Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Northern Ireland Medical and Dental Training Agency: Recruitment of Emergency Department Staff

12 February 2014

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Jim Wells (Deputy Chairperson)
Mr Roy Beggs
Mr Mickey Brady
Mrs Pam Cameron
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr David McIlveen
Mr Fearghal McKinney

Witnesses:

Professor Keith Gardiner	Northern Ireland Medical and Dental Training Agency
Mr Alistair Joynes	Northern Ireland Medical and Dental Training Agency
Ms Margot Roberts	Northern Ireland Medical and Dental Training Agency

The Deputy Chairperson: Welcome, lady and gentlemen. We have Mr Alistair Joynes, who is the chief of the agency board in the Northern Ireland Medical and Dental Training Agency (NIMDTA); Professor Keith Gardiner, who is the chief executive of the postgraduate medical team in the Northern Ireland Medical and Dental Training Agency; and Margot Roberts, administrative director of NIMDTA. You are very welcome. This is a hot topic, as you know, and an issue that has been raised constantly. Your name has been referred to several times during recent debates, so we are keen to hear from you. I do not know who is leading off, but feel free to begin.

Professor Keith Gardiner (Northern Ireland Medical and Dental Training Agency): I included some slides in the information that we sent ahead. I will talk through them initially.

I will start by explaining what NIMDTA does. It is responsible for the training of postgraduate medical and dental trainees across Northern Ireland and all five trusts areas and in general medical and general dental practices. Altogether, there are about 1,800 medical trainees and 60 dental trainees whose training we are responsible for managing. We also manage the appraisal of all the general practitioners in Northern Ireland, who all need an annual appraisal. We also provide continuing education and continuing professional development for general practitioners, general dental practitioners and dental care professionals such as dental nurses and hygienists.

When training doctors and dentists we aim to do a number of things. First, the funding comes from the Department. The ultimate finished product that we are trying to produce is individuals who are skilled in their specialty. That means that they have the skills, knowledge and attitude to deliver that

specialty at consultant level; more than that, however, they need to be able to lead in that specialty. They need to be able to lead clinical teams; therefore they need to have communication, teamwork and leadership skills. Moreover, we need individuals who will be able to improve service, because medicine is always changing: they may come out today with a set of skills that will be out of date in five years' time. Therefore they need the skills to read, criticise and understand medical literature and to bring those new developments into practice so that the service is continually improved. We also need to develop individuals who have the research and development skills to move the health service forward, and the whole of medicine forward, by carrying out original research into new medicines, new operations and new forms of delivery. Lastly, from a selfish point of view, as a training organisation, we need to develop the next generation of trainers and educators who will teach in the medical school and train in the hospitals. We need to develop educators for the future.

We will move on to the third slide, which is about the structure of medical training. Undergraduate medical training is usually five years long. There is an accelerated programme for graduate entry of four years. At the end of that, if the students are successful and graduate from university, they may apply to enter foundation training. Foundation training happens across the United Kingdom. Graduates from Queen's University could apply to any other training programme for foundation doctors throughout the United Kingdom. About 80% of Queen's graduates will enter our foundation programme. The programme is two years long and, during that time, the junior doctors spend four months in six different rotations. In the first year, they are called "provisionally registered" and are under very close supervision. If they gain the competencies and progress well during that year, they will be able to be fully registered with the General Medical Council (GMC) and enter the second foundation year. The first year will usually be spent in either a peripheral hospital or a central hospital and, in the second year, it is the other way round. At the end of the second year, they can compete to enter into training in a specialty. The five major medical specialties of anaesthetics, emergency medicines, psychiatry, medicine and surgery all have a core programme between two or three years long. If they complete that core programme satisfactorily, they can compete, by interview again, to enter into higher training in that specialty. That training programme at the higher level may be between three and six years. If they get through all that, they will get a certificate of completion of training and be able to compete for consultant positions. If anyone wants to stop me at any point to ask questions, I am happy for that to happen.

I will move on the fourth slide. There are 65 different medical specialties recognised by the General Medical Council and, in addition, 39 sub-specialties, so there is a range of routes that trainees may follow during their training. I have arranged it according to inside and outside the hospital. We have public health medicines, which look at public health needs and commissioning services; general practitioners, who work in the community; psychiatrists, who work in the community and in the hospital environment. At the front door of the hospital, we have emergency medicine, which I know is a focus of attention today, and behind that, we have front line specialties of medicine and surgery, paediatrics, obstetrics and gynaecology. Behind that, we have the specialties that support a front line doctor in their work; for surgeons, that is the anaesthetists who anaesthetise patients to allow surgeons to operate. Many specialties are reliant on laboratory work to analyse blood samples or to look at tissue specimens from the pathologists, from the radiologists to carry out investigations of imaging to occupational medicine to look after the workforce in the hospital from whatever discipline.

We will move on to look at the roles in training in slide 5. If we start at the top, we see that the Department provides money for all the training to occur and does the workforce plan. It gives us guidance on the number of trainees in different specialties that we need to train.

The General Medical Council sets the standards for postgraduate medical education. Those standards are for how the curricula should be designed, how the training should be delivered, how a deanery such as ours delivers the training and should function, and how the trainers should act and what training they should have to deliver the training.

The next one down in pink is the royal colleges and faculties. Given the complexity of medical training, with 65 different medical specialties, the curriculum for each specialty is determined by a royal college or faculty. They set the contents of the curricula, what a trainee must learn, what examinations they must undergo and pass successfully, and what assessments they must get before they can come out as a consultant in that specialty.

It is then down to a deanery such as NIMDTA to make sure that the training is delivered. We are responsible for recruiting trainees into the training programmes, for allocating them to the different training posts and for managing the training.

The GMC expects us to manage the training according to its standards, and it holds us to account to ensure that we do so.

At the bottom, you will see the local education providers that deliver training: the five NHS trusts in Northern Ireland, plus the general medical and dental practices; they are the ones who employ the trainees. That is where the patients are, and that is where the training is done. They provide the supervisors and the trainers and are expected to do quality control, and we are expected to hold them to account for delivering the training according to GMC standards.

The slide on the funding of doctors in training shows us that the funding comes to us from the Department, which provides half the salary for trainees in medicine; the other half comes to the trusts via the Health and Social Care Board (HSCB). That reflects the fact that the trainees are there not just to be trained but to deliver a service, so part of the money comes through a training organisation and part of it comes through the service.

Trainees also work out of hours, and there is banding for the amount, intensity and frequency with which they work out of hours. That comes from the Health and Social Care Board to reflect the service element of out of hours. If we look at how that is constructed, we see that, for the daytime service, consultants — I have put them in amber — are mainly around during the day, and then you have senior and junior trainees in blue and green. Again, because of the health service's dependence on junior doctors and trainees to provide out-of-hours cover, 24 hours a day, seven days a week, trainees do disproportionately more work out of hours and at weekends than they do during the week.

I will move on to the delivery of training in slide 7 and work from left to right. We do the recruitment and selection for all trainees on different programmes in Northern Ireland. We allocate them to different trusts and general practices based on their preferences and how they have performed at interviews. They then require an induction to the training programme. The trust that employs a trainee will provide an induction to the hospital, and the unit to which a trainee is attached provides an induction to that training unit.

As for the formal education of trainees, we have half-day and full-day training sessions at our headquarters on the Beechill Road, but much of the training in their specialty is delivered on site in the units. They will have a supervisor on the hospital site or in the practice who will supervise their progress from an educational point of view. During that time, they will be carrying out practical work and assessing, caring for and treating patients.

That has to be supervised, because they are trainees. Clinical supervisors are responsible for the day-to-day supervision of their work to make sure that it is up to standard, to provide feedback and to teach them how it should be done. Trainees are assessed in the units throughout their training period, all of which feeds into an annual assessment. Each trainee — there are 1,800 of them — is assessed annually by us to make sure that they are progressing. If they are not, we try to introduce remedial or corrective training to get them back on track. Unfortunately, each year there are some who do not make progress and have to leave a programme.

We are also responsible for the revalidation of all trainees in Northern Ireland. Since December 2012, all doctors are required to be revalidated every five years. There will be trainees who get into difficulty because of illness, whether physical or mental, or because of problems with learning: they might be dyslexic, for example. Others will get into trouble with the police or be up before the General Medical Council. Part of our role is to support trainees and to help them into remedial programmes if at all possible. There will also be a track of academic trainees with whom we, and the university, work to make sure that we deliver people who can lead whole specialties.

The last group is trainees who work less than full time. Given that 60% of those entering medicine are female, we have an increasing number of trainees who want to work less than full time or who want to have career breaks.

I will move on to emergency medicine: delivery of service. I put this into three tiers. Fully trained doctors and consultants who lead the service; they provide much of the daytime delivery of service and lead the service during the day. Increasingly, there is a move towards consultants being there for more of the week and more of the day, and I suppose that there may be an argument for having 24/7 consultant care to get the best-quality care.

I called the next group "middle grade". I put that very much in the context of emergency medicine. That grade is made up of a number of different groups. The group in amber is the trainees. At that

stage from years 4 to 6, they are called speciality trainees (ST). The Belfast Trust emergency department on the Royal site has five higher trainees in emergency medicine. It also has a number of staff grades. Different emergency departments have GPs coming in to do sessions. They work in general practice most days but also do sessions in an emergency unit. Then, of course, there are the locums who come in for a shift for a week, a month or six months to fill a gap.

At the more junior level — again, the training grades are in amber — CT refers to core trainees. In emergency medicine that is core trainees 1 to 3. In the emergency medicine unit in the Belfast Trust, there are two such trainees. There are locum appointments for training (LATs) who are usually appointed for six months or a year at a time.

We have quite a number of GP trainees who rotate through emergency medicine to get experience that will help them to understand how an emergency unit works when they refer patients to it and help them to assess emergency patients.

Junior grade also includes foundation year-2 trainees (F2s). Locums and nurse practitioners all work at that level assessing patients who come in on the front line.

I will now go on to the structure of emergency training. I am sorry that this is a bit complex, but, if I can, I will explain it quickly. In the first three years of emergency medicine, trainees have to spend time in different specialties, because they have to gain a wide range of skills to meet anything that comes through the front door. They often spend the first six months in emergency medicine, but they also have to do six months in general medicine and a year in total in anaesthetics and intensive care. The implication is that if we recruit four trainees into emergency medicine, only one will be in emergency medicine during that first year, because the others will spend time rotating through the other specialties. That is part of the curriculum set by the College of Emergency Medicine. The last year of core training is spent entirely in emergency medicine.

After that period, if they get their examinations, have satisfactory supervisors' reports and satisfactory assessments, and they complete core training in emergency medicine, they can compete by competitive interview to get into higher specialty training. The size of the column refers to the number of trainees that we have in the programme at any time. Each year, we bring about 12 trainees into the core programme. Therefore, in those three years, we have some 36 trainees. The column for the higher specialty trainees is shorter, and that is because there are six positions each at a higher level. Altogether, there are 18 posts at a higher level in emergency medicine in Northern Ireland.

The bottom box shows the locum appointments for training. Those are free-standing posts that do emergency medicine only. They are not co-ordinated with medicines, anaesthetics and intensive care. Therefore, it does not enable them to progress along the training programme.

The next slide builds on that and indicates that, at the end of three years, trainees may go down a number of different routes. Due to the type of training that they have undergone, they are attractive for other specialties to recruit. Therefore, it would be an advantage for anaesthetists, intensive care, general medicine or general practice to have them. We find that, even though they have gone through an emergency medicine core training programme, they will go off in different directions; they will not all stay in emergency medicine, and it is their choice to do so. Some may go overseas. We lose quite a few every year to Australia, as it is very attractive for the Australian Government to have them come to work in Australia. Others do not get their exams and drop out of a programme, while others progress into higher specialty training.

We will now look at the slide showing emergency medicine staffing in Northern Ireland, and I have shown the staffing of all the training grades. You will see that the greatest number of trainees working in emergency medicine come from the most junior groups — the F2 groups. They will be in emergency medicine for four months only. Essentially, they come in raw from foundation year 1. They have no experience and need to be heavily supervised. They are not the type of people you want looking after you in the middle of the night as a sole practitioner. They are junior and they need to be closely supervised.

GP trainees will also work there, and you will see that they are the second most common group. They need that experience to help them to become good general practitioners. Again, however, when they start they have never done emergency medicine before and they need a great deal of supervision.

The next group is the locum appointments. I have shown this group with a blue and a red component, and that is where our vacancies are in emergency medicine. We have 18 posts altogether, and there

are nine vacancies. That is because those posts are freestanding and do not allow trainees to progress in a career in emergency medicine. It gives them experience, and the health service gets some service out of them; however, it is not a training programme because it is not matched up with anaesthetics, intensive care and medicine.

For core trainees, half the bar is blue and half green, which is because half of it is spent in emergency medicine and the other half is spent doing general medicine or anaesthetics. In the second year, virtually none of them is in emergency medicine: they are out in the other specialties.

CT3 shows that they are back in emergency medicine. There is a reduced number for the higher trainee because there are only six each year — 18 in total.

The last slide will give you a bit of hope. The crisis in emergency medicine staffing is a problem across the United Kingdom; it is not unique to Northern Ireland. As a result, an emergency medicine task force has been set up nationally in England led by Health Education England working with the College of Emergency Medicine and the Department of Health in England.

They have looked at this to see how they can improve recruitment and retention in emergency medicine. That is partly about promoting emergency medicine as a career, trying to make it more attractive and trying to reduce any barriers or blockages that would prevent people from either entering or staying in the speciality. I want to point out three things. First, from this year, we are recruiting trainees into a six-year rather than a three-year programme, and we are currently doing that. Therefore, rather than have the block after three years, if we can get trainees in we hope that they will stay for the entire six years. This is run-through training, and the block in the centre has been removed.

Secondly, trainees who are already in the programme and are progressing satisfactorily will be allowed to stay in it without having to go through another interview. That is the second component. So we are removing that barrier.

Thirdly, there is a plan, and we will see how many we get out of it, to allow entry into emergency medicine from other specialties. Therefore we are trying to get people in who have done core surgery training and will have skills that will be useful in an emergency department. There is a route of entry for them at the ST2 level, so they would avoid the first two years of training. Again, that is to try to attract more people into the specialty of emergency medicine.

To deliver that, we need to expand the number of higher positions in emergency medicine from six to 12 a year. The trusts, because of the pressures that they are under and the number of locums and so on that they have appointed, have agreed in principle to fund the expansion of the higher specialty training positions in emergency medicine to get them up from six a year to 12 a year.

Hopefully, that gives you some sort of background. I am sorry if I have gone through a complex area quickly, but I am very happy to answer questions.

The Deputy Chairperson: Thank you, Professor Gardiner. That was very helpful. Most Members would believe that the system, up until recently, has worked well and supplied an adequate number of the appropriately graded clinicians to man — or woman — our A&Es.

Kieran and I are very aware of the situation affecting Lagan Valley, the Ulster and the Downe. Clearly, the system has broken down because A&E services at weekends had to be removed from both Lagan Valley and Downpatrick because of the lack of middle-grade doctors. At the special council meeting that we attended to deal with the issue, the explanation given was that there simply was not an adequate supply of staff at that level to ensure cover at weekends. The result would have been having to close the unit at very short notice. They mentioned the Australian problem: we were told that 50 graduates a year go to Australia. Having been trained in Northern Ireland, are they under no obligation whatsoever to staff Northern Ireland hospitals or, at least, hospitals in the British Isles? Can they simply up and go?

Professor K Gardiner: Yes.

The Deputy Chairperson: Is that a new trend, or is it something that you could have foreseen? Should we not have been training more to take account of that?

Professor K Gardiner: After coming out of medical school, they need to do the first year somewhere in the UK, so the new graduates, to get onto the GMC as a full registrant, need to do the foundation programme, and they need to do it somewhere in the United Kingdom. You will see from the document that I have supplied that our foundation programme positions are all filled, and the F2 positions in emergency medicine are all filled.

The problem comes after they have completed foundation 2: they can go anywhere in the world where they are offered a job. Australia also has a need for people to work in emergency medicine, and many of our trainees at the end of the foundation programme will go to Australia for a year or two years. That is partly about life experience, and working in emergency medicine probably seems more attractive to them than working here.

Mr Dunne: Why?

Professor K Gardiner: It is probably something to do with climate, work/life balance and such.

The Deputy Chairperson: Pay.

Professor K Gardiner: Yes, pay. That is not unique to Northern Ireland. Trainees used to be very eager to get onto training programmes at a very early stage, but now they are choosing to say, "I have a different aspiration for my life". There is a new generation out there — a generation X — who have different aspirations from people like me who would have gone straight in, competed and tried to get up the career ladder. They will say, "No, I want to see a bit of the world. I want to do something different. I can wait for my career to resume in two years".

The Deputy Chairperson: Since we cannot stop them making that choice, should the number of trainees not have been increased to compensate for that? Should that need not have been foreseen three or four years ago?

Professor K Gardiner: The number of graduates has increased. I suppose that there are reasons for that. Because of 9/11 and, I suppose, 7/7, there has been a change in immigration to the United Kingdom made by the UK Borders Agency. Doctors who came here previously from India and Pakistan to get training for a number of years are no longer coming. Those junior doctors would have staffed and kept alive a lot of units throughout the United Kingdom, but they are just not there any more. They are not getting visas to come into the country to work.

What that means is that a gap has been left. In response, the Government, here and in the rest of the United Kingdom, have increased the number of medical students. When I was going through, there were 150 per year. This year, 275 are coming out. There is no shortage in the number of graduates who come out; it is what they choose to do thereafter. If you put it up to 350, I am not sure that that would actually alter the situation. I think that people would still go. I suppose that ultimately, if you get the number high enough, you would end up with enough people who would be so desperate to get a job, they would take any job. However, at present, they are going to other places in the world.

The Deputy Chairperson: The standard of input with regard to A level qualifications is getting higher and higher. There is no shortage of capable young people in Northern Ireland.

Professor K Gardiner: No: absolutely not.

The Deputy Chairperson: You are, however, painting a very bleak picture. Ultimately, you are saying that because of market forces and people's desire to go elsewhere, we cannot supply sufficient doctors to man smaller hospitals out of hours.

Professor K Gardiner: I suppose that there are different models for staffing hospitals. You are looking to us, I suppose, because we are a training organisation. However, the number we train actually has to follow from what you ultimately need. So, we need direction from the top with regard to the number of consultants, general practitioners or trained doctors that you need. That is what should drive the number of trainees who we train in each different specialty. Otherwise, we are producing a vast excess of doctors, which you do not really need. It costs a lot of money to train them. You are talking about £75,000 a year per trainee effectively to pay for their salary, banding and training. To produce more trainees than you ultimately need will be very costly. I wonder whether what we should be doing as a health service is actually looking at a different model of how the service is delivered. It

should not be so dependent on trainees to provide out-of-hours and weekend service; it should be more dependent on trained doctors. The number of trainees should be aligned to what you need to produce the number of trained doctors at the end.

The Deputy Chairperson: Is there another issue? Has A&E and emergency medicine become so unattractive for all the reasons that we are aware of, such as the bedlam in some of those places at the weekend and the issues with drink and drugs? Is the issue that, although we may produce enough capable people, they opt to go down the route of general practice or daytime hospital, rather than A&E? Are you finding that problem?

Professor K Gardiner: You are absolutely correct. If you look at where vacancies are, you see that the common areas where we get vacancies are emergency medicine, psychiatry and surgery. There are probably a number of reasons for that. Again, look at emergency medicine. If I were a junior doctor in emergency medicine, I would probably be working here three weekends out of five because a lot of the work is out of hours, in the evenings and at weekends. That is when units tend to be busiest and when they need to have the most staff in them. That is when doctors need to be on the rota.

There are pressures. There is the risk for junior doctors in being referred to the General Medical Council and being in front of politicians and in the media. There is risk of litigation against them. If you have a demoralised consultant workforce, that is also not a very good role model. If junior doctors see their consultants burnt out, tired and fed up, they will not want to go into that. They will look at them and say, "I do not want to end up like them." Compare that with working in general practice, which is now largely a daytime speciality. A general practice trainee would be required to do 72 hours on call in a year. If you work in emergency medicine, you will work unsocial hours every week. So, it is not a very attractive career option currently. I suppose that these moves from the College of Emergency Medicine, which I mentioned, are one little step along the way, but to get people attracted to it, you need to make the working environment less hostile so that you do not get so much abuse from staff and are not under so much pressure. That almost needs to be fixed before you can actually make it attractive enough for other people to want to come into it.

Mr McCarthy: Chair, you have covered most of what was on my mind.

The Deputy Chairperson: We were at the same meetings together.

Mr McCarthy: I am 100% in support. Surely, it is not impossible in the service to visualise what will be needed. Keith, I think that you said that it is difficult to know how many people need to be trained up. I am not convinced about that. Surely, the powers that be have been in the system long enough to know what to expect. Therefore, that should not be insurmountable. I hear what you say. If we had a bigger spread of people to do the work, it would mean, surely, that they would be required to do weekends less often, making it more attractive. Finally, Chair, is there any incentive that could be thought of, such as a bigger salary or something along those lines, that could attract the right people to do the jobs that we are looking for?

Professor K Gardiner: There has been a change in delivery. When I was a junior doctor in emergency medicine back in 1984, virtually all of the service was delivered by junior doctors. Two consultants worked in the unit. If you go to a unit now, you will find that most units have four or five consultants, and some of them might even have 10 consultants in emergency medicine. So, there has been an increase in the number of consultants over the years. You are right to say that there has been a moving of who is delivering the care, and I think that that is the right move. If I were going to an emergency department, I would like to think that my care was either being delivered by someone who knew what they were doing or were being carefully supervised by someone who is an expert in that specialty.

The ultimate step of where we are leading with this is probably consultant-delivered care in emergency medicine 24 hours a day, but you will need teams of 16 consultants per unit to delivery that. This means that you will have a big expansion in the consultant workforce in emergency medicine. So, if the Department were to come to us and say that we need to increase because the workforce plan is now to have 16 consultants working in, say, five units, we would deliver that treatment. We might need some investment to produce the training posts to do that.

Mr McCarthy: The worry is that the investment is not there or that there is a reluctance to put the investment in to get to where we want.

Professor K Gardiner: There is some work ongoing by the Public Health Agency to look at workforce planning for each different specialty, and it takes time to work through that. It is a complicated model. It is looking at the average age of appointment of a consultant in a specialty, how long they are spending in that specialty, when their retirements are coming up and what the plan for the service is. So, we need a clear direction for what the plan for the service is first, and then we need to know who is already in post so that we can work out going from a to b for the expansion that will be necessary. At the moment, we do not have the flexibility to say that we have too many trainees in surgery and that we will move the money from surgery into emergency medicine. We only have half of the salary of each trainee, so we can only move half of that salary from one area to another. If we were to move a trainee's salary from surgery, for example, to emergency medicine, that could destabilise a surgical rota and cause a collapse of a surgical service in a particular trust. So, if you were really wanted to do that expansion without affecting any other service, you need to put more money into training to deliver an expanded number of trainees to meet a consultant expansion. For example, in oncology, you will be aware that a new unit for radiotherapy will be delivered in Altnagelvin. To get ready for that, we appointed extra trainees four years ago so that, by the time that that unit opens, we will have the trainees coming out to be able to staff that unit at a consultant level.

The Deputy Chairperson: Hopefully not on Bondi Beach.

Mr McCarthy: You mentioned retirement. It is a cycle, and when people come to retire, there is no one there to take their place. That is a disappointment for people who expect a service.

Professor K Gardiner: People can retire at different ages, and there will be a choice over when they will retire. You can do some sort of predictions. You can look at a specialty and say, "What is the average age of retirement in that speciality?" If you use that as a marker, you may be able to predict better when people are going to retire and replace them. However, you get people, particularly in stressful environments, who will pack up earlier and say, "I have had enough of this" and maybe they will retire on grounds of stress or ill health.

Mr Beggs: In case emergency dental treatment arises during the conversation, I declare an interest, as I have family members who are dentists. You highlighted the heavy workload, the unsociable hours and the high risks of working in emergency medicine. You seem to have explained to us that the new plan is not going to make much difference this year. Is it going to make any difference next year? Do we not need to be more radical in solving this problem?

Professor K Gardiner: There are things that we can do, and there are things that we cannot do. There is a possibility that you could expand the number of higher trainees. That is what we are hoping to do, but, in the paper, I illustrated to you that two people we got in this year are going to Australia, and two have not progressed well enough, so we are not going to be able to have an expansion this year.

We could also look at expanding the number of core trainees, but that is not a very efficient way of getting numbers out the other end or getting service from them during their time because of the way that the training is structured. They spend only 25% of their time in their first two years in emergency medicine. If the Department came to us and said, "We will give you extra money to create extra training posts at a core training level", we will do that. Our block to doing that currently is that to complete their training at a core level, they need to go to anaesthetics and intensive care. They are not much use in that environment, so they are not contributing much service because they are coming into a highly specialised environment without skills. By the end of the six months in those environments, they will have their skills, but, by that time, they are moving on.

Mr Beggs: My concern is that the problem has existed for some time. I looked back to an Assembly question from Alasdair McDonnell three years ago and saw that there were eight middle-grade doctors to be available in the Royal, but there were four unfilled posts, and there were eight junior-grade doctors and two unfilled posts. If you looked at the weekend rotas, you could see that the consultants were on call, so there were no consultants present, and we had undermanned middle-grade doctors. What has happened in those three years to try to solve that problem?

Professor K Gardiner: We have volunteered for this run-through training, with support from the Department. That is the major initiative that has happened in the past two years. We have been very successful at filling our core training posts in emergency medicine and filling the higher speciality training posts in emergency medicine. So, in respect of the actual career progression posts, we have

been more successful than most of the rest of the United Kingdom in filling those training programme posts.

The problem that we have had is attracting people to the short-term posts that are freestanding. That is why there have been vacancies. We have tried to promote emergency medicine as a career. We have an annual careers fair. We made sure that emergency medicine features each year in as positive light as we can. If you want us to increase training posts, we need to be given money to do that.

Mr Beggs: What else is being done to ensure that this is more attractive, because unless you get people in, you are not going to change anything? In particular, it seems that there are limitations that are stopping people coming in, and those have to be overcome. For instance, with regard to general practice training, can you require people to be there longer so that they contribute more? If you want to be a GP, you have to have served more time. Has there been some radical thinking to ensure that the billions of pounds of public money being spent delivers the service needed and not just meets the needs of some who wish to go in a particular direction?

Professor K Gardiner: The curriculum and the requirements for general practice training is set nationally and agreed by the GMC. So, the Royal College of General Practitioners submits a curriculum, which is approved by the GMC, and we have to work to that curriculum. Emergency medicine is not an essential component of training in general practice. If it were, it would help with the number of general practice trainees who were in emergency medicine. It would probably help them in their future careers in dealing with emergency patients, and it would help the service by contributing to it.

Mr Beggs: Why can that not be changed? I am conscious that, at one point, few in the Civil Service wanted to go to Brussels to get experience, but it was essential that they gain experience there in order to be able to draw down funding and schemes that would benefit Northern Ireland. An incentive was put in to ensure that that would happen, and it brought about improvement. Why can incentives not be put in to reflect the benefits to society and the doctors training to ensure that we have the necessary man hours?

Professor K Gardiner: A new group, the Shape of Training is looking at how training is delivered across a range of different specialties, to try and address the needs of the service, which is what you are coming to. The group will try to tie in the output of the training more closely to what the service is. As part of that, there is consideration of perhaps extending general practice training from three to four years. Obviously, that would come at a cost, but within that cost, for example, Northern Ireland, general practice training may have six months of emergency medicine built into it. However, that is probably several years away and it has not even been agreed. It has just been floated as an idea. Nevertheless, your point is well made: that is a potential method getting general practitioners useful experience and getting a useful service.

Mr Beggs: It is clear that the problem existed three years ago. How will we ensure that it will not exist in three years' time?

Professor K Gardiner: One of the things we can do is try to support this run-through training as vigorously as possible. As I said, we have some blocks to moving money from one specialty training to another block. Had we, for example, 100% of trainees' salaries, we could move trainees from one specialty to another. We would need political and departmental support because we would get some flak for that. We are going to end up removing core surgery trainees or core medical trainees to create more training opportunities in emergency medicine, which may get all of you some grief from your local hospitals saying, "They're destabilising your service". So, we would need support to say that for the greater good of emergency medicine in the future, some of the resources that are in other disciplines need to be redirected towards emergency medicine to provide a training pathway to having more emergency medicine consultants. Either that, or additional money needs to be invested to provide that expansion of training posts. Those are the two options: either expand the number of training posts or move money from somewhere else, but there barriers to moving money from somewhere else.

Mr McKinney: Thank you, professor, for your clear, concise and comprehensive presentation. It presented very well and gives us a greater understanding of your service.

Professor K Gardiner: Thank you.

Mr McKinney: I also commend staff in accident and emergency units who face daily pressures, of which we are all aware through recent headlines.

You are obviously talking about the supply side, if you like, in training to a capacity. However, if the capacity or demand side were different; would that reflect differently on your needs? In other words, we understand that, potentially, in the order of 30% of those who present at the Royal should not be there in the first place. If the demand side were to be altered; would you be having a different discussion today?

Professor K Gardiner: I suppose that, with Transforming Your Care and the idea of shifting the care from the hospital sector into the community, you would need more people in the community to manage those patients, keep them in the community and avoid pressure. That is an ideal that is strived for throughout the United Kingdom. In fact, Health Education England, the body responsible for training all groups of professionals in the health service in England, has decided that 50% of the output of training in England should be general practice training trainees to provide a workforce to manage patients more in the community.

Mr McKinney: Could we change the demand side? Would that, therefore, impact on your presentation, if you like, in that you would now be talking about GPs?

Professor K Gardiner: The service needs to change before the training. It should really follow the service. The numbers we should be delivering should reflect the workforce planning that is being done. Where we do the training should reflect where the patients are. If they are being treated more in the community, then more of our training should be done in the community. If more doctors from a general practice or hospital background are needed to work in the community and who are now working in the community, we should aim to train them for that.

Mr McKinney: Would that, in your view, resolve some of the issues around the crisis in accident and emergency departments?

Professor K Gardiner: Yes, it would be helpful. The problem is that, because of patient perception or a lack of availability of out-of-hours service, more patients are going to emergency units than need to be or should be there.

Mr McKinney: You have helpfully included the factsheet from the College of Emergency Medicine in the worksheets here. Do you recognise, then, the claim that accident and emergency is "anything and everything" in the public's perception?

Professor K Gardiner: That is reasonable, yes. I have been a surgeon for the past 30 years, so I know exactly what it is like to be on the front line of emergency departments.

Mr McKinney: This factsheet also reflects that "crowding increases mortality". Are we saying, therefore, that people are dying in our accident and emergency units as a result of overcrowding?

Professor K Gardiner: As a training organisation, we would not have that data. That type of data would be held in trusts. Concerns are raised with us by trainees about their training and the impact of workload on their training. We do get what you might call intelligence from trainees about their work pressures. Sometimes they will raise patient safety concerns if their work pressures are intense or they are worried about patients getting lost in the system. We do not have data on the total number of those incidents or what the reasons behind them have been. All we have are the trainees who have concerns, which we bring to the attention of the trusts.

Mr McKinney: I am reflecting back on this document, which is included in your literature. What do you understand by the statement:

"Perverse incentives produce dysfunctional systems"?

Professor K Gardiner: I did not write the factsheet, so I cannot give you a complete understanding of it. In general practice, there is an incentive by way of payment for services to hit various targets, such as getting people's blood pressure and cholesterol measured and hitting all those targets, which are very good from a preventative point of view, because they prevent diseases for years to come. However, it might mean that there is less capacity in general practice to deal with people who have an urgent problem and who, perhaps, cannot get an appointment with their general practice as quickly as they would like. In today's world, where there is a degree of consumerism, they are not going to wait for two days, three days or a week for an appointment. They will go to the emergency medicine department because they want to get an answer and get it sorted out today, even if it means waiting for a number of hours.

Mr McKinney: That is right; waiting for a number of hours may be more attractive than waiting for a number of weeks. If we dealt with the issue of waiting for a number of weeks, it is almost that, ergo, we would be substantially dealing with the problem.

You went through the issue quite quickly and I did say that it was clear; if I have missed something, forgive me. Can emergency doctors get training points in the same way as others get them? In other words, could that be an attraction in the system?

Professor K Gardiner: I am not sure what you mean by "training points". Could you explain a wee bit better?

Mr McKinney: I am not entirely sure, it is something that I have heard anecdotally, but it is about equitability. Is everyone trained in the same way and is it classified as the same scale?

Professor K Gardiner: Do you mean of pay?

Mr McKinney: No, I mean in terms of a training score.

Professor K Gardiner: It is hard to give you a straight answer to that, because each trainee has to follow the curriculum in that specialty and each specialty will have a different curriculum and different requirements. We would expect them all to get equal quality of induction, formal education, supervision and support. We would expect them all to get the same standards of support and would seek to get the highest quality of education no matter what discipline they are in. If they are in a hard-pressed specialty, it could be the case that the service could impact on the education and make the education and training more difficult if they had an intensive workload. That would be one of the markers of concern; the workload being so intense that they cannot learn.

Mr McKinney: Chair, I have one final point. I am conscious that I am taking up more time than others, but, is it possible that, at the start of training when the contract begins, if you like, that contract could extend to staying here as a result of their training rather than going further afield?

Professor K Gardiner: There is no method that I know of at the moment to do that. Margot may have information.

The Deputy Chairperson: It is not a contract that you sign and then pay a fee if you break it.

Mr Alistair Joynes (Northern Ireland Medical and Dental Training Agency): I think that it also has to reflect on the British Medical Association (BMA) and other organisations that have traditionally negotiated very strongly on behalf of doctors at every level. It might be very difficult to get a contract that would be so binding.

Mr McKinney: It would not be impossible, at the start of training, for a contract to be signed that says that they commit, as a result of this training, to stay in either hospitals or services in Northern Ireland or the UK or wherever.

Professor K Gardiner: The corollary to that is that you would commit to provide them with a job. We could end up with, say, 10 trainees coming out in obstetrics and gynaecology and not need them. At the moment, we have no commitment to provide them with a job. We have committed to provide them with the training and then they can go and seek a job anywhere in the United Kingdom or elsewhere in the world.

Mr McKinney: Perhaps I could turn it another way: has any work been done on looking at the dynamics of such a contract either way to see whether it would be a valuable addition to the solution?

Professor K Gardiner: I think that we would have major objections from the BMA and it would be out of keeping with the rest of the UK. It would essentially be offering them different terms and conditions of appointment to a training programme.

The Deputy Chairperson: You spend £75,000 training them and they can do whatever they like at the end of that training.

Professor K Gardiner: You could do, but most of them want to stay.

Ms Margot Roberts (Northern Ireland Medical and Dental Training Agency): The problem for us is that we are not the employer of these trainees. We are just the organisation that recruits, trains and assesses them. The employment contract rests with the individual trusts, so there would have to be a national agreement on that. Certainly if we were told that we, as an organisation, could act as the employer, it may be something that we could possibly look at, but I am sure that the BMA would, on behalf of the trainees and junior doctors, probably fight that very strongly.

Mr Dunne: Thank very much for your informative presentation. It was straightforward and useful.

Most issues have been covered, but on the funding of doctors and training and the running of the out-of-hours, to me, your illustration, Keith, made it quite clear that the out-of-hours service is effectively being run by junior doctors, so there is little or no expertise there for the public when they go. As a result, those people are probably moving over to A&Es in our hospitals. Is that an issue that needs to be addressed? What struck me was when you mentioned that we have no consultants at that point. Is it a problem that consultants are not willing to work the unsociable hours any longer and are selective in what they are doing and when, so much so that they do not want to engage in the out-of-hours work?

Professor K Gardiner: Traditionally, consultants have generally been on the ground during the daytime hours and have provided an on-call service out of hours. That is the way that the contract has been set up. I think that there are consultant contract negotiations going on at the moment to get that consultant contract changed so that people would work out of hours routinely as well as in-hours. At the moment, although the surgeons may be in during the night operating, they are not required to be there throughout the night. In emergency medicine, I know that some trusts have managed to persuade consultants to work into the evening, and they work routinely at weekends. However, there is still nowhere that I know of in Northern Ireland with 24-hour consultant cover in an emergency unit.

Mr Dunne: So, that is a vacuum that needs to be filled.

Professor K Gardiner: You have middle-grade doctors, some of whom are associate specialists, or staff grades or middle-grade trainees working during the night who will have some years of experience in emergency medicine. They can call their emergency medicine consultants, or, if there is a crisis, they can bring them in. However, there is a difference between having the consultants actually present and having them on call.

Mr Dunne: Absolutely. It goes back to the fact that the public need to use the out-of-hours service more, and we need to do more to encourage people to use it. If people are aware that consultants are not available, they have a lack of confidence in the service, and they therefore go directly to A&E. Again, it is about trying to address the ongoing problem of people going to A&E when they should not be there in the first place. To me, that issue needs to be addressed.

Are you saying that we could not run A&Es without the junior doctors?

Professor K Gardiner: At the moment you could not. In fact, that applies not just to emergency medicine but to all acute specialties. The out-of-hours service is currently based on the junior doctors.

Mr Dunne: Why is that? Is it partially because the doctors and consultants can be selective in the work that they want to do? Should trusts not push doctors towards working in those A&Es?

Professor K Gardiner: Of course, there is a 48-hour European working-time limit on the amount of hours that can be worked, so if the consultants work at night, they are not going to be there during the day. That means that you would then have a reduction in the throughput of elective work during the day, with either a reduced number of patients coming to clinics, reduced scopes being done in day-procedure units or reduced operations being done. So, you would possibly have to double the number of consultants to maintain the same service. Obviously, you might get a better, more efficient service for the patients out of hours, but it is going to come at a cost if you are going to provide consultants 24 hours a day.

The Deputy Chairperson: Can I just lead on from Gordon's question? Should NIMDTA not have the power to tell people where they are going? At the minute, they always gravitate towards the big teaching hospitals, such as the City Hospitals, the Royals or the Altnagelvins of this world. They prefer not to go to Downpatrick, Coleraine or the Lagan Valley. What would be wrong in saying, "If you are needed, no matter what grade you are, you will go there, because we need you to cover those hospitals", rather than saying, "I want to work only in the greater Belfast area"?

Professor K Gardiner: That has been raised with us before; we are not unfamiliar with that problem. There are a number of reasons that impact on where trainees are placed. We have training posts throughout all the trusts in Northern Ireland — not in every specialty in every trust, but throughout them all. If all the posts are filled at recruitment, all the posts in that speciality in all those trusts will be filled. If we have vacancies, that is probably where the problem will arise. Where people get placed is based on how they perform at interview and also partly on their preference. For example, in general practice training, we have 13 posts in each of the five trust areas. We have 65 in each year, and 13 go to each of those five areas. In foundation, they all go to those different areas. It is in the hard-pressed specialities where the vacancies are going to arise. We do not actually have any trainees in emergency medicine at Downpatrick, and we have not had any trainees in emergency medicine at Downpatrick. So, it is not a withdrawal of trainees that has been the problem. There may have been a problem recruiting middle-grade non-training grades, but not trainees.

Mr Dunne: Just on that, Downpatrick is, what, 28 or 30 miles from Belfast?

The Deputy Chairperson: It is 26 miles from the Royal.

Mr Dunne: Belfast is not 100 miles away. You have the greater Belfast area, where the majority of people in Northern Ireland reside. Yet you say that there are posts in Downpatrick, which is 30 miles away, and you cannot get them filled.

Professor K Gardiner: No, we have never had training posts in emergency medicine. We just do not have them. That has not been the problem. It is not that we have not been sending them there; there are no training posts in emergency medicine in Downpatrick.

The Deputy Chairperson: It is straight down the motorway to the Lagan Valley. It takes 20 minutes.

Mr Dunne: Perhaps they have had it too good for too long. Maybe there needs to be some more direction. Managers need to start managing. I think that that is where it really has to be taken on board. In any organisation, people will do the work that is easiest and most accessible. Where there are difficulties and challenges, people will avoid them. Perhaps that is what is happening, and medical professionals are avoiding risk areas.

Keith, you mentioned that the risk is increased in A&Es in the evening, at night and at weekends. The media picked up on that point. Should that be the case? Surely resources should be managed so that the risks are reduced. We need to take action now to reduce those risks, and we need to have medical professionals in place to manage those risks throughout the periods when people need to attend hospital.

Professor K Gardiner: I will defer to my service colleagues, because that is really a service issue.

Mr Dunne: I appreciate that you are a training organisation.

Professor K Gardiner: We want to look for where the highest-quality training is, and we want our trainees to be in those high-quality training units. At the end of the day, we are looking to produce a high-quality finished product. So, we have a long-term and a short-term view. If I was looking for

where I would get the best training in emergency medicine, I would look for which unit has the biggest range of patients, the biggest volume of patients, the highest quality of delivery and all the support services. So, I would want a unit that had an anaesthetist, surgeons and an intensive care unit on site. That is where you are going to get the best-quality training. You want a unit where bypass procedures are not in place. For example, trauma will bypass Downpatrick, and acute cardiac events will bypass Downpatrick. If trainees were sent there, they would not get a full range of exposure to emergency situations. Do you understand what I am saying?

The Deputy Chairperson: It is all about what they want; there was no mention of the community's need. It is about what people in the community prefer.

Professor K Gardiner: It is about the community's need. Ultimately, you want the best-trained doctors looking after patients in Northern Ireland. That is a long-term aspiration. That is what we are there to deliver: a finished product that has specialty expertise that can lead the service. That is a long-term view. So, if you want a highly trained product at the end of the day, trainees have to go to high-quality units along the way.

Mr McKinney: However, we want the best-trained people to be in the right place so that the patient gets the best outcome. That is what we want. The equation has to be complete. It is not just about having the right person somewhere; they have to be in the right place. I think that that is a point that the Committee would accept.

Mr Joynes: From our point of view, though, we have to ensure that the curriculum can be delivered to the individual. They should come to the end of their training year, go through their assessment and move on to the next year of training. If they have had limited exposure in a unit, they will clearly not be able to progress. That then represents another problem for us and for the future.

Professor K Gardiner: To come back to your point, it really depends on who you want to be the trained doctor in that unit. Who do you want to deliver the care and service in that unit? Ultimately, I think that people who are fully trained, rather than trainees, should lead and deliver the majority of the service. Trainees should be there to get the best possible training, and they do that through contributing to the service. At the end of the day, we need to be able to deliver for you the best trained professionals. The only way that we can do that is by making sure that they get high-quality training along the way, and that comes through the breadth, quantity and quality of supervision.

Mr S Gardiner: Thank you, Professor, for your presentation thus far. When I saw the name Keith Gardiner, I said, "What's my son coming here for? He repairs cars, not human beings". Thankfully, you are on the right side of repairing human beings.

Why do we not recruit new super-paramedics, as has happened in Wales and London? Surely that would lessen the pressure on A&E departments.

Professor K Gardiner: Sorry, I missed the word that you used.

Mr S Gardiner: Paramedics. Why do we not recruit new super-paramedics, as has happened in Wales and London?

Professor K Gardiner: I think that that model could be looked at. What I am really saying to you is that not all care in emergency units needs to be delivered by trainees. A whole spectrum of people could do that. You could prevent people coming in by getting better services in the community, or you could have advanced nurse practitioners, paramedics or trained doctors who are specialty doctors but not at consultant level. So, you can provide other delivery-of-care models. Paramedics are a very good group with many useful skills in resuscitation, intubation and dealing with the acutely ill. They could provide a very valuable service in our emergency units. We do not train paramedics, and we are not commissioning paramedics. I think that that is a very good suggestion. It has been used elsewhere, and I would support it. However, we do not have the power to deliver it for you.

Mr S Gardiner: You could throw your weight behind it, and we will do our best from this Committee.

Professor K Gardiner: OK.

Mr D McIlveen: Thank you for your presentation. Obviously, I take on board the fact that you are primarily a training organisation. However, I suspect that the trusts have now become very much reliant on the fact that you deliver a fairly significant number of fresh bodies, I suppose, into the system every year. I suspect that, if NIMDTA disappeared tomorrow, a few trusts would panic about how they are going to fill their pressures for this year.

My understanding is that the training year starts around the first Wednesday in August. At what point would you inform the trusts that certain specialities are not going to receive the number of recruits that they were expecting?

Professor K Gardiner: The recruitment has already started. The applications have been coming in since December. We are into recruitment, which started in January. That will probably go on for about four months. We are still in round 1, there will be a round 2, and, sometimes, we have a round 3. If we can fill all the posts in the first round of recruitment, that is absolutely fantastic. We do that in some specialties. In emergency medicine, we usually have a round 2. We are planning for a round 2 again this year, because we anticipate that we will have difficulty filling the fixed one-year posts, as we did in previous years. The interviews have happened for the first round. The offers have been made, but we have not heard as yet whether people have accepted them. So, we cannot tell you today where we stand to date.

However, we have planned a second round of interviews for emergency medicine. Last year, we went to a third round. Each round takes a number of weeks, because the posts need to be advertised, trainees need to be given an opportunity to make travel arrangements to come for interviews, interviews need to happen, and offers need to be made. The cycle goes on. We can really get only three rounds of interviews. We did it last year in two different specialties: emergency medicine and core surgery. However, that can go on right into May. We try to let the trusts know by the end of May or the very start of June about the fill rate of those posts. At the end of May or the beginning of June, we will tell the trusts what their allocations are for the start of August and that we cannot fill all the posts. We will usually leave the training money in the trust to enable them to have the opportunity to try to fill those posts, even at a late stage, with non-training grades.

Mr D McIlveen: So, locums.

Professor K Gardiner: Yes, locums.

Mr D McIlveen: One thing jumped out at me in the emergency medicine staffing graph that you showed. I was quite astonished by how many GPs find themselves in emergency medicine. It is basically all of them. Going back to the opening question about numbers, allocations and balancing everything in that way, why do you not just increase the number of GP trainees?

Professor K Gardiner: It is very expensive. Last year, about 77% of our entry of GP trainees was female. It is more family-friendly, with less out-of-hours work. A lot of those trainees will have maternity leave during their GP training, and some of them will want to come back and do less than full-time training. So, even though the training programme is three years, trainees will often spend four years doing it because of maternity leave or the fact that they are working less than full time. We end up paying those GPs' salary, because they are out in practices. We end up paying 100% of the salary. So, it is very expensive to train a GP compared with a hospital doctor, because we end up having to pick up their maternity leave costs as well.

Mr D McIlveen: So, from the GP point of view, the graph as it stands is probably something that you would want to see going in the other direction.

Professor K Gardiner: No, I do not think that we would plan to reduce the number of GP trainees.

Mr D McIlveen: I mean GP training in emergency medicine.

Professor K Gardiner: I think that it is useful training for them, but they have five different specialties for which they can get recognition in their training. There is obstetrics, paediatrics, medicine, emergency medicine and psychiatry. Those are the five specialties that will count towards their training, but, as I said, emergency medicine is not a compulsory part of their training. It is one of the options but not a compulsory part.

Mr D McIlveen: On a slightly different matter on the retention of trainees, obviously, I am conscious that we have had a fairly broad conversation about those who decide to go to different countries and so on. However, there are those who find themselves remaining here, but they pull out of their training or do not find themselves in a position to go into a full-time position. You mentioned trainees raising concerns. I think that NIMDTA is in a very privileged position in this situation, because you have fresh eyes going into the service. It is probably difficult to say this without sounding a little bit unkind, but those who have been working for the health service at clinician level for a number of years may find themselves a little bit ingrained in the culture and perhaps do not see some of the things that are going on around them that maybe need to be called. I think that you mentioned that there are times when trainees will come to the deanery and say that they have genuine concerns about patient safety. Taking that to its next step, have you had any past experience of trainees coming to the deanery who have effectively taken on a position of whistle-blower and subsequently found themselves being bullied or harassed by more senior members of staff?

Professor K Gardiner: Trainees can raise concerns in a number of ways. They can raise them through trust processes, through incident reports or by speaking to their clinical supervisor or their clinical director. That is one route. They can also raise them through the General Medical Council's survey. Every year, the General Medical Council has a national trainee survey across all the United Kingdom. The GMC will ask the trainees whether they have any concerns about patient safety. If they do, the GMC will send those concerns to us to get them investigated, responded to and addressed. Whenever we visit different trusts and look at the educational experience, trainees may use that opportunity to bring forward concerns directly with our visiting teams. Again, we will feed those concerns back to the trusts and ask for them to be evaluated to see whether they are genuine and, if they are, to have them addressed. Some trainees bring concerns to us about being undermined, sometimes by more senior doctors and sometimes by other professionals, for example, midwives, nurses or managers, and it could even be by patients. A variety of such concerns is raised with us, and we work with the trust to get them investigated, managed and dealt with. We listen and take the concerns back to the trust. Any concern about undermining or patient safety must go back to the trusts because they have the data to analyse whether there is a common pattern. Also, all trainees are employees of a trust, so we do not have knowledge of the internal systems. The trainees and their consultants or trainers are employed by the trust, so it has to be dealt with in the trust, although we vigorously uphold trainees' rights and support them.

Mr D McIlveen: I am conscious that time is moving on, but you have raised an interesting point. My understanding is that, if one off your trainees went to the GMC and said that they had stumbled on a serious issue that was a problem to patient safety, the GMC would contact NIMDTA, which would begin working with the trust. Will you give me a couple of examples of what working with the trust involves?

Professor K Gardiner: The GMC, in its survey last year, divided the concerns into immediate concerns and non-immediate concerns. We received an email from the GMC to tell us, within 24 hours, that an immediate concern had been raised. We went to a secure part of the GMC website to find out what that concern was and then looked at it. Then I personally wrote, on that day or within 24 hours, to the medical director of the trust to ask them to look into it. The trusts had a very swift turnaround in responding to that concern.

We then looked at the response to see whether the trust had recognised what the concern was, whether the action plan that it had come up with addressed it and had done so in a timely fashion. We had to make a judgement on whether the response was satisfactory, and, if not, we went back to the trust to say that it was not satisfactory. We then had to report on all of those concerns to the General Medical Council, which also looked at them. The GMC has a response to concerns assessment team that analyses responses from us and from the trust to see whether it considers them satisfactory. If it feels the response has not been adequate, it will come back to us with further questions.

Mr D McIlveen: Deputy Chair, I appreciate you indulgence, and this is my final question. So a trainee goes back to the post where they had raised the issue. I know that the Minister has done a lot to try to ensure that protections are in place for whistle-blowers, but there will still be an air of suspicion around this trainee. Some of their superiors might feel that he or she is, for want of a better word, a troublemaker. What steps and safeguards does NIMDTA have in place to ensure that the whistle-blower's training is not adversely affected by having raised a concern?

Professor K Gardiner: We have a whistle-blowing and bullying policy. We have a learning and development agreement with each trust, within which we require each of them to have a mechanism

to deal with the undermining and bullying of trainees. If, for example, a trainee were to come to me and say that he or she was being undermined by a superior, we would go to the trust. I have had meetings with medical directors about undermining. We have gone out and got the information on who was responsible, and those people have been removed from a training environment for a period. We vigorously uphold trainees' rights, support them and take their concerns to the highest point in the organisation, if necessary, to get them addressed because we will not tolerate their being undermined or bullied.

Mr Beggs: I was interested in what you said in your presentation about some going into emergency medicine but choosing not to enter a training programme because it is more lucrative to provide locum cover in various health and social care trusts. So are you saying that trusts need these skilled, trained employees to go through training programmes but also have perverse incentives that stop people training?

Professor K Gardiner: Correct.

Mr Beggs: What discussions have there been to remove such perverse incentives to ensure that there is the skilled training necessary?

Professor K Gardiner: Again, that is probably outside a true training remit. The departments are still being staffed, and the services are still being provided. Trusts are getting the staff from locum agencies. The junior doctors — they are not actually trainees — will get more money from working for a locum agency than from taking a training post. So a number of trainees will decide, "I would like the flexibility of working as a locum for the next year so that I can work when I want to work rather than doing a training programme. All right, I will not make progress along the training ladder, but I will do this for six months, a year or two years. I can earn more money that way. I can pay for trips. I can take three months off and go to Australia if I want to because I have that flexibility." It is a lifestyle choice.

It is harder to assess the quality of these doctors because they could appear in one hospital today and another one tomorrow. They could work for a week or a month at a time and then decide that they want a month's holiday. It is down to their personal choice. We cannot make them enter training programmes. The Department has tried to make some progress by coming up with an arrangement to get a standard rate of pay for locums across all trusts to try to cut the agencies out. That may be one method that could be pursued more. Not getting that exorbitant rate of pay could remove the perverse incentive to work as a locum for an agency.

The Deputy Chairperson: May I ask you a different question, Professor Gardiner? Are you a member of the BMA?

Professor K Gardiner: No.

The Deputy Chairperson: You are not. Are any of the senior staff of NIMDTA members of the BMA?

Professor K Gardiner: I suspect that they are. I was a member in the past but am not currently.

The Deputy Chairperson: Could there be a conflict of interest? You mention with reverence those three magical letters: BMA. You can see that the BMA has incredible power; we know that. I have to say, as I keep saying, that the BMA tail is wagging the health service dog. We keep coming back to the BMA. Surely, we have to do not what is best for the BMA but what is best for the people of Northern Ireland.

Professor K Gardiner: I agree with you.

The Deputy Chairperson: Run this past me. We spend almost £0·5 million training these excellent medical staff. We pay them salaries of between £40,000 and £80,000. Yet it is they who decide where they will go and what they will do. Spin that on its head. Go down to Knock to the police headquarters at Brooklyn. If you have a middle-grade police officer who is based in Donaghadee —

Mr Dunne: There is no station there, Jim.

The Deputy Chairperson: Well, an officer based in Holywood, Bangor or somewhere else in north Down. That police officer may say, "I do not want to go to Enniskillen because there is a much wider range of criminals in north Down. I can specialise in drug dealers, shoplifters or whatever. Mr Chief Constable, I would simply prefer not to go." Meanwhile, there is a dire need for that middle-grade police officer in Enniskillen. What do you think the Chief Constable would say to that police officer?

Professor K Gardiner: That is an armed force. It is a completely different structure.

The Deputy Chairperson: Take a middle-grade manager in the Ulster Bank. It is the exactly same principle.

Professor K Gardiner: The Ulster Bank is the employer. Here, trainees have an employer for six months here and a year there. There is not someone who employs them for their eight years on the programme.

The Deputy Chairperson: I know that this is a trust issue rather than a NIMDTA issue. However, surely there must come a stage when doctors, whether they are trainees, middle-grade or whatever, are sent wherever they are needed and go there because society has invested so much money in them and pays them jolly well for what they do. This is why Downe Hospital is closing at the weekends. We cannot get the doctors to go there, because they would prefer to stay in the Royal or the Ulster. That is no way to run any health system. The ultimate outcome of that will be that many small hospitals' A&Es will close, full stop.

Professor K Gardiner: If you want to deliver high-quality care somewhere, you need a range of people working in that system who can provide such care seven days a week. How many places can you afford to have a consultant delivering care 24 hours a day, seven days a week?

The Deputy Chairperson: We have four hospitals with A&E in Northern Ireland. The logic of what you are saying is that we concentrate on the big attractive hospitals, and, if we cannot coax people to go beyond Carryduff or Glengormley, we will simply close the services to communities.

Professor K Gardiner: It comes down to the range and quality of services that you want to provide. It depends on what you can afford and how much money you want to invest. If you want high quality in multiple sites, 24 hours a day, seven days a week, you will need many more highly trained consultants to work on those sites.

The Deputy Chairperson: We also need consultants and middle-grade doctors to go where they are needed rather than where they want to go.

Mr Joynes: We are the training part. We have access only to the junior doctors, the doctors in training. We have very little control over the people who manage the service on multiple sites.

The Deputy Chairperson: I accept that. However, they should be given the contract when they start training with NIMDTA. That is where it should be signed.

Mr Joynes: I suspect that none of us would necessarily disagree with that. It is possibly an aspiration that needs to be considered. Going back to your analogy, I have no doubt that there is a factor in the PSNI contract of employment that says to a constable who does not like where he is being sent, "I hear what you are saying, but that is where you are going." We do not have that facility, and I suspect that the trusts do not either. It is a much bigger issue than just —

The Deputy Chairperson: The BMA would never accept it — end of argument. The BMA would just not run with it.

Mr Joynes: I think that the BMA would oppose it very strongly. However, that is not to say that, ultimately, it could not be negotiated. I do not know. It is certainly a very big issue that would have to be subject to a fairly elongated set of complex negotiations.

The Deputy Chairperson: Why do we pay locums less? Do we not pay locums less?

Professor K Gardiner: We do not employ the locums in the first place. The service employs them. We employ locums for training, which is a fixed-term post.

The Deputy Chairperson: Are those locums paid less for training than if they were not locums?

Professor K Gardiner: Yes.

The Deputy Chairperson: Why is that the case?

Professor K Gardiner: Locums are often considered for short-term, unattractive, out-of-hours working in high-pressed specialties. A trust usually pays a premium to get them to work there. The agency that employs them and acts as their agent will get its cut as well. So you are paying not just the trainee but the agency. The trainees get more for working for an agency than they would for working for the trust directly.

Mr Joynes: Or for taking the training post.

The Deputy Chairperson: Gentlemen and lady — Ms Roberts, you did not really get much of a look-in there unfortunately. I am sure that you are very concerned about that.

Ms Roberts: I am all right. I agree with everything that has been said so far. *[Laughter.]*

The Deputy Chairperson: Mr Joynes, I hope that you will emphasise that you had your arm in a sling before you came to the Committee and did not have it put on afterwards. We have not been that rough on you. I hope that it all goes well for you.

Mr Joynes: That is fine; thank you.

The Deputy Chairperson: This issue will run and run. It is a mix of responsibility between the universities, NIMDTA, the Department and the trusts. I know that the fact that we are told, time and time again, that an essential service is being removed because we do not have the staff to provide it is not entirely your issue. However, we really have to get our heads together to ensure that very nice, brand new, modern buildings are not vacated because we do not have the staff to fill them. The trusts have put a lot of money into really good buildings such as Downe, Enniskillen and the new children's hospital coming to the Royal. It is essential that we find some way of ensuring that we have adequate levels of trained staff to go into them.

When we go to public meetings in places such as Downpatrick or Lisburn, they rather miss all the nuances of what is going on. They just think that they are being starved of essential staff. Their community is suffering and has to travel into greater Belfast or wherever. I wish you well on this one. It is a difficult issue that will keep coming up. You might not have been a well-known organisation until a few months ago, but your profile will rise dramatically over the next few months and years. I do not know whether that is a good thing or a bad thing.

Thank you. Your attendance is much appreciated.