COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Management Structures and Salaries in Health and Social Care Trusts

18 November 2010

NORTHERN IRELAND ASSEMBLY

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

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Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Mrs Michelle O'Neill (Deputy Chairperson)
Mr Mickey Brady
Dr Kieran Deeny
Mr Alex Easton
Mr Tommy Gallagher
Mr Sam Gardiner
Mr Paul Girvan
Mr John McCallister
Ms Sue Ramsey

Witnesses:

Mr Colm Donaghy	)	Belfast Health and Social Care Trust
Dr Andrew McCormick	)	Department of Health, Social Services and Public Safety
Mr John Compton	)	Health and Social Care Board
Ms Mary Hinds	)	Public Health Agency
Mrs Mairead McAlinden	)	Southern Health and Social Care Trust

The Chairperson (Mr Wells):
We will move straight on to discuss management structures and salaries in the health and social care trusts. First, I will make a very pleasant correction to the agenda. We were referring to Mairead as the acting chief executive of the Southern Health and Social Care Trust. Mairead, it gives me great pleasure to congratulate you on your appointment as the permanent chief executive of the Southern Trust. You have appeared before us many times in your acting-up roles, but you have now been made official, as it were. Congratulations for that, and we will make sure that we refer to you properly throughout the meeting.

Mrs Mairead McAlinden (Southern Health and Social Care Trust):
Thank you.

The Chairperson:
The other witnesses who are giving evidence are very well known to us. Also with us is Dr Andrew McCormick, who is the permanent secretary of the Department of Health, Social Services and Public Safety (DHSSPS), and Colm Donaghy. Am I right in saying that this is your first time before us as chief executive of the Belfast Health and Social Care Trust?

Mr Colm Donaghy (Belfast Health and Social Care Trust):
I think that that is right.

The Chairperson:
You have appeared before us wearing several other hats. We are also joined by John Compton, who is, of course, the chief executive of the Health and Social Care Board, and Mary Hinds, who is director of nursing at the Public Health Agency. You are all very welcome, and we are delighted that you could all come. You are a bit like the ‘A-Team’, in that the line-up is very strong.

Dr McCormick, I particularly thank you for changing your schedule. You should have been in London today, and we are very grateful that you changed your schedule. I suspect that there is a fast car waiting outside to take you to an airport immediately after this meeting to get to the

meeting in London. It is much appreciated that you came here.

I ask you to make a presentation for 10 minutes, and I will then ask questions.

Dr Andrew McCormick (Department of Health, Social Services and Public Safety): Thank you for accommodating us; it is much appreciated from my point of view. I will be going down to my own car as soon as the meeting finishes, as you suggested, to get to the airport. I will say a little bit about three topics, and I will then bring in John to speak about the management cost issue and Mary to speak about the travel and patient safety issue that has been receiving attention.

I am grateful for the opportunity to give account. That is what we do; we are accountable to you and to others, such as the Public Accounts Committee. That is the nature of our roles, and we are always very conscious that everything that we are responsible for is public funds and taxpayers' money. That means that the responsibility is on us to secure the right outcomes. That is essentially about value for money. The National Audit Office defines value for money as the optimal use of resources to achieve desired outcomes. That means looking at what is most economically advantageous in the long term. That is the definition that we work to if the Audit Office holds us to account on the issues in question.

I will say a few words on those points by way of an introduction. The main point is that, as accounting officer, I am fully satisfied that we deliver well on the issues that we are discussing today. I can defend the management costs of the health and social care system, the approach to remuneration for senior executives and the travel that has been undertaken, particularly John's trip to Kaiser Permanente, as securing value for money. That is my position, and I am happy to take detailed questions on all those examples. We take those issues very seriously. We do not spend public money lightly or without due regard for an assessment of what we are trying to achieve.

The focus has to be on how we secure the best outcomes for the public we serve and how we secure patient safety and good management. Health and social care is a highly complex area that requires highly skilled and highly trained managers, as well as people who are prepared to step up

and deal with the difficult and complex issues that we face. I want to persuade the Committee that it has every reason to have confidence in the management teams and the fact that they are committed and delivering with a public service ethos in mind and with the right attitude to handling things because they are public servants. That is my continual experience in working with the team leaders.

I will go into a bit of detail on the senior executive pay issue, which is one matter that comes through strongly in the research paper that the Committee considered a week or two ago. As I said, I think that that is an issue that it is proper for the Department to answer on, because my colleagues with me today have no responsibility for the system. The system applies to them as individuals, but I have to answer on those issues. That is the nature of the accountability that I have. I have been involved with the senior pay issues, and I want to discuss, at the level of principal in the system, how things work.

In 2001, the Public Accounts Committee had a major evidence session on senior executive pay, and, from that point onwards, it required Departments to apply strict and more centralised controls on senior executive pay than would be the case across the water, for example, where, as has been said, the levels of remuneration are markedly higher. Therefore, that control has been in place, and we already have the system, which works in several dimensions. The job evaluation methodology looks at the responsibilities, accountability and levels of requirements that are placed on each individual in each job. That methodology is a systematic job evaluation procedure that places the jobs in one of nine bands, which are set out in the paper that we sent to the Committee. However, I am conscious that we sent that paper only this morning, so I will cover this subject briefly. The job evaluation methodology assigns each job to a level, and individuals are placed somewhere in that pay range, depending on the rules of assimilation that apply at the point at which they take a new job. That is the basic structure. We recognise that the pay ranges that were established in the early part of the previous decade were quite long. However, the expectation was that individuals would progress up those scales through a combination of annual cost of living increases and a performance related award. That was the system that was set up, and the jobs were assigned to ranges on that basis.

The next big step was the review of public administration (RPA), which led to our changing

from having the larger number of trusts to the five large trusts that we have now. That involved every individual applying for a new job, re-evaluating the new jobs via the existing methodology and assimilating people on to the new ranges at their new jobs, depending on where they started. In line with our commitments to the Public Accounts Committee, we imposed strict limits on promotion increases whereby 10% was the increase for stepping up to a new job with materially larger responsibilities. That is how it worked. The consequence is the lack of pattern in the distribution of salaries, and that becomes apparent in the research paper. It is based on a system that was approved by Ministers and was operated under strict control since 2001. It has some anomalies and flaws, but it is a system that is based on job evaluation and progression.

The major changes that were made in 2007 led to some complications and left us with a difficult pattern. Senior pay is never dealt with by collective bargaining or negotiation. Government after government and Minister after Minister have used external independent advice to secure an evidence-based view of the right thing to do about senior pay. That is exactly what has happened for the Senior Civil Service, where the Senior Salaries Review Body (SSRB) recently sent a report to the Committee for Finance and Personnel. The Department of Health, Social Services and Public Safety, in conjunction with the Department of Finance and Personnel (DFP), commissioned the Senior Salaries Review Body to look at senior pay in the health and social care system. That report was commissioned in 2008 and was received in June 2009. It made some recommendations, but it has not been acted on or disclosed, because the time is not right. The Minister recognised at that time that it was not the time to change the structure, but the report made some important recommendations and drew out some points. It recognised that the existing system has some serious difficulties and that there are overlaps with the Agenda for Change system, which applies to health and social care staff at third tier and below. That leads to increasing anomalies and difficulties in dealing with the senior executive cadre.

Those issues will, at some stage, need to be addressed to ensure that we deliver a system that is fair and defensible in equality terms and in value for money terms. It must also be based on consistent job evaluation, because jobs change and there is a need, at times, to re-evaluate. That is a difficult and delicate process, and now is obviously not the time to be evaluating jobs upwards when there is any doubt at all about that process. Only the very clearest cases could be justified in any way in the present economic times. However, there are issues to be addressed,

and it is important to deliver a fair and proper system.

A further complication is that the contracts that were put in place a number of years ago had to be amended so that, from December 2008, anybody taking a new appointment has had to accept a contract that limits the progression on those large ranges to a number that DFP imposes. Essentially, it is an Executive decision as to what the progression would have been. Of course, at present, it does not apply due to the current pay freeze. During the past couple of years, however, Ministers set strict limits on increase amounts. That applies to those who have taken new contracts, which is some 20 people. Sixty people are still in jobs in which they have older contracts with a larger progression element. That is a contractual entitlement. Again, governments have to work on the basis that, when they enter into a contract, they have to fulfil it. That is one of the issues that led us to anomalies and difficulties in the pay structure in the context where the level of reward is, generally speaking, markedly lower than it is in organisations across the water. I do not hear colleagues complain regularly or say that they have difficulties with that; I hear about commitment to do the job. As those who advise and operate the system, it is the Department and Minister's responsibility to consider the merits of issues, to consider where it is possible to take action and to do so.

There is also discussion about having doctors and other senior professionals in management. The most important point to make about that is that the very fact that doctors are in leadership roles is integral and central to running health and social care. They do not cease to be doctors when they take responsibility for executive management roles. On the contrary; it is because they are doctors that they can fulfil the responsibilities that are required of medical directors, who deal, day and daily, with issues that require them to draw on their professional competence. There is nothing anomalous or unusual about their continuing to be paid as doctors. That is the nature of their employment contract, and it is right and proper to do that.

Part of my repeated philosophy on that comes from the Fulton report of the 1960s, which stated that we need professionals on top, not just on tap. The health and social care system depends fundamentally on having professionals in leadership and management roles to take and share collective and corporate responsibility for difficult decisions. There is a requirement on organisations to have on their executive board a medical director, a nursing director and a director

of social services so that the organisation's responsibilities can be fulfilled. Therefore, there should not be any doubt about or difficulty with that. The point, then, is that individuals receive their entitlement under their contract of employment.

Furthermore, some medical directors will go back into practice. Many of them regularly maintain a degree of clinical practice while they do the job of executive director. In fact, at the time of the review of public administration, a dozen or so of the trusts' medical directors went back into clinical practice. Therefore, and on that basis, it is entirely proper of them to maintain their medical role and to continue to receive their salary. That is the nature of the contractual arrangements, and that is how the system works. It is not about responding to issues on an ad hoc basis. There is an underlying system and procedure that are framework set and that have been approved by successive Ministers who operate that system. That is an outline of the position on senior executive pay.

Shortly, I will bring in John Compton to discuss management cost. I want to make the point firmly that we are on target to deliver savings that we committed to in the review of public administration. The expectation is that we will deliver £49 million out of the £53 million by the end of March 2011. There is delay in one element, that is, shared services. Our being on target is evidenced, given that we can trace it organisation by organisation and by looking at the number of jobs that have disappeared from the system. So far, 1,400 jobs have been taken out. Therefore, that target is demonstrable and evidence based.

As we explained in previous evidence sessions, other costs have emerged that mean that, if we look purely at management cost figures, there are offsetting increases. However, those costs would have been there anyway. Therefore, the costs of Agenda for Change arrears and higher employer superannuation contributions would have been there in any case and would have been larger. The fact is that we can demonstrate that we have achieved major progress towards meeting those targets. We expect to secure £49 million out of £53 million by March 2011. John can go into that in more detail.

I now come to the issue of overseas travel. Mary will explain fully why we believe that the training that was undertaken was good value for money. As I said at the beginning of the session,

I, as accounting officer, am confident in defending that. I make it very clear that we have advised all organisations to be cautious and very restrained in their use of all kinds of travel, especially overseas travel. That is the nature of the directive that I sent out, and I will strengthen that, because the context has become more difficult since that note was sent.

We need to distinguish carefully between costs that were incurred before and after that directive was sent. The context has been changing, and to reflect on the 2007-08 and 2008-09 figures as though they represent today's situation is to distort the picture. There is a lot of distortion and misrepresentation of the truth of this matter. It is very important to say that we have always applied tight constraints on the kind of travel in question. We always look at it very carefully, and we proceed only when there is good justification for it. We reinforce that message, and we continue to bear down, because, as I said at the outset, we are very committed to securing good value for money. Mary can give the detailed story on patient safety training, which is a very good thing to have been doing. It is important for Northern Ireland, as a region, to ensure that we maintain excellence in delivery for the patient. That is what it is about, and the justification for that training is very strong.

I was aware of John's visit to Kaiser Permanente in California before it happened. I can stand by it as justification. One of the primary functions of the organisation is to secure high performance in the Health Service in Northern Ireland. How can I demand that from John while forbidding him to find out how high-performing organisations work elsewhere? The visit was justifiable, and the lessons that were learned are good and are being put into practice. Evidence emerges from them. Indeed, I undertook a similar visit in 2006. Things are learned that cannot be secured in other ways, and it is important for leading a complex system that we ensure that we are aware of good practice and developments from elsewhere and are able to implement them. It is demonstrable that such knowledge has been obtained from such visits.

Therefore, I ask the Committee to consider very carefully how we should proceed. We want to secure the best outcomes for the people whom we serve. We want to apply careful practice and restrict those things as tightly as possible, whether that is proceeding with travel, adding value or securing good value for money. We have a low proportion of management costs in comparison with many other areas, and we believe that we get good value from our structures.

The jobs are demanding; they have wide spans and lot of responsibilities and demands. In the end, it is obviously for the Committee to judge. The Minister will instruct us as to what to do. He will take account of the Assembly's views and of what is acceptable in public opinion. Our advice and recommendation is that the matters in question need to be looked at very carefully and not dealt with as though they were just a means of securing good publicity. The Committee should look at those things very carefully and take account of our evidence.

Mr John Compton (Health and Social Care Board):
Thank you, Chairperson. Just as the Committee asked me to do following a supplementary request, I will talk about management costs and a little bit about travel as it pertains to the board. The Committee, following the report that it published, asked me to indicate the method by which management costs are ascertained and built up and to comment on management costs as they pertain to the health and social care system. I sent the Committee a letter about that, but, essentially, our management cost is given to us. A standard methodology is applied right across the public sector; we do not create a methodology for ourselves. We apply the methodology that is given to us. That is an important issue.

That methodology is made up of three parts, including a description of what happens for a board with its costs and of the corporate functions of an organisation. I indicated that those are all 100% associated with management costs and their various constituent parts. There is also a body of individuals that falls into the clinical operational departments. Some clinicians will have managerial tasks; for example, clinical directors, heads of physio departments or senior social care personnel. In part, those roles will be attributed to the management costs. There is no attempt to avoid inclusivity in the management costs.

The final cost is to do with support functions, which, again, are all 100% involved. I indicated the salary levels to which that applies. It goes right down to relatively junior staff in an organisation, and it includes allowances and overtime payments. Any payment that is payable to those individuals is part and parcel of the total sum that provides the management cost. Therefore, we think that we have an inclusive system that is very transparent and in which the management costs of each organisation are publicly recorded each year.

Dr McCormick indicated that there was some variance, particularly in 2009. That is associated with the fact that arrears were back-paid to a number of staff as part of Agenda for Change. In some instances, that back pay stretched back to 2004, but it was payable in one year. I indicated already that any payment in any given year is accrued and, therefore, is attributed in that year. There were additional issues with changes in the superannuation regulations. All that was required to express itself in one year. Therefore, from our point of view, our system way of building our management costs is very transparent and open.

I will turn now to the position in 2010. That is slightly easier to talk about, because it is not complicated by one-off arrears payments, which create difficulties in any one year. In 2010 we have spent about £4·45 billion on the health and social care system, and about £149 million of that is attributed to management costs. By any definition that is used for management costs, we are spending a little over 3% on those costs, that is, 3p in every £1 is spent on managing and organising the system. Given the scale of what we are trying to do, I think that that is entirely reasonable and fair. Compared with the rest of the UK, the same methodology using exactly the same numbers will produce a figure of around 5%. Compared with other parts of the UK, we are considerably ahead in the allocation of management costs, and we have made considerable strides on that.

There was also some discussion of the RPA and whether we had made savings. We have reduced the number of trusts from 18 to six, including the Ambulance Trust, so we have reduced the number of senior personnel from 188 to around 80. As Dr McCormick indicated, of the 1,700 staff that we expect to reduce, as declared by the Minister at the outset of the process, we have reduced the number by 1,400 plus. That process is well on its way. As of September this year, we have accumulated some £42 million of the savings towards the £49 million target, and we expect to hit that target on time at the end of this financial year.

It is worth noting that, in the two-year life of the Health and Social Care Board, we have had the privilege, through the Minister and your good selves, to invest £183 million in new services right across the spectrum of service provision. That includes care for the elderly, new hospital services, drugs, family and childcare and disability services. That investment was inextricably linked to the delivery of the management costs, and, without the delivery of those costs, we

would not have been in any position to have made that investment. Not only is there demonstrable evidence that we have made the savings but there is demonstrable evidence that those savings have re-expressed themselves in front line services and front line staff.

Of course, it is important that all that is audited, and it is my understanding that the whole process is shortly to be audited independently. I believe that that will reaffirm everything that I said about management costs.

Therefore, from our point of view, there is good performance to talk about and a good story about management costs to tell. Our management costs are treated seriously, and we look at them very earnestly. We can always have a debate about how the 3% plus is spent, and I am sure that from time to time we will have that debate. However, the fundamental question to ask is whether it is reasonable to be spending a little over 3p in every £1 to run what is a very complicated and large health and social care system. There is at least as compelling an argument that we should be spending a little more, rather than less. However, we are satisfied with what we spend, and we will continue to do that and to be extremely prudent in regard to the management costs.

Let me turn specifically to the issue of training, as I was asked to do. I welcome the opportunity to have a factual and accurate debate about the issue. The board and I support fully the ministerial position on training, which is probably best described as follows: the Minister expects prudent, careful and cautious decisions. There is no ban; there is an instruction to be careful and prudent.

In the two years that the board has been in existence, four members of staff have travelled outside the UK. As a result of the attention that that has attracted in the past few days, we are doing a considerable amount of work to double- and triple-check to ensure that there are no further examples of individuals travelling. That is leading us to the answers, and we will do so through a series of freedom of information questions.

Three staff travelled for health and safety work, which I strongly support, and my colleague Mairead will talk about that in some detail later. The first thing to note is that they applied to a training opportunity. They did not simply respond to a request. They had to make application,

and that had to be successful. Not all applications were successful. We should be applauding the fact that we have staff who are capable enough to make application and be successful, as opposed to berating them for going on a training exercise. It is my understanding that the course is funded through the patient safety forum and that the costs associated with the training are payable by the Health Foundation, which is an independent charitable trust, at no cost to the public purse. The only cost to the public purse is £14,000 or thereabouts, which is for travel, accommodation and associated costs.

Much has been said about me in the past few days. From 12 -17 March, I attended a programme run by Kaiser Permanente, an internationally renowned organisation, as one of a party of 15 to 20 senior clinicians and managers from throughout the UK. The programme, which was organised by the University of Birmingham, covered a range of subjects: long-term condition management; clinical engagement; IT systems and how they might affect efficiency; inpatient hospital systems, including the efficiency of average lengths of stay; and primary care throughout the day. I travelled on Friday 12 March and arrived late that day in Los Angeles. The programme commenced on the Sunday and concluded at lunchtime on the Wednesday. I travelled back to Northern Ireland on the 3.30 pm flight from Los Angeles, arriving back in Belfast at 4 o'clock or thereabouts the day after. I returned to work the next morning at 8.00 am and spoke at a conference at 9.30 am.

Intellectual property is an important issue. When participating in training of that nature, one cannot go and just visit. Organisations charge, and that organisation charged £2,250. We are trying to buy and learn their intellectual property. I have no control over that cost. The remaining costs, £3,600 in total, have been published in the press. Everyone can read them, and they include economy class flights and the basic costs associated with those.

In the two-year period to date, the board's total expenditure commitment for travel outside the UK, of which I am aware — I am double- and triple-checking — is in the order of £18,000. That clearly demonstrates that the organisation has responded convincingly to the ministerial commitment to prudence. People cannot in any way suggest that it shows a careless or casual approach.

The product of the work in which I was involved is expressed in the commissioning plan, which has just been approved and will be with the Committee shortly. It led, in part, to the announcement on primary care partnerships and working differently with GPs, long-term condition management arrangements, clinical engagement and the new arrangements that we are making for IT. That has not happened simply because I went to the States, but my involvement there was helpful in completing the programme of work for the commissioning plan. It is for others to take a view on whether that was the correct position to have adopted, but, in my view, it was a reasonable position, and I seek your support on that.

Again, I reassure the Committee that the authorisation processes for such trips are robust and rigorous. Anyone who wishes to attend a course outside the UK must have the approval of the senior management team, and, if I wish to attend a course, I must secure the approval of the chair of the board. Everything is fully auditable and published. My understanding is that all the organisations from which I commission services have exactly the same processes in place. There is no attempt to do anything other than to ensure that everything is entirely transparent and reasonable.

In a difficult climate, training is always an issue. People will say that there is, perhaps, a soft underbelly and that we should rethink what we do in training. My view, however, is that training is critical and essential. If we are serious about having a safe service that is innovative, new and makes the best of modern treatments, we must equip our staff to be able to deliver it. For me, such a commitment is the sign of a successful, caring organisation. All of that expresses itself not in my trips or training courses but when an individual who has a problem needs a professional on the ground. Training of that nature is important. It is, of course, essential that the training is carried out prudently and responsibly. If Northern Ireland were to retreat to a system wherein we did not facilitate training with other internationally recognised bodies, that would create a great deficit.

I am sure that, in the next number of months, the press will raise many issues from right across the public sector about all sorts of alleged expenditure that is, for example, inappropriate. The key issue for the health and social care system is to focus on the outworkings and implications of the current budget. That is the story. Anything else is, I believe, a distraction.

Ms Mary Hinds (Public Health Agency):
I apologise for being a late entry to today's event. In the interest of brevity, I will not go through the report that I sent to the Committee this morning. I hope that members have a copy in front of them.

It is important that I highlight a few key issues about safety training. As the report indicates, although the majority of healthcare is delivered to the highest standards by dedicated teams of professionals, serious failures can and do occur. Such failures can be devastating for patients and their families. It is widely acknowledged that adverse events occur in one in 10 admissions to hospital and that at least half of those are preventable. In the report, those adverse events are costed in pounds, shillings and pence. However, more important are the distress, anxiety, deaths and injuries that result.

Much work on safety has been ongoing in the Health Service since 1999, when the report 'To Err is Human' was published. All of the many initiatives that have been taken forward in Northern Ireland are detailed in the report that I provided to members. The culmination of the work was in 2007, when the Chief Medical Officer created the HSC safety forum. Its specific role was to share training, to promote proactively a culture of learning and to facilitate education and learning on the improvements in science and methodology. There is a range of other elements to its role, but I will not run through all of them.

In case anyone thinks that the forum is a huge quango, it is made up of a director, who is a doctor, two safety officers and one administrator. Its average budget allocation is £300,000 a year, but that has fluctuated and has been less in some years and more in others. In addition, the forum was awarded £150,000 by the Health Foundation, which is a charitable organisation based in London whose role is to promote and facilitate learning and safety.

From August 2009, Eddie Rooney, chief executive of the Public Health Agency, became the chair of the forum's steering group, which is made up of the trusts, the Patient and Client Council, departmental, board and public health colleagues, and a representative of service users, Mr Gerry Bond, who has been before the Committee. From 1 September 2010, some nine weeks ago, I

became operationally responsible for the HSC safety forum and shall remain so. I came into the role because I have some responsibilities for safety and quality, and I chair the serious adverse incidents group. In taking on responsibility for the forum, I hope to strengthen its extremely valuable work.

The impact of the safety forum on training is the important issue for discussion. The forum supports a range of initiatives that have a direct impact on patient care, and it adopts the approach of the Institute for Healthcare Improvement (IHI) in the States, which advocates collaborative working and the use of care bundles. Collaborative working is the way in which a group of professionals work together, and the use of care bundles is a scientific method of drilling down into specific patient interventions, such as dealing with central line infections, ventilator associated pneumonias (VAPs) and a range of other clinical procedures.

Members have copies of a table outlining some of the material impacts that collaborative work and the use of care bundles have had on patients in Northern Ireland. I shall pick out a few of them. Surgical site infections cause complications in 2·6% of all operations, resulting not only in the pain, suffering, scarring and disability of patients but in costing the Health Service money, because patients must stay in hospital longer and require more interventions and medication. The training that the forum accessed and, subsequently, provides, in conjunction with implementing the use of care bundles, has helped to ensure that, since 2004, surgical site infections in Northern Ireland have decreased by 54·4%, resulting in a saving to the Health Service of £1·9 million. That was reflected in the director of public health's report. More importantly, it saved patients from distress and injury.

Central line infections increase the length of hospital stays. The implementation of the care bundle that deals with matters such as hand hygiene, protective equipment, appropriate cleaning lotions and the good selection of veins has halved the rate of central line infections in the Southern Health and Social Care Trust. As a result of training and getting people involved, Belfast City Hospital has not had an infection since December 2009. Staff want to provide excellent healthcare, and they want us to help them. My job, and the job of everyone at this table, is to facilitate that.

Ventilator associated pneumonias are experienced by people on long-term ventilation. Those people are already vulnerable and very ill, and the evidence shows that VAPs increase their length of stay by, on average, 28%, costing up to £22,000 per patient. The mortality rate for those who develop VAPs is 46%, compared with only 32% for those who do not. Ventilator associated pneumonias take lives, so stopping their occurring saves lives. Components of the care bundle make that difference. As members can see in our paper, since 2008, there have been no ventilator associated pneumonias in the Erne Hospital and, in the past year, none in the Southern Health and Social Care Trust. The Belfast Health and Social Care Trust, which deals with the vast majority of complex cases, has reduced the frequency of VAPs by nearly two thirds. The impact is of that work is significant and saves lives.

The Committee's role is to challenge as well as to support, and a number of reasonable questions have emerged. I know that we are tight for time, so I shall address as many of them as possible. Who accesses training, and is it necessary? The Institute for Healthcare Improvement, which provides the training, is recognised worldwide as an expert in improvement methodology. We all aspire to have a world-class Health Service in Northern Ireland. Therefore, if we are to stay not just in but ahead of the game, staff members need to access that training. A range of front line-staff do access it — they have the uniform and are at the bedside — including doctors, nurses, pharmacists, patient safety leads and governance leads.

In addition, some are service improvement staff and safety forum staff, who then help to facilitate learning at a local level. Trusts chose each staff member for training with a view to their maximising the impact of that training when they get back to base. When they come back, they train others or lead collaborative projects that make a difference to patient care. To give you a feel for the sort of events that staff run, I listed some that we have managed to pull together. A conservative estimate is that the training has impacted on about 1,800 staff. That is an extremely conservative estimate because those staff have gone on to run events in their respective trusts, and I cannot quantify those.

The IHI methodology is to test and spread. It is about doing, not talking. Some members of the Committee are fond of numbers: the 100,000 Lives campaign was one of the great projects that the IHI took forward. I was director of nursing at the Mater when it became the first hospital

in the UK to register for that campaign. The former head of IHI, Don Berwick, has a mantra:

> "Some is not a number. Soon is not a time."

He says that because we in the Health Service frequently say that we will make the biggest difference to the widest group of patients as soon as we can get round to it. In effect, Don Berwick was saying that the implementation of the care bundles would save 100,000 lives by 6 June 2004 — he saved 122,000 lives. It is, therefore, a matter of applying the evidence.

Could such programmes be accessed in the UK and the Republic of Ireland? At the moment, they are not provided locally in either jurisdiction. However, even before I took on operational responsibility for the forum, staff had been looking around to see what programmes they could access. Scotland invested in the region of £19 million in the work of the Scottish patient safety fellowship programme. They tendered, and they then brought the IHI over. They allow us two places every year, for which we have to pay, but at least we get them, and we send staff on that training. It is interesting, though, that trusts in Scotland still access the IHI training in the States because it is so highly valued.

Could those training programmes be delivered through the use of technology? That is a reasonable question now that technology is so much better, but, at the moment, it cannot deliver the three programmes that we access. The IHI provides videos, which any member of the Committee can access, but those tend to last for no longer than 45 minutes to an hour, because learning by video can be difficult. However, should members get the chance to watch them, they are fascinating. Of the programmes that we access, two include distance learning elements, but those are part of the integrated programme and help to minimise costs.

Could IHI come to Northern Ireland to deliver training? Although we are small and beautiful, sometimes we are a little too small to achieve the required economies of scale. We have been trying to build stronger links since the inception of the Scottish fellowships. With my colleagues in Scotland, I will examine whether their contract and tendering process can accommodate some arrangement. We must bear in mind that that learning is happening in the context of Scottish Government policy.

Could cheaper hotels have been identified? That question has caused much upset among

members, and it is an area of concern. Much has been written and said in the press and other media. The Institute of Healthcare Improvement arranged the training and block-booked rooms in the hotels where much of the training was held. The practice has been for the majority of participants to stay in that hotel. The participants are upset by all the coverage of them in the press. They feel that there is a perception that they have been on some sort of jolly. They worked hard, starting at 7·30 am and finishing late.

Flights and accommodation are booked by the trusts, which, as John said, have robust processes in place. However, through contact with some of my colleagues in England, I understand that we could and should consider other options, such as hotels in the vicinity of the training. I assure the Committee that I will explore all options while ensuring that staff can get from A to B safely and prudently.

Would the resources involved be better used for front-line staff such as nurses? That, again, is not an unreasonable question, particularly of me. I have appeared before the Committee on numerous occasions to fight the corner for nursing. No one knows more than me the importance of nursing. As John Compton said, training budgets are often attacked in times of stringency, as highlighted by the Royal College of Nursing (RCN). The investment in training that we are debating improves patient care immeasurably and saves lives. I think that somebody on the Committee worked out that the £30,000 spent would equate to 10 nurses, two for each of the five trusts. Could two nurses in each trust make the difference that all of these staff have made in compiling care bundles and implementing the lessons that have been learned? I do not think so.

I would be the first to say that nursing is important to patient care. However, so are medicine, pharmacy, and the safety and governance leads in the organisations that we commission and with which we work.

I am not given to quoting Florence Nightingale, but she said that the first requirement is to do patients “no harm”. Our first priority is to keep patients safe. We know that we can do something about harm and injuries, and we are professionally and morally obliged to do so. IHI is a world leader, and the staff and the health and social care system should be supported. Trusts have robust processes in place. I now have operational responsibility for the safety forum, and I

hope to build on the legacy of training, capacity building and leadership for patient safety. We will examine how to do things differently and more cheaply because we do not have the same amount of money or resources as previously.

We cannot afford to stop learning. If we were to stop training, we would fail the patients for whom we care. I fully appreciate the Committee's concerns about the use of public money. I understand entirely your role to challenge and scrutinise. I also understand that those concerns are raised because the Committee is just as passionate about wanting a world-class service in Northern Ireland.

I have seen at first hand the difference that training can make to patient care. I helped to start some of it, for which I make no apology. Training can not only make a difference to patient care but to the morale of staff who want to do their best for patients. The staff want to be part of a world-class service. The investment in training is an investment in patients, staff and the future of our safe and sustainable service. I am happy to take any questions.

The Chairperson:
Thank you, folks. Perhaps today is the first time that some of you have been exposed to this type of financial scrutiny. We, as MLAs, get it daily. The average MLA earns £43,146, a figure that is repeated ad nauseam in the papers. That is the same salary that MLAs received 10 years ago, but that is a different issue. This type of scrutiny is something to which we, as politicians, are well used, because it comes with the territory. It is perhaps unusual for Health Service professionals to be faced with it, but that is the nature of the current situation.

It is worth saying that a battle royal is going on down in Stormont Castle in defence of Health Service funding. Last week, the Committee decided to support that battle because it wants to achieve the maximum possible protection for the Health Service budget. The difficulty is that, although the issues under discussion today may be small in the overall quantum, they make it more difficult to defend the position that Health Service funding should be protected. Therefore, when such issues arise, as they do all the time, they are irritants to many of us.

There are one or two ways in which the Department and the trusts have not helped themselves

in the battle. I presume that the Deputy Chairperson will want to come in straight after me, and quite a few other members will have questions. Why, in the annual reports of each trust, are staff allowed not to reveal their pay? I notice that some staff in the Southern Health and Social Care Trust are quite shy. The salary of the acting director of finance, for instance, is not detailed in the report. A director of finance and estates in the South Eastern Health and Social Care Trust was also quite shy about revealing his or her salary. If we, as public servants, have to declare to the public every penny that we spend and every penny that we receive in expenses and salary, why are top-level health trust employees, who are often on substantial salaries, allowed to step aside and not declare theirs? We need to get that out of the way as a technical issue.

Mrs McAlinden:

I have the Southern Trust's annual report with me, and it clearly states the salary of every executive — acting and substantive. The briefing that was given to the Committee examined the salaries for 2008-09, when none of the staff named was in an acting director position.

The Chairperson:

Does that mean that, from this year onwards, there will be no option for staff not to declare their salaries?

Mrs McAlinden:

There has never been such an option; we have always declared salaries.

The Chairperson:

Why, then, in 2008-09, did at least a dozen people say that they did not want theirs to be listed?

Mrs McAlinden:

The people named were not in director roles that year.

The Chairperson:

Perhaps I have got something totally wrong. From 2001 to September 2009, the salary of Mrs Clarke, for instance, who was the acting director of performance and reform in the Southern Trust, is not stated in the annual report.

Mrs McAlinden:

The salary for 2009-2010, during which Mrs Clarke was an acting director, is stated in the annual report. I have it here, and I am happy to share it with the Committee.

The Chairperson:

What about the acting director of older people and primary care services? That salary was not stated in the annual report.

Mrs McAlinden:

I have the annual report here, Chairman. I am happy to show you that that salary is quoted.

The Chairperson:

Are you saying that, from this year onwards, every salary is stated?

Mrs McAlinden:

I am saying that, for the year in which those individuals were in acting director positions, 2009-2010, their salaries are shown in our annual report.

The Chairperson:

There may be some problem of semantics here. Those folks are at the top of their profession. Their designation does not worry me; I want to know how much the top people in each trust earn. A couple of weeks ago, the Deputy Chairperson mentioned that some folk who were already in post did not have to disclose their salary but that all new staff were obliged to do so. Are you saying that, from now on, everybody will have to declare their salary?

Dr McCormick:

It is not a question of from now on; there is no option of non-disclosure.

Mrs O Neill:

The Audit Office report that we discussed some months ago picked up on that issue. We were told by an official from the NI Audit Office — I cannot remember the gentleman's name — that

it was a problem that had happened in the past, but that it would not happen in the future.

Mr Compton:

I want to clarify that the predisposition is that all information will be published. An individual has the right to ask that something not be published. In my experience, I have not known anyone whose request has been successful. He or she would have to demonstrate all sorts of things to indicate that publishing the information would be detrimental.

Ms S Ramsey:

Stephen Nolan.

[Laughter.]

The Chairperson:

His salary is probably bigger than all of ours put together.

Mr Compton:

A number of years ago, perhaps in 2003-04, you might have found a different set of circumstances, but in recent times — and certainly since the inception of the board — we have always disclosed information. I am aware that, historically, one or two of the legacy organisations decided to exclude the publication of one or two salaries. That was back in about 2007-08. However, all organisations are now required to publish those salaries.

Mr Donaghy:

I can back that up. Over the past four years, I have worked in three trusts, and no one in any of those trusts has refused to have their salary published. All salaries have been published along with the other information in those reports.

The Chairperson:

Let us turn to the issue of consultants or senior clinicians who transfer to management. We accept that the consultants have negotiated a deal for themselves that is wonderful — there is no other word for it — and that we are tied to that. It is a UK-wide deal, and we must accept it. It was probably a child of its time. If those negotiations were to start today, that would probably

never happen. However, when individuals transfer to trust management, why do they take their salary with them? Consultants and senior clinicians require such high salaries because they make life or death decisions on the ward. Such responsibility requires a significant salary, but when they move into management, why do they take that with them? They no longer make life or death decisions on the ward, or if they do, that is only a small proportion of their work. Why does that happen?

Mr Donaghy:

To drive patient safety, it has always been a Holy Grail to ensure clinical engagement in our organisation. Our medical directors, the people about whom you are talking, transfer on the medical contract. If they were not able to transfer on the medical contract, we would not be able to take the opportunities to engage much more closely with our medical colleagues. They have a responsibility for governance and safety in our organisations that works right down through the organisations. The managers have corporate responsibilities for our medical workforce and right across the organisations. In particular, they are responsible for ensuring that we have proper governance arrangements in place and for ensuring the safety of patients and clients. It is much wider than an individual responsibility; it is a massive organisational responsibility.

The Belfast Trust, of which I am chief executive, has more than 20,000 staff and a turnover of £1·2 billion. You can imagine the scope of a medical director’s responsibility.

In recognition of that and in order to attract senior medical people into the management of our organisations, it is important that those staff can transfer on their contracts. That ensures that, down through the organisation, we can attract further doctors to assist with the management and safety issues in the body. It is incredibly important that we are still able to do that.

The Chairman mentioned the big salaries that some of our senior executives receive. I want to put that into context and compare the situation in Northern Ireland with that of other parts of the United Kingdom. For example, I have a director of acute services who is responsible for a budget of £330 million and for 5,000 staff. That is the equivalent of a large trust in England, which would have a chief executive, a director of acute services, a director of human resources and a full management team to manage such a budget. We have one director managing a budget of

similar size.

It is important to recognise, as John Compton pointed out, that our management costs are substantially lower than those of other healthcare systems. We ensure that that is still the case, particularly when we consider that some of our directors have a breadth of responsibility that is perhaps three times the size of that in a legacy trust.

The Chairperson:
Presumably the reason that you pay large salaries is so that you can attract and maintain the best possible management staff. Three or four years ago you may have had difficulty attracting a personnel manager/director at £95,000 a year or a director of finance at £105,000 a year. Surely in the present economic conditions, you will have no difficulty attracting someone to apply for a director of personnel post with a salary of £100,000 a year.

Mr Compton:
I could not disagree with you more on that. In the past two years, we have had nothing but the most significant difficulty in recruiting senior staff to all aspects of the health and social care system. The most recent senior post to become available is that of director of finance in the business services organisation. It is being advertised for the second time. We have failed to recruit for that post.

Ms S Ramsey:
What are the wages?

Mr Compton:
The wages are up to £80,000.

The Chairperson:
Sue's going to apply.

Mr Compton:
For senior appointments, across the system in the past two years we have received no more than an average of two shortlistable candidates. Frequently, we have only one shortlistable candidate.

The jobs in question are very demanding and onerous, and there is truly a serious capacity issue. If you ask me what challenges we face in health and social care, I would say that a main one is how we will regenerate and develop the ability to sustain senior personnel. From where we are fixed, there are 101 reasons why that is the case. However, I can see that the man and woman in the street would say that the jobs are very attractive and have very large salaries. They think that we will be able to fill those posts easily in the current economic climate. I have to say that that is not proven by what is happening on the ground. We struggle with that situation, regardless of where it is.

Mrs O'Neill:

Thank you for your presentation. It is important that we have this conversation and that we get to the detail. There is so much being talked about in the media, and budgets are tight. As a scrutiny Committee, our role is to make sure in our own heads that we are supporting something that is right, proper and that provides value for money, as you yourselves said.

Where training is concerned, it is important that we look to best practice and to international standards. I think that everyone clearly recognises the benefits of that practice. Indeed, Mairead McAlinden spoke passionately and gave examples of how such practice benefits patients. We should all take a step back and say that it has to happen. As I said at the start, value for money has to be the cornerstone of all those decisions.

As a result of the presentation, I am slightly more settled and have a better understanding of how things work. The Chairperson picked up on my two main points, which were about disclosure, or lack of, in some instances, and about senior salaries, especially the difference between what a chief executive and a clinical director receives.

I want to pick up on a few details from the briefing that Research Services provided. Colm, perhaps you can pick up on this point. The Belfast Trust provided the Assembly's Research Services with information on corporate managers, but other trusts simply provided information on administrative and clerical staff. It is not clear whether the term "corporate managers" equates with administrative and clerical staff. Therefore, I do not know whether we are comparing like with like.

Mr Donaghy:

I think that we are. What we refer to as our corporate functions are probably called the support functions in other trusts, and that includes the entire range of clerical and administrative support. The two are, in my view, the same.

Mrs O'Neill:

If every trust used the same language, it would be easier for us to grasp the details.

Mr Compton:

I welcome the comments and the support for training. I fully accept that it is the Committee's role to scrutinise and challenge. That is a sign of a healthy system of care and treatment, and we welcome it. I reassure the Committee that, when publishing annual management costs, all organisations are required to submit information in the format that I outlined in my letter to the Chairperson. All organisations report in the same way. There is no sense in which an organisation hides, for want of a better word, any elements and does not report them. Everything is reported. I want to be clear that the financial scrutiny that is applied to each organisation is independently audited. It would be a most remiss state of affairs if an organisation were found to be acting ultra vires in that respect. To avoid creating confusion, it is important that all information is received in the same way.

There is an important point to be made about the medical director. When the trusts were set up, they were required in statute to have on their board a number of personnel, one of whom had to be a medical director. That was not optional. Anyone who is a medical director must be a qualified doctor. Again, that was not optional. Often, medical directors are also involved in clinical practice. That means that they do the job of medical director, and they are also involved in some clinical practice, even though it is not full time. Importantly, medical directors are also involved in appraisal. Increasingly, and given the point that we have reached in medicine, all doctors are appraised on their competence, capacity and ability to discharge the job. The medical director is instrumental in each organisation in ensuring that that appraisal process and, therefore, the quality and satisfactory performance of the doctors right across the organisation, are as they should be. Frankly, there would be a serious gap if I could not receive such an assurance, and I

would not be able to run the organisation and, as a commissioner, I would not be able to commission services. It is simply not doable.

Mrs O'Neill:

On that point, are there no set criteria for how much time someone spends in the role of clinical director?

Mr Compton:

Normally, when a clinician stays to carry out clinical practice, there is a negotiation with that individual. Let me make it clear that the majority of their time will be spent in the role of medical director. However, they might spend, for example, two sessions of a 10-session week in clinical practice.

Mrs O'Neill:

Does that vary between trusts?

Mr Compton:

It can. Some carry out the role of medical director full time and are not involved in clinical practice, whereas others do up to two sessions.

Mr Easton:

Thank you for your presentation. I appreciate that management does a good job in difficult circumstances. I also agree that managers sometimes have to go away to look at new medical practices and so on. I support that, as long as it saves lives and involves new medicines, for example. Although that is great, we face a difficult period, and we have to make sure that every penny counts. I am scrutinised for everything that I do, and, although it might annoy you at times, the Committee must scrutinise you in the same way. That does not make us enemies, but it means that we have to try to work together. I should say, Andrew, I supported the budget last week, so just you remember that.

I know that under the RPA you reduced management numbers and costs and so forth, and that is all well and good. However, last week, we were shown figures for the different range of

managers. There are, certainly, still hundreds of them at different pay levels. Is there not scope for further reductions?

I have never been able to get my head around one issue in the RPA. I will not name names, but there were certainly people with directorships or in high management posts whose pay was protected when they were given jobs at lower grades. I know that some jobs were created for them. I could name one individual involved, but I will not embarrass him by doing so. I have never been able to get my head around why that has happened. That is certainly another issue that I want to see addressed. Those are my two main points.

Dr McCormick:
I will respond to your latter point. That matter was handled carefully, individual by individual. I was involved personally in handling some cases in which there were issues. We were under several constraints. The Minister and the previous direct rule Minister had both said that they would carry out the RPA without any compulsory redundancies if at all possible. That has been achieved. However, the corollary of that is that we have to follow contractually based procedures for dealing with voluntary severance, be it voluntary or early retirement or voluntary redundancy. That places an obligation on the employer to identify suitable alternative employment for individuals.

Therefore, with regard to the first requirement, I had to send several letters to the service to tell it that when individuals had not obtained a post, it must please encourage them to apply for further posts, even if it regarded those posts to be below the level of that which the person held previously. For certain individuals that was difficult, so we had to manage that properly and thoughtfully. The first approach was to persuade and encourage by telling people that we value their service and that, although there may not be a place at chief executive or director level, they should please apply because there may still be a very senior post in the organisation. We took that as far as we could.

In a number of cases, we had to say that people were not placed for that process. It was not something that we did by whim; we had an obligation under redundancy procedures to identify suitable alternative employment and to offer it where it was available. It happened in a number of

cases for a relatively short period, but something else then arose. We have handled the process thoughtfully, case by case. There is actually an obligation in such situations. If someone steps down from, say, a role at band 4 in the Hay pay and grading structure and accepts a job at band 6, their employment contract provides for pay protection, with limits, time expiry, and so on. It is part of their entitlement. Therefore, it is not a matter of choosing to do it that way in some cavalier fashion; it is about following proper human resources practice and guidelines that were set down by the Public Service Commission. That took a lot of time and management effort during the transition period. However, I assure the Committee that we did carried out that process thoughtfully and properly. I suspect that I am aware of the case to which you referred. We had to deal with that case thoughtfully and carefully within procedures.

The question of whether there is further scope is linked to —

Mr Easton:

I want to make a point about further scope where managers are concerned. When I was a young man — that was a long time ago — I started work in an A&E department. One manager was in charge of A&E, the X-ray department and the medical records department. Now there is a manager for each department, even though there are fewer departments generally. For example, there are no longer medical records departments at Bangor Community Hospital or Ards Hospital. All those records are kept at the Ulster Hospital. Although they still exist, the X-ray departments at those hospitals have been reduced, and the one at the Ulster Hospital has been maintained. Why are there now separate managers for all those departments? Twenty years ago, when I started work as a young man, there were fewer managers. That is why I get confused. Is there further scope for reductions?

Dr McCormick:

First, and this goes to what John Compton said earlier, the jobs that we now have are increasingly complex and demanding. The nature of medicine has evolved a lot in the past number of years, so the procedures and requirements that have to be fulfilled cover the full range of governance obligations on the clinical side, as well as accountability. A publicly funded service is an absolute commitment in this jurisdiction, and this is seen as the right thing to have. However, the corollary of that is that it leads to additional obligations to report, analyse and be accountable. A

private sector organisation would not have those levels of obligations. I am sure that my colleagues will give further evidence and reasons in response to your point.

Mr Compton:

Again, I share your view that we should minimise management costs. There is e no question about that. I believe and hope that we have demonstrated this afternoon that we have made very serious efforts to do that. However, it comes down to the fact that we spend little more than 3p in the £1 to manage those costs. That is the fact of the matter. I know that people will say that there is a manager here and a manager there, and they may ask why one manager cannot be employed instead of two. There will always be that debate on the ground. However, the real hard issue is that, out of the total block of money that we have, little more than 3p in the £1 is spent on management costs. By any stretch of the imagination, that is not a huge investment in management.

There will always be a necessary and responsible debate about the way in which management is organised and about the nature and shape of that. Where there are opportunities to do things differently, we should take them. It oscillates back to the question of whether 3p to 3·5p in every £1 is a reasonable amount to spend on the management of the sort of organisation that we have, with the complexities and changing circumstances that we have, such as the number of personnel working in and coming through the system, as well as the number of people who come through the system to be treated, supported and cared for. Ultimately, I consider that to be the real issue.

Mr Donaghy:

I agree with John, but let me give the Committee another example, because I think that it is important to reassure members that we are not complacent about management costs. We are not saying that, because it is a very tight 3·2%, there will be no further reduction in management costs. I can give the Committee an example. As changes happen, we constantly examine what we do and where we can reduce our administration. Recently, the number of medical secretaries was reduced in Belfast, because we now have voice recognition technology for consultants and others, which means that they do not need the same level of medical secretary input. We constantly flex with changes in administration and technology as they happen. We are not complacent about the fact that we have a 3·2% management cost.

Mr Gallagher:

I thank the witnesses for their presentation. I do not question the commitment of any of you to improving the Health Service for everybody who needs it. However, I have an issue with management costs and the topics that we are discussing. I did not support a motion last week that called for the Health Service to be ring-fenced, and the reason was that I think that there are serious questions about the costs that we are discussing. Until there is more information about such costs, I will not support the ring-fencing of the Health Service. This is an important issue that must be looked at.

Some of you used terms such as distraction and distortion when discussing reports that are out there. Those reports are not just in the regional media. Members know that many similar stories are also in local media outlets, so there are issues to be dealt with. I would prefer the word "debate" to be used, and if we were all to approach the matter in that light, we may all get on the right road that leads us to a better place.

After that long preamble, I should say that there are two parts to my question. First, on the management costs issue, you identified 65 senior executives who were appointed pre-2008. In addition to the annual cost of living increase, do they get an additional 2% or 2·4%? If that is the case, could you explain why? If new controls were introduced in 2001, it seems to me that those 65 people must somehow have escaped those controls, and a special business case has to be made to the Department of Finance and Personnel about their salary increases. Can you also tell us whether it is the case that all 65 get the increases that are applied for each year? Is it a smaller number in some years?

Dr McCormick:

In 2008, a tighter contract was introduced as the result of a tightening of national and local pay policy. That meant that we were required to offer new contract only to new appointees. Previous contracts were consistent with what had been agreed following the PAC's 2001 meeting on the matter. The methodology and the structure emerged after that time. Therefore, a pattern emerged in that period whereby that practice was acceptable and manageable. The salary ranges, as they appear in the paper, were improved, together with the progression as I described. As you said,

that comprises two elements: first, a cost of living element; and secondly, a performance based additional progression. There are degrees within that, but there are limits as to the extent to which anyone can have the higher awards. It was a well-controlled system, and the awards were not blanket awards and not for everyone. In that system, there was a clear element of *[Inaudible.]*

We have an evidence-based view that says that we have to continue with those contracts. However, we are now in a pay freeze, and a tighter regime is being applied at present. The senior executives are among the first to be affected by that, because their 2010 award had not gone through before the DFP instruction came through to apply a freeze. Therefore, a freeze is in place, which means that we have to look at the matter carefully. Even though no one is thinking about this at this stage, when the time comes for us to come out of the freeze, we will have to find a better way forward, because, as you highlighted, there are anomalies and issues to be considered.

The pre-2008 contracts were consistent with the controls that have been applied since 2001. However, I must point out that, in other jurisdictions, contracts were more generous and have progressed more fully in the period 2001-08.

Mr Gallagher:
Are those 65 appointees outside the DFP pay freeze, or are they included?

Mr Donaghy:
Tommy, I would like to give you some understanding of those 65 people. You are quite right; they sit outside national pay and conditions. All the other staff in our organisation, or most of them, are subject to national pay and conditions, regardless of whether that is in Agenda for Change or to do with medical or other types of contracts.

As a result, people make progress year on year on the Agenda for Change salary bands in line with an appraisal and performance. They also get an inflationary uplift. The 65 people do not have a national negotiation or a national contract. They are subject first of all to an inflationary uplift, and then, depending on performance, they will get a further 2%, which is about the equivalent of an increment. In answer to your other question, Tommy, not everybody receives

that.

In the absence of that type of progression, those 65 staff would not progress through the pay bands. People sometimes describe that as a bonus. In fact, it is an incremental progression that is based on performance.

Mr Gallagher:
Courses and improvement are important issues. Is it the case that the independent health foundation covers all such costs and that there is no cost to the Department?

The Chairperson:
If only.

Ms Hinds:
As I said, the running cost budget for the safety forum, which comprises four staff, is £300,000. On average, about £150,000 is allocated towards training. The cost varies, depending on whether people are in post. A lot of that is delivered locally through collaboratives and events. The IHI methodology is to test and spread. It is designed to try to spread the good practice with the fewest possible people. The health foundation money is a one-off payment of £150,000 that we have been trying to use as best we possibly can. However, we are coming to the end of that. You are absolutely right about challenging prudence. I have to get cleverer about how we use our money going forward so that we can get the best value out of it.

The Chairperson:
I have a technical question to ask. 'The Irish News' of 15 November asked what your role was. It stated that:

> "she refused to disclose Ms Hinds's role in the forum, claiming this information cold [sic] only be obtained through a Freedom of Information request."

Why the great secrecy? You have been very open with us here today, but why was a brick wall put up against that question?

Ms Hinds:

I do not know. If you go on to the website, you will see that there is plenty of information about me, and most people in Northern Ireland know me quite well. In fairness, that situation could have come about because staff were slightly overwhelmed with requests.

The Chairperson:

They tell them nothing — it is like Castlereagh. Do you see how that could create suspicion?

Ms Hinds:

Absolutely.

The Chairperson:

You answered that question today on several occasions.

Ms Hinds:

Yes.

Ms S Ramsey:

Do you have experience of that, Chairperson?

The Chairperson:

None whatsoever. My immediate thought was that there was something to hide, because your staff refused to answer.

Ms Hinds:

I am quite transparent about what I do. I have appeared before the Committee before, and I am sure that I will be here again. I am quite happy to talk to anybody about what I do in my work.

Mr Gallagher:

I think that I heard you say that you were prepared to look at the possibility of doing some training at home if you could get good value. There are 1·5 million people here and another 4·5 million across the border. Have you considered taking the Health Service people who you want

to train and making a joint bid to have some training delivered on the island of Ireland?

Ms Hinds:

It is an option, but I have not thought of it. We have been thinking about Scotland, because it has already gone through the process. Even the whole process of tendering for something as complicated as that type of training and development has a resource issue. As regards prudence, the first option would be to look to Scotland to see whether there is anything that we can do. I am not quite sure whether there is, but we will explore all the options.

Ms S Ramsey:

I am glad, Mary, to hear that you will look at all-Ireland training. Sometimes we get carried away and look towards Scotland even though examples are on our doorstep.

I want to take a positive approach to the issue. On the back of what Tommy said, we will not support what came through the Health Committee last week. I am concerned that if part of the budget is ring-fenced, social care and primary care will be the target. That does not suggest that acute services sucking up all the money is the right way forward. That would have a detrimental impact on social and primary care, which leads me nicely to slipping in a question on an issue that we are not talking about. Andrew, can we have an update of where we are with Investing for Health? You may not have that information here, but we were promised it. I worry about keeping people out of the acute sector.

The question that is relevant to this issue is the Senior Salaries Review Body, which reported last year. Do you have any idea of when we will see that report? Have you moved on any of the recommendations that it made?

Dr McCormick:

We have not. It is on the long finger, because it is not the right time to be looking at it. It is also not in a form suitable for public disclosure because it addresses the individual pay of all of the posts, so it is a very detailed report. We will put that to the Minister to see what he would like to do about it. No action has been taken on the recommendations; they are all in cold storage because of the current pay freeze.

Ms S Ramsey:

Who put it in cold storage?

Dr McCormick:

The position is that it was a report to both our Department and to DFP.

Ms S Ramsey:

Who put it in cold storage?

Dr McCormick:

It is the Minister's decision to do that.

Ms S Ramsey:

Therefore, the Minister put it in cold storage.

Dr McCormick:

The Minister decided that he wanted to re-consider it when the time is right. This is not the right time to make a change of that nature.

Ms S Ramsey:

Whether we come to that agreement or not, the time is right for us to look at that. I suggest that we should try to get more information on why it is in cold storage.

I am conscious that we should not have a knee-jerk reaction to the issues that Mary raised. The Committee has been on study visits. I am trying to be sensible about the issue. What struck me is that you said that some training started at 7.30 am and ran until 6.00 pm, and you mentioned looking at additional hotels. The way in which staff are treated is just mad. However, I am more interested, Mary, in the money that has been saved, and the report that you have given us is quite useful in that respect. Will you give the Committee an assessment — even if you do not have it today — of how much has been saved? John said that, in the two years since the board was set up, four staff have left. How do we use what people have learned from international standards, and what is the impact of that learning here? Have four, 10 or 20 people received that training? Without going into detail, when my mother was in hospital, she got a

hospital-acquired infection. From reading the report, I think that lessons are being learned, but how much is being saved? We do not want a headline that states that £14,000 was spent, but one that states that £14,000 was spent to save £1 million. To avoid knee-jerk reactions, including those of the Committee, that is the type of information that is required.

Ms Hinds:

We have not been good at telling you and everyone else about the good work being done by the safety forum and the staff in the trusts. The one figure that I have got for you is that the decrease in surgical site infections has saved £1·9 million, which is a lot of money. I will go through the figures — you will appreciate that I pulled them together at short notice — and try to quantify the savings made. When we prevent harm, injury and death, there is less reliance on resources by the acute hospitals that you mentioned. I will happily provide more figures on that.

You asked about staff going away to be trained and the subsequent cascading of that training. At some stage, if the Committee wishes, I will come back and talk for hours about IHI and its work with us, because it is fascinating. IHI's methodology is to test and spread. In other words, a piece of work is carried out and tested. There is no waiting around for any argument or discussion. The idea is to get on with it and spread it to as many people as possible. Numbers are put to it and targets set against it, and those things matter. I have a list of some of the initiatives that staff in the trusts and in the safety forum have taken forward to spread their learning to others to make a difference.

Ms S Ramsey:

That is interesting, but you should give us that information and not be shy about it.

Ms Hinds:

As I said, we are not always good at coming forward.

Ms S Ramsey:

When we read headlines that state only that something has cost £14,000, we do not see the information that you have just given to us. You cannot blame us for our reaction being that, once again, senior managers were creaming off the money, and so on. I am more interested in what is

being learned, and I am in favour of lifting international models of best practice and using them here.

Ms Hinds:

I talked to student nurses yesterday. My message to them was that not only must they speak up for their patients, they must lift their heads to observe what happens in other parts of the world. We should also celebrate the fact that sometimes we are ahead of the game, but we are not good at doing that either. If you ever visit a trust, or if the Committee has time, I will happily come back to talk about safety.

Ms S Ramsey:

I will be visiting a trust in the morning, but I do not want to say which one because I want to go in secretly.

Mrs McAlinden:

Mystery shopping?

[Laughter.]

Ms S Ramsey:

I have two quick points to make. I am all for reskilling and upskilling. I sit on another Committee that deals with that. In addition, I had the pleasure of sponsoring the West Belfast and Greater Shankill Health Employment Partnership this morning. We need to learn about how staff in the health sector are being reskilled and upskilled. That is a good project, and I advise members to consider it. My cynical question about money is: does it create problems when the chief executive earns less than a director — Colm?

Mr Donaghy:

It does not cause difficulties at all.

Ms S Ramsey:

You are like a wee duck, flapping away underneath the water.

Mr Donaghy:

Yes, underneath I am flapping away. It creates no difficulty whatsoever. In NHS management, it has always been the case that managers earn considerably less than their medical counterparts, but that has not affected their commitment to doing the job. It is recognised that the expertise that doctors bring to the table is extremely important, so we have no difficulty. In fact, even though their salaries are different, medical directors have no difficulty fitting in with the chief executive's accountability arrangements. It is, therefore, a two-way process.

Mr Girvan:

Thank you for your presentation and for the information that we received. When I look at the issue from the community's perspective, it comes across that the management structure is shaped like a brick as opposed to a pyramid. It goes out, and then there is a small tier below, which seems to be the way that it has operated. Alex Easton mentioned when he was in the Health Service, many centuries ago as a young man —

Ms S Ramsey:

Florence Nightingale was still working.

Mr Girvan:

At that stage, one manager was in charge of each area. Now, there seem to be many more. I am not talking about whether people are classed as senior management on the scale under discussion today. That is another point. We are talking about senior management. However, below senior management are several tiers that create a broad sphere, and that structure must be examined. Irrespective of what people say, there is a need to rationalise management structures.

To help me to illustrate a point, think of the NHS as a private company. Throughout the world, private hospitals deliver high standards of healthcare. I appreciate that you go to America to see how things should be done. If you travel to see how things work in other areas, you will also see how efficient and accountable management can be made to be.

Sue referred to the report that will not see the light of day, either because it has been hidden or because it might say things that we do not necessarily want to hear. Perhaps it recommends

rationalising some of the positions that we are talking about, or it might involve some people taking on additional responsibilities, but getting rid of a whole tier below them. That is fine; I accept that, in some areas, that must happen. Are plans in place to rationalise and improve the management delivery programme in the Health Service? At this stage, we are dealing only with management. I know that we are dealing with management-level directors, but there is a whole tier below them that needs to be looked at seriously.

Having spoken to people in the Health Service, I know what is really happening. I have had to attend hospital, and I use the Health Service at present. You mentioned rationalisation and front-line automated telephone services. Nothing frustrates the community more than those automated telephone services. People would rather speak to a real person, instead of trying to work their way through the system while talking to a machine. Irrespective of that, that is what the people whom I see on the front lines are talking about. The poor secretaries are the girls who get all the grief, and the boys behind the scenes bat everything away —

The Chairperson:
Boys are secretaries as well.

Mr Girvan:
Sorry. Normally, I speak to a woman. They are the ones who get all the grief, and the boys behind the scenes just bat things away and let their secretary deal with them. A good secretary saves a consultant from an awful lot of hassle. What is being done, and what plans do you have in place to rationalise that? I am sorry to hear that that report has been put into a cupboard for another day. I would rather know now, because it is important.

Dr McCormick:
The fact is that organisations face a challenging future. The Budget settlement will be immensely challenging. I am grateful for members' comments in support of health and social care. I also noted Sue's concern about social care. What we can demonstrate more clearly than any other region is the importance of integration and working together. That is beneficial in every aspect of prevention, early intervention and proper patient care. The integration of health and social care is simply that valuable. That is why the Minister still seeks the best possible protection and priority

for all budgets, not just for the budget that is narrowly defined as being for health, never mind that of acute services. We must examine that properly and effectively.

In the financial context, the best case that is available will involve difficult decisions. The best case that the Executive or Sammy Wilson can ever dream of giving us will still leave us having to find major efficiencies and make changes. Even in what we understand to be the best case available, site closures and reductions in the workforce would be required. Hence, I take your point entirely: that means that we must re-examine the scope to rationalise organisations and management. That could involve a reduction in the number of sites and, therefore, the need for fewer staff. Pressure on the budget causes us to think about those possibilities. I accept that that leads to public concern among about access to services. We try to reassure the public that we have a managed and timely process that can secure the retention of safe and high-quality services as those changes are made. However, that, in itself, requires committed management and leadership.

I ask that we make judgements on the basis of how organisations deliver and perform overall. If they can deliver a better outcome with a larger proportion of management, why would that be bad? If organisations are delivering a poor outcome with a high proportion of management, that is when the regional organisations, the board and the Department need to intervene and challenge. We must examine those issues and try to focus on what is being achieved and how it is being achieved. We must focus on delivering the right kind of changes.

Mr Girvan:
I am not against training. Training is vital in any organisation, especially in a field as important as health. It is vital not only that we follow the rest of the world, but, perhaps, that we lead the world in many areas.

I have been heavily involved in the private sector. A number of years ago, a programme was run in which people were asked to carry out their own job re-evaluations and write out their job descriptions and core responsibilities. Some of them put forward responsibilities that did not reflect their roles. They had written down what they deemed themselves to be involved in, and, had they been paid accordingly, the company would have been bankrupt within a week.

Unfortunately, that often happens in management. People take part in programmes in which they write up extremely detailed job descriptions of their responsibilities. However, when one grills the figures and details of those descriptions, it is clear that, although they might carry out some of those responsibilities, they do not carry out all of them.

From a director level, I understand that management is a difficult area. I acknowledge that directors are needed, but there is definitely a need to focus on that area in more detail. The figures that have come to the Committee only go down as far as one tier of the management structure.

Mr Donaghy:
I hope that I can address some of those issues. In the context of the review of public administration, you will be aware that managerial and administration staff were reduced by 1,400. That included those tiers below director, co-director and assistant director level. The reduction went right down through the tiers. If those staff were currently in post, we would have an additional salary bill of £45 million.

Mr Girvan:
Given that the budget stood still over those years, how did that reduction in staff reflect on the front-line delivery of services?

Mr Donaghy:
Those were managerial posts. Notwithstanding what Andrew said, I want to make you aware that, given what we face, we will have to look again to determine what can be reduced even further, potentially with regard to managerial costs.

As I said earlier, we do that constantly. However, you mentioned, for example, some of the private healthcare systems. In the private healthcare system in the USA, 10% is spent on management costs; in Canada, that figure is 17%. The National Health Service Confederation published those figures not that long ago. Our figure of 3·2%, which is comparable —

Mr Girvan:

The 3·2% to which you refer covers only the top tier.

Mr Donaghy:

Sorry, it does not. The 3·2% is the widest interpretation of management, including all the administration and support costs.

The Chairperson:

Only the Southern Trust gave the Committee a document that clearly defined what it understood to be management. Only that trust gives us a clear understanding of what constitutes management costs. The suspicion is that a trust can always stay below the 4·1% level by simply moving folk who are in management to positions with a clinical heading.

Mr Compton:

I will make a couple of points. First, I will return to what I said earlier: every year, each organisation is required to submit its management costs, using the formula that I described to the Committee. There is no hiding place. The trusts are required to include everyone. The little more than 3% that is being discussed — people have talked about 3·1%, 3·2% and 3·3% — includes all management costs, not only at the top but right down through the organisation. The costs refer to the total number of individuals involved, and, as I said, that extends to fairly low reaches of the organisation.

That information is audited and detailed, and, to refresh members' recollection, I remind you that it falls under headings: board and corporate functions, clinical operational departments and support services. The information includes all staff in the organisation who are involved in any of those functions or in any part thereof, as regards the clinical operational side of services.

The Chairperson:

John, the problem is that the Southern Trust told us how it apportions each position to clinical or administrative staff. If all trusts were to do that, we could compare like with like. However, a trust has discretion over whether a person's job is defined as clinical or management.

Mr Compton:

I hear what you say, and, if we have not communicated with the Committee correctly, we will do that. It is critical that there is a clear appreciation that we are talking about little more than 3p in the £1 in each organisation. We may need to present that information in a different way.

Dr McCormick:

Let us come back to the Committee on that.

The Chairperson:

Will you set a common standard? I used the example of the Southern Trust because the Committee understands how it reached its figures.

Mrs McAlinden:

We deliberately provided detailed information because of an apprehension that there might be some flexibility. All trusts and DHSSPS organisations work to the same circular, and we gave the Committee detailed information on how that circular is applied in the Southern Trust. On management costs, it should be remembered that we have implemented our reform of public administration (RPA) measures. We have reviewed administration. The Southern Trust has taken £5·5 million out of administrative costs at the same time as achieving CSR savings of £36 million with a reduced management workforce. It is timely that I make those points on behalf of our managers. I assure the Committee that, in meeting and talking to the managers, as many members have, you will appreciate that they work well performing complex tasks.

The Chairperson:

In light of Mairead's comments, perhaps John will answer my next question. The document that members received from the Assembly's Research Services states that, instead of the £50 million that it was claimed had been saved:

> "there is a real terms savings on management costs of almost £6.7m".

You say that much of that difference is due to the Agenda for Change. However, you knew that Agenda for Change was on the way when you promised the £50 million, and you knew that there was going to be a significant backdating —

Mr Compton:

No.

The Chairperson:

Agenda for Change was ongoing in the middle of this process, while the £50 million was being promised.

Mr Compton:

The figure in your document is wrong.

The Chairperson:

Right, well we would like to know why it is wrong, John.

Mr Compton:

We can certainly get you that information, but that figure is wrong. As of September this year, the figure was about £42 million, and we are on our way to saving £49 million. I will pick up on Mr Girvan's point: that money has been reapplied in the service. In the past two years, the board has invested £183 million in new and important things. Without having made such savings, that figure would not have been £183 million.

Some critical messages must be appreciated. An effort has been made, and change has been brought about through the RPA. That was difficult to implement, but it has been a success. It is difficult to overstate the complexity of going from 18 organisations to five large trusts plus the Ambulance Trust, or from four boards to one board. It has been a huge rationalisation in a relatively short space of time, and it has delivered. We can certainly make the information available to you. We can also give you the circular about how management costs are determined in each organisation, and you will see that there is a formula for everyone to apply. There is absolutely no desire on the part of the system to do anything other than present transparently what is, I think, a good story.

We have made huge efforts to improve the management costs and arrangements. I would not

come to the Committee and quote a figure of £42 million if I were not assured that it was accurate. It is not a manufactured number of the Agenda for Change or the additional costs that are associated with superannuation. It is the money that we took out of the system. Think about it logically. Given the reduction from 188 senior director-level staff to 80, and the removal of 1,400 staff, rising to 1,700 staff, from the system, you can see that £6 million is not right. Just do the division. When that number of people has been taken out of the system, the figure must be more than £6 million. It simply could not be less.

Mr Donaghy:

I support John in that. Had those 1,400 posts not exited the system, we would have £45 million of additional costs in the system.

Mr McCallister:

John, you are saying that the formula is common right across the service?

Mr Compton:

Everyone adheres to that circular.

Mr McCallister:

How do you compare that with trusts across the water and with other parts of the country? Is it linked into that, or is there benchmarking?

Mr Compton:

It is quite clear that one can benchmark across the UK. There are some difficulties because we have an integrated system, and the UK has a separate local government system. However, the figures, as best we can understand, show the English position to be a little over 5% — around 5·1% or 5·2% — whereas our figures are sitting at 3·1% or 3·2%. We are demonstrably more efficient in that respect. If that figure was wrong, I would say so. We are here to tell you honestly what the numbers are, to tell you in a straightforward way how they are arrived at, and to tell you that we are genuinely confident that we have made significant changes, that those changes have generated real cash and that that real cash has been reinvested.

Mr McCallister:

Are the figures that Colm gave comparable with the States and Canada?

Mr Compton:

They are, very much so. Internationally, it gets more complicated, because there are a lot of fees for item service, so it is very difficult to compare like for like in that situation. However, when international colleagues ask us how much we spend on management and we say that we spend a little over 3%, most of them just look at us as if we cannot be serious and that we must be spending more than that. They wonder how we make it work with 3%.

Mr Girvan:

Do you play the poor relations?

Mr Compton:

Yes.

Dr Deeny:

Thank you, ladies and gentlemen. Welcome to the throng. I am delighted that this conversation is taking place. It had to take place, and it is good for you, as our senior managers, it is good for the Health Committee, and it is good for the public, because openness and transparency are what it is all about nowadays. It is expected of me as a GP and as an MLA. Even in the Committee, Sue Ramsey never leaves me alone.

Ms S Ramsey:

He has to take two days out to upskill every week. *[Laughter.]*

Dr Deeny:

That is correct.

The figure of 3·2% is impressive. Senior people in this Building, including our First Minister, say that we should cut the number of MLAs, for example. Some people think that we need 108 MLAs. Perhaps we should cut the number of Departments or the number of Ministers. It got me

thinking that, if we add up all the salaries of the MLAs and Ministers, what percentage of the block grant would that be? That would be interesting. I make that point because people right across the board are saying that everyone, including those in health, should be more efficient, and I agree with them.

The need for clarity was mentioned. It is good that the public know what people do. Mary mentioned an Internet presence, which is positive. The Belfast Trust is the biggest in Europe, but I note that it has a director of clinical services, a director of specialist services and a director of head and skeletal services. Many will wonder whether that means a great deal of duplication at senior level.

Maths was my best subject at school, believe it or not. We asked for the number of staff who earn roughly £40,000 and above in the Health Service, which is those staff who earn the salary of an MLA and upwards. Not counting the clinical people, such as the nurses, the social workers and so on, I worked out that the number among the five trusts is roughly 701, which brings me back to Paul's point. I accept that you have made worked hard to make efficiencies. Colm, you talked about the reduction in staff of 1,400 staff, which must be admired. John, you referred to the RPA. Your predecessor's senior colleagues sat in front of the Committee about a year ago and discussed hygiene in hospitals. Mr Bond was here, too. I asked what would happen if dirt was found on a hospital ward. I was told that it depended on where the dirt was: if it was in a corridor, it was the responsibility of such-and-such a manager; if it was in a bed, it was the responsibility of a different manager; and if it was in the laundry, it was the responsibility of somebody else. People picked up on that, and it triggered the Committee's discussion of bringing back matrons or ward sisters and having one person to whom the staff were accountable. People can see the duplication when different staff members are accountable to different line managers. That issue should be re-examined. Ward staff, for example, may feel that they have to answer to five different people. The reduction of such duplication would be one way of achieving efficiency. Is that being done so that there is no overlap of managers? I am sure that there may well be justification for having the three directors to whom I referred in the Belfast Trust. One is the director of head and skeletal services, but what about the rest of the body?

Mr Donaghy:

The rest of the body is covered by the other directors.

Dr Deeny:

Do you understand the point that I am making?

Mr Donaghy:

I understand entirely. However, the information on the Belfast Trust is not up to date. That is not the fault of the researchers. In Belfast, we have reduced the number of directors, and the post of director of head and skeletal services no longer exists.

Dr Deeny:

That is good news.

Mr Donaghy:

The director of clinical services post no longer exists, nor does the director of mental health and learning disability services. One of those directors is now the director of acute services. The director of specialist services whom you mentioned is now the director of cancer and specialist services. Thus, that portfolio has widened quite considerably.

Dr Deeny:

Has the trust lost its director of mental health?

Mr Donaghy:

Our director of mental health retired due to ill health.

Dr Deeny:

I am arguing from the other side now.

Mr Donaghy:

I know that you are. We reallocated that portfolio to one of our other directors. Our director of social work and child and family care is now also responsible for mental health, learning

disability and physical disability. That director is responsible for a portfolio of services with a budget of over £300 million.

Ms S Ramsey:

Did she receive a wage increase?

Mr Donaghy:

There was an increase of £6,000.

Ms S Ramsey:

I agree that there should be a wage increase for additional responsibilities.

Mr Donaghy:

She was given an additional responsibility payment. That, in itself, demonstrates the size and scope of the portfolio. We constantly review how we manage the service. It was mentioned that a number of managers may be responsible for different services on different sites.

The reduction that we made to the number of managers has meant that those managers have responsibilities across services and care pathways, rather than in institutions. Therefore, one manager is responsible, across a number of institutions, for a particular service or care pathway. That is why you sometimes have a number of managers who might be responsible; however, they have a much wider scope of responsibility.

We are currently looking at how we get a better site management matrix in our organisations and that we supply that care pathway across the service management. Such a site management matrix could mean having individual A&E departments, or a number of services could be on one site. Given that our management is spread so thinly, we have to ensure that we get the matrix right. We believe that the care pathway service management gives us a better focus on patients and plans. Kieran asked who is in charge on individual sites, and site management gives us a better focus as to who is in charge. We are currently reviewing that in Belfast.

The Chairperson:

There are a couple of outstanding questions on training. Although the issue is not so much the cost involved, but I understand that one of the hotels that was used in Boston is used by the Dalai Lama and Bill Clinton. Were alarm bells not ringing in the minds of those who sent out folk to such hotels? I understand that the IHI block book rooms, so I can appreciate how the situation arose. However, the public will question whether it was wise to have staff staying in that standard of hotel as opposed to the Four Seasons or whatever hotel was down the road. Can steps be taken to avoid that obvious issue in the future? Would $80 a night not have been better than $204?

My other question is a bit more serious. On the Berlin trip, four-star accommodation was used for 14 health administrators. How many of those folk are front line staff?

Ms Hinds:

According to the information that I have at this point, four staff of a non-clinical background were involved. The rest were doctors and nurses, and there was one pharmacist.

The Chairperson:

What is the value of sending four administrators, rather than clinical staff, to such training?

Ms Hinds:

Perhaps I used the word “administrator” too loosely. The staff concerned have governance and safety leads in their trust. I do not have their titles with me, but I can get them for you if you wish. We have to remember that safety is a front line issue, mainly for clinical and social care staff. Unless the right notes get to the right patient in the right place at the right time, the doctor cannot make the right decision, and unless the systems are in place to ensure that patient care is safe, no matter how hard our clinical staff work, mistakes will happen. Therefore, we have some governance leads who are not clinical staff, but they are exceptionally talented, and they make a huge contribution to patient safety in Northern Ireland. I will happily come back at another stage to go through the detail of that with you, should you wish.

Your point about the hotel is well made. There has been a practice of booking staff into the

conference hotel. As Sue rightly said, we have to make sure that we treat staff well and that they are safe. Now that the form has come to me, I will examine other options.

The Chairperson:

Most of this has come to light as a result of FOI requests by one journalist. Is there anything more out there that we should know about? Is this the tip of the iceberg, or can we expect, when we open our papers on Monday morning, to find further revelations? The headline in 'The Irish News' reads "The Jet-Set Health Managers", which, I am sure you accept, is a snappy headline but not one that you want to see on a Monday morning.

What is out there? Is there more to come, or have we seen the worst of what some allege to be overgenerous training?

Dr McCormick:

I assure you that we are consistent in applying high standards of control. We will make sure that there is regular planned disclosure and transparency. This is a corollary of what has been said about salaries, but we have it in mind to plan a general disclosure of costs in a managed way so that there is nothing to hide and no sense that there is anything to hide. That will provide evidence that the situation is well regulated, well managed and continuing to come under tighter control as we face the difficulties that lie ahead.

The Chairperson:

One point was not brought up by any of the questions that were asked. Why is it that you have one trust, and across the river, you have another of equivalent size, yet there is a big variation between what senior management is paid in each? Some of the trusts are not that different. I accept that Belfast is on a different planet when it comes to expenditure and staff and so on. However, why do you feel that you have to pay someone £20,000 or £30,000 more in one area than you do in another? Is there any reason for that?

Dr McCormick:

As was pointed out earlier, that relates to the long ranges that are part of the existing pay system and how people came to be placed on that range. It is based on their career history, the length of

time that they have been in post and their previous salary. It is a consequence of a system, which is as I described it. Individual placements and salaries are a consequence of that system. As we go ahead, the question that we must ask is whether that system is sustainable.

Ms S Ramsey:
It is also to do with the pay scale and the difference in pay between male and female staff.

The Chairperson:
Earlier, I quoted the absence of the salary of the director of finance in the South Eastern Health and Social Care Trust. That is declared in page 75 of the annual report. Many salaries were not declared, but that one was subsequently declared in the annual report, so I want to correct that point.

Dr McCormick:
We are clear about everything. In the past two years, there has been full disclosure of all salaries.

Mr Gardiner:
I want to make a point, but you continue, Chairman.

The Chairperson:
The witnesses are obviously enjoying the discussion, but we have given it two hours. I almost feel like asking whether you would take the job if it were offered to you. It feels like a job interview rather than a question-and-answer session.

I think that some useful material has emerged from the session. We need to have some format that allowed us to compare trusts to see how they varied. I quoted the Southern Trust simply because it was easiest to understand. Some trusts may be able to deliver personnel or finance services at a lower rate than others more effectively. Perhaps, therefore, they could learn from each other and even reduce the figure so that is it below 3%. It would be useful to have a common structure or framework that allows us to identify who is spending how much on what. I am very relieved, Colm. You must have wielded the axe. If you have sacked all those directors having been there for only three weeks, you have really made no secret of the fact — *[Laughter.]*

Mr Donaghy:

That happened before I arrived, Chairman.

The Chairperson:

Sam has been trying patiently —

Mr Gardiner:

I have been very patient with you, Chairman, but you keep going on. I record my appreciation, because the witnesses have been with us for over two hours. You have really earned your salary, which has been discussed a lot here this evening. Each one of you handled your questions very professionally, if I may say so.

I refer to Mrs O'Neill's comment about ring-fencing the Health Service budget. It is a pity that she was not at Craigavon Borough Council on Monday evening, because two of her colleagues from Sinn Féin moved a motion that called for the protection of essential services.

Ms S Ramsey:

Absolutely.

Mr Gardiner:

I have to remind her that they should come here; the Assembly makes that decision.

The Chairperson:

I think that the Mayor of Dungannon and South Tyrone Borough Council wishes to come back on that.

Mrs O'Neill:

I would love to know what Samuel Gardiner considers to be essential services because, obviously, he does not care about social work or public safety.

Mr Gardiner:

Health is paramount in my estimation.

Ms S Ramsey:

Social care and public safety.

Mr Gardiner:

If you do not have health, everything else will fail.

The Chairperson:

It is a pity that we could not —

Ms S Ramsey:

You need to go back to the drawing board, Samuel.

Mr Gardiner:

No, I do not.

Ms S Ramsey:

You do.

Mr Gardiner:

You just need to screw your head on.

Ms S Ramsey:

All the money is wasted in hospitals.

The Chairperson:

You hope that the minimum that happens is that at least the health elements, if not more, are protected.

Mr Gardiner:

Yes.

The Chairperson:

In the absence of any further questions, I thank the witnesses very much for being so forthright with us today. It has been very helpful. There are one or two points that we might want to take up with you in writing. Thank you.