Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Appointments Cancelled by Hospitals: Health and Social Care Board/Health and Social Care Trusts Briefing

6 February 2013

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Sue Ramsey (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Mr Roy Beggs
Ms Paula Bradley
Mr Mickey Brady
Ms Pam Brown
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr Conall McDevitt
Ms Maeve McLaughlin

Witnesses:

Mr Colm Donaghy	Belfast Health and Social Care Trust
Mr John Compton	Health and Social Care Board
Mr Sean Donaghy	Northern Health and Social Care Trust
Mrs Mairead McAlinden	Southern Health and Social Care Trust

The Chairperson: I welcome John, Colm, Sean and Mairead to the Committee meeting. You are well aware of why you are here. We could have had all the trusts here, but we thought it important to have a mixture: some that are very good, some that are not very good and some in the middle, together with the chief executive of the Health and Social Care Board. We have had research done on this. I assume, John, that you will take the lead on this?

Mr John Compton (Health and Social Care Board): Yes. I will say something at the outset and then hand over to the chief executives.

The Chairperson: Members have a lot of questions, so we will take your presentation and then invite members to ask questions.

Mr Compton: Thank you very much indeed. I will be brief because it is more important to have the questions than to make the statement.

It is fair to say that the system is as concerned as anybody if there are cancelled outpatient appointments and there are particular difficulties in that regard. It is important to understand what a cancelled outpatient appointment means, and also where we actually are with performance.

Although we report clinics and collect data on them as being cancelled, it does not always mean, for the individual patient, that the clinic is actually cancelled. For example, if a consultant is unavailable at short notice to hold his or her clinic and a colleague holds it for him, that will be recorded as cancelled by that individual, but the clinic will go ahead as normal, and the patient will not suffer any detriment. In other situations, there are circumstances where clinics or individual appointments are cancelled because tests have not been fully completed and the information is not available to enable the clinic to take place in a sensible way. Sometimes, it is also due to the fact that individuals will be brought ahead, or the consultants will say that they want to revise when they want to see individuals in that context. So, to make the assumption that a cancelled clinic automatically means that the individual patients are always affected is incorrect. It is more a matter of how we record the information. However, my colleagues will go into the detail if there are specific things in regard to individual circumstances.

It is also important to remind ourselves of the target: 50% of all people should be seen within nine weeks. We are currently working at 67% of people being seen within nine weeks, a very marked improvement and about a 40% reduction in waiting times in the last 12 months for that. We expect, by the end of this year, to be at about 70% with regard to waiting for outpatient appointments. So, we are very mindful and not at all complacent about the fact that there are issues about whether clinics are cancelled, but I think it important to have the context and the perspective.

By and large, reasons for cancellation are to do with normal circumstances: illness on the part of individuals holding the clinic; complicated family circumstances that make them unable to attend work on that particular day; or other clinical duties. It is very rare for a clinic to be cancelled in a casual manner, and that is because we now have a booking system that works on a six-week arrangement. Part of the booking system that we have across the Province ensures that we book people in an orderly way: first of all, on the basis of clinical need; secondly, on the basis of chronology. Those clinics are booked six weeks in advance, so that avoids circumstances where there are very short-notice, last-minute, unplanned things. So, we have a system in place to mitigate what might be described sometimes as casual change around how clinics are booked or, in other ways, sorted out.

Clearly, it is something that we pay attention to and that we want to see improve. It is important to remind ourselves that we have about 1·5 million appointments across the year. Frankly, in the information and the way we collect it, it is not possible for us to discriminate between the 180,000 on the cancellation block. We cannot say how many of the 180,000 are, in fact, hard cancelled or, as I described to you, are as a consequence of a change in who is running the clinic or a change whereby the clinician calls the individual sooner or later than planned. We are working on that to make sure that we get that information better, but I think the proof of the pudding is where we are with the targets. If we have a target to do it within a nine-week period at 50%, and we are 67% and moving towards 70%, it shows that we are taking the matter seriously.

I will pause at that point. If there are particular queries or questions for the individual organisations, they are more than capable of answering.

The Chairperson: Thank you. I actually said, not five minutes ago, that we all live in the real world and people do get sick. We need to accept that people get sick and sometimes appointments are cancelled.

If you look at the total, John, you see that 182,813 appointments were cancelled. We have a breakdown of the reasons for hospital cancellation. Reasons given include the following: "annual leave"; "study leave"; "consultant has retired"; "consultant in theatre"; "consultant unavailable"; and "consultant on ward round", which is fair enough. So, I take on board the point that you made in your introduction that an appointment is not necessarily cancelled when somebody arrives at a clinic if another member of staff takes the clinic. Are you telling me that the figure of nearly 200,000 is wrong and that they are not actually cancelled appointments?

Mr Compton: They may not be cancelled in that sense. If you read that, you might assume that 180,000 people were either told not to attend the clinic or that they received a telephone call or letter to say that their appointment had been cancelled. In fact, if a clinician is unavailable and a colleague clinician holds the outpatient clinic, it will go ahead as normal. The patient will see no detriment or effect as far as they are concerned. If I were a consultant, the clinic held in my name would be marked as "cancelled" because I, the clinician involved in that, was not there.

The Chairperson: So the records are not right, then?

Mr Compton: It depends on what the objective is in counting cancelled clinics. It is not accurate to say that 180,000 people did not get an outpatient appointment. We are counting the nature of why a clinic was cancelled, not the individuals attending them.

The Chairperson: OK. We could be here all day talking about the terminology. I am going to ask you to provide me with a breakdown of the figures under these five or six headings. I know that you do not have it now. Out of that figure, give me the figures for when another clinician took the clinic and figures for how many of them were cancelled due to annual leave, sick leave, study leave, ward rounds and theatre. We will look at all those figures. We take on board that people become ill, and that is fair enough; you cannot factor that in. However, those six or seven headings can be factored in and, to me, if they are not being factored in, there is something wrong with the administration.

Mr Compton: That is why I pointed out that we have a partial booking system, which plans six weeks ahead. That takes account of annual leave and of a series of issues. So, for example, someone might be on study leave but the clinic goes ahead. That clinic will be marked as "cancelled" because the senior clinician in whose name the clinic was to be held was not there, but that does not mean that the clinic did not take place.

The Chairperson: Can you not design a programme that shows that the clinic went ahead but just not with the stated person?

Mr Compton: We do not collect information in the way that you suggest. Maybe we could.

The Chairperson: John, why not?

Mr Compton: Over the past 24 months, we have made tremendous efforts to improve on the amount of information that we collect and how we collect it. We are continuing to make those improvements.

The Chairperson: The evidence that I have in front of me tells me that nearly 200,000 appointments were cancelled. You are telling me that that is not accurate information because a percentage of those appointments might have gone ahead.

Mr Compton: Yes.

Mr Colm Donaghy (Belfast Health and Social Care Trust): We understand and recognise that cancelling outpatient clinics, particularly at short notice, can be very upsetting for people.

The Chairperson: I appreciate that, Colm.

Mr C Donaghy: It is important that we minimise it as much as we can. However, as you recognised, there are instances of clinics being cancelled at very short notice because, for example, a consultant is unwell, in theatre and the theatre overruns because of emergencies, or was called in the night before because of emergencies. We want to minimise that as much as we possibly can. The other thing that we want to do when that happens is provide an alternative appointment as quickly as possible. As John said, we are looking at exceeding the target this year to 70% of people being seen within nine weeks. When a clinic is cancelled, the clock is not restarted in respect of the time that the outpatient has to wait. It remains nine weeks, and we try to see people within that nine-week time frame.

The Chairperson: Colm, I know people who have arrived for an appointment to be told that it has been cancelled. John is telling me that there are other reasons for that, so give us the information and tell us why that is. According to the information that we have in front of us, some clinics and appointments are cancelled because a consultant has retired. Common sense would tell you not to schedule appointments for a consultant when he or she has retired. Now we are told that it is because they are on annual leave, so the way that appointments are worked out maybe needs to be changed. I am aware that other members have a lot of questions, as I do. Can you give us a comparison with the cancellation rates for when consultants are running their own private clinics? Do you have that information?

Mr Compton: No, we do not have that. That is not information that we hold. When an individual is doing a piece of work privately, they are doing it privately.

The Chairperson: What is the rate of cancellation for work that brings in additional money for you?

Mr Compton: I do not have that information in front of me at this point in time.

The Chairperson: Can you give me that information?

Mr Compton: Yes; we have that information. When we commission the work, we know whether the work is cancelled or not.

The Chairperson: So, you can give us the figures for that additional work. It could take place on a Saturday, for example.

Mr Compton: Yes; we know that information.

The Chairperson: We hear all the time about incentives to reach targets. Has the board looked at incentives as a way of decreasing the cancellation rate?

Mr Compton: Yes; we are looking at incentives, but that would clearly be a change in policy. The Department and the Minister would have to agree the mechanism by which we would do that. We would be keen to introduce that. From our point of view and that of the providers, there would be no particular objection to that as long as it were done proportionately and sensibly. We are currently exploring how that might work. However, it would be a policy change. Policy clearance would be required before that change could be implemented.

The Chairperson: It is not all bad news, Mairead, your trust is very good at this. Sean, the information that we have indicates that, in the Northern Trust, 13·5% of all outpatient appointments were cancelled. That seems to be the highest rate of all the trusts. Have you any explanation?

Mr Sean Donaghy (Northern Health and Social Care Trust): Sue, we are back to the context of the exchange that you have just had with John. The number of cancellations recorded for the Northern Trust does not represent that level of lost resource; it simply does not. A significant proportion of those appointments were cancelled for clinical reasons. We, as an organisation, will rebook those appointments up to six hours before the time of the appointment. If a mother has an early delivery and her consultant obstetric outpatient appointment is reasonably and sensibly cancelled, that will count as a cancellation. However, that slot may well be used if it is possible to arrange for someone to attend at short notice. Similarly, we have instances in which GPs will refer to both a general physician and a gastroenterologist. The general physician will see that patient and be able to meet the need expressed by that patient or as outlined by their primary carer. As a result, the subsequent gastroenterologist outpatient appointment is cancelled but is reappointed in due course.

This is a gross statement of all cancellations, not netted off for those appointments that were reused or cancelled for appropriate clinical reasons.

The Chairperson: I am aware of that, Sean, but you will appreciate that I was focusing on the ones where the consultant was on annual leave or study leave. I know that there are times when the consultant might be called away because something else is happening in the hospital. If that is not factored in, people are getting appointments when it is known rightly that the consultant could be off on annual leave.

Mr S Donaghy: This may not be the case in every area, but, for some of the figures in the Northern Trust area, the cancellation is the cancellation of a slot but not of a patient. For one reason or another, it may be necessary that a planned clinic can no longer take place. However, no patient ever received a letter saying please come on 15 January or whatever the date happens to be. Therefore, no patient has to receive a cancellation letter, and no patient will turn up to find that the clinic is not operational.

The Chairperson: Is it different across all trusts? Is a different computer system used?

Mr Compton: No; it is all done on the one system. I am not saying that there are not exceptions, but the six-week notification generally takes account of both annual leave and study leave. The reason for organising the clinics with that six-week timetable is so that we are able to take account of that. It is important to contrast this with where we were before. Clinics were often organised many months in advance, and, therefore, it was sometimes very difficult to get outpatient appointments. Clinics were overbooked because of the need to see people. In the middle of all that, clinics became very difficult and cumbersome. The system that we have now is much more straightforward and delivers better outcomes at outpatient clinics.

The Chairperson: The paper that we got from the Northern Trust blames the high level of cancelled appointments on the fact that the patient administration system (PAS) has:

"been set up with limited codes".

It goes on to say that staff:

"default to 'consultant cancelled appointment' as a 'catch all'."

Are you telling us that the figures that we have are wrong?

Mr S Donaghy: In the Department's response to your original letter, the point was made that some of those categories are not as reliable as we would like them to be to have a fine-grained analysis of the reason for cancellations. That was effectively reiterated in the briefing paper from the Northern Trust. There is a frank admission there that some of those categories are not reliable. There was a footnote in the Department's response to say that you need to combine some of the categories before drawing conclusions on what is and is not comparable.

The Chairperson: Are you happy with the 13·5% cancellation figure?

Mr S Donaghy: I regard that figure as accurate, given how we have applied the data definitions that are promoted for recording cancelled clinics.

The Chairperson: Are you happy with that figure?

Mr S Donaghy: I am not happy with that figure. I re-emphasise that we do not regard that figure as representing lost resource. A significant proportion are patients who never had an appointment with us, and it was a clinic slot that was cancelled. It has been suggested to me since that that is an inappropriate application of the data definition and that we should re-examine that and look to see whether we can structure our systems so as not to record those as cancellations. We will certainly take that point forward.

The Chairperson: I do not want to be flippant. However, if I am a consultant who is employed to work anywhere in a hospital and I am taking two weeks off in August, nobody should schedule appointments for me in that time. There is a common-sense solution to this. All of what you are saying just confuses me, and you do it all the time. There is a start, middle and end.

Having taken on board what you said, I want to talk to Mairead. Your trust has the lowest figure of all the trusts. Are you doing anything different from the other trusts to achieve that?

Mrs Mairead McAlinden (Southern Health and Social Care Trust): I support what my colleagues said in that we are using data definitions that are many years old. They are NHS-derived and are, probably, no longer fit for purpose with regard to the scrutiny that you and, indeed, we wish to apply to our system.

We have set out in our briefing note some of the initiatives that we have brought in to our trust which are no different from those that my colleagues have brought in. I take on board your point about consultant annual leave. However, consultants are human like the rest of us. To tell them to give us an eight-week window before they take any annual leave is, sometimes, a significant ask when life interferes with process. So, although I would be assured that, in the main, the eight-week consultant-annual-leave policy is applied rigorously, we have to be flexible with our consultant colleagues and accept that, at times and at short notice, they may need annual leave.

The Chairperson: I accept that, Mairead. I do appreciate that, sometimes, something comes up. However, the fact is that 98% of the time you can actually factor all of that in.

Mrs McAlinden: I agree.

The Chairperson: Something comes up in only a small percentage of the time. So, we are dealing with nearly 200,000 cancelled appointments. You must be doing something different because you have the lowest rate.

Mrs McAlinden: Again, I think that it is down to managerial effort and clinical leadership. I must say that that is no different from any other trust. We have the benefit of very dedicated administrative staff in our book-in centre. I must pay tribute to them. I must also pay tribute to the management leadership that is shown by directors and their staff. Certainly, our clinical colleagues have shown us great support in bringing those new systems and processes into place.

It is worth noting that, in the NHS generally, there is almost a 7% cancellation rate under that category. So, again, we are not that far from what is happening in the NHS. Significant things are happening there that do not happen in Northern Ireland, such as choosing book systems.

Again, I would have to support colleagues in saying that, sometimes, when we record a hospital cancellation, it does not affect the patient at all. You will see in the Department's briefing note that a number of appointments were noted as cancelled, but actually the patient got their appointment sooner.

The Chairperson: What do you mean by sooner?

Mrs McAlinden: Well, it states here that over 8,000 appointments were brought forward. That may well be where we have created a waiting list clinic and we have been able to offer appointments sooner than were originally booked.

The Chairperson: But some of that is through additional money from the Department to deal with waiting lists.

Mrs McAlinden: Correct.

The Chairperson: So, we are paying for it twice.

Mr Wells: Madam Chair, I want to ask a question. I am coming back later. I want to establish —

The Chairperson: I will actually bring you in now, Jim.

Mr Wells: Thanks, Madam Chair. We have to make absolutely certain here that the reason for the chasm — and that is what it is — between the Southern Trust and the rest is not explained by a different recording method. Is each trust recording that information in the same way? For instance, Sean, your figures are not higher because you have a much larger number of people who are being rebooked with someone different. Is that the reason?

Mr S Donaghy: As a result of my investigations to prepare for the Committee, I can say that there may be an element of recording error that would partly explain that. I would not like to suggest that it wholly explains the difference, but it is certainly a part of the difference in the range of performance across trusts. I made the point earlier that we in the Northern Trust cancel some appointment slots that were never given to patients for the sensible, ordinary diary-planning reasons on which the Chair elaborated. However, they are counted in those figures as cancelled appointments. No patient received an appointment or a cancellation notice.

Mr Wells: Do exactly the same set of circumstances occur in other trusts?

Mr S Donaghy: As I say, as a result of your inquiry, I have established that the core performance metric for outpatients is how long those patients wait. Earlier, John mentioned that two thirds of patients in Northern Ireland will be seen within nine weeks. In the Northern Trust, that will be four fifths by the end of March. Our attention and time are focused on how long patients are waiting. We

attend to all of those metrics, including, in particular, that of "did not attend" by patients because that can represent a lost resource, whereas an advanced cancellation by the hospital may not represent a lost resource. I cannot answer directly your question on whether everyone is recording in same way. You have exposed that information to more attention than it has received in the past.

The Chairperson: John, as chair of the board, can you answer the question about whether all recording is the same across the trusts?

Mr Compton: My understanding is that, yes, we are recording information in a similar way. I cannot give a guarantee that it is absolutely the same. However, the expectation is that it is recorded similarly across all of the organisations. In the last —

The Chairperson: Sorry; but we are being told that the system is not working and that the figures are different.

Mr Compton: There are a couple of things. The PAS is a very old information system that needs to be continually upgraded and may, indeed, need some form of fundamental replacement. The reason why we are able to generate that information in the way in which it is generated — incomplete as it is — is that we have spent a lot more time on data management and have invested, through all the organisations, much more in data control. We are much better now at data capture, as far as all this is concerned. When you get better at data capture, the one thing you find very quickly is that that throws up conundrums that you did not quite know existed.

We have been looking at it the other way round: how long are people waiting; is the length of time they have to wait improving and are we getting to the nine-week target? The evidence clearly suggests that we are improving as far as that is concerned. If you compare last year with this year, you see that there is quite a marked improvement in that information.

What you are pointing out to us — not unreasonably — is that, now that this has been exposed, we equally need to give as much attention to understanding it in a different way to see whether there are material differences between, from our point of view, one organisation and another in the core specialities. There may be material differences in some of the very specialist areas, because you are very limited in your ability to arrange an alternative outpatient appointment for individuals in those groups. However, in the core areas, it is reasonable that we should look at that in respect of the information that is thrown out our way.

The important message that I want to leave with the Committee is that the new booking system, which is six-week orientated, and which takes account of study leave, annual leave and all those issues, does not always avoid the difficulties, but it does take account of them, so that we do not have 180,000 people turning up who do not get seen. I think that what we are trying to explain is that we have a system that generates information in a certain way. A percentage of those 180,000 people will have their appointment cancelled, but that will be rearranged according to the nine-week arrangement. One of the ways of judging whether we are doing that is to look at whether we are we making the 50% target. As I said to you, we are at 67% for the nine-week target for outpatients.

Mr Wells: But, John, if you look under the heading "consultant cancelled appointments", you see that the Northern Trust had 17,113, the Western Trust had 8,333, and the Southern Trust had 461. Those figures are so out of kilter with one other that either one trust is doing things much more effectively than anybody else or a huge number of people in the Northern Trust are having their appointment handed on to someone else, which, in my opinion, does not constitute a cancellation at all. Those figures are miles apart, and that would, therefore, lead me to believe that there must be some difference in recording the figures. No matter how well you perform, that is a loss.

Mr Compton: I do not dispute that. My point is that we have given so much attention to the system and that we are much more accurate. I think that people need to appreciate that, if this conversation had taken place two years ago, we could not have generated any of this information and a lot of the differences in the information. When you start to do this, you start to get the information and all of that. That does not mean to say you just look at that and say, "Oh dear, it is what it is". Clearly, we will look at and examine it. That is the whole purpose of this.

Mr Wells: I think that this one should be aimed at the board rather than the trusts. On pages 42 and 43 of the paper, the Southern Trust has given us some idea as to how it deals with the situation. For instance, it has a text-messaging service to remind patients of appointments. If a consultant gives

notice of a cancellation within six weeks, the head of service will intervene and either not approve the request and just say, "No; sorry, you are doing it" — I think that that is a very important point — or liaise with the consultant team to cover the clinic where other staff are available.

What I have found, sitting on this Committee for four years, is that, for many of the solutions to the problems we have in health service in Northern Ireland, we do not have to go outside the boundaries of Northern Ireland to discover the secret of what to do. If we could introduce best practice in any specific trust throughout the Province, many of our problems would be solved very quickly. Surely, the role of the board is to look at best practice in a certain trust where success has occurred and then say to the other trusts, "Here, boys, look at what is going on down the road. Is it not about time you introduced those systems?" That clearly must have led to some of the reductions in the Southern Trust area. Is there any plan to roll that out throughout the Province?

Mr Compton: Yes. I want to be very specific about this. The board meets each of the organisations on a fortnightly basis to talk about the activity in each of the hospitals, including outpatient elective activity and inpatient activity, so that we are clear that we are getting the volume of activity and planned amount of activity through the organisation. Clearly, where there are good learning events and exercises in one organisation, they are shared between organisations. They are also shared at trust level. So, we do all of that.

The point here is that we are on the journey to get the thing to be better. You cannot, when you switch the information, switch the way we do this and switch the collation of it, instantaneously move it from one place to another. What we have is a clear journey that shows that, if you were to compare where we were this time last year with this time this year, we have many tens of thousands of people who are being seen more quickly, and, as a consequence of that, we are on that journey. So I would expect that, if we were here again this time next year, we would have many more people seen inside the nine-week target. That is the objective. We will work towards cleaning out all of that information. What we need to know, out of the 180,000, in very straightforward terms, is how many people were directly impacted on and delayed in terms of a clinic.

Remember the target. Even if that individual patient had his clinic cancelled, the time is not restarted. The time sits as it is. They are already in the time zone for the nine weeks.

Mr Wells: John, you keep quoting that you are making considerable progress, and you cite the figure that 70% are now hitting the nine-week target. That does not excuse the situation in which one trust is working very hard and is helping to make that target figure rise while others are lagging well behind.

Mr Compton: I accept that.

Mr Wells: I ask the question of the trusts here: have you a system whereby, if a consultant asks for a cancellation less than six weeks in advance, you will intervene and say "No"?

Mr S Donaghy: We do; yes. We also have a text-booking service for reminding outpatients of their appointments, but that will not affect hospital cancellations. It will affect "did not attend" rates, and those have dropped markedly across all the trusts, and they have dropped markedly in the Northern Trust. However, both the specific things you mention are in place in the Northern Trust.

Mr Wells: Do you have a system whereby hospitals work collaboratively? If an appointment is cancelled in hospital A, will it contact hospital B to try to rearrange it?

Mr S Donaghy: We use all of our resources collaboratively. I could not give you instances of that in relation to hospital outpatient appointments but yes, that will happen also.

Mr Wells: You are saying —. Sorry Colm, I am interrupting you.

Mr C Donaghy: I was just going to add some clarity to that as well. In the majority of cases where a patient is directly affected — and that is what I think we want to get to — the issue is which of those cancellations directly affects the patient, in the context of a patient receiving a notification that a clinic that he was expecting to attend has been cancelled. In the majority of cases, the patient will also receive a telephone call, or there will be a rearranged appointment in the letter, immediately. We all follow that process.

In the context of Belfast, and John has alluded to it, we have certain complexities around the very specialist services that we have. So, sometimes, if a consultant is not available to provide some of those very specialist services, it is more difficult for us to get a replacement within the necessary time frame.

Last year, for example, we had industrial action, which meant that, again, those figures are included in these cancellation figures. We also had a modernisation programme in relation to vascular surgery, ENT and rheumatology that ran across our trust. That meant that, in advance, we cancelled clinics, but not patients. Several thousand clinic slots were cancelled, but not actual patients. I think that what the Committee wants to get to — as I understand it — is the number of actual patients who had outpatient appointments cancelled.

Mr Wells: Finally, let me say that if private industry worked like this, companies would close down. Some of what is going on here just would not be tolerated in the private sector. Are you saying that with holidays for consultants, where a consultant gives you notice that he is going on holiday — maybe he has a cheap easyJet flight to Corfu or something and wants to pick up the chance — you look at the bookings and realise that it will cause a huge impact on the waiting list, do you intervene and say "Sorry, you can't go"?

Mr C Donaghy: Can I maybe use that one, Jim? We require consultants to give us six weeks' notice to ensure that if any clinic is in place, they can make arrangements to have it covered. In those cases, as Sean indicated, when that consultant cancels the clinics and he is replaced by another consultant who provides the clinics for those patients, they become "cancelled slots" for that consultant. The computer records them as cancelled slots. No patient is called to that outpatient clinic. However, the consultant will have given us six weeks' notice and we will have made arrangements for someone else to provide those outpatients with their clinic.

Mr Wells: That is a slightly different answer to the question.

The Chairperson: Why were we not given those figures?

Mr Wells: We need those figures.

Mr C Donaghy: The figures that have been given are for the total cancelled outpatient appointments.

Mr Wells: We need a breakdown that explains exactly what has been cancelled and for the various reasons.

Mr Compton: It is really important to make the point again that there is not a casual attitude to someone deciding that they are going on annual leave that I am aware of across the system. Everybody applies the same protocol. Whether you are a senior clinician or a junior member of staff, you have to seek permission for annual leave. It is for the organisation to approve or not approve that leave. As Mairead pointed out, life can throw up circumstances in which it is difficult not to approve annual leave. However, the notion that there is casualness about annual leave is not correct: that is not what happens inside the system.

The reason that we introduced the booking system is to create efficiency. When we talk about the six weeks' notice, that includes, in the round, planned leave and study leave. We know what the work of a consultant is. We have gone through a lot of demand and capacity work on how many sessions there are and how many can and cannot be filled. We are not casual about that, and the system is not casual about it.

As we get better and get that information, it definitely throws up conundrums. It throws up things that do not look as though they are correct. One place may look as if it does not have a problem while another place looks as if it does. We are currently working through that to best understand it. If we, as the board, found that something that was happening in the Southern Trust needed to be replicated in the Northern Trust, the Belfast Trust or wherever or vice versa, we would make that very direct suggestion to the organisation involved.

Mr Wells: Finally, I presume that a consultant is required to give a very long notice period before he or she retires, unless it is due to illness.

Mr Compton: The normal notice period for retirement is three months. It is not uncommon for senior staff to advise their organisation of retirement six months in advance, but the formal, contractual notice period is three months.

Mr Wells: At that point, is the booking team alerted to the fact that consultant x or y will no longer be working for the trust?

Mr Compton: The booking team is alerted to that, but the organisation will also be making alternative arrangements. For example, it may be employing a locum to cover the period between the individual's retirement and the substantive recruitment. The clinic will be booked, but the name on the top may not be changed. So, our system will spit out a piece of information that states that John Compton has retired and his clinic was cancelled because he has retired. However, in reality, Colm Donaghy ran the clinic as a locum for that period and saw all 50 patients as normal.

The Chairperson: John, it is too easy to say that.

Mr Compton: It is a matter of fact.

The Chairperson: I know, but the quoted reasons for hospital cancellations are annual leave, study leave, retirement, in theatre, unavailable, and on ward. That is without even getting into "at a meeting", "holding a lecture" and all that stuff. If you are telling me that a percentage of the cancelled appointments were not necessarily cancelled because somebody stepped in and did them, they should not be recorded as cancelled appointments. If there is a problem with the system, then change the system.

We are being told — and I accept — that it does not necessarily mean any harm for the patient and that you are complying with the nine-week time frame and all of that, but the reality is that we are paying for this twice. If an appointment is cancelled, somebody has to go back for that appointment, or else what we are doing is pouring public money into the private sector to allow it to deal with the matter and ensure that people hit the nine-week time frame. That is why we want to look at this.

Mr Compton: We are very alert to the issue of what you might describe as double payment. In the normal course of events, our payment for outpatient clinics is derived from demand and capacity. As I said, we have done a piece of demand and capacity work, so we know the number of people that can be seen inside the system. When demand outstrips what we can reasonably do, we ask each of the providing organisations whether, inside their systems, they can run additional clinics for which we will pay. If we cannot run additional clinics inside the system, we go outside the system. However, we pay the standard rate. We do not pay some ludicrously inflated rate. I can give that assurance, if that is an issue for the Committee.

The Chairperson: If you are not there to do your clinic and Colm has to step in to do it, who pays?

Mr Compton: If we are working together in the same hospital, there is no extra payment. That is a colleague doing a clinic for you as part of the normal course of events.

The Chairperson: But, if you just decide that you are not available to do the clinic, you still get paid for that.

Mr Compton: As I have said, the expectation is that we get six weeks' notice. Circumstances can emerge in anyone's life that mean that you do not get six weeks' notice. When we talk to all the organisations across Northern Ireland, I do not get any sense that the six-week rule is not well-understood, well-delivered and well-policed.

Mrs McAlinden: I just want to give Committee members some assurance on how the process works. John contracts with my organisation for 200,000 outpatient slots. If I, or any other trust, do not manage it effectively, and have to send some of them away or pay my consultant colleagues extra, John does not give me extra money for that. He will say, "I have paid you for 200,000 slots. Deliver me 200,000."

The Chairperson: You seem to be delivering anyway.

Mr Gardiner: Hear, Hear.

Mrs McAlinden: If the demand is 250,000, John will have to —

The Chairperson: I was going to say that it may be because you are a woman, but I will not.

Mrs McAlinden: Thank you, Chair.

The Chairperson: Sorry; did I say that out loud?

Mrs McAlinden: I think that it is to do with —

The Chairperson: I need to give credit where credit is due, Mairead. Your figures are pretty impressive.

Mrs McAlinden: The Committee members have pointed out that the figures are perhaps not as comparable as they could be. We, as trust chief executives, will certainly take that on board so that we can provide the Committee with the assurance information that they need. The information is not currently collected in that form, and we all need to hold our hands up to that.

Mr McDevitt: I want to compare the figures with those in other regions. Hospital cancellation rates here are 48% higher than they are in England and 44% higher than they are in Wales.

Mr Compton: Yes. Mairead has pointed out that their rate is sitting at about 6·5%, while we are sitting at 10% or 11%. So, our rate is higher; that is a matter of fact. What we are really talking about here is a complexity in the information. We have an information system that spits out stuff. Are we ultimately any worse off because of the awkwardness that individual patients experience? To be honest, I cannot answer that question, because I do not have the information.

Mr McDevitt: Let us explore that. We could spend all day slicing and dicing statistics. We are not allowed to use the L-word in the Assembly to say what we think about statistics. Can you tell us, on a regional basis, what percentage of hospital cancellations you believe lead to the complete cancellation of a clinic? I am referring to cancellations that mean that there is no one there and a patient does not see a doctor.

Mr Compton: No; I cannot tell you that.

Mr McDevitt: Mairead can tell us.

Mr Compton: I cannot tell you that information regionally. Remember that we contract with each of the organisations to deliver a certain volume of activity. Our expectation is that that volume of activity is delivered. We become interested only when it is not delivered.

Mr McDevitt: Let us do the rounds. Mairead, you have said that complete cancellation of clinics takes place in only approximately 40% of cases.

Mrs McAlinden: We have tried to give Committee members some intelligence around how the system works and the fact that, when a patient is cancelled, it does not always mean that the clinic is cancelled.

Mr McDevitt: So, it is a minority — but a substantial minority — of cases in which there is no consultant cover, and, therefore, the clinic cannot go ahead.

Sean, what is the situation in the Northern Trust?

Mr S Donaghy: Conall, I do not have that information with me. I am happy to provide it, but I do not have it available to me now.

Mr C Donaghy: I do not have it with me either, Conall, but I, too, am happy to provide it.

Mr McDevitt: That is the critical figure.

Mr C Donaghy: It is.

Mr Compton: Yes; that is the crucial figure.

Mr McDevitt: Not having it limits the capacity for an informed debate, and we end up running around the issue.

Mr Compton: Not to be complacent, but we are in an OK position as regards delivering the target that we are expected to deliver globally. We are not complacent about that — it could be better, and we expect it to be better. The detail — the way in which we collect that information, the way in which we have changed how we contract with organisations, and the way in which we expect outpatients to be called — has thrown up a whole range of information conundrums for us. We are working our way through all of them. Ultimately, we, as a board, are as interested as the Committee in getting the best and most efficient volume of service that we can.

Mr McDevitt: Given that, I suppose, for obvious statistical reasons, you are unable to give us the cost of hospital cancellations because of the complexities of recording what is and is not a hospital cancellation, you would certainly be very interested in knowing the cost of cancellations of clinics because that is a direct opportunity cost. That is a direct hit to the bottom line. You will have lost time and service opportunity. So, I wonder whether we could get from all of the trusts the percentage of the total number of hospital cancellations that have led to clinic cancellations. I take it that that is always the case; if there is no consultant cover, there is no clinic.

Mrs McAlinden: Not unless there is a consultant or an acceptably trained alternative, who may be someone of staff grade in that case. Again, I must emphasise that although consultants are paid for their annual leave as part of their contractual obligations, you would have to ask what is the cost of a consultant clinic that is cancelled due to annual leave. I would have to think very carefully before I gave assurance that we could do that.

Mr McDevitt: It would be very easy to iron that out. What is a consultant's annual leave allowance?

Mrs McAlinden: A consultant's annual leave is generally, in the main, six to eight weeks depending on his or her seniority and experience.

Mr McDevitt: Forty days?

Mrs McAlinden: It is normally six weeks.

The Chairperson: In the desert.

Mr McDevitt: Forty days? Consultants get 40 days' annual leave?

Mrs McAlinden: That is part of their contracts.

Mr McDevitt: What is the basic salary for consultants these days at bottom, entry level, or just in the door?

Mrs McAlinden: I think that it is £85,000.

Mr Compton: It is around £85,000. I have not got it in front of me. It would be in the order of £85,000.

Mr McDevitt: What sort of extra allowances do they get on top of that?

Mr Compton: Consultants are entitled, and have been entitled before, to have two pay scales. They could look for additional merit points inside the organisation and exceptional merit points outside the organisation. That is unpredictable. That depends entirely on where they go. If we ask consultants, occasionally, to work extra sessions that are above their contracted programmed activities (PAs) —

the 10 PAs as they are referred to — they will get additional payment directly for that. That is not to be confused, by the way, with being paid for additional work outside the organisation, but simply if they are asked to do work outside the organisation.

Mr McDevitt: It is around £6,500 a month, and we are taking two months out of the year. That represents an opportunity cost of £12,000 or £13,000 a year.

Mr Compton: The truth of the matter is that when you take both study leave and annual leave together for any senior staff — to be honest, I think that it is wrong to simplify it at this point — we work on a 42-week year out of a 52-week year to allow for the combined amount of annual leave and leave for continuing professional development. That applies right across the reel to a lot of senior —

Mr McDevitt: Are those five-day weeks?

Mr Compton: Yes.

Mr McDevitt: OK. So, you are basically saying that for 50 days a year, consultants are either on study leave or annual leave?

Mr Compton: Yes.

Mr McDevitt: Fifty days a year. Wow.

Mr Compton: It is no different right across the whole of the public sector. You can look at things like public holidays and annual leave that go to any member of staff in the public sector. People can have views about that. To be honest, I think that it is not —

Mr McDevitt: Let us think of it as 50 days a year. That is not 40%. It is nowhere near 40%. So, even if Mairead's guesstimate that 40% of cancellations were true, absolute cancellations due to no consultant cover, and let us say that you are losing 50 days out of your working year, that is nowhere near 40% of your working year. If you just iron it out and try to develop a picture and a trend, there is a huge shortfall.

Mr Compton: I think that, to be honest, you are trying to describe different things in a reasonably simplistic way. For example, the 42 weeks might be less than 42 weeks. If someone works as the surgeon of the week in the surgical department, that individual will have factored into his or her working profile how many weeks in the year he or she will be surgeon of the week — in other words, on call for emergencies that come into the hospital on that day. Again, that will remove his or her ability to run the outpatient clinic. You cannot be surgeon of the week and run the outpatient clinic at the same time. Lots of things like that happen and go through. So, we did a demand capacity piece of work with each of the organisations to add up — and net all of those things off, one way and another, to see what you can reasonably expect. When you look at the outpatient clinic, what number can you reasonably expect the individual to see? That demand capacity piece of work has taken place.

Mr McDevitt: I make no apologies; I am trying to simplify it because it strikes me that you are drowning in your own statistics. This needs to be simplified. A person is either available for work and is at work or is not available for work and is not work. When we are into the question of cancellations, I do not know if we really care how much leave a surgeon takes. We may be slightly jealous. Many people in the private sector who listen to this and hear that it is normal in the public service to be unavailable at a very high salary for that amount of time in a year will be exceptionally jealous.

However, that is not really the issue. The issue is productivity. The issue is whether you are delivering the goods. If you are not delivering the goods 40% of the time, there is a problem. No matter what way you crunch the statistics, it seems to me that consultants are as guilty of not delivering the goods as patients are of not turning up — if not more guilty. So, in my humble opinion, it is a question of absolutely simplifying the debate — getting out of that morass of statistics and start putting a figure on the opportunity cost of patients' not being able to access a consultant or an appropriately trained doctor for consultation. Mairead can tell us that that happens on around 40% of occasions in the Southern Trust. We need to understand how much that happens in all of the other trusts. We need to understand more or less what that costs the healthcare system. In my humble opinion, that simple figure will drive more change than this head-wreck of statistics.

Mr S Donaghy: Can I make a brief comment, Chair? It is quite right to point out clinics where consultants are not available to run the clinics as the focus of concern. That will happen in many instances when it does not represent a loss of resource either to the health service or to patients. A consultant gives six or seven weeks' notice of an intention to take leave. The clinic does not take place. There is no administrative overhead or lost accommodation cost. The consultant was entitled to his or her leave and patients were re-appointed in due course at the appropriate time. That is why we have been very focused on looking at how long patients wait for appointments and also on ensuring that there are very clear notice arrangements for consultants to take annual leave and, as Mr Wells pointed out, a dynamic that includes, "No: I am sorry. It is not possible in this instance", because it would represent a loss of resource to the public service. It is definitely a matter of regret that those figures do not exemplify that.

The Chairperson: Sean, nobody disputes that a consultant or any member of medical staff is entitled to annual leave. However, that would not be recorded as cancelled appointments because the system would work. Are we being told that, on average, across the North, there are nearly 50,000 cancelled appointments because consultants are not available?

Mr S Donaghy: There was a comment from the Department to say that some of those categories were not as reliable as they should be. I sought to develop Mr McDevitt's point and say that a cancellation in all circumstances does not represent a loss of resource: a short-notice cancellation does.

The Chairperson: Let me take you a wee bit further. How can we plan ahead? How can we take on board a commissioning plan? How can we put resources into A, B, C or D if we are being told continually that the figures are not correct and that they actually mean something else?

John, with all due respect, we will be looking at your commissioning plan. We are inundated with constituents who face this regularly. The fact is that we want to try to get in and fix it. If you are saying that the figures could be a wee bit different here and a wee bit different there, then tell us. We are not monsters; we want to work with you. The fact is that in one trust, they seem to be doing good work. I am not even going to get into the Belfast Trust because it is in my constituency. I am trying to take an overview. In one trust, it is here; in another trust, it is there. Why?

Mr Compton: Again, it goes back to the point that you make about demand and capacity. If we have accurate demand and capacity, and we ask somebody to do 200,000 outpatients appointments, frankly, as long as we get those appointments, we are not as interested if there are problems with staff sickness, absence or whatever. The point about it is whether the demand and capacity work is accurate, reasonable and proportionate, and is not a straightforward, if you like, easy ride. I do not believe that it is an easy ride.

My final point is about not drowning in statistics. I go back to the statistics. Currently, we are expected to have 50% of people through their outpatient appointments in nine weeks. We are currently sitting at 67% and moving to 70% by the end of the year. I do not think that we should lose sight of that. I am not complacent about the fact that we want it to be 100%; not at all complacent. However, that is where we are at the moment. I think there is something about having that counterbalance to the other side of the debate.

Mr McDevitt: I would like to make a couple of observations. First, to address John's point. John obviously commissions for the famous 200,000 appointments. Obviously, he wants to get the best value for those 200,000 appointments. Therefore, if there is an extreme level of inefficiency in the supplier, that is going to affect the value for money that you are getting for those appointments. It is going to affect them, and you may be able to drive better value out of the supplier.

Mr Compton: Correct.

Mr McDevitt: So, therefore, if 40% of the supplier's appointments are not productive, then, as a purchaser, I would be kind of interested in knowing that.

Mr Compton: Absolutely.

Mr McDevitt: I just want to make a further point. I take it that no one at this table is suggesting that the system assumes that a consultant who is available for work productively in the front line, crises and family circumstances allowing, for, let us say, 42 weeks of the year, is at work 52 weeks of the year. No one is saying that there is some magic productivity system whereby, even though the contract says that he has X number of weeks' holidays, and he has X number of weeks' of study leave, which he is required to take because of the nature of the job — that the system assumes him to be productive for —

Mr ? Donaghy: We assume 42 weeks.

Mr McDevitt: OK. So, if we assume that, can we please not come in here and try to suggest that holidays are cancelled appointments? Holidays could not be cancelled appointments. I have some experience of this. I know that 100% productivity is not 100% of time. It is maybe 50% of time for some people. So let us not come in here and try to give the impression that holidays are cancellations. Holidays should never be cancellations, because they should be factored out. They should be factored out because you are not productive 100% of your time. You are productive for whatever percentage of your time that you are available for work after your "holliers", after you have done your study leave, after all those other life circumstances: and we need to move the debate beyond this.

I have seen some statistical car crashes in my life, but this is right up there. It really is. And if you keep chasing this, you will all be in an early grave and a lot of people working for you will be in an early grave. It is not going to fix the problem. You need to start looking at the cost, and get the cost of this. I am sorry for the lecture.

Mrs McAlinden: Would it be possible for me to respond to what you have said? I understand your frustration. We collect information in an historical way that, I accept, is no longer fit for purpose. We have set out that a consultant has to give us six weeks' leave but, in certain circumstances, that is not always available and that is why the information is captured in this way. The concerns of the Committee that I hear are twofold: one is about patient impact, where someone turns up on the day and is told to please to go away again; and the second concern is the loss of paid activity. I can tell you, from a provider perspective, that John pays me for 200,000 outpatient appointments, no matter how I choose to deliver them, efficiently or inefficiently. If I deliver them inefficiently, I bear the risk, and, certainly, in this financial climate, I cannot afford to do that. So, we are driving very hard for efficiency. I apologise that our five trust figures are not immediately comparable, and we will do what we can to fix that. However, I wish to assure Committee members that there is no lack of management effort in driving efficiencies, and perhaps these figures are not representing that to best effect.

Mr C Donaghy: Just take up Conall's point, capacity is modelled on a 42-week year for our consultants. So, within that, you are right. Annual leave is taken into account in that context; but, as Mairead said, it does not always work out that annual leave is taken at the time that it should be. The one thing that we are doing in Belfast, and I know that the other trusts are looking at this as well, is looking at team job planning. Currently, we job plan for individual consultants, with regard to the time that they give us every half day, every session, which includes their outpatient work as well. We are currently introducing team job planning, which, we believe, will reduce the potential for cancellations in future, whether they are cancellations because of annual leave — which we cover in another way — or whether they are actual patient-affected cancellations.

Mr Gardiner: It is good to see you all here, especially Mrs McAlinden, who is our hero in the Craigavon and southern health area. Your crown is glowing; you can always hit the top. I welcome it, and thank you very much for all you do in that area.

Last August, it was reported that almost 80,000 hospital appointments in Northern Ireland were cancelled in the past year because consultants were not free to see patients. That equates to 3·2% of all patients seen. I ask Mr Compton: what does that equate to in finance? I have a list, so just jot down these questions. If you cannot remember them, I will repeat them again for you. Does that point to any bad planning on the part of the hospital administration, or to a lack of flexibility due to an inadequate number of consultants and registrars?

Many people now have mobile phones. Would it not be a good idea to send a text message a day or two before the appointment, as appropriate, so that outpatients remember to attend? Sometimes, hospital appointments are notified months in advance and people forget. I appreciate that the

Southern Trust has sent out its notice today; we have copies of it. It says that it gives patients six weeks' notice. If the person is elderly, for example, they will not remember at six days' notice. It is best to use a mobile phone, a telephone call or something like that to remind them to keep their appointment. I think that that can be reduced. Mrs McAlinden, please look at the possibility of filling that gap. I think that six weeks is too long, particularly for elderly people, to remember.

Mrs McAlinden: I certainly agree with you, Mr Gardiner. Text messaging will be in place for all our acute specialties by April. However, there is a particular challenge with introducing that type of service, for instance, for people who have dementia. We will have to be a bit more flexible and imaginative, and we are looking at pilots in respect of a number of those things. I absolutely endorse what you say.

Mr Compton: You asked about the cost associated with the 80,000 outpatient appointments. I think that the cost is where you lose, or you have had to double pay. I go back simply to the point that Mairead has made. When we contract with an organisation, we contract for a volume. By the way, we do not do it on a cost per case or on a tariff. There is no tariff in Northern Ireland; we do not have that sort of system. We do it in a negotiation with each of the organisations, and we pay broadly the same amount across each of the organisations for any piece of the activities that we do. We have a different way of costing it. So, I cannot give you a cost directly. Although it said "cancelled" — you have cited lots of reasons why appointments are cancelled — in the information that we have put back to this, we have never alluded to holidays or to study leave. We have alluded to "availability", "being treated elsewhere" or various other things. So, I need to understand that a little better.

There are definitely some issues with flexibility. It may be that you are being referred to see an individual who has a particular subspecialty, and if that individual is not available and another colleague does not have the subspecialty, that flexibility is a problem and you have to see the individual. However, again, I would go back to the fact that the time clock is running from the referral, not from the cancellation. So, when you get the referral, the nine weeks is nine weeks from that point, not from the point of cancellation. We are making progress with our ability to see people inside that —

Mr Gardiner: What are you doing when you say that you are making progress? What is that progress?

Mr Compton: The progress is that, over the last year, we have reduced the numbers of people waiting over nine weeks considerably, by several tens of thousands. We are at 67% against a 50% target, and we are moving towards 70%. That is the progress that I suggest that we are making across the region.

With regard to the phone texts, my understanding is that that is going to be — if it is not already — very substantially introduced across Northern Ireland. Texting, and all of that modern technology, is part and parcel of what we are planning to do.

Mr Gardiner: Can any of your colleagues tell me whether they have introduced it in their trusts?

Mr S Donaghy: Yes, texting has been introduced in the Northern Trust.

Mr C Donaghy: We have introduced it in a limited way in Belfast.

Mr Gardiner: How long is it in?

Mr C Donaghy: In Belfast, we introduced it this year. It is for dermatology, at this point, but it is our intention to roll it out across all our specialties. It has not been introduced across all our specialties, given the number that we have.

Mr Gardiner: But you are working on it?

Mr C Donaghy: Yes.

Mr Gardiner: That is a step in the right direction. What about yourself?

Mr S Donaghy: It has been introduced in the Northern Trust area. It was progressively introduced over the last 18 months.

Mr Gardiner: Mrs McAlinden?

Mrs McAlinden: We have introduced it as a pilot, initially. We intend and plan to have it across all our acute specialties by the end of April. There will be a complete response across our acute specialties.

Mr Gardiner: Good.

Mr Compton: The expectation is that it will be more widely available, right across, at the end of the incoming year.

Mr McCarthy: Thank you for your presentation. What brought us here in the first place is these figures. We all agree that the figure of 182,000 missed appointments as a result of hospital providers is staggering. We often criticise patients for not turning up, and rightly so, but this is shocking. However, I am encouraged by what I have heard from everyone that these figures could be vastly improved. As John said, hopefully next year, they will be vastly improved. John, you mentioned the targets. Will they be in the next commissioning plans so that, hopefully, they will be reached?

Mr Compton: Yes.

Mr McCarthy: Is there any accountability for hospital providers or consultants over the cancellations? In other words, if some person is continually falling down on their job, can you people haul them in and say that this is not good enough?

Mr Compton: Absolutely. If a consultant wishes to cancel an outpatient clinic, they have to get permission to do so. They have to give six weeks' notice, and they have to get permission from their clinical director or their service manager. The clinical director and service manager will ensure that, if they do give approval for the cancellation of the clinic, they make alternative provision to cover that clinic.

Mrs McAlinden: To emphasise the point further, where we can see a trend in cancelled clinics, that will be addressed through the medical leadership and management models.

Mr Compton: Clinical director and service manager.

Mrs McAlinden: That will be apparent to us by our monitoring.

Mr McCarthy: Finally, Colm, why does the Belfast Trust have figures of nearly 18,000?

Mr C Donaghy: For consultant-cancelled?

Mr McCarthy: Yes. That is the worst of the lot. Belfast is supposed to be the centre of excellence and all the rest of it, so why is that the case?

Mr C Donaghy: There are a number of reasons. There are over 650,000 attendances in total across six hospital sites in Belfast. The 17,600 represents about 3% of our total attendances. That is not to give an excuse. There are a number of reasons behind it. Consultants are unwell at short notice. They can have a bereavement, obviously, at short notice. Theatres can overrun due to being called in the night before for an emergency or because the theatre time has run on, so the clinic is cancelled. As I said, in Belfast, we have very specialist clinics, and, sometimes, when that happens, we do not have the body to replace them at very short notice. That having been said, we want to reduce further the number of cancellations. We do not want to be cancelling clinics at short notice. There will always be cancelled clinics; we want to minimise the number as far as we can in future.

Ms P Bradley: Most has already been asked, and I have only a couple more things. I used the patient administration system (PAS) in a hospital. Although mine was usually down to "Paula is delaying the discharge", which was nearly every day, with social work, we could not fit into the codes. The system is antiquated and needs an overhaul. I know that this is not a true reflection, even though,

when I looked at it earlier before the meeting, I was horrified. I know that PAS needs a major overhaul for all disciplines in the hospital.

If someone has been in hospital and had an operation and been told that they will be reviewed in six months, what is the target for a review appointment if, for whatever reason, they have not heard from the hospital within that time? Is it the same for a new appointment, where you have a nine-week target?

Mr Compton: Review appointments are clinically driven. That is a matter for the clinician, so it is not uncommon for some people to be seen annually, for example, or it might be that they are seen within six weeks afterwards. The review appointments are determined by the clinical circumstances because the review appointments occur after an event or after a first-order diagnosis or a first-order treatment intervention, so they are driven by the clinician.

Ms P Bradley: You mentioned an appointment being cancelled because the clinician is sick. Fair enough, that happens to us all, and that is not a problem. Everything in the hospital's power is done to try to get someone else to see the patient, whether that is the staff grade doctor or the registrar.

Mr Compton: Absolutely. I cannot emphasise enough the transformation that there has been in how we have organised outpatients on the integrated elective access protocol (IEAP) system, which is clinically driven and chronologically driven with a nine-week target, instead of the partial booking system. That has really transformed how we organise outpatients. It has thrown up a lot of anomalies with the information that you have. When a clinic is cancelled, our expectation, from the perspective of the purchasing organisation, is that the providing organisation will do all in its power to replace the individual who is off, either through a colleague or, if someone is off on slightly longer-term sickness, through locum cover. So, the expectation from our point of view is that there is not just a casual cancellation of the clinic, meaning that nobody gets treated. We expect people to make a genuine effort to cover the clinic. In many instances, that occurs.

Ms P Bradley: So, if someone was to phone the hospital seven months after they were supposed to have an appointment and be told, "You were not seen because the clinician was sick", that would not be acceptable?

Mr Compton: No, it is not.

Ms P Bradley: OK, well I will be picking that case up with somebody after this meeting.

Mr Compton: OK, that is fine.

Mr Beggs: I am concerned that there is not enough focus on this at the centre. A cancelled appointment is very stressful for an individual. Someone may be going to see a consultant about a life-changing decision, and if the appointment is cancelled a short time beforehand, it is very stressful for that individual.

I heard you say, John, that you programme 200,000 sessions a year and that as long as that is delivered nothing else matters. The quality of care should be important to everyone: it is not just a matter of ticking the boxes and getting people seen. There should be concern at an individual patient level and at the higher cost level. The estimated cost is £423 million. If I picked up the figures right, the hospitals are cancelling 10·8% of appointments. If those were all genuine cancellations in which there was no cover, and we are saying that there is a question mark over that, that would cost £45 million. The percentage that did not attend was 15%, which would cost £63 million. So, potentially we are talking about £100 million. What figure are we talking about?

Mr Compton: That is a very difficult area. First, let us be absolutely clear: there was mention of the 200,000 appointments and the big numbers, but the primary consideration we have is for the individual who turns up to an outpatient appointment. In the end, that is what determines the whole system: the quality of the experience that that individual and their family have. That is paramount. I do not want anybody to have the view that we approach this without an appreciation of the trauma and difficulty that an individual can sometimes experience.

In terms of the cost and the way in which you operate the cost, we do not have the payment-by-results system in Northern Ireland, and there are compelling arguments for why we do not. The payment-by-

results system would simply cost an outpatient appointment at x pounds, and we would pay each organisation the activity times the x pounds for the appointment, and that would be in the income. We do not do that in Northern Ireland: that is done in other parts of the UK. That would give a much more straightforward way of answering your question about cost. As the numbers for cancellations do not directly mean that the patient was not seen in all those cases, we are clearly struggling to tell you how many people did not get seen out of the 180,000 cancellations.

Mr Beggs: That is the point I am making. The centre should be taking much more information. I heard from Mairead that the information system is not fit for purpose; Sean said that the categories are not reliable; and somebody else — I think that it was you, John — said that we have an old information system. There is a question jumping out at me when I look at the reasons why consultants might have cancelled. In the bigger numbers, there are three reasons: the consultant was unavailable; the consultant cancelled the appointment; and the appointment was put back. Those are all describing the same thing. When you look at the figures from the Northern Trust and the Belfast Trust, you see that the complete opposite is happening. Quite easily, people could be recording the same reason in different categories, and I suspect that that is what is happening. So, you are not going to be able to get a solution until you know what is happening, and the trusts will not be able to get a solution until they know what is happening. In the information given to us from the Northern Trust, there is a much more detailed database out now with lots of different reasons. However, it strikes me that there are also dangers in going into too many reasons. You must be able to categorise clearly. I recall teacher absenteeism having 500 categories, and that produced the biggest load of nonsense, because nobody looked at the figures that were produced. Have the boards, the trust and you looked at what categories are needed and identified uniform systems, so that we get meaningful information, individually and to the centre?

Mr Compton: Much more straightforwardly, our first order of engagement and involvement has been to make sure that we deliver the maximum amount of service that we can. We have focused all our energy and effort on understanding that true demand and capacity and creating a new system for how we bring people forward to outpatients. Following that, the point is that, when you do that and you get into a different place, you clearly have to look at the system that we have got, and there is a clear need for us to do that as a second order.

Mr Beggs: Surely, to deliver the maximum output, you need to know the information so that you can manage the system. I remind you that, five years ago, probably in this room, I was on the Public Accounts Committee that looked at outpatient appointments. Recommendation 5 was:

> *"The Committee recommends that the Department should identify the data requirements for managing all outpatient services and ensure that systems are in place to address these."*

What has been done since five years ago?

Mr Compton: I think that we have changed absolutely —

Mr Beggs: Are the data requirements in place?

Mr Compton: Yes; not fully, but we have revolutionised how we present our data and call patients into the hospital system. It is like day and night from where it was at that time. What is being said today by the Committee — not unreasonably, and we share a lot of that — is that, having made that progress, there is another suite of information that we need to attend to. We need to understand much better any problems that lead to clinics not taking place and whether we are accurately recording them. Clearly, you are pointing out, and we have accepted, that a lot of the information does not lend itself to stating straightforwardly that they are cancelled because they did not take place — people were told or turned up and the clinic was cancelled. We have explained to you the way in which our system catches that information. We have put a huge effort into changing the data and the way in which the data works in bringing people into the system. Policing it and looking at the other side is the work that is to be done.

Mr Beggs: You are saying that there has been a huge effort and changes have been made, but I am picking up that the data is not fit for purpose. Have you discussed with all the trusts how the data should be recorded, so that we can have a uniform, meaningful information capture?

Mr Compton: Yes, we have discussed at considerable length, for example —

Mr Beggs: Why is it not agreed?

Mr Compton: No, no; if you will allow me to finish. On the demand and capacity side of the house, we have had to have extensive discussions with each of the providing organisations about how we classify that, how we count and collate it, and how we have that information. We have an agreed platform for all of that. We have a second order thing to do, which is that, when that agreed platform runs through a system and throws out information about why something did not happen, do we have an agreed platform for that information? I think that we have said that we do not, because what we have is a rather old system that we need to attend to. It is not necessarily the fact that it is an old system; I am sure that we can make changes to the system. That is where we will be going to in making sure that we absolutely understand why somebody did not turn up for an outpatient appointment. Sorry; not why they did not turn up but why our system was not able to articulate to us very specifically whether this was directly attributable to the fact that the clinic did not actually happen. We have made the point to you that we cannot say that at this time, but we have done the first half of that and are moving to the second. Running with the information and the improvement, we are making progress. I am not for one second saying that it is perfect. It is far from perfect. We are not arguing with that at all.

Mr Beggs: When will this improved system be there?

Mr Compton: The first order issue for us is to make sure that we are improving from where we were to meeting the nine-week criterion for outpatients. Now that we are in that direction of travel, I think that the second order thing is for us to look at the information, as it is currently collated, and to begin, during the course of 2013-14, to get to a different place as far as that is concerned. It is all about that one journey and that one direction of travel, and that is where we are heading to.

Mr Beggs: I recognise that there are issues that are under the control of the hospitals in how they manage their systems, but there is input from the patients as well. There are the "did not attend" and "could not attend" patients. There is a big variation in the numbers of patients who could not attend. The Northern Trust figure was 13·5%, and I think that the Southern Trust was at about 9%. Why is it that the number of could not attends in the Northern Trust is so high? Is it a transport issue or a rurality difficulty in getting to appointments? Have you introduced a flexible appointments system, as recommended five years ago by the Public Accounts Committee, so that those who cannot get to appointments by public transport can otherwise make it?

Mr Compton: The partial booking system is precisely that. It is a very flexible system as far as that is concerned.

Mr Beggs: Why are there huge variations?

Mr Compton: That is very difficult to understand because variations are always driven, in the end, by individual sets of circumstances. It is very difficult to aggregate those individual sets of circumstances. One might conclude that issues of rurality and travel may apply and may be more difficult in one part of the Province than another. In the end, however, if someone says that they cannot attend on that day, they cannot attend on that day because of the personal circumstances that affect them and their family that mean it is not possible for them to attend on that day.

Mr Beggs: I understand that. I will direct my question to Sean. If somebody reports that they cannot attend, that is good if it is reported early enough and another booking can be made. What degree of flexible booking is available for services provided in the Northern Trust area, where this seems to be an issue? I suspect that, on occasion, it is transport-related.

Mr S Donaghy: As I understand it, the figures we are looking at here refer to hospital cancellations, so they are not about people who are not able to come on the day or week of their appointment. As regards trying to reduce the numbers of people —

Mr Beggs: Sorry, cannot attend is where the patient cannot attend.

Mr S Donaghy: So, you are not referring to the data that we have been —

Mr Beggs: I am referring to the data that have been provided to us.

The Chairperson: No, Roy, those are our recent figures.

Mr S Donaghy: I have other data, and I do not have access to that data. I am not aware of significant variations, but, as regards flexible systems, there have been two major developments and both are in place in the Northern Trust area. One is partial booking, which allows us to make an appointment much closer to the time that the patient is due to be seen in hospital, as opposed to many weeks or even months in advance, which leads to a higher cannot attend or do not attend rate. The second development, as some members highlighted, is the use of text reminders to ensure that patients are receiving a timely reminder of their appointment. I am not able to comment in any depth on the cannot attend figures. Those are not part of the information that we have in front of us here.

Mr Beggs: I will go back to the management of appointments by hospitals as opposed to patients. According to the Committee's research paper, the overall Northern Ireland figures for cancellations attributed to consultants show that 26% were due to the consultant not being available and 15% were cancelled by the consultant. There were also appointments put back. Why they were put back, I do not know, but of the appointments made, we are saying that over half are put back for some reason: the consultant is not available, they are cancelled by the consultant, or they are put back. That is astonishing.

Mr Compton: Again, an appointment being put back is a clinical issue. For example, it may be that the individual has to have a diagnostic test, which has not taken place ahead of the outpatient appointment.

Mr Beggs: Is that a hospital management issue as well?

Mr Compton: That depends. It is very difficult. You are right down to very granular, individual circumstances and individual clinical conditions and arrangements. Obviously, we want to make sure that whatever needs to happen should happen ahead of the individual seeing the consultant. An appointment may also be put back because the clinician feels that it would be better for a further period to pass before they see the individual to see the nature of the condition and how it is progressing or not progressing. There is not one simplistic, generic answer that explains why appointments are put back.

On your point about flexibility, just to be clear about partial booking: individuals are offered their time but are able to choose the date and time for their appointment. When they are approached, they are given some choice within the six-week period, and one endeavours to maximise according to whatever the circumstances are for the individual. For instance, if the clinic is a specialist clinic that happens only on a Tuesday afternoon, and there is a problem for the individual with a Tuesday afternoon, we recognise that by giving them a range of Tuesday afternoons to choose from so that they have the opportunity to organise some of the difficulties that they may face on that Tuesday afternoon. So, there is a huge amount of flexibility now. I cannot overemphasise how different that is from the way it used to be; there is an absolutely enormous difference.

Mr Beggs: I have just one final question. One of the categories under the heading "Reason for cancellation" is study leave. Can the Royal Colleges not ensure that more than six weeks' notice is given for any study leave required? If that was in place, patients would not be impinged on and suffer, and efficiency in the service would be driven up. I am trying to understand why study leave would occur with less than a six-week notice period.

Mr Compton: I suppose that the core point is that it should not. What we have shared with members is that this cancellation information includes instances where the cancellation may have taken place with good notice and a patient is, therefore, not affected. So it is not giving you an insight into whether the event impacted the patient.

Mr Beggs: Can we get a table with a breakdown of the figures, including all this new data and all the new capture information, so that we are aware of what is happening?

Mr Compton: We will have a look and see whether we can provide that. We will provide whatever we can.

Mr Dunne: Thanks very much for coming along this afternoon on what is a difficult enough subject. Just to clarify, the consultants are obviously directly employed by the trusts?

Mr Compton: Yes.

Mr Dunne: Are any of them self-employed?

Mr Compton: No. Anyone who is employed by and works for a trust organisation is contractually employed by that organisation, following selection or recruitment, either on a full-time or part-time basis. In that regard, they have a standard consultant-issue contract with all the normal arrangements. I think that what you might be asking is whether someone is working on their own outside. Individuals will do that, but that is outside the normal contracted time.

Mr Dunne: Is it fair to say that there is a risk — there is certainly this perception out there — of consultants cancelling trust work to go off and do private work, which they give priority to over trust work, and on which there is perhaps a better financial return? Is there that risk?

Mr Compton: I do not believe that to be a risk. I know that that is sometimes commonly presented as being the case. I genuinely think that we have to be very careful here. The consultant workforce that works for us in Northern Ireland is, in the round, very skilled, capable and dedicated. I do not have any evidence from the commissioning organisations — I look across the whole of Northern Ireland — of people behaving in the inappropriate way that you suggest. Will you get an individual who behaves inappropriately? You might, but you get individuals who behave inappropriately in all walks of life. It is my view that, in totality, that is not the case.

Mrs McAlinden: I can further reassure Mr Dunne that consultants who undertake private work as part of their working week are required to declare that as part of their contract. Therefore, when we construct a job plan and a consultant says that they have a clinic every Friday, that is not part of the job plan and they will not get paid for that. There is a contractual obligation on consultants to declare time out for private work.

Mr Dunne: Can you give us an assurance that what I suggested is not the case and that the risk of that happening is relatively low?

Mr Compton: I believe so, yes.

Mr Dunne: OK.

You may have mentioned the point about flexibility among consultants earlier. If an appointment is cancelled, what sort of flexibility is there to bring in another consultant to carry out that appointment? I know, from experience and from the feedback we regularly get from nursing staff, that nurses could not operate in wards today without flexibility and the use of bank and casual staff. Is there such a thing as a staffing bank for consultants? Do you have that flexibility, or do people have to wait to see a specified consultant?

Mr Compton: I think that the answer is yes, we have the flexibility, but it is not always as straightforward as that. It may be quite difficult to replace someone at very short notice who has a particular set of skills and expertise that you require, but the flexibility is there. All organisations respond to that in a flexible way. When people change jobs, retire, leave, move on or get sick, there is locum cover. So there is flexibility there. Colleagues also work with one another to provide an element of flexibility. Members on colleague teams will provide elements of flexibility for one another.

Mr Dunne: So you feel that flexibility is being exercised?

Mr Compton: I think that there is flexibility, but there are limits to that. That is my point.

Mr Dunne: In the figures for, say, the South Eastern Trust, which I have an interest in, the consultant was not available in 10,000-odd cases. Are you giving us an assurance that the issue of flexibility has already been looked at there?

Mr Compton: Yes. Our system captures the information and says that the named consultant is not available. However, a locum consultant may hold the clinic on that given day, so the clinic will have gone ahead. What will have been captured is the fact that the consultant who was named for that clinic did not take the clinic on that day. Now, that is one explanation. It is not the total explanation. In absolute terms, it may simply be that the consultant was not available and the clinic was cancelled.

Mr Dunne: In the South Eastern Trust, the figure for appointments that were put back is 5,812. Will you clarify the possible reasons for appointments being put back?

Mr Compton: On the positive side, they could be put back because of a clinical reason. For example, an individual who has a chronic condition may have been admitted to hospital and may be in hospital at the time when their outpatient appointment was due to take place. That appointment will be put back. Appointments may be put back because there other tests that are required to make the consultant outpatient appointment sensible and constructive for the individual and their family. In the most simple terms, it may be that, on that day, due to planned annual leave that was well notified, the clinic was cancelled and the appointment was rearranged for two weeks later. Those are the sorts of practical realities.

Mr Dunne: Are those figures over and above the figures for "consultant was not available"?

Mr Compton: Yes.

Mr Dunne: Are you satisfied with what I would call the downtime of around 90 days? Are you satisfied that that is reasonable, when you take the leave, training and all the rest?

Mr Compton: There are two things here. There is a condition of service thing. The conditions of service are a national contract, and we work within that national contract. We are entirely satisfied with the study leave, because we want to employ a skilled and capable consultant workforce. Part of being skilled and capable is having continual professional development. I do not think that it would be appropriate for us to look to erode or reduce that in any way.

Mr Dunne: We would all be supportive of that, but there is a balance. Between leave and training, it equates to about 36% of downtime when the consultant is not available.

Mr Compton: I understand that, but the largest part of that is to do with a conditions of service arrangement. Those conditions of service apply right across the UK.

Mr Dunne: It is 36% plus sickness absence, 40% —

Mr Compton: To be honest, the reported sickness absence for consultant staff and medical staff is very low. Most organisations will tell you that recorded absence is well below 5%.

Mr Dunne: Consultants could be unavailable to the patient 40% of the time that they are employed. Does that not make them a very expensive asset?

Mr C Donaghy: To be clear, we suggested that for up to 11 weeks. When you accumulate leave, which is a contractual entitlement; study leave, which is an important part of development; and the fact that there are bank holidays. That might be as much as 11 weeks, which is about 20% of the year.

Mr Dunne: You talked about 40 days' annual leave and 50 days —

Mr C Donaghy: It is 35 days' annual leave, 10 public holidays and up to 10 days' study leave. Those three factors account for the total.

Mr Dunne: Does it vary across the trusts?

Mr C Donaghy: No; people accumulate additional entitlement to annual leave through seniority of service. We have given you the maximum figures.

Mr Dunne: We were told 40 days earlier.

Mr C Donaghy: The full allowance is 35 days plus 10 public holidays — bank holidays, in other words.

Mr Dunne: There is a considerable amount of downtime, which makes them a very expensive asset. It is a very skilled and professional job, no doubt. What is the average consultant salary these days?

Mr Compton: It is very difficult to say what an average salary is. I have not got that information in front of me, but I can give you the salary scale for consultants. That will give you the starting point and the maximum point on the scale. As we said beforehand, it starts at in the mid-£80,000s and goes to in excess of £100,000.

Mr Dunne: They are also entitled to bonuses.

Mr Compton: From my point of view, that is the wrong language. They are not bonuses. The contract enables two things to occur. It entitles people to apply for additional awards on the basis of skills and expertise inside the organisation in which they are employed. They are then entitled to apply across Northern Ireland for a different level of skills and exceptional payment. There is a process by which that goes through. That process is very rigorous. It is not a casual process or —

Mr Dunne: I take it that it is effectively performance-related.

Mr Compton: It is, although it depends what you mean by performance-related. If you have a national expert in a particular speciality, they will have put a huge effort in to become a national expert. They are working for us, and we want to capture that person and retain them in Northern Ireland. That individual may well accrue extra payment. If you mean performance-related on whether they see 110 people while the average person sees 100, it is not balanced on that.

Mr Dunne: Obviously not, on those figures.

The Chairperson: Just a couple of questions from me, then, just to try and tie some of this down. John, you have mentioned the nine-week waiting limit a few times in your paper and the presentation. What is the figure that it currently sits at?

Mr Compton: In November 2012, we had 32,000 patients waiting longer than nine weeks for a first outpatient appointment as opposed to 54,000 in the same month in 2011. We deliver about 67% of all first outpatient appointments within nine weeks, and the target is 50%.

The Chairperson: And you are looking to go to 70%.

Mr Compton: We expect to be at about 70% come March. That is the direction of travel at this point.

The Chairperson: Is there a percentage of that — that nine-week appointment scale — being sent to private clinics?

Mr Compton: Oh yes, some of those people will have gone outside the normal system. That goes back to what I call the demand —

The Chairperson: I know that you do not have it now, but can you get me a breakdown of that?

Mr Compton: Yes.

The Chairperson: So, while you are reaching 67% on the target for people to be seen within nine weeks, some of that is going private.

Mr Compton: Some of it is; yes. That will either have been in additional capacity, either through the running of extra clinics in the trusts, and we will pay for those extra clinics in the trusts, or we will go outside the trusts. I will give you the numbers for that.

The Chairperson: And that is across the island?

Mr Compton: Yes.

The Chairperson: In the course of this presentation, it has been said that the system does not work; it is an old system; there is a proposal to change the system; it is about collating information; is it the right information that we are collating? In your paper, you say:

> *"The Board reviews hospital cancellation rates on a regular basis and, in the context of Trusts delivering agreed volumes of core activity and the Ministerial maximum waiting times ... will raise any areas of underperformance with Trusts."*

Roy made the point that some of these issues were raised going back five or six years. I think that I was on the PAC at that time. What do you mean? How often do you review hospital cancellations?

Mr Compton: We generally meet with the organisations fortnightly to go through all their activity. If major issues are drawn to our attention in terms of ability to deliver on the ministerial target, we raise that with the organisation. There could be issues with demand and capacity in what we refer to as the core contract. In other words, if I contract with any of my colleagues to do 200,000 outpatient appointments, say at the start of the year that this is the amount of money for the 200,000 outpatients, and there is a persistent failure to deliver towards that, that matter will be raised with the organisation. It will then be escalated appropriately depending on the nature and scale of the difficulty that we confront.

The Chairperson: I appreciate that. However, giving Mairead a target of 200,000 means that Mairead could probably reach it every year. That does not take away from the fact that there have also been cancelled appointments.

Mrs McAlinden: Again, from a provider perspective, John's organisation is to say that we have x number of consultants and he expects us, with very challenging metrics, to deliver that. So, when John set me my 200 appointments target, he did that with some degree of challenge to see how effective we can be.

The Chairperson: Do you use those private clinics to meet that target?

Mrs McAlinden: If there are more than 200,000 appointments required of us, we will go to the independent sector.

The Chairperson: Roughly, what is the level of scale of pay?

Mrs McAlinden: It is paid on a fee per item basis.

The Chairperson: Is it dearer to use a private clinic than it is to use contracted consultants?

Mrs McAlinden: It can be dearer, but it is paid on a fee per item. Therefore, you only pay for what you get.

The Chairperson: That is fair enough. Well, it is not fair enough.

When was the last time the board raised the issue of hospital cancellation rates with the trust formally?

Mr Compton: I would need to take advice in terms of the meetings that take place on a fortnightly basis to see whether that has been raised with anyone. I have not raised it directly with any of the chief executives.

The Chairperson: You also mentioned the indicators of performance — it came up in the direction for 2012 — and it included two performance indicators. One was the rate of review of outpatient appointments where the patient did not attend, and the other was the rate of new outpatient appointments cancelled by the hospital. Why is that included as a performance indicator if you are saying that the figures that we are getting do not paint an accurate picture?

Mr Compton: I am not completely clear what you are asking me.

The Chairperson: You told us throughout the course of this that the information in the figures that we had did not paint an accurate picture of cancelled appointments.

Mr Compton: Oh yes, in terms of the cancellations.

The Chairperson: So, if you are looking at the performance indicator for 2012 around the rate of cancelled outpatient appointments, what work has been done on that to get an accurate figure?

Mr Compton: We do not come at it from that perspective. If we were using the example of the 200,000 outpatient appointments, if that were the number, we would know, on a monthly basis, how many of those clinics should have taken place and how many people should have been through that system each month. If that information is true and people are coming through the system at that level and at that rate, then we are content that that performance is adequate. What we are trying to point out to you today is that when we have information that talks about various cancellations and why there are cancellations, it is not fit for purpose for the system that we are currently in. It reflects something that was to do with a system that was operating in a different way, and it is something that we will have to attend to. That is the commitment that I have given you today.

On the do-not-attend thing, we collect that information because we want to understand the implications for those who do not attend.

The Chairperson: I appreciate that you might not have this information here. However, across all the trusts, are there clinics that are inclined to cancel more often than others?

Mr Compton: I am not particularly aware of that. If we had a repeated situation like that, we would expect the organisation to be alert to that.

The Chairperson: Are there clinics that cancel more often than others in the Belfast Trust?

Mr C Donaghy: I can give you an instance where we may have long-term sick with a consultant, which means that we have to initially cancel that consultant's outpatient appointments and rearrange them in the longer term for that consultant. There may be a long-term sick issue for some of our consultants, which means that we have to rearrange appointments on a longer-term basis.

The Chairperson: That is fair enough, but are you telling me that they are not necessarily cancelled appointments? In the figures I have, they are cancelled appointments.

Mr C Donaghy: They are not cancelled patients. Some of them are cancelled slots, but a patient was never in that slot.

The Chairperson: I know, but we are trying to — It is called accountability. We are getting inundated with all this stuff and being told things that do not necessarily fit in. Give us the relevant information.

Mr C Donaghy: There is no particular picture of a particular specialism that presents more frequently for cancellations. Occasionally, one specialism may be affected by someone who has long-term health problems or other recruitment problems, but there is no particular specialism.

The Chairperson: You might not have this information. Has the Department given additional money because there has been an increase in waiting lists for a particular speciality on the basis that a lot of the appointments were cancelled?

Mr Compton: Not in that regard, no. For example, say we looked at dermatology and found that there was a particular problem, we do not say, "Here is an amount of money. Go and fix dermatology." If that is the question that you are asking, that has not been the case.

Mr McDevitt: I have a quick observation. I am more and more concerned about the value for money at the heart of all this, because in John's example of the 200,000 episodes in the Southern Trust, I cannot see how you have any way to determine whether or not you are getting value for money from Mairead simply because you do not know her inefficiency level. Therefore, a basic cost issue is going unanswered. Those 200,000 appointments could well be bought at a 20% discount. I take it that Mairead, doing the best for her trust, builds in modelling around the current inefficiency level, because

the current inefficiency level is unquantified and taken for granted. It is factored in. We do not know what it is, and, therefore, we have to assume that it is in the system. It is certainly not outside the system, because we would know what it was, and, therefore, we are getting bad value for money. The real job of work that we need to do is to drill down on the opportunity cost of all this and figure out how we make the health service more efficient, because one thing that is certain is that it is inefficient.

Mr Compton: I do not disagree with you. It is not quite as straightforward as you point out, because our commissioning plans for last year and this year contain an efficiency target for each organisation. That runs through and is very substantial, and it is derived from —

Mr McDevitt: John, I accept all that. There are efficiencies from base x, but the problem is that, if base x is built on a flawed premise, you have a problem. This story tells us — it is nobody's fault; it is a systems conspiracy issue — that base x is miles out. It has to be. Therefore, the tariff is probably out because the tariff is clearly factoring in a degree of inefficiency that should not be there. So, you are maybe looking a bit better than you really feel, Mairead.

Mrs McAlinden: To be fair, Mr McDevitt, I wish that we had that degree of built-in inefficiency because it would make my life a lot easier.

Mr McDevitt: You do. If you have a 40% cancellation rate —

Mrs McAlinden: John, in his calculations, does not care about that. That is my problem as a provider.

The Chairperson: Mairead, celebrate that you are doing well.

Mrs McAlinden: John cares about saying, "I have x consultants that I pay for, and I expect x clinical sessions out of them". That produces 200,000 —

Mr McDevitt: The price that John is striking is against what he has paid historically as a notional efficiency that he will squeeze out of you. That historic price is built on a historic inefficiency that has been there for ever. We know for certain that you are getting better and not worse, and, therefore, that level of inefficiency has been systemic. It is the only assumption that we can make.

Mr S Donaghy: There are opportunities in that area to create greater efficiency, and I think that we can get better efficiency. It is not the only area in the health service in which we can deliver better efficiency, and we have a drive for efficiency in the service.

The Chairperson: I will bring Roy in quickly, because we have a permanent secretary waiting out there since 2.00 pm.

Mr Beggs: The question was asked: are there any areas with particularly high levels of cancellations? The information that I have is that the mental health and elder care hospital cancellations are up nearly 20%. Are you not zoning in on the areas with the highest levels of cancellations to identify the specific problems and the actions that can be taken to drive them down? In driving them down, the overall figure will significantly improve.

Mr Compton: That is a good example, because there are particular issues in one organisation with regard to mental health, and we are talking to it directly about that. That is a combination of workforce, its ability to recruit workforce and how that is organised. Mental health is a particularly complex area in terms of outpatients, and you are much more likely to have complicated outpatient delivery points, to be honest.

I am not aware of some cyclical notion that we have one discipline or specialty across Northern Ireland. There are, from time to time, particular problems in each area. Those are often related to long-term sickness and the ability to recruit, either temporarily or permanently, replacement individuals. If someone has a chronic illness, the organisation has to responsibly manage that individual's situation correctly. Therefore, you cannot recruit and replace someone's post until you have sorted that HR system out. It may be that it is not possible to recruit locum cover for that period.

Mr Beggs: Similarly, there are areas with particularly high did-not-attend figures. I remember that five years ago, when the Public Accounts Committee looked at it, four out of specialist 10 areas in the

Mater had the highest did-not-attend level. Are you taking specific actions there or engaging with people in the community to try to see what specific actions can be taken to get more people to turn up for their appointments?

Mr Compton: The answer is yes. That is partly because we have reformed the way in which we do it and the parcel booking system to avoid having high did-not-attends. We are also working with primary care differently, so that we do not filter through many referrals that should not necessarily come to the second stage of attending acute hospitals. So, yes; we are doing that.

The Chairperson: OK. You will be glad to know that we have not finished with this today. We will come back to it, but I thank you for coming and for the paperwork that you provided. We have asked you for further information that would be useful to get that sooner rather than later. So thanks very much.

Mr Compton: Thank you.