Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Cancelled Outpatient Appointments: DHSSPS, Health and Social Care Board and Southern Health and Social Care Trust

13 November 2013

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Mr Roy Beggs
Mr Mickey Brady
Ms Pam Brown
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr Fearghal McKinney

Witnesses:

Mr Jackie Johnston	Department of Health, Social Services and Public Safety
Dr Eugene Mooney	Department of Health, Social Services and Public Safety
Mrs Sara Groogan	Health and Social Care Board
Ms Anita Carroll	Southern Health and Social Care Trust

The Chairperson: You are very welcome, folks. We have Eugene Mooney, assistant director of the Department's information and analysis directorate. I think Jackie Johnston is not here.

Dr Eugene Mooney (Department of Health, Social Services and Public Safety): Jackie has been delayed. He sends his apologies, Chair.

The Chairperson: So he may join us then; OK. Anita Carroll from the Southern Health and Social Care Trust and Sara Groogan from the Health and Social Care Board, you are very welcome. The procedure is that I will ask you to adhere as much as possible to a 10-minute presentation. You can decide among yourselves who will lead that. We will then open it up to questions from members. I hand over to you at this point.

Jackie has just joined us. You are very welcome, Jackie.

Mr Jackie Johnston (Department of Health, Social Services and Public Safety): Apologies, Chair.

The Chairperson: You are OK.

Dr Mooney: Good afternoon. I will begin by thanking you for this further opportunity to update the Committee on the work that we have been undertaking to address the issue of hospital-cancelled outpatient appointments. While I am aware that the Committee is fully conversant with the issues

surrounding hospital-cancelled appointments, it might be helpful to revisit a number of the key points of the discussion so far.

It is important to state at the outset that the Department, the board and the trusts are fully committed to improving the process of booking and monitoring consultant and outpatient appointments. We have genuinely greatly appreciated the Committee's interest and input into this matter.

We have provided two types of information in the briefing paper that we submitted to the Committee. The first piece of information is the Department's quarterly outpatient activity return, which is familiar to you. It collects information on hospital-cancelled outpatient appointments on the basis of the number of appointments cancelled in any given month or year. It is a count of appointments. The figures refer to attendances in all programmes of care. Although that information is useful, it did not fully address the issues raised by the Committee. The Committee was rightly concerned about not only the reasons for hospital-cancelled appointments but an assessment of the impact of those on patients.

The second piece of information, which has been developed by the short life working group, is new to the Committee. It refers to a count of patients who had attended an outpatient appointment during any given month or year and whose previous appointment was cancelled by the hospital and the impact that that had on the patient. It is, therefore, a count of patients. A regular and quarterly updated version of that report should be available from the period ending December 2013.

As you know, the short life working group was directed to address the Committee's request to have a fuller understanding of the reasons for hospital-cancelled appointments and, importantly, to provide information on the impact of those on patients. The information that you have before you does just that. We are now, for the first time, able to see clearly the number of patients who attended an outpatient appointment, the number of new and review appointments, those that were previously cancelled, the impact of those on patients in terms of whether the appointment resulted in a change in time, date or location, and, importantly, if the impact was positive in that the appointment was brought forward or negative in that the appointment was put back. We are able to quantify the impact in terms of the number of days that that involved.

A further action that resulted from the work of the short life working group was that the Department updated the technical guidance for completion of quarterly outpatient activity returns (QOARs) to include the agreed list of regional and subregional codes and remove the "other" category. The trust staff implemented the agreed regional and subregional codes on 1 July 2013. Moreover, the completion of the variable "reason for cancellation" became mandatory from that date. Any requests for new local codes must now be discussed and managed through the Department's hospital liaison group. This will ensure that there is no proliferation of local codes, which caused difficulty in the past.

I would like to draw out a few of the key points on the new data that was sent to the Committee on 10 October, in order to be helpful. Consider chart 1. There were 106,077 attendances at consultant-led outpatient appointments during July 2013. Of those, 33,729 were new, representing around 32%, and 72,348 were review appointments, representing around 68%. Of patients who attended their appointments in July 2013, 6,509 had previous appointments cancelled by the hospital. Around 20%,1,299, were new appointments. About 5,210 were review appointments. The split between new and review appointments is similar for August 2013. That is shown in chart 2 in your briefing pack. Of the 6,509 patients who attended in July 2013 following a previously cancelled appointment, 986 did not experience a change in date; five had the location changed and 981 had the time changed. Again, that is in chart 1.

Again, in August 2013, around 15% of affected patients did not experience a change in date. The converse of that is, of course, that there were 6,500 patients who attended in July 2013 following a previously cancelled appointment. There were 5,523 — about 85% — who experienced a change in date. Again, that is in chart 1. Of the 5,523 who experienced a change in date, 1,556 or 28% had their appointment brought forward and 3,967 or 71% had their appointments put back. On average, patients who had their appointments brought forward were seen 20 days earlier; 14 days for new appointments and about 21 days for review appointments. Patients whose appointments were put back were seen 21 days later; 16 days for new appointments and 23 for review appointments. Again, that is in chart 1. Figures for August were similar in that, of those patients who experienced a change of date, almost three quarters had their appointments put back for approximately three weeks. Those patients whose date was brought forward were seen around three weeks earlier.

I will turn to considering the reasons for cancellation. While the revised coding structure was implemented by trusts at the beginning of July, it obviously applies to appointments that were

cancelled after 1 July. If appointments were cancelled prior to July 2013, they will have been coded under the old structure. That is estimated to be fairly small; 8% for July and 4% for August. Because of that, coverage of the reasons for cancellation is slightly reduced. The issue will resolve itself over the next few months. However, rather than wait until that time, and in order to give the Committee some indication of the type of information that we will be able to produce, the Department undertook further analysis to approximate the reasons for hospital cancellations, along with the associated impact. When that work is complete, we will obviously furnish the Committee with a copy of the results. However, I think that it is worth mentioning a few of the salient findings.

Of those patients who attended an appointment in July 2013 and had had a previous appointment cancelled by the hospital, 23% had had their appointments cancelled because the consultant was unavailable for personal reasons. That ranged from around 27% in the Belfast Trust to 17% in the Southern Trust. Around 15·6% were rescheduled and put back due to management of the clinic. Ten per cent of them were cancelled at the consultant's request because they were no longer required. Ten per cent were rescheduled and brought forward because an earlier appointment was requested by a health professional. About 6% were cancelled because the consultant was absent for clinical or medical reasons.

I will now turn briefly to consider the targets and indicators. During a previous session, the Committee pointed in particular to the high number of cancelled review appointments and suggested that that might be so because they were not subject to any targets and would be easier to cancel. Officials explained that it was not possible to set a target around the length of time for a review appointment because that would depend on clinical circumstances. Nevertheless, the Department shares the Committee's concerns about the level of cancelled appointments, both new and review, the impact that that has on patients, and the potential loss of capacity as a result. That is why, in addition to the current indicator of performance, the rate of new appointments cancelled by the hospital, we propose to include in the forthcoming commissioning plan direction an additional indicator and a target for 2014-15. I understand that a draft of the indicators of performance direction, detailing the new indicator, has been shared with the Committee. The proposed target, which has just been agreed with the Minister, will focus on achieving a significant reduction in the number of hospital-cancelled appointments, both new and review, while the indicator of performance direction will direct attention to achieving a reduction in the ratio of new to review appointments that are cancelled by hospitals.

Based on the current number of cancelled hospital outpatient appointments, which is 167,172, the effect of the target would seek to reduce that by some 28,420, representing a 17% reduction in 2014-15. The accompanying technical guidance will ensure that those reductions are applied across all specialties and to all health and social care trusts. That will also help to ensure progress in all areas, including mental health, which has been raised by a member of the Committee.

Committee members suggested that good practice in one health and social care trust, the Southern Trust, should be cascaded to others. I understand that, as a result of discussions at the short life working group, staff from other trusts have visited the Southern Trust to see how it manages its appointments.

In conclusion, we believe that we now have a more robust platform of information to enable us to address the issues of hospital-cancelled appointments, and we have the necessary commissioning plan direction, targets and indicators to affect positive change. We are obviously happy to take questions from members on any of the issues that have been raised.

Mr McCarthy: Thank you very much for your presentation. You will agree that the number of cancellations is horrendous and far too excessive. The result for people who do not get their treatment when they are supposed to get it is endured pain. Before I ask a question, I must put to you that I am aware of an incident at Musgrave Park Hospital, where an elderly patient was supposed to have her operation. It was cancelled. The reason given was that there was a high level of absenteeism due to staff sickness. Can you confirm or otherwise whether it was decided some time ago that there was no longer a need for a dedicated ward with beds and nurses at that hospital? As a result, people have not had their operations and continue to suffer. That is an incident that I am aware of, and perhaps you could address that.

The second question relates to your looking at the feasibility of changing the patient administration system (PAS) to record data on cancelled appointments in a different way. You concluded that it would take too long and cost too much. Can you tell the Committee how long it would have taken and how much it would have cost?

Dr Mooney: I do not know to what degree the short life working group actually looked at that in order to give an accurate estimate. The patient administration system is a fairly complex system that is primarily used to manage patients across the service. So, in that sense, it is a secondary use, really, for us in terms of information. Maybe some of my colleagues in the trust —

The Chairperson: Sorry, I think the point here is that we are being given an explanation as to why the short life working group cannot deliver and we are told that it is about cost. So I suggest that you address the question.

Ms Anita Carroll (Southern Health and Social Care Trust): When I chaired the short life working group, we tried to explore changes to the system with the suppliers, CMS. The lead-in time would have been at least one year, and the initial cost was at least £60,000 to £80,000. So that was the kind of cost that —

Mr McCarthy: That seems like a lot of money. Could it not have been done on a cheaper basis?

Ms Carroll: That is the only supplier, and that is the only basis that we have for going forward with the system.

The Chairperson: Just picking up on Kieran's question, that seems to be a tiny amount of money to be able to access the correct data, which is what we need in relation to this major issue across communities. Do you not agree?

Mrs Sara Groogan (Health and Social Care Board): There are a number of issues with the patient administration system. It is actually scheduled for replacement. It is a historical system which has existed for some time and was created to do different things than we now ask of it. That is acknowledged. I believe that the totality of the patient administration system is under review and, therefore, it is a question of short-term spend versus what the short life working group could reasonably do now to provide more coherent information.

The Chairperson: Was a business case done in relation to the cost?

Dr Mooney: No, there was no formal business case. I suppose I am curious as to what additional information is not available. What we were trying to do was to produce information for the Committee as quickly as possible and in the most efficient way. We thought that we had done that. However, if there is additional information that you require, obviously we can look at that.

The Chairperson: I want to bring in Fearghal on this issue. I am asking that you accept that this is not just information for the Committee, but information that surely you need in order to be able to explain and deal with cancelled appointments. Again, I suggest that a cost impact of between £60,000 and £80,000 is not significant, even if it were to take up to a year.

Mr McKinney: I am quite surprised that this is what you are telling us. The object of this exercise, surely, is to achieve the best for patients, not trying to present us with information that somehow satisfies the Committee in the short term. That information could now be flawed, because we have not got the system for getting the information.

Mrs Groogan: The key point is that we all accept that. This is the first time that we have been able to have this range of information and see those improvements as we move forward.

Mr McKinney: Surely the short life working group was about getting to the bottom of this, not getting to the bottom of the Committee. It was about getting to the bottom of it, and you have not done that.

Mrs Groogan: I think that we have come quite a long way from where we started.

Mr Johnston: We are really on an improvement path here. We fully accept that the situation is far from ideal and there needs to be a lot of improvement introduced to the system. One of the key outputs of the short life working group is that we now have a more robust coding system, so the statistics put in front of you for July and August are more robust and accurate with respect to reasons for cancellation. We want to move on on two fronts. One is to improve performance by giving the trusts something to aim for, so we are proposing this new target of reducing overall cancellations by

17%. We will also take up other improvement issues such as, for example, having another look at the patient access administration system to see what further refinements can be made to give us even better information. So, this is really the start of a process. We are not bringing you something that is finished, and saying "That is it." We fully accept that more work needs to be done.

Mr Beggs: You mentioned that you did not want to spend £60,000 to £80,000 because you are already looking at a new system. Has the decision been taken to introduce a new system, and when is it coming in? If you have not taken any decision, what is the timescale for this alternative system that you are talking about? I can understand not moving some way if you are already on another process, but has any other decision been taken and, if not, when will it be taken? Even taking one year to put in a new system might still be good time spent and value for money. How many years away is your next process?

Mrs Groogan: There is a plan in place. I do not know the full detail of it, but, from an ICT perspective, one of the key regional priorities is to have the current system upgraded and made fit for purpose for its uses today.

Mr Beggs: Will you come back to us with that information?

Mrs Groogan: Yes.

Mr McCarthy: Musgrave is in the Belfast Trust, which comes top for cancellations. There is no earthly reason why beds and staff should have been taken off when there was a demand for them. What can you tell us?

Mr Johnston: If you give me the details, Mr McCarthy, I will follow it up with the trusts and come back to you as a matter of urgency.

Ms Brown: Thank you for your presentation. Chart 1 *[Inaudible.]* over 4,000 *[Inaudible.]* Do you measure the impact that *[Inaudible.]* ?

Dr Mooney: No. If there is a delay, it could be for *[Inaudible.]* The clinic could be cancelled and the consultant could be called away to deal with another issue or an operation in theatre or whatever in the hospital. All that we can say is that, when you get a high level of cancelled appointments, there can be a loss of capacity. Obviously, there will be times when the consultant is required to deal with another issue in another part of the hospital. It is very difficult to disentangle what that is. We have certain codes, but I do not know whether we would be able to go into that level of detail.

Mrs Groogan: The average time for reappointing for a new patient was 16 days, and it was 21 days for a review patient. A proxy of potential impact would be around how quickly those patients could be reinstated.

The Chairperson: The question is about the impact on health, not the reasons why appointments were cancelled.

Mrs Groogan: As I said, the best proxy that we have is that the average length of time for a new patient to be reinstated was 16 days and was 27 for a review patient. Therefore, the potential impact is in days rather than weeks or months.

The Chairperson: But there is no assessment of the impact on the person's health. Some people are waiting for up to 100 days.

Dr Mooney: We can say whether they were brought forward or put back. We do not have the information to talk about an individual patient and the consequence of that particular delay in them receiving their appointment.

Ms Brown: I am a bit confused. The question has not been answered at all. The question was about whether you have measured the impact that the delay had on their health.

Mrs Groogan: No. I am not sure how that would be done. What we can say, obviously, is that the longer that it would take for a patient to be reappointed, you could suppose the greater the impact that that would have on their health.

Ms Brown: Do you know the reasons for the 4,000 delayed appointments?

Dr Mooney: Yes, we have some details on the reasons. That is also included in your pack.

Ms Anita Carroll (Southern Health and Social Care Trust): There is a breakdown of time change, location change and date change for each of those categories of patient, either new or review.

Dr Mooney: We still have the reasons that they have been cancelled, whether the consultant was unavailable or the medical staff were unavailable. We still have a detailed list of reasons at a regional and subregional level.

The Chairperson: The reasons are not in the papers that we have received.

Mrs Groogan: It is table 1A.

Dr Mooney: It is table 1A and table 1B.

The Chairperson: It does not relate to chart 1, which we are looking at.

Mrs Groogan: The reasons quoted are consultant not available; medical staff or nurse not available; patient treated elsewhere; consultant cancelled appointment; appointment rescheduled/brought forward; appointment rescheduled/put back; cancellation following validation or audit; administrative processes; hospital transport not available; cancelled by hospital in order to re-book as an alternative method; patient cancelled as appointment is no longer required; patient cancelled but the appointment is still required; GP cancelled appointment; and reason not recorded —

The Chairperson: Sorry, folks. The question, again, is whether you can provide a breakdown of the reasons for those 4,000 delayed appointments, not the overall reasons?

Mrs Groogan: In those categories, yes.

Mr McKinney: Specifically for the 4,000 delayed appointments. Were 1,000 cancelled by the consultant, who was unavailable for personal reasons? Have we got those figures?

Mr Johnston: Yes. The consultant being absent due to administrative management reasons accounted for 170; the consultant absent for clinical/medical reasons, 766; the consultant absent due to personal reasons, 3,157; the consultant ill, 330; and the consultant left the trust or retired, 60. That is a total of 4,483. I apologise if you do not have those figures in front of you, Chair.

The Chairperson: We don't.

Mr Johnston: That is what I was referring to when I said that we had more robust data to present to you to allow you to analyse this better.

Mr McKinney: I have found that figure. It is in the right-hand column of page 126. What constitutes "personal reasons"?

Ms Carroll: It could range from a family bereavement or a consultant has an ill relative.

Mr McKinney: On occasions that affected 3,157 people.

Ms Carroll: Appointments.

Mr McKinney: I asked specifically, for the record, what constitutes "personal reasons". You are telling me that those are bereavement or an ill relative.

Ms Carroll: Because the other reasons are broken down. If you look in all the categories, there are administrative and management reasons, and the clinical, medical and personal reasons. There are a significant number of incidents of "personal reasons". Within the Southern Health and Social Care Trust there are just 287.

Mr McKinney: No, let us just pick the 3,157.

Ms Carroll: The total?

Mr McKinney: Yes.

Dr Mooney: With regard to "consultant absent for personal reasons", we explained to the Committee last time that there are a series of gradations in terms of the information. We have a series of local codes, which we mapped up into subregional and regional. If I look at the subregional code for "consultant absent for personal reasons", at a lower level, to see the reasons, those could be for annual leave, study leave, industrial action or personal reasons, including, as my colleague said, bereavement or maternity leave. One of the consultant's children may have been sick, and he needed to take time off. It is those types of reasons.

Mr McKinney: Yes, Eugene, I can understand that, but have you found out those personal reasons in the 3,175 category? Surely you need to know that.

Dr Mooney: We do not have that detail in front of us just now but, yes, we can look.

Mr McKinney: Have you sought it?

Dr Mooney: We have it. We could break down within those particular codes how many were annual leave, study leave, industrial action, and how many for other, personal reasons. However, we could not go any further into it than that. What we were trying to do —

Mr McKinney: Sorry, you are telling me that you have gone into it in detail but you cannot go into it in detail.

Dr Mooney: No. What I am saying to you is that we have information at a regional and subregional level that we are content with. This is where we got into difficulties last time. There are a series of local codes, some of which are applied differently across the trusts. We have an agreed set. However, if someone within the category is on leave for personal reasons, I could not tell you whether that personal reason was because the person's child was sick or they were bereaved. I am sure that that information exists somewhere. It might exist in the trusts, given that the person contacted them and said that they were not able to take their appointment due to a particular reason.

Mr McKinney: Yes. Obviously, we can look at it from the patient perspective, but this is a management perspective. When we come to that extent — nearly 3,200 not getting their appointments — and we are not privy to or assessing in a drilled-down way the information that is affecting so many people negatively, would it not be appropriate to drill down into that information to arrive at solutions? For example, for July and August, it may be appropriate that it was annual leave, and if it is always going to be about annual leave, maybe we should get a replacement in to cover annual leave, and that, in itself, might resolve the stress.

Dr Mooney: The trust would be looking at that level of detail.

Mrs Groogan: That goes back to Jackie's earlier point, which is that we recognise entirely that we are on a journey in this. This is the first time in these two months that we have had this level of information, and now it is about what it is telling us; where it is telling us to target; where we need to focus those improvements; and where we need to work with trusts around that.

Mr McKinney: Do you accept that, as it is presented to us, there are significant shortfalls here too?

Mr Johnston: Very much so. I accept fully the point that you make, which is that, if you are going to manage the system effectively, you need more detailed information. Maybe Anita can tell us how it

works at an operational level in her trust at the moment. You have those standard codes that you are obliged now to input against, but is there a further layer of detail in the operational side of the trust?

Ms Carroll: I can speak for the Southern Trust. We may have a consultant who requests to cancel a clinic that we have already started to book into, ie within the six weeks. We generally try to make all the consultants make us aware of their leave requirements at least eight to six weeks in advance to avoid getting into a cancelled situation. Nevertheless, if we have a consultant who, due to some extenuating circumstances, has to cancel a clinic while we are in the booking cycle, they complete a clinic template to advise that their clinic will be cancelled, and they have to indicate on that the reasons. That is just for us. It is a tick-box exercise for personal reasons, and we do not necessarily ask them to provide all of the detail around that. However, that is assuming that we, as a management system, are fully implementing that and that consultants are putting their hand up much earlier in the system and telling us when they want their annual leave. They understand, under partial booking, that we will start booking patients in a six-week cycle. Once we get that cancellation, we know that that clinic is going to be suspended, and we then stop booking any patients into that clinic. That is the routine that we use, and that is probably why our numbers are a little bit lower.

The Chairperson: I am going to refer to members, because a number of them have a line of questioning around this. Fearghal, you are happy enough.

Mr Beggs: I note your comment that this is the first time that you have useful information and data that you can compare. Do you accept that that is an indictment of those who have been managing the health service in Northern Ireland?

Dr Mooney: No. This is new information, but we had information in the past that looked at —

Mr Beggs: Which was pretty meaningless.

Dr Mooney: Well —

Mr Beggs: I move on.

The "Consultant Absent (Personal)" category is one of the largest categories that would be under management control to a degree. It is one of the things that you can manage and work with staff to try to improve. It is the biggest number that is jumping out at me. Why is there such variation between the trusts? The Southern Trust has 287, and you have brought someone from the Southern Trust here. Why did you not bring someone from the Belfast Trust or the South Eastern Trust, which have much higher figures? Why is there such variation in those numbers?

Mr Johnston: We brought Anita because she chaired the short-life working group for the region. You are right: we should have the other trusts come to another Committee hearing to explain that. As we say, we are at the start of the process, and anything that we can glean through the evidence produced here will add value to that.

Mr Beggs: My information is that the Northern Trust is the second biggest trust, so why does the South Eastern Trust, for instance, have almost 50% more consultant absences due to personal issues?

Mr Johnston: I do not know the answer to that question.

Mr Beggs: You mentioned that there was a variation of between 17% and 27%. Obviously, there are problems in some areas. Do you accept that?

Dr Mooney: Yes, and I think that the information and the points that you are picking up are perfectly valid. That is the type of discussion that I imagine that the board will be having with those trusts to try to understand where that variability is and why certain trusts are not performing as required. I think that it is perfectly reasonable to raise that, and I assume that the board will take that up with the trust.

Mr Beggs: Can you confirm that the heading of "Consultant Absent (Personal)" does not cover personal annual leave?

Dr Mooney: It covers annual leave, and it covers study leave. Another code covers industrial action, and other personal reasons are included.

Mr Beggs: Is it not seen as unprofessional to arrange patients to come in and then to take a holiday without giving due notice?

Ms Carroll: I suppose that that is what I was trying to explain earlier. We have a clear annual leave policy, and, therefore, we try to hold all of our medical staff to giving sufficient notice so that we do not start to book clinics when we know that they will be off on holidays, because, then, you will have to cancel.

Mr Beggs: Do the other trusts do this?

Ms Carroll: All trusts, I think, have annual leave policies, as far as I am aware.

Mr Beggs: Do they have a policy of that shortened period where you must give notice?

Mrs Groogan: The implementation of partial booking is variable across trusts, but all trusts have some form of partial booking, particularly for new patients. The implementation of policy on review patients is being rolled out across the trusts. For context, it is important to say that, with the volume of outpatient appointments that take place every month, I do not think that we will ever get to a situation where it will be impossible not to cancel for personal reasons, because the NHS staff group is very large, and there will always be unforeseen circumstances. So, we want to try to target reasonable reductions to that and look at where, as a Health and Social Care Board, we can focus and target that and what would be and look like a reasonable reduction.

Mr Beggs: I move on to another category. Can you explain exactly what it is? It is listed as "Consultant Cancelled Appointment". That is different from "Consultant Unavailable". Can you explain how you are certain that items are appropriately grouped under this description where appointments are no longer required at the consultant's request?

Dr Mooney: I will let my colleague deal with that in a moment. That could be that diagnostic tests that the consultant had been waiting for have come through, and, having seen the result, the consultant decided that it was no longer necessary to treat the patient. Perhaps Anita can add to that.

Ms Carroll: We have trained staff to use that code when a patient is awaiting results, and the diagnostic comes back and indicates to the consultant that a further appointment is not needed. That is when they use that code.

Mr Beggs: Again, there are big variations between each of the trusts. Does that mean that some trusts are bringing in patients who may not need to be seen?

Dr Mooney: It might be because of the nature of the conditions that some of the trusts deal with. The Belfast Trust, because it is a regional centre, will, obviously, deal with different cases than others across the regions.

Mr Beggs: Another large category is called "Appointment Rescheduled - Put Back". The sub code in that category that makes up by far the greatest proportion is called "Management of Clinic". I notice that two of the codes, "External Incident" and "Internal Incident", are listed as being used zero times. Under "Management of Clinic", 2,111 cancellations were reported. What does this heading actually mean? To a degree, does it mean poor management of the clinic?

Dr Mooney: I have some of the reasons why they categorise that. It is what it says. Some are put back, and some are held in a new clinic on a later day.

Mr Beggs: Why are they put back?

Dr Mooney: We do not have the exact reason other than that it is part of the management of that clinic for whatever reason. It might well be that there is a change in time. It could be on the same day but in a different time slot. The time slot might be removed because the consultant has requested that it be put back. We do not have all the individual reasons. We have some of it.

Mr Beggs: Can you give us a breakdown of the various sub-codes that you have and that you have not already provided to us?

Dr Mooney: We will share that with the Committee. As you said earlier, you have to manage it at a particular level, and, yes, I understand that those affect individual patients. It is useful to get as much detail as you can about the consequence of that for the patient and the exact distribution of the reasons for it. When we started the journey, as Jackie said, we had a system in which quite a range of local codes were being used, and the first thing that we had to do was to try to bring some sort of order to that, and the group did that. We are now more confident. We mapped that up from those local codes into subregional and regional codes. From a management perspective, our focus has tended to be on the regional and subregional codes. The type of information that you have is on the very local codes, and there will be a certain variability in how some of the trusts continue to use those. Those are more for operational purposes and to enable the trusts to know the individual reasons and challenge their staff about that. Quite honestly, some of us in the Department will not know each individual patient in that local area and whether that is reasonable or not. It is for the trusts to manage that.

Mr Johnston: We could try to take some of those larger numbers and see if we can get you more detailed analysis of what underpins those. If you bear with us, we will try to get that at a trust level.

Mr Beggs: The other large category that you have listed here is where the patient has cancelled. Why have you included it among all those other categories?

Ms Carroll: It is part of the quarterly return. It is the total cancellations, and that is just following the format of that, in that it is all of those.

Mr Beggs: To a degree, it is not under your control. However, what if, for instance, you are not taking into account local transport arrangements and are booking appointments at times when people cannot get to them? I remember trying to get to Antrim hospital for Translink one day as part of a study, and I left home at about 6.00 am to get to a 10.30 am appointment using public transport. So, how do you use the information on patients cancelling to ensure that slots are best utilised and are not being cancelled at short notice, so that we are maximising the ability of the NHS to treat people?

Ms Carroll: From a trust perspective, we do a number of things to try to minimise patients cancelling their appointment, one of which is the partial booking system, which is about giving the patient the choice, in the first place, to select an appointment that suits them, rather than sending them out a fixed appointment that may not suit them. We do 100% partial booking in the Southern Trust for every new appointment and every review appointment. Despite that, people do not necessarily turn up for appointments. On top of that, we confirm appointments by letter, and, for all patients for whom we have a mobile phone number — we extensively try to capture that number at every interface with patients — we send a text reminder three working days before appointment to say, "You have an appointment at Craigavon hospital" or whatever. Those are all the steps that we are taking to try to manage it as best we can. Aside from PR campaigns about the missing space — you know what that is doing — we actively and very rigorously try to make sure that we get patients to their appointments.

Mr Beggs: Is that good practice applied by every trust?

Ms Carroll: I think most trusts do —

Mr Beggs: Do we know if every trust uses it?

Mrs Groogan: Does every trust use partial booking for new patients? They do. Not all use it for review, but they are in the process of implementing it for all. The text reminder is not in use in every trust. I understand that that is because it was agreed that a number of trusts would pilot it and test whether it had an impact or not, so that it could then to be rolled out.

Mr Beggs: Do you know the outcome of that test?

Mrs Groogan: Not yet.

Mr Beggs: How long has it been running?

Ms Carroll: We have been running it for about a year in the Southern Trust. I suppose it has just become part and parcel, because, for most appointments, such as dental appointments outside of the trust, it is a common enough practice. I suppose that one of the biggest challenges around it has been getting mobile phone numbers. That is why I said that, at every interface, we try to ask for mobile phone numbers at reception.

The Chairperson: That is good work and good practice, but the focus is on the patient, whereas we are dealing with appointments cancelled by hospital providers. I think the last statistic that we saw for last year was something like 182,000. That is the issue, and that is where the focus needs to be.

Mr Beggs: *[Inaudible.]* unless the booking system takes account of local practicalities, they will get cancellations, because people will not be able to get there.

Mr Brady: Thanks for the presentation. I am just looking at table 1a. How many cancellations were true cancellations? By that I mean cancellations that resulted in the patient's appointment being cancelled or put back without there being any clinical need to do that?

Dr Mooney: Sorry, I did not quite catch that.

Mr Brady: It was about appointments that were put back without there being any clinical need to do so — true cancellations in that sense.

Dr Mooney: I think the information that you have there all refers to true cancellations. The figures that we have there, whether for new or review appointments, are of actual cancellations.

Mr Brady: Are the Department and the board happy enough that those are true cancellations and that none were cancelled or put back where there was no clinical need to do that in terms of the patient's condition?

Mrs Groogan: That is the thing that, for the first time, we can definitively say. The table shows appointments that had an impact on the patient where there was a change in date, a change in location or a change in time. I have a figure to September, which is 20,667 that had an impact on the patient.

Mr Brady: So, if you have that information to hand, that would give you a handle on the situation and would go some way towards improving it.

Ms Carroll: Yes. Part of the work of the short-life working group was to define the data and then put in place the measure, the measure being the number of days in the future that the appointment was rescheduled to or the number of days that it was brought forward. That is the first time that we have had that information.

Mr Johnston: *[Inaudible.]* progress that next year by suggesting a 17% reduction target. So, from the figures that we have at the moment, if that target is achieved, we should see a reduction of about 28,000 next year. That is the first benchmark to aim for, and then we will want to see further improvement.

Dr Mooney: I think you raised the point last time about mental health in particular, so, as part of that target, we require that that reduction is spread across all specialties and all trusts. It will not be a question of looking for easy hits in that.

Mr Brady: As a point of interest, if a consultant is not available and the patient sees a junior doctor or somebody else who is available — not the consultant they were scheduled to see — how does that fit in with the appointments? Presumably they are going to see a particular consultant about a particular condition, but there may be a junior doctor available, whom they see instead. Would that mean that they would have to be rescheduled?

Ms Carroll: Not necessarily, because most consultant clinics are constructed around the consultant and maybe his or her registrar and a series of juniors. That is how clinics actually take place. Not everyone is going to see the consultant at the clinic, because the clinic numbers do not work like that.

So, if the clinic went ahead with a registrar in charge with, for example, two juniors or whatever, that clinic would not have been cancelled.

Mr Brady: Presumably, then, for all those cancellations when the consultant was not available, the person would have needed to see the consultant. Is that too simplistic an interpretation?

Dr Mooney: I think that the trusts would be better able to answer that. I think it is about whether it is a consultant-led clinic. If the consultant had agreed with his team who sees that patient, that is a clinical decision.

Mr Brady: The point that I am making is that it does not really matter whether the consultant is playing golf, on holiday or whatever, you have to presume in all these cancelled appointments that the consultant was the person who needed to be seen. If the registrar was there, why would the appointment need to be cancelled if it was the registrar who they were going to see anyway?

Dr Mooney: A consultant can cancel an appointment because that consultant may be the person who is taking a particular clinic. He may be the person who is called to deal with an emergency in another part of the hospital and, in those circumstances, it would be cancelled.

Mr Brady: That is what I mean. So, those are all appointments that the consultant needs to be dealing with as opposed to any other member of his team.

Mrs Groogan: Those are outpatient appointments, so it is probably not as easy from a referral letter to say whether you need to see a consultant or a member of junior staff as it would be, for example, for your treatment consequences or your operation. So, I do not think that you could automatically conclude that all those patients would have required consultant assessment.

Mr Brady: Is it possible to find that out?

Mrs Groogan: I am not sure that it would be. I am not sure how you would go about that, but it is probably a mix of both: some will have needed to see a consultant and some will have been appointed to the consultant as part of the booking process.

Mr Brady: Really, what I am saying is that there is an assumption that the team cannot function without the consultant being there, and that is not necessarily the case.

Mrs Groogan: Not necessarily, and it would depend on supervision and on the seniority of the other doctors who were there.

Mr Gardiner: The May 2013 headlines stated that more than 27,000 hospital appointments were cancelled between 2011 and 2012 because consultants were on leave. That seems to be following the trend. That was very damaging to the health service, I think you will agree; I certainly think so and am critical of it. What action has been taken in the six months since May to manage consultants' holidays better?

Ms Carroll: I will describe the process that we follow in the Southern Trust. Consultants are required to give a minimum of six weeks' notice and to send their annual leave plans through.

Mr Gardiner: There were 27,000 appointments cancelled between 2011 and 2012.

Mrs Groogan: All trusts follow the good practice of the six weeks' notice leave policy, but it goes back to the earlier point that, even with the best planning in the world, there are still 1·5 million outpatient appointments in any given year. We are dealing with a huge staff group, and while attempts are made to better plan that leave and good practice guidelines have been put in place, it is difficult to reach a point where there would never be unplanned leave. However, this has given us the ability, as I said, to be able to look at what reduction in that would be reasonable and to move forward on that basis.

Dr Mooney: *[Inaudible.]* It is not any mitigation, but the number of hospital-cancelled appointments over the last number of years has declined from about 216,800 in 2008-09 to around 167,000 now. It is far too high, we accept that, but —

Mr Gardiner: I am talking about cancellations in 2011-12. There were 27,000. There is no improvement there. I think that you need to go back to the drawing board, sort yourselves out and see what you can do. That is not good for the health service or for the patients in particular.

Mr Johnston: I accept your point entirely. It is a performance management issue at trust level. What we are trying to convey today is that we have got better and robust information now, so the next steps will be to use that information to tackle the issue that you have identified.

Mr Gardiner: When you come back to us in a year's time, we will look at the improvements that you have made. Hopefully, there are improvements.

Mr Johnston: I hope that the target will provide a focus over the incoming financial year to ensure that inroads are made around reducing the number of cancellations. We would like to see that 28,000 reduced by using that target.

Dr Mooney: We fully accept that the number of cancelled hospital appointments is far too high. We have put a target in place that is fairly significant. If that target is met, it will result in around 28,000 fewer cancelled appointments. We have also put in other indicators. We are looking at the ratio of new appointments against review appointments, because, again, we accept that there are far too many review appointments relative to new appointments, and we need to look at how we can bear down on that as well. So, the Department has put in place a range of measures. We expect the board to manage that and to work with the trust to try to ensure that those targets are met. We do take the issue extremely seriously.

Mr Gardiner: What is the board doing at the moment to make those improvements?

Mrs Groogan: At this point in time, the board meets the trusts on a regular basis to discuss a range of performance issues. Clearly, when the target and the indicator are introduced next year, we will put in place the same performance management arrangements for them as we do for any of the other targets on waiting times or the delivery of core capacity. So, at this point in time, it is about looking primarily at whether the trusts are in a position to deliver the volumes of outpatient activity that they need to. If they are not, we need to look at why not and what their reasons are for that. So, as Eugene said, I think that this is a really good platform for us to move forward with the performance management arrangements.

Mr Gardiner: I think that you need to move fast to make improvements. It is not good. It is definitely not good for the health service.

Dr Mooney: We will not wait for the target to come in in practice; this is something that the trust will be doing now. The board will obviously have those conversations and, in turn, the Department will have a conversation with the board about the best way to bear down on and reduce the number of cancellations. So, we will not simply wait for the introduction of the new target. We expect people to be dealing with this as we speak.

Mr Gardiner: Right, OK. We will watch this space.

The Chairperson: I have a number of short questions. Initially, regarding the reasons for cancellations in each of the trusts, are you able to monitor the number of cancellations across each speciality and for individual consultants?

Dr Mooney: We will be able to monitor that across the specialities, yes. The target will look at that.

The Chairperson: Can you do it now?

Dr Mooney: Yes, we can.

The Chairperson: You can. You have that information now across specialities and for consultants.

Mrs Groogan: I think that the trusts monitor it on an individual consultant basis.

The Chairperson: So, that information is available now. How do you use the data collected to monitor the performance of consultants?

Dr Mooney: *[Inaudible.]* in terms of annual appraisal.

The Chairperson: If the trusts have the data, how do you use that? You are saying that you have information across the specialities and for consultants, so how do you use that to monitor performance?

Ms Carroll: It is only now that we have the data available to us in that kind of format. You are saying, "How would we then drill into that data to make it speciality specific?". Yes —

The Chairperson: Sorry, I was told a minute ago that data is available across the specialities and for consultants, and now I am being told that it is only now available. Do we have it or do we not?

Dr Mooney: If you are asking whether we have information on the numbers, or on some of the things that we have been talking about, for cancelled consultant appointments for those reasons and by those specialities, we —

The Chairperson: I am talking specifically about the role of the trusts. In any other management process, if data was available that flagged up that there are cancellations across a number of key specialities and for a number of consultants, surely performance monitoring would kick in.

Mr Johnston: We do not have that information with us. We can find out what action is taken. If there are incidences —

The Chairperson: I am asking the trust. If the trust has that information, is it not monitored?

Mr McKinney: Chair, can I just re-emphasise the point? If you were making widgets and there was a failure to make the widgets because the person responsible was not attending work or for whatever reason, you would employ some sort of employment targets or calculation around that, per consultant. I am not talking about the wider figures. We are using the wider figures to monitor the performance of consultants within specialties. Are you doing that?

Ms Carroll: Consultants undergo appraisals, but —

Mrs Groogan: It is difficult to speak on behalf of all the trusts; only one trust is represented today. It is very much a trust management issue and it is also a medical management issue, which none of us can talk about. That is the honest answer.

Mr McKinney: Is your answer is simply no?

Mr Johnston: No, but we can find out. That is the answer.

Mrs Groogan: There are detailed consultant appraisal processes for things like this, but I am not familiar with them because it is down medical lines and nor —

The Chairperson: We are not asking you to speak on behalf of all the trusts. Just speak for your own trust.

Ms Carroll: My difficulty is that that is handled under consultant appraisal. It is not part of the work that I am involved in.

Dr Mooney: You are asking whether the trusts have information, which they would, across the specialties about which consultants are cancelling clinics and whether, if the numbers of cancelled clinics are high in particular areas, the trusts would have conversations with those consultants. It is not unreasonable to do so. I do not know whether they are doing that. I imagine that they should be doing it and that they are doing so, but we can come back and clarify that. That is part of how their work is managed and the contract that they have to undertake particular volumes of work. So, those things are routinely managed within trusts.

The Chairperson: OK. The other side of that is, if you have that information, how do you use it to reduce the number of cancelled appointments? We are suggesting that it is not necessarily the responsibility of those who are sitting in front of us. Whose responsibility is it? Is it that of the chief executives of the trusts? Who implements or deals with that data?

Dr Mooney: If a particular trust is looking across the specialties and trying to find out where high rates of cancellations are in a particular specialty, the trust's chief executive has responsibility for finding out where those cancellations are not defensible. There may be reasons why a particular consultant is always called away to A&E or called away at different stages. Those explanations will be gone through with that individual. Ultimately, it will be for a trust's chief executive to deal with. There are lines of accountability. We will look to see how that is managed from the Department through the board to the trust. If there are such problems, and we have the information in front of us, it would be addressed as part of performance management. That will be the case more so now that we have a particular target in place.

As I said in the opening statement, the target is not just about the reduction; it will be looked at across specialities and will be applied across all trusts.

The Chairperson: When will the figures for April 2012 to March 2013 be published?

Dr Mooney: Sorry, when the figures for —

The Chairperson: For cancelled appointments. That is what we are talking about.

Dr Mooney: The new sets of figures —

The Chairperson: We do not have the figures for April 2012 to March 2013. When will they be published?

Dr Mooney: I will check to find out when they will be published. One of the things that we referred to is that we intend to publish the new figures that we have available on a quarterly basis.

The Chairperson: It is not the new figures that we are looking for. We are looking for the overall annual figures.

Dr Mooney: I will check to find out when the figures for 2012 to 2013 will be published. I will come back to you with that date.

The Chairperson: Can I ask that they are forwarded to the Committee so that they can be given proper scrutiny?

Dr Mooney: Yes.

The Chairperson: I want to touch on the differences in table 1 and chart 1 because there was a bit of confusion there. From my reading of it, chart 1 seems to indicate that, of the people who turned up for an appointment in July, nearly 4,000 had previously had an appointment cancelled, which resulted in a delay for them averaging three to four weeks. Table 1a is not about people who came through the door of the hospital in July; it is about appointments that were booked through the hospital admin teams. The total number of appointments cancelled by hospitals across all trusts in July was almost 30,000. That is a very stark statistic relating to the levels that we are dealing with. Again, it is about the breakdown of the reasons for those delays, because we have not had that. I ask the Department to confirm that it will forward that information that the Committee is requesting.

Dr Mooney: Yes. What we have presented to you there is the number of appointments out of a total of 106,000 appointments in July that were cancelled, the impact of that, whether there was a delay experienced or there was no delay, and the impact of the particular days.

We have only two months' worth of new information. We had to hold the short life working group. We had to agree the regional code and get all those things in place. We have produced the information. My staff in the Department are looking at further analysis of things on this, which is why we shared

some of that with the Committee in the opening statement. We will undertake further analysis and submit that to the Committee; there is no issue there.

We are looking at this and will do the analysis, but this is information in development and it will take a while for us to get a proper handle on it. Our intention is, as soon as possible, to begin quarterly reporting of the information. If there is information that the Committee feels that it would like but it has not got, we will endeavour to get that to you as quickly as possible.

The Chairperson: We have been specific about the breakdown that we are requesting regarding that July figure in table 1a.

Mr Johnston: Just for clarification, what is missing from table 1a that you would like to have?

The Chairperson: We are talking about chart 1 and the people who turned up for an appointment. Nearly 4,000 people had an appointment cancelled previously. Then we come to table 1a, which is not about the people who came through the door of a hospital.

Mr Johnston: OK. I take your point.

The Chairperson: We are looking for the breakdown of that. We have been specific enough, and you are clear on what we are asking.

Mr McKinney: I just want to check something. We asked specifically at the start about the correlation between that and 1a. It was explained that this was the connection. I would be concerned if it is not, and if there is some refinement, if you know what I mean. That is the best way of describing it.

Ms Carroll: Table 1a is the full list of all the cancellations, which includes patient-cancelled as well as hospital-cancelled appointments. Do you know what I mean? It is the whole thing.

The Chairperson: It seems to make Fearghal's point that it is two different sets of data and is not connected.

Mr McKinney: I am concerned that one was being explained as being central to the other, which it may not have been.

Dr Mooney: We will write to the Committee to set out the information that you require. We will map the table to the particular charts for you separately.

Mr Beggs: I would guess that the cost of organising and running consultants' surgeries and appointments would be around £100 million a year. It strikes me that, if it was a business, it would be carefully monitored by its owner to make sure that its output was good. What are the key performance indicators that the board should be looking at to satisfy itself that, in an ideal world, we get the best possible output? Is the board going to micromanage every detail? What is the best aspect for the board to look at? You allocate the money, so how will you monitor and manage whether you are getting the performance required?

Mrs Groogan: The board will generally use a range of performance indicators to ensure that it gets value for money in the output from what it commissions —

Mr Beggs: What is the key bit of information?

Mrs Groogan: I think that it would be performance against service and budget agreements so that the volumes that are delivered by trusts are the volumes of outpatient activity that the board has commissioned them to deliver. Behind that would be a subset of indicators around how they maximise their productivity to ensure that they deliver those volumes through reducing cancellations, the introduction of partial bookings and that range of service improvements —

Mr Beggs: Is this new?

Mrs Groogan: No. The board has been monitoring delivery against core activity with trusts for probably just over a year. It is about saying, "You are commissioned to deliver this volume of outpatient appointments and you have delivered that volume; is there a variance or not?".

Dr Mooney: I think the point made at the last meeting was that the trusts effectively get paid for just the volume of the service that they deliver. When we talked about whether there was a loss of productivity there, they said, "Well, there is an analysis that looks at demand and capacity, at whether the capacity is there to meet the demand, and the services are commissioned appropriately in order to meet that demand". If a trust finds that it is not able to meet that, it is not as though that money is paid. A trust is paid only for what it delivers.

Mr Beggs: Do you also appreciate that patient experience is to be built into this? You should not operate like some of the airlines by booking in extra patients and consider it tough if they are left standing there.

Mrs Groogan: One of the key differences is that we are not operating an airline or running a business. These are major and complex organisations with patients at the end of that. I suppose that it is about those indicators from the macro to the micro level. So, it is about accepting that the key performance indicators terms are around the delivery of core activity, but, in the delivery of those volumes, there are expectations around quality, safety and patient experience.

Dr Mooney: On a general point, we accept that this type of performance is not conducive to a good experience for patients. We are looking separately at patient experience, and a programme of patient experience surveys will be built into the next commissioning plan direction. So, we will also be asking patients about their experience as an inpatient, of A&E and the service in general.

Mr Beggs: Can you assure me that the trusts are aware that you are not just asking for numbers or for boxes to be ticked, and that they are aware that how patients are treated in achieving good outcomes and performance is also important?

Dr Mooney: Yes.

The Chairperson: OK. Thank you. Obviously, the Committee has a number of points that it is seeking to clarify with you. We look forward to receiving that information, particularly the published figures for 2012-13. We will be looking to interrogate those figures and will be back in contact with you.