Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Cancelled Hospital Appointments: DHSSPS/HSCB Briefing

1 May 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 Jackie Johnston	Department of Health, Social Services and Public Safety
Dr Eugene Mooney	Department of Health, Social Services and Public Safety
Mr Michael Bloomfield	Health and Social Care Board
Mr John Compton	Health and Social Care Board

The Chairperson: I welcome Jackie, Eugene, John and Michael. A copy of a research paper presented to the Committee last week is before you on the table. Members are likely to refer to it during questions, so it is useful that you have a copy. I invite you to make a 10-minute presentation and the evidence session will then be open to questions. I ask that only one person answer Committee members' questions and that your answers be as succinct as possible.

Mr Jackie Johnston (Department of Health, Social Services and Public Safety): Chair, I will make a few brief opening remarks before handing over to Michael Bloomfield, who will deliver the substance of the presentation. I thank the Committee for inviting us to update it on actions taken by the board and the Department since the previous evidence session on cancelled appointments on 6 February. John, Eugene and Michael are with us today for that.

I apologise to the Committee for the lateness in providing some of the information that you requested for your recent briefing paper. That was due to the need for officials to check a wide range of information supplied by a number of sources before submitting it to the Committee. I apologise for its lateness, and we will make sure that we do better next time. I will now hand over to Michael.

The Chairperson: OK, Jackie. It is very hard to shout at people when they apologise.

Mr Michael Bloomfield (Health and Social Care Board): Thank you, Chair, and good afternoon. I recognise that the Committee is familiar with the issues relating to cancelled hospital appointments, having considered it on a number of occasions, including at the evidence session on 6 February, which was attended by the chief executive of the board and a number of trust chief executives. Therefore, I do not propose to rehearse the issues in detail.

However, it may be helpful by way of introduction to outline some key issues and the work that has been taken forward since the February session. Fairly obviously, a cancelled appointment is defined as one that was intended to be held but did not occur. It is inevitable that there will always be cancelled clinics owing to sick leave, bereavement, and so on, and it is not always possible to arrange cover to take the clinic.

However, the way in which cancelled clinics are recorded means that reported numbers overstate the capacity that is lost. Many clinics reported as cancelled do not necessarily have an impact on individual patients. That is for reasons such as if there is a minor change to a clinic, such as the start time is put back or brought forward by half an hour, or there is a change to the end time, the whole clinic is recorded on the system as being cancelled and set up again.

In that scenario, if a clinic is taken by another consultant, again the first clinic is recorded as cancelled and is set up again. There are other small changes. For example, if an individual's appointment is brought forward so that he or she benefits from it, the original appointment will still show as cancelled. Similarly, sometimes appointments are put back for perfectly legitimate reasons, such as the results of a diagnostic test indicating that further time or some medication is required. Those will show simply as being cancelled. There is a range of reasons that clinics show as cancelled, but they do not result in lost capacity and do not necessarily impact on patients. I understand that the issue was highlighted by the Committee as a particular issue of concern at the session on 6 February. I will refer in a moment to the work that has taken place since then to address that.

Notwithstanding that, the number and rate of cancelled appointments, based on the way in which they are currently recorded, has reduced from 12·3% in 2008-09 to 10·8% in 2011-12. That is approximately 182,000 appointments out of 1·5 million that take place annually. Two main actions are required to minimise the number of cancelled appointments. First, consultants and other clinical staff are required to give at least six weeks' notice of their planned annual or study leave. Secondly, patients should be given the opportunity to choose a suitable time and date for their appointment, which should be offered to them no more than six weeks into the future, a practice that is known as "partial booking". A combination of the six weeks' notice of leave and patients only being booked six weeks in advance for a date and time that suits them reduces the likelihood of hospitals cancelling appointments at short notice, as trusts at that stage should be able to be reasonably confident that the clinic will be held. That is quite a significant change from the past, when fixed appointments were given many months in advance, and there really was no way to be sure that the clinic would take place. There are a number of factors that could have prevented that.

The main reason that it is important to minimise as far as is possible the number of cancelled appointments is to avoid capacity being wasted that could be used to see patients and so reduce the time that they wait for their outpatient appointments. In that regard, it is important to highlight the fact that waiting times for outpatient appointments have been steadily reducing over the past couple of years. The Minister's target for 2012-13 was that at least 60% of patients would wait no longer than nine weeks for their first outpatient appointment by March 2013, with no one waiting longer than 18 weeks. Provisional performance information for the end of March shows that 78% of patients are waiting for less than nine weeks, against a target of 60%. That provisional information also shows that, at the end of March, 22,000 patients are waiting longer than nine weeks, which is down 20% from at the same in March 2012, when 28,000 patients were waiting for more than nine weeks. It is significantly lower than in the autumn of 2011, when 60,000 patients were waiting for more than nine weeks.

On the other part of the Minister's target that no one should be waiting for longer than 18 weeks, the provisional information for the end of March indicates that around 4,300 patients are waiting for more than 18 weeks. However, that compares with 10,000 patients in March 2012 and around 30,000 in the autumn of 2011. There are similar improvements over the year on waiting times for treatment. In March 2013, 68% of patients waiting have been waiting for less than 13 weeks, against a target of 60%. Around 15,500 patients have been waiting for more than 13 weeks, compared with 18,000 at the same time in March 2012 and over 25,000 in the autumn of 2011.

The approach that is currently being taken by the board, working with trusts, is to ensure that that momentum is maintained from April onwards during 2013-14. The board has approved additional activity for trusts to undertake where there is a recognised shortfall in capacity and/or there is a backlog of patients needing to be seen. The board continues to meet all trusts every fortnight to monitor their performance on elective care in great detail, to ensure the delivery of agreed levels of activity and that waiting-time targets are achieved and waiting times improved on. In the context of cancelled appointments, a central part of the board's monitoring of elective performance is the delivery by trusts of an agreed level of core capacity in every outpatient specialty. Those capacity volumes were established following a detailed demand-and-capacity exercise that took account of the number of consultants and other clinical staff in each specialty; the number of clinics that staff should hold each week; and benchmarking productivity on the number of patients to be seen in each clinic. From that, we worked up the total number of patients who should be seen in each specialty each year. The reasons for any under-delivery of that core activity by trusts are examined in detail at our regular meetings, including the number of hospital cancellations and patients who do not attend. If the recorded level of cancelled appointments — that 10% — had an impact of that scale on lost activity, it would be evident in a trust's failure to deliver its core activity volumes, which is not the case across the board. The under-delivery of core activity is treated very seriously. When there are examples of significant under-delivery of activity by trusts, they are escalated to chief executive-level meetings and correspondence. In the 2013-14 commissioning plan, the board has signalled its intention to retract funding from trusts if they continue to under-deliver against the core volumes of activity agreed with them in the contract. With respect to securing increases in productivity from trusts, those core capacity volumes have been increased by 2% in all areas in all outpatient specialties in 2013-14, so that trusts are required to deliver increased levels of activity.

I will now address the way in which cancelled appointments are recorded. Following the Health Committee evidence session on 6 February, a short life working group was established to revise the guidance for recording cancelled appointments, with the objective of being able to determine the number of patients impacted on by a cancellation. The Southern Trust took the lead on that group on behalf of the service, with membership from all other trusts, the Department and the board. The group has met on two occasions and has agreed a definition of when a patient is impacted on by a cancellation. The regional codes have been reviewed, and clear definitions setting out what each category should include have now been agreed to achieve that consistency, which the Committee has previously considered to be lacking from the figures. Those revised definitions are being circulated for consideration over the next number of weeks with the aim of finalising this exercise completely by the end of June. The expectation is that new data that more accurately indicate the true level of cancelled appointments, the impact of lost activity and the impact on patients will be available to be reported on from July this year. That should certainly address the issue that has been highlighted in the past.

The Chairperson: Thank you. Michael, you are aware that the Committee has done a lot of work on this issue over the past weeks. We are aware of some of the material that you covered. We have commissioned research papers. Are you aware that, of the cancelled appointments in 2011-12, 83% were for review appointments?

Mr Bloomfield: Yes.

The Chairperson: Why do you think that the rate of cancellations for that type of appointment is so much higher than for first appointments?

Mr Bloomfield: When clinics are set up, they will have a number of new appointments and a number of review appointments. Additional clinics are also set up specifically for review appointments, and a higher rate of patients do not attend for review appointments. Over recent years, there has been a move to look at alternative ways of doing review —

The Chairperson: We are not talking about "did not attends". We are talking about cancelled appointments.

Mr Bloomfield: I am coming to that. Over the past number of years, a range of measures has been taken to look at doing review appointments in different ways: telephone reviews, nurse-led reviews and ensuring that review patients can be seen as quickly as possible. Some review clinics were set up but were cancelled and replaced by other ways to review patients in a more timely manner. That may be one reason to explain a number of the cancelled review appointments. The focus on ensuring that new patients are seen as quickly as possible may have resulted in some review appointments being cancelled.

The Chairperson: Are you aware that there is no Department target for the length of time that people should wait for a review appointment?

Mr Bloomfield: Yes. There is no standard time in which any patient should be seen other than a clinically indicated time. It is different for every patient.

The Chairperson: So there is no specific target for a review appointment.

Mr Bloomfield: No. There could not be a target for a review appointment. It is different for each individual in clinical circumstances.

The Chairperson: Given that there is no target, do you think that it is easier for hospitals to cancel review appointments rather than first appointments?

Mr Bloomfield: It should not do. There is a lot of focus on —

The Chairperson: Eighty-three per cent of cancelled appointments were review appointments.

Mr Bloomfield: Yes.

The Chairperson: It seems easier to cancel review appointments than first appointments.

Mr Bloomfield: That could be the case. However, although there is no target for review appointments, they are monitored for the total number of patients who are waiting beyond their clinically indicated time and how long they are waiting. When the board allocates additional funding to trusts to carry out additional activity, it allocates funding for new and review appointments. If trusts see 10,000 additional new appointments, that will generate a number of review appointments. It ensures that both are seen. It is not a case of either/or.

The Chairperson: If you are talking about cancelled appointments in 2011-12, 83% were for review appointments. If there was monitoring, what happened to deal with that between 2011 and 2012?

Mr Bloomfield: The board highlighted to trust areas where there were high numbers of patients in particular specialties for review appointments and required them to bring forward action plans to focus specifically on seeing review appointments. That has led to a combination of more review clinics being carried out and alternative ways to review, and looking to best practice elsewhere as to how long to continue to review, how regularly to review and who carries that out. As I said, there is a move to have —

The Chairperson: So the figures for 2012-13 should be better.

Mr Bloomfield: I do not have the number of cancelled review appointments for 2012-13.

The Chairperson: If the situation was monitored and the board did what it did, the indication is that the figures for 2012-13 should be better.

Mr Bloomfield: They should be.

The Chairperson: Why was the short life working group on cancelled appointments set up?

Mr Bloomfield: That was to do with how the information was recorded. The Committee correctly pointed out that the figure of 180,000 cancelled appointments in 2011-12 is fairly meaningless as to how many patients that impacted on. The patient administration system is used by trusts to record, for operational management purposes, what has happened in individual cases. It is being used by the board and the Department to generate figures such as waiting time figures. When we look at how it generates the number of cancelled clinics, it does not provide the required information. There is also a lot of scope for trusts to generate local codes. That can be seen in the inconsistency between the number of cancelled clinics for different reasons between trusts. The purpose of the short life working group was to agree a more sensible and consistent approach that will get to the heart of the issue and

establish which of the clinics that did not take place for one reason or another resulted in lost activity and which of them resulted in a patient who would have been seen not being seen.

The Chairperson: Jackie, why has the Department not set a target for the length of time that patients wait for a review appointment?

Mr Johnston: As Michael explained, each individual need and experience is different. Therefore, it is difficult to set an overall global target to cover all patients.

Mr Wells: We had an interesting session with one of our Assembly researchers, who dug a bit more deeply into the statistics and produced some very interesting material. One of the most telling comments came from the Southern Trust; it reckons that, for 65% of those who have had cancelled appointments, there is a negative impact on their health and treatment. That was the first time that I had ever heard that type of statistic. I suspect that it was the first time that the Department had heard it as well. Is the board in a position to tell us how many patients from each trust — not just the Southern Trust — have been negatively affected by a cancelled appointment?

Mr Bloomfield: No. That is the purpose of the new recording definitions and the way in which recordings are done that will emerge from the short life working group, which are expected to be available from July. I outlined the current performance and the improved performance for patients waiting over nine weeks. If a hospital cancels a patient appointment, that patient's waiting time continues. There is no issue that that patient's waiting time clock has stopped. The fact that we know that, at the end of March, approximately 78% of patients were waiting for less than nine weeks does not suggest to me that there is a —

The Chairperson: Michael, is that not for only first appointments?

Mr Bloomfield: That is for first appointments.

The Chairperson: Come back to my point. Eighty-three per cent of cancelled appointments were for review appointments. Do not try to cloud the issue. If we are talking about first appointments or review appointments, you need to say that.

Mr Bloomfield: I am outlining the performance for first appointments. I was trying to make a point about first appointments. If a large number of those were being cancelled and a patient was being impacted on, it would be difficult to rebook that patient and get him or her in within nine weeks. So I do not believe that the impact on new appointments is as significant. The issue with review appointments is that a patient should be seen within a clinically indicated time.

Mr Wells: Having heard that figure, I would have suspected that you would have been beating down the door of Craigavon Area Hospital to speak to the Southern Trust to find out where it got that information from. It is noticeable that the Southern Trust's cancelled appointment rate is significantly lower than the other four trusts; in fact, in some cases, it is 50% lower. It is clearly on board in tackling the issue. Have you spoken to the Southern Trust to find out what is going on?

Mr John Compton (Health and Social Care Board): Absolutely. Indeed, the Southern Trust is chairing the short life working group and will be bringing the issues to bear and how they are handling it. The issue for us is that we probably viewed cancelled appointments as telling us one piece of information. The Committee — quite rightly — said that the man or woman on the street assumes that a cancelled clinic equals a cancelled clinic and that patients do not get to see a doctor, nurse or whomever. However, we know that cancelled clinics cover a range of things. We want to trace whether a given clinician did or did not hold a clinic, and not so much whether an individual patient was disadvantaged. In the working group, come July and the end of the summer, it is important that we are able to say who was directly impacted on. We will be able to say whose clinic was cancelled and, as a result, who did not see a doctor. We will also be able to see patterns for repeated cancellations by individual clinicians, which will allow an organisation to respond appropriately to that individual. If different methods and approaches are being implemented by various trusts that are helpful, and if the Southern Trust has a particular way of recalling people or looking at reviews, we will be able to feed that in. That is the purpose of the short life working group.

Mr Wells: I would say that you need to have a very long conversation with the Southern Trust and the Northern Trust. Some 384 consultants' appointments in the Southern Trust were cancelled because

of ill health, and 1,240 appointments were cancelled in the Northern Trust. That is comparing like with like, and you cannot argue with those statistics. Clearly, one reason why the Southern Trust is getting on top of this is that it has various categories in which it simply does not accept the reason for a cancellation. It will say, "Thank you very much for the information. We do not accept that as a valid reason, and you are going ahead with your consultation." That is why the board and the Department need to have a long chat with certain ladies in the trust headquarters at Craigavon hospital because they have already done this. To some extent, we do not need to reinvent the wheel. If a trust has tackled this issue effectively, the only thing you need to do is roll that out throughout the country.

Mr Compton: Correct. That is part and parcel of why we are putting groups and organisations together, along with the board, to make sure that, if there is learning across the trusts and organisations, that is robustly transferred from one place to another.

Mr Wells: Is there any evidence of a patient having died or become seriously ill as a result of a cancelled appointment?

Mr Compton: I am not aware of any evidence. In our serious adverse incident reporting, we are not aware of any issues being reported to us on that pretext.

Mr Dunne: Thank you, gentlemen, for coming in this afternoon. We are quite concerned about consultants cancelling appointments because of annual leave. Based on the figures — excluding the Belfast Trust because its information was not totally accurate — for the 531 consultants in the four other trusts, an average of 26 appointments a year were cancelled as a result of leave. Is there a policy across the organisation for the time when consultants are supposed to apply for leave, and is that consistent across the trusts?

Mr Bloomfield: All trusts have a policy that requires clinicians to give six weeks' notice for annual leave.

Mr Compton: We pointed out that if, for some reason, somebody needs one or two days' leave urgently or at short notice, they may arrange for a colleague to take their clinic. That is important with regard to cancelled clinics. That clinic will be called cancelled and restarted under the second doctor's name but there will be no difference for a patient. A patient will be seen on the same day at the same time. That is the point about the definition of "cancellation". If we were in a situation in which it was clear to us that doctors, in an ad hoc way, were taking annual leave and therefore disabling our ability to deliver clinics in the middle of all that, it would show up on the total numbers on the other side. We police that every fortnight: we meet each organisation every fortnight.

The Chairperson: John, how does that fit in given that, on average, there are 26 cancelled appointments a year for each consultant?

Mr Dunne: Annual leave only.

The Chairperson: You have given a definition that, technically, if it is a cancelled clinic it is not really a cancelled clinic. However, based on the information that we have that they are cancelled clinics and cancelled appointments, perhaps your recording is wrong. There is time for a wee bit of honesty and to say that, on average, each consultant has cancelled 26 appointments a year because of annual leave.

Mr Compton: There are a couple of things. First, the way in which we recorded the figures is not satisfactory because it does not provide the information that is reasonable for you, as a scrutiny body, to challenge and question us on, and we have been looking at it slightly differently. Secondly, if a clinic, for instance, is held by an individual consultant on Mondays and Tuesdays throughout 52 weeks of the year, that clinic will be put down as "Dr Compton's clinic". However, at the start of the year, I will not be there for at least six of those clinics because I will be on leave. It is the title of the clinic and the way in which the cancellation is recorded, so that it will get caught as leave —

The Chairperson: I take that point. What about the other 25 cancelled appointments? We are not talking about small numbers. We are talking about the 27,000 appointments that were cancelled by consultants because of annual leave.

Mr Compton: The issue that we are trying to explain — we may not be explaining it very well — is that when a clinic is cancelled and 20 people are due to come to that clinic, if my colleague takes the clinic for me, those 20 people will still be seen, and there will be no issue. However, "Dr Compton" will not be at the clinic. We have not recorded the information in a way that discriminates and explains all that. The short life working group has to —

The Chairperson: Is some of that down to the fact that the consultant rings in one morning to say that he is taking the day off and the six weeks' notice has not been given?

Mr Compton: I am sure that, on occasion, that happens, but, to be honest, I think that it would be wrong to leave you with the impression that there is a casualness among the consultant fraternity about how they handle all that. Occasionally, things will happen at very short notice for people, and that is just life, but —

The Chairperson: I appreciate that.

Mr Compton: Come the autumn, when this has been running and we have been recording information from July, August, September through to October, the short life working group will be in a much better position to be able to explain and to answer the questions that you, quite reasonably, are asking. We had been recording the information for a completely different purpose, and it is not helpful to mix the two.

Mr Bloomfield: If I could —

The Chairperson: Sorry. I interrupted Gordon. Let him finish, and then Michael can come in. Apologies, Gordon.

Mr Dunne: I think that you covered a lot of my issues. Table 3 of the briefing paper shows that the "consultant on leave" figure for the Belfast Trust is 13,371, as against the "consultant absent: annual leave" figure for the Southern Trust of 1,238; I know that Jim has an interest in that trust. How is that compatible?

Mr Bloomfield: I think that that table highlights the reason why there is a need for the short life working group to do the work. The table uses several categories, two of which are "consultant absent: annual leave" and "consultant on leave". The Belfast Trust has nobody in the first category because it does not use "consultant absent: annual leave", but it does have some people in the "consultant on leave" category. The South Eastern Trust and the Southern Trust have small numbers in the "consultant on leave" category and larger numbers in the "consultant absent: annual leave" category. There is no consistency regionally in how the guidance is interpreted and how this is reported.

Mr Wells: Even if you add them all up cumulatively, there is still a ratio of 13:1 against the Belfast Trust. No matter what way you look at it, the "on leave" category is much higher there than in the Southern Trust.

Mr Bloomfield: We need to be careful about drawing too many conclusions from any of those figures in the absence of trusts taking a consistent approach in how they use them. That is the purpose of the short life working group: to reduce that down to a number of clear categories; to give clear guidance to all trusts on to use it; and to ensure that they report it consistently.

Some appointments shown as cancelled because of consultant leave were rebooked under somebody else's name. So all those appointments reported as cancelled because of annual leave —

The Chairperson: I am going to let Eugene come in. You cannot blame that on us, Michael.

Mr Bloomfield: No.

The Chairperson: We are basing our evidence on the information that we got from you. It is not our fault if you think that you have given us the wrong information.

Mr Bloomfield: It is the information that is in the system.

The Chairperson: You are in a position to change that.

Dr Eugene Mooney (Department of Health, Social Services and Public Safety): That is the point: we are in the process of changing it. As was said, the quarterly return was not set up for this level of scrutiny and the types of questions that the Committee is asking. I think that the Department has been transparent on this. That information was very heavily caveated. The Committee asked for a breakdown, but we were reluctant to provide the information because we did not think that it was really fit for purpose in respect of the fine-grained analysis to come out of it, given the proliferation of local codes and how some trusts apply local codes and guidance. That is why I have concerns about the provision of official statistics and national statistics to inform these types of debate. We need to understand that that information —

The Chairperson: Every Committee member wants to ask questions because this is a very important issue, so I will cut to the chase and then bring Mickey in.

MLAs and others are also concerned about the fact that constituents who have had an appointment cancelled are then, lo and behold, able to get an appointment in the private sector.

Mr Gardiner: With the same consultant.

Mr Brady: Different specialties have different cancellation rates. The research paper indicates that mental illness has a 33% cancellation rate, which is one of the highest, and yet it has only about 5,000 attendances or referrals a year for hospital appointments. Transforming Your Care is about keeping people in the community and ensuring that they have access to appointments, clinical appointments and so on. Is the board aware of those figures? How does that square with the need and desire to keep people in the community? I would suggest that cancelled appointments have more of an impact on people with mental health problems because, as far as they are concerned, there may be more urgency. Trauma and orthopaedic has one of the highest number of appointments — about 165,000 — and yet it has only about a 6% cancellation rate. Is it doing something right or something better? Can that be looked at in light of the rates for other specialties? Can lessons be learned from it?

Mr Compton: We are aware of the complexity on the mental health side of things. You are quite right, Chair: this is our information. You asked for it, and we gave it to you. However, the issue here is that, frankly, the information is not fit for purpose, so we are having this cross-cutting discussion that, to be honest, is not helpful. It is not that there is any reluctance — please do not assume that there is reluctance on our part. It is simply that we need the information to be fit for purpose. That was the reason for the short life working group and why we are changing how we do the codes and are implementing a new policy and a new way of doing things from 1 July.

I am sure that there will be teething problems, as there always are when you switch these things in the first quarter, but I expect that, during this year, the information will be much more accurate and will allow for more of the scrutiny that you are talking about.

Clearly, on issues such as trauma versus mental health, we know that there is probably a higher "did not attend" rate for mental health appointments. The nature of the illness or disability is almost predisposed to create that situation, whereas on the orthopaedic side, it is clearly not; you have only to think of the logic of plaster casts being removed and so forth. There are some quite significant differences between those situations, but it is not helped —

The Chairperson: John, we need to concentrate on the cancelled appointments.

Mr Compton: That is the point that was being made; only 6% of orthopaedic appointments are cancelled, yet a very high number of mental health appointments are cancelled.

Mr Brady: My point is that there is a relatively low rate of referral for people with mental health illness but a very high rate of cancelled appointments. Again, I would suggest that people with mental health problems may not attend for various reasons, but those who do attend, or hope to attend, are having their appointments cancelled. That has a greater impact —

Mr Compton: I would not dispute that.

Mr Brady: — which leads to ongoing greater trauma and problems for those people. That needs to be addressed.

Mr Compton: I would not dispute your point at all.

Mr Brady: Daisy Hill Hospital has a very good mental health unit that deals with many people. People need that facility to be operating at full strength. That percentage of cancelled appointments for a relatively low number of patients is an indication that something is going wrong somewhere that needs to be addressed urgently.

Mr Compton: I absolutely accept what you say. I am keen to assure the Committee that the platform of information on which all our understanding of this situation is based will be more robust as a consequence of the working group that was set up after our most recent meeting. We are moving reasonably quickly because we are changing an entire system. I hope that, by the end of the summer, the information that will come out of that will be much more straightforward and will give a much more robust platform for an informed debate.

Mr McCarthy: I want to follow up on the Chair's earlier observations on the private sector or, as it is called, the independent sector. Table 2 of your briefing paper, which outlines the cost of the use of the independent sector, shows that figures are unavailable for three trust areas. What is the reason for that?

Mr Bloomfield: That information was provided directly by the trusts. The information has to be sourced by trusts from the independent sector providers directly as to whether appointments are cancelled. Those trusts must not have been able to provide that information.

Mr McCarthy: You must consider that to be unsatisfactory. Are you taking measures to change that and to find reasons, excuses or whatever? At least that would be better than simply saying that the information is not available.

Mr Bloomfield: Patients are sent to the independent sector only after trusts have delivered the amount of activity that they should and could have delivered. If trusts are cancelling patients and clinics, those same patients are not being sent to the independent sector instead.

The focus of the independent sector is to ensure that it sees the volume of patients whom it is required to see; it is provided with funding to ensure that those patients are seen. The same level of recording of whether a patient's appointment was cancelled is not currently available in the independent sector.

Mr McCarthy: Are you going to do something to make it available?

Mr Bloomfield: We will certainly need to make sure that it is available from the point of view of patient experience, because it is not satisfactory for individual patients. We need better information about whether independent sector providers are providing a good service to patients and not cancelling appointments unnecessarily. We will ensure that that information is made available.

Mr McCarthy: Good.

The Southern Trust has the lowest cancellation rate of 6%, and the Northern has the highest at 13·5%. Are there any factors that can explain these differences? Is the board doing anything to encourage other trusts to come into line with the Southern Trust?

Mr Bloomfield: Certainly, the board does things to encourage trusts. We require them to deliver a certain amount of activity for a certain amount of funding. If they do not deliver that activity because appointments are cancelled, there is a possibility that they will not get all of the funding, so there is a very strong incentive for trusts to minimise cancellations. As for making comparisons between two organisations, we keep coming back to the issue that it is very difficult to draw conclusions from this information until it is more robust and fit for purpose. However, there is a strong incentive for the trusts, and the board raises with them regularly the requirement for them to ensure that they minimise cancellations, achieve maximum productivity and see as many patients as they can.

Mr McCarthy: You must be disappointed that the Northern Trust has come out with the highest rate, given the difficulties that it seems to have encountered in recent times. You have already said that funding could be withdrawn. Is there something else that you could do?

Mr Compton: I will reinforce what we said in the commissioning plan, which the Committee considered some weeks ago. There is a clear statement in that commissioning plan that the core contract that we have with each organisation flows from work based on demand and capacity and carries with it the possibility of financial penalty if an organisation is simply sloppy in how it works. There can be reasonable explanations for why work cannot be undertaken, but, if trusts are sloppy, we have signalled that there will be a very direct involvement. We will also escalate the performance element with the trusts' boards because this is not just about money; this is about how an organisation is set up and organised and how it performs its functions. We will look at both the performance function and the financial function.

The issue uncovered for us by the Committee was that we were capturing a piece of information and looking at it slightly differently. We are looking at the information at the bottom end, if you like. We have an expectation of whether we are meeting the nine-week target for outpatients, the 13-week target, or whatever, and we are doing that. Our system, however, was collecting information that, over time, had spilled into all sorts of practices, which made it no platform for understanding that information. The short life working group is completing its work, and we expect to have a different platform of information from 1 July onwards. By the second half of this year, that platform will be much more robust and enable us to do what you are talking about, which is making comparisons. If there appears to be a material difference in percentage terms from one place to another, that will be material for us to work on.

We looked at the other side: on the demand and capacity side, we know exactly what each organisation should be delivering. We have a contract with them to deliver that, and we ask them whether they are doing so. If the answer is yes, all is well; if the answer is no, unless there is a reasonable explanation, there will be escalation. That escalation carries with it a performance escalation and a financial escalation, which is our discharging our job as a board correctly.

Mr McCarthy: John, have you taken that action against any of the trusts to date, not just because of cancelled appointments but for any other misdemeanours?

Mr Compton: Absolutely. I assure you that there have been some very robust conversations between me and chief executives about underperformance in contract. There is a written requirement to fix any underperformance. They have to explain how it will be fixed and detail the actions that they will take to do so. The financial sanction was introduced this year.

Mr McCarthy: You say that you have had conversations, but have you taken funding away from any trust?

Mr Compton: No, but we have required trusts to give us a detailed explanation of how they will reinstate the activity on which they have fallen behind.

Mr McCarthy: Would funding otherwise be withdrawn?

Mr Compton: Yes.

The Chairperson: Just on that point, and I took note of this when Michael mentioned it earlier, you talked about retracting funding. What does that mean? Who would suffer? Are you targeting failing senior management? To me, if you take away funding from a trust, that means that the people in that trust area will suffer.

Mr Compton: I will outline this at its most simple level: if a trust is contracted to do 10,000 things a year for us, we give it an amount of money to do them. We have said that, if that trust fails, is well below the 10,000 figure and has no adequate, sensible explanation, we will withdraw a fraction of its money. We understand fixed costs and marginal costs in the organisation. We will do that because we will have to provide alternative arrangements for the individuals affected.

The Chairperson: I appreciate that, John, and I know that you are in a very sensitive position, but that means to me that someone who lives in that trust area could then become the target. Rather than

always targeting the patient, why not target those employed to deliver the targets set by your board and the Department?

Mr Compton: Financial escalation is one way; it is not the only way. This should not be reduced to a simple debate about finance because we have had a very exhaustive debate about this. Finance is only one of a number of factors. It is a performance issue between our board and the board of a trust. It is a way publicly to indicate the HSCB's dissatisfaction, should it get to that point, with performance in an organisation — to highlight to that organisation that we expect better and to pressurise, if you want to put it that way, senior management and senior clinicians into addressing a performance issue. It is not just about money, but, in the end, I think that we have to use that, too. It is only one of the available tools. The withdrawal of money would not be to disadvantage a population because this is not about disadvantaging the population.

The Chairperson: So you will target those who are supposed to deliver. In case I forget, you mentioned that you hoped to have proposals in place over the next couple of weeks or next year. Did you say that?

Mr Compton: No, we submitted our commissioning plan this year, which you considered a few weeks ago, and our proposal for how we will enact that. That commissioning plan has now been endorsed by the Minister, so we will get on and do it.

The Chairperson: OK, apologies for that.

Mr McDevitt: I just want to return to what Mr Bloomfield described as the independent sector. What is your assessment of why it is so efficient?

Mr Bloomfield: The independent sector does not provide the full range and breadth of services provided by the health service. It sets up a dedicated clinic to see a number of patients, and consultants in the independent sector do not provide the wide range of other services provided by the health service. Also, patients selected to go to the independent sector are, on many occasions, the more straightforward cases.

Mr McDevitt: The cancellation rates in the independent sector are very impressive. I take the point that you may not want to look at one trust and compare it in real terms with another, but, according to the trend, the independent sector in the Northern Trust is about six times less likely to cancel than the health service, as is the case in the Southern Trust. What do you put that down to?

Mr Bloomfield: Booking arrangements in the independent sector are likely to be much shorter term. Patients are contacted within a couple of days of their appointment, as opposed to six weeks in advance, so they are more likely to go. The independent sector is much more likely to be sure that it will be able to provide a clinic, and there is less opportunity for things to happen in between.

Mr McDevitt: Is there a financial incentive for the independent sector to get patients in the door? Does it get paid only for people who turn up? Is there, in effect, a different contract in place with the independent sector?

Mr Bloomfield: It gets paid only for the volume of patients that it is contracted to treat.

Mr McDevitt: So, if a patient does not turn up, does it get paid?

Mr Bloomfield: Does the independent sector get paid? No.

Mr McDevitt: It does not, but the public sector does?

Mr Compton: There are a couple of things to say on that. It is a fee-for-item service in the independent sector. There is much more of a cost-and-volume contract in the statutory sector. In the independent sector, if I contract with you to run a clinic on a Saturday morning to see 10 people, that is the totality of the service. In our system, the same individuals could be involved in emergency work or training and teaching work. An awful lot more goes on in our system, and it does not pay by results.

Mr McDevitt: Do we know how many consultants in the public sector — NHS consultants — work privately for us as well?

Mr Compton: We do not record that information. Individuals, depending on their contractual arrangements, are expected to declare whether they work in the independent, or private, sector. As you know, once they do their contracted work for us, their first option is to do extra work for us, and their second option is to do private work. I am sure that there are numbers and that organisations have said that staff have recorded and declared that they do independent work.

Mr McDevitt: I will help you, John. Mr Beggs has provided me with some numbers. The Belfast Trust says that it does not know, as do the Northern Trust and the South Eastern Trust. However, interestingly enough, the Southern Trust does know: it says that the number doing private work is 58, which includes 17 NHS locums and nine agency locums. So 58 of the 200 privately. The Western Trust's figure is 42. We know that the Northern Trust's cancellation rate when working publicly is 13·5%; when working privately, the rate is only 3·6%. There seems to be a bit of an efficiency gap between when these ladies and gentlemen turn up for work as public servants and when they do so as private practitioners.

Mr Compton: I was hesitant about giving you information because it may be that, substantially, that private work is associated with independent sector work, but it may not be exclusively so. Consultants are expected to declare work in the private arena. They do other outside work in the private arena: they may, for example, be expert court witnesses. Work such as that is also declared as private work. I am a little reluctant to say too much because the platform of information that we have held to date has not been fit for purpose.

Mr McDevitt: Help me out. Do you think that I am making a reasonable assumption that most private sector work is being done by locum consultants who also work in the NHS? As a reasonable person, is that a reasonable assumption for me to make?

Mr Bloomfield: There are two or three forms of independent sector provider. We have independent sector providers coming from GB, independent sector providers in the Republic of Ireland and locums.

Mr McDevitt: I am asking you to help me out here.

Mr Bloomfield: The local independent sector providers are staffed predominantly by health service consultants.

Mr McDevitt: So it is a reasonable assumption for me to make that, probably, the majority of all private work done in Northern Ireland is done by people who work for the NHS in Northern Ireland?

Mr Compton: Yes, that is not unreasonable.

Mr Bloomfield: On the clinical side.

Mr McDevitt: That is what we are talking about — cancellations. How come people are six times more efficient when doing the job for you privately than when doing the job for you publicly?

Mr Compton: That may be the case, but the platform of information that we have at present does not allow that information to be derived. We can say that, if you run a private clinic or buy a private clinic somewhere, that private clinic happens. As I said, cancellation does not mean that the patient was not seen — that is the issue.

The Chairperson: Based on the information that we have, it does, and that is what we are working off.

Mr Compton: I have said that I think that the information given to the Committee is unsatisfactory, and we have a process to get that information into a much more satisfactory format. I am sure that we will be invited back when we have that satisfactory format to have a robust discussion. At that point, the information will be what the information is, and that will enable us to have a better debate.

The Chairperson: Based on the information and evidence in front of us, the point that Conall is making is —

Mr Compton: It is not unreasonable on the basis of that information, and I accept that it is our information.

Mr Bloomfield: Many of the independent sector outpatient clinics are arranged and booked only a week or two before they take place. A consultant, for example, says that he or she will work next Saturday morning, and the independent sector contacts 30 people until they find 20 who agree to come in on that morning. That clinic is much more likely to happen than when appointments are booked six weeks out, given that a range of other factors can take place in the interim.

Mr McDevitt: May I take it that you will reflect on all the factors? I am not saying that these are bad people; they are not. They are great people, and we all value them greatly. However, how can someone turn up for work with his or her NHS gloves on and be six times less efficient in cancellation terms than when they turn up for work operating a pretty lucrative pay-per-item private contract — it is about money, lads

Mr Compton: Of course. There is no issue with that at all. We are enormously sensitive to the independent sector, or the private sector, whatever language one wishes to use. It is public money, and we are very concerned about its proper discharge and use. In our commissioning plan, we signal that, for some big specialties — orthopaedics, to name but one — we really need to contract differently to avoid that short-termism. We need to contract because we know that we cannot fix the demand and capacity problem in orthopaedics in anything under than 36 to 48 months. We should contract over a longer period with a consistent provider so that we can do that differently. We signal all of that, and we are looking at solutions to avoid the very issue that you raise, namely the short-termism and, not to put too fine a point on it, this question: am I ripping off the system? We are very sensitive to that.

Mr Beggs: I want to follow up on some of the questions that the Chair asked. A document on outpatient activity statistics states that appointments cancelled by hospitals:

"indicate a potential loss of productivity within the health care system."

Do you accept that?

Mr Compton: Of course; that is logical. When we get the platform of information on cancelled appointments and actual cancellation of individual patients who have come into the system, a percentage will, undoubtedly, be hard cancellations, and those represent a loss of productivity. As Michael said in his presentation, we require increases in productivity on the other side and for that side to make sure that it sees 2% more people at no additional cost to our system. That is part and parcel of our contract arrangements this year. The platform will help us to understand the position better. We have been looking at it on the other side: so if our target is 60%, we are at 78%, and the numbers are coming down —

The Chairperson: Let us look at the here and now. Roy, maybe the same question should be directed to the Department.

Mr Beggs: The figures that the Minister gave us are that the cost of an outpatient-led appointment is between £38 and £477. Why has the Department not taken a greater interest in this?

Mr Johnston: The Department's main focus has been on the overall waiting time target. However, we are looking to the short life working group to give us more robust information that we can then interrogate.

Mr Beggs: Do you not accept that, traditionally, when a waiting list gets longer, you pay for private sector sessions, which cost between £60 and £477? You throw money at the issue instead of looking at the day-to-day management.

Mr Johnston: We will pursue that when the robust data is available.

Mr Compton: I think that this is what you are asking: are we paying twice? We do not pay twice.

Mr Beggs: An opportunity is lost when the first appointment is missed.

Mr Compton: When we look at demand and capacity and tell a trust to do 10,000 things or 1,000 things, we expect it to do them. The trust, if it does not do those 10,000 or 1,000 things, may have to send someone to the independent sector, but it gets no extra resource from the HSCB to do so. The trusts are expected to do that from within their existing resources, which is a point of considerable tension.

The Chairperson: If the trust fails, waiting lists get longer and patients suffer. Although we may not be paying in monetary terms, we are paying —

Mr Compton: We can go only on what is said at fortnightly meetings, from which we know that there has been quite a dramatic drop in the numbers. We come at this from both sides. When we, as a board, commission from the independent sector, we do so because the capacity in our system is not great enough. If, for example, we know that we can do only 1,000 of something but have 1,200 —

The Chairperson: I accept all that, but, although we may not be paying in money, people are having to wait longer — that is the reality.

Mr Compton: The evidence that we showed you is that, in the past 18 months, waiting times have moved significantly for everyone across Northern Ireland. We are convinced that that is the right direction of travel.

The Chairperson: That is only for first appointments. In the figures that we have in front of us, 83% of cancellations relate to review appointments.

Mr Compton: Again, I accept that. As I have told you, we have a platform of information about which it is difficult for us to have a proper debate. I am sure, intuitively, that some of what is being said here is correct. Why would it not be, even if the platform of information is incorrect? I hope that the platform becomes more robust. With that more robust platform, it is quite reasonable that we will be held more robustly to account for the issues that emerge, and I expect that to happen.

Mr Beggs: I am very interested in this new platform. The 2007 Northern Ireland Audit Office report highlighted missed appointments and the cancellation of clinics. The report stated that that would have an "adverse impact" on patients. Do you accept that?

Mr Compton: Of course I accept that missed appointments have the potential to have an adverse impact on patients. However, the only other point that I will make is that, when it comes to what we do and what we have to handle, the world in 2013 is a very different place from what it was in 2007.

Mr Beggs: From 2008-09, the Department requested that trusts comprehensively record reasons for cancellation. Yet, we are told that, in the last full year, 2011-12, a quarter of cancellations were either not coded with a reason or were coded incorrectly. Whose fault is that? I would pose that question to all senior management in the health service.

Dr Mooney: In that instance, other than the actual reasons for cancellation, there was a proliferation of local codes, which were at the discretion of the people who administered the system rather than —

Mr Beggs: Mr Compton, who was following this? Who was making sure that trusts were delivering what the Department wanted?

Mr Compton: Of course, it should be the board through the performance management of the organisation. As I told you, our concentration was less on that information than on the numbers of people going through the system.

Mr Beggs: Sorry, may we come back to the issue? If there are cancellations, the total number going through the system goes down: is that correct?

Mr Compton: No.

Mr Beggs: Sorry?

Mr Compton: No, it is not.

Mr Beggs: If you have to spend additional money in the private sector to reduce waiting lists, that money is not available for other services. Did services reduce?

Mr Compton: No. The point that I have made at length is that, given the way that cancellations are recorded, it is not unreasonable for anyone to assume that a cancellation means that something did not happen. What we have tried to point out this afternoon is that cancellation means that a given doctor did not hold that clinic, not that the clinic did not take place. Therefore, there was no reduction in the volume of patient activity.

The Chairperson: I have to keep saying this for the record, John: based on the information in front of us, there was a reduction

Mr Compton: For the record, we accept that the information given to you is information from our systems and that, therefore, it is not unreasonable for you to have your view. What I have said —

The Chairperson: Based on what you are saying and the information that we have in front of us, can you give us a ballpark figure of how many of those 187,000 were seen?

Mr Compton: To be honest, I really do not know.

The Chairperson: They were not all seen.

Mr Compton: Of course, they were not.

The Chairperson: I would say that a substantial number were not seen.

Mr Compton: I would prefer to wait until we do the work in July. Anything that you say is just speculative, and I am sure that, if I said something, it would be quoted —

The Chairperson: I am not speculating; I base that on information that I have received.

Mr Compton: No, I am saying that, if I say something speculatively, it will be quoted. I would much prefer to talk about something that is accurate.

The Chairperson: We have facts in front of us.

Mr Compton: Correct. I have told you that the facts are not helpful. We have a process to fix that, and the timescale for fixing it is from July onwards.

Mr Beggs: I put it to you that, given that a quarter of the reasons for cancellation were not recorded or were recorded incorrectly, nobody really knows the reason for many of them. Is that a reasonable deduction?

Mr Compton: No. What this whole process has uncovered is that we have an information system that collects one set of information that is not fit for purpose, and we are fixing it. It is our information in front of you, so it is not unreasonable for you to ask the questions. I have no issue with that at all. However, the point is —

Mr Beggs: Why were the reasons for cancellation not comprehensively recorded?

Mr Compton: I cannot answer that. As I told you, and as my colleague Eugene pointed out, there is local variation in how people record and interpret. Through the working group, we have got that back to a different situation. From July, we will have a platform in which the recording is more standardised.

Mr Beggs: Mr Johnston, we have been told that there is variation and that people interpret this in different ways. The Department did not follow the guidance. Is it reasonable to assume that not only were the board and the trusts not particularly interested in the cancellation of appointments by consultants but that the Department was not particularly interested either?

Mr Johnston: The main focus was on the overall waiting times and on monitoring that performance. So in a sense —

Mr Beggs: Do you accept that cancellations and unknown reasons for cancellations can affect waiting times?

Mr Johnston: Given the discussion that we have had, I think that that is an issue, yes.

Mr Beggs: Thank you, but it took some time to get that out of anybody. The man on the street knows that, if you cancel an appointment, something does not happen and waiting lists get longer.

The Chairperson: The woman on the street would find that out more quickly.

Mr Beggs: The man or woman on the street. Do you accept that, sometimes, what is needed is a little bit of common sense and less box-ticking?

Mr Johnston: We would need accurate data to give you a more informed answer on that point.

Mr Beggs: Your Department asked for better recording of information in 2008-09. Why was that not followed up?

Mr Compton: In our —

Mr Beggs: I am asking the Department.

Dr Mooney: Following the Public Accounts Committee hearing, we changed from counting the number of clinics to counting the number of appointments. We were asked to look specifically at the number of hospital outpatient appointments that were cancelled. We were not asked to interrogate the reasons for those cancellations much further. That is why detailing the reasons was at the discretion of those recording them.

Although we produced guidance on mapping and how the local code mapped up into the regional code, we were not in a position to monitor in detail the proliferation of local codes in particular trusts. Since 2008-09, we have looked at the percentage of cases that were not coded or were coded incorrectly and tried to reduce that from 38% to 22%.

We have been fairly transparent about how we think that this information can be used and stretched beyond the purpose for which it was gathered. In that, we have had external views —

Mr Beggs: Can we just cut for a wee minute? Are you saying that, as long as a number was recorded, you did not really care whether it was meaningful?

Dr Mooney: No. That is not what I am saying.

Mr Beggs: That is what I read into this. Lots of statistics have been gathered since 2008-09, but they are not meaningful. Is that factual?

Dr Mooney: We published the number of hospital appointments that were cancelled. We placed a caveat on the reason for those cancellations because there was a variability that we could not stand over.

The short life working group has begun to address that. We have agreements in place about what the local codes should be and how they will map up into the regional code. We also have a programme of when we expect to be able to provide that information to the Committee. We should be able to relate which cancellations had an impact, the date and time when appointments were made, whether they

were cancelled and whether they were brought forward or pushed back. We will have much more comprehensive information to report to you.

Mr Beggs: I want to move on to the issue of your recording only the number of new appointments cancelled by hospitals. What is the rationale for using that as the main indicator?

Dr Mooney: Are you asking what the rationale is for recording the cancellation of new appointments?

Mr Beggs: Yes.

Dr Mooney: The rationale for that is to be able to provide management information. The debate that we are having here is about whether that affects the services delivered to patients. We would expect that, if we had fewer such cancellations, we could keep on top of them and move towards a position in which there were not so many.

Mr Beggs: What is the rationale for not recording the number of review appointments cancelled?

Dr Mooney: We do record the number of review appointments cancelled.

Mr Beggs: Yes, but you do not use that information as a performance indicator.

Dr Mooney: The point was made earlier that we could not set a target for review appointments because they are at the discretion of clinicians and based on the particular circumstances of patients. It would not make sense for us to do that. We have a number of indicators of performance, but we do not have a target.

Mr Beggs: I fully understand that some reviews are required quarterly and some annually. However, is it not significant when one is cancelled?

Dr Mooney: Yes; and that is why we have a number of indicators of performance. We would expect —

Mr Beggs: You have not been using the number, or percentage, of review appointments cancelled as an indicator.

Dr Mooney: We have. We have a number of indicators —

The Chairperson: Just for clarification, the Health and Social Care (Indicators of Performance) Direction (Northern Ireland) 2012, issued by the Department, contains the following performance indicator:

"Rate of new outpatient appointments cancelled by the hospital."

This is the issue that Roy is touching on; the rationale for including that as an indicator. It is based on the indicators of performance direction issued by the Department

Dr Mooney: From the Department's perspective, looking at the rate of review of outpatient appointments where the patient did not attend, which is one of our indicators —

Mr Beggs: The one that we are very interested in at the moment is the rate of review appointments that may have been cancelled by consultants.

A Member: By the hospital.

Mr Beggs: Yes.

Dr Mooney: Part of our rationale for that is to support the outpatient waiting-time targets. It is another indicator of whether they are moving in the particular direction in which we want them to move.

Mr Beggs: Sometimes, to achieve your outcome, some very rational measures should be looked at. I agree that you can go into too much detail at times. However, it appears to me that with this accounting for two thirds of all the outpatient appointments that have been cancelled, it is perhaps indicating something that is clearly an issue that is affecting overall performance and, therefore, should be followed up. Because this has not been there as an indicator, it would appear to have been abused, frankly.

Mr Bloomfield: What we have been trying to say is that —

The Chairperson: Sorry. Let the Department answer this first.

Dr Mooney: Absolutely; and it is certainly my focus to ensure that we have as much comprehensive information in the public domain as possible to inform these types of debates. We collect it for the specific purpose of making ourselves accountable, and so that you can look at the statistics and see the impact on patients.

Mr Johnston: Obviously, it is also one that the Department is going to have to take on board. We are going to have to take this discussion back and have a close look at it. That goes without saying.

Mr Beggs: Can you make sure that, when you complete the review, we do not end up with a whole bureaucratic system and lots of meaningless statistics? There should be statistics that will be utilised, and that are meaningful and capable of bringing about results.

Mr Johnston: Yes.

The Chairperson: Have you read the indicators of performance direction issued by the Department?

Mr Johnston: Yes.

The Chairperson: Have you read it, Eugene?

Dr Mooney: Yes, I have.

The Chairperson: The performance indicator is:

"Rate of new outpatient appointments cancelled by the hospital."

There is an issue here, given that two thirds of outpatient appointments are for review appointments. Correct me if I am wrong. Is this a play on words by the Department, based on the stuff said earlier about an appointment and a review appointment? What is the rationale for including this when 83% were review appointments?

Dr Mooney: We are concerned about the number of appointments cancelled. When we have received the outworkings of the group, we will have a better understanding of the impact of those. As far as review appointments are concerned, we would not like to see a high level of them not being taken up for whatever reason; either the patient did not turn up or —

The Chairperson: But, there is: based on the information that we have, 83% of cancelled appointments were review appointments. We will come back to that. If you have an indicator for new outpatient appointments, why not have another for the cancellation of review appointments? We will come back to you on that.

Mr Beggs: I will ask one final question. There is a danger of gathering too many statistics. Will you look very carefully at the Southern Trust, which has been operating relatively successfully compared to the others? It has a lower level of cancellations. Look at what that trust is doing. Sometimes, it is not just about statistics: it is about what management is doing with the information. Sometimes, too much effort can be put into box-ticking and gathering information which is all useless. Look to see what is working and successful, and try to implement that rather than try to direct everything from the top. Do you accept that that would be good rationale to follow?

Dr Mooney: Yes.

Mr Gardiner: What are the cancellation rates per trust for new outpatient appointments?

Mr Bloomfield: You want those figures and you want to know whether they are current?

Mr Gardiner: Yes.

Mr Bloomfield: The rates referred to previously, but based on the current method of reporting, show a discrepancy between organisations. With regard to new outpatient appointments, the percentage in 2011-12 regionally was 6·8%. The Belfast Health and Social Care Trust was 6·8%; the Northern Health and Social Care Trust was 6%; the South Eastern Health and Social Care Trust was 6·5% — sorry, I am reading "did not attend" percentages. I apologise.

The Chairperson: Try to give us numbers rather than percentages.

Mr Bloomfield: Are you asking about hospital cancellation rates for new outpatients?

Mr Gardiner: Yes.

Mr Bloomfield: In 2011-12, the percentage regionally was 6·1%. The Belfast Health and Social Care Trust was 6%, which is 11,400; the Northern Health and Social Care Trust was 8·1%, which is 5,200; the South Eastern Health and Social Care Trust was 6·4%, which is 5,400; the Southern Health and Social Care Trust was 3·5%, which is 2,700; and the Western Health and Social Care Trust was 7%, which is 6,100.

Mr Gardiner: The Southern Health and Social Care Trust is coming out reasonably well.

Mr Bloomfield: The Southern Health and Social Care Trust was 3·5%, which was the lowest.

Mr Gardiner: How often do you monitor those rates?

Mr Bloomfield: We monitor them, as well as a range of other factors, fortnightly with trusts. To come back to the point that we tried to make earlier; the focus on all the performance agenda in relation to elective care over the past number of years has been on reducing the time that patients wait for appointments. That includes review appointments. There has been a focus on how many patients are waiting beyond their clinically indicated date and for how long.

When all the indicators are going in the correct direction, that means that waiting times are reducing. There is then less of a focus on cancellations.

The Chairperson: Are the figures that you gave Mr Gardiner for this year up to the present?

Mr Bloomfield: No, they are for 2011-12.

The Chairperson: Based on that, he is asking how often you monitor the rates.

Mr Bloomfield: Monitoring them is not a separate process; it is within the arrangements for monitoring elective waiting times —

The Chairperson: — that you do every two weeks?

Mr Bloomfield: Yes, that we do every two weeks.

The Chairperson: OK.

Mr Bloomfield: So, if everything is fine, and if a waiting time in a specialty is nine weeks, we would not look at that.

The Chairperson: OK. Let Sam come in because I think that he is trying to develop a theme.

Mr Gardiner: Do you think that those rates are satisfactory?

Mr Bloomfield: No, we would seek to minimise —

Mr Gardiner: What are you doing to improve them?

Mr Bloomfield: We are requiring trusts to make sure that they are partially booking all their patients by giving them six weeks' notice. I am genuinely trying to answer the question, but a point that I was going to make earlier was about what the man in the street would think.

The way in which we have built up the number of patients that a trust should see in every specialty, the capacity it has, does not have an inbuilt level of cancellation. It is as follows. If I am a consultant, how many weeks do I work per year? Of my working week, what should my job plan be? How many face-to-face outpatient sessions should I have per week? In each of those, how many new patients and review patients should I see?

That is all worked up into a total figure for that specialty for that trust. Provided that the trust is delivering that number of appointments, the board is content. We would not have a reason —

The Chairperson: Is it not the other way around? Consultants are employed by the trust, so the trust should decide what is needed, rather than the consultant.

Mr Bloomfield: There was a regional exercise in which trusts were involved about benchmarking against best practice, and whether, in a particular speciality, you should see six, eight or 10 patients; so that we, as commissioner, could be satisfied about what the number of contacts should be for the funding we give trusts in a particular specialty.

Mr Compton: To answer your question, individual clinicians did not determine unilaterally who they would or would not see — I think that is what you are asking. That is not the case. We asked a complete discipline what happens. We then looked at benchmarks, gave those benchmarks to other people and agreed a number as far as that was concerned. That then became the demand figure.

The Chairperson: No, I thought that it was individuals.

Mr Gardiner: When was the last time the board raised the issue of cancellation rates with new and review outpatients with the trusts?

Mr Bloomfield: We raise it on an ongoing basis with trusts in areas where —

Mr Gardiner: What do you mean by "ongoing"? How often?

Mr Bloomfield: We meet every fortnight. To be clear, if a trust is delivering the core volume that we have agreed, we do not look at its hospital cancellation rate in that specialty because it is delivering to contract. If it is not — and there are a number of specialties where trusts are not delivering the core volume — we delve into the range of factors, and cancellation rates are one of those.

The Chairperson: Maybe you should change the way you look at it, because we are still faced with the issue. The evidence in front of us shows that there were 187 cancelled appointments.

Mr Compton: We have agreed to do that, and we will do it differently from July.

Mr Gardiner: How soon will you do it?

Mr Compton: From July. We expect to introduce the new recording system from July, and it will presumably take the first quarter to run through, analyse it and look at the information. Realistically, it will be from July or August to the end of September or the beginning of October, when we look at the first quarter to see how that has all bedded down, whether we are correct and what the problems and issues are. We will do that from then on.

Mr Gardiner: There is a wee bit of negligence if you have not done that already, because it is important given that the public are depending on treatment and the staff are waiting for the patient to come in.

Mr Compton: I understand that. On the other side of it, the numbers that we have to date will not materially move — they need to be validated for the end of the year, but they will not materially move — and they show a substantial improvement in outpatient performance across the system. We are very mindful of what the public expect of us and of our responsibilities in ensuring that people wait as little time as is practicable.

Mr Gardiner: I hope to see an improvement.

Ms Brown: Thank you very much for your presentation, gentlemen. I appreciate that you have already said that the information presented is unsatisfactory in this format. My question is for the Department; it has probably been pretty much answered. However, for the sake of clarity, I will ask it. It will not take too long. Is it fair to say that the group will consider how to reform the patient administration system that you use to report cancelled appointments?

Dr Mooney: As my colleagues outlined, the short life working group will address the issue that is uppermost in all our minds — the consequence of a hospital cancelled appointment. The group met today down at the Business Services Office (BSO) to see how we can draw out the information from the patient administration system into the outpatient universe and pull it together at trust level. We expect to have much more comprehensive information with you fairly shortly. We are working on that issue.

Ms Brown: Will the group look at the issue that some trusts currently record cancellations as "reason not known" or "reason coded incorrectly"?

Dr Mooney: Yes.

Ms Brown: John has probably already answered this question, but when will the group produce the report?

Dr Mooney: As John said, we hope to get the information together on the first quarter, and we hope, sometime in September, to be able to have at least a preliminary analysis of the July and August figures. There will always be teething issues with this, but we also have in place monitoring arrangements, through the hospital liaison group, to check on a regular basis to make sure that the codes do not get out of hand again. We propose to put a system in place whereby no local codes can be added to the system until they have gone through that group and have been agreed across the board. We are trying to tighten up how the information is coded. We will have it mapped out from local to regional codes, and we will have information that will allow us to look at when the hospital cancelled the clinics, the date, time and location, and whether appointments were brought forward or pushed further back.

Ms Brown: OK. Thank you. Obviously, the Committee will be keen to see the results. I assume that they will be shared with us.

Dr Mooney: Absolutely.

Mr McDevitt: I have a really quick question. This is the second time that we have looked at those figures. Obviously, we will come back to them again. It is one way of looking at efficiency. How should we measure clinical efficiency? What model should we use? What do we need to change to get that model? What would it be? What is the thing that would stop debates around, "he said, she said."?

Mr Compton: What we need to manage, with regard to clinical efficiency, starts with what the journey is for the patient, the individual — the journey time from when he or she first goes to the GP and is then seen at secondary-care level, if that is what is required, and if he or she has diagnostics. So, a journey time is needed. That is clinical efficiency, because it leads to better decision-making for the individual; whether he or she needs intervention, and what the nature of that intervention will be. That intervention should happen in a timely way. The timeliness of the total journey is quite important as far as efficiency is concerned.

Then, there is benchmarking of the impact when somebody turns up to a given clinic with a given condition. Do our results for the population of Northern Ireland look as though they sit sensibly in comparative data for bigger, similar or other populations?

Those are the issues that I think would be quite important for clinical efficiency.

Underneath that is the patient experience. It is always important to talk to people about what their experience was like. You can go through something that, apparently, is very efficient, but not feel very good about the experience. So, there is an issue with regard to patient experience. As far as we are concerned, those issues are all being looked at. We are trying to, if you like, refine and improve how we do that right the way through with regard to the journey time and patient experience, benchmarked against peer outcomes for given conditions.

The Chairperson: With regard to the point that you mentioned a few times, Eugene, the paper that we got from the Minister states that a lot of the use of local and regional codes in trusts is to be completed before their next meeting on 29 April. Has that been done?

Dr Mooney: Yes. I understand that there have been two meetings. If the local codes and the mapping to the regional codes is not complete, it is very nearly complete.

The Chairperson: So, we do not know whether it is done. This is a letter from the Minister informing us that the trusts were to complete that before the next meeting on 29 April.

Dr Mooney: The local codes and the mapping to the regional codes were agreed at that meeting on 29 April.

The Chairperson: OK. The Minister tells us that an audit would be used and that it would be initiated and completed before the next meeting on 29 April. I will allow you to go back and check that out with the Department.

We have to accept and welcome the fact that there has been progress on the nine-weeks waiting target. We are not always negative about stuff. Do you think that the figure of nine weeks could be improved upon if there were fewer cancelled appointments in the system?

Mr Compton: Possibly. The issue there, remember, is that to get to the nine-week target in the way that we are talking about with regard to numbers means that many, many people are seen well inside the nine weeks. You could not possibly do that and have everybody banged up into the ninth week.

The Chairperson: I know. John, do we accept that the target could be reduced?

Mr Compton: It is a possibility. Yes. There is potential for that. Of course, there would be.

The Chairperson: The full target is that 50% of people should be seen within nine weeks for a first appointment and that no one should wait longer than 21 weeks. Based on the figures that we have; in December 2012, over 7,000 people were waiting longer than 21 weeks for a first appointment. So, again, my question is to the Department: why is that target not being met? Is the Department looking into it? Has the board investigated it? Why are people having to wait over 21 weeks?

Mr Johnston: The Department looks to the board. There are constant monitoring meetings between the Department and the board on targets. The Department looks to the board to ensure that that is being improved upon.

The Chairperson: Taking on board the constant monitoring, I gave you the figure on December 2012, when over 7,000 people were waiting longer than 21 weeks for a first appointment. What is the figure now?

Mr Bloomfield: There has been significant progress since the end of December. Provisional figures show that, at the end of March, 3,000 patients were waiting over 21 weeks — 22,500 over nine weeks; 4,300 over 18 weeks; and 3,000 over 21 weeks. That needs to be seen as a direction of travel in a two-year period. Would we all have —

The Chairperson: I will commend you on that if you are telling me that the figure has come down from 7,000 in December to 3,000 at the end of March.

Mr Bloomfield: We want it to be better.

The Chairperson: I am actually commending you. When I am being nice to you, let me be nice. I am commending you for that. I know that it needs to get better. We all want it to get better. However, based on your figures, 7,000 people waiting 21 weeks is now down to 3,000 waiting 21 weeks.

Mr Bloomfield: Yes; at the end of March.

The Chairperson: OK. That is, probably, a good point on which to end. I think that we have exhausted some of this stuff. We will be back, John, based on the figures that we got from the Department.

Mr Compton: I understand that. We accept that.

The Chairperson: If there is other information, feel free to give it to us. Thanks very much.