

Public Accounts Committee

Report on the Use of Locum Doctors by Northern Ireland Hospitals

**Together with the Minutes of Proceedings of the Committee
Relating to the Report and the Minutes of Evidence**

**Ordered by The Public Accounts Committee to be printed on 15 February 2012
Report: NIA 37/11-15 Public Accounts Committee**

**REPORT EMBARGOED UNTIL
00:01am on 7 March 2012**

Membership and Powers

The Public Accounts Committee is a Standing Committee established in accordance with Standing Orders under Section 60(3) of the Northern Ireland Act 1998. It is the statutory function of the Public Accounts Committee to consider the accounts, and reports on accounts laid before the Assembly.

The Public Accounts Committee is appointed under Assembly Standing Order No. 56 of the Standing Orders for the Northern Ireland Assembly. It has the power to send for persons, papers and records and to report from time to time. Neither the Chairperson nor Deputy Chairperson of the Committee shall be a member of the same political party as the Minister of Finance and Personnel or of any junior minister appointed to the Department of Finance and Personnel.

The Committee has 11 members including a Chairperson and Deputy Chairperson and a quorum of 5.

The membership of the Committee since 23 May 2011 has been as follows:

Mr Paul Maskey (Chairperson)
Mr Joe Byrne (Deputy Chairperson)
Mr Sydney Anderson
Mr Michael Copeland
Mr John Dallat
Mr Alex Easton
Mr Paul Girvan
Mr Ross Hussey
Mr Mitchel McLaughlin
Mr Adrian McQuillan ¹
Mr Conor Murphy ²

1 With effect from 24 October 2011 Mr Adrian McQuillan replaced Mr Paul Frew

2 With effect from 23 January 2012 Mr Conor Murphy replaced Ms Jennifer McCann

Table of Contents

List of Abbreviations used in the Report	iv
Report	
Executive Summary	1
Summary of Recommendations	4
Introduction	6
Trusts need to develop a better understanding of their requirements for locum doctors	8
Control over the costs of using locum doctors must be improved	10
Action is needed to minimise the risks to patient safety when using locum doctors	11
Appendix 1	
Minutes of Proceedings	17
Appendix 2	
Minutes of Evidence	29
Appendix 3	
Correspondence	69
Appendix 4	
List of Witnesses	105

List of Abbreviations used in the Report

C&AG	Comptroller and Auditor General
the Committee	Public Accounts Committee
DHSSPS/the Department	Department of Health, Social Services and Public Safety
DFP	Department of Finance and Personnel
EWTD	European Working Time Directive
RMMLS	Regionally Managed Medical Locum Service

Executive Summary

Introduction

1. Locum doctors are employed across the Health Service to meet fluctuations in activity levels and to cover vacancies or short-term absences of medical staff. Trusts obtain locums both from within their own substantive staff and from private agencies. Properly managed, locums play an important role in helping hospitals achieve flexibility. Excessive use can be costly, particularly in the case of the Western Trust which is heavily reliant on agency locums, and can have a negative impact on patient care and satisfaction.
2. In recent years the demand for locum doctors has risen due to workforce issues such as increased difficulty in filling vacancies and the impact of European legislation governing working hours. In the four-year period to March 2011 almost 8 per cent of Trusts' overall medical staffing expenditure related to locums. Payments to external recruitment agencies for locums totalled £74 million while payments to substantive staff working over and above their contracted hours (internal locums) totalled just over £35 million.

Overall Conclusions

3. The Committee's overall conclusion is that Trusts need better information on the use and costs of locum doctors – particularly on locums drawn from existing staff. With better information, Trusts could improve their workforce planning and use locums more cost effectively. For example, the Department estimates that savings of £1 million may be achieved through greater use of internal cover instead of approaching agencies where the rates charged can be substantially higher.
4. The Committee also considers that Trusts need to get better at managing the potential risks to patient safety of using locum doctors. They need to be more consistent in the way they screen and induct locums and the way they manage their performance. In the Committee's view, one failure to rigorously follow procedures is one failure too many. In particular, the Committee was very concerned that compliance with the controls for sharing information about poorly performing doctors between Trusts has not been sufficient to allow a hospital, intending to engage a locum, to make an informed decision as to whether it is appropriate to employ the doctor concerned or not.

Trusts need to develop a better understanding of their requirements for locum doctors

5. For a planned, flexible workforce strategy to be successful, Trusts need to improve their understanding of the use of locum doctors through greater use of data and better demand forecasting.
6. The Committee finds it disturbing that Trusts do not have management information on the use and costs of internal locums ready to hand. While information is available in relation to the use of agency locums, Trusts are unable to easily extract information relating to the use of internal locums. In the Committee's view, the current inability to extract basic information is totally unacceptable because it limits the extent to which Trusts can manage the use of locums, demonstrate efficiency or benchmark, either locally or against other regions.
7. The Committee notes the Department's intention to pilot a Regionally Managed Medical Locum Service (RMMLS) in April 2012, which will address the deficiencies in the capture of information in relation to internal locums. Roll-out across the Trusts will be dependent on the results of the pilot.

8. The latest workforce planning document published by the Department was insufficiently detailed to enable effective deployment of resources. If the allocation of resources is to be fully effective, future reviews need to include a full breakdown (at specialty level) of the number of staff required, their training needs and the needs of patients.

Control over the costs of using locum doctors must be improved

9. The Committee has concerns that private sector recruitment agencies may be holding Trusts over a barrel and creaming off substantial profits at the taxpayer's expense by dictating inflated rates of pay for covering shifts. Moreover, the Committee is aghast at 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.
10. Where Trusts have difficulty securing cover for gaps in rotas, external agencies and individual doctors find themselves in a position where they can "barter" for rates of pay substantially higher than would be paid to substantive staff. The Committee considers that this situation is unacceptable. The Department's view is that, if introduced, the RMMLS will improve the position by offering greater opportunity to systematise and organise staffing.
11. The Committee welcomes the various actions which the Department is taking to "bear down on costs" and notes the Department's estimate that introduction of the RMMLS may initially generate savings of £1 million each year. The Committee considers that the Department should undertake some work to estimate the expected level of savings to be generated from each of the other planned initiatives. The Committee recommends that the Department establish the Regionally Managed Medical Locum Service as a matter of urgency and expects that the Department provide a progress report on what has been achieved by September 2012.

Action is needed to minimise the risks to patient safety when using locum doctors

12. Trusts are responsible for ensuring that the risks involved in appointing locum doctors are minimised. However, arrangements for pre-employment checks are not always formalised and there is a risk that checks may not be completed at all times. Trusts need to make sure that their appointment checks are thorough and rigorous to ensure that a complete consecutive picture of performance is established before appointing a locum.
13. The introduction of the European Working Time Directive (EWTd) acknowledged the need for doctors to take sufficient rest periods to protect their health and safety. Adherence to the requirements of the EWTd also protects patients by ensuring that, for example, doctors providing treatment or care are not overtired.
14. The Committee was surprised to learn that the Department does not consider that it, or health and social care providers in general, have a responsibility for monitoring individual doctor compliance with the conditions of the EWTd. While the Committee appreciates that the arrangements in Northern Ireland mirror those in place elsewhere in the United Kingdom, it considers that the arrangements in place whereby Trusts rely solely on doctors to self-police their compliance with the EWTd is flawed. The Committee expects health and social providers to take a more active role in view of their statutory duty of care to patients.

15. Trusts unable to fill doctor shortages by using contracted agencies or internal locums, face the difficult choice of using staff supplied by non-contracted agencies or suspending services. Contracted agencies are required to undertake stringent compliance vetting procedures when submitting doctors for locum positions. The Committee considers that the use of non-contracted agencies creates additional risks to patient safety and was shocked to discover the extent to which some Trusts (the Southern Trust) are reliant on such provision. The use of non-contracted agencies should be sanctioned only in exceptional circumstances and with the greatest care taken to ensure that the risk to patients is minimised.
16. Information relating to poorly performing doctors must be widely circulated across the health and social care sector so that a receiving employer can contact a former employer about a particular locum to ascertain the details of any concerns which may exist so that they can make a decision as to whether they feel it appropriate to employ that individual.
17. Given that the use of locums can create patient safety risks, the Committee was surprised that the Department does not monitor the number of adverse incidents involving locums and compare this against the numbers involving substantive staff members. The Committee considers that the Department should begin recording relevant information in this area so that it can demonstrate whether additional harm is caused to patients as a result of employing locums.

Summary of Recommendations

Recommendation 1

1. The Committee recommends that each Trust, in agreement with the Department, determines the optimal split between permanent staff and locums and benchmarks actual locum use against this each year. Adherence to the optimal split offers the potential for Trusts to generate financial savings.

Recommendation 2

2. In the absence of basic management information, Trusts are not well positioned to manage their use of locums effectively. While the Committee welcomes the Department's assurances that the new Regionally Managed Medical Locum Service (RMMLS) will address the current deficiencies in management information and will allow increased use of substantive staff to cover vacancies, it is concerned that the plans surrounding its implementation are beginning to slip. The Committee recommends that, as a matter of urgency, Trusts implement actions to capture basic information on all locum episodes in order to improve their ability to manage and oversee the use of locums.

Recommendation 3

3. The Committee recommends that all future workforce planning exercises must include a detailed analysis of demand and activity levels by medical speciality in order to reduce the need for unplanned locum appointments.

Recommendation 4

4. The Committee notes that the Department has produced a formal estimate of the savings it expects to achieve through implementation of the Regionally Managed Medical Locum Service. The Committee recommends that the Department establish the service as a matter of urgency and expects that the Department provide a progress report on what has been achieved by September 2012.

Recommendation 5

5. The Committee welcomes the Department's acceptance of the need for stringent controls in the appointment of locums. The Committee recommends that the Department should issue immediately to Trusts the planned reminder about complying fully with the relevant checks prior to appointing a locum doctor. In addition, the Committee recommends that Trusts should also develop a monitoring schedule which will allow them to identify the level of compliance with the controls in place for locum appointments and to take action where deficiencies are identified.

Recommendation 6

6. In the Committee's view, given the risk to patient safety, it is not sufficient for Trusts to rely on doctors to verify their compliance with the EWTD. In order to protect the interests of patients, the Committee recommends that the Department ensures Trusts have effective arrangements in place for monitoring the total number of hours worked by each doctor, whether in substantive employment or working as a locum. In addition, this process should measure not only hours worked but that rest breaks are being achieved, and/or adequate compensatory rest provided.

Recommendation 7

7. The use of "off-contract" agencies creates additional patient safety risks. The Committee recommends that the use of such agencies must be limited to exceptional circumstances only and that, where they are used, Trusts must put procedures in place to ensure that the performance of such agencies at least matches the service standards and prices available from contracted agencies.

Recommendation 8

8. The Committee recommends that the Department examines the extent of compliance with the controls in place within Trusts for logging concerns about the performance of locum doctors.

Recommendation 9

9. The Committee recommends that, in future, all adverse incident reports concerning a doctor's performance should specify the nature of the doctor's employment. This information should then be used to monitor the number of adverse incidents which involve locum doctors and to compare this figure against adverse incidents involving doctors in substantive posts.

Introduction

10. The Public Accounts Committee (the Committee) met on 7 December 2011 to consider the Comptroller and Auditor General's report "*The Use of Locum Doctors in Northern Ireland Hospitals*". The main witnesses were:
 - **Dr Andrew McCormick**, Accounting Officer, Department of Health, Social Services and Public Safety;
 - **Dr Paddy Woods**, Deputy Chief Medical Officer, Department of Health, Social Services and Public Safety;
 - **Ms Diane Taylor**, Director of Human Resources, Department of Health, Social Services and Public Safety;
 - **Mrs Elaine Way**, Chief Executive, Western Health and Social Care Trust;
 - **Mr Kieran Donnelly**, Comptroller and Auditor General; and
 - **Ms Fiona Hamill**, Treasury Officer of Accounts.
11. Northern Ireland hospitals provide a wide-ranging programme of care to patients. Some hospitals operate 24 hours each day, 365 days a year while others provide care within specified periods. Hospitals are only able to maintain crucial services where they ensure that appropriate numbers of doctors are available to cover every shift.
12. Increasingly, hospitals are finding it difficult to ensure that the optimal number of doctors is available to cover shifts at all times. In recent years, an increasing number of doctors have elected to work fewer hours, reflecting broader community preferences for balancing work and private life. In addition, new immigration laws have led to a decline in the number of international medical graduates, and the European Working Time Directive (EWTD) has introduced restrictions on the number of hours doctors can work.
13. Where a hospital has an insufficient numbers of substantive doctors available to provide the required services, it has three options as follows:
 - a. pay existing staff (known as *internal locums*) to cover the additional hours;
 - b. recruit additional (*temporary*) staff if the post is to last several months;or, where (a) and (b) are not feasible or successful;
 - c. approach an external agency to provide staff (*agency locums*).Managed use of locum doctors allows hospitals to respond to varying activity levels and to cover short-term absences or vacancies.
14. If none of the options outlined above are successful, and the demand for clinical services outstrips hospital workforce supply, key services may have to be withdrawn.
15. In the four years to March 2011, Trusts spent over £100 million providing locum cover for doctor shortages in hospitals. Staffing is a particularly challenging issue for the Western Trust where locum costs in 2010-11 represented nearly 17 per cent of the overall cost of employing doctors.
16. Trusts must take steps to safeguard the quality of patient care by reducing the clinical risks associated with using locum doctors who may be unfamiliar with their colleagues, their surroundings, the patients under their care or with procedures and practice local to the Trust in question.

17. In taking evidence, the Committee focused on three key areas, as follows:
- The extent to which Trusts understand their requirements for locum doctors;
 - The extent to which the costs of using locum doctors are controlled; and
 - The extent to which the risks to patient safety are minimised when using locum doctors.

Trusts need to develop a better understanding of their requirements for locum doctors

There will always be a need for hospitals to use locums to sustain service provision, but Trusts should determine the optimal level of locum use and measure compliance against this level each year

18. Delivering patient outcomes while maintaining quality and making efficiencies will not always be possible using the substantive workforce. Since 2007-08, the level of locum expenditure compared to payments to permanent doctors across Trusts has varied considerably. Costs in the Belfast and South Eastern Trust have remained relatively static at around 5 per cent; costs in the Southern Trust were higher at an average of around nine per cent. Costs in the Northern Trust have been significantly higher peaking at almost 16 per cent in 2008-09. Within the Western Trust, the percentage spend on locums has risen sharply since 2008-09 and by 2010-11 stood at around 17 per cent.
19. The Committee appreciates the difficulties faced by Trusts in recruiting sufficient staff in some specialities and grades and agrees that locums are an essential part of providing quality care. For a planned, flexible workforce strategy to be successful Trusts need to improve their understanding of the temporary use of locum doctors through greater use of data and better demand forecasting. Carefully identifying service activity and demand will help Trusts to predict where and when the need for locums will occur, allowing shifts to be filled with flexible use of substantive doctors. Better use of substantive staff will allow Trusts to begin to develop their own optimal locum doctor ratio, based on the needs and requirements particular to themselves.

Recommendation 1

20. **The Committee recommends that each Trust, in agreement with the Department, determines the optimal split between permanent staff and locums and benchmarks actual locum use against this each year. Adherence to the optimal split offers the potential for Trusts to generate financial savings.**

The limited management information available on the extent and cost of using internal locums makes it difficult for Trusts to verify that locum use is managed effectively

21. The Committee finds it disturbing that Trusts do not have management information on the use and costs of internal locums ready to hand. While information is available in relation to the use of agency locums, Trusts are unable to easily extract information relating to the use of internal locums. In the Committee's view, the current inability to extract basic information is totally unacceptable because it limits the extent to which Trusts can manage the use of locums, demonstrate efficiency or benchmark, either locally or against other regions.
22. During the session, the Department told the Committee that, in February 2012, it planned to commence operational work on the establishment of an internal pool of locum doctors — the Regionally Managed Medical Locum Service (RMMLS). The Department considers that the RMMLS will address the current deficiencies in the information available on internal locum use and provide a valuable source of information with which to support monitoring, review of locum activity and workforce planning. Additionally, it expects that use of the RMMLS will generate efficiencies by maximising the extent to which substantive doctors are used to cover vacancies.

23. The Committee was dismayed to learn, from correspondence the Department submitted following the evidence session, that the implementation timescale for the RMMLS has been revised. The Department is not intending to pilot the service until the beginning of April 2012. The subsequent rollout of the system across the Trusts will be subject to the results of this pilot exercise.

Recommendation 2

24. **In the absence of basic management information, Trusts are not well positioned to manage their use of locums effectively. While the Committee welcomes the Department's assurances that the new Regionally Managed Medical Locum Service (RMMLS) will address the current deficiencies in management information and will allow increased use of substantive staff to cover vacancies, it is concerned that the plans surrounding its implementation are beginning to slip. The Committee recommends that, as a matter of urgency, Trusts implement actions to capture basic information on all locum episodes in order to improve their ability to manage and oversee the use of locums.**

Comprehensive workforce planning would assist in predicting resourcing difficulties

25. Workforce planning assists organisations identify trends and anticipate shortfalls in staffing levels. Medical workforce planning is a complex process and involves co-operation across several organisations. Effective medical workforce planning enables organisations to balance the availability of suitably qualified medical staff against patients' needs.
26. The Department is aware of the need for good, strategic-level workforce planning at all levels within the sector and told the Committee that the recent Compton review of health and social care¹ was highly relevant to departmental thinking about how it deploys its total workforce. The Department also referred to the fact that at Queen's University Belfast, the medical school intake had been increased from 154 to 250 in 2005 and that this is now beginning to show in the rising number of junior doctors within the workforce.
27. The latest workforce planning document was published in the absence of completed specialty planning and therefore did not include a complete breakdown (at specialty level) of the number of staff required, their training needs or the needs of patients. In the Committee's view, to be fully effective, workforce planning must drill down to specialty level. With advance planning, specific gaps in staffing levels and training can be identified upstream and planned for.

Recommendation 3

28. **The Committee recommends that all future workforce planning exercises shall include a detailed analysis of demand and activity levels by medical specialty in order to reduce the need for unplanned locum appointments.**

1 Transforming your Care: A review of health and social care in Northern Ireland, DHSSPS, December 2011

Control over the costs of using locum doctors must be improved

Trusts must be in a position to quantify their success in bearing down on costs

29. When a vacancy arises, Trusts will firstly try to employ an internal locum. Where this is not successful, Trusts will turn to established contracts, where locum agencies provide the required staff at predetermined rates. Where this is also unsuccessful, Trusts face a situation where they must either suspend a service or pay inflated sums to engage a locum. Substantive staff are not only relatively inexpensive in comparison to locums provided by agencies but also provide the greatest continuity of care to patients.
30. In light of the significant workforce shortfalls in some specialties, the Committee has concerns that private sector recruitment agencies can hold Trusts over a barrel in hiring locums to plug gaps: they can dictate the rates paid for locums and cream off substantial profits at the taxpayer's expense. Further, the Committee notes that doctors employed within Trusts, when asked to cover an additional shift for rates in line with their standard salary rates, will sometimes "barter" with Trusts for rates more in line with agencies.
31. The C&AG's report showed that agency locums are generally paid higher rates than internal locums, and the Committee was astounded to hear evidence of one particular instance where a locum doctor was paid almost three times more than a permanent doctor. In the Committee's view this is difficult to justify. The Department told the Committee that it anticipates that future costs will be better controlled by the combined impact of a reconfiguration of services, the availability of greater numbers of medical graduates and (depending on the results of the pilot) the introduction of the new RMMLS which will function essentially as an agency providing internal locums.
32. The Committee acknowledges that the introduction of the RMMLS should help Trusts by using permanent staff to manage changes in activity, fill gaps and maintain services when demand is high. Following the evidence session, the Department calculated that, if implemented, the RMMLS could initially generate savings of £1 million per annum by improving control and increasing the negotiating power of Trusts.

Recommendation 4

33. **The Committee notes that the Department has produced a formal estimate of the savings it expects to achieve through implementation of the Regionally Managed Medical Locum Service. The Committee recommends that the Department establish the service as a matter of urgency and expects that the Department provide a progress report on what has been achieved by September 2012.**

Action is needed to minimise the risks to patient safety when using locum doctors

Pre-employment checks must always be completed and evidenced prior to offering a locum appointment, and appraisals should be completed for each locum episode

34. Prior to offering a locum position, Trusts are responsible for establishing that individual doctors have the requisite qualifications and experience to undertake the work, are not subject to any reservations about their work in previous employments and have been subject to a health assessment. In practice, where external recruitment agencies provide locums, they undertake these pre-employment checks on behalf of the Trust.
35. The C&AG's report and evidence given to the Committee indicates that Trusts consistently need to demonstrate that the credentials of each locum doctor are confirmed before any offer of employment is made. The Committee welcomes assurances from the Western Trust that it has procedures in place to verify that individuals are, in fact, qualified doctors and notes the on-going work within the Belfast Trust to verify that contracted agencies fully comply with the terms and conditions of their contracts. The Committee expects the Department to seek assurances from all Trusts that pre-employment checks are effective.
36. The Department acknowledged that there was a need to remind every organisation of the importance of collecting and retaining evidence that the requisite checks have been undertaken prior to offering locum appointments. As part of that, the Committee welcomes the fact that the Department is currently consulting with its counterparts elsewhere in the UK, on the options for developing a joined-up approach to regulating external recruitment agencies supplying medical locums.

Recommendation 5

37. **The Committee welcomes the Department's acceptance of the need for stringent controls in the appointment of locums. The Committee recommends that the Department issue immediately to Trusts the planned reminder about complying fully with the relevant checks prior to appointing a locum doctor. In addition, the Committee recommends that Trusts develop a monitoring schedule which will allow them to identify the level of compliance with the controls in place for locum appointments and to take action where deficiencies are identified.**

The Department must accept responsibility for monitoring compliance with the European Working Time Directive

38. The European Working Time Directive (EWTd) was introduced in Northern Ireland in 1998 to protect the health and safety of workers by introducing minimum rules for rest periods, leave entitlements, length of working week and night work. Failure to comply with the EWTd can create risks to patient safety where, for example, doctors who are tired are providing treatment or care.
39. There are no systems or safeguards in place to enable a Trust to know whether a locum doctor has exceeded the safe level of hours set under the EWTd. Like the NHS in England, Scotland and Wales, Trusts rely instead on professional self-regulation by doctors. The Committee considers that this issue is too important to be left to a system of self-policing by doctors, given the potential risks to patient safety if doctors are working when tired as a

result of working too many hours. As individual doctors can work, quite legitimately, across more than one Trust, the Committee considers that information on the total number of hours worked by each doctor should be collated centrally and shared across the entire health sector.

Recommendation 6

40. **In the Committee's view, given the risk to patient safety, it is not sufficient for Trusts to rely solely on doctors to verify their compliance with the EWTD. In order to protect the interests of patients, the Committee recommends that the Department ensures Trusts have effective arrangements in place for monitoring the total number of hours worked by each doctor, whether in substantive employment or working as a locum. In addition, this process should measure not only hours worked but that rest breaks are being achieved, and/or adequate compensatory rest provided.**

The additional risk created by using non-contracted agencies to provide locum staff must be realistically assessed by Trusts prior to any decision to appoint a locum

41. Each of the Trusts across Northern Ireland has contracts in place with external agencies for the supply of locum doctors. Individual contracts outline the agreed rates of pay and specify various conditions, such as the requirement for external agencies to confirm the qualifications etc of staff provided. Such conditions provide a degree of assurance over the likely quality of care which will be provided by doctors supplied by these agencies.
42. The Department told the Committee that, on occasion, some Trusts can experience difficulty in obtaining staff cover from internal locums or contracted agencies. In these circumstances individual Trusts will seek locum cover from agencies, other than those contracted, in order to provide staff to maintain services. The Committee was astounded to discover from information provided by the Department following the evidence session that the practice of using non-contracted staff was far from being an exception to normal practice. In particular, in the last two years, a significant proportion (74 percent and 87 per cent respectively) of Southern Health and Social Care Trust expenditure on agency locums was paid for locums provided by non-contracted agencies.

Recommendation 7

43. **The use of "off-contract" agencies creates additional patient safety risks. The Committee recommends that the use of such agencies must be limited to exceptional circumstances only and that, where they are used, Trusts must put procedures in place to ensure that the performance of such agencies at least matches the service standards and prices available from contracted agencies.**

All health and social care providers must be fully informed where a problem is identified with the work of a doctor

44. Within the United Kingdom public health sector, an alert system operates, which requires employing Trusts to report any allegations or concerns made against employees. The Department told the Committee that in the case of locums, quite often an investigation will not have been completed before the individual concerned may seek further locum work. The aim of the alert system is to ensure that the receiving employer can contact the former employer to ascertain the details of any concerns which may exist so that they can make a decision as to whether they feel it appropriate to employ that individual.

45. The Committee is aware of a recent case where a doctor, albeit in a substantive post, left one Trust under a cloud and took up employment with another Trust without disclosure of the incident. The Committee acknowledges that there are procedures in place to ensure that Trusts are fully informed about allegations or concerns involving prospective employees but notes that in this case, something clearly went wrong. It is unacceptable that, where concerns are raised within one Trust about the performance of a locum, there is the possibility that the individual can take up employment in another Trust or specialty. The Department acknowledges that, in this case, its alert system was not sufficient to prevent the doctor taking up another position.

Recommendation 8

46. **The Committee recommends that the Department insists on full compliance with the controls in place within Trusts for logging concerns about the performance of locum doctors.**

The use of locums can create additional risks to patient safety, and it is therefore important for the Department to monitor the extent to which locum appointments result in injury to patients

47. For various reasons, the use of locum doctors in hospitals can create additional risks to patient safety. Controls such as undertaking pre-employment checks, completing appraisals for individual locum episodes, sharing information on locum performance and ensuring compliance with the EWTD, collectively contribute to reducing these risks.
48. Where risks to patient safety are not effectively mitigated, there is potential for negligence and injury to patients. While details of adverse incidents (and near misses) are recorded and reviewed, the records maintained do not consistently record whether the employee involved was permanently employed or was acting as a locum.
49. The Department told the Committee that there is no evidence which points to a disproportionate degree of risk to patient safety arising from the employment of locums. While the Committee acknowledges the assurances provided by the Department, in its view, to be fully transparent, it is necessary to monitor the number of incidents which relate to locum employment.

Recommendation 9

50. **The Committee recommends that, in future, all adverse incident reports concerning a doctor's performance should specify the nature of the doctor's employment. This information should then be used to monitor the number of adverse incidents which involve locum doctors and to compare against adverse incidents involving doctors in substantive posts.**



Northern Ireland
Assembly

Appendix 1

Minutes of Proceedings

Wednesday, 23 November 2011

Room 29, Parliament Buildings

Present: Mr Paul Maskey MP (Chairperson)
Mr Joe Byrne (Deputy Chairperson)
Mr Sydney Anderson
Mr Michael Copeland
Mr John Dallat
Mr Alex Easton
Mr Paul Girvan
Mr Ross Hussey
Mr Mitchel McLaughlin
Mr Adrian McQuillan

In Attendance: Miss Aoibhinn Treanor (Assembly Clerk)
Mr Phil Pateman (Assistant Assembly Clerk)
Mr Danielle Saunders (Clerical Supervisor)
Mr Darren Weir (Clerical Officer)

Apologies: Ms Jennifer McCann

2:00pm The meeting opened in public session.

2:13pm Mr McQuillan entered the meeting.

2:05pm Mr Copeland and Mr Girvan entered the meeting.

4. **Briefing on NIAO report 'The Use of Locum Doctors by NI Hospitals'**

2:06pm Mr Easton declared an interest stating that he is currently the Assembly Parliamentary Secretary for the Department of Health, Social Services and Public Safety; and further in this role has undertaken recent work on the use of locum doctors; and therefore should withdraw from participating in this inquiry.

2:07pm Mr Easton left the meeting.

2:09pm Mr Hussey entered the meeting

2:10pm Mr Anderson entered the meeting.

2:13pm The meeting went into closed session after the C&AG's initial remarks.

Mr Kieran Donnelly, Comptroller and Auditor General; Mr Sean McKay, Director; and Ms Claire Dornan, Audit Manager; briefed the Committee on the report.

2:48pm Mr Hussey left the meeting.

2:53pm Mr Hussey entered the meeting.

The witnesses answered a number of questions put by members.

[EXTRACT]

Wednesday, 7 December 2011

The Senate Chamber, Parliament Buildings

Present: Mr Paul Maskey MP (Chairperson)
Mr Sydney Anderson
Mr Michael Copeland
Mr John Dallat
Mr Paul Girvan
Mr Ross Hussey
Mr Mitchel McLaughlin

In Attendance: Mr John Simmons (Assembly Clerk)
Mr Phil Pateman (Assistant Assembly Clerk)
Mrs Danielle Saunders (Clerical Supervisor)
Mr Darren Weir (Clerical Officer)

Apologies: Mr Joe Byrne (Deputy Chairperson)
Mr Alex Easton
Ms Jennifer McCann
Mr Adrian McQuillan

2:03pm The meeting opened in public session.

4. **Evidence on the Northern Ireland Audit Office Report ‘The Use of Locum Doctors in NI Hospitals’.**

The Chairperson reminded Members that Mr Alex Easton had excluded himself from participating in the Committee’s inquiry as he was the Assembly Parliamentary Secretary for the Department of Health, Social Service and Public Safety.

The Committee took oral evidence on the above report from:

- Dr Andrew McCormick, Accounting Officer, Department of Health, Social Services and Public Safety (DHSSPS);
- Dr Paddy Woods, Deputy Chief Medical Officer, Department of Health, Social Services and Public Safety (DHSSPS);
- Ms Diane Taylor, Director of Human Resources, Department of Health, Social Services and Public Safety (DHSSPS); and
- Ms Elaine Way, Chief Executive, Western Health and Social Care Trust.

2:19pm Mr Girvan entered the meeting.

2:33pm Mr Copeland left the meeting.

2:34pm Mr Copeland entered the meeting.

2:49pm Mr Dallat left the meeting.

2:54pm Mr Dallat entered the meeting.

3:40pm Mr Copeland left the meeting.

3:45pm Mr Copeland entered the meeting.

3:45pm Mr Girvan left the meeting

2:19pm Mr Girvan entered the meeting.

3:52pm Mr Frew and McCann left the meeting.

4:04pm Mr Hussey left the meeting.

4:08pm Mr Hussey entered the meeting.

4:30pm Mr Copeland left the meeting.

4:32pm Mr Dallat left the meeting.

4:35pm Mr Dallat entered the meeting.

4:43pm Mr Copeland entered the meeting.

4:44pm Mr Anderson left the meeting.

4:46pm Mr Anderson entered the meeting.

The witnesses answered a number of questions put by the Committee.

Agreed: The Committee agreed to request further information from the witnesses.

[EXTRACT]

Wednesday, 14 December 2011

Room 29, Parliament Buildings

Present: Mr Paul Maskey MP (Chairperson)
Mr Sydney Anderson
Mr Michael Copeland
Mr Alex Easton
Mr Ross Hussey
Ms Jennifer McCann
Mr Mitchel McLaughlin
Mr Adrian McQuillan

In Attendance: Miss Aoibhinn Treanor (Assembly Clerk)
Mr Phil Pateman (Assistant Assembly Clerk)
Mr Danielle Saunders (Clerical Supervisor)
Mr Darren Weir (Clerical Officer)

Apologies: Mr Joe Byrne (Deputy Chairperson)
Mr John Dallat
Mr Paul Girvan

2:04pm The meeting opened in public session.

2:06pm Mr Hussey entered the meeting.

2:14pm Mr Anderson entered the meeting.

2:40pm The meeting went into closed session.

2:40pm Mr Easton declared an interest stating that he is the Assembly Private Secretary for the Department of Health, Social Services and Public Safety and that he will exclude himself from participating in the Committee's Inquiry.

2:40pm Mr Easton left the meeting.

5. Issues arising from the Oral Evidence Session on NIAO Report 'The Use of Locum Doctors by NI Hospitals'

The Committee considered an issues paper on this evidence session.

Agreed: The Committee agreed to request some additional information from the Department of Health, Social Services and Public Safety.

[EXTRACT]

Wednesday, 11 January 2012

Room 29, Parliament Buildings

Present: Mr Joe Byrne (Deputy Chairperson)
Mr Sydney Anderson
Mr Michael Copeland
Mr John Dallat
Mr Alex Easton
Mr Paul Girvan
Mr Ross Hussey
Mr Mitchel McLaughlin

In Attendance: Miss Aoibhinn Treanor (Assembly Clerk)
Mr Phil Pateman (Assistant Assembly Clerk)
Mrs Danielle Saunders (Clerical Supervisor)
Mr Darren Weir (Clerical Officer)

Apologies: Mr Paul Maskey MP (Chairperson)
Ms Jennifer McCann
Mr Adrian McQuillan

2:01pm The meeting opened in public session.

3. Matters Arising

2:22pm Mr Easton declared an interest stating that he is the Assembly Private Secretary for the Department of Health, Social Services and Public Safety.

Correspondence from Department of Health, Social Services and Public Safety

The Committee noted correspondence from Dr Andrew McCormick, Accounting Officer, DHSSPS requesting an extension to the deadline to the information sought by the Committee following its evidence session on 14 December 2011.

[EXTRACT]

Wednesday, 25 January 2012

Room 29, Parliament Buildings

Present: Mr Paul Maskey MP (Chairperson)
Mr Joe Byrne (Deputy Chairperson)
Mr Sydney Anderson
Mr Michael Copeland
Mr John Dallat
Mr Alex Easton
Mr Paul Girvan
Mr Mitchel McLaughlin
Mr Adrian McQuillan
Mr Conor Murphy

In Attendance: Miss Aoibhinn Treanor (Assembly Clerk)
Mr Phil Pateman (Assistant Assembly Clerk)
Mrs Danielle Saunders (Clerical Supervisor)
Mr Darren Weir (Clerical Officer)
Ms Angela Kelly (Assembly Legal Services)

Apologies: Mr Ross Hussey

2:02pm The meeting opened in public session.

7. **Consideration of draft Committee Report on ‘The Use of Locum Doctors by Northern Ireland Hospitals’**

4:36pm Mr Easton declared an interest stating that he is the Assembly Private Secretary for the Department of Health, Social Services and Public Safety.

Mr Easton left the meeting.

The Committee considered its draft report on ‘The Use of Locum, Doctors by Northern Ireland Hospitals’.

Paragraphs 10 - 19 read and agreed.

Paragraph 20 read, amended and agreed.

Paragraphs 21 – 22 read and agreed.

Paragraph 23 read, amended and agreed.

Paragraphs 24 – 26 read and agreed.

Paragraph 27 read, amended and agreed.

Paragraphs 28 – 29 read and agreed.

Paragraphs 30 – 31 deferred for further consideration.

Paragraphs 32 – 34 read and agreed.

Paragraph 35 read, amended and agreed.

Paragraph 36 read and agreed.

Paragraph 37 read, amended and agreed.

4:47pm Mr Anderson left the meeting.

Paragraphs 38 – 40 read and agreed.

Paragraph 41 deferred for further consideration.

Paragraphs 42 – 43 read and agreed.

Paragraph 44 read, amended and agreed.

Paragraphs 45 – 47 read and agreed.

Paragraph 48 deferred for further consideration.

[EXTRACT]

Wednesday, 15 February 2012

Room 29, Parliament Buildings

Present: Mr Paul Maskey MP MLA (Chairperson)
Mr Joe Byrne (Deputy Chairperson)
Mr Sydney Anderson
Mr Michael Copeland
Mr John Dallat
Mr Alex Easton
Mr Paul Girvan
Mr Mitchel McLaughlin
Mr Conor Murphy

In Attendance: Miss Aoibhinn Treanor (Assembly Clerk)
Mr Phil Pateman (Assistant Assembly Clerk)
Mrs Danielle Saunders (Clerical Supervisor)
Mr Darren Weir (Clerical Officer)

Apologies: Mr Ross Hussey
Mr Adrian McQuillan

2:00pm The meeting opened in public session.

2:21pm Mr Easton left the meeting.

2:29pm The meeting went into closed session.

2:31pm Mr Easton entered the meeting.

3:00pm Mr Easton declared an interest stating that he is the Assembly Private Secretary for the Department of Health, Social Services and Public Safety.

3:01pm Mr Easton left the meeting.

3:02pm Mr Anderson left the meeting.

3:07pm Mr Anderson entered the meeting.

6. Consideration of Draft Committee Report on 'The Use of Locum Doctors by Northern Ireland Hospitals'

The Committee considered the second draft of its report on 'The Use of Locum Doctors by Northern Ireland Hospitals'

Paragraphs 22 – 23 read and agreed.

Paragraph 24 read, amended and agreed.

Paragraph 31 read and agreed.

Paragraph 32 read, amended and agreed.

Paragraph 33 read, amended and agreed.

Paragraph 35 read, amended and agreed.

Paragraphs 42 – 43 read and agreed.

Consideration of the Executive Summary

Paragraph 1 – 17 read and agreed.

Agreed: The Committee agreed the correspondence to be included within the report.

Agreed: The Committee ordered the report to be printed.

3:25pm Mr Murphy left the meeting

[EXTRACT]



Northern Ireland
Assembly

Appendix 2

Minutes of Evidence

7 December 2011

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	<i>Department of Health, Social Services and Public Safety</i>
Ms Diane Taylor	<i>Department of Health, Social Services and Public Safety</i>
Dr Paddy Woods	<i>Department of Health, Social Services and Public Safety</i>
Mrs Elaine Way	<i>Western Health and Social Care Trust</i>

Also in attendance:

Mr Kieran Donnelly	<i>Comptroller and Auditor General</i>
Ms Fiona Hamill	<i>Treasury Officer of Accounts</i>

1. **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?
2. 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.
3. 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.
4. **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.

5. **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.
6. 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.
7. **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.
8. 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.
9. 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.
10. 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.
11. 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.
12. **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.
13. **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.
14. 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.

15. 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.
16. **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?
17. **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.
18. 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.
19. **The Chairperson:** You say that some assistance will be in place next year to tackle those issues.
20. **Dr McCormick:** The additional junior doctors.
21. **The Chairperson:** Why were they not in place this year or last year?
22. **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.
23. **The Chairperson:** Were there loads applying for medical school? Were there not people coming out of medical school all along?
24. **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.
25. 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.
26. 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.
27. **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.
28. 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.
29. **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.
30. 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 —
31. **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?
32. **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?
33. **The Chairperson:** Yes, let us bring Elaine in, and then I will let John in.
34. **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.
35. **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?
36. **Ms Diane Taylor (Department of Health, Social Services and Public Safety):** That doctor is not a locum doctor; he is a doctor in training.
37. **Mr Dallat:** It is all about information, Diane.
38. **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.
39. **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?
40. **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.
41. **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.
42. **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.
43. **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.
44. **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.
45. **Dr McCormick:** The information should have been —
46. **The Chairperson:** I want to bring in other members. There are three supplementary questions to that question.
47. **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?
48. **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 —
49. **Mr Copeland:** If a doctor is employed internally and works extra hours, what is the difference between being a locum and being on overtime?
50. **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.
51. **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?

52. **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 —
53. **Mr Copeland:** I do not doubt that they are complex. The question is whether they need to be complex.
54. **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.
55. **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?
56. **Mrs Way:** Yes, it is legal, Chairman. Dr McCormick said —
57. **The Chairperson:** Is it morally correct?
58. **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.
59. 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.
60. **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.
61. **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.
62. 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?
63. 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.”
64. 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.
65. 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.

66. **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?
67. **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.
68. **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.
69. **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.
70. **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?
71. **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.
72. **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.
73. 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.
74. **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.
75. **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?
76. 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?
77. **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.
78. **Mr Copeland:** I was not asking that.
79. **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.
80. **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.
81. 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.
82. 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?
83. **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.
84. 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.
85. **Mr Copeland:** This is the Public Accounts Committee. The crunch in the question was how much money you expect to save.
86. **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.
87. **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.
88. **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.
89. **Mr Copeland:** He did not know.
90. **The Chairperson:** Will you supply that to Committee when you find that out?
91. **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.
92. **The Chairperson:** I thought you mentioned a figure of £29 million, whereas the actual figure is £22.5 million.

93. **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.
94. **The Chairperson:** We are asking you if we can have the savings.
95. **Dr McCormick:** We will do our best to come up with that.
96. **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?
97. **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 —
98. **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.
99. **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.
100. 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.
101. 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.
102. 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.
103. **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?
104. **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 —
105. **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.
106. **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.
107. **Mr McLaughlin:** Is that generally true throughout the health service, not just here in the North? Is this best practice?
108. **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.
109. 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.
110. **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.
111. **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.
112. 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?
113. 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.
114. **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.
115. **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?
116. **Dr McCormick:** That absolutely should not happen.
117. **Mr Girvan:** I know that it should not.
118. **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.
119. **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.
120. **Dr McCormick:** Thank you.
121. **Mr Copeland:** It is a fairly simple way of doing it.
122. 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?
123. **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.
124. 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.
125. 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.
126. **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.
127. 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.
128. 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.
129. **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?
130. **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%.
131. 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.
132. **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?
133. **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.
134. **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?
135. **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.
136. **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?
137. **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.
138. **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.
139. **Mrs Way:** Yes.
140. **Mr Copeland:** Thank you very much for your patience.
141. **Mr McLaughlin:** I do not know whether I should ask Michael to answer my questions.
142. 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?
143. **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.
144. 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.
145. 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.
146. 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.
147. 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.
148. **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?
149. **Dr McCormick:** The numbers vary. The Western Trust has contracts with 18 different locum agencies.
150. **Mr McLaughlin:** For locum doctors?
151. **Dr McCormick:** For doctors, yes.
152. **Mr McLaughlin:** Not for nurses or —
153. **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.
154. **Mr McLaughlin:** Do they deal with different specialties? What is the explanation for dealing with so many agencies?
155. **Mrs Way:** Doctors want to live in Belfast.
156. **Mr McLaughlin:** No, sorry. What is the explanation for using 18 agencies?
157. **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.
158. **Mr McLaughlin:** To help me understand this, did they have to compete with each other to get on the list?
159. **Mrs Way:** Yes, they did.
160. **Mr McLaughlin:** They provided prices for the supply of doctors, and you ended up with 18 agencies on the list?
161. **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.
162. **Mr McLaughlin:** That is what I am asking. Some of the agencies are identified by the specialties that they can offer?
163. **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.
164. **Mr McLaughlin:** Up to now, has each trust operated independently on the procurement of locum services?
165. **Mrs Way:** I cannot speak for other trusts.
166. **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.
167. **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.
168. **Mrs Way:** Not in Northern Ireland; there are 18 across the UK.

169. **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.
170. **Mrs Way:** Yes, that is true.
171. **Mr McLaughlin:** I need time to recover from that. I find that astonishing. I need a doctor. *[Laughter.]*
172. **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.
173. **Mr McLaughlin:** Andrew, is the regional strategy that we are talking about the Department's response to those anomalies?
174. **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.
175. **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?
176. **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.
177. 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.
178. 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.
179. **Mr McLaughlin:** Thanks for that; you anticipated my next question.
180. **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.
181. **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.
182. **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.
183. 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.
184. 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.
185. **The Chairperson:** The answers need to be a wee bit shorter, Andrew. Does that satisfy you, Ross?
186. **Mr Hussey:** Yes.
187. **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?
188. **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.
189. **Mr Girvan:** That is correct; or past.
190. **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.
191. **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.
192. 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.
193. **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?
194. **Dr McCormick:** It is not only possible; it happens, frankly and truly.
195. **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?
196. **Mrs Way:** Yes we do.
197. **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?
198. **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 —
199. **Mr Copeland:** Think or know?
200. **Mrs Way:** Sorry?
201. **Mr Copeland:** Think or know?
202. **Mrs Way:** Think or know what?
203. **Mr Copeland:** Whether they have radiologists.
204. **Mrs Way:** They will know. I personally would not know which of the 18 agencies had radiologists.
205. **Mr Copeland:** I mean the person who is securing the services on your behalf.
206. **Mrs Way:** They would know.
207. **Mr Copeland:** So, they would know that, if they phoned a specific agency, they would possibly have a radiologist available.
208. **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.
209. **Mr Copeland:** Would you ever find the same doctor registered at two different agencies at £50 an hour and £45 an hour?
210. **Mrs Way:** You would not get that in two agencies. One doctor would not put themselves forward for one job through two agencies.
211. **Mr Copeland:** I am giving in; it is too complex.

212. **The Chairperson:** Go ahead, Sydney, very briefly.
213. **Mr S Anderson:** Are you letting me in?
214. **The Chairperson:** Yes, you asked nicely.
215. **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?
216. **Mrs Way:** Some of them might be.
217. **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?
218. **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.
219. 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.
220. **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.
221. 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?
222. **Mrs Way:** I do not have specific figures —
223. **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.
224. **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.
225. **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.
226. **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?
227. **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 —
228. **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?
229. **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.
230. **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?
231. **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.
232. **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.
233. 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?
234. **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 —
235. **Mr McLaughlin:** Instead of an internal market, they are outbidding you?
236. **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.
237. **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.
238. **Mr McLaughlin:** That should have started. If I were going for a regional strategy, I would have started that work.
239. **The Chairperson:** The Department sets an approved rate, but it is obviously not being adhered to. What is that approved rate?
240. **Ms Taylor:** We can share the circular with the Committee.
241. **The Chairperson:** OK. Sometimes, it is two or three times whatever the cost is. I appreciate that.
242. **Mr Hussey:** Do you pay the agency or the doctor?
243. **Mrs Way:** The agency.
244. **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.
245. 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.
246. **Mr McLaughlin:** You get to talk to each other. *[Laughter.]*
247. **Mr Hussey:** Or talk about each other.
248. 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?
249. **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.
250. **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?
251. **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.
252. **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?
253. **Mrs Way:** It requires them to tick it; it is a yes or no.
254. 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.
255. **Mr Hussey:** Obviously, that applies to the west. What is it like —
256. **Dr McCormick:** It is my understanding that the other four trusts have electronic rostering in place.
257. **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.
258. **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.
259. **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.
260. **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.
261. 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?
262. **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.
263. 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.
264. **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?
265. **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.
266. **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.
267. **The Chairperson:** Go raibh maith agat, Ross.
268. **Mr Hussey:** I will try to spell that later.
269. **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.
270. **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.
271. **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.
272. **Mr S Anderson:** I am pleased to hear that it is making inroads to prevent the likes of that happening.
273. 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?
274. **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.
275. **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.
276. 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.
277. **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?
278. **Dr Woods:** There are still issues to be addressed.
279. **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?
280. **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.
281. **Mr S Anderson:** Do you see that joined up approach that we keep talking about

- happening in the near future, rather than in the distant future?
282. **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.
283. **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.
284. **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.
285. **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?
286. **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.
287. **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.
288. **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.
289. **Mr Hussey:** If you need a doctor tomorrow, you will not have time to check GMC registration, will you?
290. **Mrs Way:** We will. It is all online.
291. **Dr McCormick:** Can I just clarify —
292. **The Chairperson:** John, have you finished?
293. **Mr Dallat:** No. Having employed the doctor and checked out his credentials, who assesses that doctor's competence to do the job?

294. **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.
295. **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.
296. **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.
297. 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.
298. **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?
299. **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.
300. **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?
301. **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.
302. **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?
303. **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.
304. **The Chairperson:** That is a different matter to the inquiry that we are working on today.
305. **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.

306. **Mrs Way:** The permanent secretary will probably sack me when I go out, but I will be bold —
307. **Mr Dallat:** Let him, it is worthwhile.
[Laughter.]
308. **The Chairperson:** You need to keep this brief.
309. **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.
310. **Mr Dallat:** You have every right to be.
311. **Mrs Way:** You will not sack me, will you?
312. **Dr McCormick:** Not for that; no way.
313. **The Chairperson:** Do not celebrate just yet; you have another lot of questions to go through.
314. **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?
315. **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.
316. **Mr S Anderson:** Does that come to the agency?
317. **Mrs Way:** Yes, and, under contract, it has to —
318. **Mr S Anderson:** It has to sign that extra declaration?
319. **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.
320. 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.
321. **Mr S Anderson:** Who is “we”?
322. **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 —
323. **Mr S Anderson:** How long does it take to do that? Not long?
324. **Mrs Way:** Not long.
325. **Mr S Anderson:** OK. Thank you.
326. **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?
327. **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.
328. **Mr Copeland:** Have any of those agencies been removed from your list?
329. **Mrs Way:** Not since October 2010. No.
330. **Mr Copeland:** But one was removed?
331. **Mrs Way:** A doctor was removed, not an agency.
332. **Mr Copeland:** So no agency has ever been removed?
333. **Mrs Way:** Not an agency. No.
334. **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.
335. **Dr McCormick:** Yes, I will do that.
336. **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?
337. **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.
338. **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.
339. **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?
340. **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.
341. **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.
342. 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?
343. 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?
344. **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.
345. 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 thorough 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.
346. 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.
347. 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.
348. **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?
349. **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.
350. 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.
351. **Mrs Way:** May I say —
352. **Mr McLaughlin:** Can you explain how it has improved, please?
353. **Mrs Way:** We found it really difficult. I balked 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.
354. 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.
355. **Mr McLaughlin:** Why was it so difficult?
356. **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.
357. **Mr McLaughlin:** I would hope so. Are medical records maintained and updated contemporaneously?
358. **Dr McCormick:** Appraisal records?
359. **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?
360. **Dr Woods:** In general, any medical practitioner, locum or otherwise, should record that.
361. **Mr McLaughlin:** On computer?
362. **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.
363. **Mr McLaughlin:** Does that reflect not only the details of the patient but the doctor who treated that patient?
364. **Dr Woods:** It should be signed off by the individual, ideally with their GMC number affixed.
365. **Mr McLaughlin:** So there would be some information if we sought it.
366. **Dr McCormick:** Record-keeping is an absolutely fundamental part of good practice.
367. **Mr McLaughlin:** I imagine so. Would that not have been a source of the information?
368. **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.
369. **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.
370. **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 —
371. **Mr McLaughlin:** Who would notice?
372. **Mrs Way:** The consultant.
373. **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.
374. **Mr McLaughlin:** Are you saying that, as part of the appraisal process, their CV would be —
375. **Dr McCormick:** No, as part of the appointment process.
376. **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.
377. 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.
378. **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.
379. **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.
380. **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.
381. **Dr McCormick:** Yes, we have that.
382. **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?
383. **Ms Taylor:** It is covered in the letter —
384. **Mr McLaughlin:** But this is very recent: it is the 2010 report.
385. **Ms Taylor:** Yes, my letter was written in the past month, and I have got responses in. It is very current information.
386. **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?
387. **Ms Taylor:** It provides assurances. No, it does not indicate why there were discrepancies in the past.
388. **Mr McLaughlin:** In your experience, do you have an explanation as to why trusts were not doing that?
389. **Dr McCormick:** One factor was that most of the locums were well known and were internal workers.
390. **Mr McLaughlin:** I suspect that people know who they are dealing with.
391. **Dr McCormick:** I want to make sure that we follow the procedures carefully, thoughtfully and proportionally. I do not think that it was —
392. **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?
393. **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.
394. **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 —
395. **Mrs Way:** It is 11 hours.
396. **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.

397. **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.
398. **Mr McLaughlin:** Which the Western Trust does not have.
399. **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.
400. 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.
401. **Mr McLaughlin:** Is that sufficient? Does that avoid the problem? I suspect that it does not. It is down to the individual doctor —
402. **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.
403. **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?
404. **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.
405. **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?
406. **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 —
407. **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 —
408. **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 —
409. **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.
410. **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.
411. **Mr McLaughlin:** The right hand should know what the left hand is doing.
412. **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.
413. **Mr McLaughlin:** He could turn up at the Mater Hospital the next morning at 9.00 am.
414. **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.
415. **Mrs Way:** That is right. And us, as well. If damage is done, we have to pay compensation.
416. **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.
417. **Mr McLaughlin:** There should be a single information management system.
418. **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.
419. **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.
420. **Dr McCormick:** I take the point.
421. **The Chairperson:** Maybe we should get a tachograph for doctors. *[Laughter.]*
422. **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.
423. **Mr McLaughlin:** Is she a doctor?
424. **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.

425. 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.
426. 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?”
427. **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.
428. 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.
429. 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.
430. 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.
431. 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.
432. **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.
433. 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?
434. **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.

of discrepancy, so we need to challenge that as well. Thank you again.

435. 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.

436. 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.

437. **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



Northern Ireland
Assembly

Appendix 3

Correspondence

Chairperson's letter of 16 December 2011 to Dr Andrew McCormick

Public Accounts Committee

Dr Andrew McCormick
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16 December 2011

Dear Andrew,

Public Accounts Committee Evidence Session on the Use of Locum Doctors by NI Hospitals

Thank you for your participation in the Committee's evidence session in this inquiry.

As the Committee agreed I would be grateful if you could provide the following information.

- 1) A breakdown by hospital of the usage of locum doctors within each of the Health and Social Care Trusts.
- 2) An estimate of the savings that will be achieved following the implementation of the regionally managed medical locum service.
- 3) Confirmation as to whether any doctors or officials currently employed by the Trusts or the Department hold a directorship or have any ownership of any of the contracted or non-contracted agencies who provide locum services.
- 4) A copy of the HR circular, as referred to at the session, which confirms the detail of the approved rate for the provision of locum doctors.
- 5) For each hospital in each Trust, the number of cases in which locum services have been obtained by engaging with a non-contracted agency.
- 6) An overview of the audit findings conducted on behalf of the Belfast Health and Social Care Trust by the Business Services Organisation (BSO).
- 7) Confirmation as to whether the tendering process for locum agencies for each Trust was conducted in conjunction with the Central Procurement Directorate and a copy of the contract specification used.
- 8) Confirmation of whether the agency contracts provide claw-back arrangements for the eventuality of failure to supply locums.

I would appreciate your response by 6 January 2012.

Yours sincerely,



Paul Maskey MP MLA
Chairperson
Public Accounts Committee

Correspondence of 22 December 2011 from Dr Andrew McCormick

From the Permanent Secretary
and HSC Chief Executive

Dr Andrew McCormick

Paul Maskey MP MLA
Chairperson
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**Sláinte, Seirbhísí Sóisialta
agus Sábhálteachta Poiblí**

MÁNNYSTRE O

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Our Ref: AMCC 3215
SECCOR/332/2011
DH3-11-4986

Date: 22 December 2011

Dear Paul,

Public Accounts Committee Evidence Session on the Use of Locum Doctors by NI Hospitals

Further to your letter dated 16 December 2011 requesting additional information following the evidence session held on 7 December 2011 on "The Use of Locum Doctors by NI Hospitals".

The department is currently working with its colleagues in the health and social care sector to provide the information as requested. However, given the detailed nature of some of the information requested, particularly the breakdown by hospital of locum usage and your request regarding the ownership of locum agencies, I am requesting an extension of the deadline for response to 20 January 2012.

I will of course endeavour to provide the information earlier than this if possible.

Yours sincerely

Andrew McCormick

ANDREW McCORMICK

Correspondence of 20 January 2012 from Dr Andrew McCormick

From the Permanent Secretary
and HSC Chief Executive



Dr Andrew McCormick

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Our Ref: AMCC 3271
SECCOR/332/2011
DH3-11-4986

Date: 20 January 2012

Dear Paul,

Public Accounts Committee Evidence Session on the Use of Locum Doctors by NI Hospitals

Further to your letter dated 16 December 2011 please find attached a part response to the additional information requested.

The information required to address points 3 and 5 is taking some time to pull together but is expected to be collated by next week. My officials have agreed with the Committee clerk that we would respond by 20 January on those points for which we have all the information requested.

I apologise for any delay and will follow up this response with the outstanding information as soon as possible.

Yours sincerely

Andrew McCormick

ANDREW McCORMICK

1) A breakdown by hospital of the usage of locum doctors within each of the Health and Social Care Trusts.

Hospital	2009/10			2010/11		
	Agency Locums	Directly employed Locums	Total Locums	Agency Locums	Directly employed Locums	Total Locums
	£m	£m	£m	£m	£m	£m
Southern HSC Trust						
Craigavon Area	1.0	1.3	2.3	1.6	0.3	1.9
Daisy Hill	1.1	0.7	1.8	1.5	0.6	2.1
St Luke's	0.0	0.1	0.1	0.0	0.0	0.0
Community Medical/ Other	0.2	0.4	0.6	0.1	0.3	0.4
SHSCT Total	2.4	2.5	4.9	3.2	1.2	4.4
Western HSC Trust						
Altnagelvin Hospital	1.4	0.9	2.3	3.1	0.4	3.5
Erne Hospital	2.3	0.9	3.2	3.3	0.5	3.8
Tyrone County Hospital	0.1	0.0	0.1	0.2	0.1	0.3
Lakeview Hospital	0.1	0.0	0.1	0.1	0.0	0.1
Gransha/ T & F Hospital	0.4	0.0	0.4	0.7	0.1	0.8
Other: Community Services	0.8	0.1	0.9	0.5	0.0	0.5
WHSCCT Total	5.1	1.9	7.0	7.9	1.1	9.0
Belfast HSC Trust						
Royal Victoria	2.4	0.7	3.1	2.5	0.7	3.2
Belfast City	1.5	0.5	2.0	1.3	0.3	1.6
Greenpark	1.3	0.4	1.7	1.3	0.2	1.5
Community	0.0	0.3	0.3	0.0	0.2	0.2
Mater	0.3	0.7	1.0	0.5	0.4	0.9
BHSCT Total	5.5	2.6	8.1	5.6	1.8	7.4
South Eastern HSC Trust						
Ulster	1.2	0.1	1.3	1.0	0.2	1.2
Lagan Valley	0.4	0.2	0.6	0.3	0.2	0.5
Downe	0.6	0.2	0.8	0.5	0.1	0.6
SEHSCT Total	2.2	0.5	2.7	1.8	0.5	2.3
Northern HSC Trust						
Antrim	2.1	1.7	3.8	1.6	0.9	2.5

Hospital	2009/10			2010/11		
	Agency Locums	Directly employed Locums	Total Locums	Agency Locums	Directly employed Locums	Total Locums
	£m	£m	£m	£m	£m	£m
Causeway	2.3	0.2	2.5	1.8	0.7	2.5
Hollywell	0.3	0.0	0.3	0.5	0.0	0.5
Mid Ulster	0.5	0.7	1.2	0.1	0.4	0.5
Moyle	0.1	0.0	0.1	0.0	0.0	0.0
Whiteabbey	0.1	0.1	0.2	0.0	0.0	0.0
NHSCT Total	5.4	2.7	8.1	4.0	2.0	6.0

Note: Figures may not add due to roundings

2) An estimate of the savings that will be achieved following the implementation of the regionally managed medical locum service.

The Regionally Managed Medical Locum Service (RMMLS) Project represents a collective effort by Trusts within HSCNI to more effectively manage expenditure associated with the use of locum doctors in Northern Ireland.

In the short term the immediate action was to establish a regional database to record the details of locum doctors, pre-employment checks, shifts worked, any identified performance issues etc. One of the key benefits of this approach was to broaden the pool of locums that all Trusts have available to them, and therefore increase the likelihood of filling the post from within the HSC. Additionally, the regional database provides the opportunity to centrally record all requests for HSC locum bookings, providing a valuable source of information to support monitoring, review of patterns of locum activity, inform workforce planning etc.

The development of the central registration database has commenced along with the associated business process. The original aim was to pilot the system with the February 2012 rotation of junior doctors. Unfortunately, there was some delay to commencing the system development until such times as the revenue funding for the project could be secured. Current planning is to pilot the system at the beginning of April 2012 with the subsequent rollout subject to the results of the pilot.

In the medium term opportunities exist through this project to utilise the regional database as a tool to support the management of locums on a regional basis i.e. the sourcing and placing of locum doctors via a shared service.

In the longer term this project also provides a vehicle to support the processes associated with the management of revalidation of medical locums and the discharging of the Responsible Officer function for locum doctors who are not employed on a full-time basis by a Trust i.e. career locums.

The projected savings have been calculated based on experience of a similar scheme in England, but recognising the full cost reduction is subject to project scope being extended to include those locum doctors who provide services via a locum agency (i.e. career locums). In Northern Ireland we are focussing, in the first instance, on those locums who also hold substantive posts in the HSC. On this basis the projected savings are £1m per annum. The savings are both direct and indirect. Directly savings will be derived from a reduction in locum related expenditure. Indirectly savings will be derived from reducing the manual effort and paper based processes associated with securing locum shift coverage.

Whilst the majority of locum activity is undertaken by those locums who also hold substantive HSC posts, there is, and will continue to be, a need to utilise locum agencies for those 'hard to fill' posts i.e. for some particular specialities where there is a shortage of expertise. In such cases the rates of pay can on occasions be significantly above those rates that would be paid to an HSC locum. The projected savings profile reflects the fact that maximum savings will not be realised by the project until such times as all locums are registered with the central registration system.

3) Confirmation as to whether any doctors or officials currently employed by the Trusts or the Department hold a directorship or have any ownership of any of the contracted or non-contracted agencies who provide locum services.

Information to follow

4) A copy of the HR circular, as referred to at the session, which confirms the detail of the approved rate for the provision of locum doctors.

A copy of circular HSC (TC8) 3/2011 entitled "Pay and Conditions of Service: Remuneration of Hospital Medical and Dental Staff, Doctors and Dentists in Public Health and the Community Health Service, and Dentists in the Community Dental Service and Salaried Personal Dental Service" is attached as requested.

Locum tenens appointments are covered at Annex A: Section 7 of the circular.



HSC (TC8) 3 2011
Pay and Condi...

Details on remuneration for locum consultants can be found at Schedule 22 of the Consultant Terms and Conditions of Service (NI) 2004 which can be accessed at www.dhsspsni.gov.uk/consultants-terms-conditions-of-service-revised-may-2008.pdf.

5) For each hospital in each Trust, the number of cases in which locum services have been obtained by engaging with a non-contracted agency.

Information to follow

6) An overview of the audit findings conducted on behalf of the Belfast Health and Social Care Trust by the Business Services Organisation (BSO).

The Belfast HSC Trust has undertaken the audits of agencies with which they have contracts. They adopted a dual approach which has involved visiting the offices of Direct Medics which is based in Belfast and for those agencies based outside Northern Ireland they have undertaken a mail based audit.

The Trusts Human Resources Workforce Governance Team visited Direct Medics in November 2011. They reviewed the files and information held on a sample of agency workers who were currently placed with the Belfast Trust to ensure that the terms of the contract were being adhered to. The audit identified no areas of concern and the Trust staff who conducted the audit were impressed by the standard of records retained by the agency.

The audit of the other non-NI based agencies which is being carried out at a distance is not quite complete. Three audits have been completed and the remaining four are ongoing. In a situation where the external agencies fails to comply with the Trust request for information, the Trust will advise them that failure to do so may result in them being taken off the contract. However, at this stage there are no concerns regarding the agencies.

Overall, the Belfast Trusts view would be that the audits have confirmed that the agencies are complying with the requirements of their contracts.

7) Confirmation as to whether the tendering process for locum agencies for each Trust was conducted in conjunction with the Central Procurement Directorate and a copy of the contract specification used.

The tendering process was undertaken by HSC Business Services Organisation Procurement and Logistics Service (PaLs) who are the Centre of Procurement Excellence responsible for Goods and Services for HSC organisations.

No “personnel specification” is provided at tender, rather standard recognised titles are used, for example Consultant, Associate Specialist, Specialist Registrar, etc and these are combined with specific terms and conditions of contract which place an obligation on the contractor to provide workers to a particular standard.

Documents are agreed with Human Resource specialists at Trusts before tendering and those specialists are fully involved throughout the tender process from developing documents through to tender evaluation.

In addition, the current position is that BSO Procurement and Logistics Service is engaged in the development of a Regional Medical Locums Framework which will develop further the approach to market.

As requested, the following contract documents have been attached.

8) Confirmation of whether the agency contracts provide claw-back arrangements for the eventuality of failure to supply locums.

There are no specific “claw back” arrangements for failure to supply other than contained in para 15 of the Standard Conditions (extract set out below). This clause would relate to a position where the contractor had committed to supply and then failed. However, BSO have stated that they have no indications from Trusts that this is a significant problem in these contracts.

HSC Business Services Organisation Procurement and Logistics Service - Conditions of Contract for the Supply of Services

Default by contractor

14 *Without prejudice to any other right or remedy, if the contractor does not provide the services in accordance with the specification or at the times specified in the contract the authority may:*

- *require the contractor to remedy the default within such time as the authority may specify by providing or providing again (as the case may be) without further charge to the authority such part of the services to the service specification*
- *without terminating the whole of the contract terminate the contract in respect of part of the services only and thereafter provide or procure the provision of such part of the services itself*
- *itself provide or procure the provision of the services until it is satisfied that the contractor is able to carry out the services in accordance with these conditions*
- *terminate the contract.*

15 *If the cost to the authority of executing or procuring such services or part of them exceeds the amount that would have been payable to the contractor for executing or procuring such services, such excess shall be paid by the contractor to the authority in addition to any other sums payable by the contractor to the authority in respect of the breach of contract.*

16 *All or any of the remedies in conditions 14 and 15 may be exercised by the authority in respect of any default by the contractor.*

SS16B Standard Conditions of Contract

Revised 01 Apr 2009
Standard Conditions of Contract
Supply of Services SS16B

HSC Business Services Organisation Procurement and Logistics Service Conditions of Contract for the Supply of Services

Interpretation	Patents etc
Organisation	Confidentiality
Variation of conditions	Data protection
Performance	Inducements to purchase
Timing	Insolvency
Staff	Publicity
Termination	Use of agreements
Default by contractor	Law
Price and payment	Electronic catalogue - electronic trading
Indemnity	Mediation
Insurance	Third party rights
Employment, Equality & Discrimination Legislation	Environmental considerations
Severability	Comptroller and Auditor General Audit Rights
Waiver	Acceptance
Accrued rights and remedies	Expenses
Variation of services	Administration charge
Transfer and sub-contracting	Mandatory exclusion of economic operators

Interpretation

- 1 In these conditions of contract the following definitions shall apply:

The authority means the HSC Business Services Organisation, an Organisation of the Department of Health, Social Services and Public Safety, or the health authority placing the contract. Health authority means a Health and Social Services Board, Organisation or Health and Personal Social Services Trust, as the case may be.

The contract means the agreement concluded between the authority and the contractor, including all specifications, patterns, contractor's samples, plans, drawings and other documents incorporated or referred to therein.

The contractor means the person who by the contract undertakes to supply the services to the authority as provided for in the contract. Where the contractor is an individual or partnership the expression shall include the personal representatives of that individual or of the partners.

The contract price means the price exclusive of value added tax that is payable to the contractor by the authority under the contract for the full and proper performance by the contractor of its part of the contract.

The services mean the services and the goods that the contractor is required to supply under the contract.

Personal data has the same meaning as in section 1(3) of the Data Protection Act 1984 and subsequent amendments and orders to this act.

Unless the context otherwise requires it, reference to any statute, order, regulation or other similar instrument shall be construed as a reference to the statute, order, regulation or instrument as amended or re-enacted by any subsequent statute, order, regulation or instrument.

- 2 The heading to these conditions shall not affect their interpretation.

Reassignment of Contracts – Review of Public Administration

This contract will be awarded to the successful tenderer(s) on the understanding that at a time within the duration of the contract, there may be a need for reassignment from the contracting authority to an alternatively named body within the Northern Ireland Health and Personal social Services. The name of the alternative body will be that as defined under the current Review of Public Administration and any subsequent enabling legislation. It is understood that without prejudice the successful tenderer(s) will accept any reassignment of this contract. The contracting authority will not be liable to pay any compensation whatsoever in connection therewith.

Organisation

- 3 Subject to condition 4, where the HSC Business Services Organisation has negotiated the contract with the contractor such negotiation has been undertaken by the Organisation in its capacity as agent for the authority, so that it incurs no personal liability on the contract or on any other contract resulting from such negotiation.
- 4 Where exceptionally the HSC Business Services Organisation makes it clear in its official order that it is placing the order on its own account as principal, condition 3 shall not apply and the HSC Business Services Organisation shall be the authority with all the rights and liabilities of the authority under the contract.

Variation of conditions

- 5 The services shall be supplied solely in accordance with these conditions. All other contractual terms which in any way add to, vary or contradict these conditions upon which the contractor may seek to rely or otherwise impose on the authority shall be excluded and shall not form part of the contract (whether or not such other contractual terms post-date these conditions) unless the authority has specifically agreed in writing to be bound by any of such other contractual terms.

No later version shall be binding unless it has been agreed in writing and signed by an authorised representative of the authority.

Performance

- 6 The contractor shall carry out the services to the satisfaction of the authority in accordance with the service specification.

Timing

- 7 Time shall be of the essence with regard to the obligations of the contractor under the contract.

Staff

- 8 The contractor must employ sufficient staff to ensure that the services are provided at all times and in all respects in accordance with the service specification. The contractor must ensure that a sufficient reserve of staff is available to meet the service specification during holidays or absences.
- 9 The contractor must employ for the purposes of this contract only such persons as are careful, skilled and experienced in the duties required of them and must ensure that every such person is properly and sufficiently trained and instructed and carries out the services with regard to:
- the task that person has to perform
 - all relevant provisions of the contract
 - all relevant rules, policies, procedures and standards of the authority
 - fire risks and fire precautions
 - the need for those working in the National Health Service to observe the highest standards of hygiene, courtesy and consideration
 - the requirements of the Health and Safety at Work Act 1974, and/or Health and Safety at Work (NI) Order 1978 any associated amending orders and other relevant legislation and codes of practice.
- 10 The contractor shall provide its staff with a form of identification that is acceptable to the authority and which staff shall display on their clothing at all times when they are on the authority's premises.
- 11 The contractor shall instruct its staff not to smoke on the premises except where it is expressly permitted to do so.
- 12 The contractor shall remove from the premises any of its staff where the authority requests this on grounds of efficiency or public interest.

Termination

- 13 The Authority may at any time by notice in writing summarily terminate the Contract without compensation to the Contractor in any of the following events:
- 13.1 If the Contractor being an individual (or where the Contractor is a firm, any partner in that firm) shall at any time become bankrupt or shall have a receiving order, administration order or interim order made against him, or shall make any composition or scheme of arrangement with or for the benefit of his creditors, or shall make any conveyance or assignment for the benefit of his creditors, or shall purport to do so, or if in Scotland he shall become insolvent or notour bankrupt, or any application shall be made for sequestration of his estate, or a trust deed shall be granted by him for the benefit of his creditors.
- 13.2 If the Contractor being a company shall pass a resolution, or the courts shall make an order, that the company shall be wound up (except for the purposes of amalgamation or reconstruction), or if an administrative receiver on behalf of a creditor shall be appointed, or if the courts shall make an administration order, or if circumstances shall arise that entitle the courts or a creditor to appoint an administrative receiver, or which entitle the courts to make a winding-up order or administration order provided always that such termination shall not prejudice or affect any right of action or remedy that shall have accrued or shall accrue thereafter to the Authority.
- 13.3 The Authority may terminate this Contract forthwith by notice in writing to the Contractor if the Contractor is in breach of this Contract and shall have failed to remedy the breach within (30) days of receipt of a request in writing from the Authority to remedy the breach such request indicating that failure to remedy the breach may result in termination of this Contract.

- 13.4 The Contractor may terminate this Contract forthwith by notice in writing to the Authority if the act or omission of any health care establishment would amount to a breach of this Contract by the Authority if it had been committed or omitted by the Authority and that health care establishment shall have failed to remedy such act or omission within 30 days of receipt of a request in writing from the Contractor to remedy the same such a request indicating that failure to remedy the same may result in termination of this Contract. The Contractor undertakes to provide a copy of such request to the Authority at the same time it is received by the other health care establishment in question.
- 13.5 The termination of the Contract (in whole or in part) under clauses 13.1 – 13.4 shall be without prejudice to:
- 13.6 (where the Contract is terminated in part only) the continuance and validity of the part or parts of the Contract not terminated by the notice under clauses 13.1 – 13.4;
- 13.7 the rights or obligations of either party, which have accrued prior to the date of termination.
- 13.8 In addition to its rights under any other provision of the contract the authority may terminate the contract at any time by giving the contractor three months' written notice. Upon the expiration of the notice the contract shall terminate without prejudice to the rights of the parties accrued to the date of termination.

Default by contractor

- 14 Without prejudice to any other right or remedy, if the contractor does not provide the services in accordance with the specification or at the times specified in the contract the authority may:
- require the contractor to remedy the default within such time as the authority may specify by providing or providing again (as the case may be) without further charge to the authority such part of the services to the service specification
 - without terminating the whole of the contract terminate the contract in respect of part of the services only and thereafter provide or procure the provision of such part of the services itself
 - itself provide or procure the provision of the services until it is satisfied that the contractor is able to carry out the services in accordance with these conditions
 - terminate the contract.
- 15 If the cost to the authority of executing or procuring such services or part of them exceeds the amount that would have been payable to the contractor for executing or procuring such services, such excess shall be paid by the contractor to the authority in addition to any other sums payable by the contractor to the authority in respect of the breach of contract.
- 16 All or any of the remedies in conditions 14 and 15 may be exercised by the authority in respect of any default by the contractor.

Price and payment

- 17 The contract price for the services shall be net, i.e. after the deduction of all agreed discounts. The amount of any early settlement discounts shall be shown separately in the contract. The only sums payable by the Trust for the provisions of the service shall be the sums as specified in Schedule II plus Value Added Tax, as may properly be chargeable by the contractor. All other costs will be paid by the contractor.
- 18 An invoice shall be rendered on the contractor's own invoice form to the authority at monthly intervals clearly marked with the authority's order number.
- 19 Invoices shall show the period and the amount of the services for which payment is claimed together with the agreed charging rates and any other details the authority may determine as being part of the service specification.

-
- 20 The authority shall pay the contract price to the contractor, by BACS (Bank Account Clearing System) if the authority so chooses, at the end of the month following the month of the receipt of the services or receipt of a valid invoice, whichever is later.
- 21 Whenever under the contract any sum of money shall be recoverable from or payable by the contractor the same may be deducted from any sum then due or which at any time thereafter may become due to the contractor under the contract or under any other contract with the authority.
- 22 If for any reason the contract comes to an end otherwise than at the end of a completed calendar month the authority must pay in respect of the partly completed calendar month 1/365th of the annual contract price for each completed day worked by the contractor in the partly completed calendar month.

Indemnity

- 23 Without prejudice to its liability for breach of its obligations under the contract the Contractor shall be liable and shall indemnify the Authority, any Health Authority and the Minister for Health Social Services and Public Safety against any loss, costs, expenses, claims or proceedings whatsoever arising under any statute or at common law in respect of:

- Any loss of or damage to property (whether real or personal)
- any injury to any person, including injury resulting in death

in consequence of or in any way arising out of the provision of the services or the use of the Authority's premises by the Contractor, its employees or agents except insofar as such loss, damage or injury shall have been caused by negligence on the part of the Authority, its employees or agents.

Insurance

- 24 The contractor shall insure against its liability under condition 23 with a minimum limit of indemnity of £10 million in any insurance year or such other sum as may be agreed between the contractor and the authority.

Employment, Equality and Discrimination Legislation

- 25 The Contractor shall comply with all current employment legislation including anti-discrimination legislation as enacted in Northern Ireland and shall take all reasonable steps to secure the observance of this condition by all its staff or agents employed in the performance of the contract.

Severability

- 26 If any provision of the contract is or becomes illegal, void or invalid, that shall not affect the legality and validity of its other provisions.

Waiver

- 27 The failure of either party to seek redress for breaches or to insist on strict performance of any provision of the contract or the failure of either party to exercise any right or remedy to which it is entitled under the contract shall not constitute a waiver thereof and shall not cause a diminution of the obligations under the contract.
- 28 No waiver of any provision of the contract shall be effective unless it is agreed to by both parties in writing.
- 29 No waiver of any default shall constitute a waiver of any subsequent default.

Accrued rights and remedies

- 30 Neither the expiration nor the termination of the contract shall prejudice or affect any right of action or remedy, which shall have accrued or shall thereafter accrue either to the authority or to the contractor.

Variation of services

- 31 The authority may at any time vary or add to the service specification in accordance with this condition and no such variation or addition shall affect the continuation of the contract.
- 32 The authority shall give the contractor at least one month's written notice of any variation or addition. The notice shall give details of the variation or addition and the date on which it is to take effect.

Transfer and Sub-Contracting

- 33.1 Neither party shall assign the whole or any part of the contract without the previous consent in writing of the authority, such consent not to be unreasonably withheld. The Contractor(s) shall not sub-contract the supply of any services without the previous consent in writing of the authority, such consent not to be unreasonably withheld.
- 33.2 Further to 33.1 (and subsequent to the date of implementation of the contract) should the Contractor(s) transfer ownership, either partly or whole to another company, as a going concern or otherwise, such Contractor(s) shall provide the Organisation with a minimum of 4 weeks advance notice in writing.

As a minimum precondition, and without prejudice, the Transferee shall comply with the short-listing requirements as met by the Transferor such as financial standing, technical ability, quality standards, service support etc.

The decision as to whether this contract may transfer, with or as part of any transfer of ownership of the Contractor(s), shall remain that of the Organisation and the contracting authorities and shall be notified, in writing, to a minimum of two weeks prior to the transfer. The Organisation in conjunction with the contracting authorities exclusively reserve the right to accept that termination of the whole or part of the contract has taken place by reason of transfer of ownership of the company, and if so the Organisation and/or the contracting authorities shall not be liable for any compensation arising there from.

Patents etc

- 34 The contract price shall include all payments made or to be made to any third party in respect of any right, patent, design, trademark or copyright used for the purpose of performing the contract.
- 35 The contractor shall indemnify the authority against any costs or claims arising from any infringement of any right, patent, design, trademark or copyright.

Confidentiality

- 36 The contractor and its staff must not disclose to any person (other than a person authorised by the authority) any information acquired by them in connection with the contract.
- 37 Without prejudice to the generality of condition 36, the contractor and its staff must not disclose to any person (other than a person authorised by the authority) any information acquired by them in connection with the provision of the services which concerns:
- the authority, its staff or its procedures
 - the identity of any patient at any of the authority's hospitals or other establishments

- the medical condition of or the treatment received by any patient.

Commitment to openness and access to information.

The supplier/tenderer will be expected to acknowledge the HSC Business Services Organisation, Procurement and Logistics Service's commitment to openness and public access to information. The Freedom of Information Act 2000 applies to all NHS bodies with effect from 1 January 2005. All NHS bodies will have a policy on managing requests for information in accordance with their legal obligations.

Tenderers should be aware that whilst submitted information is treated as 'commercial and in confidence' the Organisation may be obliged to release any such information at a future date, if requested.

The HSC Business Services Organisation, Procurement and Logistics Service requires the supplier/tenderer, in submitting information in support of any quote or formal tender, to specifically identify any information, which it is reasonably considered is commercially sensitive and which should be held in confidence during the course of the tendering process. The tenderer should indicate why the information is considered to be confidential and for what period it should be regarded as being held HSC Business Service Organisation, Procurement and Logistics Service in confidence. The tenderer is advised that the use of blanket protective markings such as "commercial in confidence" will no longer be regarded as appropriate or as binding on HSC Business Services Organisation, Procurement and Logistics Service.

Data protection

- 38 The contractor must protect personal data in accordance with the provisions and principles of the Data Protection Act 1984 and the Data Protection Act 1998 and in particular the contractor must ensure compliance with the authority's security arrangements and ensure the reliability of its staff who have access to any personal data held by the authority. In addition, if the contractor is required to access or process personal data held by the authority, the contractor shall keep all such personal data secure at all times and shall only process such data in accordance with instructions received from the authority.

The contractor shall indemnify the authority and the Minister for Health, Social Services and Public Safety against all claims and proceedings and all liability, loss, costs and expenses incurred in connection therewith made or brought by any person in respect of any loss, damage or distress caused to that person as a result of the contractor's unauthorised and/or unlawful processing or the contractor's destruction and/or damage to any personal data held by the contractor, its employees or agents.

Inducements to purchase

- 39 The contractor shall not offer to any Health Authority or its representatives as a variation of the conditions of the contract, or as an agreement collateral to it, any advantage other than a cash discount against the contract price.
- 40 The authority shall be entitled to terminate the contract and to recover from the contractor the amount of any loss resulting from such termination in the following circumstances:
- if the contractor shall have offered or given or agreed to give to any person any gift or consideration of any kind as an inducement or reward for doing or forbearing to do, or for having done or forborne to do, any action in relation to the obtaining or execution of the contract or any other contract with the authority or any health authority, or for showing or forbearing to show favour or disfavour to any person in relation to the contract or any other contract with the authority or any health authority
 - if the like acts shall have been done by any person employed by it or acting on its behalf (whether with or without the knowledge of the contractor)

- if in relation to the contract or any other contract with the authority or any health authority the contractor or any person employed by it or acting on its behalf shall have committed any offence under the Prevention of Corruption Acts 1889 to 1916, or shall have given any fee or reward to any officer of the authority which shall have been exacted or accepted by such officer under colour of his office or employment and is otherwise than such officer's proper remuneration.

Insolvency

41 The authority may at any time by notice in writing summarily terminate the contract without compensation to the contractor in any of the following events:

- if the contractor being an individual (or where the contractor is a firm, any partner in that firm) shall at any time become bankrupt or shall have a receiving order, administration order or interim order made against them, or shall make any composition or scheme of arrangement with or for the benefit of their creditors, or shall make any conveyance or assignment for the benefit of their creditors, or shall purport to do so, or if in Scotland they shall become insolvent or notour bankrupt, or any application shall be made for sequestration of their estate, or a trust deed shall be granted by them for the benefit of their creditors
- if the contractor being a company shall pass a resolution, or the courts shall make an order, that the company shall be wound up (except for the purposes of amalgamation or reconstruction), or if an administrative receiver on behalf of a creditor shall be appointed, or if the courts shall make an administration order, or if circumstances shall arise that entitle the courts or a creditor to appoint an administrative receiver, or which entitle the courts to make a winding-up order or administration order provided always that such termination shall not prejudice or affect any right of action or remedy that shall have accrued or shall accrue thereafter to the authority.

Publicity

42 The contractor shall not advertise or publicly announce that it is supplying services or undertaking work for the authority without the prior written consent of the authority, such consent not to be unreasonably withheld.

Use of agreements

43 Upon receiving a written request the authority may allow the contractor to use Authority purchase agreements for goods or services. Should the authority allow such use it is on the understanding that the goods or services so purchased by the contractor against these agreements are only for the performance of the contract. The authority retains the right to withdraw consent for the use of any agreement instantly at any time without giving any period of notice and without giving any reason. All information received by the contractor concerning Authority purchase agreements shall be held in confidence in accordance with conditions 36 and 37.

Law

44 The parties shall accept the non-exclusive jurisdiction of the Northern Ireland courts and agree that the contract is to be governed and construed according to Northern Ireland law.

Electronic Catalogue / Electronic Trading

45 In the event of the introduction of an electronic catalogue or trading facility the following shall apply:

Contractors will supply product details of the goods and services supplied under the contract in a form and upon media specified by the authority. It shall be the responsibility of the contractor to ensure that all such details are correct as at the date upon which they are

delivered to the authority and that such details do not contain any data or statement which gives rise to any liability on the part of the authority following publication of the same in accordance with this clause. The contractor warrants that such details are complete and accurate as at the date they are delivered to the authority and that in the event such details cease to be complete and accurate then the contractor shall promptly notify the authority in writing of any modification or addition to or any inaccuracy or omission in such product details.

The authority shall reproduce the product details provided by the contractor in the Authority's electronic catalogue, which shall be made available to Health Authorities.

Before "going live" the authority will submit a copy of the relevant sections of the catalogue to the contractor for approval and the contractor undertakes to approve the same without unnecessary delay.

Subject to condition 34, the contractor grants to the authority a licence to use and exploit the product details provided as aforesaid for the purpose of illustrating the range of goods and services available under the Authority's contracts for an indefinite period subject to the contractor notifying the authority in writing that it no longer wishes such product details to be included in the Authority's catalogue.

If requested in writing by the authority, the contractor and the authority, shall forthwith negotiate in good faith an agreement to use such electronic trading system as the authority may specify in its request. For the purposes of this condition, "electronic trading system" shall include, without limitation, Electronic Data Interchange with such message standards and protocols as the authority may specify and the world wide web.

The contractor shall indemnify the Authority from and against all liability of the contractor arising out of or in connection with any statement relating to the goods and services or information or material on or description of the goods and services provided by or on behalf of the contractor, which is included in the Authority's catalogue or associated material.

Mediation

- 46 Any dispute, difference or question between the parties to the Contract with respect of any matter arising out of or relating to this Contract which can not be resolved by negotiation and except insofar as may be otherwise provided in this Contract shall be referred to Arbitration under the provision of the Arbitration Act (N.I) 1937 or any statutory modification or re-enactment thereof by a single Arbitrator to be appointed by agreement between the parties or in default of agreement by the President for the time being of the Chartered Institute of Arbitrators.

Alternatively consideration will be given to the use of Alternative Dispute Resolution by way of mediation.

Third party rights

- 47 Except as otherwise provided in this contract, including without limitation clause 28, this contract is intended and agreed to be solely for the benefit of the contractor and the authority and no third party shall acquire any benefit, claim or rights of any kind whatsoever pursuant to, under, by or through this contract.

Environmental considerations

- 48 The contractor shall comply in all material respects with applicable environmental laws and regulations in force from time to time in relation to the products/services the subject of the contract. Where the provisions of any such legislation are implemented by the use of voluntary agreements or codes of practice, the contractor shall comply with such agreements or codes of practice as if they were incorporated into English law subject to those voluntary

agreements being cited in the tender documentation. Without prejudice to the generality of the foregoing, the contractor shall: -

- comply with all reasonable stipulations of the authority aimed at minimising the packaging in which the products the subject of the contract, or any products supplied by the contractor to the authority as part of performance of the services, are supplied;
- promptly provide such data as may reasonably be requested by the authority from time to time regarding the weight and type of packaging according to material type used in relation to all products supplied to the authority under or pursuant to the contract;
- comply with all obligations imposed on it in relation to the products/services the subject of the contract by the Packaging Waste Regulations 1997 (or any other equivalent legislation giving effect in any part of the European Economic Area to the Packaging and Packaging Waste Directive 94/62/EC);
- label all products supplied to the authority under the contract, and the packaging of those products, to highlight environmental and safety information as required by applicable UK and EU legislation;
- unless otherwise agreed with the authority, insofar as any products supplied under the contract comprise or include electrical or electronic equipment, manage the said equipment and associated consumables at end of life to facilitate recovery, treatment and recycling and provide any information which the authority may reasonably require from time to time regarding the costs of such activity;
- promptly provide all such information regarding the environmental impact of any products supplied or used under the contract as may reasonably be required by the authority to permit informed choices by end users;
- where goods are imported into the United Kingdom then for the purposes of the Producer Responsibility Obligations (Packaging Waste) Regulations 1997 (as amended) the Contractor shall assume the rolled-up obligations for all the activities performed outside the United Kingdom in relation to the goods and the packaging which is used for the containment, protection, handling, delivery and presentation of the goods in addition to any other obligations he may have pursuant to the said Regulations.

The contractor shall meet all reasonable requests by the authority for information evidencing the contractor's compliance with the provisions of this clause.

Comptroller and Auditor General Audit Rights

- 49 The Contractor shall keep secure and maintain until two years after the final payment of all sums due under the Contract, or such longer period as may be agreed between the parties, full and accurate records of the Services, all expenditure reimbursed by the Authority and all payments made by the Authority.

The Contractor shall grant to the Authority or its authorised agents, such access to those records as they may reasonably require in compliance with the Contract.

Acceptance

- 50 Tenderers are invited and received only on the clear understanding that the HSC Business Organisation (herein referred to as the "Organisation") may in its sole discretion draw the full range of goods and services required either (a) entirely from one successful Tenderer (b) partly from each of several Tenderers to the extent to which specified parts of the respective Tenders have been accepted for that purpose by the Organisation.

Expenses

- 51 The Organisation shall not be responsible for any payment in connection with any expenses which may be incurred by the Tenderer in the preparation and submission of this Tender.

Administration Charge

- 52 Without prejudice the Organisation shall be at liberty to charge an administration fee, not in excess of 10% of the gross cost of any other services purchased, as a result of a breach of Clause 14.

Mandatory Exclusion of Economic Operators

- 53 The Public Contracts Regulations and the Utilities Contracts Regulations 2006 require contracting authorities to exclude economic operators (suppliers, contractors and service providers) from public contracts where they have actual knowledge that the economic operator has been convicted of offences as listed in Regulation 23(1) (subject to paragraph 2). Your attention is drawn to the Pre-qualification questionnaire or the Additional Information Schedule III, which must be completed declaring any such offence.

SS17A Special Conditions of Contract

Revised 01 Apr 09

Special Conditions of Contract SS17A



TENDER NO: 103566

CONTRACT TITLE: Contract with Recruitment Agencies for the

Supply of Agency Staff to the Western HSC Trust

CONTRACT PERIOD: 1 February 2010 to 31 January 2013

SPECIAL CONDITIONS OF CONTRACT PERTAINING TO

ALL CATEGORIES OF STAFF

1. Introduction

The Western HSC Trust require short-term temporary cover in certain categories of staff in order to meet service requirements due to emergency and peak demand periods.

Personnel supplied by the Contractor will be regarded as Recruitment Agency employees and not Trust employees. The parties must agree and acknowledge that the Agency Worker is either self-employed or employed by the Contractor and that no employment relationship between the Agency Worker and the Trust exists or is to be implied.

The Recruitment Agency must be registered with the Equality Commission (where there are more than 11 employees) in relation to Fair Employment legislation.

2. Job Descriptions

It is the responsibility of the Contractor to ensure each member of personnel supplied by the Contractor meets the requirements laid down by the Trust and may provide any worker it supplies with a copy of the job description and personnel specification for the post.

3. Complaints operational policy and procedure

The Contractor shall operate a clear written procedure for handling complaints. Such procedures shall enable the Trust to make complaints quickly and simply and shall require the Contractor to investigate and resolve a complaint in accordance with strict timescales. The Trust will assist with the Contractor by providing the necessary information surrounding any complaint made, to enable the complaint to be investigated fully by the Contractor.

All complaints made by the Trust to the Contractor shall be acknowledged in writing within 3 working days by the Contractor. The Contractor shall keep a full written record of the nature of each complaint and details of the action taken as a result of the complaint. The Contractor shall ensure that all complaints are resolved within 10 calendar days of the complaint being notified to the Contractor unless the nature of the complaint requires additional investigation or action by a professional or government organisation (e.g. the PSNI). The details of how the complaint has been resolved if it has been resolved should be notified to the Trust in writing within 10 calendar days.

The Contractor will operate, within their Quality Assurance System, a central system for complaints to analyse and identify any pattern of complaints.

The Contractor shall ensure that all Recruitment Agency Personnel supplied are promptly and fully informed of related complaints and takes demonstrable action to ensure no recurrence of the action complained of (with the exception of complaints regarding Fraud or a Confidential Reference provided by the Trust to the Contractor).

The Contractor, upon receiving poor reports of the performance of Recruitment Agency personnel in a Confidential Reference written to it by the Trust or by any Agent acting on behalf of the Trust, shall not assign that Recruitment Agency Personnel to the Trust until the Trust, or its Agent, is satisfied that the problems have been resolved and will not recur.

The Contractor will maintain a full written record of the nature and details of each complaint received and the action taken to resolve each complaint.

The Contractor will operate a clear, written policy, a copy of which is to be given to all Recruitment Agency Personnel, to enable Recruitment Agency Personnel to report a complaint.

4. Human Resources Issues

The Contractor will provide structured orientation and induction to newly appointed Agency personnel. The Trust will however provide orientation for Recruitment Agency personnel to ensure they are conversant with necessary policies and procedures, particularly with regard to health and safety and fire procedures. Recruitment Agency Personnel must conform to the Trust policies and procedures as they apply to the facility in which the member of staff is based. All Recruitment Agency personnel placed within the Trust must adhere to Trust policies and procedures. These will be located in each department throughout the Trust.

The Contractor will ensure that records are retained of all documentation relating to the recruitment process. The Contractor will ensure that the following information for all Recruitment Agency Personnel is obtained and verified by the Contractor at recruitment and prior to any Recruitment Agency Personnel being sent on their first assignment with the Trust under a Supply Contract. Where necessary in accordance with the Conditions of Contract, this information shall be updated, monitored or reassessed as prescribed within the Conditions of Contract. The information relating to all Recruitment Agency Personnel must be retained by the Contractor within the Contractor's Records.

The required information in connection with each Recruitment Agency Personnel will include but is not limited to:

- a) Full name and address
- b) Verified personal identification and a recent photograph (the Contractor is required to see the original of the Recruitment Agency Personnel's passport or driving licence. A photocopy of one of these documents is to be maintained on the Recruitment Agency Personnel's file)
- c) A pre employment health assessment must be obtained and confirmation of fitness to undertake the role received prior to appointment. A Health Declaration is to be completed by the Recruitment Agency Personnel.
- d) A completed application form with details of full employment history including details of all previous or current employment or engagement by other agencies

The Contractor shall ensure that the Recruitment Agency Personnel completes an application form that meets the requirements of legislation and requests full details of that Recruitment Agency Personnel's previous employment history. Where the previous employment history is not continuous, and shows gaps between employers, the Contractor should question the Recruitment Agency Personnel to establish the reasons

for such gaps, and must be satisfied that a full explanation has been provided. The Contractor will ensure that this explanation is recorded.

- e) Evidence of all previous, relevant training and qualifications received. Original certificates must be inspected by the Contractor as part of the Validation of Qualifications check.
- f) Evidence of results of any tests undertaken by the Recruitment Agency personnel as part of the selection process.
- g) Evidence of current registration with relevant regulatory body e.g. type of registration, date obtained, expiry date.
- h) A written record of the formal face-to-face interview conducted by the Contractor with the Recruitment Agency Personnel. This is to include (but not limited to) the date of the interview, where the interview was undertaken and the name of the interviewer. It should also include a record of questions asked of the candidate and the responses provided.
- i) Details of next of kin, together with an emergency contact telephone number.
- j) The Contractor is responsible for ensuring that Recruitment Agency personnel selected for posts have the language and communication skills necessary to carry out the duties of the post safely and effectively. The Contractor will be required to ensure that communication skills are assessed as appropriate for the position.
- k) A copy of the Recruitment Agency Personnel's immigration status and eligibility to work for the Recruitment Agency.

The Contractor will ensure full compliance with immigration legislation and rules imposed and will retain relevant documentary evidence

- l) Documentary evidence that the Recruitment Agency personnel is legally entitled to live and work in the United Kingdom in accordance with the requirements set out in Section 8 of the Asylum and Immigration Act (1996) and the Immigration (Restrictions on Employment) Order 2004.
- m) A copy of the Recruitment Agency Personnel's driving licence that legally allows them to drive in the UK (as necessary in respect of the duties to be carried out by that Recruitment Agency Personnel)
- n) Reference Reports: The Contractor shall use its best endeavours to ensure that these references are relevant to each speciality in which the Recruitment Agency Personnel may be placed under the Supply Contract. The Contractor must as a minimum obtain 2 references; one from each of the current and most recent employment held by the Recruitment Agency Personnel and must contain details of work undertaken during these employments/placements. The references must be provided by the Recruitment Agency Personnel's previous line managers (i.e. more senior personnel at their current/previous employment/placement) and must be obtained from the business address of the current/previous employment/placement. Where the person is to be engaged in an area working with Children and / or Vulnerable Adults, and where the person has previously worked in a position which involved work with one of these groups, verification, so far as is reasonably practical should be obtained as to why he / she ceased work in that position. The reference must clearly show the relationship between the referee and the Recruitment Agency Personnel in that appointment to establish that the reference is from the Recruitment Agency Personnel's previous line manager. Where a particular line manager has left the employment of the Recruitment Agency Personnel's previous employer then the reference is to be sought from the personnel department, or hospital management at the previous employer for that particular

Recruitment Agency Personnel, unless the previous employing organisation has in the interim ceased to trade. Where the Recruitment Agency Personnel has previously been employed/placed within the HSC Trust, the Contractor will ensure that a reference is obtained from their last HSC employer/placement. The Contractor will also reserve the right to approach any previous Employer for a reference where required.

- o) The Contractor shall operate with clear, written policies, processes and procedures for the recruitment and selection of Recruitment Agency Personnel which meet all the requirements of equality legislation and employment law. In particular the Contractor shall comply with the Department of Health's Code of Practice for the supply of Temporary Staff to the NHS (published June 2002).
- p) The Contractor's Recruitment policy must involve interviewing all staff prior to appointment. The Contractor shall use only suitably trained and experienced personnel to undertake interviews. The interviewer should have suitable experience for the type of assignment that the Recruitment Agency personnel will be undertaking. In all cases the interviewer is to be suitably trained and experienced to conduct the interviews and receive regular updates on training in this area. The interviewer shall have relevant qualifications and relevant experience or training in interviewing techniques and shall be able to assess, select and place Recruitment Agency Personnel within the Trust according to their qualifications, competencies, clinical experience and skills.
- q) The Rehabilitation of Offenders (Exceptions) Order (NI) 1979 means that the provisions of the Rehabilitation of Offenders (NI) 1978 do not apply to people whose employment is in Health and Social Services. The Contractor therefore is required to elicit any information on previous convictions, cautions, charges, prosecutions or bind-over orders from any potential worker that it intends to supply to the Trust. Applicants to the Recruitment Agency will be required to complete a written Declaration of any previous convictions, cautions, charges, prosecutions or bind-over orders. Applicants will also be required to disclose whether or not they are the subject of a police or other investigation and whether or not they have any prosecutions pending.

Where the Recruitment Agency would propose to supply any worker who has previously been convicted of any criminal offence it must consult with the appropriate person in the Trust who will confirm whether or not the worker is acceptable.

5. Protection of Children and Vulnerable Adults (NI Order 2003) (POCVA) strengthened by Article 46 July 07 and Safeguarding Vulnerable Groups NI Order 2007

The Contractor will ensure when required "enhanced" vetting checks are carried out with Access NI. to enable the Trust to comply with the protection of Children and Vulnerable Adults legislation.

The Contractor will provide when required written confirmation that the Access NI check was undertaken within the previous 12 month period.

6. Employment and Equality Legislation

The Contractor and the Trust will each comply in all respects with relevant employment and equality legislation including but not limited to:

- Equal Pay Act (NI) 1970 (as amended)
- Sex Discrimination (NI) Order 1976 (as amended)
- Social Security (Claims and Payments) Regulations (Northern Ireland) 1977
- Rehabilitation of Offenders (NI) Order 1978
- Health and Safety at Work Order (NI) 1978
- Rehabilitation of Offenders (Exceptions) Order N.I. 1979

- Disability Discrimination Act 1995 (2006) (as amended)
- Asylum and Immigration Act 1996 – Section 8 (as amended)
- The Employment Rights (Northern Ireland) Order 1996
- Race Relations (NI) Order 1997 (as amended)
- The Fair Employment and Treatment (Northern Ireland) Order 1998
- The Employment Rights (Dispute Resolution) NI Order 1998
- The Public Interest Disclosure (NI) Order 1998
- Working Time Regulations (NI) 1998 No 386 (as amended)
- Human Rights Act 1998 c42
- The Northern Ireland Act 1998 c47, section 75
- Data Protection Act 1998
- Maternity and Parental Leave Regulations (Northern Ireland) 1999
- The Equality (Disability etc) (Northern Ireland) Order 2000
- Part-time workers (Prevention of Less Favourable Treatment) Regulations (Northern Ireland) 2000
- The Fixed Term Employees (Prevention of Less Favourable Treatment) Regulations (NI) 2002
- The Employment (NI) Order 2003
- Employment Equality (Sexual Orientation) Regulations (NI) 2003
- The Protection of Children and Vulnerable Adults (NI) Order 2003
- The Employment Relations (NI) Order 2004
- Conduct of Employment Agencies and Employment Businesses Regulations (NI) 2005
- The Safeguarding Vulnerable Groups NI Order 2007

And all future legislation relevant to the operating of the Contract that occurs during the term of the Contract.

It is the responsibility of the Contractor to monitor the hours of workers it supplies to make sure that the provisions of the Working Time Regulations are complied with.

The Contractor will be required to comply with all policies, codes of practice, and guidance issued by Department of Health and DHSS&PS in relation to international recruitment of Health Care Professionals.

Training, Learning and Development

- 1) The Contractor will have a written policy and procedures for the training and development of Agency personnel.
- 2) The Contractor will ensure that the training needs of individuals are identified and arrangements put in place to meet them.
- 3) The Contractor will require Recruitment Agency personnel to provide evidence of training previously undertaken and to retain evidence of ongoing training and development activities.
- 4) Records will be retained by the Contractor of all training, learning and development activities completed by Agency personnel.

- 5) The Contractor will ensure that the impact of training is evaluated as part of the quality improvement process and through supervision and appraisal of Agency Personnel.

Supervision and Appraisal

- 1) The contractor will ensure all Recruitment Agency Personnel have their performance appraised to promote the delivery of quality services.
- 2) The Contractor will ensure there is a written policy and written procedures detailing the arrangements for the supervision and appraisal of staff.

7. Indemnity

The contractor will fully and effectively indemnify and hold harmless the Trust and the Secretary of State against any claim brought by any person who is or has been an Agency Worker or who purports to represent any such person to the extent that such claims relates to that person's employment (by any employer) or termination of such employment including without limitation any claim under the Transfer of Undertakings (Protection of Employment) regulations 1981 (as amended) in respect of the services.

8. Occupational Health Requirements

The Contractor will be expected to demonstrate to the Trust that the personnel supplied are medically fit to carry out the full range of responsibilities specified in the Job Description. In the event of an individual who requires specific adjustments, the contractor's occupational health will provide appropriate information on possible adjustments which may be required to enable that individual to undertake the duties of the job.

The Trust expects the standard of fitness to be the same as for staff directly employed by the Trust. All staff providing direct clinical patient care must show documentary evidence of the following :

- 1: Freedom from TB disease with immunisation where appropriate
- 2: Immunisation against Hepatitis B with post-immunisation testing of response
- 3: Evidence of testing for Hepatitis C and HIV being offered
- 4: Immunity against Rubella and Varicella

For EPP workers there must be evidence of Health Clearance as follows :

- 1: HIV (antibody negative) and
- 2: Hepatitis B (surface antigen negative or if positive, e-antigen negative with viral load of 10X3 genome equivalent/ml or less) and
- 3: Hepatitis C (antibody negative or if positive, negative for Hepatitis C RNA)

All tests above must be by identity validated sample and from UK laboratories.

9. Performance / Misconduct

The Contractor will be required to have their own appraisal of Personnel and operate its own Disciplinary Procedures. The Standard of performance of Recruitment Agency Personnel must be the Contractors responsibility. Unsatisfactory performance will be reported to the Contractor for immediate appropriate action. However the Trust reserves the right not to use a particular member of personnel. This right will not be used unreasonably

The Contractor will be required to provide a regular communication system with the appropriate departments within the Trust to review assignments, clinical and professional performance of personnel placed with the Trust.

Where a member of personnel, provided by the Contractor, fails to meet the performance standard required by the Trust, the Contractor will be required to provide an alternative member of personnel who is acceptable to the Trust.

Senior Trust personnel, in conjunction with a senior Contractor representative, may need to interview Recruitment Agency Personnel to give them the opportunity to explain the action or to provide information about a situation. Should an investigation be required the employee of the Contractor will be expected to participate in such an investigation and the Contractor will be expected to support the Trust's actions. Where the Recruitment Agency Personnel is unwilling to co-operate, the Trust will no longer use that Recruitment Agency Personnel. Where the matter is identified as requiring criminal or professional investigation the Trust will immediately, in conjunction with a senior Contractor representative, notify appropriate authorities.

10. Health and Safety

Recruitment Agency Personnel placed with the Trust must at all times comply with the Trusts Health and Safety Policies and Procedures. Recruitment Agency Personnel must ensure to take reasonable care for the Health and Safety of both themselves and others with whom they come into contact and who could be affected by their work. Personnel must comply with health and safety rules and procedures pertaining to their own area of work. All Recruitment Agency personnel must receive on-going training in health and safety matters. The cost of any training, which the Trust is required to provide, will be met by the Contractor.

The Contractor shall endeavor to ensure that each Agency Worker adheres to the Trust policies and procedures including those relating to fire, manual handling, environmental policy and health and safety. The Trust shall inform the Contractor in writing of any Agency Worker's breach of such policies and procedures and the Contractor shall promptly take action to remedy such breach

11. Uniforms and Personal Identity

Recruitment Agency Staff, where applicable, will wear a uniform supplied by the Contractor. Where special protective clothing is required, the Trust will provide this. Recruitment Agency Personnel must conform to any dress code specified by the Trust.

The Trust may supply an additional means of identification.

12. Acceptance

Tenders are invited and received only on the clear understanding that the Trust may in its sole discretion draw the full range of goods or services required either (a) entirely from one successful Tenderer or (b) partly from each of several Tenderers to the extent to which specified parts of the respective Tenders have been accepted for that purpose by the Trust.

13. Expenses

The Trust will not be responsible for any payment in connection with any expenses, which may be incurred by the Tenderer in the preparation and submission of this tender. In addition, the Trust will not be held liable for expenses incurred by the Contractor's staff.

No travel, flight or accommodation expenses will be paid unless the contractor has already received "in writing" agreement to such.

14. Quality Systems

Tenderers should be in a position to demonstrate that effective quality systems are in place within their organization with regard to supply of goods and services. Accreditation to ISO 9001: 2000 or equivalent will be considered as desirable.

15. Contract Extension

The Trust may at any time before the completion of the contract period invite the Contractor (s) to agree to extend for a further two periods of twelve months commencing from the termination date of the original contract period.

16. Award Criteria

The Contract will be awarded to the most economically advantageous tender(s) on the basis of:

Price 70% and

Recruitment Process/Systems 30%

Please see Additional Information Document SS20 for completion

17. Tender Evaluation

There may also be a requirement for the tenderer to attend an interview and/or make a presentation to the Evaluation panel. There may also be a requirement for the Evaluation team to carry out site visits at Tenderer's premises to audit systems and procedures. Site visits may be announced or unannounced.

18. Price Amendment Application Form

Prices tendered must be quoted in Sterling (GBP) and fixed for a minimum period of 12 months from the start of the Contract, or as determined by BSO PaLS.

Applications for price amendment against any contract awarded may only be considered provided such application is submitted to the BSO Procurement Directorate. Application forms are available from the PaLS Sourcing Team and must be forwarded At Least 4 weeks prior to the requested effective date.

19. Finance

The Contractor will be responsible for all administration and payroll procedures including National Insurance, Pay As You Earn, SSP and SMP where applicable. together with any other management costs in respect of work undertaken for the Trust by Recruitment Agency Personnel

The Contractor will submit invoices to the relevant finance departments on a weekly basis appropriately referenced with Trust point of liaison at the facility in which the worker has been working, in a format agreed by the relevant Trust.

- i) The Contractor will agree with the Trust a process whereby Recruitment Agency personnel will be engaged. Where recruitment Agency personnel are engaged outside of the agreed process, no liability to the Trust will arise.
- ii) Recruitment Agency Personnel must complete a time sheet specifying the number of hours worked each day. The appropriate Manager within the Trust must countersign the time sheet. Arrangement for validation of time sheets must be agreed.
- iii) Where a member of Recruitment Agency Personnel applies for and is successful in obtaining any post with the Trust, no additional fee will be levied by the Recruitment Agency, provided the post has been advertised by the Trust.

20. Response Time/Protocol

The Contractor shall respond to the initial request for cover in a time to be agreed between the Contractor and the Trust. The details of these arrangements will be issued to the Contractor by BSO Procurement & Logistics Service.

21. Management Information/Contract Management

The successful Contractor will be required to submit Management Information (MI). The range of MI required, its frequency and timescales for submission will be agreed with the successful tenderer(s).

The MI may be required at individual business unit level, as well as at top level in the HSC organisation. It must be capable of being submitted in electronic format and be free of charge to HSC organisations.

It is strictly a requirement of the contractor to submit MI when requested and required Please see Appendix 1 – Management Template which shows a sample of the typical information required.

As part of the contract management the successful Contractors will be invited to attend regular contract review meetings with the BSO and possibly with the Trust, where performance and all other issues pertaining to the contract will be discussed. The Management Information provided will also be discussed. The frequency of these meetings will be advised upon award.

22. Termination

In addition to its rights under any other provision of the contract the Trust may terminate the contract at any time by giving the contractor three months written notice. Upon the expiration of the notice the contract shall terminate without prejudice to the rights of the parties accrued to the date of termination.

Dated this _____ day of _____ 2009

SIGNED by or on behalf of the Tenderer by a person expressly authorised to sign on behalf of the Tenderer:

Signature _____

Print Name _____

having read and accepted the Terms and conditions as stated.

HSC BUSINESS SERVICES ORGANISATION PROCUREMENT AND LOGISTICS SERVICE

SCHE

TENDER NO: 103566

CONTRACT TITLE : Contract with Recruitment Agencies for the
Supply of Agency Staff to the Western HSC

CONTRACT PERIOD : 01/02/2010 - 31/01/2013

Medical / Dental

Reference	Pay Per Hour	Working Time Directive at 12.07%	Agency Fee	Nett Charge to Trust
Foundation Year 1				
Foundation Year 2				
Specialist Registrar ST1 & 2				
Specialist Registrar ST3 and Above				
Middle Grade Staff Grade/Speciality Doctor Associate Specialist				
Consultant				

% Increase for Bank Holidays	
------------------------------	--

12th July
13th July (Junior doctors
Summer Holiday August
Christmas Day
Boxing Day
27th December (Junior d

COMPANY _____

CONTACT NAME: _____

TITLE: _____

Correspondence of 3 February 2012 from Dr Andrew McCormick

From the Permanent Secretary
and HSC Chief Executive



Department of
**Health, Social Services
and Public Safety**

www.dhsspsni.gov.uk

Dr Andrew McCormick

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Our Ref: AMCC 3290
SECCOR/332/2012
DH3-11-4986

Date: 3 February 2012

Dear Paul,

Public Accounts Committee Evidence Session on the Use of Locum Doctors by NI Hospitals

Further to your letter dated 16 December 2011 please find attached the information that was outstanding from my previous response to you dated 20 January 2012.

The information required to address points 3 and 5 has taken some time to pull together and is presented in a way that addresses your request given the constraints of time and the availability of information.

I apologise for the delay in responding and trust the information provided addresses the issues raised by the Committee.

Yours sincerely

Andrew McCormick

ANDREW MCCORMICK

1) Confirmation as to whether any doctors or officials currently employed by the Trusts or the Department hold a directorship or have any ownership of any of the contracted or non-contracted agencies who provide locum services.

There are 19 agencies that have contracts covering the five HSC Trusts in Northern Ireland as follows

Northern HSC Trust - 19 agencies
Western HSC Trust - 18 agencies
Belfast HSC Trust - 9 agencies
South Eastern HSC Trust - 9 agencies
Southern HSC Trust - 7 agencies

Company reports were obtained for each of these agencies and circulated to each Trust. All Trusts confirmed that there were no named principals of these agencies who were current employees of the HSC.

Of these agencies 4 are NI based, 13 based in England, 1 based in Dublin and 1 on the Isle of Mann. It should be noted for example that, in the case of the Southern Trust, it has 7 contracted agencies but it could be using an agency which may be off contract for them but this agency could have a contract with another HSC Trust.

2) For each hospital in each Trust, the number of cases in which locum services have been obtained by engaging with a non-contracted agency.

There are occasions when non-contracted agencies have to be used to source doctors in a particular specialty. This is not done lightly or as a first port of call for Trusts. There are robust processes in place in all Trusts to obtain permission at the highest level before this type of expenditure can be authorised. In these instances it is the difference between sustaining a service and taking the decision to close the service on a temporary basis on the grounds of patient safety.

The following information provides the Trust response to the information request. As you will note the information as requested is not available in all instances.

Belfast HSC Trust

The number of occasions in which locum services have been obtained by engaging with non-contracted agencies is as follows:

- Belfast City Hospital - 2 occasions during 09/10
- Royal Jubilee Maternity - 6 occasions during 09/10
- Royal Belfast Hospital for Sick Children - 5 occasions during 09/10 and on 7 occasions during 10/11. One locum procured in 09/10 continued in locum employment during 10/11.
- Musgrave Park Hospital - 7 occasions during 09/10. Locums procured during 09/10 continued in locum employment during 10/11

Western HSC Trust

The Western Trust has gone off contract on 16 occasions since the establishment of its new contract with came into effect from 1 October 2010.

- Altnagelvin Hospital - 2
- Erne Hospital - 14

Northern HSC Trust

The number of cases in which locum services have been obtained by the Northern Trust through a non-contracted agency is as follows:

- 2011/12 - Antrim Hospital – 2
Causeway - 7
- 2010/11 - Antrim Hospital – 2
Causeway - 2
- 2009/10 - Antrim Hospital – 4
Causeway - 2

South Eastern HSC Trust

This information is not held centrally by the Trust and is therefore not available in the format requested. Each sub directorate (eg Surgical Directorate, Medical Directorate etc) is responsible for obtaining locums from the agencies concerned. Where the "on contract" agency cannot supply the staff at sub directorate level, the requesting manager will go "off contract". This is to avoid unplanned service closure or disruption. These sub directorates span the entire Trust and would not be constrained to any one hospital, which is why the information cannot be supplied by hospital site. The Trust is now considering the creation of a database to capture this information in future, in advance of any regional solution being developed.

However, of the £2.2m spend on agency locums in 2009/10 £149k (6.8%) was paid to non-contract agencies. In 2010/11 £590k (33%) of the total agency spend of £1.8m was paid to non-contract agencies.

Southern HSC Trust

The Trust has been unable to identify the number of occasions that they went off contract for the engagement of locum doctors. The provision of a full response would have involved a manual, resource intensive and time consuming exercise to go through all of the booking forms/invoices to determine if they were a contracted agency. It should be noted that a database has also been developed in 2011 which will allow electronic recording of all locum bookings which will allow the Trust to interrogate the number of shifts booked through contracted and non-contracted agencies.

However, of the £2.4m spend on agency locums in 2009/10 £1.8m (74%) was paid to non-contract agencies. In 2010/11 £2.8m (87%) of the total agency spend of £3.2m was paid to non-contract agencies.



Northern Ireland
Assembly

Appendix 4

List of Witnesses who gave Oral Evidence to the Committee

List of Witnesses who gave Oral Evidence to the Committee

- 1) Dr Andrew McCormick, Accounting Officer, Department of Health, Social Services and Public Safety (DHSSPS);
- 2) Dr Paddy Woods, Deputy Chief Medical Officer, Department of Health, Social Services and Public Safety (DHSSPS);
- 3) Ms Diane Taylor, Director of Human Resources, Department of Health, Social Services and Public Safety (DHSSPS);
- 4) Mrs Elaine Way, Chief Executive, Western Health and Social Care Trust;
- 5) Mr Kieran Donnelly, Comptroller and Auditor General; and
- 6) Ms Fiona Hamill, Treasury Officer of Accounts.



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