if the clinical need is the same, it is an order of people being put on the waiting list. It is how the treatment should go.

Q123 Mr Allan: The trusts are doing it wrong then?
Sir Nigel Crisp: Any case where that is actually happening needs to be looked at by the Chief Executive and corrected. Where that is brought to anyone's attention that needs to be dealt with. This was what people believed. You need then to look at the facts and see if that really was happening.

Q124 Mr Allan: So have you followed up the British Orthopaedic Association survey results where they say that in 52 out of 100 units this was happening?
Sir Nigel Crisp: We have not done it specifically on orthopaedics. We have done it on procedures generally because this committee has debated that before in terms of whether waiting times distort clinical priorities and we are reinforcing the message and wherever it comes to light, if it is happening, it needs to be investigated and acted on.
Ms Edwards: The whole driver for us is to make sure that we have got sufficient capacity to meet the urgent and non-urgent patients, and the whole methodology we are now putting out through the NHS is to make sure that the urgent patients get treated first and then all other patients get treated in routine order, and by growing capacity we should be able to keep going with both of those. The total waiting list for this sort of thing is actually falling, which shows that we do have the capacity to meet the demand.

Q125 Mr Jenkins: Sir Nigel, before you go away with the concept that we only deal with money, you deal with, by its very nature, the oldest section of the population, which is vulnerable, sometimes frail.

[7] Ev 16.

When we refer to reducing time in hospital beds I do not want anyone to go away thinking that we are doing it to save money. We do not just know the price of everything and the value of nothing. We are here to provide a value service and there are good clinical reasons why it is better to get people out of hospital, as we know the risks in hospital. Will you, as the person safeguarding the running of the NHS, do everything in your power to ensure that those reasons are explained out there and that if people have to stop in hospital they will be able to get the care they require irrespective of meeting a target date on some chart?

Sir Nigel Crisp: Let me start with the first bit of the question, which is in a sense what happens at the point at which the patient comes into the hospital: what are their expectations about coming out in five days and so on? If you look at the very best practice around the country it involves GPs knowing exactly who they refer and on what criteria, it involves some pre-assessment being done and it involves a discussion with the patient early on about, amongst other things, particularly if they are older people, their social circumstances and whether there is somebody at home to look after them and all the rest of it. The next point though is that what happens next depends slightly on what location you are in. I happened to be in Swindon recently and I saw the new community unit that is next door to the main hospital there, and they bring out their older orthopaedic patients out of the main hospital and put them in this community hospital, partly because they have that facility, but also partly to move them on from an acute setting to one which is a purely rehabilitation setting and provides a very good service. Not everyone has that facility locally. That is what needs to happen right the way through the system. People need to be informed and know exactly what the expectations are and that is where we want to be. Everything that this Report says, and this is the challenge I gave the British Orthopaedic Association, that we are not yet running a really planned service, is, "You have made progress, you have got 50% of trusts using care pathways, so you have got a reduction in length of stay, you have got a narrowing of some of the variations and so on, but it is not enough", and that is why these plans are so important.

Q126 Jon Cruddas: Given the scale of the investment in the dedicated centres and given that they provide so much of the solution to the issues in terms of lost theatre time, false referrals, etc, are you entirely confident that you will have the staff to fill them in terms of them coming on stream trained and having greater capacity in terms of human labour?

Sir Nigel Crisp: That was the essential reason why we went out to the independent sector as well. If you look at the procurement we are doing from the independent sector, it is about additionality to the NHS; it is about bringing in additional staff, so almost all of those services will be bringing in doctors from abroad to work in those services, so that we do get an increase in capacity as well. That is only part of the increase but it is an important part. We are a very fast-growing service and if you look at the figures for the last year to September I believe that there was a net increase in all staff in the NHS of 58,000, between September 2001 and September 2002, which is a small town as it were in terms of the increase in people. We are growing very fast indeed. The majority of those as I recall it are professionally qualified people because we are training more people. The increase in people coming from medical schools has gone up significantly. We are growing, we are bringing more people into the service, but we are also trying to expand, so we are slightly chasing a moving target. At the moment we are recruiting and expanding capacity at about the same rate.

Q127 Chairman: Thank you. One last question of Ms Edwards. I am sorry you have not had a great deal to say this afternoon but we always like to give our witnesses the opportunity of saying something. If you have another look at paragraph that leapt out at me, paragraph 3.5 on page 2, you read there, ". . . 10% of the 650 orthopaedic consultants who responded told us that they prioritise mainly on the basis of the need to meet waiting time targets". You are the Director of Access. I take it therefore that when we come to consider this matter in three years' time this situation will not repeat itself?

Ms Edwards: As I said earlier, what we ask consultants to do is prioritise in two broad ways: first, in terms of the clinically urgent, and the very strong message, as Sir Nigel said, was that clinical priority must take precedence, so all clinically urgent patients must be treated first in priority. Then for the routine patients the expectation is that they will be treated in chronological order. Therefore, for two patients with identical conditions the decision would be which one has waited longer and who went onto the waiting list first.

Q128 Chairman: The way you put it makes eminent sense. The way that these 10% of orthopaedic consultants put it would, I suspect, infuriate the public, because the way it is put here, and this is a Report agreed by the department, is that it says that 10% of these orthopaedic consultants prioritise not on clinical need but to meet targets. The way you answered the question was that these people only dealt with it on the basis that two people had been waiting the same amount of time. That seems sensible. This phrase here is giving the wrong impression, is it not? Nothing is being done in the NHS just to meet targets in this matter of hip replacements. That is what you are saying, is it? Targets are irrelevant. We are simply looking at the individual patient, are we? Can you give us categoric assurance on that point?

Ms Edwards: That is our policy, that clinical priority takes precedence.

Q129 Chairman: And that scenario does not happen in the NHS?

Sir Nigel Crisp: What I said earlier in response to Mr Allan, I think, was that where we discover that anyone is not doing that, then it needs to be acted on immediately because that is not acceptable.

Q130 Chairman: If it was 1% I could understand it but 10% are saying that they are prioritising mainly on the basis of meeting targets. You have told us quite clearly that this is wrong. What worries me is that so many of these orthopaedic consultants feel that the system has pushed them in a direction where they are prioritising mainly on targets. That surely is totally unacceptable, is it not?

Sir Nigel Crisp: It is, and that is why again I replied as I did, which is that where we find any evidence that that is happening, or where anyone reports particular instances of that happening, it needs to be investigated and corrected, which is a smaller number than this.

Chairman: I hope the fact that we have raised it this afternoon will give more power to your elbow. Sir Nigel, Ms Edwards, thank you very much for what has been a very interesting hearing on a matter of great importance to many people. We are still faced, following our earlier report some years ago, with a very mixed record in terms of waiting times, delays and inappropriate referrals. We still have not got sufficient information from you on surgeons who are performing too few operations and that is a matter on which we will look forward to hearing from you in the various notes that you promised and to which we will return in our report. Thank you.

Supplementary memorandum submitted by the Department of Health

Question 19 (Jon Cruddas): For Diagnostic and Treatment Centres, what do you anticipate the throughput in terms of hip replacements?

The Department is expecting NHS Treatment Centres to deliver an additional 144,000 operations a year by the end of December 2005. There is not a separate breakdown for hip replacement operations, but within this planned additional capacity NHS TCs are planning to provide capacity to treat a further 38,000 orthopaedic operations per annum.

The main independent sector treatment centre (IS-TC) programme, when fully operational, is expected to deliver a total of 250,000 operations per annum. We expect the programme to deliver 42,000 orthopaedic operations by December 2005—a supplementary treatment centre procurement will provide up to a further 25,000 operations per annum, the majority of which will be orthopaedic.

Question 22 and Question 70 (Jon Cruddas and Mr Williams): Why was a private sector Diagnostic and Treatment Centre built within two miles of Ravenscourt Park?

In 2002 we asked Primary Care Trusts (PCTs) to undertake a planning exercise to identify their capacity needs to meet the inpatient waiting times of six months for 2005. This exercise identified capacity gaps that could not be met by the NHS, and we looked at how these might be filled by the independent healthcare sector.

The five London Strategic Health Authorities worked together to plan for the needs of London. The North West London SHA was already developing the NHS treatment centre at Ravenscourt Park to meet its capacity needs. At the same time, Central London SHA identified gaps that could not be met by the NHS and it was agreed with the independent sector that an Independent Sector—Treatment Centre (IS-TC) should be built at the Royal National Orthopaedic Hospital, Stanmore.

Question 71 (Mr Allan): Did the NHS universally look at registries throughout the history of hip replacements, which we have heard have been going on for 40 years, or, did it take the NAO report for this to come forward? And, was any cost comparison done between the model in the UK and some of the international registries?

In April 2000, reports by the National Audit Office, and by the National Institute of Clinical Excellence, (Technology Appraisal *"Selection of Artificial Joints for a Primary Total Hip Replacement"*), noted that evidence of long term effectiveness of hip implants was not available for the full compliment of those implant types in current use. Both reports recommended that the establishment of a national hip registry would help address this issue. As a result of these reports, the Department looked at the possibility of a joint registry, and in October 2000 set out proposals for a registry in its consultation document National Joint Replacement Registry—A Consultation Document. In July 2001, the Department announced that it would establish the National Joint Registry (NJR) in response to the Royal College of Surgeons' report *"Investigation into the 3M Capital Hip"* (July 2001). The NJR would collect data on hip and knee replacement surgery in the NHS and independent healthcare sector in England and Wales.

When preparing the consultation document the Department looked at various models of registries. This included looking at national registries in other countries such as Australia and Canada, and an official visited the Swedish registry to discuss how it worked. We visited regional registries in England, such as those in Trent and the North West. We also looked at registries of other medical equipment such as the National Pacemaker Database, the National Breast Implant Registry, the Central Cardiac Audit Database, the Hydrocephalus Shunt Registry, and the National Heart Valve Registry.

The Department considered the financial models of the other registries, but as the NJR was going to be bigger than the other registries and entirely electronic the Department carried out its own financial modelling in 2001. This estimated that the NJR would cost around £600,000 to develop, and up to £1,600,000 per annum to run. To ensure that the cost of the NJR was competitive the contract was advertised in the Official Journal of the European Union. Following a comprehensive tendering process the contract was awarded to AEA Technology in September 2002. The cost of the contract was for £714,884 to develop the NJR, and £1,615,000 to run in year one and £1,569,000 in year two.

In deciding the how the NJR would be funded we had to consider how the NHS was changing with more emphasis on empowering front line staff through the Shifting the Balance of Power programme, with PCTs holding 75% of funding, and trusts being ultimately responsible for local audit. With around 25% of hip and 20% of knee replacement operations carried out in the independent healthcare sector, we also had to consider how it would contribute to the NJR, as the independent sector receives the same benefits as the NHS from the NJR.

The Department decided to fund the development of the NJR. Once the NJR became operational on 1 April it became self-financing through a levy placed on the sale of hip and knee implants to the NHS and independent healthcare sector. The levy is set by the NJR Steering Committee. The levy for 2003–04 was agreed at £25, and the Steering Committee agreed to keep it at this rate for 2004–05.

The Committee asked about the administration fee of £2.50 (going down to £1.70 after two years) that is paid to the implant suppliers to collect the levy. The levy on the sale of implants is an innovative way of funding the NJR. It was important to get this right, otherwise the NJR might have failed early on. AEA Technology did suggest that they would collect the levy direct. However, the suppliers already had an invoicing system with hospitals that AEA Technology had not, and it was easier to collect the levy from the 20, or so, suppliers rather than over 500 hospitals in the NHS and private sector. It was for these reasons that it was decided that the supplier's route was more reliable to ensure that the NJR got off on a sound footing, and has worked well in the first eight months of operation. Ministers have asked the NJR Steering Committee to review the levy system after it has been working for a two-year period.

Questions 108–110 (Chairman): Do you not think that you really should give urgent consideration to introducing a minimum volume of work for NHS surgeons in regard to operations and did you assess the risk when this Committee previously recommended this?

Yes, we are giving consideration to the issue of a minimum volume of work for NHS surgeons in regard to hip operations. However, whilst there have been various studies carried out on whether surgeon volume improves outcome for patients following hip replacement operations the conclusions are mixed. Additionally, the NHS has systems in place to monitor surgeon performance. Since the original hearing in 2000 the Department has introduced a number of policies aimed at setting standards, raising quality and monitoring clinical performance through clinical governance and clinical audit. The National Joint Registry set up in 2002 provides the first step in assessing the issue of volume of work against out come as it will generate the data for clinical audit and for performance appraisal purposes.

While these are important safeguards the Committee's point on whether surgeon volume impacts on outcome is an important one. We are inviting all of the relevant interest groups such as the Royal College of Surgeons, British Orthopaedic Association and British Hip Society, to join a working group and provide advice in summer 2004.

Question 117 (Mr Williams): How long has the National Schedule to Reference Costs been in existence, and what has it achieved so far in terms of narrowing of ranges and also in the work it has actually done?

The first Reference Costs collection was undertaken in 1998.

The impact of Reference Costs on reducing variations in costs across the NHS has been mixed. However, the range of costs reported for elective inpatient admissions for primary hip replacements in NHS Trusts, between 2001 and 2002, fell from £12,341 to £6,074; a decrease of over 50%. Although some of the cost ranges have increased, this is partly because, as procedures change, it is difficult to compare like with like. The introduction of the national tariff, which began in a small way in 2003–04 and becomes fully operational in 2005–06, will undoubtedly drive down cost differences.

10 February 2004

Printed in the United Kingdom by The Stationery Office Limited
5/2004 938787 19585