Northern Ireland
Assembly

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Departmental Response to the 'General Report on the Health and Social Care Sector in Northern Ireland — 2008'

11 February 2010

NORTHERN IRELAND ASSEMBLY

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Departmental Response to the 'General Report on the Health and Social Care Sector in Northern Ireland — 2008'

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Members present for all or part of the proceedings:
Mr Alex Easton (Acting Chairperson)
Mr Thomas Buchanan
Mrs Dolores Kelly
Mr John McCallister
Mr Conall McDevitt
Mrs Claire McGill
Ms Sue Ramsey

Witnesses:
Mr Sean Donaghy)
Dr Miriam McCarthy) Department of Health, Social Services and Public Safety
Ms Diane Taylor)

The Acting Chairperson (Mr Easton):

On 19 November 2009, the Committee heard, in closed session, from the Northern Ireland Audit Office (NIAO) on its 'General Report on the Health and Social Care Sector in Northern Ireland — 2008'. The Public Accounts Committee referred that report to the Health Committee. That is the first time that that happened and, in effect, it is a pilot scheme for the Health Committee and for all Assembly Committees. In consenting to take part in the pilot scheme, the Committee

agreed to have a one-off briefing from the Audit Office, and over the next few months, it will call the Department to account on each chapter heading in the report. On 14 January 2010, the Committee heard evidence on section 2 of the report. Today's session deals with section 3, "Health Service Initiatives". I refer members to the suggested questions, an extract from the report and an extract from an Assembly research paper, all of which are included in members' Committee packs.

I welcome Mr Sean Donaghy, the undersecretary of the resources and performance management group, Dr Miriam McCarthy, the undersecretary of the healthcare policy group, and Ms Diane Taylor, the director of human resources. I invite you to make a 10-minute presentation, after which members will ask questions.

Mr Sean Donaghy (Department of Health, Social Services and Public Safety): Thank you and good afternoon. It is good to be here again and to have an opportunity to discuss the report. All the initiatives in the report are important and will have a considerable impact on shaping how the Health Service takes forward its challenges over the coming years.

In your opening remarks, you said that this is a new process. The PAC's pilot scheme is a new process for all parties involved, including the Department and the Committee. However, we very much welcome the process, and hopefully, as a result of the discussions that we will have over the next three Committee sessions, we will learn together which areas additional improvements may be made in.

In addressing section 3, today's session is specific to the review of public administration (RPA), the introduction of a new general medical services (GMS) contract, the introduction of a new contract for consultants, and the introduction of Agenda for Change, which is the generic term that we give to the new terms and conditions for the majority of health and social care (HSC) staff. Before handing over to my colleagues, I will make some comments on each of those areas, and I will perhaps have a little more to say on the review of public administration. Dr McCarthy will talk about the GMS contract, and Diane Taylor will talk about the consultants' contract and Agenda for Change.

The NIAO noted that the initiatives are big challenges and huge change processes. They came through at a time when we were managing the impact of the review of public administration.

However, we are determined to see them through. It will be a big challenge to manage all the initiatives in concert, but we are determined to see them through and to deliver the associated and expected benefits.

As I am sure members will recall, the Executive approved the review of public administration in June 2002. The idea was to review Northern Ireland's system of public administration and to put in place improved, more modern, accountable and effective arrangements for public service delivery in general. To put it in context, there were two phases to that plan for the health services. The first phase was the establishment of five new integrated HSC trusts, and, alongside that, the retention of the Northern Ireland Ambulance Trust. That was done in the context of replacing 18 trusts with six, so it was a major programme of streamlining and reducing management overheads across the six new trusts. That happened in April 2007. The second phase was introduced more recently on 1 April 2009. That entailed new organisational arrangements for replacing the four health and social care boards, the four health and social care councils, as well as a number of other agencies. Members will know that we now have one board, one Public Health Agency, and one new Patient and Client Council. We are well on the way to completing the RPA within the agreed timetable, which was set originally to end in March 2011.

RPA reforms are one element of the DHSSPS proposals to deliver 3% per annum over three years from 2008 to 2011. The RPA reforms are targeted to produce a reduction of approximately 1,700 posts in management and administration across health and social care. The savings that are associated with those plans are estimated at £53 million per annum.

Based on the figures that we collected from trusts, by September 2009 we had removed around 1,100 managerial, administration and clerical posts from across the system. As I said, the most recent RPA phase took effect on 1 April 2009, and we will continue to reduce the number of posts up to and, indeed, beyond March 2011.

The Audit Office reported that the costs of introducing RPA are considerable; and, indeed, they are. To date, the capitalised cost of early retirement and redundancy payments to people who have left the HSC voluntarily amounts to approximately £67 million. In that process, we are required to take account of forward payments to individuals and to represent the cost as a single lump sum. By the end of the implementation period, we expect that figure to rise to just under

£80 million, which is a change to the £90 million that our colleagues in the Audit Office forecast when the report was written.

I should pick up on another point in the report that asserts that those substantial sums are being spent "in compensating senior officers". The sums are substantial in any context, even in an organisation with a payroll of more than £2 billion. Our colleagues in the Audit Office accept that that is not the case. Payments were made to staff at all grades throughout the organisations, and if we define senior staff in three tiers, those who report to directors and above, chief executives and directors below them and those who report to them, senior staff constitute approximately a third of the staff who left through voluntary early retirement and redundancy arrangements. The arrangements were made available to all staff and were by no means exclusively to senior staff.

I should also say that the payments are entitlements that are based on the statutory provisions for staff in the HSC. Staff in the HSC receive those payments in common with NHS staff. All payments were made in line with those provisions; no additional compensatory elements were built in. In addition, we brought forward a specific test to be met in every case. That should reassure the Committee. For every post that was approved for voluntary early retirement or redundancy, the relevant organisation had to demonstrate that it would recover the cost in a little more than three years and that after three years it could show a return on every case.

It is also important to note that health and social care is the only major public service that has gone through the review of public administration process. That process is underpinned by a significant piece of primary legislation that was taken through the Assembly according to an exacting timetable to allow, in particular, the second RPA phase to be met by 1 April 2009. The reforms are not simply about reducing costs, and the savings that have been achieved by virtue of how the comprehensive spending review (CSR) has been constructed allow some reinvestment in front line services.

In addition to reducing costs, the reforms are targeted at creating better quality and safety of service through improved governance and assurance arrangements. They are also targeted at streamlining, to which I referred, as a result of moving from 18 to five trusts and from four boards to one and the creation of the new Public Health Agency. The reforms also target improved health and well-being and a reduction in health inequalities as a result of the focus that was

brought, primarily, by the new Public Health Agency working in conjunction with partners in local government, and the improved involvement of individuals and communities, which is, in part, the role of all bodies but, in particular, that of the Patient and Client Council.

Before passing to my colleagues, who will talk about two elements of that in particular, I shall comment briefly on the general medical services and other contracts. The general medical services contract was introduced in 2004, and all three areas were agreed nationally. That is an important point. They were negotiated on a national stage primarily by the Department of Health in London. Although there was input from the four Administrations, negotiations were done with a national outcome in mind.

The new general medical services contract came into force in April 2004, and it was designed to produce a wider range of higher-quality services for patients and to empower them to make better use of primary care. The contract gives greater flexibility to practices, and it is designed to reward them for delivering clinical and organisational quality, primarily through a quality and outcomes framework (QOF) that requires registers to be developed for a range of diseases. That framework sets outcomes that are linked to the better monitoring of those diseases to ensure better prevention and care over time for individuals who have diseases. It also facilitated the modernisation of practice infrastructure, including premises and IT.

At the end of the section of the Audit Office report that deals with the new general medical services contract, specific reference is made to the fact that the report by the Westminster Public Account Committee described out-of-hours arrangements as "shambolic". We do not think that that applies in any way to the arrangements in Northern Ireland. It is clear that some of the arrangements were difficult, particularly in the south of England, and that some areas were simply not covered by out-of-hours services. In our view, that is not the case in Northern Ireland.

The new consultants' contracts were introduced on 1 April 2004 and were designed to facilitate a more effective system of planning and timetabling consultants' duties. The outcome of that should be greater transparency about the commitments that are expected of consultants and, hopefully, for patients, fewer tired doctors and services that reflect better patients' needs.

Agenda for Change was implemented some six months later in October 2004, and it has three key strands. The first is an individualised job evaluation scheme through which every member of

staff in Northern Ireland — that is, over 60,000 individuals — had their jobs evaluated. That is to ensure fair pay for the jobs, which was a key outcome for the process.

Secondly, Agenda for Change created a common set of terms and conditions and a knowledge and skills framework to describe the competencies that are required for a variety of roles across the HSC. Thirdly, a personal development planning cycle was established to ensure that staff development is better linked to service demands. The benefits that have come from Agenda for Change include fairer pay, better pay for many individuals and better career development through the new knowledge and skills framework.

I shall pause there, and I invite Dr McCarthy to make some additional opening comments on the new general medical services contract. Diane Taylor will then make some additional comments on Agenda for Change and the consultants' contracts.

Dr Miriam McCarthy (Department of Health, Social Services and Public Safety):
I shall cover in detail a couple of points on the GMS contract that Sean touched on. First, it should be recognised that general practitioners are and have been the bedrock of our Health Service since 1948. They are the point of contact for the vast majority of people with self-limiting diseases and many chronic diseases. They are the practitioners who tend to know patients and their families very well; they often know them over many generations. They act as a key gatekeeper for referrals to hospital and other services. They are central to how we deliver care.

Prior to the introduction of the new contract in 2004, although the service was adequate, it was recognised that improvements could be made in some areas. In particular, it was considered at that time that a greater emphasis on quality and standards was required, rather than merely a response to demand. A greater emphasis was also placed on general practitioners in primary care providing a wider range of services. It is fair to say that a greater emphasis on relating remuneration to outcomes based on population needs was required. Lastly, a greater emphasis was placed on addressing GPs' workload concerns and the high levels of job dissatisfaction that they were experiencing at that time.

The contract addressed those areas in a number of ways, and I shall highlight a couple of the big messages that are part of the contract. The quality and outcomes framework was a central

plank in the improvement of services. QOF set a framework for general practitioners to offer incentives and additional payments for specific standards of patient care. It focused on standards and outcomes, and it linked remuneration to those standards and outcomes. That was pivotal and instrumental to changing the emphasis in primary care, and, in a very real way, it has delivered significant improvements. We tend to do better than other parts of the UK in the award of QOF points to general practice. There has been a real commitment to and excellent uptake of that framework across Northern Ireland. Indeed, the uptake levels suggest that we are well ahead in that area.

In addition to the QOF work, enhanced services have offered flexibility to target national, regional and local health priorities. There is a little more flexibility with that, whereas QOF applies across the UK and is agreed on a four-country basis.

Those enhanced services allow practices to meet the needs of patients in their local primary and community care settings, of which there are many. For example, Northern Ireland has 11 direct enhanced services, three of which are national, as well as 52 local enhanced services that are tailored to specific local needs and priorities. I shall illustrate the breadth of those services. Some focus on chronic disease, particularly chronic respiratory disease such as asthma, and on diabetes and smoking cessation and a range of self-management issues. A really diverse group of services is being enhanced.

Everything that we know from the patient experience survey indicates that general practice is of a very high quality. We feel it is important that users measure general practice objectively. Last year, we participated in the patient experience survey, which is applied and agreed across the UK. We invited approximately 220,000 people to participate, and we got a response from well over 100,000, which represents 45%, across Northern Ireland. The survey provided real and meaningful information from which we could learn about the system and how best it should be improved. Local general practitioners are able to learn from that information, and the point is that continuous improvement and valuable feedback from daily service users add to that process.

Another key plank of the new contract was that it tended to focus on the daytime and the out-of hours services in a slightly different way than had been the case prior to 2004. We have three trust-based and two mutual organisations that provide out-of-hours services to a high standard of quality and responsiveness. The results of the patient experience survey support that. That

survey included answers to questions that were asked specifically about out-of-hours care. Of those who responded, 75% rated the out-of-hours service as good, and only 10% felt that it was poor. That was a very positive response that I am not sure would be mirrored across all of the United Kingdom.

In summary, the GMS contract has delivered considerable patient activity through QOFs, as well as explicit and incremental improvements in quality. It has provided us with much richer information about what is going on in general practice, and it has allowed us to seek the views of patients and carers about how they access services. Those improvements represent a real advance since 2004. I will be happy to pick up on specific issues that members may wish to raise on any of those matters.

The Acting Chairperson:

Diane Taylor would like to comment. Given that we are running out of time, will you condense your remarks as much as possible?

Ms Diane Taylor (Department of Health, Social Services and Public Safety):

I will cover the consultants' contract and Agenda for Change. Northern Ireland introduced the new contract for consultants in 2004, in line with the national position. The new contract sought to modernise pay and introduce a more efficient use of consultants' time, particularly the length of time that they spent with patients, meaning direct patient care.

The contract was changed because the existing one, which had been in place for about 40 years, allowed consultants to earn up to 10% of their salary in private practice without any penalty. They could also see private patients during Health Service time. That created a conflict of interest, because consultants, rather than employers, had discretion over how they spent 50% of their working time. At the same time, the former contract did not allow for continuous professional development (CPD) to keep up the consultants' skills.

The new contract recognises a basic working week of 40 hours that was divided into 10 programmed activities (PAs), typically of around four hours each. Those 10 PAs should breakdown into 7·5 periods spent on direct patient care and 2·5 on supporting professional activities, such as CPD, clinical audit or teaching. The new contract also allows time protected for teaching juniors and medical students, and there are incentives for consultants who will

deliver care at evenings or weekends, when time and a third is offered.

The introduction of the new contract will ensure that there is a much more efficient use of consultants' time. Each consultant must agree a job plan with his or her trust, and that is a transparent way of seeing exactly what a consultant is delivering for the trust each week.

Job planning took some time to put in place, and the Department has worked closely with the British Medical Association (BMA) to ensure that job planning has progressed. To measure the benefits for patients, employers and consultants, the Department has developed a benefits realisation framework. Work on that framework is in progress, and it is with the BMA for comment.

The Agenda for Change pay system for staff was introduced in 2004, and it provides a fair and equitable pay system that benefits staff and employers and, ultimately, patients. It ensures that staff are paid on the basis of the job that they do and the skills and knowledge that they apply to that job. It is consistent with equal pay for work of equal value, and it allows greater flexibility to devise new ways of working that will deliver the range of quality services that are expected. It designs jobs around the needs of patients rather than the grades of the staff who are able to do the job, and it defines the core skills and knowledge that staff need to develop in that job. Extra money was paid to address local recruitment and retention difficulties where they exist.

The agreement has been implemented at each stage of the way in partnership with trade unions in Northern Ireland, and that process has been ongoing for about five years. Today, more than 99·7% of staff are on Agenda for Change pay rates, which is around 70,000 staff. The remaining 0·3%, which is the approximately 129 staff who are left in the Health Service, have been through the process, but their jobs need to be re-examined to ensure that they get a fair grading. They will have to go through the job evaluation process.

Around the same number of staff — 99·7% — have received their arrears, which have been backdated to the implementation date of October 2004, and 129 current staff have yet to be paid arrears. A significant number of staff who have left the service have yet to be paid arrears.

A benefits realisation document has been developed. It was agreed through the Department of Finance and Personnel and the trade unions, and it has been issued to employers in the Health

Service organisations. It will commence in April 2010, which will be the first round of monitoring.

As a result of Agenda for Change, it is expected that patients will receive treatment more quickly, staff will develop new roles and there will be shorter waiting times for services. Given that the contracts are more flexible than they were previously, there is now access to services over a seven-day week. The new pay bands end a demarcation in roles, which the old system encouraged.

The other strand that was mentioned was the knowledge and skills framework. The career and pay progression strand of Agenda for Change is mandatory for all staff, and work on that is being taken forward locally and nationally. In Northern Ireland, around 45% of staff have what is known as a knowledge and skills framework (KSF) outline, and 10% have a personal development plan (PDP). Those figures are low nationally, but we have taken steps to re-energise the KSF process in Northern Ireland, and we have staff who are dedicated to working on and moving that process forward in the organisations.

The Acting Chairperson:

Thank you very much for your presentation. I ask members to ask only two questions. I have a pile of questions to ask myself, but I am conscious that some members will have to leave, so I will restrict myself to two questions.

You said that £67 million to £80 million will be spent on RPA to get the processes sorted out but that that figure had been estimated at £90 million. There will, therefore, be savings of £10 million. Where will that £10 million go?

Paragraph 3.2.2 of the report refers to the ongoing integration of accounting and other functions on single sites to enhance efficiency. Has full integration now taken place, and if not, why not?

Mr Donaghy:

I apologise; we overran the 10 minutes that you gave us. I will try to be brief.

Ms S Ramsey:

You are trying to murder us with paperwork. *[Laughter.]*

Mr Donaghy:

The £90 million that was referred to was a provision. It was money that the Department would have had to spend on RPA and would have had to find. It did not have a cash pot with a £90 million label on it ready to be used. The Department is required to find that amount from year to year. The fact that that estimate has come down to £80 million means that there is less to be found. There is not a saving as such; there is simply no need to find £10 million that would otherwise have been required, although, obviously, any reduction in the total is to be welcomed.

Accounting systems have not been integrated across Northern Ireland to date. The five health and social care trusts that are the embodiment of the 18 former trusts have radically reduced the number of payroll, human resources and accounts payable departments. However, the five new trusts and the Department recognised that a significant investment in IT systems is required to move to a single integrated service across Northern Ireland.

The health and social care services in Northern Ireland operate a system that was conceived in the 1980s and implemented in the late 1980s. Anyone who is familiar with modern accounting systems knows that Oracle and SAP and others are old systems. They deliver in that they pay invoices and staff salaries accurately, but they are manually based and require significant manual intervention. The replacement project will cost an estimated £35 million in a three-year timescale. We are in the first year of that project, and a business case to take that investment forward was approved just yesterday by the Department of Finance and Personnel.

Alongside and underpinning that investment, there are significant savings of between £4 million and £6 million per annum, which will pay for the investment over time. Therefore, money is not being diverted away from front line care services; the project will pay for itself over time, but it is a huge venture that will take time and effort to manage properly. One of the lessons from any major IT implementations that have been done across the modern world is that rushed projects very often fail. Unfortunately, the Health Service in the UK can point to too many examples of that. Therefore, we are taking the project forward carefully, and we believe that it will deliver successful outcomes in due course.

Ms S Ramsey:

I want to make a couple of points. We are in the middle of an economic downturn, although, according to some economists, we may be turning the corner. However, we all have to take hits at this time. The 2004 negotiations for the GMS contracts took place in London, but we need to remind people that we now have a devolved Government and that we are the masters of our own destiny. Will we evaluate those contracts in line with the evaluations that other regions will carry out of their own systems? In parallel, are any other policies or contracts are decided in England with the involvement of the BMA? What involvement do we have? You may not have that information to give to us today, but we can get it.

I am interested in what Diane Taylor said about private patients being seen on Health Service time. Can we evaluate a situation in which a consultant has a clinic on a Tuesday, for example, and sees, perhaps, 40 patients, but sees 90 patients in an additional clinic on a Saturday? I am being told that that is happening. Can you remind me why the Agenda for Change excluded doctors and senior executives?

Ms Taylor:

The evaluation will consider private practice for consultants. We will look at the example that you have given, and we will ask why the number of patients that can be seen on Saturdays is double the number that is seen on a Tuesday morning.

Ms S Ramsey:

Is that happening?

Ms Taylor:

We will look at that.

Mr Donaghy:

There is anecdotal evidence that it is happening. Whenever people claim that twice as much is done in the private sector, that is a matter for the private sector. The Health Service does not have either the right or the ability to intervene or attest those claims. However, it is important that we ascertain whether anything is underpinning the anecdotes.

Ms S Ramsey:

At the same clinic in the same venue, 40 people are seen on a Tuesday in Health Service time, and 90 people are seen on a Saturday in private time when there is an incentive to be paid time and a third. Why can the same person see 90 people on a Saturday but only 40 people on a Tuesday? Diane says that that is being reviewed.

Ms Taylor:

Private practice is one of the areas that will be examined in the benefits realisation framework.

You asked why the Agenda for Change contract did not cover doctors and dentists. Traditionally, doctors and dentists have always had their own mechanism for negotiating pay through the BMA, which is not affiliated to the other trade unions as such. Agenda for Change harmonised the terms and conditions from 14 different groups of staff, but it did not attempt to look at doctors' and dentists' pay.

Ms S Ramsey:

Can you give us a rundown of the policies or contracts that are decided in England?

Ms Taylor:

Yes. Generally, we are involved in everything that happens in England.

Ms S Ramsey:

We pick up the pieces of everything that happens in England.

Mrs McGill:

What is the situation for staff who have still not been paid their arrears under Agenda for Change? Has everyone received the pay to which they are entitled? Who is still waiting for pay? If a significant number of people have still not been paid, what are the implications?

Ms Taylor:

Some 99·7% of Agenda for Change staff have been paid their arrears.

Mrs McGill:

Are 200 still waiting?

Ms Taylor:

Some 129 current staff are still to be paid arrears. They are the people whose jobs have not yet been evaluated properly and who, therefore, have not been banded. There is also a number of staff who worked in the Health Service but who have subsequently left. Trusts are paying around the 10,000 staff who have left the Health Service since 2004.

Mrs McGill:

What is the time frame for paying those 129 staff? I am concerned about the very difficult situation in which staff find themselves.

Ms Taylor:

It is an extremely complex area.

Mrs McGill:

I am aware of that. I have some idea of the job evaluations that were conducted for staff in the education and library boards. The process is very stressful and creates a lot of problems for the staff whose rate of pay has not been raised to the level to which they are entitled. What is the time frame for paying those 129 staff?

Ms Taylor:

We have not set a time frame for evaluating the jobs of those 129 staff, because a review process is under way. That review relates to staff who are unhappy with their banding because they feel, for example, that it does not take account of additional duties that they think that they are doing. Once the review process is complete, we will know the total number of staff for which we must carry out a job evaluation. The staff who are not happy with the outcome will be added to the figure of 129.

Mrs McGill:

The process has some way to run.

Ms Taylor:

Yes; there is some way to go.

Mrs McGill:

My final question relates to the out-of-hours service. It seems that the change has cost a substantial amount.

The Acting Chairperson:

Is your question about Strabane by any chance?

Mrs McGill:

In deference to the Acting Chairperson and his generosity, I will not mention Strabane.

I am surprised that the feedback from users of the out-of-hours service has been so positive. It contradicts what I have heard in certain places in West Tyrone.

Dr M McCarthy:

We aware that we have a good out-of-hours service across Northern Ireland. We have a very responsive service, and this has been validated through the patient survey, and people know who to call and how to access it. In fact, 75% of people are happy with the service. However, it is clear that there is a cost to providing the service. We are looking at it in its totality and asking whether improvements could be made specifically by bringing together some elements and dealing with them regionally. We have been exploring that for some time, and it is coming to completion with the help of the health and social care boards, which are looking at the logistical issues. Therefore, we anticipate further improvements not only in the effectiveness of the out-of-hours service, which is something to be proud of, but in its efficiency and how it is run without compromising patients' ability to get responsive care for urgent issues that they bring to GPs' attention out of hours.

Mrs McGill:

The cost of the out-of-hours service went up from £6 million in 2003-04 to almost £20 million in 2007-08, but I would like to see the responses and the geographical spread of the 75% who said that the out-of-hours service was good. I am keen to see the methodology of that survey, particularly for areas in the west where people have to travel. It is much more difficult for people in rural areas to access the service than it is for those who live in Belfast.

The Acting Chairperson:

I declare an interest under Agenda for Change as a former member of Health Service staff.

Mrs D Kelly:

I might have to do that as well.

Mr McDevitt:

What are your reflections on the GMS contract in the light of the swine flu outbreak?

Dr M McCarthy:

We look most often to general practitioners to provide general medical services for the entire population and specifically to immunise people, as well as to offer ongoing advice on the prevention and management of illness. I think that it is fair to say that they played a valuable role in every stage of the swine flu pandemic. Many people will have contacted their general practitioner, and, at the outset, they may have been advised to stay at home, remain off work and take antiviral drugs to prevent the spread of the flu. As the vaccine became available, GPs vaccinated people who were at risk, and we were very keen to vaccinate those people as quickly and effectively as possible, because, at that point, we were anticipating a major pandemic. Therefore, it is very important to vaccinate high-risk folks who have chronic disease quickly. GPs have also agreed to vaccinate children who are under five years old, and they have progressed that. Therefore, they played a valuable role and made a major contribution to the management of the pandemic. They also reassured individual patients and their families.

Mr McDevitt:

I presume that those of you who work at a senior level in the Department felt that you were under tremendous strain during the swine flu outbreak and that you put in a lot of extra hours during the pandemic period. Is that the case?

Dr M McCarthy:

There was a commitment across the entire Health Service to ensure that we had all the measures in place to manage the pandemic as effectively as possible, and our Chief Medical Officer, Dr Michael McBride, really led on that work and ensured that we were well prepared. Looking back, we coped very well and responded very effectively.

Mr McDevitt:

Did you get any extra money for the hours that you put in?

Dr M McCarthy:

Personally, I did not. It is part of my role to respond to issues as they arise and to do so under my current contract.

Mr McDevitt:

Does the GMS contract serve the region well through its stated commitment to provide additional benefits to patients and to secure a quality of outcome framework for patients, given that GPs, for one reason or another, were able to use the opportunity to increase the revenue stream to their practices during the outbreak?

Dr M McCarthy:

It must be recognised that general practitioners provide general medical services under the terms of their contract. Providing specific immunisations is not part of that general medical contract. Therefore, whenever they administer immunisations, they are entitled to receive additional payment. They receive that payment, and administering immunisations is a really valuable part of the service. That is within their contractual arrangements, and it is, therefore, entirely appropriate for childhood vaccinations across quite a range of diseases.

Mr McDevitt:

Does that mean that you are happy with that?

Dr M McCarthy:

That is the way that the system works, and GPs play a very valuable role.

Mr McDevitt:

You cited the GMS contract as a huge advance for the region. You used terms such as “quality” and “value for money”. Are you happy in the light of what we went through, and I know that it was an exceptional circumstance, that the contract delivers the contractual arrangement that guarantees that we get best value for money from those who are already paid very well to deliver GP services to the community?

Dr M McCarthy:

Our primary care system and practitioners, which includes general practitioners, dental practitioners and pharmacists, provide a very valuable service. It may be helpful if I reflect for a moment on Sue Ramsey's question about the UK element of the contract and the national arrangements. Unfortunately, I did not get the chance to respond to that question.

The contract is agreed on a UK-wide basis. The ongoing monitoring of and adjustment to the GMS contract goes forward on a UK-wide basis, and representatives of all four Administrations are at the table and have the opportunity to discuss strategic direction and specific issues. Therefore, the contract is not imposed on us. We have the ability to influence it, and it is important to note that a key area that we can influence is the quality and outcomes framework, which we are continuing to develop. There was an important change in April 2009 when the National Institute of Clinical Excellence (NICE) began to play a major role in developing that quality and outcomes framework. That puts the framework on an evidence-based platform, which will help to ensure that we get value out of what we expect from the quality and outcomes framework.

We also have local flexibility with the GMS contract through locally enhanced services. We can tailor things to meet particular needs for people who are in certain areas or other aspects can be tailored. The contract is implemented on a UK-wide basis, but that does not stop us from having some flexibility to respond to our particular needs in Northern Ireland.

Mr McDevitt:

Perhaps the Committee could request a breakdown of the specific additional costs to the Health Service here arising from the need to be able to provide those extra vaccines.

I want to ask two quick questions, one for Mr Donaghy and one for Ms Taylor. Mr Donaghy, you said that senior staff account for about one third of all leavers. What proportion of the total cost of redundancy and severance pay was paid to senior staff members? Ms Taylor, you mentioned the Agenda for Change and the efficiencies that are being achieved in the redesign of jobs. What percentage of staff members had their pay increased, and what percentage had their pay decreased as a result of the Agenda for Change?

Ms Taylor:

I do not have the exact percentage to hand, but the vast majority of staff members had their pay increased. We are going to carry out a pay audit, which will tell us how many staff had their pay decreased. That happened in a number of areas where, when the pay calculation was done, some staff members found that they owed the system money. Their banding and pay went down.

Mr McDevitt:

Perhaps you will provide the Committee with a breakdown of those figures.

Ms Taylor:

Yes.

Mr Donaghy:

So far as the proportion of funds paid to senior staff members is concerned, I said that one third of the staff who left could be defined as senior, if you take reporting to a director as representing a senior grade. They tend to have longer service, they are paid more, and will therefore count for significantly more than one third. I do not have the figure, but I will provide it.

Mrs D Kelly:

Thank you for your presentation. I am not sure whether Agenda for Change affects me — I left the Health Service at the end of 2003 or beginning of 2004 — but I have noted it anyway. I always end up on the wrong side of things in such matters; I am either too young or too old.

I tabled some questions to the Minister on Agenda for Change, and it is my understanding that the full cost of the programme was met by the Department and given to trusts. Why are a number of staff, in this case, nursing-assistant staff and nurses at Knockbracken, still awaiting their back pay? How many staff overall are awaiting their back pay? Surely there is an inequity in the system if the senior staff received their golden handshakes, which cost up to £90 million, and the staff at the bottom of the scale who are earning £5 or £6 an hour are not getting their money. Surely that should have been handled better.

Mr Donaghy:

First, the Department funded the cost of Agenda for Change. It was funded through the system. There was debate about the precise costs, but the Department takes the view that those were met

and that the funds are available to all health and social care bodies.

The review of public administration, voluntary early retirement and voluntary redundancy are quite separate from Agenda for Change, and many staff who were on Agenda for Change terms and conditions have benefited from those packages if they met the criterion.

Mrs D Kelly:

That is the case if they are at the top end of the scale.

Mr Donaghy:

It is also the case if they are at the bottom end of the scale.

Mrs D Kelly:

There were not many such staff.

Mr Donaghy:

I made the point that one third of those who exited the service were senior staff. We will, of course, reply in due course to the question of what proportion of funds that accounts for. However, those packages were available to all staff.

I will return to the point about back pay. In response to members' comments, Diane made the point —

Mrs McGill:

Sorry; Claire McGill. Was that in response to my comments?

Mr Donaghy:

Yes.

Mrs McGill:

Claire McGill.

Mr Donaghy:

In response to Claire McGill's comments —

The Acting Chairperson:

From Strabane. *[Laughter.]*

Mrs McGill:

It is an important point.

Mr Donaghy:

To be deferential, I tend to refer to Committee members either as "members" or "Chairperson", but if you would prefer me to use personal titles, I would be happy to do so.

Ms S Ramsey:

It is St Valentine's week. Love. *[Laughter.]*

Mr Donaghy:

Cheers.

There are 129 current employees who have not received their full back pay. We attribute that in large part to the fact that there are appeal mechanisms in Agenda for Change that allow people to dispute whether they have been placed correctly. Due process has to be applied; people have to be given the opportunity to have a hearing and for that to be properly judged before any outcome is imposed. A proportion of that 129 staff is affected by that situation. If the staff in Knockbracken are faced with that position, they are 129 people of 71,000 who are waiting for arrears to be paid. It is important to get that sense of balance. It could be that you are speaking about a pocket of staff affected by those circumstances.

Mrs D Kelly:

Does that mean that of all the staff, only 129 have not received their back pay?

Mr Donaghy:

Of all current staff, our best information is that 129 have not received back pay. Perhaps Diane will comment some more on that.

Ms Taylor:

I will say a bit more about reviews. Arrears have not yet been paid to the staff who do not agree with their banding and have asked about a review. More or less as soon as they got their banding, they submitted reasons for not agreeing with it. A process of checking whether their banding should remain the same, go down or go up is ongoing.

Mrs D Kelly:

That should not take long to do.

Ms Taylor:

In theory it should not. It is being done in partnership every step of the way, and that slows the process. I think it that we will be halfway through 2010 before that process is completed.

Mr McCallister:

Are those people different to the 129 staff that you mentioned?

Ms Taylor:

We have not categorised them as not having arrears, because a good proportion of them could have already been paid, but they say that they are not being paid at the right rate.

Mr McCallister:

Does that mean that the 129 are —

Ms Taylor:

We know that their jobs are not right and that they need them to be evaluated.

Mr McCallister:

Does that mean that they are additional?

Ms Taylor:

Some could be caught in that situation.

Mrs D Kelly:

You have just conceded that their jobs are not right or as they should be.

Ms Taylor:

It is not that their jobs are not right; rather, it is that there are odd things about those posts resulted from the job evaluation. A full job assessment questionnaire, which is a 46-page document, needs to be completed for them.

Mrs D Kelly:

Craigavon is one of the areas that it is losing its out-of-hours service, so I wish to ask about that. You said that the Patient Care Service has said that it is satisfied that there is a good service, but we have now heard that that service will be cut. What are the criteria for out-of-hours services, and what flexibility do trusts have to cut those?

Dr M McCarthy:

Not all trusts across Northern Ireland will need to examine the responsiveness of their out-of-hours providers. I am not aware of the specifics of the Craigavon service. However, I do know that, for example, providers will need to look, and are looking on an ongoing basis, at the utilisation of the service. For example, quite a number of staff work in the out-of-hours service between 11.00 pm and 6.00 am, but that is not a time when people tend to call them. The figures that I have suggest that doctors treat perhaps only a handful of people and take only a handful of additional phone calls at night. The trusts may want to consider putting more people on earlier in the evening when there is a peak demand and fewer people on late at night at, for example, 2.00 am or 3.00 am. However, the service must be tailored to meet people's needs. The big thing is to ensure that people are dealt with in an appropriately speedy manner when they call with an urgent problem. The providers are always looking at that. However, I cannot comment on the specifics of the Craigavon service without seeing the proposals for that area.

Mrs D Kelly:

Are you really telling me that the out-of-hours services should be based on local need and that the removal of those services should not be seen as an efficiency measure or a cut that has been made because of reduced funding? Decisions about those services should not be led by money and finances.

Dr M McCarthy:

At the moment, I am aware that trusts are looking at how out-of-hours services can respond

effectively to local needs. In everything that we do, we should be thinking about responding effectively and maintaining high standards on quality as efficiently as possible.

Mrs D Kelly:

I am not sure whether Claire got an answer to her question about why the service costs £19 million as opposed to £6 million. I do not think that we got an answer to that.

Dr M McCarthy:

The service is a complex one that runs for quite a significant proportion of the week. It costs between £18·5 million and £19 million to run at the moment. However, as I say, we are endeavouring to see whether aspects of the service could be provided on a regional basis. That may help to reduce costs and perhaps make it easier for patients and carers to access and use the service. We are addressing that matter, and a lot of detailed work is going into considering it.

Mrs D Kelly:

I am interested to hear why a service that used to cost £6 million now costs £19 million. I am very keen to hear the answer to that.

Mr Donaghy:

The answer is relatively straightforward, but it may not please all parties. The agreed contract that started in 2004, which was a year after £6 million was spent on the service in 2003-4, no longer required general practitioners to provide an out-of-hours service. That meant that that service had to be provided separately. One of the explicit costs of moving from the old contract arrangements to the new contract arrangements was paying more for out-of-hours services. That was one of the explicit factors that pushed up the cost. The overall judgement that was made at a national level was that the sum of the parts of the new arrangements was greater than the sum of the parts of the old arrangements, even though the cost of out-of-hours care increased.

Mr McDevitt:

It might be helpful for the Committee to receive a detailed breakdown of the additional foreseen costs that have been accrued as a result of the GMS contract on either an itemised or a job-lot basis, whichever way those are organised. This brings us back to the question about phase two of the vaccination programme for swine flu. That was an unanticipated cost. The other scenarios that worry me are those that might lead to unanticipated extra costs. Frankly, such situations

would seem to begin to defeat the very purpose of agreeing the contract in the first place.

I would appreciate it if the Department would provide an honest corporate assessment of Ms Ramsey's point about whether it continues to be in the regional interest to be tied into a UK-wide collective agreement. I would also like an assessment of how the Department could corporately justify that, specifically in the light of swine flu and other potentially unforeseeable incidents. Such unforeseen situations leave big questions in my mind.

Mr Buchanan:

What has been the cost of the new contract for consultants? Was a benefits realisation plan implemented or prepared at the outset? Was there anything in the new contract to direct consultants to where they should work? I ask that because it is very difficult to attract consultants to certain rural areas in Northern Ireland. Most consultants want to work in an urban setting and do not want to move to a rural area.

One such area is the south-west quarter of Northern Ireland, which takes in Enniskillen, Omagh and up to Altnagelvin Area Hospital. I make no apology for lobbying for that area, and, over the years, we have had serious difficulty in attracting consultants to it. Miriam spoke about better quality and safer services, but what about equality? To achieve equality, we need to get consultants to move out of urban areas and into rural areas.

Mr Donaghy:

Specifying in a contract where people should work is not a practice that we have followed. Whenever people apply for a job, their judgement on whether they want the job is partly based on whether they want to live in the area in which the job is located. That tends to apply in any walk of life. There is nothing in our contracts that allows Northern Ireland healthcare, as a national entity, to compel or direct people to work in Enniskillen rather than in Belfast or Omagh. We advertise our jobs, and the number of people who apply for them reflects how attractive the prospect is. We have that in common with employers in most other walks of life.

Thus far, we have not said that we will direct consultants to where they work. Doing so would mean applicants not knowing where they would be working, and it remains to be seen whether that would discourage people from applying for a job in Northern Ireland. There is some debate about whether such a policy would be helpful in the employment of junior medical staff, but it

would certainly not be suitable in the permanent appointment of senior medical staff, who generally see out a lifetime career in the posts to which they are appointed.

Ms Taylor:

When the contract was introduced in Northern Ireland in 2004-05, it cost £21 million. That had risen to £29 million by 2007-08, which is the last year for which figures are available.

I said that a typical contract contains 10 PAs, which is the number of sessions each week for a doctor. In Northern Ireland, and nationally, new consultants might be put on 10 PAs. Existing consultants did a diary exercise about the work that they undertook. When those consultants went on to the contract, most of them were on more than 10 PAs. On average, a consultant in Northern Ireland is on 11·3 PAs, of which 8·4 are spent on direct clinical care for patients.

With hindsight, it would have been a good idea to have a benefits realisation plan implemented from the outset in 2004. That did not happen, and we are keen to get one in place as soon as possible.

Dr M McCarthy:

Returning to the question about where consultants work, a key issue that should not be overlooked is that there are geographical issues that sometimes act as incentives or deterrents to where people choose to work. Mr Buchanan is right about that. However, another key element is the specialisation that has occurred recently in medicine, which means that consultants need to work in bigger groups to keep up their skills and expertise.

What tends to happen much more frequently now is that consultants work in networks so that they have good links with their colleagues in other centres. I think that that will continue as we move forward. The consultants tend to work across hospital sites in a trust and, sometimes, across hospital sites in several trusts. That works to the professionals' advantage, because it maintains their skills and expertise. Importantly, provision of those specialist services also works to patients' benefit. For example, the specialist services can be delivered as outreach in more rural areas. That is an important changing dynamic.

Mr Buchanan:

How does that networking happen? Is it done by telephone link or by some other means? Do

consultants go out to those rural locations?

Dr M McCarthy:

It can be both. Obviously, it will vary depending on the particular specialty. For example, our cancer services' regional component is based in Belfast, but oncologists are in cancer units. Many highly specialist folk might go out and provide clinics and a number of other facilities.

As well as visiting consultants, telephone links have been established for that communication. Radiology links are much easier to establish because radiologists can access X-rays on their computer screens, and it is even possible to do that at home. Therefore, there are many aspects to the networking, but it all means that there is a joined-up approach to healthcare provision, rather than thinking that a site or place is the only component.

The Acting Chairperson:

Thank you for your interesting presentation. We hope to see you again soon.