Northern Ireland Assembly

Committee for Finance and Personnel

OFFICIAL REPORT (Hansard)

Sickness Absence in the Northern Ireland Public Sector: DHSSPS and Belfast Health and Social Care Trust

9 April 2014

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Daithí McKay (Chairperson)
Mr Dominic Bradley (Deputy Chairperson)
Mrs Judith Cochrane
Mr Leslie Cree
Mr Paul Girvan
Mr Ian McCrea
Mr Mitchel McLaughlin
Mr Adrian McQuillan
Mr Peter Weir

Witnesses:

Ms Marie Mallon	Belfast Health and Social Care Trust
Ms Patricia Corbett	Department of Health, Social Services and Public Safety
Mr Tom Hamilton	Department of Health, Social Services and Public Safety

The Chairperson: I welcome Patricia Corbett, the director of human resources in DHSSPS; Marie Mallon, the deputy chief executive and director of human resources in the Belfast Health and Social Care Trust; and Mr Tom Hamilton, the deputy director of personnel and corporate services in the Department. Will you give us an update on where we are with the report, the findings and how the Department has acted on them?

Ms Patricia Corbett (Department of Health, Social Services and Public Safety): Certainly, I am glad to do that. Thank you for this opportunity to provide oral evidence on the Audit Office report on sickness absence in the wider health sector. You have just introduced my colleagues. Marie is the HR director for Belfast Health and Social Care Trust, but she is here to represent directors of all the trusts in Health and Social Care (HSC). Tom has a specific role of representing the Department on any aspect of its sickness absence. My role in the Department is director for the HSC with responsibility for HR, pay and policy.

The primary reasons for sickness absence in the HSC are not unexpected. They are due to the physical and emotional demands of the job. All the trusts continue to very proactively address, manage and attempt to reduce sickness absence. Measures are being undertaken, which include rapid referral to physiotherapy, staff counselling, health fairs to promote positive health and well-being, sand the training of managers in the management of stress and how to get the best out of our Occupational Health Service (OHS). As you know from the information provided in the Audit Office report, within the trust, there are two main causes of sickness absence: musculoskeletal problems

and mental health issues. Both are increasing, and trusts are giving particular priority to addressing those causes.

There is also a significant level of sickness absence for which the cause of illness is unknown. The trusts have highlighted that that may typically relate to short-term absence of one to three days where, under absence protocols, individuals are not required to self-certify or produce medical certification.

That is just a general update. I will turn to each of the recommendations in the report to give you a flavour of the position at the moment. For recommendation 1, clearly, we all agree that the information systems for measuring sickness absence must be fit for purpose and the data required for analysis and reporting robust. The implementation of the new HR, payroll, travel and subsistence (HRPTS) system across the trusts provides that facility and will enable the Department to gather data, review sickness absence and inform the development of future policies or interventions with the trusts.

As part of the Department's governance arrangements with the trusts, each trust is required to establish a realistic sickness absence target, and that is expressed as a percentage of available staff days to be achieved. The Department intends to examine the target set in 2013-14, which was 5% of available working days lost, and use that to inform the baseline for 2014-15. That is as directed in the Northern Ireland Audit Office (NIAO) report.

Recommendation 2 is about addressing the long-term sickness absence caused by mental health issues and musculoskeletal illness, and looking at monitoring. The primary reasons for that sick absence in the health and social care sector are not unexpected: it is due to the physical and emotional demands of the job. There are varying levels of sick absences between the staff groups, and that is also not unexpected. For example, it is not appropriate to compare the sickness absence of administrative grades with those of nursing absence levels, or to compare the Northern Ireland Civil Service (NICS) with the health and social care sector in sick absence.
Factors such as contact with infectious patients and the nature and intensity of the work would need to be taken into account in any such comparison.

All trusts continue to proactively address, manage and attempt to reduce sickness absence.
Examples of measures being undertaken include rapid referral to physiotherapy and staff counselling, rolling out of health fairs to promote positive health and well-being, and providing training to managers on the management of stress and how to get the best from the Occupational Health Service. At a recent workshop we had with trade union colleagues — I say "we"; it was the HR directors in each of the trusts and the Department — we agreed to work more closely and collaboratively in finding ways to support staff and improve attendance.

The final recommendation was mostly about monitoring. The new HRPTS system will provide an excellent opportunity to review the area of sickness absence. Once the new system is fully established, the Department will work with trusts to set appropriate targets and establish a robust and consistent baseline. The reports from the system are still being tested and, once our departmental statisticians are content that those reports are fit for purpose, we will commence regular monitoring. That will be a great improvement as the current information is compiled from manual returns. The new reports will be used to give us early warning of issues of concern and, indeed, to highlight areas where there is best practice.

A key opportunity from the new system will be the improvement of sickness absence by making information available to front line managers in real time. In addition, regional sick absence reports by variables such as the reason for absence or by particular group will provide greater granularity and scope for analysis, and, indeed, early intervention. Over time, those reports will provide the trust organisations and the Department with a much more comprehensive and robust picture of sick absence across the region.

Absence levels within DHSSPS have reduced significantly over the past number of years. Although the 2012-13 target of 8·2 days was not met, the Department's absence level was significantly below the NICS average of 10·6 days. The target for 2013-14 is 7·5 days. The main reasons for absence due to illness are in line with the NICS overall, with anxiety, stress, depression and other psychiatric illnesses being the main issues, followed by musculoskeletal problems. The Department has a very successful workplace health improvement programme aimed at encouraging and supporting staff on health-management techniques. In the Department, we also have an improvement plan, which includes regular briefings to the board to raise awareness, early referral of cases to Occupational Health, measures to improve recording of absence and complete return-to-work interviews, and additional support for managers where there are particular complex issues in cases.

The Chairperson: Thank you. We are just going straight to questions.

Mr Weir: Thank you, Patricia. Just go over one of the statistics again. Did you give figures for the Department for 2012-13?

Ms Corbett: The 2012-13 target of 8·2 days was not met.

Mr Weir: Right. The Audit Office reports that we have, on the face of it, been given a clean bill of health — forgive the pun — for the Health Department, because the figures were pretty good. Figures were produced for 2011-12 showing that the absence level had gone down to 7·1. To be fair, I think that, in 2011-12, of all the Departments, the Health Department had the best figures, but there seems to have been a little bit of regression if you have gone up to 8·2 this time around. I am just wondering what you see as the factors that led to a little bit of slipping back. Do you think you have produced targets that are challenging enough in that regard?

Mr Tom Hamilton (Department of Health, Social Services and Public Safety): I will pick that one up. Unfortunately, yes, over the last couple of years, the figures have gone up, although the trend over the longer period is downward from 11·4. Month on month, we have, on average, between eight and 12 or 13 people off sick. Unfortunately, for the last couple of years, we have had quite a significant increase in people suffering long-term conditions such as cancer and heart diseases. Just under 50% of the staff in the Department — I think we have 638 staff — are over the age of 50. There is a tendency for people not to go off sick as frequently as in other Departments, but when they do, it tends to be for the more serious type of conditions. As I said, over the past year or two, we have seen a significant increase in more serious conditions.

We have robust procedures in place. We have tried to tighten up referrals to OHS. During the year, when we had the good figures of 7·1, we referred people, as probably most NICS Departments do, at around 20 days. We have reduced that to 15 days and are trying to get people to OHS more quickly. After they have been seen by OHS, we try to get to the nub of the issue and see whether there are any adjustments that we could make in the workplace that would enable them to get back to work as quickly as possible. Unfortunately, we have seen that increase in those serious conditions.

Mr Weir: There is the issue of the Department and there is the issue of the trusts. I appreciate what was said about not necessarily comparing like with like with trusts because there are factors such as the number of the staff on the front line in the trusts who are in direct contact with patients. There is always the danger that they are more likely to pick up infections, even colds or the flu if that is going around.

You mentioned the HR managers coming together to try to apply best practice. That is very useful if you have other good procedures in the Department, but if those are not rolled out to the trusts, there will be a limited amount of value because that is where the bulk of the staff will be. How do you ensure that whatever good practice and lessons you have learned directly in the Department are applied across the system? The thing about the sector is that the Department itself is arguably just the tip of the iceberg: there are a lot of organisations directly connected through the trusts. How do you ensure that that is rolled out across the full spectrum of the health sector?

Ms Corbett: You are absolutely right. Part of my role in the Health Department is to work with and understand what is happening across the NICS. I then take that best practice and the lessons learned into a forum where I meet the HR directors from across the trusts every month. I should add that each trust has its own policy, albeit as part of a regional framework, for tackling sick absence. Many innovative approaches are being adopted in the trusts, some of which are similar to what is happening in the NICS. There are different and additional measures and activities taking place and each trust has its own plan for addressing those, so sharing best practice involves two-way communication.

Did you want to add anything to that?

Ms Marie Mallon (Belfast Health and Social Care Trust): I am happy to comment. Taking the point about the issue of infection, it is not only about our staff picking up infections from the patients. We are very sensitive to the fact that we would not want our staff to endanger the lives of patients. It is one thing for someone to come into an office environment with a sore throat, and I apologise if my voice goes today, as I have a sore throat. I will keep away from you —

Mr Weir: I am sitting beside Paul Girvan, and he is 10 times worse. You will certainly not be sending him to any ward in Northern Ireland. *[Laughter.]*

Ms Mallon: I just could not bear the thought of not appearing due to sickness as it would have been too ironic.

It would be another thing to send a nurse to a vulnerable patient, so we are very conscious of that. That is a factor, and we accept that. I am happy to give an overview of the approach that we take in trusts generally, if that would be helpful.

The Chairperson: Yes.

Ms Mallon: Health cannot be compared with other Departments, but it can rightly be compared with other health systems in England, Scotland, Wales and so on. We do that, and the industry norm, as it is described in HR circles, is around 5% on average. That means that some organisations will do better than others. In Northern Ireland and, indeed, throughout the UK, all trusts are conscious that it is not just about meeting targets that are set, which is absolutely the right thing to do, but also because sickness has a cost. It has a financial cost, which is hugely important, and it has a cost in patient continuity and care.

If sickness levels are too high and you are dependent on temporary, bank or agency staff, that is not the best way to treat patients. We push very hard on sickness levels. In health, we are well placed, because of the nature of our business, to understand that, if we try to be proactive in securing our staff's health and getting them to take responsibility for their health and well-being, that has an effect generally on the population, which is a good thing.

Our approach is threefold, one of which is the preventative measures that we undertake. Patricia rightly said that the two main reasons for sickness absence in health right across Northern Ireland are musculoskeletal and mental health, with mental health being the highest. A big part of that is bereavement. Another big part could be depression associated with personal lives. People go through these things in life. We know the statistics for depression. Some of it will be stress associated with the workplace or other situations, marital or otherwise. It is interesting to note that that is reflective of society; it is the same as the Civil Service. It is hugely important. The other one is musculoskeletal.

So, what do we do? Knowing, as we do, that that is responsible for 40% of our long-term absence, we put in place strategies to address that. The mental health strategies are extensive. It is about looking at risk assessment individually and collectively with individuals. It is about managers being able to spot the signs of stress. We have training that we give to managers to say, "Look out for these signs of stress with your staff". We have booklets and information that say, "Here's what to do. Here's how to address it. Here's how to have the conversations". If there is a limit to what someone can do, we ensure that they are referred to Occupational Health, our staff counselling service or whatever is appropriate to their needs. That is hugely important.

Health and social care is very pressurised. I should emphasise social care because many of our social services staff, nursing staff etc have to deal with very challenging behaviour from our more vulnerable clients and so on. That can cause pressures, as well as the pressures you hear about in emergency departments (EDs), wards and so on. We have to take account of that and try to be proactive. We do a risk assessment, and we work very closely with a health and safety agency to understand what that means and how we can bring about improvements in certain areas.

When it comes to the situation in which people need a referral, we try to intervene and assist. When it comes to musculoskeletal issues, it is about preventative measures and then addressing them. Across Northern Ireland, a huge number of nurses — there must be over 20,000 nurses — deal with patients every day, lifting and handling. We have lifting and handling as part of our mandatory training to ensure that they can do that safely, but things happen. We make sure that we have the right equipment and so on. If they have musculoskeletal issues arising out of their own health, there are a number of schemes in health across the patch in which they get pretty rapid access to physiotherapy. We make sure that our patients are not disadvantaged by that. We have ring-fenced some money to try to put in physiotherapists to look at our staff specifically to accelerate their return to work. We also use things such as phased return to work, where people can take it easy; maybe they will not go into their normal job. We get them back into work. A TUC report stated that work is good for you. We know that it is good for mental health. Those sorts of approaches are taken.

We have many health and well-being — it is about more than just health — initiatives right across the trusts. We have things such as choirs, Zumba dancing, Weight Watchers, looking after yourself, mental health issues, sexual health, men's health, health preventative measures and health improvement measures. Those are all to try to ensure that our staff are in the best place they can be with their health before they come to work. That all having been said, it is still a challenge. It is a challenge to move it that other 0·5%.

Although I have seen a downward trend from the formation of the trusts since RPA in 2007, it is plateauing at around 5·5% on average across the patch. I am delighted to say that, in line with the recommendations, we have implemented the new human resources, payroll, travel and subsistence system, which will measure sickness levels more accurately and give us more detail on the types and categories of sickness, and will give managers real-time information as opposed to retrospective information — sometimes, it is a little bit late — so that they can apply the third part of our plank, which is our absence protocol. It is a jointly agreed absence protocol with trade unions. Managers are obliged to follow an approach that includes triggers. A certain amount of absence triggers a certain amount of action, including return-to-work interviews, counselling, disciplinaries, referrals to Occupational Health and all the things that should happen so that there is not a passive approach. Ultimately, there is accountability for that from the point of view of holding managers to account.

Sorry if I have gone on a bit on that. It is a potted version of our approach.

Mr Weir: It was very useful.

I have one final question arising out of that. It was interesting to listen to what you said about the very thoughtful approach that has been developed. I appreciate that, if you look at other branches of the public service or the Civil Service, you see that some problems are particularly acute for you. You talked about musculoskeletal illness and the situation in which nurses, porters or whatever are helping to lift patients regularly, which would have a particular impact. If you are sitting in a rates office and the lifting you are doing is lifting a rates bill, it is not going to be quite the same strain. The thought occurred to me that you are coming at this from two particular situations. One is the general thing of dealing with the various medical problems, be they mental or physical, of your staff in that broader sense as an employer. You are also, in adopting strategies, perhaps in a unique position in the Civil Service and the public service. Because you are the Health Department, a range of those things are particularly acute to you regarding potentially providing solutions, such as looking at physiotherapy. You have a degree of expertise of input through medical thinking on how best to get people back to work etc.

I think that Patricia talked earlier about trying to ensure that there is roll-out from the Department through the trusts and HR. With a lot of that stuff, you are potentially in the position in the public service in Northern Ireland of being the closest to best practice in a lot of areas of any of the Departments because you have on hand a certain level of expertise, which is not necessarily going to be there in the other Departments. To what extent is there interaction between the Departments to try to share that degree of best practice? It strikes me that, if, generally speaking, you have been more successful in reducing the number of sickness days, although there are some things that may be peculiar to you, there are also a lot of lessons for across the Civil Service. To what extent are you sharing that best practice? Is that being sought to try to ensure that what permeates in health will permeate in the Department of Justice, the Department of Education or whatever?

Mr T Hamilton: There are various forums. It is certainly discussed. I think that Colin Lewis is coming in a few weeks to talk generally about the NICS and what is happening in different Departments. Colin and his team liaise frequently with us and look at programmes we have in place. I know that Ken Addley was here last week and talked about the WELL programme. We have our workplace health improvement programme, which fits in with what Ken is doing. We very much link in with the like of the Chief Medical Officer's report and the issues being flagged up, such as the mental health issues and the obesity issues. We try to have our own programme in the Department that seeks to address those issues through a range of programmes, such as healthy eating, fitness, weight loss, depression and mental illness.

As I said before, we have a fairly high percentage of staff who are over 50 in the Department, so we look at what we can do to provide help for staff who have caring responsibilities for, in many cases, elderly relatives, as opposed to some other Departments, such as the Social Security Agency (SSA), which has more staff with child-caring responsibilities. So, we tend to try to tailor what we can offer by way of support to our staff. There are opportunities through DFP's corporate human resources (CHR) to share that information so that we can hopefully get best practice across the NICS.

The Chairperson: Leslie, I am going to bring you in at this point, because we have sort of delved into your line of questioning.

Mr Cree: Yes, you are getting very close to a subject that is very dear to my heart, and that is the matter of mental illness and musculoskeletal illnesses. You touched on what has been happening there, but obviously it is not enough, because the incidence is increasing. What further plans have you, if any, to address that particular concern?

Ms Mallon: I mentioned health and well-being. We have a health and well-being group that consists of professionals from within the trusts as well as HR, Occupational Health and so on. We set down a plan every year for how we are going to address those two major causes. We work very closely with bodies outside of the trusts, including health and safety and people who deal with mindfulness, which has become one of the new issues. It is about cognitive therapy, how you perceive what is happening to you in life and how you react to it. All the time, we work to best practice. As was mentioned before, it is probably easier for us to do it because we can access best practice and use it in the implementation of our stress strategy and how we roll that out. We import anything that is known to help.

One of the big things that we have found about mental health is that people have lots of private issues etc, but things like being together in a group and exercising really help. That is why we have the exercise classes, the Zumba dancing and the choir. They are not medical interventions as such, but we use them to deal with individuals as people and to engage them with other people, because we have found that that is one of the best ways, so that they are not isolated with their problem. Our experts tell us that that mindfulness is really helped by that approach. So, we are informed by the experts regarding the strategy that we deploy.

Mr Cree: Is that something new that you are telling us here?

Ms Mallon: I can speak for my trust. We have a programme called Here 4 U. It is a whole approach to outline how we can improve people's mental and physical welfare. People can tap into that on their own just by saying that they want to join, or we can refer them if they have gone through staff counselling or Occupational Health. It is that idea of engaging people in a positive way so that they are far removed from their problems. That is not to say that they will not have problems. One of the practical things that I will say, for example, is that a lot of individuals, particularly during recent years, have had financial problems, which have had a big bearing on their mindset. Some of the trusts offer help and assistance regarding, for example, Citizens Advice, so that people can go to get confidential counselling about their problems. So, it is a more holistic approach. It is not just saying that we will deal with the symptoms of your problems, but that we will try to assist you with your problems.

Mr Cree: I accept all that, but is that a new idea or is that something that you have been doing for a long time?

Ms Mallon: We have certainly been doing Citizens Advice for a long time. The Here 4 U programme has just been the last couple of years in its totality. There have been different interventions over the years, but this is an intense version of it. We also do things like health fairs. If you go into a canteen area or whatever some days, you will find some of our Occupational Health and other people checking people's cholesterol, their blood pressure and all that. So, the totality of the number of things that we are doing is the most recent. We have always done some things, but bringing them together in one major programme is the difference.

Mr Cree: Do you not think that all that activity brings further stress?

Ms Mallon: Not at all.

Mr Cree: I will just ask you one other quickie. There is a table in the report that provides a breakdown regarding the mental health issues, the musculoskeletal ones and the unknown one. Can you fill us in a little bit more? That is quite a significant proportion.

Ms Mallon: You are absolutely right: the unknown one is one of those codes you never want in anything. It is sort of like a dump code, and it tells you nothing. We are happy to say that the new HR, payroll, travel and subsistence (HRPTS) system, which all trusts have implemented in the past few months, does not allow anyone to enter anything unless they are explicit about the condition. For

example, if they go into the system and are asked about the condition and they reply that it is post-surgery recovery, the system will force them to categorise the type of surgery. The manager cannot fill in that field on the computer unless they give exact information. In that way, we will, in future, have more precise information than "other", which is not helpful.

Ms Corbett: The other element of that system is that we will use what are known as the sickness absence recording tools (SART) codes that are recommended by the medical professions. It is used in the NICS as well, so you are using the same recording tool, which is in European use, so that the information can be compared, not just with the public sector but, in time, we will be able to compare with other trusts or similar health bodies as well.

The Chairperson: Leslie touched on some key points about mental and musculoskeletal illness. He talked about healthy eating, which is a big issue. Often, when you go into hospital, you get a plate of chips when you are taking a break from seeing a patient. Do you believe that the Department of Health, our hospitals and places in the Department's remit where you eat are exemplary in comparison with other jurisdictions and even with European standards?

Ms Mallon: Our Chief Medical Officer was mentioned, and it was only last week that I heard Dr McBride on the radio once again emphasising the issues around obesity and healthy eating. We in the Department are very aware of what he is saying and his requirements. In our canteens, you are quite right, you will see chips, but you will also see healthy options. There is an issue about choice, and it is a debate as to whether you exclude chips. The first thing that you see when you go into where I am situated, in the City Hospital, is the salad bar and the healthy options. You can then go to the hotplate, where, inevitably there will be chips as well as other hot food. It is about choice, but, on balance, if you look throughout the canteen, most of the food is healthy. However, it is about giving people choice.

The Chairperson: Is it any better than any other workplace? The Department of Health should be leading in healthy eating.

Ms Mallon: That is a fair point. Whether it is better than other workplaces, I am not sure, because I do not know about other workplaces. I have not done the benchmarking. However, I take your point.

The Chairperson: It is important that, if you are to deal with sickness absence, you look at the public health aspect, active travel and healthy eating. If I am queuing to pay for my diesel at a filling station, all I will see is a row of chocolate and crisps. If I go into a hospital and do not see a healthy option when I queue for food, the whole way that the place is laid out is wrong. There are ways and means of highlighting certain choices to people in the hospital jurisdiction. Health needs to make that a priority if it is to be seen as the Department that promotes health.

Ms Mallon: We try to do that, which is why the salad bar is the first thing that you see, but yes, I am happy to reflect that back to the trusts.

The Chairperson: What is the Department doing about active transport? It is something that the Institute of Public Health (IPH) raised with us. Two of its main issues were healthy eating choices and active transport. Is the Department of Health offering enough choice and accommodation for staff in that regard?

Ms Mallon: It signed up to the Cycle to Work scheme to encourage people to cycle to work because it is a healthy thing to do —

Mr Cree: You are saying the right thing.

Ms Mallon: We also encourage it for environmental reasons. It has a big take-up. You will regularly see, if you come into hospitals, lots of folk, including our doctors, interestingly enough, cycling to work. We try to provide somewhere for them to chain their bikes and so on. We encourage that.

The Chairperson: How do you encourage it?

Ms Mallon: Through staff bulletins, through organisations' intranet and by sending out flyers saying that it is part of what people can access. It is part of the Here for You strategy in Belfast. There may

be a different name for it in other trusts that people can access. We list the things that they can access to make their lives better.

It is everything from cycle to work to all the health issues that they can access; it is also issues around work-life balance and family-friendly policies. There is a cohort of policies that, overall, we include in our trust — they will have different names elsewhere — that are about our approach to improving working lives, improving your health, improving your balance and improving your availability for work through ensuring that there are care policies, etc. It is a strategy within a strategy, and there is good take-up of it.

Mr Girvan: I have a point on the mental health issue from a management point of view, as it needs to be looked at. Through another Committee that a number of us sit on, we identified that people are reluctant to put themselves forward as whistle-blowers because of an evident culture of bullying that exists, specifically in the Health Department. As a consequence, some people who go forward end up taking time off because of stress-related sickness, and I can think of one area in the private sector in particular. The management decided to get rid of one person, and it halved overnight the sickness in that one area of the department. Has there ever been an investigation by management into perhaps big areas in which people are off with stress and individuals may be the cause?

Ms Mallon: In a system with 70,000 staff across Health and Social Care —

Mr Girvan: I am talking about one in which almost 1,500 people worked in that place, and they were able to deal with it.

Ms Mallon: I agree with you. In my career in the health service, I have dealt with many instances of bullying. You are absolutely right: it can have an impact on a Department and on many people, so it has to be addressed. Let me be very clear: bullying is not tolerated or accepted in Health and Social Care. Where it happens, it has to be addressed, and it has been addressed.

Mr Girvan: It is usually coming right from the top. By that, I mean from consultants down.

Ms Mallon: In my time, I have dealt with consultants who bullied, but it does not matter whether it is a consultant or a clerical officer, it is not acceptable. We survey our staff to find out what is going on. All our bullying policies and our approaches to bullying and harassment are agreed by and with our trades unions, which work in partnership with us to ensure that that environment does not happen.

I have responsibility for the whistle-blowing policy in the trust. We have whistle-blowers dealing with all sorts of things, and their rights and confidentiality are protected. I take your point: if you do not address a problem — it may be only one individual — the impact can be catastrophic, so why tolerate it? We set out to do all we can to prevent it and deal with it when it arises.

Mr D Bradley: Morning. I want to ask you about the comparability of information and statistics among DHSSPS, the trusts and NICS, as those organisations collect different information and forms of information. What attempts have been made to align the information so that there is direct read-across?

Ms Mallon: I certainly do not know of any attempts because the comparator — I mentioned this at the outset — was probably more appropriate to other health and social care settings. You are right: it creates a difficulty because, if we try to compare ourselves with any sector, whether Civil Service, education etc, it is hard to tell quite how well we are doing.

Ms Corbett: You are absolutely right. Having the data and the information to allow us to do comparisons is what informs future policy and interventions. What is clear for us in the Department is that the monitoring over the past years has all been manual, and you will know the issues and the problems that manual recording brings. In addition to the point that Marie raised about the short-term absences where the cause is "unknown", there is a huge amount of data that we cannot get at and examine.

The advantage of, and the investment in, the new HR system will bring with it that commonality that will provide, not only the data on the days absent, but, as I said earlier, an industry-standard identification of the reason for the absence. We will then use that data, not just the reasons for the absence and the number of days, but to segment it by working groups, which is something that we

have not had access to, so that appropriate comparisons can be drawn either at consultant, nursing or admin grade.

There will be grades where it will be appropriate to make comparisons with the Northern Ireland Civil Service and others where we would not want to make that comparison because of the nature and intensity of the work, the rostering hours and other influencing factors. However, we could find, not just appropriate comparators, but benchmarking to take single packages of best practice and apply them to particular grades or types of illness. The opportunities that lie ahead from having that rich source of data and information will enable us to make improvements and give us information that we have not previously had access to. That will inform and change thinking on how we deal with those issues.

Mr D Bradley: I have just noticed that, on page 30 of the report, it states:

> *"DHSSPS does not hold information beyond the summary level identified in its six-monthly report. It is therefore unaware of underlying issues, for example the extent of long-term sickness absence, the main causes of sickness absence or any relationships that may exist between sickness absence levels and age, gender or grade."*

Is that what you are talking about addressing?

Ms Corbett: That is exactly the point, and you have added further segmentation to the data, by age, gender and grade. We do not have access to that; moreover, collecting data manually is prone to human error. It is out of date by the time you get it. We are doing the analysis manually, so it is six-monthly, it is retrospective, it does not provide managers with data and information that allows them to manage and to take action and interventions that can enable improvement. Everything is in an historic sense, but we are moving towards a real-time system where we can, if you like, get real-time reports. Focusing on particular areas will make the difference.

Mr D Bradley: You said that much of the information was collected and recorded manually. Are you now moving to an electronic system that will improve the collection, recording and comparability of information?

Ms Corbett: Yes, that is the new HR, personnel, subsistence and travel system that is being rolled out across all trusts. The data will be recorded by managers and staff electronically, and the Department will have access to it. Our statisticians will be able to draw down the data and slice and dice it to provide management information reports. It is not just the Department; the trusts and line managers in the trusts will have real-time information on their staff, on the trends, on the historical position and be able to act accordingly at all levels, at management level, front line management level, senior management level in the trusts and then at a regional level at the Department.

Ms Mallon: We are not sitting in the trusts counting things up manually. The old system was electronic, but there was a manual transfer of information through salaries and wages that inputted it, and it was a bit archaic. Nevertheless, even within its limitations in the trust, managers are regularly informed of their performance as part of their accountability review. The Department cannot access that in the way that is needed to understand data across Northern Ireland, and that is what Patricia is emphasising. However, I would not want you to think that we do not examine on a monthly basis, because our sickness figures go to our board every month, the same as with other trusts. The old system is not sophisticated, but it still provides us with some information. We think that the new system, once it is embedded, will be super.

Ms Corbett: It will also allow proactive management.

Ms Mallon: Yes, across the whole region and with the Department, which will be really good.

Mr D Bradley: Are you happy that the new system will identify the gaps in information identified in the Audit Office report?

Ms Mallon: Absolutely. The beauty of it was that it was a system that we designed. For example, one of my assistant directors spent two days a week for months, along with others, going through every element of it and making it our own. What do we want? What do we need? What are the issues and

challenges? How can we make the system work for us? That time and detail have meant that we have a super system, so we are looking forward to using it to its full extent.

Mr D Bradley: It is good to have all that information to have the comparability and so on, but will it lead to any real results in reducing sickness absence levels?

Ms Mallon: We believe that it will, first, because it is real-time information. Managers in health, for example, sometimes look after hundreds of staff not in their sight line. They will only have to go on to their dashboard to see information on appraisal, absence, who is in and who is not, for example. Having real-time information and having conditions recorded will help to inform our strategy on what areas of health and well-being we concentrate on. Are there other things that we need to do by way of prevention? Then we centrally, corporately and as part of the accountability review process, will be able to hold managers to account in complying with the absence protocol, given that we have all the information about an absence, the reasons and so forth. We will be able to ask, "What have you done to deal with that?" That should all result —

Mr D Bradley: Can you give us an example of the information that you will receive through the new system, how you will act upon it, and what improved outcome it could bring?

Ms Mallon: Certainly. People are forced to go in and say what is wrong with someone. So if someone has recently gone into hospital to have surgery, we can see that that surgery is associated with a bone — musculoskeletal — if it is an operation on their shoulder, for example. That means that we know that there is an issue there and that, if we could accelerate their physio service, they could get back to work more quickly. Therefore, we have that immediate information and can refer it to our internal staff physio service to help them to return to work more quickly. That is happening as we speak.

Mr D Bradley: That is a good illustration of an individual case. I was thinking more of the broader bands of sickness that might be revealed through the information.

Ms Mallon: Even under the old system, we could identify that some of our ancillary and general staff — our support, domestic, portering, cleaning, catering and so on — were the groups with the most sickness. They traditionally have higher levels, although those levels have almost halved, certainly since my time before the trusts, and they are very good. We know that there is a high level of sickness there. What are we going to do? We have attendance managers and experts who do case management work with individual managers. We would send them in to say, "Your sickness levels are becoming problematic. Give me your top three — or whatever number of people — who have poor attendance. We'll case-manage this through with you". There is real-time information. We can see it centrally, the managers can see it, and we can go in there. I do not want you to think that we go in in a heavy-handed, punitive way, because people may be genuinely sick. However, if we see a pattern of absence that looks problematic, we can send people in quickly to work with the manager to deal with it.

Mr D Bradley: What was the figure that you gave for the total cost of staff illness in the health service?

Ms Mallon: We have not given a figure.

Mr D Bradley: Is there a figure?

Ms Mallon: No. As I understand, there was a figure in the report, and I looked at that. I am not sure how it was made up, because there is the cost of absence through the loss of productivity with people being absent. However, there is an additional cost if you have to backfill a nursing post, for example. If somebody is off in an office, you will not backfill; but you will not leave a nursing shift unsafe, so you will backfill nursing posts. So there is a cost in the loss of productivity and also one associated with additional staff. However, as I understand it, that has not been costed across health.

Ms Corbett: No, we do not have it.

Ms Mallon: That is a lack of sophisticated detail.

Mr D Bradley: You would think that it would be costed. I would like to know what the total cost is and how cost-effective interventions are.

Ms Mallon: Absolutely. I understand that that is one of the points of having the new system: it will give that level of detail, including, where someone is off sick, if there is a consequential backfill that increases the cost.

Ms Corbett: My understanding is that, with the new system, we will be able to extract data and turn it into costing data for the cost of the actual absence. We then need to marry it with the other costs from the trusts, such as the backfilling of nursing or locum posts.

Mr D Bradley: After the new system is up and running, when will that information be available?

Ms Mallon: The last trusts went on the new system last month.

Mr D Bradley: Will the information be available within a year, say?

Ms Mallon: Yes.

Ms Corbett: I think that we will need a full year of data for it to be meaningful. You could not start to do it for quarters or months; it would not be meaningful. We need to get through a full cycle, and that will give us a baseline of data to move forward with.

Mr D Bradley: That is grand. Thank you very much.

The Chairperson: I want to come back to Paul's point about whistle-blowing. I am most familiar with the Northern Trust. I think that the treatment of whistle-blowers by the structures and the management has been appalling. It is something that is impacting hugely on people's health and well-being. Especially in the hospital setting, when it is a life-and-death situation, I know of nurses being afraid to speak out. Nurses have been familiar with cases where somebody has lost their life and have faced a moral dilemma: whether to speak out, do the right thing and be treated negatively as other whistle-blowers have been treated; or stay quiet and ensure that they have a contented working environment. The whistle-blowers whom I have dealt with have been through hell as a result of mistreatment, as some people in managerial positions have frowned upon their whistle-blowing. It is a big problem that ties into what the Minister said yesterday, in the review that was announced about the culture of not speaking out. I cannot speak at length about other trusts, but I know that the Northern Trust requires particular focus.

So, with respect to occupational categories, have you a mechanism to identify issues? We found issues with respect to the Causeway Hospital. In certain examples, the maternity service has not been up to a sufficiently high standard. Does that affect levels of sickness absence among staff? If those stories go in the media, they affect morale. If it is not being dealt with satisfactorily internally, that will have a greater impact.

Ms Mallon: I do not have an intimate knowledge of every whistle-blowing case across Northern Ireland, but our Minister has made it clear, and rightly so, that whistle-blowers should feel free to say that there is an issue or problem. There is nothing new about whistle-blowing policies and encouraging whistle-blowing. Of course, in any trust, you want people to raise issues, but if people do not feel safe in doing so they can go through the system of whistle-blowing that I deal with in the trust. It would be outrageous if people felt threatened in any way. If staff feel that they work in such an environment, it is bound to have an impact on their health. There is no question about that. I work with the other HR directors, right across Northern Ireland, and I know of no trust that would institutionalise that sort of approach. If it happens, it is entirely regrettable, but it goes against the policies and what is required in those trusts. If people have to go outside the trust, it is an instance of failure for the trust that people feel they cannot complain directly and internally. I accept that, but no trust would want anyone to feel bullied, intimidated or unable to speak out. I agree that, of course, it would add to sickness and feelings of pressure, and it should not be tolerated.

The Chairperson: Marie, you have highlighted the fact that you deal with whistle-blowing cases in Belfast Trust. What is your own analysis? You will be aware of cases. What have been the health impacts on people who have been through that process? Is there a need to review that process at the moment?

Ms Mallon: I think you should always review any process. Certainly, I have a very good individual who deals with whistle-blowers directly. That person has a nursing background and deals with them in a very compassionate way. I have had no complaints about how they have been treated.

Leaving aside whistle-blowing, per se, as a policy and so on, remember that, in health, we have very skilled, effective and able trade unions which tell us very clearly if they think there is a problem, either of a collective or an individual nature, within the organisation. So we do not just rely on people coming through managerial lines or, in the extreme, having to go through a whistle-blowing way. We relate very closely with our trade union reps, who represent individuals and groups, and we listen to them if there are any problems, for example, in departments as we talked about earlier. So you have the protection of the individual, who can raise it at any time managerially. If they do not feel they can do that, they can raise it through their trade unions, through HR — which is usually seen as a safe, almost neutral, pastoral approach to these things — or through the formal whistle-blowing policy. So, there are mechanisms. You will always hear about the bad things, but I hope the evidence demonstrates — through staff surveys and checks by Investors in People and other accredited bodies — that there is certainly not a culture of that in health. So that is not just my feeling. However, if cases go wrong with one individual, I accept that that is still not good enough.

The Chairperson: I would argue that, with respect to the Northern Trust, there is certainly a culture there, going on the number of cases that I have processed, and the Public Accounts Committee has encountered similar cases. There is an issue there.

Ms Corbett: And the Minister has —

The Chairperson: I will give you one: I am happy to do so.

Ms Mallon: I certainly accept what you say, but I know that the management team there obviously wants to deal with that, and I hope that you are finding that that is the case.

The Chairperson: No, we are not.

Ms Corbett: And a review has been kicked off, so —

Mr D Bradley: If I may wander outside the remit for a moment, I have had experience, and I am sure that other MLAs here are in the same position, of quite a few complaints against the health trusts by patients. I get a very strong impression that the whole procedure is weighted against the complainant and that there is very little objectivity in dealing with complaints. Where there are independent people brought in to adjudicate on them, they are usually former employees of the Health Department or one of the trusts, so that there is an innate bias. Even though the people are described as external and independent, they have been part of the system in the past and therefore there is, as I call it, an innate bias. There may be a need for a totally independent commissioner for dealing with health complaints, especially some of the more serious ones.

Ms Corbett: I think that we need to be careful that we do not pre-empt the review that the Minister has kicked off. We have not come today with any evidence or figures to be able to respond to your concerns in that area. Hopefully, those will be picked up as part of that wider review. If there is anything in particular you need us to come back to you on, we are happy to do so.

Mr D Bradley: There are quite a few.

The Chairperson: Here is another anecdote. We are dealing with a case in the Northern Trust which I have highlighted to the Minister. A young couple from Ballycastle lost their child, primarily because of lack of access to an operating theatre in 2008 in the Causeway Hospital. An internal report in 2009 found that the hospital was at fault, and they did not get access to that report until they brought the trust to court in 2013, so they had to wait five years or whatever it is. It was not the fault of staff, but because the facilities and structures were not in place. It was a managerial issue, as far as I am concerned. However, the staff would have been aware of the reason for that death in 2008 and they could not say anything, and did not say anything, from 2008 all the way to 2013. The stress on those individual members of staff must have been immense, but the failing of the management and the structures meant that they were put under that stress, as well as the patients.

Ms Mallon: That, as you say, will, no doubt, be part of that review and inquiry.

Ms Corbett: Hopefully, all those issues, including the impact on staff, stress levels, sickness absence, the handling of complaints, the protocols and the processes will be part of that. We should not really cut across that at this point.

Mr Mitchel McLaughlin: We have all been wrestling for some considerable time with the issue of sickness absence. In December 2012, according to the audit report, the Department informed all the arm's-length bodies, including the trusts, that they would be required to take steps to minimise sickness absence during 2013-14. Is that a calendar year, or what is it?

Ms Mallon: 1 April.

Mr Mitchel McLaughlin: So, a financial year. Does that include the Ambulance Service?

Ms Mallon: Yes.

Mr Mitchel McLaughlin: Does it include all agencies and strata of management, as well as medical?

Ms Mallon: Certainly all the trusts. I am representing the trust, but it is all the employers.

Ms Corbett: Yes.

Mr Mitchel McLaughlin: All the employees?

Ms Mallon: Employers — the agencies and so on.

Ms Corbett: Yes.

Mr Mitchel McLaughlin: You were to undertake a review, and report by September of last year. Was that review completed?

Ms Corbett: The review of sickness absence levels?

Mr Mitchel McLaughlin: Yes.

Ms Corbett: I think the reason that the full review has not been carried out is that we do not have the data because of the transfer from one system to another. I think it was recognised in the report that we would be moving to that.

Mr Mitchel McLaughlin: Who set September 2013?

Ms Corbett: I am not sure who set September 2013.

Mr Mitchel McLaughlin: But you did not have the ability to deliver it?

Ms Corbett: Well, 2013 was when we got the figures. Each trust does report back, and the Department holds accountability meetings with each trust twice yearly, and there are interim reports on that basis.

Mr Mitchel McLaughlin: No, but it says:

"undertaking a review and report to the body's Board and DHSSPS by September 2013".

Who would have set that target, when the capacity was not there?

Ms Corbett: That was the target set by the audit report.

Mr Mitchel McLaughlin: Not according to this.

Ms Corbett: Which recommendation are you looking at?

Mr Mitchel McLaughlin: Read paragraph 2.32:

"DHSSPS informed each of its arm's length bodies".

There are then three bullet points, and the last one says "undertaking a review".

Ms Corbett: Yes, there have been reports, but we have not had a formal review. That would happen at the end of year. It does say September 2013, but we have not completed that.

Mr Mitchel McLaughlin: For the evidence of this session, the reason that you have not completed it is that you do not have the capacity and, presumably, you did not have it when the target was set.

Ms Corbett: The issue as I understand it — I will check to ensure that this is absolutely correct — is that we have two systems running. We have the system that, as you described it, is the old system —

Mr Mitchel McLaughlin: Sorry, I am assuming that there was something in place — something that needed to be improved, augmented or whatever to give us an improved performance. In December 2012, the Department wrote to all its various agencies and structures. It also set a target for producing a review. There is a straightforward answer to this, I assume, which is that you never at any time had the capacity, and it still is not there.

Ms Corbett: At this point in time, I think that that is correct, yes.

Mr Mitchel McLaughlin: OK. How do we define long-term and short-term absences?

Ms Mallon: An absence of 20 or more days is long term, and below that is short term.

Mr Mitchel McLaughlin: Presumably, the review developed some kind of report and summary of the patterns and themes that emerged. That is absolutely critical if we are going to respond and do something about the other targets.

Ms Mallon: Even during the period, as we implement, we do know the short- and long-term absences; we know the reasons. So, there is a continuous review and analysis of statistics. Short term, for example, is around one or one and a half, compared with long-term, which is four or four and a half. That is the variation. So, short term is a lot less than the long term.

Mr Mitchel McLaughlin: When you say one and one and a half. What is that?

Ms Mallon: Per cent; apologies.

Mr Mitchel McLaughlin: It is just for the record.

Ms Mallon: Sorry about that. If the average is around 5·5%, less than 2% is short-term. I am glad you raised that point, because it is important. I have worked in the service for a long time. Years ago, the short-term absence was the longer. Therefore, the casual absence was the problem. I think that the casual absence in health has been well reduced. You will know the Monday/Friday-itis, when people took off, and there was a question mark on all of that. It is now the longer-term absences, which relate to surgery, illness, musculoskeletal, mental illness, and all of that, as opposed to the more casual absence that was a feature 15 or 20 years ago.

Mr Mitchel McLaughlin: This Committee and the PAC, which I was on previously, have inquired into the issue. I think that they have satisfied themselves that our issue is long-term absence. Clearly, a detailed analysis of that might establish whether there is any abuse in the system or whether the responses of the individual Departments within the public sector are adequate to addressing that in any meaningful way, such as by setting realistic targets and having the means and the wherewithal to do something about those targets. Given that we have completed our year and are into 2014-15, how quickly will that year's data be processed? When will the review be complete, so that we can see the themes?

Ms Corbett: To be clear, as part of the governance arrangements with each of the arm's-length bodies, including the trusts, that are clearly referred to in here, end-year accountability meetings are

held with the Department. Those are usually held in May or June to allow the data to be gathered. That is an opportunity for each of those arm's-length bodies and the trusts to feed back, specifically with regard to the review, and to give evidence on those underlying issues. We will have that by June of this year, in respect of each of the bodies. What we have not done at this stage, and could seek to do, is wrap that together into a more comprehensive report giving the figures before last year.

Mr Mitchel McLaughlin: But as we move through the first year and complete that, we have a data set that will be augmented by further reports and inputs. Remind me of the definition of long-term absence.

Ms Mallon: Twenty days or more.

Mr Mitchel McLaughlin: Are we expected to accept that those issues will be addressed at the wash-up at the end of year?

Ms Corbett: Not at all.

Mr Mitchel McLaughlin: That is what I am getting at. At what point after the 20 days will this get flagged up as something that somebody should take a look at before it becomes 30 days and 40 days?

Ms Mallon: Absolutely. This goes to the policies that all of the trusts have, which define absence as 20 days. That does not mean to say that they do not act until 20 days. That is the definition with regard to the stats. If, for example, you were off and it was to do with mental health or some other area where we think that we could help or intervene, you would be referred to occupational health pretty much straight away. If you were off for surgery, and we know that you will be coming back in six weeks, you will still be off for 20 days, but if you have a line that says that you are coming back, we will not refer you. Therefore, there are triggers, including looking at 20 days and other things, but that does not stop any action in an individual case; 20 days is there for recording purposes, but the action that you take as a manager will depend on the illness of the individual.

We do not like to push people into occupational health automatically because they have been off. People are ill, and we know that they are coming back. They may be getting treatment for cancer. There is no automatic "We are going to send you to occy health"; each case is taken on its merits. However, for recording purposes and the definition of long and short, it is 20 days. Action can be and is taken before that, depending on the individual circumstance.

Mr Mitchel McLaughlin: Given that we are trying to improve the process as we go through it — I accept that, because in the lifetime of the Assembly up to now and whatever length of time it has left, we can record an improvement and an increased focus that has produced some outcomes — you indicate that we will have the ability to identify and disaggregate the causes to be able to establish whatever patterns and themes, which is probably not the right word but I cannot think of the right word, to allow us to address those issues. For instance, we had a correspondence from the Chartered Society of Physiotherapy, which talked about a pilot scheme. You made a number of references during this session to access to physiotherapy. It has given us some indication — the evidence has to be tested, but it is quite impressive — of where you can make an intervention and give people a more rapid access to physiotherapy, which would at least deal with the musculoskeletal dimension. However, it said that that was a pilot scheme that has been discontinued. Which is it?

Ms Mallon: It was not a pilot scheme that was discontinued; it actually came from our trust. We have two physiotherapists — two staff — who are dedicated to occupational health.

Mr Mitchel McLaughlin: Sorry, are you talking about one trust?

Ms Mallon: Yes, I am talking about one, and there are others.

Mr Mitchel McLaughlin: What is there across all the trusts?

Ms Mallon: I do not have the numbers right across the trusts.

I was exemplifying two things; the first was to assure you that it has not stopped. Because there was pressure on patients being seen, we took our physiotherapists out and targeted them towards our

patients for a few months, but they will come back. Not only do we think that it is a good scheme, we reckon that for every pound invested, you probably save £3-plus on sickness levels. We wish to extend the scheme, and we will write to the Department, which has been very good about supporting it — the other trusts will say the same thing to you — and if there is any way that we can ring-fence money, this is self-financing. There are no fears. I am happy to give the Chartered Society of Physiotherapy the positive message that we will not be stopping the scheme; we are making it available quite widely.

Mr Mitchel McLaughlin: Well, it gave us a very blunt — and this is absolutely up to the minute. We got this last week: the scheme was discontinued. Was the scheme in one trust area only? Would you be prepared to testify that it is value for money?

Ms Mallon: Ours is not discontinued.

Mr Mitchel McLaughlin: Is it going to be introduced right across the service?

Ms Mallon: That depends on the financing debate with the Department and other people.

Mr Mitchel McLaughlin: But you are only after saying that it saves you money.

Ms Mallon: It does save, and I would commend it.

Mr Mitchel McLaughlin: But why is it not in the —

Ms Mallon: It was piloted, and it has now been evaluated. It is part of the discussions. Patricia holds monthly meetings, and it will be on the agenda for the HR forum to discuss with other trusts and to commend it as evidence-based improvement. We are at one on this.

Mr Mitchel McLaughlin: What they are telling us is quite startling. Of those who work, 80% indicated that physiotherapy had prevented them from going absent at all, and of those already off sick, 80% indicated that physiotherapy had shortened their absence. Respondents indicated that the service had shortened their absence by an average of six weeks. That is incredible.

Ms Mallon: Yes, I have had those same people — ie those physiotherapists — along with our occupational health presenting to the directors in our trusts to say, "Look at how well this works". We are absolutely at one. I know the Chartered Society of Physiotherapists. I am happy if you want to direct them to me, and I will give them an equally positive message.

Mr Mitchel McLaughlin: We will be happy to do that.

Ms Mallon: Ok. We will share that.

Mr Mitchel McLaughlin: I have to say that, in general, I am reassured. I could examine why you took until 2012 to send out the directive, but what would be the point? We should encourage the Minister, the Department and you to continue.

I think that early interventions might get to the heart of the issue of how the long-term absence stats are pulling the overall stats up. As you have indicated and as is well recorded, the short-term statistics have shown a significant improvement over recent years. Let us —

Ms Mallon: It really is common sense, is it not?

Mr Mitchel McLaughlin: It seems to be, yes. I nearly followed through on that. OK. A bit of common sense would be a good idea.

The Chairperson: Time has got the better of us, unfortunately. We have a couple of other questions about benchmarking. If it is OK, we will send those to you in writing for a response.

Ms Mallon: Surely. Absolutely.

The Chairperson: OK. Thank you very much.