Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

# OFFICIAL REPORT (Hansard)

## Transforming Your Care: Use of External Consultants

16 May 2012

# NORTHERN IRELAND ASSEMBLY

# Committee for Health, Social Services and Public Safety

## Transforming Your Care: Use of External Consultants

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**Members present for all or part of the proceedings:**
Ms Sue Ramsey (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Paula Bradley
Ms Pam Brown
Mr Gordon Dunne
Mr Samuel Gardiner
Ms Michelle Gildernew
Mr John McCallister
Mr Kieran McCarthy
Mr Conall McDevitt

**Witnesses:**

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|---|---|
| Dr Andrew McCormick | Department of Health, Social Services and Public Safety |
| Mr John Compton | Health and Social Care Board |
| Ms Pamela McCreedy | Health and Social Care Board |

**The Chairperson:** I welcome back Andrew McCormick, who is now joined by John Compton and Pamela McCreedy. After the presentation, the meeting will open up for members' questions and comments. For your information, John and Pamela, some of our earlier discussions might be interlinked.

**Dr Andrew McCormick (Department of Health, Social Services and Public Safety):** I will make a start, and if John or Pamela needs to supplement what I say in my introduction, they will do so. Thank you for the opportunity to be here today.

We have a commitment to use external consultancy in relation to the planning, design and implementation of the Minister's decisions arising from 'Transforming Your Care' (TYC). The report's proposals represent a major and significant change to the entire system. It affects every aspect of the service, its infrastructure and all planning. TYC represents a total and systemic change that is unprecedented. As I said earlier, it is not the sort of thing that is done even every decade.

At the outset, it is important to note that this is not about efficiency savings and is not driven mainly or solely by the budgetary context. We need to ensure that we make the best use of resources and that the right resources are deployed in the right places. The review's overwhelming purpose, however, was to ensure that the system delivers high quality, is resilient and safe, and delivers the best possible outcomes well into the future. A change that arises from the direction set and resolved now should be viable and last well into the future. The programme is partly about ensuring that we use our resources

with a view to the long term as well as the short term, and that requires the investment that we are now making.

The planning and design phase of the transformation programme is under way, and we will then move into the implementation phase. During the previous session, we talked a little about the development of the population plans and the completion of those, as proposals, by the end of June. They will provide a road map and a direction of travel for the rest of the transformation process and will identify and assess the needs in each local area, or, as sometimes referred to, health economy. They will outline how those needs can be addressed in a way that is safe and resilient, delivers the best available quality of care and is consistent with the financial context. They will also set out how each of the five local commissioning group areas in Northern Ireland will move to a transformed service by 2014-15. Therefore, those plans will examine the changes in services that are needed over the next two to three years, and that is a very complex piece of work.

The magnitude and scale of work being undertaken in a very short timescale is unusual. That is why we made the judgement that external consultancy support is essential to support Health and Social Care (HSC) staff in the planning and design phase. The transformation process must be undertaken while minimising the disruption to the delivery of existing services, and the way that we are organised, including how staff members are deployed in the board, the Public Health Agency (PHA) and the trusts — is to deliver the existing services. The layering of a unique transformation process on top of that will place an immense demand on the system.

Our approach will ensure that the transformation programme is led and delivered by those with the best local knowledge and skills, complemented by people with experience of large-scale health system transformation. The external consultants have been put in place to secure expertise in that domain. One turns to consultants when something needs to be done quickly and effectively, using quick access to expertise not readily available in the organisation. In that context, the Minister and the Department of Finance and Personnel (DFP) approved a business case that covers the deployment of internal support — extensive internal support will be deployed — and external support in the planning and design phase of the transformation programme. A rigorous public procurement exercise led to Ernst and Young being appointed at a cost of some £660,000. The three of us sitting here know that the figure is £660,000, and rumours of any other figure are inaccurate and should not be paid attention to. We know that as a matter of fact, and I want to make that clear.

Given the complexity, we anticipate that further external support will be required to take us through the implementation phase. I believe that to be the case, and I support it. The Minister made it clear to us that it was hard to convince him about the need for the phase that has been approved and that that will also be the case for future phases. So we will need to bring him well thought-through analysis and reasoning behind the implications of doing it and doing it in different ways. If, as we expect, further approvals are granted by the Minister and DFP, there will be fresh procurement exercises, and there is no guarantee that any firm that has worked with us before will succeed in those. We will look at how to ensure that we get the best possible value for money from any future phases that are approved.

We are also working with DFP on the general funding of 'Transforming Your Care'. There is always a distinction between DFP approval for whether expenditure can be incurred, which involves one set of decisions, and where the money comes from, which requires a separate set. We are still engaged with DFP on the £70 million of transitional costs proposed in the TYC report. John and his team put that forward as an estimate of the amount of additional funding that would be needed to make change happen properly. There is a very strong case for that funding to be additional. That has not been accepted by DFP; we are still engaged and working with DFP on that process. That will include funding for the consultancy, but there are other important elements as well, such as work on integrated care and building, and identifying and energising integrated care partnerships. We need to secure some service change. As I said earlier in response to a question from Jim, some service change will happen sooner, some will happen later. All of that will require some pump-priming to make it happen.

We also need to look at workforce change. There is a bid for additional resources to provide for that, elements of which are voluntary redundancy or early retirement. Those measures are a necessary part of change and will be handled in the most proper and effective way possible. Julie will be with you in a few weeks' time to discuss June monitoring. At that point, she will be happy to give you further details of what we are asking for.

Those are the reasons that we wanted to give to you today for what has been approved. It is a very significant set of changes. Some upfront investment is needed because we have to ensure that we

properly build in the long term. The requirement on us is to ensure that there is payback from the investment in the medium to longer term and that we secure progress towards the delivery of better outcomes in the quality and safety of services. No shortage of detailed analysis and questioning has gone into this. That has led us to the conviction that it is the right thing to do.

**The Chairperson:** To be honest, I remain to be convinced. I thank you for the letter that you sent us. It refers to £661,000. I do not want to focus on the consultancy firm; I have a difficulty with consultancy in general getting that type of money, so it is not about the firm. The briefing paper states that the consultants were:

> *"appointed through a tendering process to support the development of the Population Plans over the next 2 months and bring best practice thinking to the work on Integrated Care Partnerships."*

Is that for a two-month contract? Will any work be done after two months?

**Mr John Compton (Health and Social Care Board):** Precisely, the current contract is for the population plans, which are due to be delivered at the end of June.

**The Chairperson:** So it is a two-month contract?

**Mr Compton:** That is the current contract. Then, as Andrew said, there will be a separate procurement process. We have to talk to the Minister and DFP about any further use of consultants.

**The Chairperson:** So £661,000 is for a two-month contract?

**Mr Compton:** Yes. It is for the —

**Dr McCormick:** It is a very intensive —

**The Chairperson:** Andrew, as the three of you sit there now, you are giving a commitment that the amount of £661,000 will not increase but that a possible second phase of the work could cost more.

**Dr McCormick:** Yes.

**The Chairperson:** So when the BBC said that the final cost could be £900,000, it might be right?

**Mr Compton:** The £900,000 is a completely erroneous and misleading figure. The current contract is for £661,000. It is impossible to suggest the out-turn of a further contract and further use of consultants beyond that period. At the press debate, the Minister said that he was prepared to invest a small number of millions of pounds across a three-year period to save hundreds of millions.

**The Chairperson:** We will look at that. The £661,000 is for a two-month contract. On what date was the Health and Social Care Board (HSCB) set up, John?

**Mr Compton:** In 2009.

**The Chairperson:** So between 2009 and now, are you telling me that the board does not know what the needs of the population are?

**Mr Compton:** No, that is not the issue. The board, in partnership with others, produced a major strategic document that reshapes the total health and social care provision for Northern Ireland. It is fundamental and a huge transitional arrangement. Yes, we have a great deal of information about the needs of the population of Northern Ireland, but we need to be able to produce population plans that accurately reflect how we will put in place the key components of 'Transforming Your Care'. How will we, for example, move over a three to five period into five to seven hospital networks? How will we introduce the 17 integrated care partnerships across Northern Ireland? How will we assure ourselves that in learning disability and mental health, we have fully achieved by 2015 that no one is resident or domiciled in a hospital? The 99 recommendations in TYC are absolutely huge. Of course, we have lots and lots of information on needs and numbers, and all of that will be part of what we do in the population plans. I emphasise again that the population planning process is led by the service and its personnel. We asked for and were granted additional support. I think that that is important. As we

produce the population plans, it is also important that we learn from other places and have other experiences brought to our attention. That is one of the benefits that any consultancy firm brings. The people working in the consultancy and bringing that information to us are skilled and have extensive experience, and they are highly skilled at producing that information.

**The Chairperson:** Andrew, I am glad that you were here for our earlier discussions. The document that went into the public domain last night was mentioned. How can we expect trusts to do what that asks of them, which comes from the 'Transforming Your Care' report? You will bring in consultants when work on the population plans is already being done.

**Dr McCormick:** Those are different strands of work that are going on in parallel. That is just normal business across —

**The Chairperson:** If we have the expertise internally to do that type of work, why have we not got the expertise internally to do this further work?

**Dr McCormick:** As John explained, what is going on through TYC is more radical and far-reaching and requires a higher level of engagement and —

**The Chairperson:** I know that other members want to come in, but let me ask you a question. I received an e-mail last night asking me to go to a meeting. As you know, each local commissioning group has been asked to work closely with its local HSC trust to develop a population plan by the end of June. The e-mail asked me, as a public representative, to get involved and meet other stakeholders. I and others in my constituency — I am sure that other members have received similar requests in their constituency — have been asked to go to a meeting to discuss and develop a population plan. Where does Ernst and Young fit in? Am I to do the work for Ernst and Young?

**Mr Compton:** No, not at all.

**The Chairperson:** Where does the local commissioning group fit in?

**Mr Compton:** First, the production of the commissioning plan is being led by the local commissioning group in partnership with the trusts. That is the understanding of the lines of accountability. It is a commissioning decision, essentially. We are looking to Ernst and Young to support the local commissioning groups and the trusts in their preparation of that plan. It is quite reasonable for the groups to meet all sorts of people. In fact, we have a spreadsheet that shows all the public meetings and discussions taking place right across Northern Ireland over the next number of weeks, engaging all sorts of individuals — local councils, local MLAs and local groups. All sorts of things are occurring in the production of the commissioning plan. We want to explain the direction being taken. Writing 'Transforming Your Care' was one thing; expressing it on the ground is another, as telling people what it means for them and their constituency is quite different. It is a shift away from preserving the integrity of the current system by commissioning for a population and then building whatever structures are needed for that population.

**The Chairperson:** Surely, given that the board was set up in 2009, the work of the local commissioning groups and the availability of statistics for people attending hospitals, primary care, community care and GPs, all that information is there? Why do we need to give somebody a contract for £661,000 for two months' work?

**Mr Compton:** Remember that the contract is not for one individual; we are talking about more than 15 people being involved over the two-month period with all the local commissioning groups. If we look at it another way, we are investing about £100,000 in each of the local commissioning areas to support organisations often commissioning in excess of £500 million. So it is important to have some perspective about what we are doing. The majority of the work is being done by the key staff in the local commissioning groups and the trusts, and they are being supported by staff from Ernst and Young, who won the contract. Frankly, if we did not do that, we could not deliver completed population plans by 30 June, which is really important, because we have started a journey from which we cannot roll back. We have to make the journey deliverable and deliver it within a timescale. We know that our system and our whole set-up has vulnerabilities, and if we do not keep the momentum going, those vulnerabilities will express themselves and cause us all sorts of difficulties. No major transition of this shape, of which I am aware, has taken place anywhere in the UK or Ireland without having to use some consultancy support. We are not unique in using consultants.

**The Chairperson:** The permanent secretary, in his presentation at the earlier session, and on the basis of the document that we talked about earlier, said that the work was to do with assessing population plans. I wrote that down. Where does that link in with what the trusts are doing, outside of what the board should be doing and what the commissioning groups need to be doing? Do we need to bring someone else in?

**Mr Compton:** I am obviously not explaining it correctly. The line is that the board has been asked to produce five commissioning plans for the five populations. In addition, it has been asked to produce a Northern Ireland-wide summary — some things must be dealt with on the basis of a population of 1·8 million as they apply across Northern Ireland. That is the task to be completed by 30 June. To deliver that, the local commissioning groups, working in partnership with the trusts, are currently engaged in a process of looking at how they might do that, and they are being supported by a consultancy firm in a relatively modest way. They are making full use of all our information, systems and processes. The staff leading that are those employed in health and social care. We have not handed the task over and asked Ernst and Young to give us population plans.

**The Chairperson:** But we have a draft commissioning plan, a copy of which we received this morning.

**Mr Compton:** The draft commissioning plan is different from the population plan. The Health and Social Care Board is obliged to produce a commissioning plan for each year, which we have done this year, and you have the draft. I was asked to produce a report, 'Transforming Your Care', on how we should take forward the shape of health and social care over the next five years and set out the key actions necessary. That report produced 99 recommendations, and I suppose that the ones that people most readily read about are those concerned with changes in residential care, institutional care, primary health and social care and the configuration of hospitals. Those are profound changes to the way in which our current service is organised, not small ones.

We had to start somewhere, and that is where the population plans come in. Next year, when we have to deliver, as we are expected to, a commissioning plan for 2013-14, the population and commissioning plans will merge. We will have an annual statement of the direction of the population plan over the following five years, with a view to having, at the end of that five-year period, fully functioning integrated care partnerships, five to seven hospital networks, no further institutional care as a place of residence, and changes to family and childcare services with an emphasis on pregnancy to age 5. I cannot emphasise enough how profound all those changes are.

**The Chairperson:** We received a draft copy of the commissioning plan only this morning, so I have just had a glance at it. I am quite a sensible person — I do not want members to comment on that — but I remain to be convinced that the consultants are needed. The draft plan states:

> *"This Commissioning Plan specifies what services are to be provided for the local population including associated commissioner requirements and expectations. Details of how these services will be provided — consistent with Ministerial priorities, commissioner requirements and available resources —will be set out in the individual Trust Delivery Plans 2012/13 (to be completed in May 2012)."*

So that information should all be there.

**Mr Compton:** Yes.

**The Chairperson:** So why do we need another group to come in to provide population plans? Are the services currently commissioned for our constituencies not taking on board population size?

**Ms Pamela McCreedy (Health and Social Care Board):** I will add a few points that might bring parts of this together. You are absolutely right that the level of information available to the board and local commissioning groups identifies needs. The task is to convert and translate what was outlined in 'Transforming Your Care' into delivery. So a lot of the skills and expertise of the management consultancy help us to examine different scenarios, model how those would work and consider their implications for other aspects of the service in a three-to-five-year period, not just one year.

You referred to the primary and community care infrastructure required to support that. That is one of those enablers, so when the needs of a local population are identified, we look at the options for how

TYC can be articulated through that. You also referred to the trust delivery plan, which is key to providers. The population plans are about integrating the primary care, community and acute elements. They look at it together for the needs of each population, and the trust delivery plan is purely the community and acute elements. This is about bringing all of that together.

**The Chairperson:** Let me come at it from another angle: are you telling me that, unless we get population plans, the constituents I represent will not get the service that they deserve?

**Dr McCormick:** No.

**The Chairperson:** Are you telling me that, without population plans, we will not be able to plan for the people I represent?

**Dr McCormick:** We are saying that the commissioning plan is fit for purpose for the financial year 2012-13. It should probably have been produced a little earlier. We completed it earlier than last year, and we are very glad of that. The cycle of planning for 2012-13 needed to be finished before the start of the year. As Pamela said, the population plans are different in that they look at a longer time horizon with a specific momentum for an unusual change. They are not routine; they are over and above the normal process. Every year, we produce a commissioning plan, and it rolls forward and is revised in a steady state. When the Minister was appointed last summer, he decided that a radical review was needed. He felt that we could not go on as we had been and that there was a need to look at services in a much more radical way. That was his decision, and he then commissioned John and his colleagues to undertake a review.

We have the output from December, and the central recommendation from that was to take planning to another level. That means looking at each of the five local commissioning group areas in Northern Ireland to determine what radical and substantial changes are needed to secure highly effective and improved services that will fit the needs of the population on a longer horizon. Yes, the commissioning plan for 2012-13 is right and appropriate in the short-term, immediate context. As John said, when the time comes for the 2013-14 plan, it will be informed by the new and radical thinking that emerged from the major report and the work on population plans. Those are vital steps in moving to a sustainable, effective, safe, resilient healthcare system that is less vulnerable to imposed or sudden change.

Michelle always reminds me that we must not repeat what happened in south Tyrone and in a number of other contexts, where a sudden workforce crisis led to unplanned or difficult-to-plan change. That is the track record, and we need a better planning process, which is well worth an investment of relatively modest sums. No one can get their head round the scale of our spend, which is £4 billion a year. It is too enormous for any of us to grasp, but £600,000 is a figure that we can begin to recognise. Even that sounds like a lot, but it is a tiny proportion and a proportionate investment in a radical change programme to move to another level in a way that will help your constituents and the public whom we all serve to get a better service. That is the aim and the objective. We are not doing this for the good of our health or to please anyone else; we are doing this for the good of the population to ensure that the long term is secured.

**The Chairperson:** I will be honest and say that I am not convinced, but I will open up the meeting to members. Perhaps I can be convinced by the end of the session — we will see.

**Dr McCormick:** We will do our best.

**Mr Wells:** John, I have quizzed you for years, and I know that, by the end of the session, you will have convinced me that all swans are black and all crows are white. I know that I will not win the argument, because 12 years of bitter experience have shown me that you are the master of spin. *[Laughter.]*

**The Chairperson:** That is him being nice.

**Mr Wells:** It could be worse; you could have been a QC.

This will be futile, but I will try: £661,000 divided by 15 equals £44,000 for two months' work from each person. That equates to an average salary of £264,000 for each consultant per annum. I obviously made the wrong career choice. I could be convinced that we need consultants, but £661,000 for two months' work? Are these people worth a quarter of a million each for their ability?

**Mr Compton:** First, when you put something out to tender, you put it out to tender with a specification, which we did. I assure you that we followed the procurement route very correctly; it was meticulously observed. After that, it is up to the organisations to tell us what they would charge, or ask us to pay, for their support. The successful organisation, although the bids were not completely judged on price, was at the lower end of bids. It is for the organisation to decide how it pays its individual members of staff, and I honestly do not think that it is correct to make a simple mathematic calculation and divide the cost by the number of individuals. That is not how those organisations operate.

**Ms McCreedy:** We use the government buying solutions framework to procure, and that is consistent with the daily rates as outlined in the framework contract. Of each of the 10 organisations in the framework contract that had an opportunity to bid for the work, the daily rates were already agreed as part of the further OJEU and first-stage competition. They draw down from those daily rates in the second procurement stage, which was in response to the invitation to tender.

**Mr Wells:** At least Dick Turpin wore a mask. Frankly, you are saying that they see those as their daily rates. Well, that is a daily rate of £10,000, which means £661,000 for 60 days of work, which is —

**Mr McDevitt:** It is not 60 days, it is 40 billable days.

**Mr Wells:** So it is £15,000 a day. Am I on a different planet or does the very fact that they say to you, "I am worth £15,000 a day", and you just say, "Well, if you say so, it must be right", mean that it never occurs to the Department to go back and tell them that, frankly, they could do it for half that amount and still be very happy. They could carry out a wonderful headline-making study that would do much for their kudos in later tender applications.

You are not unique, because I found the same attitude in the Department for Regional Development (DRD) and when on other Assembly Committees. Just because a consultancy says that it is worth £15,000 a day does not necessarily mean that that is good value. Do you not sit down and ask yourselves whether you are getting what you want for a reasonable price, or are you being fleeced?

**Ms McCreedy:** Further to Andrew's point, we have the pricing schedule as submitted in the tender documentation. If my recollection is correct — I do not have that information to hand — the average daily rate is more like £1,000 to £1,500 a day for each person; it is not £10,000 or £15,000.

**Mr Wells:** Divide £661,000 by 40 for me. What does that get you?

**Mr McDevitt:** £16,600.

**Mr Wells:** A day.

**Mr McDevitt:** That is the team rate.

**Ms McCreedy:** All right, but there are 20 people.

**Mr Wells:** There are 15 people, according to John.

**Mr Compton:** I said that there are 15-plus.

**Mr Wells:** So that works out at just over £1,000 a day each. Is it good value for the taxpayer to pay anyone £1,000 a day for a population study?

**Dr McCormick:** Let us look at how public procurement works. Successive Public Accounts Committees (PACs) will have pressed successive Departments of Finance and Personnel, and Departments generally, on procurement: in fact, the subject was aired at the PAC with DFP a few months ago. The issue is to ensure that we have a procurement process that is competitive. The only way to secure value for money is by testing the market and ensuring a proper competitive process. That is the route that we followed.

There are several stages to each public procurement process. First, organisations must compete to get on to the framework. That is all handled by the Central Procurement Directorate (CPD) in DFP. Its central handling allows the rates to be established in competition. The only way to buy anything

through competition is by getting the best deal that you can. As accounting officers, John and I are under an obligation to secure what is most economically advantageous to the public purse, and we recognise and accept that responsibility. The process will be audited and subject to scrutiny, and a post-project evaluation will determine whether we got what we asked for and secured best value for money.

In essence, if we were suddenly to try to step up internal resources, it would not be effective. Therefore, we judged the options very carefully. The analysis of the business case in this process involved examining carefully and rigorously the option of not using consultants. That examination was documented, and we can demonstrate that our choice of options was the correct one.

After that, it is a matter of what the market will offer. As John said, several of the other bidders were more expensive. However, as Pamela explained, the financial element had largely been tested when organisations were applying to get on to the framework contract. After some standardisation of price, which was established through a central contract, the question then was who would offer us the best quality of product. Then there is a rigorous scrutiny process involving examination of the bids and a dialogue to establish which is the best choice. That is what the selection panel of John and his colleagues did. That process is carried out very conscientiously because we know that we are subject to scrutiny by the auditors and the PAC. This is public money, and we have a responsibility to use it in the best possible way. We looked at the alternatives and convinced the Minister and DFP that, in this context, it was the right thing to do.

I understand the reaction — it is totally understandable. However, the question is whether it would be far easier not to act. If all we were concerned about was avoiding public criticism, we would not be doing this. We are doing something that will produce a positive and beneficial result.

**Mr Wells:** Andrew, I could be convinced, and I am sure that John will convince me, as he always does, of the need for consultants. However, £1,000 per person per day strikes me as exorbitant. I am not reassured by the fact that that is the going rate. I am certain, from my experience on the Committee for Regional Development, that there is a cosy cartel between consultants. Collectively, they set a figure and then tender around it. Given the present economic situation, however, I suggest that, if you went back to them and said, "You could do that for 60% less", that would be a very good opening deal. It is the sheer quantum of what we are being asked to pay that concerns me.

John, you produced the Compton report, which will be your epitaph, in a remarkably short time, and while still working as chief executive of the Health and Social Care Board. I am sure that that involved an awful lot of hard work, and the Committee is very grateful to you for that. Given that you showed that you could produce that document internally without bringing in consultants —

**The Chairperson:** Here is the sting.

**Mr Wells:** You know what is coming next, do you not? Given that such skill is so evident within the board, was it not possible to have done this internally?

**Mr Compton:** No, it is not. It really is not straightforward. The first point is that the population plans are different from the report, although the Minister appointed a panel for support in the middle of my work on TYC. I appreciate and understand that it was not the same order of money. There was a recognition that it could not be done in that way.

The simple, practical truth of the matter, to be blunt and straightforward, is that during the 111 or 120 days of the production of 'Transforming your Care', 16-hour days — I mean 16-hour days — were not uncommon, nor was working seven days a week. People can work like that for a short period to complete a task. The current work is about translating that into a practical, deliverable service for 1·8 million people. Frankly, it is not possible, fair, reasonable or decent to ask the numbers of people who would be required to work in that way to do so — it is not doable. If you think about it for a moment or two, I am sure that you will agree.

A clear feature of 'Transforming Your Care' was the ambition to look outside Northern Ireland and think about how things have been done differently. In looking at involving consultants, we are bringing that ambition. Northern Ireland is not unique, yet I know of no example anywhere that involved this, or even a much smaller, scale of change without the extensive use of consultants. Ours is not extensive use; it is quite modest and proportionate to the total amount of work that we are doing. That is the issue. We have an obligation to deliver the population plans coherently and directly. I realise that we

will be scrutinised afterwards on whether the expenditure was correct and proportionate and delivered what it said that it would.

We need, for example, to model different scenarios, but we do not have a full modelling capability. If, for instance, there is a change in the number of a population, hospital beds or workforce, that alters the cash number. Many consultancy firms have the modelling capacities that allow us to examine what would happen if we did one thing as opposed to another. We do not have the sophistication in our system to facilitate all of that modelling capacity. Often, consultants design a bespoke and procured modelling system that is part and parcel of their unique contribution to helping us with population plans.

**Mr Wells:** You mentioned that further consultants will be engaged. May I suggest a different model that focuses on prestige and the ability to secure further contracts? The winning consultancy will be able to put on its CV that it did the spade work for this major overhaul of health in Northern Ireland. I suggest offering a daily rate of £300 a person a day and asking whether they will do it.

**The Chairperson:** Remember that this is the Minister-in-waiting's proposal.

**Mr Compton:** The Minister made it clear that there are two stages, the first of which is the design of the population plan. He also made it quite clear that any subsequent contract would be different. The current contract is to deliver a specific service, but implementation is different. It is about making savings and managing money. The Minister said that a later contract would probably have a deliverability specification so that payment would be linked to the delivery of the product on the other side.

If someone told you that their work would save you a particular amount and control your expenditure by a particular amount, the contract would be directly linked to performance. A future contract would have a different contractual arrangement. There are two distinct areas of work: the current one is about setting the direction and being specific over five to seven years; the support and implementation will be handled differently with a different shape and different type of contract.

**Mr Wells:** I told you that it was futile.

**The Chairperson:** You are the Minister-in-waiting. We will wait to see what happens.

**Mr McDevitt:** I want to go back to the structure. From which framework was this called? Was it the managing services framework?

**Ms McCreedy:** It is from the multidisciplinary contract, "Buying Solutions".

**Mr McDevitt:** What specific skills outlined in the tender document were not available in-house? Your briefing paper states:

> *"it is essential to have appropriate skills and resources to plan".*

**Ms McCreedy:** We have referred to the skills and expertise needed. The establishment of integrated care partnerships was one of the key recommendations in 'Transforming your Care'. Although it is recognised by the current team of management consultants that we have integrated health and social care, we wanted a consideration of a more vertical integration of primary care, working with secondary care, with regard to integrated care partnerships. As we had not undertaken that approach in Northern Ireland, it was essential that we acquired the necessary skills and expertise. John can provide more detail on the partner —

**Mr McDevitt:** My experience of this type of work is that the skills are outlined very clearly. Specifically, what skill set are you purchasing?

**Mr Compton:** Dr Richard Lewis, who is the lead and supervising consultant, led on integrated care pathways for the Department of Health in the rest of the UK. We have nobody who has done that.

**Mr McDevitt:** He is a former public servant, John.

**Mr Compton:** He has worked in the public service, the private sector and educational establishments. The consultants will draw on the expertise of Professor Dame Catherine Elcoat, who is a senior nurse. She has been a member of the chief nurses senior professional advisory group, and she led three clinical advisers for the UK Healthcare Commission on the impact on nursing and how nursing should be best organised. These people have substantial and significant expertise. We have some expertise, and I will not suggest that we should hide our light under a bushel. However, we need that support.

Specifically, the consultants have skills in areas such as programming modelling, and they have products that do the sort of work on numbers that I outlined. We do not have those products. We will have access to the intellectual property and experience of the individuals and to the modelling abilities that will help us to deliver, in a collapsed and short period, what I expect to be coherent and robust population plans that will set us off on a five-year journey.

**Mr McDevitt:** How many billable days is the contract based on?

**Mr Compton:** Billable days?

**Mr McDevitt:** Yes, billable days. That is how you will have assessed this. It is a basic calculation.

**Ms McCreedy:** I do not have that to hand.

**Mr McDevitt:** Is it two months' work?

**Ms McCreedy:** It is.

**Mr McDevitt:** So the contract is for 40 billable days, is it not? That is normally the way it works.

**Dr McCormick:** It depends on the number of consultants. As John said, there are over 15 —

**Mr McDevitt:** No, I am talking about billable days. We can talk about a per diem rate for each consultant. What is the average consultant rate?

**Ms McCreedy:** You are dividing £661,000 by the —

**Mr McDevitt:** No, I am asking you about the average consultant rate, because the CPD will have produced for you a matrix that included the average consultant rate. What was it?

**Ms McCreedy:** I do not have the exact average because you are asking for the composite average rate. There is a rate for partner level and a rate for director level.

**Mr McDevitt:** Give us the range. At what level are they billing you for partners per diem?

**Ms McCreedy:** About £2,000 a day.

**Mr McDevitt:** What is the workhorse rate?

**Ms McCreedy:** Off the top of my head, there are 15 to 20 days of Richard Lewis time involved in the work integrated care partnerships.

**Mr McDevitt:** At about £2,000 a day?

**Ms McCreedy:** Yes.

**Mr McDevitt:** That is fine. That accounts for it. Will Dame Elcoat have 15 to 20 days as well?

**Ms McCreedy:** That is included, yes.

**Mr McDevitt:** At £2,000 a day?

**Ms McCreedy:** Yes.

**Mr McDevitt:** So you still have £500,000-odd to spend?

**Ms McCreedy:** The senior consultants come in at about £1,500 a day, and the rate is about £1,000 a day at consultant level. That is an average spread of the daily rates.

**Mr McDevitt:** A rate of £1,000 a day at consultant level is premium product.

**The Chairperson:** Especially when you are not spending your own money.

**Dr McCormick:** It is a premium piece of work.

**Mr McDevitt:** That rate represents an absolutely premium product. How many of the consultants are locally based?

**Ms McCreedy:** About half.

**Mr McDevitt:** Does the team number 16 or 17, John?

**Mr Compton:** Something of that order.

**Ms McCreedy:** Many of those local people work in England and further afield as part of their normal course of business.

**Mr McDevitt:** I understand that.

**Mr Compton:** About half are based in Belfast.

**Mr McDevitt:** I understand that the lead consultants are special individuals. What skill sets do the rest of the team have that are not available to you inside the system?

**Ms McCreedy:** John referred to those. In the main, the support to the local health economy is on the modelling. To some extent, we have information on the needs, but we have to articulate that through to delivery. So the skills are modelling and clinical engagement and the outworking of those. The team for the integrated care partnerships is where those number of individuals —

**Mr McDevitt:** I understand that they may have a proprietary product that allows you to crunch the data in a really good way.

**Ms McCreedy:** They have experience of this from their work in strategic health authorities and elsewhere.

**Mr McDevitt:** I accept that, but I am still trying to find out what specific skill sets you sought when tendering. Are these people statisticians? Are they economists? Are they health economists?

**Ms McCreedy:** In the main, they are healthcare specialists.

**Mr Compton:** They have a range of skills.

**Ms McCreedy:** It is not an accountancy-based approach. They have expertise gained from working as nurses, doctors and in social care.

**Mr McDevitt:** That is the other bit that I am curious about. How many worked in the health service at some stage in their career?

**Ms McCreedy:** Without trawling through their CVs, I would say that possibly a quarter or half worked in the health service at some point.

**Mr McDevitt:** How many have retired from the health service and are in receipt of a pension?

**Mr Compton:** I am not aware of any. Looking at them from a straightforward age perspective, I would say none.

**Ms McCreedy:** I am not aware of any.

**Mr McDevitt:** Do you think that paying £661,000 is good value for money?

**Mr Compton:** I do, given what we are being asked to do. At one level, people have been complimentary about 'Transforming Your Care' and said that it was a sensible and visionary document with a good strategic direction. The document is a bit like an onion: you need to read it all, because it suggests a fundamentally and profoundly different way of delivering health and social care to 1·8 million people. Sometimes, people ask what it means for hospitals and the five to seven networks. This will be a very different way of working for the whole hospital sector. Integrated care partnerships are not just some aggregation of what happens on the ground and having people talking to one another and explaining things differently: they are a profoundly different way of delivering primary health and social care.

The way in which that change is presented and suggested as the way forward means that it carries with it a tremendous opportunity to bring to a population of 1·8 million a fantastic health and social care system for the future. That is not a criticism of the current system, which is a great system. However, if we leave it as is, it will start increasingly to fail. The core of the 'Transforming Your Care' argument was that change was simply unavoidable, as the system could not be left as it was.

**Mr McDevitt:** When the two principal consultants are removed from the tender, you are paying an average of over £1,000 a day per consultant. Exceptionally few public service consultancy frameworks pay that rate. I am sure that people in the CPD do a very good job, but my professional experience of CPD — I do not need to declare an interest because I do not have one — is that it does not have the faintest idea of what it is purchasing most of the time. I think that you probably know that, too. You should know what you are asking it to purchase, but it does not know what it is purchasing. This is an exceptionally generous management services contract for any scheme. I am familiar with the amount paid out during the police change programme. I am not against the idea of buying in external expertise; I am familiar with the need for it and have seen it work well on many occasions. However, this is unbelievably generous, particularly at a time when, as I understand it, consultancy rates are highly competitive.

**Ms McCreedy:** The winning firm was exceptionally competitive vis-à-vis some of the other bids. That includes the daily rate. I have seen —

**Mr McDevitt:** With the greatest of respect, Pamela, you are working off a framework that has not been updated for six years. Six years ago, consultants would have lobbed in prices —

**Ms McCreedy:** They are discounting those —

**Mr McDevitt:** — three times that level. Perhaps you could have justified the market six years ago because there was a lot of activity, government was doing a lot, and there were a lot of PFIs in the market. However, this level of per diem expenditure for basic consultancy is difficult to justify.

**Dr McCormick:** I would not describe it as basic.

**Mr McDevitt:** You are talking about a proprietary product, Andrew, and I accept that. The chances are that the delivery agents for the proprietary product are very well qualified, but they are doing exceptionally well for their firm by billing themselves out at that rate.

**Dr McCormick:** Those who drew up the specification were clear that this was a challenging project. The market responded to the specification, which is not, by any means, a standard one, because it is not a routine piece of work. Obviously, we have to be conscientious in applying the tests, working within the procurement guidance and doing all the right things in that context. In assessing the tenders, the panel asked whether they were in line with the specification, which was the first test, and whether they got to first base as a proper response to that specification. That is a matter of judgement, which, I believe, was conscientiously undertaken by the panel, who took time to read all

the tenders and associated documentation. Then, as Pamela said, there is a competitive element. We can procure only in line with what the market offers. There is always a judgement as to whether or not to go ahead, and John, as the accounting officer considered that conscientiously, and I signed off on it.

**Ms McCreedy:** There was a significant discount against the daily rate on the contract applied in that amount.

**Dr McCormick:** Against the framework.

**Ms McCreedy:** Yes. The contract is an old contract that had been rolled. Should we procure again if that is the case? That would be under a new contract, which is due to commence in July. It would be interesting to see what those new daily rates might look like.

**Mr McDevitt:** If the current consultants do not hit the 30 June target, what is the penalty?

**The Chairperson:** They will get another £50,000.

**Mr Compton:** They will hit 30 June —

**Mr McDevitt:** No. If they do not hit 30 June, what is the contractual penalty?

**Mr Compton:** We have not anticipated at all that they will not hit 30 June.

**Dr McCormick:** The population plans are created by a team that includes the consultants; they do not produce them. The penalty, constraint or requirement to produce their deliverables is not as simple as that.

**Mr McDevitt:** Is it correct that 30 June is an arbitrary date? It is an immovable date, I take it, from your point of view as permanent secretary?

**Dr McCormick:** It is what the Minister specified, and he made clear that it was important.

**Mr McDevitt:** If, for some reason, 30 June is not met, and if, for some reason, the service provider is a contributory factor in not doing so, what is the penalty?

**Ms McCreedy:** We will know well before 30 June —

**Mr McDevitt:** You still have not answered my question.

**Ms McCreedy:** I know, but we have such regular meetings to assess where we are that we will know if the contractor is not delivering —

**Mr McDevitt:** There are no penalty clauses, are there?

**The Chairperson:** He is not asking whether they will meet the deadline; he is asking what the penalty will be if they do not.

**Mr Compton:** Ultimately, it is our choice and our decision. If we feel that a contract is being poorly or not properly attended to, we have the right of sanction. That is clearly in this contract and in all contracts that we let.

**Mr McDevitt:** Even though it is such a time-critical project, you have not written in any penalty clauses.

**Mr Compton:** Not in the way that I think that you are describing it. It is not as simple as that.

**Mr McDevitt:** Clawback?

**Mr Compton:** No, not quite like that.

**Ms McCreedy:** It is part of the normal contract management.

**Mr Compton:** It is part of the normal contract management. If they were failing in their contract management, there would be penalties. However, as we measure progress weekly — we ask who is where and what is happening — we will know pretty quickly whether it is going offline.

**Ms McCreedy:** The specification went beyond just hitting the 30 June date. It was aligned to the integrated care partnerships and the component parts as it went along, so they also have to deliver those component parts.

**Mr McDevitt:** OK. Thank you.

**The Chairperson:** He is still not convinced.

**Mr McCarthy:** I am not convinced either. The Compton report was produced some time ago. When it came to the Committee, it got a reasonable sail through. The public was happy to go along with it, but I am afraid that it will hit the buffers now. This £661,000 is only the start. Your briefing paper states that it is expected that "several" more millions of pounds will be spent as we go along. That could mean hundreds of millions of pounds.

**Dr McCormick:** No.

**Mr McCarthy:** I am really very disappointed that we are going down this road. Someone said that a number of hospitals would close. The report states that there will be five to seven hospitals. There will be major redundancies and, in my opinion, our health service will be decimated.

We all support working for efficiencies, and so on, but I am concerned about the scale of those efficiencies and the use of consultants. The £661,000 has already been spent. That is a scandalous figure, and we have not even started yet. I am not convinced that we are spending money to save people's lives and the health service. I think that we are gambling with people's lives.

I think that it was John who said that he guaranteed that this would turn out to be the best thing since sliced pan. I am not so sure. You are the expert, John, and I hope that that is the case.

You have employed consultants and will employ more. Is it fair to say that, when the consultants decide which hospital has to close, they will be the hatchet men and women to do the job?

**Mr Compton:** No.

**Mr McCarthy:** It seems to me that that could happen.

**Dr McCormick:** The consultants provide expert advice and analysis in support of the development of plans that will deliver the best quality health and social care system that we can draw together. It is fundamentally our responsibility, working under the Minister's direction, to do that. We have persuaded him and DFP of the need for some supplementary help for a short period to achieve that. As John mentioned, the Minister said at the press briefing that he was prepared to consider spending a small number of millions, given that we have to save hundreds of millions because of the obligation in the Budget. If we were to save just by applying cuts, we would end up with a damaged system. If we do it by taking expert advice —

**The Chairperson:** Andrew, nobody is disputing that. My concern is the fact that every time any Department goes to do something, we pay hundreds of thousands of pounds to external consultants when we should have the expertise internally in Departments. That is the issue.

**Dr McCormick:** It can be proven that attempting to employ people with the expertise would not provide value for money. As we do not always need people with this modelling experience, employing them as civil servants on a lifetime contract would be foolish in the extreme. It is always right for any business sector and any organisation to employ a combination of permanent staff to do what is permanently required and to bring in short-term expertise on contract through a variety of means of procurement. We do not need those experts in perpetuity, and so we do not buy them in perpetuity

but in short bursts. That looks awful to the Committee, and I understand that point of view. However, in managing and trying to drive forward a change process, we believe that it is the right thing to do. It is a question of doing our very best to explain that and to ensure rigorous project management that is overseen and managed carefully throughout the process. We need to draw on genuine additional expertise that adds value that we cannot add any other way, and it gives us access to a breadth of perspective and knowledge beyond what we have in the system. Attempting to employ people with that expertise would not be cost-effective. I understand the concerns, and the Minister has said that he will take further convincing before he goes further, so that process goes on.

**Mr McCarthy:** What about the millions of pounds already spent? If the Minister says that we cannot go any further, that money has gone. Those millions could have been spent on providing better nurses.

**Mr Compton:** First, at this point, we are not spending any more money than the £660,000 — that is a matter of fact. Secondly, Ernst and Young is a successful company and will not recommend any closures. Any recommendation to close, change or re-profile will come through the staff who work inside the system and go for ministerial endorsement. That is the position; the consultancy will not be asked to do it.

You talked about decimating the system, but I ask you to reflect on the consequences of not doing anything, which would, frankly, be pretty disastrous. My personal view is that the population in Northern Ireland, by and large, is unaware of how fragile the entire current health and social care system is and how it must change dramatically in a planned, sensible and proportionate way over the next three to five years. If that does not happen, I have no doubt that I and others will be back at the Health Committee discussing why somewhere has closed, why something has gone wrong and why something has not worked in the way that it should have. That is what would happen.

**The Chairperson:** I remain to be convinced because, in my head, that is why we have the Health and Social Care Board, the Public Health Agency and the Department.

**Mr Compton:** Absolutely.

**The Chairperson:** I am still not convinced of the need for others to do the population plan.

**Mr Compton:** Others are not doing the population plan; they are helping.

**The Chairperson:** It is a play on words, John. You are —

**Mr Compton:** No, it is not.

**The Chairperson:** Well, you are paying consultants £661,000.

**Mr Compton:** It is not a play on words. We are not asking them to do the population plan; we are asking them to support us in the production of —

**The Chairperson:** Well, if I go to a meeting about the local commissioning plan and the population plan, should I put my bill in to get money because I am helping?

**Mr Compton:** That is different. We have gone out to tender.

**Ms Gildernew:** John, a few minutes ago, you talked about the consequences of not doing anything. I am not sure whether you used the sliced pan phrase; it does not sound like something that John would say.

**Mr McCarthy:** I did.

**Ms Gildernew:** We know that there will be consequences if we do not do anything; it is about how we do that something. Every single one of us around this table has heard from people who work in their field, whether it is health, education or whatever. Those people have attended conferences and all-day seminars and have put forward suggestions, ideas and ways in which they see that things could be done better, savings could be made, efficiencies could be delivered and patients' care could be

improved. I expect that they have said to all of us that, every time that they go to such meetings, they spill their guts about what they think could be done better but never see any change or improvement. They ask where all those reports go and why are they never acted on. People are frustrated and angry that the ideas that they have from working in the system are just set on a shelf somewhere. We are not suggesting that you do not do anything; we are suggesting that you could have listened to some of the health professionals who have worked in the field and have brought forward good, rational, cogent suggestions, very few of which have been acted on.

I apologise, Sue, that I had to leave for a wee while. I was not going to ask anything because I missed the presentation, but I just cannot help but feel a wee bit disillusioned. I do not know whether any of you have a copy of 'Developing Better Services'. John, we asked you in November and December about the further layer of bureaucracy. A line in 'Developing Better Services' was that the trusts and the commissioning groups, along with the community, would devise the plans for their area, in conjunction with others. Presumably, these consultants are the others. We could not get that answer out of you before Christmas, but it sounds like it is now coming at a fairly hefty price tag.

I cannot help but think that Kieran was a wee bit diplomatic, because I also wonder whether the aim of bringing in consultants was to provide political cover so that unpopular decisions could be made and somebody else could be blamed. You know the feeling of the Committee. You heard me say on the radio that we had a fantastic session here with the five chairs of the local commissioning groups. I think that they impressed everybody on the Committee with their breadth and depth of knowledge of how health and social care could and should work, as well as with their vision. They are five genuine people who want to do their best for the population whom they serve; the people being brought in by you are consultants. It does not seem to me that people on rates of £1,000-plus a day will really care about the most vulnerable, such as people who have had meals on wheels taken off them at 85 years of age or those whose care package has reduced to 15 minutes a day. They will not understand, in any shape or form, what the most vulnerable in our society are suffering and going through daily. The briefing paper states:

> *"several millions of pounds of external consultancy will be needed to support this change agenda but that this will help generate hundreds of millions of savings."*

At what cost?

**Mr Compton:** I will make a number of points. First, the local commissioning groups and their chairpersons wanted the external support. They recognised the enormity of their task and strongly stated their requirement for support. There is a real need to understand that it is support; it is not doing. Ernst and Young will not say, "This hospital should close" or "This health centre should change", or "That day centre should close". That is not what it is about. Ernst and Young consultants are there to bring their expertise to how we develop the integrated care partnerships — I spoke about Dr Richard Lewis, for example — and to give us modelling tools to enable us to look at the implications of, for example, reducing length of stay from six and a half days to six days, to five and a half days, and so on. People are at us all the time about that. What are the implications for bed usage, community support or for the interplay between primary and secondary care? The consultants will use modelling techniques to help us to understand that better than we could from the information that we currently have. It is absolutely —

**Ms Gildernew:** I am sorry to interrupt, but do you not think that you already know that? In the earlier session, Andrew talked about acute care. He mentioned problems with accident and emergency admissions and the fact that care packages were not always in place in the community to support individuals on their discharge from hospital. None of us wants people to have to stay in hospital for longer than necessary, but if they are to be cared for properly, the support must be available at home. You know what needs to be done to reduce bed numbers: put care packages in place in the community.

**Mr Compton:** Everyone needs to reflect on why the population plans are different. First, do not assume the existence of any institution or any facility anywhere. Some population areas might have 15,000 to 18,000 medical admissions a year. The first question is this: how many need to go to hospital? The second question is this: if they do, to what type of hospital do they need to go? Only when you understand that do you look at the current infrastructure and say how you will use it differently. That is what a population plan is about. It is not about using the current infrastructure.

The evidence from the system is that a proper pull-through system, if I may use that phrase, means the efficient discharge of patients. What is the nature of their discharge, to where should they be discharged, and how quickly can they be discharged to home? How many care packages would be needed if we modelled medical admissions all the way through? Those are the perfunctory tasks ,and tools from the organisation will help us to get there.

We tend to have a fixed view of our health and social care system, because we know it as it is, and we know the buildings and the services as they are. A population plan states that, for example, 350,000 people live in area, it details their age structure, their deprivation scores and the needs that they are likely to generate. It asks how we will organise that safely, securely and sustainably over a period. That is what we are doing on the commissioning side. We are asking for support to enable us to do it; not to do the job, but to support us in doing the job. We are asking senior people about their extensive experience elsewhere. We tell them what we are doing and ask them how that worked in, for example, an urban area in Manchester or a rural area elsewhere. We are asking them to give us that information and a test against which we can judge our decisions. Using that modelling and those tools, we can deliver a product that allows us to explain to the population what we are trying to do and how the service will look different. People need to think about health and social care services differently; they cannot simply say that we should not touch a hair on the head of a particular service because it is more important than anything.

The important issues are the demands of the population and how to turn those into outcomes. Are services organised in such a way that allows them to be safe and sustainable? Does a certain service deliver to patients the best possible outcomes for their particular problems or difficulties? That is what we are engaged in doing now, and it is not at all straightforward. Were it just a straightforward aggregation, of course, we could do it, but it is not. The people who work in the service in Northern Ireland will bring forward the recommendations, supported by others. It will not be others who make those recommendations. I am sure that, when the population plans come to the Committee, I will be here; the chap or woman from Ernst and Young will not.

**The Chairperson:** They will be having a nice holiday somewhere. *[Laughter.]*

**Mr Wells:** They will be in Barbados.

**Dr McCormick:** I support Michelle's point that we need to reinforce, in every possible way, a culture that is receptive to ideas from within the system. So I welcome what you said and recognise the need to be rigorous in pursuing any good ideas within the system.

**The Chairperson:** I will sum up. I do not think that anybody is disputing where we need to go or what we need to do to get there. The difficulty is that we have the expertise and all the statistics that you mentioned, so do we need to pay out that amount of money to get whatever information you are requesting? I am still not convinced. I supported the need for the board and the Public Health Agency and all of the work that needs to be done there. The commissioning groups are in place and the board is in place, so can we not use that expertise? I do not want to open up the meeting again for another round of questions, but I am still not convinced that we do not have that expertise in-house.

**Mr Wells:** To be fair, John, you are absolutely right about the 16 hours a day. I followed you and watched you in action, and you were ubiquitous. You were in Omagh one minute, Antrim the next. That was an exhausting period, but it shows the quality of what exists in-house in Northern Ireland. I think that you have underplayed, to some extent, what you and your team could achieve. If they were given a grand a day, I am sure that they would be able to repeat those 16-hour days.

**The Chairperson:** Thank you. There are times when you leave here and we are still in dispute. An excellent piece of research was presented to us today by the Assembly's Research and Information Service. It showed that there is a need for research, and so on, but it is a matter of how much money should be spent on it. Before you go, Andrew, I want to use this opportunity to make a request. Lesley-Ann had to wait for eight weeks for some information from the Department. We have asked her to carry out another bit of work, so will you ensure that she gets the information?

**Dr McCormick:** We will do our best.

**The Chairperson:** We do not have £661,000 to spend to get others to look at that.

**Ms Gildernew:** Will you also ensure that the information is accurate? There were a few difficulties with our figures today.

**The Chairperson:** Thanks very much and good luck.