From the Permanent Secretary
and HSC Chief Executive

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Dear Ms Boyle

Public Accounts Committee Evidence Session – Request for Follow Up Information - NIAO General Report on the Health and Social Care Sector 2012-13 and 2013-14

Further to your letter dated 20 October 2015 seeking additional information, I have attached my response to your queries in the Appendices attached.

I trust that you find this helpful.

Yours sincerely

RICHARD PENGELLY

Appendix 1

Could you explain why during March 2015 only 27% of urgent breast cancer referrals in the Belfast Trust were seen within 14 days? This is well below the target that every urgent breast cancer referral be seen within 14 days which appears to have been substantially met by the other four Trusts.

In the Belfast Trust there has been a steady increase in the numbers of referrals with spikes in referrals in November 2014, December 2014, and March 2015, over and above existing capacity within the Trust. In March 2015, for example, the Belfast Trust received 313 urgent referrals to their breast clinics, whereas the normal average is around 60 referrals a week, or 240 a month. Capacity was not available in October 2014 to December 2014 to see all patients within 14 days and efforts focused on seeing patients who had been waiting the longest therefore performance against the target declined. In addition, following the introduction of digital mammography to the service, there was an associated requirement to address Interventional Radiology capacity which had a negative impact on the number of patients that could be seen at the one stop clinics.

An additional fortnightly clinic was put in place from April 2015 to provide additional capacity which continues in place. Other Trusts also provided support by seeing women referred who were resident in their areas.

The Department was advised by the Belfast Trust, in June 2015, that an action plan to bring the 14 day target back in line, and maintain it, had been put in place. This plan was initially successful as 100% compliance with the target was achieved in the first two weeks of October 2015. Unfortunately, one of the three consultant surgeons is now unexpectedly on sick leave and is not expected to return for some months.

In response to this, the Trust has:

- Engaged a full time agency breast surgeon;
- Acted up the Associate Specialist as a consultant;
- Continued the additional fortnightly evening ad-hoc one stop clinic through to February 2016; and
- Commenced recruitment of a substantive consultant breast surgeon.

The HSC Board is closely monitoring performance.

Appendix 2

Could you provide the Committee with a summary of the controls which the Department has in place to mitigate the risk that consultants may be incentivised to cancel public patient treatments to boost demand for their private patient treatments?

Firstly, there is an ethical requirement placed on doctors to put the interests of their patients first. *Good Medical Practice*, the General Medical Council's (GMC) core guidance for all registered doctors, states (para. 78) "You must not allow any interests you have to affect the way you prescribe for, treat, refer or commission services for patients." This guidance was developed further by the GMC in *Financial and commercial arrangements and conflicts of interest*, published in 2013. This latter guidance states (para 15) **"**You must not try to influence patients' choice of healthcare services to benefit you, someone close to you, or your employer." As with any guidance from the GMC, serious or persistent failure to follow this guidance will put a doctor's registration at risk.

There are a range of further controls in place to mitigate the risk that consultants may seek to boost demand for their private practice by cancelling health service commitments. These include the terms and conditions of the consultants' contract, the code of practice, job planning within trusts, the monitoring of outpatient cancellations and the delivery of agreed activity by trusts.

The Terms and Conditions of Service for Consultants in Northern Ireland (the consultants contract) contains at Schedule 9, *'Provisions governing the relationship between HSC work and private practice'.* In particular, paragraphs 24 and 25 relate to '*promoting improved patient access to HSC Care'*

> *'Subject to clinical considerations, the consultant is expected to contribute as fully as possible to reducing waiting times and improving access and choice for HSC patients. This should include ensuring that, as far as is practicable, patients are given the opportunity to be treated by other HSC colleagues or by other providers where this will reduce their waiting time and facilitate the transfer of such patients.*
>
> *The consultant will make all reasonable efforts to support initiatives to increase HSC capacity, including appointment of additional medical staff and changes to ways of working.'*

In addition, consultants are expected to comply with the 'Code of Conduct for Private Practice', which sets out standards of best practice for HSC consultants in Northern Ireland about their conduct in relation to private practice. Consultants should ensure that, except in emergencies, private commitments do not conflict with HSC activities included in their HSC job plan.

Consultants should ensure in particular that:

- private commitments, including on-call duties, are not scheduled during times at which they are scheduled to be working for the HSC;

- there are clear arrangements to prevent any significant risk of private commitments disrupting HSC commitments, e.g. by causing HSC activities to begin late or to be cancelled;
- private commitments are rearranged where there is regular disruption of this kind to HSC work; and
- private commitments do not prevent them from being able to attend a HSC emergency while they are on call for the HSC, including any emergency cover that they agree to provide for HSC colleagues.

Effective job planning should minimise the potential for conflicts of interests between different commitments. Consultants working within the Trust are required through the job planning process to agree with the Trust a timetable which outlines their commitments to the Trust and to their private sector work. All consultants are expected to complete and review their job plan on an annual basis with their employer. This review should include a review of the consultant's activity levels, where and when work is completed. An effective job plan review should ensure that consultants are complying with the terms and conditions of their employment as noted above.

The cancellation of out-patient clinics is also monitored and analysed in Northern Ireland by the Information Analysis Directorate, DHSSPS. The rationale for cancellation is analysed by Trust, by outpatient type and by reason. This information is published annually and trusts are required to manage cancellations attributable to both professionals and patients.

Trusts require consultants to formally request cancellation on clinical sessions and to provide the reason for cancellation. Clinical sessions are only cancelled when approval has been given by senior management. The number of clinical sessions cancelled and the reasons for cancellation are discussed and monitored by Trusts.

Trusts are set Service Budget Agreement activity levels by the HSC Board for all specialities and achievement of these is closely monitored within trusts, with any under delivery of activity investigated.

Within trusts the booking of clinical sessions is also closely monitored to ensure that lists are fully booked.