PUBLIC ACCOUNTS COMMITTEE

OFFICIAL REPORT
(Hansard)

Report on the Use of Locum Doctors by Northern Ireland Hospitals

7 December 2011

NORTHERN IRELAND ASSEMBLY

PUBLIC ACCOUNTS COMMITTEE

Report on the Use of Locum Doctors by Northern Ireland Hospitals

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Members present for all or part of the proceedings:
Mr Paul Maskey (Chairperson)
Mr Sydney Anderson
Mr Michael Copeland
Mr John Dallat
Mr Paul Girvan
Mr Ross Hussey
Mr Mitchel McLaughlin

Witnesses:

Dr Andrew McCormick	)
Ms Diane Taylor	) Department of Health, Social Services and Public Safety
Dr Paddy Woods	)
Mrs Elaine Way	) Western Health and Social Care Trust

Also in attendance:

Mr Kieran Donnelly	)	Comptroller and Auditor General
Ms Fiona Hamill	)	Treasury Officer of Accounts

The Chairperson:
Our next item is the evidence session on the Audit Office report on the use of locum doctors in NI hospitals. Do any Members wish to declare an interest?

At our meeting on 23 November, Mr Alex Easton declared an interest in that he is the

Assembly private secretary for the Department of Health, and, therefore, he excluded himself from participating in the inquiry, so he will not be in attendance today.

Joining us today is Dr Andrew McCormick, accounting officer for the Department of Health, Social Services and Public Safety, who is here to respond to our Committee. You are very welcome. Perhaps you will introduce yourself and your team.

Dr Andrew McCormick (Department of Health, Social Services and Public Safety):
I am the accounting officer for the Department. I am joined by Elaine Way, the chief executive of the Western Health and Social Care Trust; Paddy Woods, deputy chief medical officer; and Diane Taylor, the Department's director of HR who covers HR issues across the health and social care system.

The Chairperson:
You are all very welcome. You have been here before, Andrew, so you will know that I usually start by asking a few questions and trying to get a picture, then other members will delve deeper into that. I remind you that you should try to be succinct in your answers without missing any points. There are a lot of questions that we need to get through.

Paragraph 2.8 gives information on the use and cost of locum doctors. That information is poorly collated and analysed by the trusts. In some circumstances, doctors and agencies could simply be cashing in on the trusts because they are disorganised. Can you demonstrate to us that the taxpayer is getting value for money? Large sums of money are being spent on locum doctors, so it is a value-for-money question.

Dr McCormick:
I welcome the opportunity to answer that and your further questions. I assure the Committee that, fundamentally, there is good scrutiny and objective information underlying the decisions to engage locum doctors. The need is genuine in a range of circumstances, which I can explain in further answers, and the approach taken by all of the organisations provides for an assurance that that value for money is largely obtained through the vast majority of the engagement.

I acknowledge the weaknesses in information that the Audit Office found during its scrutiny. I assure the Committee that there is good regional-level information, especially on the

engagement of agency locums. That aspect of the data is well established. We are able to extract a lot of detail from that. As the report highlights, less detail is available on internal locums. That is partly because they are trust employees and trusts do not operationally have such a need to distinguish between the activities of their employees in their main jobs and in their engagement as locums.

That is part of the background as to why we are where we are. We are taking account of the points that have been made in this report and through our own work and scrutiny of the area. The new regionally managed medical locum service for Northern Ireland will be introduced next year. That will provide a much more systematic regional database and a much more systematic, thorough and comprehensive assessment of the information that is available. It will ensure that we keep full track of everything that happens.

The underlying point remains that locum doctors are needed to cover a range of different gaps in the service. Some of those gaps are short term and very temporary, and others represent a longer-term issue in the deployment of medical resources across Northern Ireland. That is a very significant issue at the moment.

We are very conscious of the need to ensure good scrutiny and oversight of their activities from the point of view of the general responsibility to provide high-quality and safe services, which is our first responsibility as a health service. We also need to ensure the best possible value for money, which was the point of your question, Chairman. As the Audit Office report highlights, there are weaknesses. I am happy to explain those further as the session continues.

The Chairperson:
Thank you for that. I think that we all agree that there definitely is a need. You cannot run hospitals without staff, whether or not you use locums. However, to return to the question, some of the trusts could be disorganised, and some doctors and agencies could be just getting their arm in, for want of a better phrase.

Dr McCormick:
There is no lack of organisation. The sessions that are required are subject to clear procedures in each organisation so that the level of decision-making is appropriate to the nature of the engagement. If it is relatively routine and comes at the predetermined rates for internal locums,

there will be fewer stages in the decision-making than in one of the highly exceptional cases in which it has been very difficult to find a locum for a particular shift or engagement. That is where there is vulnerability, but that is not in the system of how those things are checked and organised; it lies in the fact that we are trying to maintain a fairly wide range of services in Northern Ireland. We are conscious of the need to provide a balance between the centralisation and local accessibility of services. That gives rise to some of the issues with which there are real difficulties. Sometimes, trusts are faced with some very difficult decisions. They do not approach those in a disorganised way; they approach them very carefully and thoughtfully. However, they can come under pressure to pay a large amount for a particular engagement. There is an issue in that regard. We try everything possible to ensure that we get engagement at an acceptable rate. Therefore, the first call is to look at internal locums. We then turn to the established contracts, in which predefined rates have been agreed between each of the trusts and the relevant locum agencies. We do everything possible to engage at the best possible price and so avoid the risk that you have highlighted.

There are occasions when a trust manager will face the choice between paying a large amount and having to suspend a service. The report describes cases in which that issue arose. We have to take that case by case and make sure that the first consideration is to ensure that quality and safety are maintained.

Obviously, there is a need not to pay anything above what is possible. However, there are times when the only way to maintain a service is to pay quite a large amount for the engagement of a locum. That is not good, but the alternative, which is not to have the service, is worse. There are times when the right decision is to suspend a service. However, most of the time, it is important to maintain service continuity. We, therefore, have to make sure that all our efforts are geared towards minimising the risk of a service not being provided. The regionally managed service will provide greater opportunity to systematise and improve the organisation. There is room to improve, and we are acting on that. Again, that has been partly stimulated by the attention on the issue, which we recognise and acknowledge. We will have that better system in place next year, and that will improve the situation. However, I do not accept that there was a major issue with disorganisation.

The Chairperson:

That leads me to my next question. Has the shortfall in the numbers of doctors, referred to in the Audit Office report, created a situation where some in the private sector are holding the health service over a barrel about hiring locums to fill in the gaps. The conclusion that we can draw from paragraphs 1.9 and 2.7 are that locum agencies dictate the rates paid to locums and cream off substantial profits at the taxpayers' expense. So, Andrew, why has the Department's workforce planning been so flawed that it has not anticipated and addressed the shortages more effectively and avoided such squandering of resources?

Dr McCormick:

I think it is fair to say that there are significant workforce shortfalls in some of the specialties that are the subject of the report, not only in Northern Ireland but across the rest of the UK and, indeed, in other jurisdictions. So, it is by no means a problem unique to ourselves. The shortages in the specialty of accident and emergency affect a much wider area than here. From a long-term perspective, a decision was taken in 2005 to expand the medical school at Queen's University, and, as a result, the intake rose from 154 to 250. The full benefit of the new supply of additional doctors in the system in Northern Ireland is coming on stream only now and into next year as those doctors move into the post-graduate training process. It is a long-term planning issue.

As I said, in 2005, we had significant expansion. Since then, we have fine-tuned that and revised down very slightly the intake this autumn and for next year. The total supply of doctors will improve. However, there will still be issues in a number of specialties because of the way things work. We have an effective, broad workforce planning process. It is up to individual organisations, the trusts especially, to manage the succession planning and organisation of matching supply with demand through their workforce management. The Department has a strategic role in ensuring that the broad pattern of the workforce is the best that it can be. However, that is susceptible to changes that are difficult to correct quickly, given the length of time it takes to train doctors. So we have to watch out for that carefully.

The Chairperson:

You say that some assistance will be in place next year to tackle those issues.

Dr McCormick:

The additional junior doctors.

The Chairperson:

Why were they not in place this year or last year?

Dr McCormick:

The new supply from the medical school is only now beginning to work its way through the system. The decision to expand was taken in 2005.

The Chairperson:

Were there loads applying for medical school? Were there not people coming out of medical school all along?

Dr McCormick:

Yes. However, doctors can move around. Indeed, it is highly advantageous to Northern Ireland for some doctors to move away for a while and then come back. That is just part of how a profession like that works in general terms. However, it has meant that, over the past number of years, we have had to recruit doctors from overseas and from across Europe to fill the harder-to-fill vacancies.

I want to point out that the deployment of the medical workforce is strongly affected by the fact that specialties are provided on a lot of sites across Northern Ireland. The fact is that we are trying to maintain quite a large number of relatively small hospitals. If you consider that in the UK context or wider, that means that we have to maintain more of a particular kind of rota, and those rotas depend heavily on the doctors in training. If we are deploying a lot of the doctors in training to fill certain specialties, that can lead to shortages in others. The clearest example I can give on that point is in relation to emergency surgery. A larger proportion of junior doctors in Northern Ireland have to be deployed into emergency surgery — more than we need for their long-term training — because we are trying to maintain emergency surgery on more sites than is sustainable. That affects vacancies in other specialties and makes it harder to deploy the total workforce.

This is a complex pattern affected by the need for good, strategic-level workforce planning and good, detailed workforce planning across each of the individual organisations, as you have already drawn out. There is a need to think very carefully as a region about how we deploy the

total workforce. That is highly relevant to the work that is currently going on in John Compton's review of services. This is a very significant issue and requires us to ensure the best possible deployment of resources so that the doctors are used as effectively as possible in the interests of the community.

The Chairperson:
It is a complex matter, but it has been complex for a number of years. It could have been tackled prior to this. Other members will probably want to delve into some of those questions as well.

One of the most important things for the Assembly is that the Audit Office also keeps a check on the Departments. Paragraphs 1.10 and 1.11 of the report refer to the difficulties that Audit Office staff had in obtaining the information they needed to undertake their work on this report. I find it quite disturbing that some of the trusts apparently do not have the detailed information they need for the management of locum doctors at their fingertips. What steps are being taken to ensure that the decision-making on the management and use of locum doctors is as informed as possible? Information is usually the key to success.

Dr McCormick:
I agree strongly. The main response to that is the establishment of the regionally managed service. The first and very important phase of that will be to draw together a fully comprehensive regional database that will hold information on locum engagement of all types across the trusts. That will ensure better information flow at regional level; it will inform the planning of contracts, the negotiation of contracts and the development of service. Therefore, it will make a significant difference to the kinds of issues you have already expressed that cause concern, and I understand the Committee's concern about the issue.

I recognise that there were some difficulties in the initial information, but I think that it took some time to extract the detail that was requested, and —

The Chairperson:
Why does it take time, Andrew? Is that information not available at the push of a button? If you are paying something out, your accounts have to balance at the end of every year, so, how is that difficult?

Dr McCormick:

I think I said in answer to the initial question that we had readily available information. The database on agency locums was relatively easy to interrogate to secure the detail that the Audit Office required. I will ask Elaine to add some detail on the information relating to the trusts' internal locums — the nature of the information held and the reasons it is held — because that is what informs the systems that are established, and management information systems are tailored to what management requires to take the decisions. The vast majority of people — 80% to 90% — who work as locums are trust employees, so the main information on their work is available within their host organisation. There is not that much difference, from a trust management point of view, between them doing their normal work and some shifts as locums. Would it be helpful if Elaine provided more detail?

The Chairperson:

Yes, let us bring Elaine in, and then I will let John in.

Mrs Elaine Way (Western Health and Social Care Trust):

As Dr McCormick said, it is very easy for us to quantify the cost of the external locums, because we have invoices and bills from the external agencies. If one of our internal doctors acts as a locum — in our case, 78% of our locum work is undertaken by our own doctors — it will go through as pay. It could be that some people take pay as overtime or as an extra shift, and it is very hard for our finance staff to differentiate between locum work and non-locum work. When the Audit Office asked us for the information, it would have required a lot of detailed work involving going back to consultants to ask when they worked as a locum and when they worked overtime.

Mr Dallat:

Dr McCormick, how can you make those claims with any degree of sincerity when, a few weeks ago, the papers carried a horrific story about a doctor who worked in a Belfast hospital and left under a cloud but popped up almost immediately in another hospital in Northern Ireland after claims that he was doing things in the hospital that were absolutely outrageous. You know who I am talking about. This is the doctor who was caught in a Belfast hospital allegedly filming female doctors undressing, and he popped up in Coleraine a few weeks later. How can you make a claim to this Committee that things have changed?

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

That doctor is not a locum doctor; he is a doctor in training.

Mr Dallat:

It is all about information, Diane.

Ms Taylor:

I appreciate that, and I take your point. That doctor moved rotation from one trust to another and the incident was not disclosed to the new trust.

Mr Dallat:

Where does that fit into the report that we have to write in order to reassure the public that hospitals are safe places to go and place their trust in, when, only a few weeks ago, the most fundamental weakness was discovered, where a doctor, who was under a cloud, moved from one hospital to another one 30 miles down the road?

Dr McCormick:

The procedures that should address that kind of issue are very clear. They require that appropriate alerts are raised by an employer who is aware of an issue in relation to that kind of incident. There is a very clear procedure and process for that, which involves the sharing of information between organisations. Clearly, that did not happen on that occasion, but the procedure for dealing with those issues is there. We recently reinforced to all the organisations by correspondence that we take very seriously the obligation on all the organisations to maintain everything to do with quality of care, including patient dignity. That is an essential responsibility, and it is very important that it is always acted on. Clearly, something went wrong in that case. I acknowledge that; I am not sure whether anyone has anything to add in relation to what we could or should have done.

Mrs Way:

We maintain a list of locums who have worked for us, and if there are any concerns, we would keep that list to ensure that, in such an instance, such a person would not be re-employed. One of the benefits of the regional model that the permanent secretary described is that there will be a central agency for recruitment of locums, and information will be held centrally.

Dr McCormick:

I would be keen to satisfy the Committee in relation to the concern that Mr Dallat raised. Dr Woods will say a little bit about the alert system.

Dr Paddy Woods (Department of Health, Social Services and Public Safety):

The general system, where there is a concern about a practitioner who it is anticipated will seek work elsewhere, is that an alert will be issued. That signals, as you well put it, that there is a cloud over the practitioner. Often, they are the subject of an ongoing investigation. In almost every instance, it is an investigation that has not concluded, so no definitive sanction can be applied. The aim of the alert mechanism is that the receiving employer can contact the former employer to ascertain what the details of the concern are and, on the basis of that, make a decision as to whether they feel it appropriate to employ that individual.

Mr Dallat:

I want to make it clear that I am not passing any judgment on an individual. It is purely on the failure to inform the Causeway Hospital in Coleraine that there was an investigation.

Dr McCormick:

The information should have been —

The Chairperson:

I want to bring in other members. There are three supplementary questions to that question.

Mr Copeland:

I want to address something with you, Elaine. You indicated that it is easy to distinguish an agency locum because you get an invoice that says what it is for. In ascertaining the cost of locums who were not supplied through agencies, has a non-agency doctor got contracted hours? Is his rate of pay the same for each month, and would variances in the rate of pay not indicate some service above and beyond the contract that could well be ascribed as locum hours? Surely, it cannot be that difficult to establish it internally from national insurance and hours. I am not quite sure what way their pay works, but, from experience in industry, I know that the people who make the payroll know everything, and it is usually a matter of making an enquiry to find the information that is required. Is that a fair statement, or is there something intrinsically difficult about that?

Mrs Way:

I am told that it is not easy to identify the difference. Doctors may work shifts, so they will get a shift allowance for that. If you were to look at my pay advice, you would see that it is very straightforward; it shows what I get and all of the deductions. However, very many of our clinical staff work in different ways and have different variations. For example, we could have a consultant who might be a clinical leader: we pay them more money for doing that. Therefore, they will be registered on our payroll system in a certain way. As I understand it, we do not currently have a facility to put a number against it that says that they are working as a locum. In the interests of complete openness with the Committee, even when someone is working as a locum internally, there can be a variation in the rate because we can actually —

Mr Copeland:

If a doctor is employed internally and works extra hours, what is the difference between being a locum and being on overtime?

Mrs Way:

We will pay overtime at a rate that is established as part of national terms and conditions. It is acknowledged in the Audit Office report that, even where we are using internal doctors to do locum work, they can barter with the employer. They will say that, instead of our going to the locum agency, where it might cost us £x, they will do the work for less than £x but more than their basic rate of pay or the overtime rate. We have those discussions with our internal doctors about how they are remunerated for the work.

Mr Copeland:

So, to employ a doctor to do task x on overtime would be less expensive than employing him to do the same task as a locum. Is that right?

Mrs Way:

It depends on the circumstances, including where you are asking them to work, whether you are asking them to cover a shift and whether, for example, you are asking them to move from Altnagelvin to the Erne. The working arrangements are quite complex. What I do know —

Mr Copeland:

I do not doubt that they are complex. The question is whether they need to be complex.

Mrs Way:

In terms of managing locums better, the Audit Office has recommended that we need to improve the management information that we receive. As a trust chief executive, I absolutely accept that.

The Chairperson:

There are another couple of supplementary questions to come on that, but I want to bring you back to one point. It is not only the private sector that might have some of the health trusts over a barrel but individual doctors. They can renegotiate their level of pay if they are asked to do an extra shift. Is that legal?

Mrs Way:

Yes, it is legal, Chairman. Dr McCormick said —

The Chairperson:

Is it morally correct?

Mrs Way:

Dr McCormick said something about how it is on the front line. I am a manager of front line services, and my primary aim is to ensure the provision of consistently high-quality services.

I hope that, at some stage, I am asked why the Western Trust spends more than anywhere else. We have particularly challenging circumstances in the west that mean that, on occasions, I or the medical director have to ask staff to work exceptionally. Doctors are aware that the alternative is agency staff, which can be much more expensive. In many ways, we are able to maintain a safe service at a lower cost than if we were to use external agencies. As to your first question about value for money, we always start with our own doctors. They are cheaper than locum agencies.

The Chairperson:

I appreciate that. However, when they are able to renegotiate their level of pay, I do not know whether it is value for money or not.

Mr Hussey:

Paragraph 1.9 shows that doctors can come out of their contracts and negotiate additional rates as locums, yet we cannot identify where that is happening in the trust. Those doctors are working outside of their contracts. I cannot understand why they are not paid two separate sums or shown as two different members of staff, even, so that the figures can be identified.

Elaine, you mentioned that the trust has spent more on locums. I was going to ask you a question later about a breakdown of the use of locum doctors in the Western Trust, but I ask you to consider that now. Can you supply the Committee with data on locum use at a hospital level within the Western Trust?

The point was made earlier about whether this is right or moral, etc. You have somebody who has a job, and there is an agreed overtime rate. Paragraph 1.9 of the report states:

"Hospitals use their own internal staff as locums. Staff are used to cover absences and are normally remunerated at nationally agreed rates as specified in Departmental circulars."

And then they can say that actually they do not want to be paid at that rate and want to negotiate a special deal. That is not morally right. It is totally immoral, particularly when the country is in the state that it is. If any other civil servant were to do that, all hell would break loose. If any other job were to allow that, all hell would break loose. It does seem to be totally morally corrupt that someone could do that.

Again, back to the Western Trust in particular, and the breakdown of usage across the hospitals in the Western Trust area. I suppose that if somebody were based in Altnagelvin and required to go to Omagh, they would have you over a barrel.

Mr S Anderson:

Going back to John Dallat's question about the doctor who moved from one trust to another under a cloud, are we saying that one trust might not allow that particular individual to work, but he could go to another trust that will, depending on what sanctions are taken? What are we saying here? If the trust in which he was employed found that there was something that it was unhappy with, are we now being told that he or she could work somewhere else, for a different trust within Northern Ireland? Is that what we are being told, Dr Woods?

Dr Woods:

No. A concern has to be investigated, usually by the employing trust, to establish its substance.

When an employing trust is aware that an individual may seek employment elsewhere, there is an onus on it to use our regional alert system. These alerts go across the UK, so that all employing trusts are aware of concerns about an individual. By definition, those are issued when investigations have not been concluded by the initiating trust. No definitive decision will have been arrived at about whether the concern is of substance and needs to be addressed through a sanction by the employer or, if serious enough, through the GMC, which is the regulator. No definitive decision will have been made about the need for a sanction against someone's employment or registration.

Mr S Anderson:

If something takes place and has to be investigated, surely that should be sorted out and investigated before that person is allowed to go to another trust, whether there is anything to be answerable to or not? It would happen anywhere else, in any employment. If something takes place, that needs to be brought to a conclusion before that person can go to a, b or c employment across the UK. There seems to be something wrong when a person can float about before an issue is resolved. It looks as if there is something just not right here.

Dr Woods:

There is a circumstance in which it can occur, and that is the subject of today's hearing. Locums are very often employed for a short period of time, in which case, the trust that becomes aware of the concern is not in a position to conclude the investigation. Indeed, in the case of training grade doctors, fixed-term appointments with employers are usually in rotation locally and can be for three, four, six or 12 months. So there is potential for that, and that is one reason why we have the alert mechanism. Situations can quite legitimately occur where a period of employment concludes before an investigation is concluded.

Mr S Anderson:

How good is the alert mechanism? If a doctor decides to move at regular intervals, how quickly will that be picked up? Will it even be picked up? Is there not a possibility that, depending on what way you want to work the system, you can hop about here, there and anywhere before the alert system kicks in?

Dr Woods:

The onus certainly falls on the initiating employer, who would certainly be aware of somebody's

contract coming to an end. That should, by definition, trigger the request for an alert. We have examples of that.

Dr McCormick:
For perspective, there is a set of circumstances that applies to doctors in training who are going through a series of rotations, and that means a degree of movement. However, that is planned, and the Medical and Dental Training Agency provides central oversight of that. There is still, as has come out, room for improvement in ensuring that the alert system is fully operational and works in each and every case, as it has to in order to provide the assurance that it is intended to provide.

The vast majority of locums who may have short-term engagements in a range of organisations will have a main job, and their oversight, appraisals, revalidation and all the professional oversight issues will fall to their main employer. The key issue is to make sure that, if something goes wrong when they are doing a locum shift in another hospital or another trust, that information is passed back to the main employer. Similarly, the main employer should draw attention to any issues that are relevant to any organisation that is engaging them as a locum. So, there has to be good, responsible oversight in all those issues. It is complex, but we have to manage that complexity. We recognise and accept that, and we have to have systems at regional level and in each organisation that are adequate for that purpose. We definitely recognise the need for improvement on the points that have been raised.

The Chairperson:
I ask Members, when they are asking supplementaries — it goes for us all — to be brief, because we can sometimes stride across into other people's questions.

Mr Copeland:
Apologies, but I have three questions. I want to go back to something that Elaine said a few minutes ago. I just want to get it right in my own head. If you employ a locum outside the overtime arrangements, do you face an additional exposure to him doing something wrong or incorrect? Does he have to supply additional insurance to indemnify you against his actions when he is acting not as an employee on overtime but as a freelance, if that is not an inappropriate term?

How do you protect yourselves against someone whom you may or may not know, working outside their normal contracted hours, not on overtime, committing or making a mistake? Does he have to have insurance? Does your insurance cover him when he is working for you, or are you in a position of risk by the nature of the way in which you are employing that individual?

Mrs Way:
We do not insure our doctors. They are not insured by us. Each professional carries insurance. That said, there is no evidence that services are any riskier because they are delivered by locums.

Mr Copeland:
I was not asking that.

Mrs Way:
If we were employing a locum, be it an internal or external locum, we would ask them to sign a form that says that they are not going to breach the European working time directive in terms of hours worked. We would be concerned that someone might be tired and make a mistake. Therefore, certainly, we ask them to sign that. However, they might sign it anyway. I have thought about that. There is an individual professional responsibility for doctors to tell us the truth about what they are working. That goes back to the point about the regional system. At the moment, as I may say later, a number of the doctors who work for us live in Belfast, and they are likely to do some locum work in Belfast. A one-off shift is very different from longer-term cover, say a number of weekends. Under the new regional system, employers would be alerted to those hours worked, independently from the form that the doctors actually sign for the hours worked.

Mr Copeland:
Thank you. I have three questions that I would like to put. Given what you have just said, accepting that someone has signed a document to say that they will not work more than a certain number of hours is perfectly fine until something goes wrong. However, when it has gone wrong and it has been discovered that they have worked more than the set hours, unfortunately it is too late for the person who may, in unfortunate circumstances, have suffered because of that. I would have thought that having some knowledge — it seems to me that we cannot tell what we are paying them for, we cannot tell the rate we are paying, we are negotiating whether it is overtime or locum and we have no way of telling how many hours they have worked. The IT section

might need to be looked at.

Dr McCormick, I have three questions, and two are destined for you. However, I will not be offended should you feel that one of your colleagues is better placed to answer them. I have another question for Mrs Way, and I will be as brief as I can, given the requirement requested by the Chair.

Dr McCormick, paragraph 1.12 shows that hospitals are spending £22·5 million on sourcing locums through private-sector agencies, notwithstanding the fact that there will be a profit mixed up in that £22·5 million somewhere. Agency locums tend to be more expensive than those who are sourced internally, despite what we have just said. What timescale is envisaged in your plan to establish an internal bank of locum doctors, hopefully slightly more regulated and defined than currently, and what savings do you expect to derive from such a move?

Dr McCormick:

The plan for the regionally managed medical locum service is that it will start operational work next February. The first aspect of the work will be to deal with the process and the data that we have been talking about already to ensure that there is a drawing together of the regional information. The second main phase is then to move into a shared-service model for the employment and management of locums and to provide an internal agency, as it were, so that there is a regional function providing support under the auspices of the Business Services Organisation that provides consistent handling of the information and better governance and accountability across all six trusts, including the Ambulance Service. That is the nature of the initial phases of the work, and it will lead to improved control and improved negotiation power. That will then exert some downward pressure.

We will still have some difficult cases; that is the nature of it. We have already said that 80% to 90% of the doctors who work as locums are employees of the service. That internal agency — that regionally managed service — will embrace all of that activity and ensure that we bear down on costs. It will not eliminate each and every difficult situation where there may be pressure and the problem of bartering, but it will put us in a much stronger position to negotiate and manage that process.

Mr Copeland:

This is the Public Accounts Committee. The crunch in the question was how much money you expect to save.

Dr McCormick:

As the report draws out, it will not be making large numbers of millions, because we are talking about a total function of around £29 million a year for all of the locum spend. One of the further points is that the service will change as well. If there are changes in service configuration, they will start to affect the issue and reduce the need for locums. We also have to look at revalidation, so there will not be a like-for-like comparison readily available. What we are quite clear on is that taking this action will ensure downward pressure on the cost. I hesitate to put a figure on that, unless anyone has better information to quantify that precisely.

Mr Copeland:

It is an aspect in which we will probably take an interest in the future. I can understand that there are difficulties surrounding it and that savings are not actually the real issue. It is to stop expanding costs and make sure that money is not being spent inappropriately. I can follow that, but I would have thought that, if you are setting out to save money, you would have some indication of the likely outcome. I suggest that, with £22·5 million on sourcing locums through the private agencies, their profit margin may well be the amount that could be saved, but that is only me.

The Chairperson:

I do not think you actually gave a figure for the saving. You said that it was not going to be many millions.

Mr Copeland:

He did not know.

The Chairperson:

Will you supply that to Committee when you find that out?

Dr McCormick:

As the thing takes effect and once hard information is available, we will model that and establish

the difference it has made. That will be part of the evaluation of the process, which will take some time. It will be a year or more before we can even start to quantify that. If we can make a broad estimate of potential savings, as we would in a business case, we will write to the Committee with that information.

The Chairperson:
I thought you mentioned a figure of £29 million, whereas the actual figure is £22·5 million.

Dr McCormick:
Sorry, the £22·5 million is the agency spend, and £29 million is the total locum spend. As you say, the opportunity is to bear down on the agency spend. That requires the further application of all of the principles of managing the process, which we have talked about already, and making sure that the trusts are in a stronger bargaining position and have both the information and the access to alternatives. The strongest position that a locum doctor can be in is when they can say that there is nobody else. If that remains the case then the position does not change. That sometimes is the case, and that is their strongest suit. Regional management allows possible sourcing of alternatives from one trust to another, but that is not always easy given the geography and where doctors live in Northern Ireland, so we need to be aware of that point.

The Chairperson:
We are asking you if we can have the savings.

Dr McCormick:
We will do our best to come up with that.

Mr McLaughlin:
This has come up several times. I am interested in what Elaine said in response to an earlier question. For the purposes of payment and management, and even for implementing the European working time directive, someone somewhere has to sign off or authorise locum payments, overtime payments and shift payments. The problems that we are talking about, and which have been outlined here, all speak to fairly systemic failures that have been solved in other places. I will come back to it when I get my chance. Is there a uniform system and a consistent approach across the trusts? Who signs off the different categories of expenditure?

Dr McCormick:

I think that that is best illustrated by a specific analysis of the hierarchy of decision-making in one organisation. The more routine cases will be dealt with in a more straightforward way. Where the case is —

Mr McLaughlin:

It will be bad enough if it turns out that there is not, and it will be worse if we have a hierarchy of people signing it off and there are multiple signatures on a payment slip. I just want to know who signs off for a locum claim, for an overtime claim and for a contract period.

Mrs Way:

I probably should have said this much earlier, but, as a trust chief executive, I want to tell the Committee that we very much welcome the Audit Office report, because there is good advice for us in terms of looking at areas for saving money. I do not want to spend a single penny employing locum doctors, be they internal or external. My strong preference would be to have a stable permanent workforce that saves me from having to do that. I will probably return to that when I get the opportunity to respond to Mr Hussey.

We have very tight approval systems. A short-term locum, which is anything less than four weeks, can be approved by a senior doctor. We call them lead clinicians or divisional clinical directors. However, if a locum is going to work for us for more than four weeks, we require the medical director to sign the approval. There is a very detailed form which requires people to say what shifts they are going to work, what hours and for what length of time. That is very closely monitored.

On the basis of a recommendation in the Audit Office report, we have tightened up the number of individuals who can actually go out and procure a locum. That is now firmly restricted to the medical HR function. The agencies that we have on contract now cannot take a call from a ward sister, manager or doctor; it is done through medical HR. That is the locum bit of it.

I move now to asking people, particularly junior doctors, if they would work more hours. Somebody mentioned the European working time directive, which we may come back to. It is a complicated system that allows junior doctors to earn more money if they go above certain hours. Others may work extra hours, and they will be signed off by the senior clinician, who will ask

them to do it and sign that they have done it.

Mr McLaughlin:

How does that square with your difficulty in distinguishing between these bills? On one hand you are telling me that there is an authorisation chain which can be accessed. How can that not be deployed to differentiate between the different lines of expenditure distinguishing between locums, overtime and staff, doctors?

Mrs Way:

My understanding is that it is the way the financial management systems can report the information. It is not easy, in payroll terms, to differentiate between the payment streams. That is what I am —

Mr McLaughlin:

I find that completely unacceptable; I think that it is balderdash. I do not accept that as an explanation. To tell me that that is why you cannot answer that question is not a serious approach to this Committee.

Mrs Way:

That is what I am told. The Audit Office asked us whether we could pull out the figures for the internal locums and exactly what they were paid, but it was very difficult for us to get that from our existing financial systems. I assure you that that is my complete and truthful answer to your question.

Mr McLaughlin:

Is that generally true throughout the health service, not just here in the North? Is this best practice?

Dr McCormick:

Our solution to move to better practice is to introduce the regional service and introduce a consistent database that captures all locum activities. That is the way forward, and we are grateful for the stimulus from this work to do that and make sure that that comes into being. If I understand what Elaine is saying, I think we have a situation where information is captured with clinical approval as to whether something happens, but that data is not all captured into the

finance system. Therefore, it is difficult to interrogate.

It relates partly to the fact that we are in the process of updating and renewing finance systems. The finance systems that we have in the health and social care system in Northern Ireland are relatively old, and that is one reason for the change that is being made to regionalise and renew the ICT systems. Information is recorded but not necessarily captured in a database and, therefore, not readily available for interrogation. Some of our systems are still 20th-century systems, so we need to update.

Ms Fiona Hamill (Treasury Officer of Accounts):
You mentioned the wider health service. I can confirm that there are problems with existing financial management systems right across the NHS. I was at the financial reporting advisory body at the Treasury last week. We had to give a specific derogation to the National Health Service on some of the reporting levels. The situation with accounting systems that were put in place and the management information that is now required across the health service means that most trusts and foundations are running to catch up and develop their systems in time. Therefore, it is not a local problem; it is a very well recognised national problem.

Mr Girvan:
I find it enlightening that almost 40% of all the money that comes in and is spent in our Province goes through an agency that cannot account for every penny that is spent. When you run a smaller organisation, you can tell where every penny is going. The accounting system that was set up is so complicated; it was probably designed that way to make it difficult to extract the figures.

I want to go back to the point about overtime. You mentioned the European working time directive. There are doctors who will go and work for private agencies, such as 3fivetwo, that are paid for out of the public purse. What records are kept by those who work for that organisation to carry out operations, work in theatre and do all that stuff in a hospital environment while receiving their money from another account. How is that added in to ensure that they are not breaching the European working time directive?

You mentioned the fact that someone can do that if they want to. They can sign off to allow them to do additional hours. However, it sounds very like what we were dealing with a few

weeks ago in respect of the legal profession, in which you can write up whatever you need at times. I would like a breakdown of that in relation to 3fivetwo.

Dr McCormick:

That is the responsibility of the individual doctor in the first instance. Doctors have a professional responsibility to adhere to the directive within whatever derogations they have signed for. That is a personal responsibility and ethical issue for individual doctors. There is then a responsibility on the permanent employer to be aware of the main issues. The information will depend on the individual doctor giving information at intervals to his or her employer. 3fivetwo, is also subject to that regulation.

Mr Girvan:

How do they check? I could give examples, but I prefer to keep names out of it. I am aware of doctors who have said that an operation or a certain procedure could not be carried out because they had breached their hours. The surgery was cancelled but reconvened for later that day with the same doctor who was working for another agency. We can go into details if you want, but I find that hard to understand. How can you move the goalposts halfway through to suit someone else's agenda?

Dr McCormick:

That absolutely should not happen.

Mr Girvan:

I know that it should not.

Dr McCormick:

Anyone who is aware of that has the opportunity to refer it to the regulator, the GMC. We have to be on the side of the patient in everything we do and, therefore, ensure that regulations and proper procedures are applied. There may be an explanation. However, people are accountable for what goes on. Certainly, we should secure the best possible service. That requires that the opportunity is taken to highlight such cases. If it is as you described, that is not acceptable. Such cases must be addressed, because that provides recognition that there is accountability. Doctors are aware that they are accountable.

Mr Copeland:

I was going to say that I would go back to my first question. I am almost afraid to do so. I come from a place called the private sector. In that sector, when things go wrong, money can run out. When money runs out, you can lose your house, home, life and family. I will tell you how I would have looked at that. Although £22·5 million is a lot of money, in the big scheme of things, it is not. If I had bought a service from a company, I would have got my hands on a copy of its company accounts; taken its purchases from its sales; expressed that figure as a percentage of its turnover, which would give me its margin; and divided £22·5 million by that margin. That would have indicated to me the potential savings.

Dr McCormick:

Thank you.

Mr Copeland:

It is a fairly simple way of doing it.

My second question, which I hope will not be as controversial or raise as many mayflies as the first, is about paragraph 1.5. We have covered three points in the same paragraph, so we are doing well. It states that if trusts could maintain locum costs within 8% of overall doctor costs, savings of up to £5 million could be generated each year. Is that a target? What plans has the Department made to determine the optimum split between locum and permanent staff? What targets have been set towards achieving that level?

Dr McCormick:

The statement is inherently hypothetical. The fact of the matter is that it is impossible to achieve exactly what it describes. We are determined to bear down on those costs. However, it is not realistic to expect that that level of costs could be achieved due to the range of circumstances that we face. The need for locums arises from a range of circumstances that includes service configuration issues and the actual nature of the medical workforce. Although we can undertake to apply all that we have talked about already to try to bear down on that cost, it is unrealistic to say that it is possible to achieve precisely what is described in that paragraph.

One thing that would help significantly would be the ability to secure better, more effective deployment of the medical workforce across Northern Ireland. That would require significant

service configuration. We have to look at that. There is no escaping the fact that it is one of the main underlying causes of the issues that we face. We can address the symptoms; however, the root cause is that we are spreading the total resources of the medical workforce more thinly across Northern Ireland than would secure the best quality of service.

The highest objective for us remains quality of service. That is the driver and the biggest aspect of the case for change with regard to deployment of services in Northern Ireland. That would also have the benefit of securing a more cost-effective deployment of resources. That is a very important aspect of that issue. We need to ensure that we make full use of the regional service when it is operational and empower trusts as much as possible to face down cases where they are being pressed for high-cost locum expenditure. That requires us to be smarter in the way that we manage the totality of the service and deploy resources.

Mrs Way:
Perhaps that also relates to Mr Hussey's question about the Western Trust. The permanent secretary has described some issues that are general to the whole of Northern Ireland. Our costs for locums are the highest in Northern Ireland. There are understandable reasons for that. For example, prior to the regulations of February 2008 on the employment of international medical graduates (IMGs), out of a junior doctor workforce of 150 to 170 doctors, the Western Trust employed 68 IMGs. When the Home Office introduced the new regulations in February 2008, those were lost to our workforce.

The other thing that hits us hard is the allocation that the Western Trust has received over the years from the Northern Ireland Medical and Dental Training Agency (NIMDTA), and that is reflected in the Audit Office report. There is a direct correlation between times when we get few junior doctors to support our rotas and our highest spend on locums. That document refers to the position we found ourselves in, in September 2009, when we had to withdraw some gynaecological services from the Erne Hospital because there were insufficient junior doctors there.

It is interesting that the report looks elsewhere. The spend on locums in Scotland is much lower than that in Northern Ireland, but in the Western Isles, it is 36%. In the Western Trust, since the Audit Office's report has been published, we have tendered through proper procurement processes for new contracts with locum agencies, and that has reduced our spend from 16·67%,

as is reflected in the report, to 14·6%. So, we are going in the right direction, though it is not low enough, as far as I am concerned. We have also had an improved allocation of junior doctors from the Northern Ireland Medical and Dental Training Agency.

Mr Dallat:

I hope that we are not getting off course, but there seems to be a real problem in the Western Trust with temporary employment. For example, you will know that I recently asked a question about nursing. You have over 200 nurses on temporary contracts. The average for the rest of the North is 50. Is this part of a wider problem that includes locum doctors and the whole medical profession? Why is that so?

Mrs Way:

We do not have particular problems in recruiting nursing staff. There are challenges in specialist areas and in relation to doctors. Dr McCormick has already referred to it. Those members who live in the west will understand this as well as I do: we are furthest from Belfast. The medical school is in Belfast, and doctors are educated there and then allocated from NIMDTA to various places. Many junior doctors prefer to be within travelling distance of Belfast. That is the particular challenge for us. It is exactly what has emerged from the story that I tell about Scotland. In Glasgow, the medical locum costs are 2·4%, whereas in the Western Isles they are 36%.

There may be issues as to how we report our temporary nursing staff. It may be that there are posts that have been held, covering maternity leave. We have recently had a particular problem with sickness. However, there is no policy or strategy to hold those posts. It is the recruiting of junior doctors that we find particularly challenging.

Mr Dallat:

Is it not absolutely disgraceful that there are over 200 nurses on temporary contracts, and many of them have been so for years, when the average for the rest of the North is less than 50? Is that not grossly unfair to people who have taken up a vocation to look after the sick and the ill?

Mrs Way:

We only use temporary staff where we fill up extra beds in a ward and we need to bring in

temporary nurses. We have people covering maternity leave, career breaks and so on. We have no policy to deliberately keep our nurses on temporary contracts. We try to make them permanent, and employment legislation requires us to make them permanent if they have been in a temporary post for so many years anyway. I assure you, Mr Dallat, that we took the figures that we gave you from our personnel information system at that point in time. That position will change; the challenge in respect of locum doctors is ongoing in the western area.

Mr Copeland:

The fact that the Western Trust has had difficulties with recruiting staff in some specialties and grades is alluded to in figure 4 and paragraph 1.16. It shows that, despite attempts at downward pressures, locum expenditure in the trust has increased each year since 2008-09. Does that increase indicate that the trust is being forced to pay for locum shifts at the higher end of the hourly rates that are outlined in paragraph 1.9?

Mrs Way:

Absolutely. There is a direct correlation between the allocation of junior doctors and how much money we spend on locums. For example, in February 2010, we needed 175 junior doctors to deliver our service. There were 33 vacancies, which meant that we ended up with 20 locums and 13 ongoing vacancies. When we say to people that we want them to work in west, it is described as a peripheral area. That sounds quite pejorative. They will say that we have to pay more if they are to move to the periphery. Even when we move to the regional model, which will have highly competitive rates, agencies will still say that there will be an additional premium for getting doctors to go west. Our higher costs are partly because we are charged more than elsewhere.

Mr Copeland:

Do you agree with my slight concern that doctors haggling — I did not want to use that word, but it springs to mind — over the hourly rate for a particular job almost flows contrary to the oath that accompanies that profession?

Mrs Way:

When I had a difficulty some years ago in recruiting psychiatrists for the Foyle Trust, I had the possibility of recruiting a locum who would be paid exactly double what my permanent doctors were earning. I said to my permanent consultant psychiatrist that I was not going to take the locum because it was offensive that they would end up being paid twice as much as the

permanent consultant psychiatrist, who was there all the time and did a really good job. Those doctors said that their preference was for me to bring in that person and pay them that amount because it would take the pressure off them as a team. The doctors said that they appreciated that that person would be paid more but they wanted the person to join them. I am on the front line every day. The vast majority of the doctors who work for the NHS go far beyond the call of duty. They are very hard-working and committed. They do not work very long hours, but they come in as and when they are needed. We are still in the very fortunate position in Northern Ireland of having a very hard-working and committed workforce. I do not want to spend a single penny on locum costs, but that requires the sort of change that Dr McCormick talked about.

Mr Copeland:

You will be very glad to hear that I suspect that I can answer the last part of this question for you. Is it your experience that rural trusts, like the Western Trust, find themselves paying more for locums than their urban counterparts? I think that the answer is yes.

Mrs Way:

Yes.

Mr Copeland:

Thank you very much for your patience.

Mr McLaughlin:

I do not know whether I should ask Michael to answer my questions.

Paragraph 2.7 tells us that, in some cases, locums can be paid almost three times more than permanent doctors for temporary work. That is very alarming. Paragraph 1.9 refers to internal locums bartering for agency rates. That was mentioned in one of the earlier questions. How can we justify those types of graduated salary costs when the Department is calling on trusts to identify efficiency savings?

Dr McCormick:

It is very hard to justify that. We need to adopt every possible tactic and strategy to address that issue. We have already drawn out the reality underlying the cause of the issue, which is that there are times and cases when there is no alternative and where the choice is between paying a rate as

described in the report — whether it be to an internal employee who is saying that if he is not paid the rate, the trust will have to go to an agency — or going to an agency. The escalation is from the agency with which trusts have contracts. If those are exhausted, the trusts will have to go to every possible source of supply. That is where we are trying to keep too many services running in too many different places.

The fundamental answer is to reconfigure the service in a radical and significant way. That is the kind of issue that we have to look at as a region. The point that you raise, and which comes out strongly in the report, is, as I said, that this is a symptom and we need to address the root cause.

There is a question of accountability, which was mentioned in a number of questions that were asked earlier in our discussion about the ethics and morality of the behaviour. That is an issue that individuals need to examine. There is nothing that we can do to address that, because when they are the only source of supply, the only person available, we are in a difficult position. We are not in a strong negotiating position, and we need to improve that, but that is where we are. The individuals need to examine their ethics, but that is up to them as individuals. They have responsibilities in that regard; there are aspects of what they adhere to, and the vast majority of doctors behave properly and ethically in all those cases. It is a matter for individuals to examine themselves.

From our point of view, the main strategies are to regionalise information and procurement, make sure that we have every possible contract in place and then to proceed in a timely and sensible way with the consolidation of services to make sure that we are not spreading resources too thinly and leaving ourselves vulnerable. That will never completely eliminate the issue, because Northern Ireland will never be fully self-sufficient in every possible aspect of health services. There will be aspects of expertise for which we are dependent on a very small number of individuals. That requires us to move into partnership working with other jurisdictions.

All those things need to be looked at, and they all require strategic planning and the right level of contracting. We have to do all that is possible and then look to the individual doctors who are asking for a lot of money. That is their personal responsibility, and they have a level of professional accountability in that regard.

Mr McLaughlin:

Thank you for that. I welcome the move towards regionalisation, particularly for procuring those services. I know that there are examples where the trusts act in a collective way and, perhaps, one acts as the lead organisation for certain procurement exercises. How many agencies provide locums across the trusts?

Dr McCormick:

The numbers vary. The Western Trust has contracts with 18 different locum agencies.

Mr McLaughlin:

For locum doctors?

Dr McCormick:

For doctors, yes.

Mr McLaughlin:

Not for nurses or —

Dr McCormick:

It is purely in relation to locum doctors. The Belfast Trust and the South Eastern Trust, which have less need for locum doctors because of the nature of their employment, use nine different agencies.

Mr McLaughlin:

Do they deal with different specialties? What is the explanation for dealing with so many agencies?

Mrs Way:

Doctors want to live in Belfast.

Mr McLaughlin:

No, sorry. What is the explanation for using 18 agencies?

Mrs Way:

The report covered the period just before last October. In October 2010, we went for a procurement exercise through the Business Services Organisation procurement service. We said that we need certain agencies to say that they can meet our needs and supply us with us doctors. That was tendered for throughout the UK, and there were responses and evaluations of those. The result was that we were able to put 18 agencies on a contract to say that, if we are looking for a locum doctor, we will go to them. Since we put that in place in October 2010, we have had to go to those 18 agencies on 151 occasions.

Mr McLaughlin:

To help me understand this, did they have to compete with each other to get on the list?

Mrs Way:

Yes, they did.

Mr McLaughlin:

They provided prices for the supply of doctors, and you ended up with 18 agencies on the list?

Mrs Way:

Yes, we did. Some agencies might be able to provide a good range of radiologists, and another might say that emergency medicine is where it has the most doctors.

Mr McLaughlin:

That is what I am asking. Some of the agencies are identified by the specialties that they can offer?

Mrs Way:

Some of them do a lot, and some might do only a few. As far as we are concerned, the more that we have, the better chance we have of being able to get doctors. Even with 18 agencies, there have been 16 occasions out of those 151 when they have not been able to supply us with doctors.

Mr McLaughlin:

Up to now, has each trust operated independently on the procurement of locum services?

Mrs Way:

I cannot speak for other trusts.

Dr McCormick:

Yes, that is part of the reason for moving forward in a different way. It is partly because each organisation has large numbers of doctors and separate contracts. There has been a centralisation of procurement advice on the actual process of procurement, but, moving forward, we recognise that there is room for improvement.

Mr McLaughlin:

We have a population of 1·8 million, and it takes one hour and three quarters to get from one end of the region to the other, yet we have 18 agencies.

Mrs Way:

Not in Northern Ireland; there are 18 across the UK.

Mr McLaughlin:

They supply to your trust area, Elaine. Perhaps, across the spectrum, there may be more than 18, when we consider the different agencies that might be employed.

Mrs Way:

Yes, that is true.

Mr McLaughlin:

I need time to recover from that. I find that astonishing. I need a doctor. *[Laughter.]*

Dr McCormick:

Only two of those agencies are based in Northern Ireland. Most of them operate across the UK. They supply services to the NHS across the water as well.

Mr McLaughlin:

Andrew, is the regional strategy that we are talking about the Department's response to those anomalies?

Dr McCormick:

It is one main change that we have decided to make to improve the handling of the issue and to ensure that there is better information, better procurement and more consistency in dealing with the issues. That will deliver everything that we, as a regional service, can possibly extract from it, but, as I said earlier, it does not solve the problem where there is only one individual who is willing to engage. That is the point where any monopoly supplier has a price advantage. It is very hard to break that principle other than by minimising our vulnerability to situations where there is only one individual who can meet a need.

Mr McLaughlin:

In developing the regional strategy, have you examined the costs of bringing in locums, especially in situations where they have enormous leverage with the costs? On some occasions, it must be nearly as cost-effective to send the patient to wherever there is a permanent doctor than it would be to bring in a locum to look after them?

Mrs Way:

To go back to the example of radiology, there is a national shortage of radiologists, and some of the highest fees that are being paid currently are for radiologists.
Diagnostics is fundamental to being able to say what is wrong with an individual patient and so, in a sense — I suppose it gets very much to what you are about today — trusts will say, "We will pay the higher rate to make sure that we have a full complement of radiologists." You will be well aware that we had difficulties in Altnagelvin in the not-too-distant past with our complement of radiologists, and the locums we brought in were paid at the higher end of the rates.

Subsequent to our new contract, we have brought in another locum radiologist, but we have not paid the higher rates that we paid previously. We are paying the rates that are on the contract, and we are sticking rigidly to those new rates — it makes mention of maybe three times the rate — which now include payments for travel and accommodation. In the old days, it was the rate for the job, and you might have paid for flights home to London or wherever every other weekend and paid accommodation. Now the rates include that as well. So, we are working very hard to drive the costs down, but we are not where we want to be by a long chalk.

Mr McLaughlin:

Thanks for that; you anticipated my next question.

The Chairperson:

Are you still on the same question? A couple of members want in for a supplementary. I ask members to be brief and ask that the answers are succinct.

Mr Hussey:

I have a very quick question. Dr McCormick, you mentioned consolidation and bringing certain services away from places, Omagh being a prime example. I will not go down that line because we will be here until tomorrow. By doing that, we then have a situation where GPs are saying that, if they cannot have the service in their area, they will start to disappear as well. So, it is a chicken-and-egg situation where, if we lose various facilities and services, in the west particularly, GPs will not go there either because they cannot get their patients seen. Therefore, consolidation might be a solution in one way but it creates a bigger problem in another.

Dr McCormick:

I expect that part of the service change that is being talked about and is looking to come through more fully in the review next week will be that part of what has to happen in relation to the service provision is to get as much as possible devolved and delegated to local level, so that more activity is being handled in primary care. There are initiatives, including some very significant ones in the western area, where developments in primary care will secure more aspects of service closer to the patient, including aspects of diagnostics. That is an immensely significant part of the strategy for moving forward.

The areas of consolidation are in aspects of service where clinicians would say that it is best to provide a smaller number of sites across Northern Ireland. There is a combination of change, with some aspects of service being more consolidated and others being more dispersed. One key to that is ensuring that the drive for change is very much led by GPs. That is one reason why GPs are the largest single group on the local commissioning groups (LCGs). They will increasingly be the decision-makers on the detail of how services are applied and changed. The western LCG has some very significant players who are leading change in a number of ways.

So, that is part of how we see the policy. The Minister is keen to see the commissioning side developed as part of how this whole system works, and that should ensure that there is engagement and leadership from primary care in taking this forward. I am strongly against what

you are saying and would be very concerned if it was to come to pass. We have to ensure that consistent and high-quality services are available for all parts of Northern Ireland.

The Chairperson:

The answers need to be a wee bit shorter, Andrew. Does that satisfy you, Ross?

Mr Hussey:

Yes.

Mr Girvan:

I appreciate that we have used both contracted and non-contracted agencies in Northern Ireland. I am going to ask a question that you might not be able to answer today, but I would appreciate it if you could get back to us. Are there any doctors or health officials currently in employment within the trusts that we represent who are owners or directors of any of those contracted-agencies and non-contracted agencies that are used within Northern Ireland?

Dr McCormick:

We do not know the detail of that, but I understand entirely where you are going on that point, and we will look into that and come back to you. There is certainly no question that doctors who are HSC employees will be deployed through the agencies. If I understand you correctly, your issue is about control of the organisations.

Mr Girvan:

That is correct; or past.

Mr Dallat:

Paul's issue is precisely the one that I was going to raise. It is the whole question of how ethical it might be for people involved in the medical profession to run agencies. The lead-on question from that is an obvious one: what protection do you have against cartels? All we have been told today is that you bump up the price and you pay through the nose for the service that you need to provide to the patients. I will simply add to Paul's question: what protection is there against cartels? Northern Ireland is a very small place, and everybody knows each other. There are networks going on, and it is not unusual for cartels to operate. It would be absolutely horrific if cartels were operating in the medical profession.

Dr McCormick:

Commissioning is a very important dimension of how we seek to address that issue. It does not provide complete protection, because there will be times when there is a limited source of supply of a particular service, but the previous Minister and the current Minister both made it clear that commissioning should include the right and power of commissioners to choose to commission services from an alternative provider. That is part of how that should work.

I have had discussions with the Health and Social Care Board in the past to identify whether there is scope to improve an element of competition. We do not have a fully fledged market in health and social care in Northern Ireland. We are too small to have the scale of market activity that applies across the water, but the principle of there being an element of competition that allows for commissioners to decide to deploy resources in a different way is part of the policy and the way that things can work. I share your concern about the issue of cartels. That is something that we need to be wary of and deal with, but it is not possible to rule it out completely.

Mr Copeland:

As you know, we have recently examined the legal profession, and I feel bound to say that, from what I have heard so far here today, the lawyers are amateurs at manipulating the system. As I understand it, a procurement exercise revealed 18 different agencies. Is it possible, under any circumstances, that the same doctor could appear on the lists of more than one of those agencies, and is it possible that a doctor could be procured through one of those agencies at x cost or through another at the cost of x plus y? Is that possible?

Dr McCormick:

It is not only possible; it happens, frankly and truly.

Mr Copeland:

When you ask for a doctor, it is not like asking for a plumber. You can phone a plumbing company that will send you a plumber, and he will fix the problem. Do you know the individual identity or qualifications of the doctor that you are getting?

Mrs Way:

Yes we do.

Mr Copeland:

If he is available for company 1, by implication, he must be available for company 3. Is there any exercise that actually checks whether you are getting the best possible value from the company you are deciding to purchase his services through?

Mrs Way:

Doctors can be registered with various locum agencies. If, for example, we need a locum radiologist, we will go to whichever of our 18 agencies we think has locum radiologists. They will send CVs —

Mr Copeland:

Think or know?

Mrs Way:

Sorry?

Mr Copeland:

Think or know?

Mrs Way:

Think or know what?

Mr Copeland:

Whether they have radiologists.

Mrs Way:

They will know. I personally would not know which of the 18 agencies had radiologists.

Mr Copeland:

I mean the person who is securing the services on your behalf.

Mrs Way:

They would know.

Mr Copeland:

So, they would know that, if they phoned a specific agency, they would possibly have a radiologist available.

Mrs Way:

If we needed a long-term locum and that had been approved by the medical director, medical HR would contact the agencies and ask for locum radiologists. The agencies would then send a number of CVs to the clinical director, who is a doctor. They will look at the candidates' qualifications and experience at a very detailed level, and they will always take the best fit at the most competitive price. There may be two doctors whose CVs show the same experience, but one costs £50 an hour and the other £54 an hour. We will go for the one that costs £50 an hour.

Mr Copeland:

Would you ever find the same doctor registered at two different agencies at £50 an hour and £45 an hour?

Mrs Way:

You would not get that in two agencies. One doctor would not put themselves forward for one job through two agencies.

Mr Copeland:

I am giving in; it is too complex.

The Chairperson:

Go ahead, Sydney, very briefly.

Mr S Anderson:

Are you letting me in?

The Chairperson:

Yes, you asked nicely.

Mr S Anderson:

Elaine, you talked earlier about how loyal and ethical the doctors in your hospitals are. You see these doctors that are registering with agencies at different rates — do they include those doctors that you talked about?

Mrs Way:

Some of them might be.

Mr S Anderson:

How loyal are they, or where does this whole thing sit, if they register as locums at different rates? How ethical are those individuals?

Mrs Way:

Dr McCormick alluded to the marketplace earlier. We do not have enough doctors to run and deliver the service safely in our current model. We are always going to have to go outside of the current pool of permanent doctors and ask doctors to come in and work as locums.

On occasions, it suits us very well for some of our internal staff to work as locums for us, and I am sure that other trusts would say the same about our doctors working for them. I personally do not judge it as ethical or unethical if a doctor, who is working for us as hard as he or she can, makes himself or herself available to meet our needs. The freedom that those doctors exercise in taking up those opportunities is a freedom that is available across the United Kingdom, and it is not for me to say that they cannot do that. The difficulty for us is that, if we did not use them, we would have no service.

Mr S Anderson:

Your point is taken, but, as Michael said, we had the legal profession at certain things. At the end of the day, is this all about money? To me, that is what it is all about.

I think that it was John Dallat who raised the issue of agency nurses. I know of nurses who qualified this year and cannot get permanent jobs in the hospitals and are working in residential homes, yet here we have doctors who are being paid high rates — even more so than high overtime rates, because they are getting locum rates. You tell me that some of them are. What is the percentage? Surely the alarm bells start to ring when doctors appear from different agencies,

and they should not be too hard to identify. There is so-and-so there, and there he or she is there. Would there be many of them, or is there just a few?

Mrs Way:

I do not have specific figures —

Mr S Anderson:

I am wondering what is going on. On top of all this, there seems to be a whole system at play in relation to how much money they can make at the end of the day. As my colleague said, it is all coming out of the health budget, which is the biggest budget that we have. We need to get a handle on that.

Mrs Way:

I am absolutely at one with you on that. Honestly, I do not want to spend a single penny on locum costs. However, that would require me to have an entirely staffed permanent medical workforce in the west, and we are not there yet, for some of the reasons that I have described.

Mr S Anderson:

My colleague asked a question — I will stop at this — about who is running those agencies. I look forward to the reply to that, and I hope that we do not have to wait too long to find that out.

Mr McLaughlin:

Andrew, paragraph 2.14 highlights the ludicrous situation whereby trusts end up paying higher rates to their own employees who work as locums because they have registered with external agencies — sometimes, it appears, with more than one agency. The obvious question is that, if locums are paid more money when they work through an agency, we cannot be surprised when they refuse to cover shifts as internal locums. Does the regional strategy address that issue?

Dr McCormick:

It will help us with that. It will help bring together the resources of the management side of the whole exercise and ensure that, where it is possible to secure a better service at a lower cost, that is what will result. Partly by bringing the whole thing together, it reduces the risk where someone can say, “I am the only person that you can hire.” We can say no to people, for we will have a choice. Once management has a choice —

Mr McLaughlin:

You will have to explain that, because I do not understand it from that answer, Andrew. Permanent staff — people on contracts — are registering with agencies, specifically to deploy their out-of-hours availability and specialist skills to the service. They do so because, from an individual level, you can perfectly understand that they can sometimes get three times more money than they would as a contracted employee. How does the regional strategy address that? How do you prevent that situation from arising?

Dr McCormick:

As I said earlier, it cannot prevent that if we are in a situation where there is only one person who can fulfil the obligation or the needs of the trust in a particular set context. Therefore, our strategy has to be to reduce the number of cases and occasions when we are reliant upon one individual. That is the key to dealing with high costs.

Mr McLaughlin:

Does your study quantify the extent of that particular phenomenon? Do we know how many of our permanent staff are in that position? What targets for reducing it does the strategy have?

Dr McCormick:

It is not very extensive, but it gives rise to the particular high-cost examples that are highlighted in the report. More generally, our confidence is that the regionally managed service will bring us to a situation where there is greater information and awareness of different sources of supply of service — different locums who can come in — and, therefore, it is possible to hold them to the contracted rate. If what is secured through the regionally managed service is regional level procurement, and people saying, "We will supply a service at a fixed rate", we can say, "Right, that is the deal", and trusts will be able to say "We will only engage you at that rate." That works as long as there is more than one.

Mr McLaughlin:

The theory of that is clear enough to me. I can imagine that, if you have a payroll account, you will know whether someone is already working in the service, to match against, say, invoices received for locum services. So, if the same individual pops up, you can work out just how many hours are involved and what the cost is, or so I would imagine.

However, I am less than reassured that you have calculated that and factored it in to the regional strategy. You know what the extent of the problem is and you have targets for reducing it, and you are able to tell us how you will achieve those targets over a period of time. You do not seem to have that information. Is the information system that we have so defective that we cannot match that type of information to targets going forward?

Mrs Way:

My immediate reaction to what you say is as follows. One of the reasons why I want the regional system established is that, in the past, the Western Trust has suffered from leapfrogging by other trusts. Say that we have decided that we need a locum something-or-other —

Mr McLaughlin:

Instead of an internal market, they are outbidding you?

Mrs Way:

They are trumping me, and that person goes. One of the benefits of the regional system should be that, when somebody has said that they are working in the west, they will be working in the west and no other trust. That will help to control costs as well. It is a very important aspect. Those of you who are not from the west will not be surprised to find that we in the west feel a bit hard done by when it comes to that aspect of securing doctors.

Dr McCormick:

I suggest that we follow up on the question earlier from Mr Copeland and look at how to quantify the extent to which we can bear down on those costs and look at that as realistically as we can.

Mr McLaughlin:

That should have started. If I were going for a regional strategy, I would have started that work.

The Chairperson:

The Department sets an approved rate, but it is obviously not being adhered to. What is that approved rate?

Ms Taylor:

We can share the circular with the Committee.

The Chairperson:

OK. Sometimes, it is two or three times whatever the cost is. I appreciate that.

Mr Hussey:

Do you pay the agency or the doctor?

Mrs Way:

The agency.

Mr Hussey:

It will be interesting to see how that money is divided up and how much goes to Her Majesty's inspector of taxes.

It is always good to see someone from the west in this part of the world. They do not really know what it is like up here.

Mr McLaughlin:

You get to talk to each other. *[Laughter.]*

Mr Hussey:

Or talk about each other.

Paragraph 1.15 talks about the need for trusts to deploy a more optimal number and mix of permanent doctors. In light of that, are you satisfied that your trust has the most effective rostering system in place to ensure that all possible internal solutions to gaps in doctor rotas are covered before you look for external locums? Do all trust hospitals employ electronic rostering systems?

Mrs Way:

I am satisfied, again partly as learning from the report, that we have put in place very rigorous controls on using locums. Our starting point always is whether we can try to do it internally first

of all. Indeed, the first question on our form for a locum for under or over four weeks is whether you have looked at whether it can be done internally. That is purely from a value-for-money system.

Mr Copeland:

It says "Have you looked?" Does that require someone to tick a box to say that they have, or is it just a thought thing?

Mrs Way:

It is to serve as a trigger to people as they are about to fill in the form. We have added the first question, which asks whether consideration has been given to whether it can be done using internal locums. If it is anywhere over four weeks, the medical director will push back on clinical leads and ask whether they are sure that they have looked at it and whether they could do it differently.

Mr Copeland:

Does it occasion the ticking of a box to indicate that a person has looked at it, or is it just that they have read it?

Mrs Way:

It requires them to tick it; it is a yes or no.

We are currently trying to use a pilot of electronic rostering for nursing staff, but we do not yet have an electronic rostering system for doctors.

Mr Hussey:

Obviously, that applies to the west. What is it like —

Dr McCormick:

It is my understanding that the other four trusts have electronic rostering in place.

Ms Taylor:

They have a system called Zircadian, which puts doctors in to a roster. The Western Trust does not have it, but its rostering is very good without it. It is considering whether it needs to procure

that system.

Mr Hussey:

If the Western Trust does not need it, why do the other trusts have it? If the other trusts have it, why does the Western Trust not? I could ping pong that all day.

Mrs Way:

I know. In our defence — she says, speaking on behalf of the west — there are lots of areas in which the west is leading the way and other trusts will follow our example. I was really proud to go over earlier in the year to England to receive a national prize for quality for the Western Trust. There is a relentless focus on making sure that services are safe. I have to say something about the west; forgive me. I promise you that there are areas in the west in which we have good practice and we are sharing that with others. This is an area that we will want to follow.

Mr Hussey:

I could argue and say that, in some instances, places are made safe by being closed, but I will not go down that line; I will move on to the next question to Dr McCormick.

Paragraph 2.5 sets out the various factors that have contributed to the limited availability of suitably qualified staff across the health and social care sector. Factors such as changes to immigration rules, flexibility of working hours and staff preferences have all played a part in limiting the supply of staff. Those developments did not happen overnight, and I am concerned that your workforce planning process did not anticipate the shortages and enable you to address them. The question basically is; why did you not foresee the shortages and take action to address them?

Dr McCormick:

As I said earlier, one of the most significant actions that we took was the expansion of the medical school in 2005. That is a big, fundamental change in the rate of supply of doctors. It is only coming into effect now because of the time it takes between a decision of that nature and the new supply. Some of those factors have emerged at different paces over the last number of years, so it is a complex area to manage. It can be argued that some better foresight might have been possible in relation to a number of them, but we have an overview. An annual workforce planning exercise was undertaken in 2008, which examined the totality of the medical workforce

— not at the level of specialty by specialty, but looking at the totality of the requirement for Northern Ireland, especially the need for the consultant workforce. That has been handled.

We have recognised that there was a need to expand, but the full benefits of that expansion are not yet available. That is the fact of the matter. In the meantime it has been necessary to look at sourcing medical staff from elsewhere across Europe. That has been necessary on a number of occasions. It does leave us with some vulnerabilities, which we regret, but it would be wrong to say that a lot of things were missed. The rules on immigration changed at a certain point of time. We will have had some warning of that, but not that much opportunity to adjust our activities, because such things take time to adjust to. That is part of reality. We are certainly very conscious of the long-term trends in the nature of the workforce. The male:female ratio is raised there, and that is an ongoing change which will continue to require some work. The better place to be, if we can get there, is to have a slight oversupply. That is what we need to try to get to. That way the boot will be on the other foot.

Mr Hussey:

In relation to doctors being brought in from other places, there have been documented cases of people being employed by health trusts who could not speak English. Personally, I cannot understand how anyone could go through an entire interview process without being able to speak the Queen's English — or the Queen's Irish, for that matter — and be employed in health trusts in Northern Ireland. I said that for you, Mitchel, but I will move on quickly to Dr McCormick again. Paragraph 2.7 refers to the practice of flying in locum doctors to provide cover in A&E departments at weekends. Can you explain why weekend shifts are not being covered by substantive staff? Do negotiated contracts exclude weekend work?

Dr McCormick:

The approach is normally to do that. Locum issues arise when that is not covered fully, so we have to look at the pattern of employment and work plans for individual doctors. That is normally dealt with within normal contracts. The need for locums arises where that is not fully possible.

Mrs Way:

There is a national shortage of emergency A&E medicine. Practically speaking, it is an area in which we in the west have had significant difficulty and been reliant on locums. I am pleased `to

say that we can now create a relatively new grade of doctor, a specialty doctor, and we have created some of those posts for the Erne Hospital. We have just closed a recruitment exercise and we have six good applications for those jobs, which will then further reduce our dependence on locums. We are constantly trying to find ways of making the service stable and reducing the dependence on locums.

The Chairperson:
Go raibh maith agat, Ross.

Mr Hussey:
I will try to spell that later.

Mr S Anderson:
Dr McCormick, you are earning your money today. I have three questions, and I will be as quick as possible. Paragraphs 2.6 and 2.11 refer to specialty-specific training. If significant numbers of medical graduates choose to work solely as locums, as an alternative to taking up specialty training positions, could that ultimately reduce the number of specialists available within the system? To what extent has general locum work become an attractive alternative to vocational training? From what we have heard today, I know that it has a great financial attraction.

Dr McCormick:
Those are important questions. The vast majority of locums have a main job: 80% or 90% of the doctors who are engaged in a locum capacity from time to time have a main contract. I will ask Paddy to say a bit about the work on the implications of revalidation, because the impact of that will be to require doctors to have an ongoing and systematic evidence base in relation to their practice. If that were the only factor in play, the only one affecting the future of the medical workforce in Northern Ireland, it would be a very strong disincentive to work as a locum, because it would be harder to produce what will be the prescribed requirements for revalidation. So the emerging changes in the regulation of the profession will make a significant difference in that regard. However, there is a financial incentive. Some difficulties in dealing with that remain, as has been drawn out in answers to earlier questions. However, Paddy will give a summary of the implications of revalidation.

Dr Woods:

Two points answer your question. By and large, our training programmes for specialist practice, either as consultants or GPs, are very heavily subscribed. That suggests that the evidence is that our young doctors are still opting to enter training programmes to work towards either specialist or GP practice. It is entirely sensible because, as the report implies, to opt to work as a locum for a career that may last 30 or 40 years would be to take a short-termist view in any respect, in view of the likelihood of maintaining and generating a career for any length of time under current circumstances. As Dr McCormick said, with the introduction of revalidation it will become increasingly difficult to act exclusively as a locum, because to generate the information and evidence that you will have to provide to support your ongoing registration, it will become increasingly difficult, if not absolutely impossible in practical terms, to retain your place on the medical register. It will become effectively impossible.

Mr S Anderson:

I am pleased to hear that it is making inroads to prevent the likes of that happening.

Dr McCormick, paragraph 2.11 mentions that the latest workforce planning review did not include detailed specialty planning. As a result, it did not address specialty training and recruitment needs. Surely the point of your workforce planning process is to identify the training and recruitment needs of individual specialties? In the absence of that key information, what practical use does that workforce planning document have?

Dr McCormick:

In dealing with that issue, I distinguish between two levels of planning. There is planning at overall Northern Ireland regional level, which falls to the Department as a responsibility, and then there is the more detailed process at trust level. As we have moved forward, that has been changing over the years. We are looking at an increasing emphasis on the trust-level planning process, which requires each individual organisation to look specifically at its needs. This will always be evolving of course, because the way in which we are organised and the way medicine is changing require an ongoing sensitivity to change. The Department was looking at an overall view to ensure a broad balance of numbers going into training and to ensure that there would be sufficient consultants and GPs to meet the needs of Northern Ireland as a region. That has been the broad approach. However, there is a need to ensure that that is supplemented by more detailed specialty-by-specialty work, but that is more fully carried out at the level of the

individual organisations. That is the issue and the main distinction that I would make.

Dr Woods:

It is fair to say that the workforce planning review referred to in the report is the third in a series of three that were published in 2003, 2006 and 2010. The first two of those looked at specialty workforce planning. Although the last one that was referred to did not look at it in specific terms, it stated that there were currently sufficient numbers within the junior doctor grades to generate Northern Ireland's future needs for consultants. We are still not there yet, and that is quite apparent. However, it pointed out some key shortage areas: radiology, as has been referred to already; anaesthetics; psychiatry; and laboratory medicine. Our subsequent intelligence to that says that there remain issues in generating the numbers for radiology. In 2009, our specialty advisory committee reported that, for the first time in living memory, there was competition for recruitment to consultant anaesthetist posts, which was an indicator that we were getting there, although I do not think that we are fully there yet. Psychiatry, including child and adolescent psychiatry, which had been a chronic problem for recruitment at consultant grade, and laboratory medicine were showing better recruitment figures than previously, with some exceptions.

It is almost impossible to cover all the bases in these exercises. It is an inherently crude and imprecise exercise. We are trying to project over a decade, which is the time it takes, in most instances, from being a medical graduate leaving university to being in a position to take up a consultant post. That is why it is reviewed regularly. I do not want the Committee to go away with the impression that we do it once every 10 years and leave it alone. We look over a 10-year timescale, but we regularly review and focus in on areas that have been flagged up as having specific difficulty.

Mr S Anderson:

So you are telling us that there are areas that need a lot of improvement to address the issues that you referred to?

Dr Woods:

There are still issues to be addressed.

Mr S Anderson:

Paragraph 3.6 recommends that the Department considers extending the remit of the Regulation

and Quality Improvement Authority (RQIA) to include the regulation of locum agencies. What progress has been made in addressing that issue?

Dr McCormick:

As I said earlier, the vast majority of the agencies operate on a UK-wide basis. Therefore, the potential benefit from that kind of regulatory approach would be better served if it were done in conjunction with our counterparts in England, Scotland and Wales. We have written to our counterparts to seek their views. We have followed through on the approach suggested in the Audit Office report because it will depend on working in conjunction with colleagues elsewhere to look at this. We have raised that issue with them, and we await their response. We will engage with them and see where that goes. It is an important recommendation from the report, and we want to consider it very carefully.

Mr S Anderson:

Do you see that joined up approach that we keep talking about happing in the near future, rather than in the distant future?

Dr McCormick:

There needs to be a decision made on the way ahead as soon as we can secure it. It is one that we will follow through on carefully. I take your point.

Mr Dallat:

My question relates to paragraph 3.12. I am sure, Dr McCormick, that this question must have been asked before, so it is really a case of déjà vu. However, I will ask it again, although you may have answered it earlier. Why do the trusts not check the credentials of doctors before they employ them? Do they not read the papers — particularly the tabloids throughout the world — which report on all sorts of clowns and idiots who masquerade as doctors and scare the living daylights out of their victims? I imagine that the answer is that you do check those credentials.

Dr McCormick:

We do. There are some exceptions, and it is regrettable that there are any exceptions. Part of the impact of the report and this hearing will be to make all of the organisations aware of just how essential that checking is. We need to continue to remind every organisation of the importance of fulfilling the code of practice that exists. There are clear obligations and procedures in place for

all of the organisations and those must be used. Some cases have been identified in which those were not fully fulfilled. That should not have happened; there is no question about that.

Mr Dallat:

Is there a disciplinary process that can be applied to those who fail to carry out the promises that you have just made? Is anyone in the medical profession held responsible for anything?

Dr McCormick:

There is individual accountability, and it is a matter for individual employers to judge what is the proportionate action against a persistent failure to comply. That is something that needs to be looked at carefully by employers in adhering to best HR practices. They need to fulfil that responsibility and ensure that there is sanction when sanction is appropriate. That is the way that the rules work, and they should be applied rigorously and effectively. That is what we should be doing.

Mr Hussey:

Dr McCormick, you talked about a persistent failure to comply. One failure is too many when someone comes along and claims to be a doctor. When we interview a candidate for a role in the Policing Board, we ask for a copy of their degree. Here we have a situation in which, if there are persistent failures, we might take action against a civil servant or whoever it was who decided to appoint a person. That is wrong. One is one too many.

Mrs Way:

I absolutely agree that one is one too many. Someone should never be able to masquerade as a doctor. I assure you that, in our tender documentation with the successful agencies, we clearly stated the ways in which they must assure us that doctors that they offer are of the right quality. However, we have a second aspect that we put in place to guarantee that doctors are of the right quality, which is the locum medical staff checklist form. No doctor can get his or her foot over the door until we independently check, for example, General Medical Council (GMC) registration. That is a fundamental part of employing doctors. That checklist is a detailed form of a page and a half, and everything must be ticked off. Doctors are not allowed into hospitals unless everything is checked.

Mr Hussey:

If you need a doctor tomorrow, you will not have time to check GMC registration, will you?

Mrs Way:

We will. It is all online.

Dr McCormick:

Can I just clarify —

The Chairperson:

John, have you finished?

Mr Dallat:

No. Having employed the doctor and checked out his credentials, who assesses that doctor's competence to do the job?

Dr McCormick:

That matter would be dealt with through the appropriate supervisory arrangements. In most cases, if it is a junior- or middle-grade doctor, a consultant will oversee that doctor and will carry an oversight responsibility. If the locum is a consultant, there will be oversight from the team of consultants, the medical director and the organisation.

Mr Dallat:

I asked the question because the papers constantly carry stories about those who have been employed in the medical profession and are totally incompetent.

Dr McCormick:

There are a small number of exceptions of that nature. It is very important that appropriate and proportionate action is taken as quickly as possible when that is identified.

I want to clarify the point that I made about persistent offences. In its report, the Audit Office highlighted that the misdemeanours related to the absence of written confirmation or to the practice of informal checking. It was not that someone who was not a doctor was being employed but that the full procedures were not rigorously followed. We need the procedure to

be rigorously followed, but I would not regard one failure to confirm a point in writing as a hanging offence, and, as Elaine said, there is a need to make sure that major breaches of process never happen. One case of that would not be tolerable. We need to look at that proportionately.

Mr Dallat:

All afternoon we have heard about the laws of supply and demand and about the shortage of doctors, and you are, of course, aware that we are educating thousands of teachers who cannot get jobs. Have you been screaming from the rooftops to create more positions for doctors so that we are not discussing cartels, upping the price and being regional about how we deliver the health service?

Dr McCormick:

The main intervention that was possible was to expand the medical school. That is the single biggest lever or way in which the Department can influence supply and demand. We have applied other smaller contributions, but it is difficult to do that.

Mr Dallat:

Do you go out to the schools to appeal to young people, as has happened with the PSNI, and plead with them to consider the medical profession?

Dr McCormick:

The medical school is oversubscribed, and there are also people who are already graduates and, therefore, are not getting student support, who are prepared to pay their own way through medical school. Medicine is a very attractive profession. That is not the issue. The issue has been the actual size of the graduate cohort. Up until this year, the numbers were still 154 a year.

Mr Dallat:

Elaine, you mentioned the regional strategy a few times today. How do your staff at the Gransha site feel after the devastating news that they got yesterday that the regional strategy means that their jobs will go to Ballymena, Omagh, Belfast and anywhere but Derry, which is an unemployment black spot?

Mrs Way:

The staff who had the news broken to them yesterday afternoon about the consultation exercise

were very shocked. Their morale is very low, and some people were in tears. The nature of the document is that it is a consultation document that the Department is issuing today, I think, and I have no doubt that many people will comment on the proposed locations.

The Chairperson:

That is a different matter to the inquiry that we are working on today.

Mr Dallat:

It is not. At the same time, morale is a very important part of the whole process. Elaine, you are responsible for running in Derry one of the finest hospitals anywhere in the world, and the people in that hospital, whether administrative or medical, are among the best. I do not understand why people would not want to work in Derry.

Mrs Way:

The permanent secretary will probably sack me when I go out, but I will be bold —

Mr Dallat:

Let him, it is worthwhile. [Laughter.]

The Chairperson:

You need to keep this brief.

Mrs Way:

It is very brief. On Monday, when I was going to the Department, the woman on the front desk told me that her son has just gone through Altnagelvin for training. He knows that I am here, and she said that the training at Altnagelvin was second to none and that it should be recognised as a hospital of excellence. I am bursting with pride now.

Mr Dallat:

You have every right to be.

Mrs Way:

You will not sack me, will you?

Dr McCormick:

Not for that; no way.

The Chairperson:

Do not celebrate just yet; you have another lot of questions to go through.

Mr S Anderson:

You mentioned the form that the locum fills in. I am still not quite happy. Ross said that you may need a locum quickly. How is that checked? Is it just done with a phone call or is it on a database?

Dr McCormick:

GMC registration can be interrogated online. So, you can see the status of every doctor in the UK and whether there is a flag against them. That is available.

Mr S Anderson:

Does that come to the agency?

Mrs Way:

Yes, and, under contract, it has to —

Mr S Anderson:

It has to sign that extra declaration?

Mrs Way:

No, we get the agency to sign a form that says that it will not breach European working time directives. This is the form that we use internally. Medical HR ticks it to say that a person is fit for purpose, and it has to check various things.

For me, again, on the front line, the most miserable locum recruitment is always one where it is at short notice, when a doctor is not available for something. Nevertheless, we still require the locum agency.

Mr S Anderson:

Who is “we”?

Mrs Way:

It is medical HR. One of the recommendations in the Audit Office report was that we should be clear about our process for procuring locums. So we now have a list of people, all of whom are human resources people who work solely in recruiting doctors, and they go through and check this and say —

Mr S Anderson:

How long does it take to do that? Not long?

Mrs Way:

Not long.

Mr S Anderson:

OK. Thank you.

Mr Copeland:

I will be brief, Chairman. I realise that the medical profession is not like plumbing. It is very serious. If you request a locum for a specific task, involving the use of pretty-much cutting-edge technology, and the locum who arrives is, for whatever reason, incapable either of dealing with the situation or using the technology required, what happens? Must you suspend what you were going to do and get someone else?

Mrs Way:

The most recent occasion on which we let a locum go was in January 2011. We said, “No, sorry, that is not up to what we consider as standard”. We go back to the locum agency and say to it that that doctor has done such and such. On occasion, we have referred locum doctors to the General Medical Council as well. So, as Dr McCormick said earlier, we are assiduous in assessing the performance of locum doctors when they are on our site, and we will take action. I do not have the technology examples you asked for because of the nature of the hospitals, but if we recruited a locum surgeon, who had the qualifications and experience but who we felt was not up to the task, we would terminate his or her employment with us, tell the locum agency why and

make sure we did not use that surgeon again. If we considered that surgeon to be dangerous, we would notify the General Medical Council.

Mr Copeland:

Have any of those agencies been removed from your list?

Mrs Way:

Not since October 2010. No.

Mr Copeland:

But one was removed?

Mrs Way:

A doctor was removed, not an agency.

Mr Copeland:

So no agency has ever been removed?

Mrs Way:

Not an agency. No.

The Chairperson:

Elaine, I see that you are answering a lot of the questions, but you represent only one trust. You are giving a figure which is dead-on for one trust, but we need to be sure that your figures match those of other trusts. I am conscious that Andrew is allowing Elaine to answer all the questions, and we may not be getting the full facts and figures. After this meeting concludes, could you check to see what answers come from other trusts? Some of those answers may need to be retold to us. We are only getting answers from one trust, but there are others.

Dr McCormick:

Yes, I will do that.

Mr Girvan:

In paragraph 3.1, the report refers to the fact that the trusts use both contracted-agency staff and non-contracted-agency staff. I worry about the non-contracted agencies. What mechanism is in place to ensure that the governance controls within those operations are sufficiently stringent to ensure that everything is right? How widespread is the practice of using non-contracted agencies for locums?

Dr McCormick:

Those are exceptions. Elaine gave the figures for the Western Trust earlier. We will do as the Chairman has suggested: we will look at the figures for Northern Ireland as a whole. My guess is that the number of cases in which it is necessary to use non-contracted agencies is smaller than in the Western Trust. However, I am sure that some cases of that have arisen. It requires an extra degree of care in the initiation of the contract and making sure that there is proper oversight and checking of the service provided. So it puts an extra obligation on the medical supervision and the management process to ensure that it is managed as best as possible. Elaine has some details.

Mrs Way:

We went off contract 16 times out of 151. If we have to go off contract, the director of human resources is contacted to be advised that that is the case. I spoke to the medical HR manager about how she could have confidence in an agency if it is not on contract. She said that we do not go just anywhere; we go to agencies that we have used previously and which, perhaps, did not even tender for the most recent contract. Nevertheless, relying on non-contracted agencies is something that we would keep to an absolute minimum. On the 16 times that we went off contract, we needed doctors for A&E services at the Erne Hospital.

Mr Girvan:

Andrew alluded to the mechanism that will be set up in relation to your own internal system. Hopefully, that will address the situation. Are we given assurances that that will be in place in January?

Dr McCormick:

It will be in place in February. The initial phase of work begins in February, and it is intended that it will be fully operational by September 2012. That will be a major step forward. You mentioned paragraph 3.12 and the use of non-contracted agencies. As I said earlier, the risk will

arise that there is only one possible doctor. If they are not prepared to work through the regional service or a contracted agency, we will have the same problem. We have to minimise that problem and continue to do all we can to make it even more exceptional than it is now.

Mr Girvan:

I think that this is the proverbial shot across the bows with regard to what is going on and what has, apparently, been endemic across the industry. We need to ensure that we are making proper use of public money, that it is being spent effectively and that people are not simply bartering with it and calling their own prices.

That leads me to my next point, which is mentioned in paragraph, 3.1. It has been noted that trusts have not carried out their own internal audits into these agencies. Why have they not undertaken that? It is important that the controls are put in place. How can we be sure that all the controls are there? I appreciate that you check with the GMC to ensure that someone is registered, but there could be other issues. Someone who is registered as a locum could slip through. The individual could have been having a problem in a hospital in London, and, as they cannot practise in their own hospital, decide to do exactly as John alluded to and jump across here. The doctor could live in Belfast and, as Northern Ireland is a small place, commute to any hospital in Northern Ireland. There is the potential for that to happen. Why have you not carried out an audit, and why do you not use that function, which, probably, will be there? If you are the person who is awarding the contract, you should be able to do that to ensure that they are following all precautions and to ensure that you do not end up with a guy flying in from Germany, for instance. We all know what happened. He came in and administered to a patient 10 times the amount of a drug that he should have, because the machine he was using was not the type that he was used to using. How can we be sure of the quality that we are getting?

Furthermore, when you go down the locum route, you sometimes lose the buy-in. If doctors are bought in and they are responsible for that area and that hospital, they take that as being their area. That is very important. Whereas, somebody who can fly in and fly out again has no responsibility, and they lose the link with the community that they are trying to represent. When you are doing a locum procedure, how do you ensure that it has some locality-base?

Dr McCormick:

I will take the latter point first. That is a very strong reason for seeking to bear down on the total

proportion of locum activity. That is part of where we should be going. There is a little bit of mitigation in the fact that a large proportion of locums will be providing a locum service within their own organisation, so they will have a degree of that loyalty, buy-in and personal commitment to the service. That is there in part.

On the wider issue of sourcing from outside, there is an obligation on employers within the UK to issue an alert regarding any doctor's substandard practice or performance issues, so it should not be possible to evade that alert system. That would depend more on the communication between employers, which needs to be through and complete so that we do not experience the kind of exception that was raised earlier. That fundamental check should be there for anyone working in the UK.

To come back to your first question about the audit, part of the factor is that the agencies are mainly based across the water, so for either an individual trust or for the internal audit service based in the Business Services Organisation to physically visit an organisation has not been regarded as a proportionate response to this issue. The Belfast Trust audited two of the agencies with which it has a contract, so there has been some use of that audit facility. However, it has not been regarded as the primary necessary defence in terms of securing assurance that these things are working properly.

The majority of cases will involve doctors with whom the team are quite often familiar, and therefore the judgement has consistently been that that has not been a prime area of risk. The approach we always take, both at regional level and trust by trust, is to ensure that audit resources are used according to a view of risk. This has not been the main case because there are other checks. The fundamental application of the code of practice and the use of pre-employment checks have been the main protections. The right to audit that the NIAO referred to is there as an additional safeguard. It can be used, but it has not been seen as the main way of dealing with that risk.

Mr McLaughlin:

The third section of the report deals with safeguarding the quality of care provided. Figure 7 at paragraph 3.17 of the report records the lack of information that was made available to the RQIA on the appraisal of locum doctors. We discover that information was not supplied to the RQIA by three trusts, including the Western Trust, which is represented here today. In the other two, 42%

and 43% of locum consultants were not appraised. What sanctions does the Department impose on trusts for failing to co-operate with or assist the RQIA?

Dr McCormick:
We have been pursuing the extension and fuller application of the appraisal process over the years since the guidance was issued in October 2006. Part of the issue here remains that the vast majority of these doctors are employed by one of the trusts here, and are therefore subject to appraisal within their main context. The code of practice contains guidance and requirements in relation to locums that require the appropriate transfer of information.

If someone is on a medium-term assignment as a locum, then they are appraised as such. Where they are working for shorter periods, there are different levels of information, which the report draws out, for making sure that the main employer is made aware of any issues. There are also proportionate reporting arrangements, so I think that also the situation has improved. The data in figure 7 is from 2006-07, so the position has improved significantly since that time.

Mrs Way:
May I say —

Mr McLaughlin:
Can you explain how it has improved, please?

Mrs Way:
We found it really difficult. I baulked when I saw “information not supplied”, because our style is very much one of openness and full co-operation with RQIA. The reason that the information was not supplied is that the year that RQIA looked at preceded the merger, so it was the three predecessor trusts.

In 2007, RQIA asked the three organisations for evidence of which local consultants were appraised in the previous year. I have spoken to the medical director about this, and she said that she found it very difficult to gather that information. The guidance for appraising locum consultants says that they should be appraised if they are with you for more than six months. We appraise them if they are there for three months or more, and they go into the system.

Mr McLaughlin:

Why was it so difficult?

Mrs Way:

It is quite difficult to access to records at a time of merger, change and interviews. It was the practicality of it really. For example, trying to get appraisal records for a number of locum consultants who had been employed in Sperrin Lakeland was quite difficult. I have to say that it was not just Sperrin Lakeland but Altnagelvin and Foyle. It was a practical challenge, rather than unwillingness to provide the information.

Mr McLaughlin:

I would hope so. Are medical records maintained and updated contemporaneously?

Dr McCormick:

Appraisal records?

Mr McLaughlin:

No. Do locums who are on duty treating patients record the treatment, the drugs prescribed, the responses and so on as part of the process during their shift?

Dr Woods:

In general, any medical practitioner, locum or otherwise, should record that.

Mr McLaughlin:

On computer?

Dr Woods:

It will vary from site to site depending on the availability of computerised records. There certainly should be a record, be that on paper or computer, to detail the basic facts of the encounter with the patient and what action was taken.

Mr McLaughlin:

Does that reflect not only the details of the patient but the doctor who treated that patient?

Dr Woods:

It should be signed off by the individual, ideally with their GMC number affixed.

Mr McLaughlin:

So there would be some information if we sought it.

Dr McCormick:

Record-keeping is an absolutely fundamental part of good practice.

Mr McLaughlin:

I imagine so. Would that not have been a source of the information?

Dr McCormick:

Yes, if it were possible to interrogate that information simply. However, that information would not have been translated into the kind of database of information on locum activity that we talked about earlier. That takes you into the financial system or even the main HR system. The medical record is of absolutely fundamental importance, but different systems apply here.

Mr McLaughlin:

It is probably a very extreme example, but the report mentions that some graduates decide not to take out a contract or make themselves available for a contract but offer themselves to the health service through agencies. Therefore, theoretically, it might never happen. They could travel through the health service on very short-term contracts and never be appraised in their career. They could be somewhere for, say, five months at a time and just keep moving.

Dr Woods:

Historically, that is the case. That said, I suggest that, ultimately, their CV would look rather threadbare. As Elaine has pointed out, one of the key —

Mr McLaughlin:

Who would notice?

Mrs Way:

The consultant.

Dr Woods:

One of the key elements in the appointment process is a review of the CV. Ultimately, a person's ability to construct a CV would sway the decision.

Mr McLaughlin:

Are you saying that, as part of the appraisal process, their CV would be —

Dr McCormick:

No, as part of the appointment process.

Dr Woods:

At this point and historically, a person's CV is reviewed as part of the appointment process for locums. If that were the totality of a person's practice, with the passage of time, he or she would not have a CV that would be persuasive to any clinician. The likelihood of that person being turned down for appointment becomes higher than the likelihood of appointment.

As we go forward with revalidation, the need for an appraisal becomes absolute. Appraisal is the key building block of the revalidation process. If the person is not in a position to provide a series of appraisals, not just one in a blue moon, his or her presence on the medical register becomes an issue.

Mr McLaughlin:

In 2008, we had a suggestion that RQIA should look at the records for the financial year 2006-07. RQIA conducted that exercise in August 2008. Three out of the five trusts could not supply it with the information. It was trying to help the trusts with the appraisal process. The other two trusts indicated that 42% of locums in one case and 43% in the other case had not been appraised. We should all be concerned about the quality of appraisal conducted across the trusts and the level of co-operation with RQIA in carrying out its function.

Ms Taylor:

The trusts were reminded about their responsibilities in relation to a lot of the pre-employment checks and appraisal, etc, by the Department and asked for responses on that. There has been a lot of work since 2008 and since the merger of the organisations. Appraisal for locum doctors is

now coming in closer to 80%, and it will have to improve again before revalidation begins. That is expected in late 2012. It will need to be in place for all locum doctors by then.

Mr McLaughlin:

That is very reassuring information. Can we have a copy of that? Are those stats part of the review? It indicates that somebody is bearing down on that aspect. Congratulations.

Dr McCormick:

Yes, we have that.

Mr McLaughlin:

According to RQIA, the 2010 review found that trusts had neglected to request appraisal information or exit reports from previous employers prior to their offering work to locum doctors. Has that also been addressed?

Ms Taylor:

It is covered in the letter —

Mr McLaughlin:

But this is very recent: it is the 2010 report.

Ms Taylor:

Yes, my letter was written in the past month, and I have got responses in. It is very current information.

Mr McLaughlin:

That is excellent. Does your work indicate why that problem emerged? You would have thought that that would have been a fairly fundamental prerequisite — in fact, an absolute imperative — for trusts before they could hire anyone. I am glad to hear that there has been an improvement, but do we know why?

Ms Taylor:

It provides assurances. No, it does not indicate why there were discrepancies in the past.

Mr McLaughlin:

In your experience, do you have an explanation as to why trusts were not doing that?

Dr McCormick:

One factor was that most of the locums were well known and were internal workers.

Mr McLaughlin:

I suspect that people know who they are dealing with.

Dr McCormick:

I want to make sure that we follow the procedures carefully, thoughtfully and proportionally. I do not think that it was —

Mr McLaughlin:

It is a relatively small market. Does that explain why some locums seemed to be able to avoid the appraisal process? Was it because people knew them?

Dr McCormick:

But that would mean that while they might not be subject to appraisal in their locum capacity they may have been appraised in their main capacity — their substantive posts. That may have been the case, although I am surmising there. However, it is recognising that the vast majority of those people are in the system, known to the system and subject to the main governance and oversight that applies. Again, I undertake that we pursue systematic record-keeping with regard to that issue, because that provides additional assurance to management and, hence, to the Committee.

Mr McLaughlin:

My final point relates to the point that I made earlier. Paragraph 3.23 indicates that trusts found it difficult to monitor the hours worked by internal locums against the limits set out in the European working time directive. In theory, a lot of exhausted and very tired doctors, having done a full day's work in one hospital, which is, I think, 13 hours in any 24-hour period —

Mrs Way:

It is 11 hours.

Mr McLaughlin:

They could, in fact, go to another hospital after a very exhausting shift. I am more interested in the cumulative effect of working to the outer limits of the directive and providing external locum support. Does the current situation reflect an improvement in that ability to track how many hours are worked? Do doctors sign into the computer system with their own dedicated pass code and sign out when they finish a shift? In the event of a complaint or incident in which responsibility has to be established, how do we manage the boundary between a doctor coming off shift and another doctor coming on? If we can do that, surely we can monitor how many hours a doctor has worked.

Ms Taylor:

I will take that in two parts. That is exactly what the electronic roster system that I talked about earlier, the Zircadian system, is intended to do for those doctors who are in rota.

Mr McLaughlin:

Which the Western Trust does not have.

Ms Taylor:

The Western Trust has a very good system in place. It can report back just as well as, or better than, some of the electronic systems. That is why it is considering whether it needs the other system. Regardless of whether a rota is compliant, the system is intended to indicate the number of shifts worked.

Your other point related to an internal doctor employed in the system doing locum work outside of their rota. If a doctor is going to another organisation, it is his responsibility to indicate whether he will exceed the European working time directive.

Mr McLaughlin:

Is that sufficient? Does that avoid the problem? I suspect that it does not. It is down to the individual doctor —

Ms Taylor:

There is an opt-out facility for that doctor, if they want to undertake it. If it is the tiredness aspect that you are getting at and the quality of care that might be provided, the individual responsibility

rests with the doctor.

Mr McLaughlin:

I will briefly come on to the point about why we have two systems. If we have systems, at this stage, that can record how long a doctor who is a contracted employee is on station, why can that not be made available to a hospital at which that same individual may turn up as an external locum? What is the problem? He is going to be paid. He will go onto the payroll, albeit under different conditions, but it is the same person, same work number and same registration number. That would indicate, in terms of safety, not only the hours worked in any particular work week, but, perhaps, the number of hours accumulated going back a month or two just to provide absolute assurance. Do our systems not give us that protection? Do we not share that information between our various hospitals?

Ms Taylor:

I do not know the level of sophistication of the system. I would need to write to you to tell you whether that is a possibility.

Mr McLaughlin:

I would appreciate that; it would be helpful. It is a very small region. Is there not a single procurement process that gives us a uniform system? Would that not be less expensive than going to two different suppliers for two different systems?

Dr McCormick:

Four trusts are using the same system, and one has a manual system. The Western Trust did not need to procure an electronic system. Its manual system has been allowed to develop in quite a sophisticated way. That is natural behaviour in a management organisation. The question for the Western Trust would be whether it would get additional value from investing in the electronic system. That is a matter for it to consider. Going forward, our emphasis is increasingly on regional procurement and commonality of systems, so that there is a coherence of our information across Northern Ireland. That is the right way to go. It would then allow, if that platform was there —

Mr McLaughlin:

If you, Elaine, or some of your clinical directors or commissioning agents were considering an

appointment of an external locum, would it not be very helpful to know just how many hours that individual locum had worked in some other hospital before they were —

Mrs Way:

It would be helpful. As you asked your question, I thought whether there was any possibility that we could be accused of breaching confidentiality between employers. I do not know the answer to that, but, undoubtedly, any employer who wants a locum to come in would want to know that that locum had not been working —

Mr McLaughlin:

Is that an example of a silo mentality? You mentioned different employers; we are talking about the health service. We are talking about a very small system and about trusts co-operating with one other. We are certainly talking about locums being able to travel around them. We are supposed to check that they have the necessary experience and qualifications, and we can share that data. If they have worked too many hours, we should be telling them that it is time that they went home and had a rest, in the interests of patient safety.

Mrs Way:

The Western Trust is passionate about the regional proposal for the very reason that you have described. It is one health and social care system, and we should all help one another out.

Mr McLaughlin:

The right hand should know what the left hand is doing.

Mr Girvan:

As Mitchel has said, the trusts do not communicate with one other. Someone could work all day in the Mater Hospital in the Belfast Trust as a locum registered with one of the agencies and could get a call that asks them whether they are free to work that evening. They could say yes, finish in the Mater Hospital at 5.00 pm and start in Antrim at 7.00 pm.

Mr McLaughlin:

He could turn up at the Mater Hospital the next morning at 9.00 am.

Mr Girvan:

That is the point; they could work in two trusts. The lack of communication in the whole organisation could very much create that problem. Rather than each in their own silo, there will be cross-filtration, and it needs to be policed. I do not buy in to the ethics argument that it is up to the individual. Irrespective of what anyone says, there will be those who are greedy enough — I am not saying that they are all like this — to take it if it is offered to them. That is exactly what will happen, and you could then have a problem. If an accident happens, who is liable? The doctor, yes, because of his insurance and whatever liabilities he has, but the hospital will get a bad name.

Mrs Way:

That is right. And us, as well. If damage is done, we have to pay compensation.

Mr Girvan:

We are there to protect everybody. That loop has to be closed, because there is room for abuse. I am not saying that there has been abuse; I am saying that, if there is an opportunity for abuse, it will be abused.

Mr McLaughlin:

There should be a single information management system.

Dr McCormick:

The case for that is very clear and very strong. A supplementary point about doctors turning up at different hospitals is that people talk to one another. Every individual in the team has the right to ask what someone was doing last night; they have the opportunity to challenge and ask what is going on. That is part of how clinical governance needs to work. We need to encourage every member of the team to ask reasonable questions.

Mr McLaughlin:

In fairness, the report acknowledges that there is sometimes very intense pressure on the ward. If someone goes off duty unexpectedly, you need to have someone in. You do not have time to have those kinds of conversations; you need to be able to look at the information on a screen and arrange safe cover.

Dr McCormick:

I take the point.

The Chairperson:

Maybe we should get a tachograph for doctors. *[Laughter.]*

Mr Dallat:

I am sure that people are glad that we are getting near the end. My daughter arrived in Paris at midnight to find that her onward flight was cancelled.

Mr McLaughlin:

Is she a doctor?

Mr Dallat:

No; she is a teacher. I am coming to that. They were offered a minibus if they could find a driver. During the course of the journey, they discovered that the driver was a surgeon who was going to do a full day's work after driving the whole night. I am sure that these things are not peculiar to Northern Ireland.

Today, I have heard very frank evidence. We will get a very good report out of it. I commend the witnesses for being very honest and very frank in the answers that they have given.

How do you propose to design an appraisal and revalidation system for locums that is both effective and practical? We need to hear that for the record, because some PAC in the future will come back and interrogate witnesses, saying "Well, did you implement it? How did it work?"

Dr Woods:

Ultimately, it is for the regulator to specify the requirements for revalidation. That has evolved over the past few years and is not absolutely crystallised at this point. An appraisal process will be a critical element of it.

As has been said on numerous occasions this afternoon, the estimates are that the vast majority — 80% to 90% — of doctors who work as locums have a day job, for want of a better term; there is an issue with that. It is largely for the organisations for which they work on a day-to-day basis

to establish the structures and processes, built largely around appraisal, to provide them with the information that they will ultimately offer to the GMC to seek revalidation and secure their licences.

They have to cover all of their practice, not just the practice for which they are paid out of the public purse. It must be the totality of their practice, whether they work as locums within the publicly funded healthcare sector or the private healthcare sector, as doctors for sports teams or associations, or whatever. It must be information that describes the type of work that they do in its totality. Information that indicates how well they are performing at the job that they do must be provided, again in its totality, whether that work is totally within the public sector, a mixture of public and private, or, indeed, public, private and voluntary, in some instances.

That all presents quite a difficulty for someone who works exclusively as a locum. With the introduction of revalidation, increased emphasis will be put on finding ways of using the organisations for which locums work to get information that can be brought to an appraisal so that someone can make an assessment of how good they are on an ongoing basis. It will not be just a one-point assessment at the end of five years. The GMC will expect an ongoing, at least annual, process in which individuals such as me provide information about the work we do and how well we do it. Someone has to have looked critically at that assessment to ensure that the description, evidence and information that they bring to indicate that they are doing the job, or range of jobs, that they do to a level that will satisfy the regulator. That is the process in outline.

It is accepted that there are difficulties, certainly for people who work exclusively as locums. We do not anticipate it being a significant difficulty for the vast majority of doctors who work largely in the public sector. They, of course, will have to bring information to their employer's appraisal that describes, and provides supporting information for, the work that they do outside the province of their employer.

Mr Dallat:

I listened very carefully to that and agree with every word, particularly the last part. There should be some responsibility on locums to keep their own log books up to date. Airline pilots and other people have to do it, and it is important.

The case studies on page 34 and so on are a reminder of how things can go horribly wrong.

Do patients suffer — that may be an emotive word — disproportionately at the hands of locum doctors? What steps can you take to ensure that information and data is freely available so that people base their judgements on reality rather than speculation or sensation, as sometimes happens when the media gets a particular story?

Dr McCormick:
I want to give a very clear assurance that there is no evidence that points to a disproportionate degree of risk to patient safety arising from the employment of locums. It does not follow, and there is no reason to believe that.

The principles of governance are applied as rigorously to the work of locum doctors as to that of any other doctors. I am sure that, partly as a result of this hearing, there will be further and heavier attention, because organisations are aware of their responsibilities and the statutory obligation that the legislation places on them as suppliers of services to provide high-quality, safe services. That goes right through the way everyone thinks about their responsibilities. We talk about that regularly in the meetings I have with Elaine and her colleagues in the context of annual and mid-year reviews of how our work is progressing. Right up front is that obligation.

Case studies are drawn out in the report but there is no reason whatsoever to believe that there will be more incidents or cases of concern arising from locums. Each of those was a real case, with real issues to follow up. We believe that we have a good learning process so that when issues arise, we take full account of them and there is a proportionate response in terms of dealing with individuals where individual responsibility is identified. The more challenging thing is when a systemic issue needs to be addressed in an organisation, and we have to look at that very carefully. So I think I can give that assurance.

The Chairperson:
You will be glad to hear that that was the last of the questions today. It has been a lengthy enough session, and an interesting one. We have asked for other information, and we may ask for other stuff from you after we confer. I appreciate that. This is a very important issue, hence the time given to it today. We appreciate all the work that everybody does in the health sector. That has to be put out. However, we have to ask questions and go through this to ensure that there is value for money. When you leave things open and people can barter for their salaries, that can be open to a wee bit of discrepancy, so we need to challenge that as well. Thank you again.