



House of Commons
Committee of Public Accounts

The use of operating theatres in the Northern Ireland Health and Personal Social Services

**Seventh Report of
Session 2005–06**

*Report, together with formal minutes,
oral and written evidence*

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The Committee of Public Accounts

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Contents

Report	<i>Page</i>
Summary	3
Conclusions and recommendations	6
1 The spare capacity in hospital operating theatres that is not being utilised and its impact on patients waiting for operations	8
2 The scope for better theatre management and control	11
3 The scope for improving the planning and organisation of theatre sessions and the need to improve the measurement and monitoring of theatre utilisation	13
4 The shortage of theatre staff and the limited availability of beds	16
Staffing	16
Bed Management	16
Formal minutes	18
Witnesses	19
List of written evidence	19

Summary

The extent to which hospital operating theatres are used and managed efficiently and effectively is a key issue in the overall use of hospital resources in Northern Ireland. Decisions relating to the use of operating theatres are directly related to the availability of hospital staff and beds, and to the volume and nature of emergency cases. Some 36% of available weekday theatre capacity is not being used, with little use of theatres in the evenings and weekends. This has to be viewed in the context of Northern Ireland's waiting lists and waiting times for treatment, which are currently the worst in the United Kingdom, and the spending in Northern Ireland on acute health services, which has been higher than any other region in the UK, apart from Scotland. Better use of operating theatres would contribute to reducing the length of time which patients have to wait for treatment.

Figure 1: Comparative Inpatient Waiting Lists, June 2004

Waiting List Measure	Northern Ireland	Wales	England	Scotland
Inpatients waiting for treatment per 1,000 population	30.04	25.87	22.23	17.87
Inpatients waiting 12 months or more per 1,000 population	4.041	3.063	0.011	0.00

Source: *Waiting for Treatment in Hospitals, Northern Ireland Audit Office, November 2004, NIA 132/03*

Figure 2: Per Capita Acute Service Expenditure by a Sample of Regions, 1999–2000

Region	Acute £ / head
Scotland	336
Northern Ireland	329
Wales	326
North East England	321
Republic of Ireland	315
South West England	288
Mersey	254
North West England	239

Source: *DHSSPS Acute Hospitals Review Group Report, June 2001*

On the basis of a Report by the Comptroller and Auditor General for Northern Ireland,¹ the Committee took evidence from the Department on four main issues:

- the spare capacity in hospital operating theatres that is not being utilised and its impact on patients waiting for operations;
- the scope for better theatre management and control;
- the scope for improving the planning and organisation of theatre sessions and the need to improve the measurement and monitoring of theatre utilisation;
- the shortage of theatre staff and the limited availability of beds.

As a result of our examination, we drew the following main conclusions:

There is significant spare operating theatre capacity to accommodate initiatives to reduce the unacceptably high waiting lists and waiting times in Northern Ireland

- There is no convincing explanation as to why Northern Ireland, with the highest level funding in the UK (apart from Scotland) does not get the return on the use of its theatres which is obtainable in other parts of the UK. Relatively high per capita funding, significant idle theatre capacity and deprivation and morbidity levels that are no higher than some other areas in the UK are hard to reconcile with waiting list and waiting time performance that is the worst in the UK. This is even more inexplicable given the Department's assertion that the current pattern of use of theatres in Northern Ireland matches the pattern of use in the rest of the UK.

There is scope for better theatre management and control

- A major element in improving operating theatre efficiency is the development of an effective theatre services management structure, and the establishment of a theatre policy and guidelines, together with computerised data collection systems. It is clear to this Committee that there were deficiencies in the management and control of operating theatres in Northern Ireland and that there is considerable scope for improvements and restructuring of operating theatre management in hospitals.

The need for better planning and organisation of theatre sessions and the measurement and monitoring of theatre utilisation must be addressed

¹ *The use of operating theatres in the Northern Ireland Health and Personal Social Services*, Northern Ireland Audit Office, April 2003, HC 552, NIA 111/02.

- We are alarmed at the incidence of operations cancelled at the last minute for a variety of reasons, for example, patients failing to attend for surgery, patients unfit for surgery, session overruns, delayed discharge from hospital. Some of these are perfectly avoidable. Reasons given for some others are inexcusable (for example, the persistent taking of annual leave at the last minute by consultants). They result in an unnecessary waste of theatre resources, which is totally unacceptable, given that Northern Ireland has the worst waiting list performance in the United Kingdom. We expect the Department, with Trust co-operation, to measure and monitor the rate and reasons for last minute cancellations, set targets for their reduction, and invoke sanctions on staff when necessary. Proper theatre management systems must be introduced throughout the HPSS to facilitate this.

There is a shortage of theatre staff and the availability of beds is limited

- The current level of consultant and theatre nursing under-staffing and the limited availability of beds in Northern Ireland's acute hospitals is a matter of great concern to the Committee.

Action taken since the C&AG's Report has produced measurable improvements

- The Department of Health, Social Services and Public Safety has accepted and told us that it has implemented all of the C&AG's 43 recommendations. Measures are being taken to improve the management of theatres, including the creation of more effective theatre utilisation committees, the deployment of theatre managers with appropriate authority, and the introduction of a new theatre management information system, which will be a common computerised system across all trusts. The Department is monitoring the theatre utilisation performance of each and every trust and their implementation of the C&AG's recommendations. While the actual use of theatre capacity has increased slightly since the C&AG's Report, from 63% to 64%, the Department would see improving that ratio to 70% as a reasonable intermediate aspiration. We welcome this positive response but we expect the Department to ensure that more progress is made and maintained. We will be monitoring progress closely.

Conclusions and recommendations

The sizeable spare capacity in hospital operating theatres that is not being utilised and its impact on patients waiting for operations

1. Theatres are scheduled to open seven hours (ie two sessions) each day for five days a week. There is, therefore, significant spare capacity in the evenings and at the weekends that could potentially be used, but for the most part is not. Even within the scheduled weekday use, theatres are, on average, idle almost 40% of the time.
2. More use should be made of theatres during weekdays, in the evenings and at the weekends to reduce waiting lists and waiting times that currently are at an unacceptably high level compared to the rest of the UK. Patients can suffer and their health can deteriorate while waiting for hospital treatment.
3. We recommend that the Department review current theatre utilisation patterns at individual hospitals with a view to their maximisation, and negotiate with consultants, within the terms of the new consultant's contract, to work on weekday evenings and at the weekends.

The scope for better theatre management and control

4. The Department has told us that it has implemented all 43 recommendations made in the C&AG's Report, including those on theatre management and control. It has been working with Trusts to ensure that they take all the recommended measures that are needed. This is commendable, but it is important that action is sustained and we have asked the NIAO to keep progress under review.
5. A new common computerised theatre management information system, to be introduced in 2005 throughout the HPSS, will facilitate improved theatre management and control, giving a common, consistent information base on which to compare the performance of each and every Trust. The Department needs to ensure that the existing computerised theatre management systems developed within some Trusts are compatible with this new system and that consultants co-operate fully in managing and using the new system.

The scope for improving the planning and organisation of theatre sessions and the need to improve the measurement and monitoring of theatre utilisation

6. Many of the reasons given for the last minute cancellation of operations are indicators of poor management, where the planning and organisation of theatre sessions could be improved. They include annual leave taken at the last minute by consultants; patients not turning up for surgery; patients found to be unfit for surgery; constant overruns of theatre lists by individual surgeons, and beds becoming unavailable due to the delayed discharge of patients from hospital.

7. With appropriate management such cancellations are avoidable. The Department must view the consequences of last minute cancellation of operations, in terms of a waste of resources and nugatory cost. The rate and reasons for cancelled operations need to be systematically measured and monitored by Trusts and the Department, and remedial action taken to reduce the incidence of cancellations, particularly those which are avoidable. The Department needs to set targets for reducing cancellation rates, and performance against these targets must be measured and closely monitored.
8. There was evidence of incorrect and inconsistent disclosure of utilisation data by Trusts, raising concerns about the validity of the annually published theatre utilisation data. Trusts must have timely and reliable data to compare their performance against that of other Trusts, and theatre utilisation data has to be reliable if the Department is to fulfil its monitoring and planning roles. The new common computerised theatre management systems to be introduced in 2005 throughout the acute hospital sector should facilitate this.

The shortage of theatre staff and the limited availability of beds

9. The level of consultant and theatre nursing under-staffing and the limited availability of beds is a matter of great concern and it is clear to this Committee that workforce planning and management, and better bed management is needed by both Department and Trusts. The Department told us it has now set out a definitive strategy for meeting its overall future workforce commitments, but pressure needs to be maintained by the Department to prevent slippage. It also needs to look to best practice on bed management, and to increase the volume and range of day surgery procedures to release hard-pressed inpatient surgical beds.

1 The spare capacity in hospital operating theatres that is not being utilised and its impact on patients waiting for operations

1. We were surprised to learn that, in 2001–02, there was sizeable spare physical weekday theatre capacity of 37% in Northern Ireland, yet waiting lists and waiting times were the worst in the United Kingdom. Theatres are scheduled to open seven hours (for two sessions) each day for five days a week. In view of the very high waiting lists, we are amazed that theatre sessions are not planned for the evenings or weekends. Leaving aside the fact that theatres are, for the most part, lying idle during these periods, we find it incredible that, even within the potential ten weekday sessions available each week, theatres are on average, lying idle also for 37% of that scheduled time, and in many cases more than this.²

2. The Department told us that, since the C&AG's Report, there has been a modest improvement in theatre utilisation. Spare week-day theatre capacity is currently 36%.³ However, whilst Northern Ireland's waiting list performance has improved since 2001–02, it still remains the worst in the UK.⁴

3. The Department claimed that a benchmarking exercise, which it commissioned in 2003–04, confirmed that the current utilisation figure of 64% in Northern Ireland exactly matched a sample of 16 trusts in Great Britain.⁵ In the absence of knowing how representative this small sample is for comparison with Northern Ireland, we asked the C&AG to assemble a comparative chart. This information is provided below.⁶

4. According to a national report by the Audit Commission in 2003,⁷ a well-used theatre unit would average more than 40 hours use per theatre per week, but very few units are actually this busy and the average unit in Great Britain and Northern Ireland is used for only 25 hours work per theatre per week, but this varies between Trusts from 9 to 47 hours. In Northern Ireland, the average unit is used for only 21 hours per week but varies between hospitals from 10 to 38 hours.

2 C&AG's Report, paras 4.10, 4.13, 5.48, Figure 8; Qq 2, 30–43, 149–153

3 Q 2

4 *Waiting for Treatment in Hospitals*, C&AG's Report, November 2004, NIA 132/03; Ev 20; Q 142

5 Qq 2, 109, 121–123; Ev 19; Q 123

6 Ev 20; Q 122

7 *Operating Theatres: Review of National Findings – Acute Hospital Portfolio*, Audit Commission 2003; Ev 20

Figure 3: Total Actual Operating Hours / Week per Commissioned Theatre

	NI only Hours per week	GB and NI Hours per week
Upper Quartile	24.6	29
Mean	21.2	25.2
Lower Quartile	15	21.3

5. Only four of the sixteen Northern Ireland hospitals reviewed were found to be on or above the Great Britain mean, with two of them in the upper quartile. Twelve Northern Ireland hospitals were found to be below the mean, with eight in the lower quartile.⁸

6. The Department wishes to increase the use of operating theatres from their current 67% of capacity to around 70%.⁹ However, there remains in Northern Ireland, significant spare theatre capacity during weekdays, in the evenings, and at the weekends, that is currently not being used and could potentially be used.

7. The Department told the Committee that operating theatres cannot be used more than seven hours a day, five days a week because of the difficulties of getting staff and having the resources to fund them, and because patients do not really like to be treated outside normal hours.¹⁰ We do not accept this. The funding in Northern Ireland is the highest in the United Kingdom, with the exception of Scotland, while waiting lists and waiting times are the longest. This, according to the Department, is because Northern Ireland experiences higher levels of deprivation, disability and morbidity — but so do other regions in the United Kingdom, particularly areas in large cities.¹¹ We find it inexplicable that Northern Ireland still does not seem to be able to get the return on its theatre assets (acquired at a considerable cost) which is obtainable in other parts of the United Kingdom at much lower levels of funding.¹²

8. More use should be made of theatres in the evenings and at the weekends to reduce and maintain waiting lists and waiting times that currently are at an unacceptably high level compared to the rest of the United Kingdom. Patients can suffer and their health can deteriorate while waiting for hospital treatment. No doubt, extending operating hours into the evening and weekends would require changes in staff working arrangements, but such working patterns are happening in the NHS, and there is no real reason it cannot be done in Northern Ireland.¹³

8 Ev 20

9 Q 29

10 Qq 63–69

11 Qq 2, 108

12 Q 167

13 Qq 42–43, 193

9. The cost of providing and staffing operating theatres is very high. The Department and Trusts should, therefore, be mindful of the waste of resources if those operating theatre assets are underutilised, and the scope for the potential rationalisation of theatre numbers.¹⁴ The Department, with Trusts, needs to keep theatre utilisation patterns at individual hospitals under constant review, and negotiate with consultants, within the terms of the new consultant's contract, to work on weekday evenings and at the weekends.

2 The scope for better theatre management and control

10. The C&AG's Report shows that there is considerable scope for improvement and restructuring of theatre service management and control in Northern Ireland's acute hospitals, recommending that all theatre departments should have a theatre manager with sufficient seniority and authority to review regularly how theatres are being used by clinicians, and to ensure that theatre users' committees develop their key role in ensuring the effective use of theatres.¹⁵ Systems for the planning and monitoring of theatre activity in most acute hospitals were found to be basic, paper-based, labour intensive, and limited in their capacity, with the data collection and reporting on theatre use, prone to error.¹⁶

11. Evidence of incorrect and inconsistent disclosure of theatre utilisation data by individual Trusts was found, raising concerns about the validity of the annually published theatre utilisation data. Inconsistency, inaccuracy, and unreliability in published theatre utilisation data renders publication quite pointless and comparisons useless. Theatre costing facilities were not developed within hospitals' theatre management information systems so that no unit cost comparisons could be made between hospitals. It is important that the Department and the Trusts are able to benchmark their performance against other providers, and without timely and reliable data this will not be possible.¹⁷

12. We were concerned to learn of the fragmented theatre management structures within one of the largest acute hospitals in Northern Ireland, the Royal Victoria Hospital (RVH). These did not facilitate the good use of its 20 theatres.¹⁸ Commenting, in particular, on the considerable scope for improving the management of the theatres in Northern Ireland's Regional Cardiac Surgery Unit at the RVH, the C&AG noted that the role of theatre manager was not being exercised at a sufficiently senior level and the Unit did not have a dedicated theatre users' committee. The unit's manual information systems were found to be time consuming and unreliable as an accurate source of information on the use of its three theatres.¹⁹

13. Against this background, we asked the Department whether it had defined and agreed with Trusts a common set of performance measures for the use of operating theatres.²⁰ We were told that the Department has implemented all the recommendations made in the C&AG's Report for improving theatre management and control. It has been working with Trusts to ensure that they take all the measures that are needed. This has included the introduction of more effective theatre user committees, and the deployment of theatre

15 C&AG's Report, paras 2.83–2.85

16 *ibid*, paras 2.14–2.20, 2.86, Figure 4

17 *ibid*, paras 2.86–2.87, 4.20–4.24, 4.60–4.69

18 *ibid*, para 2.50

19 *ibid*, paras 2.37–2.42, 2.50

20 Q 9

managers vested with appropriate authority that are now in place in every acute hospital in Northern Ireland. A new computerised theatre management information system, to be introduced in 2005, will facilitate improved theatre management and control, giving a common consistent information base on which to compare the performance of each and every Trust. The Department needs to ensure that the existing computerised theatre management systems developed within some hospitals are compatible with this new system, and it is essential that consultants co-operate fully in managing and using the new system.²¹

21 Qq 4, 9, 16, 78-98, 198

3 The scope for improving the planning and organisation of theatre sessions and the need to improve the measurement and monitoring of theatre utilisation

14. Many of the reasons given by acute hospitals for the last minute cancellation of operations are indicators of poor management, where the planning and organisation of theatre sessions could be improved. They include annual leave taken at the last minute by consultants; patients not turning up for surgery; patients found to be unfit for surgery; constant overruns of theatre lists by individual surgeons, and beds becoming unavailable due to the delayed discharge of patients from hospital.²² The Department added that principally, and increasingly over recent years, it has been the use and availability of intensive care and critical care capacity.²³

15. There is a need for advance notice of planned leave by surgeons and nurses to facilitate proper planning and organisation of theatre lists. The C&AG's Report cited instances in one particular hospital where planned theatre sessions had to be cancelled because some consultant surgeons were persistently taking leave at the last minute leaving no time for redeployment of scheduled anaesthetic cover, and resulting in a waste of resources.²⁴ We find this to be totally unacceptable.

16. The Department told us that, under new theatre management arrangements introduced since the C&AG's Report, such practice should not, and could not, arise and would be penalised within current arrangements.²⁵ The theatre managers and theatre user committees that are now in place in every hospital have powers to take whatever action is appropriate. Doctors who persistently go on leave without giving enough notice would be in breach of contract and could face disciplinary procedures. Offending surgeons could lose their operating time which could then be allocated to somebody else.²⁶ However, the Department has advised us that there have been no cases where a Trust has had to initiate disciplinary proceedings against any doctor for failing to fulfil their contractual commitments as a consequence of persistent non-compliance with local protocols for the notification of attendance at operating sessions.²⁷

17. The most common reason for operations being cancelled at the last minute was that the patient did not turn up for surgery.²⁸ At 30%, this is much too high and we would expect

22 C&AG's Report, Appendix 3; Q 119

23 Q 14

24 C&AG's Report, para 3.11

25 Qq 73–74

26 Qq 155–157, 194–198

27 Ev 19

28 C&AG's Report, para 4.25, Appendix 3, Q 120

the Department to try to identify the reasons for this and, where clinically acceptable, to be proactive in introducing appropriate measures to lessen what is clearly a waste of valuable clinical effort and of other resources.

18. In the NHS in England, if an operation is cancelled by a hospital at the last minute for non-clinical reasons there is a guarantee that offers another binding operation date within 28 days. We find it outrageous that there is no similar guarantee in Northern Ireland and, although we have heard the Department's comments about the shortage of funds, we strongly recommend that it should strive to introduce such a target as soon as possible.²⁹

19. A National Booked Admissions Programme is being implemented in the NHS in England which has resulted in improvements in the rate for patients not attending for surgery.³⁰ The implementation of this national programme in Northern Ireland should enable the Department to save on the costs of non-attenders which the Department has calculated for 2003–04 at some £2.5 million (based on an estimated average cost of £2,500 per operating session). The Department have told us that they are currently exploring partial booking arrangements.³¹ Booking arrangements should be actively pursued by the Department to minimise the cost of underutilised theatre capacity, and we shall be monitoring closely progress by the Department in implementing such arrangements.

20. Operations can be cancelled at the last minute because patients are found to be unfit for surgery, yet it seems that little use was made of pre-admission assessment clinics in hospitals.³² We welcome the Department's assurance that most specialties in hospitals are now doing a pre-assessment.³³ We think that, unless there are prevailing clinical reasons for not doing so, pre-assessment should be a standard procedure in all acute hospitals in order to reduce the incidence of last minute cancellations due to patients not being fit for planned treatment and we recommend that the Department promotes such activity.

21. A significant cause of the last minute cancellation of operations is where beds become unavailable due to the delayed discharge of patients. Such bed blocking is also a big problem in the NHS, but we cannot understand why this should be replicated in Northern Ireland where the funding and organisation of health and social services are integrated and should therefore present less of a problem than elsewhere in the United Kingdom, where the two services are separate.

22. We cannot accept that the problem is due primarily to the unavailability of funds to enable patients to transfer to residential or nursing accommodation or to domiciliary care, given that the health service in Northern Ireland has some of the highest funding in the United Kingdom. We are, therefore, not convinced of this funding excuse for the high incidence of last minute cancellations due to delayed discharges. The Department must take the necessary measures, offered by good practice elsewhere in the NHS, to improve

29 C&AG's Report, para 4.28; Qq 74–75

30 C&AG's Report, paras 4.32–4.33

31 Qq 183–185; Ev 20

32 C&AG's Report, paras 4.37, 4.43

33 Q 118

the management of the discharging process after treatment. This may require them to push for a greater influence with the private sector, for example, on the siting of residential and nursing homes.³⁴

23. The Department also needs to view the consequences of last minute cancellation of operations, for whatever reasons, in terms of the waste of resources and nugatory cost. The rate of, and reasons for, cancelled operations need to be systematically measured and monitored by Trusts and the Department, and remedial action taken to reduce, where possible, the incidence of avoidable cancellations. Targets should be set for a reduction in cancellation rates, and performance against these targets measured and closely monitored.³⁵ We expect to see the Department produce and monitor, a measurable monetary reduction in the level of wasted resources arising from avoidable cancellations.

34 C&AG's Report, para 5.11, Appendix 3; Qq 168–175

35 Qq 163–166

4 The shortage of theatre staff and the limited availability of beds

Staffing

24. The C&AG's Report revealed considerable shortfalls in the numbers of consultant and theatre nursing staff.³⁶ The Department told us that one of the underlying causes was a loss of capacity in the 1990s as a result of a reduction imposed on its baseline. This resulted in a number of posts disappearing and a number of beds being taken out of the system. Since then, it has taken a number of measures to correct this, including creating extra medical student places, substantially increasing the number of nursing student placements, and extensive recruitment of nursing staff in places outside the United Kingdom, notably the Philippines and India.³⁷

25. It is clear to us that the numbers of medical and nursing staff in training in recent years have been insufficient to meet the needs of the health service in Northern Ireland. This points to the need for improved workforce planning and management by the Department.

26. As part of this, it needs to monitor such matters as the rate of medical and nursing student withdrawals from training each year, and it needs to establish the reasons for withdrawal with a view to reducing the incidence of fall-out rates, which amounts to a nugatory cost to the health service. For those that complete their training, the Department should monitor the rate of those who do not take up posts in Northern Ireland, and establish the reasons for leaving so that appropriate measures can be taken to retain this expensive resource.

27. We have noted that the Department has now set out a definitive strategy for meeting its overall future workforce commitments. We welcome this, but pressure needs to be maintained by the Department to prevent slippage in this strategy.

Bed Management

28. In addition to the availability of beds due to delayed discharges, bed availability and bed management are major issues affecting the efficient running of theatres, the use of resources, and the availability of treatment for patients. One of the main reasons for the cancellation of surgical procedures was because beds were unavailable as they were occupied by new emergency cases, and/or because there was a shortage of intensive care beds (costing on average £500,000 per bed) and high dependency beds (costing on average £300,000 per bed).³⁸

36 C&AG's Report, paras 5.17–5.47

37 Q 10

38 Q 26

29. This Committee reported a similar situation in the NHS in 2001, and made recommendations on best practice in bed management. We expect the Department to ensure that it is complying with these.³⁹

30. The appropriate use of day surgery procedures, rather than inpatient surgery, affects the use and availability of beds. Any transfer of appropriate surgery from inpatient beds to day surgery should release some of the currently hard-pressed inpatient surgical beds in Northern Ireland's acute hospitals. It is evident to us that there is scope for increasing the volume and range of day surgery procedures, particularly in the light of the expected day surgery targets currently prevailing in Great Britain, and the Department must address this.⁴⁰

39 C&AG's Report, paras 5.6, 5.10–5.16

40 *ibid*, paras 5.49–5.56

Formal minutes

Monday 18 July 2005

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon
Mrs Angela Browning
Greg Clark
Helen Goodman
Ms Diana R Johnson

Mr Sadiq Khan
Sarah McCarthy Fry
Jon Trickett
Mr Alan Williams

Draft Report (The use of operating theatres in the Northern Ireland Health and Personal Social Services), proposed by the Chairman, brought up and read.

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

Paragraphs 1 to 30 read and agreed to.

Conclusions and recommendations read and agreed to.

Summary read and agreed to.

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

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

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

[Adjourned until Wednesday 12 October at 3.30 pm]

Witnesses

Tuesday 2 November 2004

Page

Mr Clive Gowdy CB, Dr Ian Carson, and Mr Andrew Hamilton, Northern
Ireland Department of Health, Social Services and Public Safety

Ev 1

List of written evidence

Northern Ireland Department of Health, Social Services and Public Safety

Ev 19

Northern Ireland Audit Office

Ev 20

Oral evidence

Taken before the Committee of Public Accounts

on Tuesday 2 November 2004

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Allan
Mr Richard Bacon
Mr David Curry

Mr Brian Jenkins
Mr Gerry Steinberg

Mr John Dowdall CB, Comptroller and Auditor General for Northern Ireland, Northern Ireland Audit Office, examined.

Mr David Thomson, Northern Ireland Treasury Officer of Accounts, examined.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL FOR NORTHERN IRELAND:

The Use of Operating Theatres in the Northern Ireland Health and Personal Social Services (HC 552)

Witnesses: **Mr Clive Gowdy CB**, Permanent Secretary and Accounting Officer, **Dr Ian Carson**, Deputy Chief Medical Officer, and **Mr Andrew Hamilton**, Deputy Secretary, Primary, Secondary and Community Care Group, Northern Ireland Department of Health, Social Services and Public Safety, examined.

Q1 Chairman: Good morning, ladies and gentlemen. Welcome to the Committee of Public Accounts of the United Kingdom. We are here, and we are delighted to be here, at Stormont in view of the fact that the Northern Ireland Assembly is currently suspended but we very much hope that this will be our last visit here because we very much look forward to the resumption of what I understand to have been an excellent Northern Ireland committee. I think this will be a very interesting hearing for us and we are much looking forward to it. We have got two very interesting subjects. The first is the use of operating theatres in the Northern Ireland Health and Personal Social Services. We are joined by witnesses from the Northern Ireland Department of Health, Social Services and Public Safety. Our first witness is Mr Clive Gowdy, who is Permanent Secretary and Accounting Officer. You are very welcome. Would you like to introduce your two colleagues, please?

Mr Gowdy: On this side I have Mr Andrew Hamilton, who is Deputy Secretary in the Department, and on my left-hand side, Dr Ian Carson, who is Deputy Chief Medical Officer.

Q2 Chairman: Thank you very much. We look to this Report with concern because we understand that spending on acute health services in Northern Ireland has been higher than any other region in the United Kingdom, apart from Scotland. These services are provided by 21 acute hospitals which, between them, have a total of 109 operating theatres, serving a population of some 1.7 million. It seems to us that this is a relatively generous provision and we would like to determine this morning why performance has not been better. Perhaps I could start by asking, Mr Gowdy, if you could please look

at figure eight in the Comptroller and Auditor General's Report, which you can find on page 66. You will see there that 37% of available weekday physical theatre capacity is not being used and yet we also understand that Northern Ireland has the longest hospital waiting lists in the United Kingdom. How can you explain then the co-existence of long waiting lists with substantial spare physical theatre capacity?

Mr Gowdy: Chairman, if I might make a point prior to picking up on your introductory remarks. Yes, we do have higher *per capita* spend on health here in Northern Ireland than in England. That is a reflection of the high levels of need we have. We have higher levels of morbidity, higher levels of disability and higher levels of deprivation, all of which are associated with higher levels of need for health and social services. That is by way of context. In terms of the utilisation of our theatres, we would certainly accept that the point that is being made in this Report is one that we need to take very seriously. It is important that we should seek to get the greatest productivity and greatest efficiency out of the use of our theatres, but there are a number of points that I am sure the Committee would find helpful by way of explanation. In terms of our use of theatres, we are comparable with what is happening elsewhere in the United Kingdom. Our pattern of use of theatres matches the pattern of use in the rest of the United Kingdom. In fact, our current utilisation figure, which has now risen to 64%, matches exactly a sample of trusts that we have compared ourselves with in England. We are not wildly out of kilter with the rest of the UK. I think it is also important to make the point that this figure of 63% utilisation actually masks a number of different things. It is an overall average for all theatres that are used in

Northern Ireland Department of Health, Social Services and Public Safety

Northern Ireland. As I am sure the Committee will appreciate, theatres are used for different purposes and in different places. One point to make is that a number of theatres are dedicated for emergency use and have to be kept ready for those emergencies and they are counted in these figures. It is also the case that a number of theatres are used for speciality procedures, such as obstetrics, some used for particular cancer operations, and virtually by definition their utilisation rate is significantly lower. We also have a number of theatres which are in rural hospitals and the catchment area for those rural hospitals and the throughput of cases is substantially lower.

Q3 Chairman: I must stop you there because in our Committee, as you know, Members do like to have short answers because they are time limited. The fact remains that you—or perhaps you do not—have the longest waiting lists in the United Kingdom, is that right?

Mr Gowdy: We have the longest waiting lists.

Q4 Chairman: You have the longest waiting lists in the United Kingdom, yet 37% of available weekday physical theatre capacity is not being used. You have given us a number of excuses but what we would like to now know from you is how you are going to meet the needs of the population of Northern Ireland, who are presently suffering from the longest waiting lists in the United Kingdom, by resolving this problem.

Mr Gowdy: We have taken very seriously the recommendations that have been made in the Audit Office Report and we have been working with our trusts to ensure that they take all the measures that are needed. As the Report indicates, there are various dimensions to this: the management of theatres, the introduction of theatre information systems, and putting as much as we can into utilising the theatres effectively. What we have been able to achieve through this is a system which is functioning better than it was at the time of the Report. All of the recommendations, with one or two exceptions, have now been fully implemented and we expect all of the recommendations to be in place by the end of—

Q5 Chairman: We will stop you there because we often get this answer but what we would like to know is why we had to wait for an NAO Report for these recommendations to be carried out. Can you please turn to figure nine on page 68 which deals with the actual use of planned sessions in Northern Ireland's largest hospital trust, the Royal Group of Hospitals Trust? You will see there that the Royal Group of Hospitals Trust were below the Bevan target of 90% of sessions cancelled. I take it that this is an agreed Report and, therefore, this figure is accepted. Why are so many sessions cancelled in this and other trusts?

Mr Gowdy: The figure you are looking at is 835?

Q6 Chairman: Yes, that is right.

Mr Gowdy: There are a number of reasons. I will try to keep my answers as brief as possible. Certainly we are seeing a number of very frail patients being dealt with whose condition can alter quite quickly.

Q7 Chairman: And that explains this level of cancellation?

Mr Gowdy: No, it does not. It is one of the factors that we have to take into account. There are also issues around the availability of staff to run the sessions. There are various reasons why they would not be available.

Q8 Chairman: Are you monitoring this to ensure that they are good reasons that are being given?

Mr Gowdy: Yes. We are doing two things. We are asking each of the trusts to take responsibility for managing the throughput of cases in their theatres and to do what they can to increase the utilisation. We are taking an overall monitoring look at how those trusts are doing that and what their outcomes are.

Q9 Chairman: I think other Members will want to come back on this. I am sure you know this Report very well and if you look at Part 4 of the Report—I would like to have a general answer—has your Department defined and agreed with trusts a common set of performance measures for the use of operating theatres so we can get some idea of what is happening around the Province? What theatre utilisation targets have been set for hospitals?

Mr Gowdy: We are introducing within the next 12 months a new theatre management information system which will be a common computerised system across all of our trusts. That will give us a common, consistent information base on which to compare the performance of each and all of the trusts. Also, we are expecting each of the trusts to report to us on the implementation—we have been doing this at six monthly intervals—of the recommendations made in the Audit Office Report plus in some of the other documents that we have issued to them from other bodies we have been dealing with in terms of theatre use.

Q10 Chairman: My last question relates to understaffing. This is dealt with in paragraphs 5.17 to 5.47 of the Comptroller and Auditor General's Report which you can find on pages 91 to 97. There is concern, is there not, about the level of consultant and nursing understaffing? Could you please explain to us what the reasons behind this are and what actions you are taking to rectify the situation.

Mr Gowdy: There are a couple of reasons which it is quite important to explain. One is that we did lose quite a lot of our capacity in the 1990s as a result of a reduction in our base line. A number of posts disappeared as a result of that and a number of beds were taken out of the system as well. What we have found is that the levels of demand have been rising to such an extent that we now need to rebuild our

Northern Ireland Department of Health, Social Services and Public Safety

capacity and that is in terms of beds, nursing and medical staff. We have done a number of things to try to correct this. One is that extra medical student places have been put into effect into at Queen's University Medical School. Similarly, we have taken action to increase very substantially the number of nursing students from 480 in the late 1990s through to the current figure of 750 per year. Also, we have been recruiting extensively in places outside the UK, notably the Philippines and India, to increase the number of nursing staff available to us. Theatre nurses in particular have been a problem area for us and we have been correcting that problem, but we still have some vacancies to address there.

Chairman: Thank you very much for those answers. Mr Curry?

Q11 Mr Curry: Mr Gowdy, if you look at the various tables there are lots of discrepancies between the performances of the trusts. Which is your best trust?

Mr Gowdy: All of our trusts are performing to high levels of utilisation against the planned sessions. Our planned sessions in theatre use are those for which the trusts are funded. As you can see from the tables, there is a very high degree of utilisation against those planned sessions. We think that our trusts are getting as much as they can with the level of funding that we have been able to give them.

Q12 Mr Curry: Which is the best one? In all theatres of life—operating theatres—some are good, some are bad and some are indifferent. Somebody must be at the top of the league table. If I am a journalist coming from the United States and I want to do a really good story about health care in Northern Ireland, where would you point me? Where would you like me to go to really get the best story?

Mr Gowdy: I am not trying to be evasive. I think that in this case what we have is a range of hospitals doing different things, they have got different case mixes, they have got different contexts within which they operate, some are rural, some are urban, some have a very wide span of specialities, others are narrower, and it is very difficult to make the sort of comparison that you are inviting me to make. From talking to all of our trusts, I believe that they treat very seriously the need to get the greatest efficiency out of their theatres but the circumstances differ.

Q13 Mr Curry: Which trust has got the greatest degree of surgeon absenteeism or sickness? Could you draw a league table on that?

Mr Gowdy: If I may, I will let Dr Carson say something about this because he has been involved quite closely in this.

Q14 Mr Curry: There is a remarkable phrase in the Report talking about surgeons not turning up, you see.

Mr Gowdy: It fluctuates from time to time in different areas. We have had some problems in terms of being able to recruit and retain enough anaesthetic consultants and other medical staff. Dr Carson may be able to say more about this.

Dr Carson: Thank you. The utilisation of our scheduled theatres across the Province is running at 95% at the moment. In fact, there are five trusts in which there have been no cancellations whatsoever of scheduled operating sessions and they are running at 100% utilisation of the scheduled capacity. As the Secretary has said, the perceived under-performance in certain organisations is influenced by a variety of factors. There are several factors that influence why an operating list gets cancelled, not just the absence of a surgeon on leave or whatever, there have got to be other services in place to enable an operation to take place. Principally, and increasingly over recent years, it has been the use and availability of intensive care and critical care capacity.

Q15 Mr Curry: I appreciate all that, but on pages 66 and 68 there just happen to be two tables. One is called "Actual Use of Theatre Capacity" and one is "Actual Use of Scheduled Sessions". I accept that is 2001–02 and things may well have moved on since then, but the fact is that sessions held as a percentage of sessions available run from 82% down to, say, 50%, because below that there are special factors at work obviously, and sessions held as a percentage of sessions intended go from 108% down to 76%. With all the factors brought together there are some people doing better than others, are there not?

Dr Carson: There is no doubt that there are individual variations in performance.

Q16 Mr Curry: There are good ones and less good ones.

Dr Carson: Yes. Having hinted to the Committee that performance has improved, not only since the Audit Office Report but since a variety of good guidance and practice has been shared with the service and the introduction of effective Theatre User Committees and good communication between trust managers and the staff who run and organise theatres, the performance has improved and is continuing to improve.

Q17 Mr Curry: I am going to leave consultants to the tender care of Mr Steinberg; I should hate to deprive him of one of his favourite topics. Can we look at cardiac surgery at the Royal Victoria? I think you have said already the Report says that the number of operations has gone down because older and sicker patients are being treated, that means more intensive care, that means fewer admissions so there are fewer operations and there is a catch-22 in operation. Surely this must be true of every large hospital in the known world, is it not? There is nothing unique to Northern Ireland about this, medical advances are making it possible to treat older and sicker patients. Is this phenomenon happening everywhere or is it particularly pronounced here?

Dr Carson: No, it is happening throughout the UK in relation to cardiac surgery. We do have an ageing population. We have had very significant advances in cardiology with interventions at the early stage of heart disease which means that the patients who are coming forward for cardiac surgery now are older and sicker and may well be at end stage of

Northern Ireland Department of Health, Social Services and Public Safety

cardiovascular disease. It is a sicker population requiring much more intervention in the post-operative intensive care period.

Q18 Mr Curry: There are other factors which you admitted as well, that perhaps there were not enough staff, no cover when surgeons were on holiday, the record keeping was not particularly sophisticated, there was no fast tracking. Demography is against you on this, is it not? Does this mean this is always going to happen? What do you do to buck demography on this as people are getting older and more dodderly and medical advances are increasing? Are you not going to be running faster to keep still on this one, as it were? How do you break out of that cycle?

Mr Gowdy: I think it is important to say that the nature of the treatment afforded to those with cardiac conditions has been changing. It is no longer the case that most people would go for a coronary artery bypass graft. Percutaneous interventions, stenting and angioplasty are much more prevalent. We are seeing a very substantial growth in those. In the year 2003–04 we had 1,600 of these percutaneous interventions and we expect to see that rise to just under 2,000 in the current year. The balance is changing away from bypass surgery. We are now able to treat patients with a range of different interventions, cardiological interventions, as well as surgery. If I may say, we are getting the waiting lists on cardiac surgery very substantially reduced. We have made use of facilities outside Northern Ireland and that has helped us to deal with some of the cases that could be transferred elsewhere, while dealing with the most difficult cases within the Royal Hospital.

Q19 Mr Curry: The key is what, the key is the technology, is that what you are saying, or is the key the management?

Mr Gowdy: It is advances in the care of cardiac patients. There are a range of interventions now available, including the use of statins and other drug treatments, as well as using stents to open the arteries. These sorts of things are now becoming much more prevalent and are usually treated on a day case basis. This is an easier and quicker way of dealing with some of these problems. Not every patient is suitable for it, of course, so we still need to have some cardiac surgery but the balance is changing substantially although the overall numbers we are treating are much greater.

Q20 Mr Curry: This was a sort of dip there, a dip where management and technology just so happened to create a problem?

Mr Gowdy: Yes. It is an advance in medicine in that we are now able to treat, through cardiac surgery, frailer, older patients than might have been the case before so there is a benefit to this patient group as a result of this.

Q21 Mr Curry: Let me move on. You state, I think, and I am sure the Auditor General would agree, that you cannot use capacity fully without more staff and more beds, is that right?

Mr Gowdy: Yes.

Q22 Mr Curry: Would you then take me up from 63% in, let us say, 5% steps and tell me how much more in terms of beds and staff and what the private sector call resources, and I call money, you need in order to keep moving up that step? What would be a good rate of utilisation? At what figure would you say you had got to where one could practically sustain it?

Mr Gowdy: If we could get to the 100% figure we would need something in the order of £48 million additional in our budget. That is in theatres alone predominantly paying for the staff and some of the consumables that are used. The predominant factor in it is staff. In addition to that—

Q23 Mr Curry: Present spend is what, just short of a billion, is that right?

Mr Gowdy: On theatres?

Q24 Mr Curry: A comparable figure.

Mr Gowdy: On our total acute services it is £800 million.

Q25 Mr Curry: You have just quoted, what, £50 million. What is the comparable figure already being spent?

Mr Gowdy: That is multiplying up the number of sessions. £2,500 per session is the cost, roughly, that we have worked out. We could do a quick calculation.

Q26 Mr Curry: An increase in terms of cost?

Mr Hamilton: The pro rata increase, if we are operating around 63% of our total capacity and the additional one-third, would cost £48 million. On a *pro rata* basis we are spending approximately £100 million at the moment on theatres.

Mr Gowdy: In addition, you would need to have in place the beds for recovery and they are quite expensive. An intensive care unit bed costs on average £500,000 per bed. For a high dependency unit bed it is about £300,000. It is very expensive to put in place the post-operative care arrangements that are needed, particularly when you are dealing with older, frailer patients.

Q27 Mr Curry: Okay, that is 100%. Give me one point between 63% and 100% that you think is a reasonable intermediate goal and the cost that goes with it and the time frame for getting there.

Mr Gowdy: Certainly we would want to increase by a couple of per cent each year if we could. We can very quickly work out what those figures are. It is not just simply putting in the money, it is recruiting the staff. We can let you—

Q28 Mr Curry: Where you are trying to get to is what I am anxious to get from you.

Northern Ireland Department of Health, Social Services and Public Safety

Mr Gowdy: I would certainly like to—

Q29 Mr Curry: Not aspirationally but reasonably.

Mr Gowdy: I would certainly like to see us get up as close to around 70%. I think that is a reasonable aspiration. It depends on getting the staff in place. It is not simply us putting the extra money in, it is needing the physical capacity to put the beds in place and having the nursing and medical staff to support that. There are some limits in terms of the fact that this is a small province, it is difficult for us to recruit and so on. An aspiration that is realistic is 70% for us, I think.

Chairman: Thank you very much for that. Mr Steinberg?

Q30 Mr Steinberg: Thank you, Chairman. Mr Gowdy, 37% is quite a remarkable figure really when you consider that theatres are standing empty almost 40% of the time, in fact it could be 40%, could it not, because this 37% could be a lot worse, could it not?

Mr Gowdy: It is a point I was making at the start, that there are variations in terms of the nature of hospitals.

Q31 Mr Steinberg: It could be more than 37%.

Mr Gowdy: In some cases it is definitely more than 37%.

Q32 Mr Steinberg: I cannot believe that.

Mr Gowdy: What you need to appreciate is that some of the theatres are used for emergency use exclusively.

Q33 Mr Steinberg: You have explained that. Tell us some basic facts. Tell us, how long are the theatres open each day?

Mr Gowdy: Primarily they are open two sessions each day for five days a week. That is a morning session and—

Q34 Mr Steinberg: How long is a session?

Dr Carson: Three and a half hours was the traditional scheduled sessional commitment for a hospital consultant, a notional half day.

Q35 Mr Steinberg: Ah, here they come, the hospital consultants. So after three and a half hours, “Stitch him up lads, we are finished. We will go home for the day”.

Mr Gowdy: There are a couple of points that need to be made here. One is that operations can be estimated but not predicted. There is a range of circumstances. A patient may need a more difficult operation.

Q36 Mr Steinberg: I understand. So it is open three and a half hours in the morning and three and a half hours in the afternoon, seven hours a day. How many hours are there in a day?

Dr Carson: I could illustrate a normal working day for myself when I was a consultant anaesthetist in the cardiac surgical unit, if that would help.

Q37 Mr Steinberg: No, I would only lose my temper because you would probably substantiate what I think. How many days a week are they open?

Mr Gowdy: What we are dealing with here is—

Q38 Mr Steinberg: How many days a week are they open?

Mr Gowdy: Five days a week. There are also sessions used at the weekends and in the evenings for emergency sessions.

Q39 Mr Steinberg: We are going to get on to that.

Mr Gowdy: Or where we have been able to put in additional resources to allow that to happen.

Q40 Mr Steinberg: So they are open seven hours a day, five days a week and possibly at the weekends. How much money have you actually had in real terms increase in the last four to five years?

Mr Gowdy: In our overall budget?

Q41 Mr Steinberg: Yes.

Mr Gowdy: Mr Hamilton would be in a better position to deal with that. Can I just say to you very quickly that it is not a case of us not being able to run the theatres continuously from the earliest hours in the morning through to the latest hours at night but between each session the theatres need to be cleaned and any of the consumables that are used need to be put in place.

Q42 Mr Steinberg: A friend of mine is in the local hospital, my wife went to visit them on Sunday, and the operating theatres were being used at six o'clock on Sunday night for routine operations. Does that happen in Northern Ireland?

Mr Gowdy: It has happened on occasions when we—

Q43 Mr Steinberg: I am not talking about on occasions, does it happen?

Mr Gowdy: Not with the level of funding we have got.

Q44 Mr Steinberg: So how much real term increase have you had?

Mr Hamilton: Over the last few years in real terms increase for service development we have had about £30 to £40 million a year.

Q45 Mr Steinberg: Extra?

Mr Hamilton: Extra.

Q46 Mr Steinberg: What are you doing with it?

Mr Hamilton: That has been used to invest across a whole range of services right across from the community to life saving interventions.

Mr Gowdy: The introduction of new drugs.

Q47 Mr Steinberg: How many more operations have taken place since you have had the increase in resources?

Mr Hamilton: We have funded 2,500 additional sessions since the last report. That is additionality, additional sessions.

Northern Ireland Department of Health, Social Services and Public Safety

Q48 Mr Steinberg: So what was it before then? What was the capacity being used before that? If it is 37% now it must have been, what, around 15%?

Mr Gowdy: It has moved up. The figures that are in the Report relate to the 63%, something in the order of 30,500 sessions held in our theatres. In 2003–04 that had risen to 33,052 sessions which equates to a 64% utilisation. The point I was making earlier was we have aspirations to increase but it is not possible to make quantum jumps.

Q49 Mr Steinberg: Tell me, do you use the theatres for private operations?

Mr Gowdy: Pardon?

Q50 Mr Steinberg: Do the surgeons use the theatres for private operations?

Dr Carson: The private sector in Northern Ireland is very small. The majority of that private sector work is done in the independent hospital sector.

Q51 Mr Steinberg: You are not answering the question.

Dr Carson: There are some situations where private patients are done within NHS facilities, that is correct.

Q52 Mr Steinberg: When do they use the theatres?

Dr Carson: Those theatres may be set aside specifically for private sector time.

Q53 Mr Steinberg: So you are telling us that NHS theatres are being used for the private sector and 37% of the theatres stand empty at some stage during the year and private medicine and private operations are taking place during that 37%?

Dr Carson: Private sector medicine is not displacing NHS activity.

Q54 Mr Steinberg: It must be.

Dr Carson: No, it is not.

Mr Gowdy: If we had more funding we would put money in to increase the NHS activity.

Q55 Mr Steinberg: How much are consultants allowed to earn on top of their contracted wage in the private sector? Is it the same as in England?

Dr Carson: It is no different from England.

Q56 Mr Steinberg: 10%?

Dr Carson: There is no limit on what a consultant surgeon can earn in the private sector, no limit.

Q57 Mr Steinberg: Yes, there is a limit, 10% of their salary.

Dr Carson: That is if you wish to retain the full terms and conditions of an NHS contract, but there are others who work outside that and beyond that.

Q58 Mr Steinberg: I got a statistic yesterday—I am not going to tell you where it came from—that was quite amazing. I was told yesterday that some of the private consultants in Northern Ireland are earning £40,000 a year extra. No, a month extra. £40,000 a month extra to boost their salaries. If they are doing

that they must be doing a hell of a lot of private work that could have been done on the NHS. Am I right or wrong?

Mr Gowdy: There is a very small proportion, as Dr Carson said—

Q59 Mr Steinberg: I am asking Dr Carson.

Dr Carson: I want to reinforce the fact that we have a very small private sector in comparison with that which takes place in England.

Q60 Mr Steinberg: I do not know about that. I know there are not many surgeons in England earning £40,000 a month, whether it is a big one or a little one.

Dr Carson: The vast majority of that private sector work takes place outwith the health service facilities in the private independent sector.

Q61 Mr Steinberg: But you did say some of it was taking place?

Dr Carson: Some of it takes place, yes.

Q62 Mr Steinberg: We will leave that to the imagination.

Mr Gowdy: The point is it is not displacing NHS, HPSS activity.

Q63 Mr Steinberg: Let us change the subject. Why are the theatres not utilised at weekends?

Mr Gowdy: There are a couple of reasons for that. One is that patients do not really like to be treated outside—

Q64 Mr Steinberg: Oh, come on, it is absolute poppycock that patients do not like to be treated on a Saturday.

Mr Gowdy: We could not run our theatres as intensively as you are suggesting outside normal hours.

Q65 Mr Steinberg: Why not?

Mr Gowdy: The difficulties are—

Q66 Mr Steinberg: Tell the truth.

Mr Gowdy: The difficulties are getting staff and having the resources to fund them. As we said earlier, we are getting a very high utilisation—

Q67 Mr Steinberg: Because the consultants will not come in and do the work.

Mr Gowdy: May I put this point first because it is an important point to make. We are getting a very high utilisation out of the sessions that we are able to fund so that our trusts are delivering for us very close to 100% of all of the sessions that we have asked them to put in place.

Q68 Mr Steinberg: If that is the case then you are at fault because you should be asking them to do more quite frankly, Mr Gowdy.

Northern Ireland Department of Health, Social Services and Public Safety

Mr Gowdy: We are trying to stretch them to do that. As I was saying earlier, we have actually seen some progress made in the couple of years since this Report was published and we are trying to stretch beyond that.

Q69 Mr Steinberg: Your theatres are being used for seven hours a day, five days a week. There is a huge capacity there that could be used but is not being used.

Mr Gowdy: Because we cannot fund it and we cannot staff it.

Mr Steinberg: Let me just move on. Can you turn to page 104, please. I see here the annual leave of consultants stops a considerable number of operations taking place. I find that remarkable because when I take my summer holidays I usually organise them at least eight or nine months before we go. My wife—she has not quite mastered the Internet yet—goes to the travel agent and she books a holiday. It seems to me what happens in Northern Ireland is the consultant goes down to his breakfast one morning and the wife says, “We are off to Benidorm”, is that right?

Chairman: He could probably afford to go to somewhere better than Benidorm.

Q70 Mr Steinberg: You are right. “Just ring in and tell the lads that we will not be in today because we are off to Benidorm”, that is what seems to happen here.

Dr Carson: Leave entitlement for an NHS consultant here is no different from what it is elsewhere in the UK.

Q71 Mr Steinberg: I am not saying it is.

Dr Carson: This document, when it looked at availability of operating theatres, considered that 48 weeks was a normal average. In fact, a consultant—

Q72 Mr Steinberg: I have got no problem with that.

Dr Carson: A consultant is only available for 42 weeks of the year.

Q73 Mr Steinberg: I have got no problem with that. The problem I have is that if it is done properly it is managed properly. If eight months beforehand, or seven months, six months, five months or four months beforehand, the surgeon says to the manager of the hospital, “I am off to Benidorm for a fortnight”, therefore the cover will be brought in. I get the impression here that about 24 hours before the operation is supposed to take place, he rings in to say, “I am off for a fortnight’s holiday”.

Dr Carson: I would want to assure you that through the new arrangements in regard to theatre management such an opportunity should not and could not arise, and would be penalised within effective theatre management arrangements currently.

Q74 Mr Steinberg: I am running out of time but I wanted to make the point that I was very, very cross when I read that. I understand that but if an

operation is cancelled in the UK, in England, at the last minute, and they are regularly, which is a disgrace because people get hyped up for their operation and go in and an hour beforehand are told “On your bike, go home, we have not got this, that or the other to do the operation”, they are guaranteed within 28 days to have that operation but in Northern Ireland they are not. That is quite outrageous. Why does that happen?

Mr Gowdy: We cannot fund that given the waiting list problems that we have got. The way to attack it is exactly the point you are making. What we need to do is to make sure that the management of leave arrangements is sharper. I think this is one of the virtues of this Report. It has certainly drawn out for us a very clear need to get those arrangements in place. Some hospitals are now doing that, Craigavon Hospital tries to arrange evening summer leave to minimise the impact on theatre sessions.

Q75 Mr Steinberg: They should all be doing it.

Mr Gowdy: People will take leave for all sorts of reasons that come up at fairly short notice. What we need to do is to make sure we manage the totality of that and get the majority of leave notified sufficiently so that it does not affect the running of the sessions. I very much take your point on that.

Q76 Chairman: I want to be entirely fair to you, Dr Carson, you are obviously itching to tell Mr Steinberg your typical day. If you remember, there was not time to answer that question. Please give us, not the hardest working day or the least working day but an average day for you or your colleagues.

Dr Carson: When I was working in the cardiac surgical unit on a normal scheduled operating session I would be in the anaesthetic room seeing the first patient in the morning at 7.30. The patient would be anaesthetised and in the operating theatre at eight o’clock. The operation would last five hours, which would take you through to one o’clock. The second patient would arrive in the operating theatre at about half past one. I would quite often work on through with a minimal stop for lunch, if any at all. The patient would be anaesthetised and on the operating table at two o’clock. The operation would last for five hours and finish at seven o’clock. The patient would end up in the intensive care unit where I would discharge that patient over to the care of my intensive care colleagues at about seven o’clock in the evening. I would then go and see my patient for the next day and do all the other additional things that—

Q77 Mr Steinberg: It is a great pity that the rest of your colleagues are not doing the same, I have to say.

Dr Carson: I would be the first person to defend those colleagues who I know work very hard throughout the health service. We are on record as saying that consultants work over and above what they are by and large contracted to do. In England, where you are trying to introduce the new consultant contract, the Department is being challenged by consultants who are looking for 12, 13 and 14

Northern Ireland Department of Health, Social Services and Public Safety

programmed activities to cover the work they are currently doing. We are trying to introduce a consultant contract here within a financial envelope for a consultant that will deliver only 10 programmed activities a week.

Mr Steinberg: I wish you success.

Chairman: We will stop there. We will let Mr Allan take over the questioning.

Q78 Mr Allan: Thank you, Chairman. I was struck by figure four on page 31 which tells us that the management information systems that we need to demonstrate how hard or otherwise consultants are working are largely manual still. This was a report in 2003 about the modern managed health service. We see that 10 of the units covered have only a manual system, two have none whatsoever, five have a mixed manual and computerised one and only four are fully computerised. The Report tells us in paragraph 2.17 on pages 29 and 30 that a business case has to be made for investing in computerised management systems. Can we take it that case has been made, Mr Gowdy? I think you said earlier that the systems are now going ahead.

Mr Gowdy: We have an outline business case from one of our hospitals which we have asked to take the lead in specifying what the nature of the system should be, that is the Belfast City Hospital. They have given us the outline business case and we are in discussion with them. We expect, and certainly hope, that will be cleared so the full business case can be with us at the start of 2005. We have to go through the tendering process and our aim is to have the system coming on stream by the autumn of 2005.

Q79 Mr Allan: Can you help me to understand how this works in the Northern Ireland context. Are you saying that one unit takes the lead and draws up a business case for all the units?

Mr Gowdy: We have asked them to do that because we are very conscious that we have got to get a consistent system in place that is going to give us and the trusts the sort of information that we, and they, need to manage and monitor this system. We are asking them, as the ones who are furthest advanced in their development of computer modelling, to take the lead. What we are doing is getting all the other trusts to feed in their needs so we ensure that we cover the totality of the needs. Obviously that would be in terms of the scheduling of theatre sessions, preparing lists and having the necessary costing information that we want to see from the system. The Belfast City Hospital presented that outline business case to us, they did that a couple of months ago, and we are discussing with them and the other trusts whether the needs are now entirely specified. We need to get approval from our Department of Finance and Personnel, which is the usual approval mechanism, and we will proceed to full business case, we hope, at the start of the year to allow us to put this out to tender.

Q80 Mr Allan: Do you publish those business cases?
Mr Gowdy: No, we do not publish them.

Q81 Mr Allan: You do not routinely publish them?
Mr Hamilton: Not routinely. We have never been asked before.

Q82 Mr Allan: Do you have anything like the Gateway Review process?
Mr Hamilton: Yes.

Q83 Mr Allan: How does that operate? Who does that for you?
Mr Hamilton: As I understand it, it is done independently.

Mr Gowdy: We have a Directorate of Information Systems within the Department which is responsible for taking forward all of the ICT needs for the whole HPSS. They work very closely with the trusts on the procurement process and so on. They review the development at each stage of the process.

Q84 Mr Allan: You are not subject to the Office of Government and Commerce Gateway Review process?

Mr Gowdy: We are subject to a similar system through our Department of Finance and Personnel which performs the Treasury function.

Mr Thomson: Chairman, if I can comment on that. Yes, we do use the same approach as the OGC and, indeed, until we have sufficient staff trained here it is OGC who do the Gateway Reviews or lead the Gateway Reviews.

Q85 Mr Allan: This business case we can expect to go to OGC and they will look at it and give a traffic light indication as they would for anything else?

Mr Thomson: Exactly the same.

Q86 Mr Allan: How does that fit in with the existing system? One of the recommendations of the Report was that the ATICS Directorate system of the Royal Victoria Hospital should be extended to other units, including some of the very important ones like cardiology. Is that kind of work on hold? Are you not advancing that recommendation until the outcome of this large scale procurement process?

Mr Gowdy: They are proceeding with that work but obviously in the knowledge of the development of this other system. We do not want to hold them back. Their system will be compatible with the system that we will have for all the others. There are only a few suppliers who provide these sorts of systems so we know the specification is going to be almost identical.

Q87 Mr Allan: Giving credit where it is due, I also notice in paragraph 220 on page 30, the Musgrave Park was praised independently by the Birmingham University unit for its system. Is that a different system again?

Mr Gowdy: It has different features, yes. We will be expecting that they will take their system and compare it to the specification that comes out of the

Northern Ireland Department of Health, Social Services and Public Safety

Belfast City Hospital model and we will see what additional needs we have to put in place. We want compatibility in these systems.

Q88 Mr Allan: You would not necessarily be telling them to get rid of their working system and to replace it with a system that you are going to procure for everyone?

Mr Gowdy: There will be a couple of decisions to be made. One is the functionality of their system compared to this new one. Another issue would be the cost. It may be that it would be more cost-effective for them to join in the overall system.

Q89 Mr Allan: Who will actually buy and own this? Will you, as the Department, be buying it for them or will you be saying to each of the units, "You must buy this new system out of your budget"?

Mr Gowdy: We will be saying to the trusts that it is a cost that they will bear, but because it is going to be done on a common procurement basis they will all be making a contribution essentially to the purchase of a system which they will all use.

Q90 Mr Allan: So you will not be giving them additional funds for that?

Mr Gowdy: There will be a need for us to secure some additional funds for this. Until the final business case is with us we do not know what the final cost will actually be. We have estimated it to be around £3 million and we will need to take that through the usual process with our Department of Finance and Personnel.

Q91 Mr Allan: These are the kinds of projects we often end up looking at on this Committee.

Mr Gowdy: I am very conscious of that.

Q92 Mr Allan: It is nice to be able to learn a bit about it at this stage before the things are signed and start going wrong sometimes. Is there an overall Northern Irish IT strategy for the health service?

Mr Gowdy: Yes, there is.

Q93 Mr Allan: Was this in there or have you somehow had to bolt it on?

Mr Gowdy: It is actually a priority within that strategy which we published about a year ago.

Q94 Mr Allan: Was that in response to this Report or did it predate the Report?

Mr Gowdy: We were conscious that we needed to computerise. The Report was very helpful in terms of defining some of the problems that were out there which gave us the momentum to say we need a common, consistent approach to this.

Q95 Mr Allan: Is there a relationship between the Northern Irish strategy and the National Programme for IT in England and Wales, which we know is the biggest IT project in the world as I understand it from a government point of view and presumably it is going to be buying similar kinds of systems on a massive scale for England and Wales? How does that relationship work?

Mr Gowdy: We work very closely with them, and our Director of Information Systems folk work very closely in terms of the specification of systems, the development of new ideas and also the benefits of procurement. Yes, we would want to make sure that we piggyback it where we can or that we get into a similar relationship with suppliers on the back of the developments that have taken place, or are taking place, in England.

Q96 Mr Allan: A final word on the professional buying. It is fine buying systems but the big question is whether or not people end up using it and those are the kinds of questions always that are raised around health service systems. What are you doing to make sure that if you put in a new theatre management system the people who are important, and I am thinking particularly of consultants here, will want to use it rather than prefer to do what they are doing already?

Mr Gowdy: We are saying that there is a need for monitoring by us as well as by trusts of what is happening in theatres. That is why we are saying a common specification is required, so that we all operate on the basis of the same information and then we can benchmark. We will be insisting that there is a monitoring return made to us on an identical basis from each trust.

Q97 Mr Allan: I am thinking not of the monitoring side but the actual management side. The whole point of this investment, £3 million, is not to get the figures right, you can do that on the spreadsheet, it is to make sure that you get this throughput figure right and that changes working practices presumably.

Mr Hamilton: The infrastructure is already in place, largely as a result of this Report, where we looked at our Theatre User Committees and what they have been doing and what information they get. Having been speaking to the people in the trusts, we know that there is a great deal more interest in the information that is being produced from the manual systems. There is almost a desire amongst the theatre user communities out there to have the computerised information available as soon as possible.

Q98 Mr Allan: You have no sense of resistance in the sense of if you improve the management system then some of the issues that have been raised about timetabling and freedom, whether or not to come in for a particular session, that relationship will be changed if you have got a management system that is really effective people are tied in on a longer timescale than they have been to date. Is there any sense that there is any resistance to that? Do you have clinicians leading implementation in that area?

Dr Carson: There would be many consultants who would have an interest in techie things and IT solutions to some of the difficulties that they have. In fact, many consultants, surgeons and anaesthetists would view the information that comes out of a theatre management system would help them demonstrate to the health service managers their

Northern Ireland Department of Health, Social Services and Public Safety

particular needs in certain areas. Another important driver which will add to the acceptance of a computerised theatre information system is the introduction of consultant appraisal where consultants now have to demonstrate to their health service managers the areas of activity which they are taking part in. There are strong drivers there but they are drivers that by and large I think will be welcomed by the profession.

Mr Gowdy: We do have in place now a Theatre Managers' Forum and all of the theatre managers across Northern Ireland, including those who operate in the private hospitals, join into this forum. That is the opportunity for us to give them some of these messages and to ensure that people fully understand the importance of managing and using the new systems effectively and we will be putting great emphasis on that.

Chairman: Thank you for that. Mr Jenkins?

Q99 Mr Jenkins: Thank you. Dr Carson, earlier on you replied to one Member and said that the Report was wrong insofar as it only took a 48 week working year for consultants, therefore four weeks holiday, and they have more holiday than that, is that correct?

Dr Carson: What I was suggesting was the estimated availability of theatres was stacked around 48 working weeks a year for the theatre facility but, in fact, individual consultants are only available 42 weeks per year.

Q100 Mr Jenkins: Let us get this one thing right. I constantly get fed up and very, very angry when people come before us and say, "This Report is not correct". Did you have a chance to speak to the staff of the Comptroller and Auditor General about this Report?

Mr Gowdy: If I may—

Q101 Mr Jenkins: I am talking to Dr Carson at the moment, please. Did you get a chance to speak to the staff when they had compiled this Report?

Dr Carson: We did, yes.

Q102 Mr Jenkins: Did you point out this fact to them?

Dr Carson: Yes, we did.

Q103 Mr Jenkins: They refused to take notice of it?

Dr Carson: Pardon?

Q104 Mr Jenkins: They refused to take notice of your observation?

Dr Carson: I am not aware.

Q105 Mr Jenkins: Did you pass the observation on to Mr Gowdy?

Mr Gowdy: Dr Carson was not directly involved, he was in a different position when this Report was compiled. I can give you an indication of what has happened here. We have agreed fully with the Report, there is no question of us having any

difference of view. What Dr Carson is reflecting is the practical experience now that we have got the Theatre Managers' Forum in place.

Q106 Mr Jenkins: You recognise the importance that these reports must be correct.

Mr Gowdy: Yes, indeed, absolutely.

Q107 Mr Jenkins: Any observations you make afterwards are immaterial, we do not take them into account. In fact, if you make an announcement that this Report is wrong we challenge your contribution to it.

Mr Gowdy: There is a full understanding of that.

Q108 Mr Jenkins: When the Chairman started talking and going through this Report, I was not very happy with the Report and I was even more unhappy with your replies because the first thing you said about the amount of money was what a poor deprived area you have got, you have got all these problems, therefore you need the extra money. I could take you to any area of a large city in England that would make your deprivation look like paradise and they manage to get on with it and they manage to produce better figures than you do. Maybe the deprivation you are suffering in Northern Ireland is a deprivation brought about by inefficiency and poor management. I suggest the taxpayers in Northern Ireland do not get a good deal for their money, especially when you get reports like this. Maybe they are not vocal enough in forcing their replies on to you.

Mr Gowdy: I would have to disagree with that.

Q109 Mr Jenkins: You said you compared your set-up with hospitals on the mainland in England that were as bad or worse than this. Name them, please, with the operating theatre times.

Mr Gowdy: We can send you a letter setting this out.¹ I do not have the names with me. It was a sample of 16 trusts and it was undertaken in the course of 2003–04. We can give you the names. What I was saying was that our outcome here at 64% utilisation matches that in England, so we are not out of kilter with what is happening elsewhere.

Q110 Mr Jenkins: I want to know and, believe me, I will be following it up most seriously. If I could turn to page 69, and I may be reading this Report totally wrong, on the range of sessions cancelled in major specialities, is it right that 36% were cancelled in cardiac surgery?

Mr Gowdy: In 2001–02 yes. The figure for 2003–04 is close to that, it was at 32% cancellations. What lies behind that is that patients for cardiac surgery are, as we were saying earlier, much frailer, much older and more likely to have conditions which would make them unfit or unsuitable for procedures.

Q111 Mr Jenkins: No, no, no. Let us get this straight. When you are a patient in hospital, when you first go in you have a GP or a surgeon come and

¹ Ev 19

Northern Ireland Department of Health, Social Services and Public Safety

assess you. They do various checks on your blood flow and your heart and they see exactly if you are fit for surgery. If you are fit for surgery you are then booked in. They do not book you in and then come along at the last minute and check if you are fit for surgery. I might be wrong, it might be different in Northern Ireland, maybe it is totally different, but in hospitals in my part of the world they check us in before we go into surgery so we cannot have a cancellation because the patient at that stage is too frail unless you get a sudden failure of the patient as they move from the ward to the theatre itself. It can happen with a very old and frail person, but I would suggest it is not 36% of the time.

Mr Gowdy: I had not quite finished the point I was trying to make. What we are dealing with here are much frailer patients. In some cases, after the clinical pre-assessment has been made some of them deteriorate and some of them actually die so there are sessions that are cancelled for those reasons. The most predominant reason, however, is that those older, frailer patients who are in the beds that are needed for intensive care after the operation are, in a sense, blocking those beds. They need the care and those beds cannot be freed up so the operations that were going to be carried out on the patients who were due for those sessions cannot be held and have to be cancelled. Is that right, Dr Carson?

Dr Carson: Correct.

Q112 Mr Jenkins: I just find it totally amazing, absolutely mind-boggling that you have got days on end—days on end—when a theatre is not being used because no-one has done an assessment on a patient before they have booked them into the system. Is that what you are telling me?

Mr Gowdy: No, quite the opposite. What I am saying is that, yes, there are some patients who have been through the assessment process who are deemed fit but who subsequently deteriorate for varying reasons. With a very frail patient that can happen. The major reason is that the very frail patients who are in the intensive care beds cannot be taken out of those beds because their condition does not allow them to be moved to another area which is less intensively nursed and because those beds are not free it is not possible to carry out the procedure on patients who will then need those recovery facilities.

Q113 Mr Jenkins: This only affects cardiac patients?

Mr Gowdy: That is why cardiac patients are such a high proportion of the cancellations, as you can see from this table. It is the most sensitive area.

Dr Carson: In Northern Ireland we have one cardiac surgical unit to cover the whole Province, it is a regional service. That unit has a fixed number of staffed intensive care beds. If a bed gets occupied by a patient who needs a prolonged length of stay, what the Secretary was trying to illustrate was that the age profile of the patients is getting older and the complexity and risks associated with the surgery is increasing. These patients are taking longer in the intensive care units and if a bed is occupied in the

intensive care unit no surgeon is going to take the risk of operating on a patient without the necessary post-operative support in an intensive care unit.

Q114 Mr Jenkins: Yes, I understand all that. Answer the question. The question was, how do you book somebody into a theatre and then say, “Oh my word, this person is not fit for an operation” and that amounts to 36% of your cancelled operations?

Mr Gowdy: The sessions are arranged in advance. They are arranged ahead in time.

Q115 Mr Jenkins: How far ahead?

Dr Carson: The operating list for cardiac surgery is planned a week in advance.

Q116 Mr Jenkins: Do you not think pre-assessment should be a bit closer if the cancellation rate is 36%? What pre-assessment do you do for these people?

Dr Carson: The pre-assessment is largely done by nursing staff now with the assistance of the anaesthetist.

Q117 Mr Jenkins: Page 104, please. There we have got reasons given for last minute case cancellations. Do you see the ranking order. 30% did not attend. Do you mean that you have got someone booked into the system and they just do not turn up?

Mr Gowdy: We were focusing there on the cardiac surgery.

Q118 Mr Jenkins: I take it for an operating theatre you do a pre-assessment for a patient. In my part of the world you go into hospital, the doctor checks your height, weight, blood pressure, *et cetera*, checks your pulse and books you in and then you turn up. Not many people do not turn up in my part of the world, to be honest. I find that such a high non turn-up rate. Do you do pre-assessments before patients appear?

Mr Gowdy: Yes. Increasingly the hospitals in most specialties are now doing a pre-assessment.

Q119 Mr Jenkins: When I go down this list I understand “bed occupied . . . shortage of intensive care”, but it is this business about lack of anaesthetists. Sick leave is obviously an emergency, but when you get to annual leave and shortage of theatre staff so you cannot book an operating theatre, court appearances, study leave, annual leave, lack of equipment, all of these are situations that should be overcome quite rapidly to allow you to re-man and re-equip the theatres to book an appointment. Why are these reasons given for cancellations? These are reasons or indicators of poor management, are they not?

Mr Gowdy: As I was saying to Mr Steinberg, these are issues that increasingly we have been focusing on as a result of this Report. This has been very helpful to us in determining those areas where it is possible to make a significant improvement by asking all of our trusts to manage the leave issues better.

Northern Ireland Department of Health, Social Services and Public Safety

Q120 Mr Jenkins: In my part of the world a surgeon has to give six weeks' notice of holiday, which we think is too short. It is okay for the surgeon to go off to Benidorm, as Mr Steinberg was saying, but it means that there are patients struggling and suffering in pain. Do you realise just how much pain you have contributed to by having such a poor record of efficiency in your Department? Do you not feel that the public out there have a right to know that the money sent to them is to relieve pain and they should know they are taking holidays ad hoc, when they want, which has cost this service substantial amounts of money and that money would be better spent on relieving pain rather than inefficiency?

Mr Gowdy: That is why we have been working so hard on all of the issues that affect the waiting lists and the waiting times. We understand fully that you have got to get patients in as quickly as possible. We have made substantial progress over the last couple of years on the waiting lists in Northern Ireland and it is because we are doing helpful things, like these recommendations from the Audit Office. It is not simply in theatre utilisation, it has to be in how the totality of the system operates, which includes trying to deal with these people who do not attend, by encouraging people actually to meet their obligations when they are offered an appointment because if they do not take it up they can prevent someone else from getting it.

Chairman: Thank you. Mr Bacon?

Q121 Mr Bacon: Thank you, Chairman. Mr Gowdy, who chose the sample of 16 trusts in England?

Mr Gowdy: I am not sure. I do not know whether Mr Hamilton would know.

Mr Hamilton: I think that was the company that we commissioned to undertake the analysis.

Q122 Mr Bacon: Mr Dowdall, from the National Audit Office we regularly get lists of all the hospital trusts in England. Is it possible that your office, together with the NAO, could assemble a chart similar to the one on page 66 but with a much larger sample so that we can see a comparison of all the English trusts compared with all these ones here as to the utilisation of capacity of theatres? It would be very helpful to get a more accurate comparison than just that of a sample.

Mr Dowdall: I will talk to the NAO.

Q123 Mr Bacon: I have no way of assessing Mr Gowdy's statement that Northern Ireland is not out of kilter other than this sample of 16 trusts which we have not got details of. It would be very helpful to have that as soon as possible.²

Mr Gowdy: We understand that the company did choose a careful sample. I do not think it was just picking any trust. We made it clear what we were trying to achieve here.

Q124 Mr Bacon: It would be very helpful to get a broader cross-section. If I could ask you to turn to page 98 of the Report. It talks about the comparative inpatient waiting lists and in figure 16 it says that the number of people on inpatient waiting lists per 1,000 of population is 28 per thousand in Northern Ireland compared with 20 in England and 16 in Scotland and that the number of people on waiting lists waiting more than 12 months per thousand of population is 5.62 per thousand in Northern Ireland, just under one in England and just under a quarter in Scotland. In other words, in Northern Ireland it is six times worse than in England and in Northern Ireland it is 20 times worse than in Scotland. Scotland is a particularly interesting case because you have a large country with a small population and some of the rural funding problems that you have alluded to in Northern Ireland. That chart was when this Report was produced, April 2003, 18 months ago. Is that chart still a reasonably accurate representation of how things stand?

Mr Gowdy: We have made some very remarkable progress since that time because we have an initiative on waiting lists which has put a lot of emphasis in place. Mr Hamilton can say a bit more about the table. Can I just say in the last two years we have secured a decrease in the number of people waiting from 60,000 in September 2002 down to 51,000 in June 2004.

Q125 Mr Bacon: 51,000 is the total number of people waiting?

Mr Gowdy: Total number of people waiting, yes.

Q126 Mr Bacon: How many of those are waiting more than 12 months?

Mr Gowdy: The so-called excess waiters, which for us are over 18 months—

Q127 Mr Bacon: This table here says over 12 months on page 98.

Mr Gowdy: We do have some figures which Mr Hamilton—

Q128 Mr Bacon: Of the 51,000, how many are waiting more than 12 months?

Mr Gowdy: It is 5% who are waiting more than 12 months.

Q129 Mr Bacon: 5% of 51,000?

Mr Gowdy: Yes.

Mr Hamilton: 95% of all patients are seen within 12 months. 75% are seen within three months.

Q130 Mr Bacon: Mr Hamilton, I was not asking about what percentage of patients was seen within 12 months. Mr Gowdy said there were 51,000 people waiting and what you mean is 95% of those were seen within 12 months and that 5% are not?

Mr Hamilton: Yes.

Q131 Mr Bacon: So 2,500 of those 51,000 are waiting more than 12 months, are they?

² Ev 19

Northern Ireland Department of Health, Social Services and Public Safety

Mr Hamilton: Sorry. 95% of people who are treated in Northern Ireland are treated within 12 months.

Q132 Mr Bacon: The only trouble is that is not the answer to my question. My question is if there are 51,000 people waiting, how many of those are waiting more than 12 months?

Mr Gowdy: We will get the figure.

Q133 Mr Bacon: On page 98 you have got 5.62 per thousand of the population waiting more than 12 months. This is a table that relates to Northern Ireland. These numbers must be knowable. It does not say 18 months, it says 12 months.

Mr Gowdy: I know it does because that was—

Q134 Mr Bacon: What is the answer? Is it 5% of 51,000 roughly?

Mr Gowdy: I think we will have to send you a note on this.

Q135 Mr Bacon: Do you think it is roughly 5% of 51,000?

Mr Gowdy: We will have to send you a note on this.³

Q136 Mr Bacon: You do not know.

Mr Gowdy: We do not have the figures here. We record our data differently.

Q137 Mr Bacon: Logically if 95% of these 51,000 people are being seen within 12 months, that means 5% are not. 5% of 51,000 is roughly 2,500, is it not? Am I missing something?

Mr Gowdy: The way we record our figures means the percentage of people treated is 95% treated within 12 months, 5% obviously beyond that. The figure of 51,000 is the number waiting at the snapshot in time taken in June 2004. If we can accelerate that, it will not necessarily be 5% of that treated in—

Q138 Mr Bacon: I am still trying to get to it. There is a table here that talks about the number of people per thousand waiting more than 12 months. I do not understand how the Acute Hospitals Review Group Report, June 2001, which is where this table is taken from, referring to Northern Ireland could have come out with this number of 5.62 unless they knew how many people they were talking about.

Mr Gowdy: I am sorry if this sounds confusing but the basis on which we record our waiting lists are those who are waiting more than the Patient Charter standards, which were 18 months and more.

Q139 Mr Bacon: We have a lot of problems with waiting lists and the manipulation or difficulty in describing the figures. This table is quite clear, it really is very clear, and you are not being clear. I have even asked you to say whether you think roughly the 2,500 I have come up with based on the answers you have just given is accurate or not and you are not able to do even that. Roughly, how many people are waiting more than 12 months? Roughly.

Mr Hamilton: We know there are 3,235 waiting more than 18 months.

Mr Gowdy: I would expect that there would be another 2,000 perhaps.

Q140 Mr Bacon: On top of those who are waiting more than 12 months.

Mr Gowdy: We will give you the accurate information on this.

Q141 Mr Bacon: If you could send us a note that would be helpful.

Mr Gowdy: It is important to give you the accurate information.

Q142 Mr Bacon: I would love a note with accurate information, that would be great. In the ballpark, 3,000 plus 2,000, so 5,000, 5,500?

Mr Gowdy: More than 12 months?

Q143 Mr Bacon: Yes.

Mr Gowdy: That is my expectation but I would like to give you the accurate figures because we do not record—⁴

Q144 Mr Bacon: The point is that in the context of the table on page 66 where you have got available sessions of 48,000 and sessions held of 30,000, it is a soluble number of people, is it not? If you increased your efficiency radically then you could do a very, very great deal to reduce those waiting lists.

Mr Gowdy: It is not simply—

Q145 Mr Bacon: I know it is not and you have given all the reasons why.

Mr Gowdy: It is getting patients right through the system from when they first present to their GP until we are able to get them back into the community again. We have to make an investment in every stage of this.

Q146 Mr Bacon: Yes, of course. This goes back to my second question about the table. It is correct, is it not, that Northern Ireland has amongst the highest funding per head of population for health in the UK?

Mr Gowdy: Less than Scotland.

Q147 Mr Bacon: Less than Scotland. Scotland has 20 times better results than you do.

Mr Gowdy: On a par with Wales.

Q148 Mr Bacon: Yes, but more than England.

Mr Gowdy: More than England. Our levels of needs, as I was saying earlier, are greater so there are reasons why that funding has to be greater.

Q149 Mr Bacon: Nevertheless, the table on page 66 shows this spare capacity of 37% on average. Of the hospitals in that table, 15 out of the 23 hospitals and 58 out of the 106 theatres are worse than average, which perhaps conceals more than it reveals. There are quite a few down at 50%. Is that because they are

³ See Q201.

⁴ Ev 19

Northern Ireland Department of Health, Social Services and Public Safety

all emergency units? If you take Belfast City downwards, Belfast City is 52%, Ards, Whiteabbey, Royal Maternity, Erne, Causeway, Belvoir Park, Coleraine and Route, are they all emergency units? Why do they have such low utilisations, roughly half the time they are not used?

Mr Gowdy: Belvoir Park, for example, is a cancer centre and does specialist cancer procedures.

Q150 Mr Bacon: What about Causeway?

Mr Gowdy: The Causeway was a new hospital which was opened during the period under this Report, so they were not operating at full capacity at that stage.

Q151 Mr Bacon: What about Erne?

Mr Gowdy: Causeway replaced Coleraine and Route.

Q152 Mr Bacon: What about Erne?

Mr Gowdy: Erne is a rural hospital in the south-west of the Province.

Q153 Mr Bacon: Belfast City, 52%. 48% spare capacity at Belfast City. That cannot be because they are all emergency units, can it?

Mr Gowdy: No. They have substantially increased their utilisation and it is now up at 78%.

Q154 Mr Bacon: Can I ask you to turn to page 55, paragraph 3.1.1. It states that there is a need for advance notice of planned leave by surgeons, but "Persistent non-compliance by some consultant surgeons has resulted in anaesthetic cover being scheduled for sessions that subsequently could not be held because of surgeons taking leave, leaving the Clinical Director with the problem of trying to redeploy the available anaesthetic cover elsewhere at little notice. This redeployment has not always been possible, resulting in a waste of resources and a potentially viable session not being held." What action is taken against persistent non-compliance by some consultants?

Mr Gowdy: If I may, I will ask Dr Carson, who is very familiar with all of these issues.

Dr Carson: I think there are several levels at which you can exercise management action.

Q155 Mr Bacon: Mr Curry just said *sotto voce* there is can and there is do. What action is taken against persistent non-compliance?

Dr Carson: Persistent non-compliance would be failure to fulfil their contractual commitments which is a disciplinary procedure within the trust.

Q156 Mr Bacon: How many doctors have been disciplined?

Dr Carson: I do not have that information.

Q157 Mr Bacon: Could you send us a note?

Dr Carson: We could look at that, yes, certainly.⁵

Chairman: Thank you very much. Under our procedure, gentlemen, we allow Members to ask short supplementaries as long as they do not take

more than 15 minutes in total, or I reserve the right, if they are long, time wasting answers, to allow them more time. We start with Mr Curry and then go on to Mr Allan, Mr Steinberg and then Mr Jenkins.

Q158 Mr Curry: Could I bring you back to Mr Jenkins's questions on the table on page 104, the reason given for last minute case cancellations. You said in response to an earlier question that you book surgery sessions a week in advance, is that right?

Dr Carson: In the cardiac surgery unit.

Q159 Mr Curry: And elsewhere?

Dr Carson: I would suspect that prior booking for elective general surgery is well in advance of that. Patients would be given dates for surgery well in advance of a week.

Q160 Mr Curry: What sort of time?

Dr Carson: I am sure there is a whole spectrum. For example, patients for elective orthopaedic surgery are probably told six months in advance and that in itself creates a problem.

Q161 Mr Curry: In the cardiac unit then, if it is a week in advance presumably nothing should be cancelled because of study leave or annual leave?

Dr Carson: Correct.

Q162 Mr Curry: Because presumably that is predictable.

Dr Carson: It is a small unit, five surgeons, six or seven anaesthetists in the unit. That information is well known within the theatre management team. The major factor for cancelled lists and non-availability of an operating theatre is the fact that intensive care capacity is already full with patients in it and those patients are not scheduled for surgery.

Q163 Mr Curry: I am looking down this list and, as Mr Jenkins said, if people do not turn up you cannot do anything about that. If a bed is occupied by an emergency you cannot do anything about that. In sector after sector we look at ways in which sick leave can be reduced and better managed, so I do not think you should take that as an absolute given. A lack of anaesthetists is common right throughout the NHS across the United Kingdom. Things like study leave and holidays and things like that presumably should be programmed well enough in advance, or noted well enough in advance, so that rescheduling can take place so there are not cancellations. What are your targets for that? You said, Mr Gowdy, that this was one of the prime areas where you felt management intervention could improve things. Have you got some sort of targets here which you could share with us?

Mr Gowdy: In terms of?

Q164 Mr Curry: In terms of reducing those rankings. What would you like to get cancellations due to holidays down to? The whole world seems to spend so much time being retrained that nobody seems to turn up for a job now.

⁵ Ev 19

Northern Ireland Department of Health, Social Services and Public Safety

Mr Gowdy: We have not set specific targets for this. We regard that as a local management responsibility.

Q165 Mr Curry: Have you asked local management to set targets?

Mr Gowdy: We have not asked them to set targets as such but we have asked them to look very carefully at the reasons why these planned sessions, for all of the reasons that are here—

Mr Hamilton: I would like to emphasise the point that we have placed a requirement on all trusts to implement in full the recommendations of this Report and that would include tightening up on the control of leave. The other issue that I would want to emphasise here so that there is no misunderstanding is that the cancellations that we are talking about impact upon the utilisation of the funded sessions. The Bevan report suggested 90% is the target and at the time of the report we were operating at 94%. We have checked again and we have increased that to 95%. The scope for improvement is between 95% and 100% of utilisation.

Q166 Mr Curry: Even if you do not set specific targets it is bench markable, is it not?

Mr Hamilton: It is.

Q167 Mr Curry: It seems to me the central issue is this: you said “We cannot use our theatres more than seven hours a day, five days a week because (a) we cannot fund it and (b) we cannot staff it”. If British Airways only used its aeroplanes seven hours a day and five days a week British Airways would be bankrupt. That is true of many businesses. The funding in Northern Ireland is the highest outside Scotland and the United Kingdom and your waiting lists are the longest. These bits of the geometry do not seem to fit together. How is it that with the highest funding, except Scotland, you still do not seem to be able to get the utilisation out of the equipment, and there is very, very high tech kit there, a return on the assets which is obtainable in parts of the United Kingdom at much lower levels of funding? What is the heart of this problem?

Mr Gowdy: The heart of this problem is the waiting list issue and the use of theatres is not the single critical dimension. It requires us to have a system that operates in its entirety right through from the efficiency of the GP and the primary care folk out in the community through the hospital system and back out into the community where people need nursing and residential care. We have to provide funding against all of those elements and with the levels of need we have got, our funding has to be higher to allow us to do more of those things. What we are trying to do is to make the whole system work more efficiently. As part of this, we fully accept that we should be driving and striving to increase the utilisation of our theatres and we have made some modest progress.

Chairman: I think that is enough, thank you very much. That question was brilliantly put, very direct, and the answer was just a complete load of waffle as far as I am concerned. Mr Allan?

Q168 Mr Allan: I would like to take us straight on from there. Mr Gowdy, you are responsible for health and social services, as you say the whole thing into residential care. Why do we have as one of the highest ranking reasons for last minute case cancellations “Beds occupied by outstanding dischargers”? You are responsible for getting them into residential homes, are you not?

Mr Gowdy: Yes, we are. The provision out there in the community is the determining factor in getting patients out of those beds. There are a number of issues that come into play there, one of which is patient choice because people do not want to be moved to a far part of the Province, they want to be near their home where their relatives are. We need to build up provision. Our provision is largely the independent sector and the decisions that are made by the private sector are matters that we can influence only to some extent. Certainly we have been doing as much as we can to put in place additional community care packages to try and get these folk out into the community. We need to look after the patients in any part of the system, we cannot just abandon people and push them out of the hospital setting.

Q169 Mr Allan: You are not pushing them out, you are taking them out. In England and Wales we get told the problem is that you have got the health service here and social services there and they are separate funding streams and they are uncoordinated. We should be able to expect you to do better, should we not, because you are doing it all?

Mr Gowdy: Yes, we are, although, as I say, a lot of the—

Q170 Mr Allan: You do not seem to be doing it better.

Mr Gowdy: The residential home sector is very largely run by the independent care providers.

Q171 Mr Allan: Presumably you have got the funding.

Mr Gowdy: It is a decision for them where they place their homes.

Q172 Mr Allan: You have got the big block contracts.

Mr Gowdy: We try to influence those things.

Q173 Mr Allan: You could shape the market.

Mr Gowdy: We try very hard to influence those things. We are looking at some alternative ways of dealing with it. An acute hospital bed is the most expensive. We are looking at putting in place intermediate care provision so that we can step those patients down from the expensive hospital sector into something less expensive, even if we have not got the residential home in place for them.

Northern Ireland Department of Health, Social Services and Public Safety

Mr Hamilton: We have been investing in the community as well as in the acute service in order to deal with the total demand for patient flows through the hospital. We have increased the number of community care packages from 15,000 in March 2000 up to 19,000 in March 2004. Some of these can cost between £15,000 and £20,000 a year. The issue for the service is what is the balance in terms of deploying those funds? Should all of those funds be used to sort out the delayed discharges issue? Yes, one could say that is one way forward but there are also people at risk living in the community and some of those resources have to be devoted to maintaining people safely in the community otherwise further down the track there is an exacerbation of their position.

Q174 Mr Allan: You are telling us that having health and social services together presents other problems of competing priorities as in our English and Welsh system of having them separate?

Mr Gowdy: Yes.

Q175 Mr Allan: Still it is all yours and you cannot blame anyone else if people are in hospital who should not be in hospital, who should be back in the community.

Mr Gowdy: We do not have the organisational barriers that exist elsewhere.

Q176 Mr Steinberg: I just want to clear up a couple of points that have been part of the discussion. Twice it was said that the reason why the theatre was being used so little was because it was a cancer hospital. Can you explain that. Because it is a cancer hospital, why should that do less work than another hospital?

Dr Carson: This particular hospital is a radiotherapy and cancer treatment unit. Cancer surgery is not carried out in that hospital. That "operating theatre" is used for placement of radium implants under anaesthesia, no surgery is actually carried out. There are only one or two patients a week accessing that operating theatre.

Q177 Mr Steinberg: It is being utilised totally by the people who need it, nobody has to wait?

Dr Carson: Nobody has to wait. It is only used for one or two procedures. No cancer surgery is carried out in that hospital.

Q178 Mr Steinberg: Could it be?

Dr Carson: No.

Q179 Mr Steinberg: Could it be used for surgery?

Dr Carson: No, because there is no back-up, recovery, intensive care, high dependency support. It is not an acute hospital. None of the other supporting infrastructure that is necessary to carry out surgery is available in that hospital, it is a stand alone site, not on an acute hospital site, and it would be unsafe.

Q180 Mr Steinberg: The other point I would like to clear up is three times Mr Gowdy has mentioned the fact that patients do not like to travel for operations

and they like to be near their relations, *et cetera*. Tell me, if somebody needed an operation who lived in Enniskillen, let us say, and there was a free bed in Coleraine, how far would that be? I do not know Northern Ireland at all.

Mr Gowdy: 60–70 miles.

Q181 Mr Steinberg: How far is Enniskillen to Belfast?

Mr Gowdy: 75–76 miles, something like that.

Mr Steinberg: How can Enniskillen be 70-odd miles from Belfast and 70-odd miles from Coleraine?

Chairman: This is a very interesting geography lesson.

Mr Bacon: Get a map!

Q182 Mr Steinberg: The point I am trying to make is certainly we had a problem in the English health service where family doctors were reluctant to send patients to another hospital because it might be too far away. I can understand that but if you have hospitals and theatres standing empty or not doing any work in one area and another hospital is very, very busy doing work in their own hospital, are people sent from one area to another area for an operation? My experience of people is that they would rather travel 30 or 40 miles to get their operation over and done with than to wait around for 18 months to have an operation ten miles away in their local hospital. That is the point I am trying to make.

Mr Gowdy: Yes, we do make use of other hospitals and we like to give people the choice. It is not universally accepted by patients that that is what they want. Some people are keener to be near their own home with their family support around them, particularly in the post-operative phase. Yes, we do it and we try to encourage people to do it and we offer it to them. We have sent cardiac patients across to England, down to Dublin and to Scotland. Yes, we have made use of that but not everybody wants it.

Q183 Mr Jenkins: I shall not ask you about the bed blockers. I did not like the answer I got but I do not think I will get much farther than Mr Allan did on that one. Have you had any costs done for the non-attenders? If we can look at page 74, 4.32, the National Booked Admissions Programme that we have in parts of England where there are pilot schemes. Have you worked out how much you would be saving if you had a booked system as to how much it is costing for the non-attenders? If you have not got a figure, could you let us have a note on it, please.⁶

Mr Hamilton: The non-attenders do not automatically lead to a loss of funds because what we have been practising up to now is overbooking, rather like the airlines, so that if someone does not turn up there is someone there to take their place. We are exploring partial booking which is increasingly recommended by the Modernisation Agency. All of our trusts are piloting some form of partial booking.

⁶ Ev 20

Northern Ireland Department of Health, Social Services and Public Safety

Q184 Mr Jenkins: You are sending a message out to people who do not turn up, "Don't worry it is not going to cost anything, we have double-booked you anyway".

Mr Hamilton: We have not sent that message out.

Q185 Mr Jenkins: I would like a message going out saying, "If you don't turn up you are going to cost someone else the chance of being on that waiting list and the actual cost to us as the health authority is X million pounds per year that could be spent on other people".

Mr Gowdy: We have a service improvement project looking at the booking arrangements because I think there are some lessons that it is worth picking up here. If people are contacted at a date close to their operation it actually reminds them and encourages them to come.

Q186 Mr Jenkins: Have you estimated what it has cost you to have these operating theatres standing empty?

Mr Gowdy: We do not regard it in those terms. As we have said a couple of times, we are getting a very high percentage of the planned sessions, the ones we can fund.

Q187 Mr Jenkins: Do not take me down that line or I will get angry again. You can have 100% of your booked time but only 40% of the time in theatre is available. We have paid millions of pounds of taxpayers' money for a theatre but it is standing there idle 50% of the time. That is a cost.

Mr Gowdy: The people of Northern Ireland are getting a return out of this. We are increasing the percentage use. We are trying our best to make sure we use our money as effectively as possible.

Q188 Mr Jenkins: That is all I am asking you to do, an estimate of what it costs to have these theatres standing empty.

Mr Gowdy: As I said earlier, if we could fund in entirety the 100% it would cost us another £48 million.

Q189 Mr Jenkins: How much does it cost for theatres standing empty? Also, have you looked at how many theatres you have got? When you say you do not do many operations, you are inserting radioactive isotopes, have you got too many theatres? Would it not be better to have a smaller number of theatres that are more effectively used? Would you get an economy of scale if you put more operations through that theatre? Have you done the work on this?

Mr Gowdy: We have a strategy called *Developing Better Services* which is designed to locate hospital services in the right places in Northern Ireland and change the use of some of our existing hospitals so that we are not providing acute services in all of them and that will reflect some of these issues around the use of theatres.

Mr Jenkins: Mr Hamilton, when you said that you have got 100% of booked time, we are so used to people coming before us and giving figures that we

will spot it immediately. I am not interested in the booked time, I am interested in the total amount of time that the theatre could be available. Do not think that you got away with that one because you did not.

Q190 Chairman: Thank you, Mr Jenkins. Just a couple of brief questions from me to end this session. I want to deal with a specific point. If you turn, please, to page 55, can we look at Royal Victoria Hospital. "The Cardiac Surgery Planning Group meets each Thursday . . . Planned leave by medical and nursing staff is notified at these meetings. However, we noted that there were no cross-over arrangements for consultant surgeons' leave. The trust explained that there are currently insufficient resources to cover elective sessions when a surgeon is on leave." What I want to know from you or one of your colleagues, Mr Gowdy, is actually dealing with this unit, since this Report was published what improvements have actually been made in the planning and organisation of theatre sessions at this unit?

Mr Gowdy: I will let Dr Carson expand on that.

Dr Carson: The operating theatre sister has been given management responsibility for the cardiac surgical theatres and a week in advance the operations are scheduled and all leave is made available to the theatre sister to enable those operating theatres to be used to maximum efficiency. We are continuing through our review group to monitor very carefully the additional investment that has been put into the cardiac surgical unit to make sure that the performance of the unit, given the investment in critical care nursing and beds and in theatre equipment, is used to maximum effect. That work is continuing.

Q191 Chairman: You have accepted in full all of the recommendations made by the Comptroller and Auditor General in his Report, have you not?

Mr Gowdy: Yes.

Q192 Chairman: Have all the recommendations now been implemented?

Mr Gowdy: There were 43 recommendations and 37 of those have been fully implemented, the remainder are due to be implemented by the end of December this year.

Chairman: Thank you. Mr Bacon would like to ask one question.

Q193 Mr Bacon: Mr Gowdy, you said that patients do not like to be treated outside normal weekday hours when you were saying people wanted to be treated between Monday and Friday. Are you seriously saying that a patient with a painful hernia offered the chance to be treated at four o'clock on a Saturday afternoon would say, "No, I am sorry, it is not a weekday"?

Mr Gowdy: No, I am not suggesting that. It was in response to the question about extending the hours considerably and making much greater use of the evening sessions as well as the weekend. No, I am not

Northern Ireland Department of Health, Social Services and Public Safety

saying that, people in pain will want to be treated as quickly as possible and if that means a weekend they will do it.

Q194 Mr Bacon: Dr Carson, you were in the process of saying that doctors who went on leave at short notice without giving enough notice were in breach of contract and they could face disciplinary procedures and you are going to send me a note of how many doctors have been disciplined. Are you aware of any doctors being disciplined?

Dr Carson: I am not aware.

Q195 Mr Bacon: You are the Deputy Chief Medical Officer for Northern Ireland, are you not?

Dr Carson: Yes.

Q196 Mr Bacon: So you would be likely to be aware.

Dr Carson: I would be informed if a doctor was suspended for breach of contract, yes.

Q197 Mr Bacon: Do you think it just does not happen because administrators are reluctant to take on consultants even if they do suddenly say at the last minute, "I will go off to the golf course"?

Dr Carson: No. I think the introduction of consultant appraisal from 2001 has made the interface between a clinical manager and the individual consultant much closer and the knowledge and awareness of what doctors are doing is now fully appreciated, not only by their clinical managers but their general managers as well. I do not know a surgeon who does not want to operate, I have to say. Certainly I am not aware of anybody who has been in breach of contract for failure to fulfil their contractual commitments. I believe that commitment from our consultants is very full.

Q198 Mr Bacon: This persistent non-compliance that is referred to on page 55, what is it and who is it who is doing it? Have you read page 55, paragraph 3.11: "Persistent non-compliance by some consultant surgeons has resulted in anaesthetic cover being scheduled for sessions that subsequently could not be held because of surgeons taking leave . . ." without giving proper notice. That was the whole point of my earlier question.

Dr Carson: I know that examples of that would now be fully addressed by our Theatre User Committees. Remember, the information that comes from theatre management systems, whether they are paper based

or IT based, those are the sorts of issues that get discussed by all the theatre users, including that surgeon who is persistently failing to comply with the requests from the theatre managers. If they do that, the theatre managers that we have now put in place in every hospital have powers, through to the chief executive of that organisation, to take whatever action is appropriate. Some of these surgeons do lose operating time as a consequence and it is given to somebody else. That flexibility and those powers are given to Theatre User Committees.

Mr Bacon: Thank you very much.

Q199 Chairman: It might have been easier to give that answer before instead of just denying Mr Bacon's question.

Mr Gowdy: Can I respond to an earlier question Mr Bacon asked?

Q200 Chairman: You may.

Mr Gowdy: The figures for—

Mr Bacon: It could lead me to ask another question.

Q201 Chairman: Escape while you can!

Mr Gowdy: I am keen to give you the information. Simply to say those waiting over 12 months at June 2004 were 6,850 and that compared to 15,000 in June 2002.

Q202 Chairman: Mr Gowdy, Mr Hamilton and Dr Carson, thank you very much for appearing before us in what we have found to be a very interesting hearing, but I am afraid that we have to repeat our point of view that the funding in Northern Ireland is the highest per patient outside of Scotland in the United Kingdom. The efficiency in theatres is absolutely vital. On a number of measures, you are one of the poorest performers in the United Kingdom despite this funding. We accept that there is severe deprivation in Northern Ireland but in many other areas of the United Kingdom there is equally severe deprivation. We will be making a number of suggestions for improvements in our Report and we very much hope that they will be implemented for the sake of the people in Northern Ireland. Gentlemen, thank you very much.

Mr Gowdy: Chairman, we will do all we can to ensure that is the case and I hope you will give us credit for the efforts that we are doing to make progress.

Chairman: We always do that.

**Supplementary memorandum submitted by the Northern Ireland Department of Health,
Social Services and Public Safety**

Question 109 (Mr Jenkins): You said you compared your set-up with hospitals on the mainland in England that were as bad or worse than this. Name them, please, with the operating theatre times; and

Question 123 (Mr Bacon): I have no way of assessing Mr Gowdy's statement that Northern Ireland is not out of kilter other than this sample of 16 trusts which we have not got details of. It would be very helpful to have that as soon as possible.

The sample of 16 Trusts, to which the DHSSPS referred in its evidence to PAC, included the following organisations:

1. Aintree Hospitals NHS Trusts
2. County Durham & Darlington Acute Hospitals NHS Trust:
 - Darlington Memorial Hospital
 - Bishop Auckland General Hospital
3. Leeds Teaching Hospital NHS Trust
4. Mid Cheshire Hospitals NHS Trust
5. South Tyneside Health Care NHS Trust
6. Southport and Ormskirk Hospital NHS Trust:
 - Southport Hospital
 - Ormskirk Hospital
7. Bromley Hospitals NHS Trust
8. Cambridge University Hospitals NHS Foundation Trust
9. Mayday Healthcare NHS Trust
10. NHS Lothian University Hospitals Division
11. NHS Tayside Acute Services Division
12. Norfolk and Norwich University Hospital NHS Trust
13. North Glasgow University Hospital NHS Trust
14. Nottingham City Hospital NHS Trust
15. Portsmouth Hospitals NHS Trust
16. United Bristol Healthcare NHS Trust

Questions 142–143 (Mr Bacon): I would appreciate a note with accurate information on the number of patients waiting to be admitted to hospital.

The total number of patients waiting to be admitted to hospital in Northern Ireland at the end of September 2004 stood at 50,684. At the end of September 2002 it stood at 60,190.

In Northern Ireland, inpatient excess waiters are defined as those having to wait 12 months or more for admission to the Cardiac Surgery specialty and those having to wait 18 months or more to other specialties.

The number of excess waiters at the end of September 2004 stood at 3,095 (6.1% of the total waiting). At the end of September 2002 it stood at 9,158 (15.2% of the total waiting)

Source: Northern Ireland Waiting List Bulletins September 2004 and September 2002

Questions 156–157 (Mr Bacon): How many doctors have been disciplined?

There have been no cases in Northern Ireland where a Trust has had to institute disciplinary proceedings against any doctor for failing to fulfil their contractual commitments as a consequence of “persistent non-compliance” with local protocols for the notification of attendance at operating sessions.

Question 183 (Mr Jenkins): I shall not ask you about the bed blockers. I did not like the answer I got but I do not think I will get much farther than Mr Allan did on that one. Have you had any costs done for the non-attenders? If we can look at page 74, 4.32, the National Booked Admissions Programme that we have in parts of England where there are pilot schemes. Have you worked out how much you would be saving if you had a booked system as to how much it is costing for the non-attenders? If you have not got a figure, could you let us have a note on it, please?

In 2003–04 there were 1,663 cancelled sessions. The Department does not routinely collect information on the split between cancellations by the patient and cancellations by the Trust.

However, an exercise undertaken in 2002 as part of the Audit Commission's Acute Hospital Portfolio indicated that, in Northern Ireland, approximately 60% of cancellations were attributable to the patient. The equivalent rate in GB was 56%.

Assuming that this proportion has remained constant, and that no alternative use can be made of the resources that would otherwise have been applied to these cancelled sessions, then, with an estimated average cost per operating session of £2,500, the maximum cost of non-attenders in 2003–04 was approximately £2.5 million.

November 2004

Supplementary memorandum submitted by the Northern Ireland Audit Office

Questions 122–123 (Mr Bacon): Actual Use of Theatre Capacity

The Committee of Public Accounts at their meeting on 2 November 2004 examined a report by the Comptroller and Auditor General for Northern Ireland entitled *The Use of Operating Theatres in the Northern Ireland Health and Personal Social Services* (NIA 111/02, HC 522.) Mr Bacon (Q 122) asked the C&AG if it were possible that his office, together with the NAO, could assemble a chart similar to the one on page 66 of the C&AG's Report (Figure 8—*Operating Theatres: Actual Use of Theatre Capacity*, showing sessions held) but with a much larger sample so that the Committee could see a comparison of all the English Trusts with all those in Northern Ireland, as to the utilisation of capacity of operating theatres.

NAO has referred us to the Audit Commission's 2003 Acute Hospital Portfolio Review of Operating Theatres which compared theatre utilisation in acute hospitals across England and Wales.

Audit Commission Acute Hospital Portfolio Review

DHSSPS has contributed to this Review by commissioning a comparative review of theatre utilisation in Northern Ireland. The basis of the work undertaken was the collection of data across 12 acute trusts (16 hospitals) in September/October 2002 and comparing it with equivalent data collected across 240 acute Trusts in Great Britain in May/June 2002 as part of the Audit Commission's Acute Hospital Portfolio Review. One of the key relevant indicators used was "total actual operating hours/week per commissioned theatre". The following comparisons between NI and GB for this indicator were made:

Total Actual Operating Hours/Week per Commission Theatre		
	NI Only	GB and NI
	Hours per week	Hours per week
Upper Quartile	24.6	29.0
Mean	21.2	25.2
Lower Quartile	15.0	21.3

Four of the 16 NI hospitals were on or above the GB mean, and two of them were in the upper quartile. However, 12 NI hospitals were below the mean, with eight in the lower quartile. The range of hours per week, including GB and NI, was from 47.16 to 9.8. Causeway was the lowest ranked hospital in NI with a score of 9.8. The Ulster Hospital was the highest ranked NI hospital with 38.03 per week.

According to the Audit Commission, a well-used theatre unit would average more than 40 hours use per theatre per week, but very few unites are actually this busy and the average unit does only 24 hours work per theatre per week, but this varies between Trusts in England and Wales from eight to 57 hours.