Accounts Commission
for Scotland

Doing the rounds

The use of locum doctors in Scotland's hospitals

JULY
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The Accounts Commission is a statutory, independent body which, through the audit process, assists local authorities and the health service in Scotland to achieve the highest standards of financial stewardship and the economic, efficient and effective use of their resources.

The Commission has five main responsibilities:

- securing the external audit
- following up issues of concern identified through the audit, to ensure satisfactory resolutions
- reviewing the management arrangements which audited bodies have in place to achieve value for money
- carrying out national value for money studies to improve economy, efficiency and effectiveness in local government and the NHS
- issuing an annual direction to local authorities which sets out the range of performance information which they are required to publish.

The Commission secures the audit of 32 councils, 36 joint boards (including police and fire services), 15 health boards, 47 NHS trusts and five other NHS bodies. In total, these organisations spend public funds worth around £12 billion a year.

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Responsibility for the contents and conclusions rests solely with the Accounts Commission.

Executive summary

Introduction

Locum doctors have long played an important role in the provision of hospital services. They are primarily used to provide cover for vacancies and for staff who are temporarily absent from duty for one reason or another. In this way, they help ensure that staffing levels continue to operate at their optimum level and so minimise disruption to patient services.

The use of locum doctors at hospitals is increasing. In part, this has been fuelled by initiatives such as *The New Deal* - which reduced the number of hours worked by junior doctors - and changes in the training regime in the wake of the Calman report. Shortages and recruitment difficulties within some specialties have also contributed to the increase.

Overall, expenditure on locums by Scottish trusts has almost doubled over the last three years, from £9 million in 1994/95 to around £17 million in 1996/97. Local studies by auditors reveal that several factors have helped to push up costs. There is evidence within some trusts of lax management control over the appointment of locums, as well as a failure to explore alternative means of providing cover. The fees charged by locum agencies have also increased.

These findings alone support the case for a detailed study of locum use and costs, but there are also more important issues concerning clinical risk and standards of patient care. While locums offer a practical solution to temporary shortages, they are unlikely to be as effective as permanent staff; locum doctors are often less well qualified or are unfamiliar with working practices within the hospital.

By their nature, locum appointments are frequently made against a pressure to fill vacancies quickly, giving rise to fears that vetting and induction procedures may be compromised in the interests of expediency. These pressures and timescales increase the risk of making an unsatisfactory or inappropriate appointment, with consequences for patient care.

Concerns over such matters led to the review by a Department of Health Working Group into ways of improving quality control in the use of hospital locum doctors. Their report, which was issued in 1995[1], recommended measures to reduce dependence on locums and proposed a *Code of Practice* regulating their appointment and employment. It also called for better data on locum demand, supply and usage in hospitals.

The Commission's study

This study, carried out by the Commission's auditors during 1997, focused on the controls over hospital locums. In all, reports were issued to 40 (out of 46) trusts throughout Scotland, as well as to two of the three island health boards, assessing local arrangements against the standards identified by the Locums Working Group.

Auditors collected data on locum episodes and costs for 1996/97 although analysis was hampered by the poor quality of record keeping at a few trusts. As a separate exercise, we also carried out a survey by questionnaire of attitudes and practices at locum agencies.

Overall, the studies found:

- annual expenditure on locums at acute trusts averaged just under £0.5 million
- two-thirds of locum costs were due to vacancies
- six specialties were responsible for 62% of locum use
- agencies' share of trust expenditure fell to 50% in 1996/97 from 56% the year before
- 60% of agency locum assignments were for less than a week.

What we found

Auditors' reports identified the need for a number of improvements in the arrangements at trusts to reduce the risk of inappropriate use of locums. Attention focused in particular on the appointment of locums as cover for short-term absences. There was evidence of avoidable use, for example in the failure to co-ordinate staff holiday arrangements or to include provision in duty rotas for planned absence such as study leave.

There were also concerns at some trusts about the practical difficulties in undertaking comprehensive vetting and induction where locums were appointed at short notice, particularly when required to provide on-call cover overnight or at weekends with minimal supervision. It was generally accepted that some of these locums were doctors moonlighting from other trusts as a way of evading the ceilings on working hours. On this, and in certain other aspects of the screening process, some trusts were relying on checks being carried out by locum agencies, although the basis for delegating responsibility had not been agreed or formalised.

At the time of our study, few trusts had in place formal policies or protocols for the appointment and management of locums. This was exacerbated in some cases by inadequate monitoring and control over locum use, all of which had the effect (in the wake of growing staffing pressures) of pushing up costs.

As trusts realised the financial implications, so they began to tighten control. Through their own efforts and by taking on board the findings from local studies, procedures have been improved and costs reduced in several trusts. Since the audits were completed, the Management Executive has issued comprehensive guidelines to trusts[2] based on the Department of Health Working Group's *Code of Practice*, which undoubtedly will assist this process further.

A key objective of the *Code of Practice* is to reduce the risk of inefficient, inexperienced or incompetent doctors being appointed as hospital locums. Along with proper screening, arrangements are being introduced to assess and report on performance. The absence of such arrangements up till now has meant that poor performance has sometimes gone unrecorded and unaddressed.

One of the most effective ways of countering risk is for trusts to appoint locum doctors for whom they can vouch directly, such as their own staff or former employees. A few trusts are developing their own supply arrangements by establishing a pool or bank of good quality, reliable locums. Current restrictions on the fees which trusts can pay their own junior doctors may be an inhibiting factor.

We believe that this policy should be reviewed in the interests of allowing directly-managed locum banks to compete fairly with agencies. The report also recommends that two national initiatives should be considered to improve controls over the use of locum doctors:

- the introduction, on a pilot basis, of a national alert system for sharing intelligence about unsatisfactory locums
- national contracts for agency services, in line with those which have been negotiated in England and Wales.

The true cost to the NHS of using locums is estimated at between £8 million and £10 million, after allowing for compensating savings from vacant posts. Much of this is paid to locum agencies whose fees were deregulated in 1995. Despite the scope for obtaining discounts from tendering, typically of around 10%, auditors reported that half of trusts visited had failed to implement this measure. We estimate that trusts in Scotland could generate cash savings of £1 million a year from this action and from reducing the use of locums for planned absence.

1 Background

Introduction

Hospital care is needed 24 hours a day, 365 days a year. While it may vary in intensity at different times of the day and night, in essence hospitals offer a continuous service, providing treatment as and when patients require it.

This has implications for hospital staffing. Doctors and nurses work in shifts that offer care and attention around the clock. As far as possible, their rotas enable staff to cover their colleagues' absences and to share responsibility for night-time and weekend working. The aim is to ensure that there are always sufficient staff on hand to cope with any eventuality.

Problems arise where staff numbers fall below optimum levels because of vacancies, or where absences occur unexpectedly. In these circumstances, a hospital may have to resort to exceptional measures to keep services going, such as bringing in temporary staff, known as locums.

The demand for locums

Junior doctors' hours

Until fairly recently, it was generally easier for hospitals to meet temporary shortages from within their own ranks simply by requiring doctors to work longer shifts. As late as the mid-1990s, it was not uncommon for junior doctors, in particular, to be on duty for more than 100 hours a week.

This was clearly not in the best interests of either doctors or patients, and the practice was effectively outlawed under *The New Deal*, which limited the number of hours that a junior doctor may work[3]. Under the current arrangements, there is a ceiling of 72 hours on the work that may be assigned to a junior doctor in an average week, including time on-call, or 56 hours for continuous duty.

As part of *The New Deal*, trusts were able to secure funding for extra posts and were encouraged to adopt flexible working arrangements between staff groups. But the initial effect of the reduction in junior doctors' hours was to make it more difficult for trusts to maintain cover in emergencies.

With fewer options available for meeting shortages internally, there was a dramatic increase in the demand for locum cover. Over the course of a single year - from March 1995 to March 1996 - expenditure on locums by Scottish hospitals almost doubled, rising from £9 million to £17 million (exhibit 1). The latest figures suggest that costs have stayed at the higher level, despite the success of some trusts in reining back spending to previous levels.

Exhibit 1: Cost of locum doctors

Spending on locum doctors by Scottish trusts has risen considerably since 1994/95

Source: auditors' reports

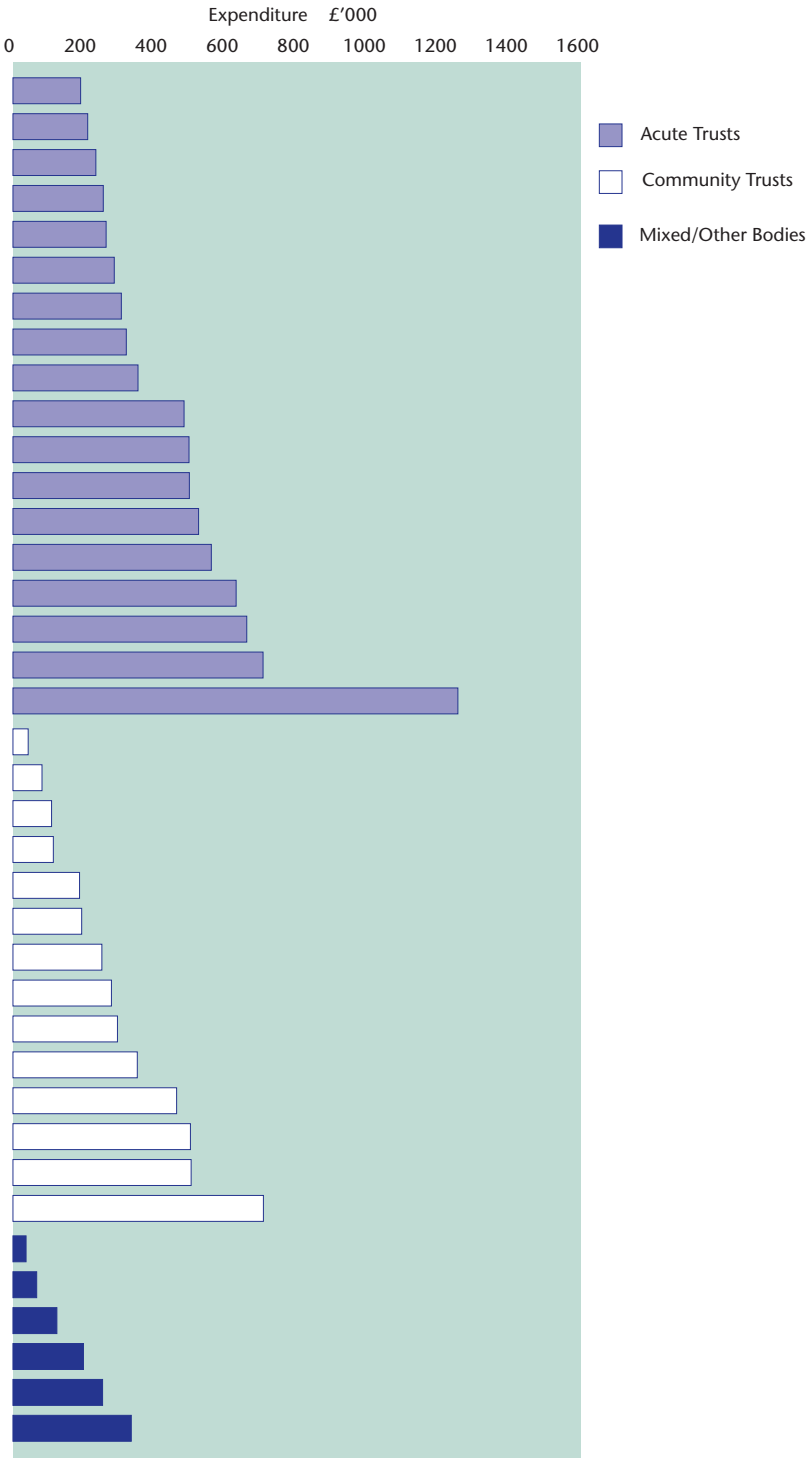
Whilst the restriction on junior doctors' hours has contributed greatly to the sharp rise in locum costs, it is by no means the only explanation. Other factors include:

- **Staff shortages** More than half of all locum appointments are to vacant posts, many of them at consultant level. A common factor in these cases is the national shortage of trained staff in some specialties.
- **Changes to training arrangements** The Calman report[4] introduced changes to the arrangements for training junior doctors, cutting the time that it takes for a junior doctor to achieve consultant status. This is being done by adopting a more intensive training regime, which will inevitably generate additional staffing pressures as it is phased in.
- **Agency fees** In 1994 the NHS Management Executive deregulated the fees that may be charged by locum agencies. In some instances this has led to increases well above the rate of inflation, thus adding to the financial burden on trusts in meeting locum costs.

This study suggests that all of these factors have contributed to varying degrees to the growing demand for locums, depending on the particular circumstances of each trust. In general, the pressures on costs have been greater in acute hospitals (exhibit 2), which provide a wide range of clinical services and need a high level of emergency cover.

Exhibit 2: Expenditure by trust 1996/97

There is considerable variation in spending by trusts, as well as by type of trust



Source: auditors' reports

Types of locum use

There are two distinct categories of locum use:

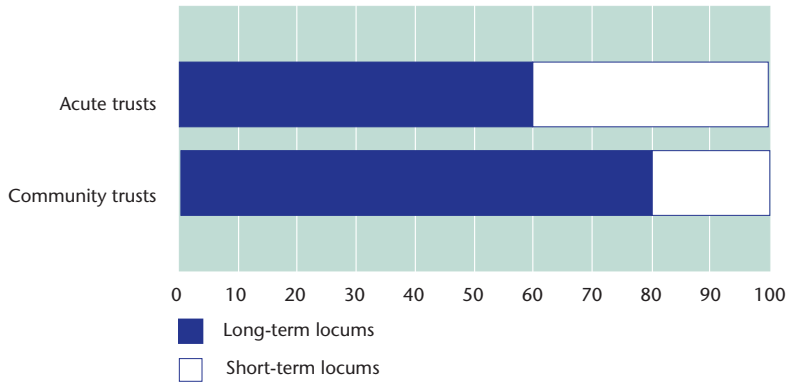
- cover for serving staff
- cover for vacancies.

The first involves the use of a locum to fill a gap in the rota caused by the temporary absence of the duty doctor, for example on sick leave or study leave. Typically the period of appointment ranges from a few hours to several days. For convenience, these appointments are referred to as short-term locums.

Long-term locums, on the other hand, are generally appointed to vacant posts which the hospital is unable to fill, or as cover for staff on extended absence such as maternity leave. Unlike short-term locums, they will normally undergo the same recruitment process as permanent staff. They will usually receive a salary rather than a fee, which will often be offset by the saving the trust makes from the vacant post.

The initiatives on junior doctors' hours and training, referred to earlier, will impact mainly on short-term cover. Spending on long-term locums is more likely to indicate recruitment difficulties for particular grades or specialties. Again the type of trust is relevant, with the average acute trust spending almost twice as much on short-term locums as community trusts (exhibit 3).

Exhibit 3: Distribution of locum cover



Source: auditors' reports, 1996/97 data

These differences are important. At one trust, annual expenditure of £100,000 may consist of the salaries of two or three locum consultants; while at another trust the same cost may represent widespread use of junior doctor locums for night-time and weekend working. The implications for the trusts in terms of quality, cost and risk management will be quite different in each case. At the first trust, the cost of locums is likely to be offset by savings in the salary budget from vacant posts; while at the second it may be possible to reduce the overall cost by reducing dependence on locums. In both cases the quality of care provided by locum doctors requires careful scrutiny and management.

Standards and costs

Concerns about long-term locum use generally focus on standards and clinical competence. Such appointments often involve doctors 'acting up' from a lower grade, or those who otherwise do not have the qualifications needed for a permanent consultant post.

For this reason, the *Code of Practice* on locum use recently issued by the Management Executive[2] stresses that the recruitment of a locum to a vacant post should be a temporary measure of limited duration, followed by a substantive appointment as soon as possible.

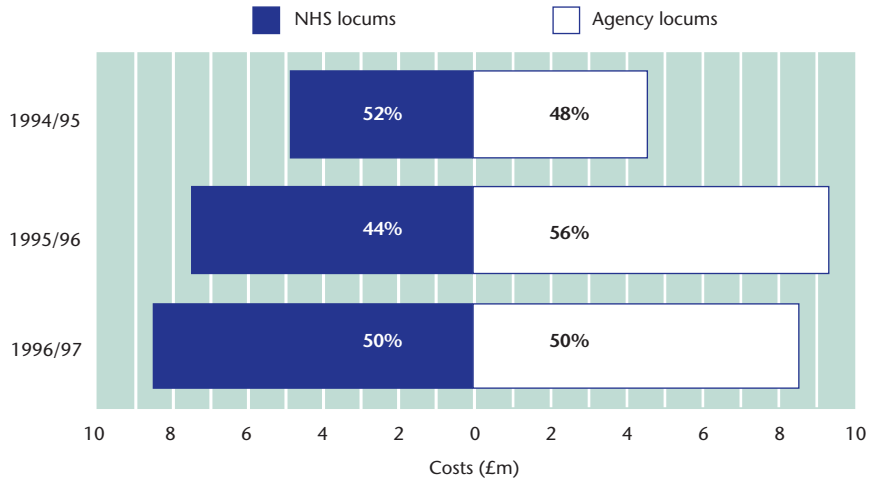
However, the issue of standards is not solely about clinical competence. For short-term appointments in particular, concerns may hinge on the use of a locum who is unfamiliar with the hospital regime and its patients.

The need for locum cover may only be identified at very short notice, leaving the hospital with little alternative but to contact locum agencies which specialise in appointments of this kind. As well as attracting the highest costs, these applications for emergency cover also present the greatest risks in terms of adequate vetting and induction.

Between 1994/95 and 1995/96, expenditure on agency locums increased at a faster rate than locum costs generally. This is partly due to price rises following deregulation of locum fees in 1994. The latest figures show a slight decline in expenditure on agency locums in 1996/97, though it still represents a significant proportion of the total cost (exhibit 4).

Exhibit 4: Distribution of costs between NHS and agency locums

Trust spending on agency locums has risen sharply since 1994/95, but fell back slightly in 1996/97, both in cash terms and as a proportion of total costs



Source: auditors' reports

Local studies

The findings from our local audits suggest that, up to two or three years ago, many trusts had limited systems of control in place, reflecting historically low levels of locum use. Few operated discrete budgetary or other control procedures, and there was poor monitoring generally of locum episodes and cost. This had several effects:

- while most trusts realised that demand was growing, in particular for short-term locums, many of them were unaware of the precise reasons for the increase or the potential financial consequences
- more importantly, very few trusts had developed formal arrangements for the authorisation and appointment of locums
- little attention had been paid to the risks associated with the wider use of locums.

Our research also confirms that the picture is changing, with trusts generally becoming more sensitive to the pressures on locum services and the implications for both costs and clinical care. This report offers the opportunity to help that process along, drawing upon the new guidelines issued by the NHS Management Executive and the many examples of good practice highlighted in individual trusts.

An important feature of the local audits was the collection of detailed data, providing trusts with information on locum costs in different specialties and the reasons for appointment, and identifying the potential for avoiding locum use altogether. We are now able to use this information to paint a broader picture of locum activity, to help trusts to assess the scope for better value for money.

The findings are explored under the following headings:

- Chapter 2: Identifying need
- Chapter 3: Appointment and performance
- Chapter 4: Sources of supply and costs.

The last chapter looks at the likely impact of recent initiatives, and considers the case for concerted action in developing solutions.

2 Identifying need

Introduction

There are about 8,000 doctors practising in Scottish hospitals. Around 90% of them are consultants or junior doctors, the common description for a doctor in training. The remaining 10% are doctors who have completed their training, most of them occupying staff grade or associate specialist posts.

The medical workforce is regulated by a complex process involving several organisations, notably the NHS Management Executive, the Scottish Council for Post Graduate Medical and Dental Education, postgraduate deans and, of course, the trusts themselves. Their combined objective is to ensure that the availability and skills of doctors meet patients' needs and the requirements for training.

This is easier said than done. The nature of healthcare is constantly changing as new treatments and technologies are developed, and the number of patients treated continues to increase. Inevitably, the supply of trained doctors does not always match demand, which generates pressures for trusts in managing the medical workforce.

Where such pressures exist, there is likely to be a need for locums. In this context, locum doctors provide a valuable service, enabling trusts to respond to changing demands. However, excessive use of locums may indicate weaknesses in the planning, recruitment and management of doctors in the hospitals concerned.

Medical staff planning

The central aim of the UK's medical staffing policies is to secure an adequate and affordable supply of appropriately trained doctors in each sector and specialty, in order to provide a cost-effective, high quality service to patients. This requires action to plan and monitor the supply of doctors against current and future demand.

Essentially, this is done at three levels:

- At national level, information is collected on staff in post, the number of vacancies, projected retirements and so on. This information is widely distributed throughout the service and forms the basis of the establishments agreed for registrar and consultant grades.
- At regional level, the postgraduate deans exercise responsibility over the training of doctors in hospital. They determine the number and range of training posts which a hospital is able to sustain, in relation to the duties and workload within each specialty.
- At local level, trusts have a primary responsibility to deliver healthcare services as agreed with their health boards. This requires them to forecast and recruit the right mix of skills and specialties to ensure that the plans can be fulfilled.

In practice, two issues dominate medical staffing arrangements at trusts. The first centres on the creation of an efficient and multi-skilled team that matches patients' needs. The second is training, which forms an integral part of the workload of junior doctors and is therefore a significant factor in determining overall staff numbers. We shall be looking at the implications of recent training initiatives later in this chapter.

The importance of staff planning in managing clinical services was recognised by the Locums Working Group. In their report[1], they stated that the aim should be to provide enough posts to meet immediate and foreseen requirements, taking account of planned absences and routine staff movements. Trusts should then be able to avoid, or at least minimise, late demands for clinical cover, which our research confirms is one of the main reasons for locum use.

Our local audits suggest that most trusts take an incremental approach to staff planning, based on historical establishments which are adjusted in line with material changes in service delivery. On the whole, the process reacts to changes rather than seeking to forecast them, although a few trusts are now monitoring staffing needs more closely as a means of containing locum costs. The need for other trusts to do the same was highlighted in more than half of all the local reports issued by auditors.

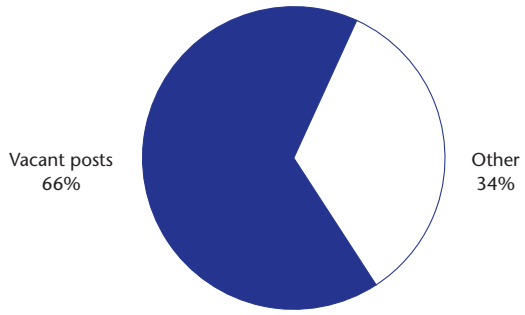
Reasons for locum use

Covering vacant posts

The common image of a locum is a doctor who is drafted in to provide temporary cover for the clinical team, but in reality most appointments (66%) are to vacant posts (exhibit 5). The proportion is higher in community trusts (75%) than in acute trusts (61%).

Exhibit 5: Breakdown of locum appointments by main reason for use

Two-thirds of locum appointments in 1996/97 were to vacant posts



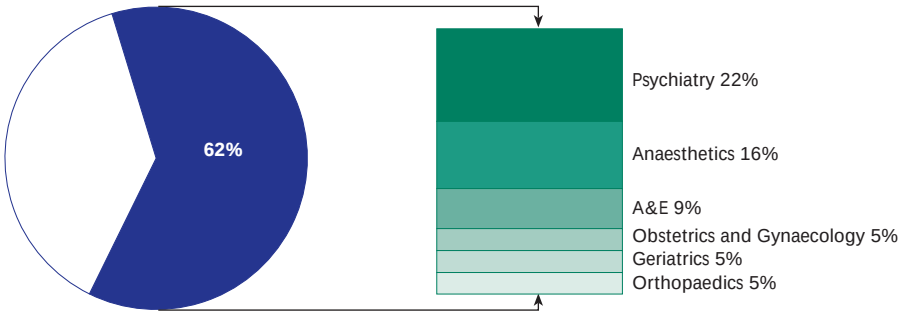
Source: auditors' reports, n=23

This use of locums is commonly (but not exclusively) related to local difficulties in recruiting doctors with particular skills. A recent survey by the NHS Confederation[5] found that trusts were experiencing recruitment problems across a range of specialties, including psychiatry, anaesthetics, paediatrics, A&E and orthopaedics.

This is borne out by our research, which showed that a relatively small group of specialties account for the majority of locum appointments to vacant posts (exhibit 6). A common explanation is that this reflects national shortages of doctors with the relevant skills and experience in the disciplines concerned.

Exhibit 6: Locum posts by specialty

Six specialties accounted for almost two-thirds of all locum appointments to vacant posts in 1996/97



Source: auditors' reports, n=18

Our review focused on recruitment practice at trusts and therefore did not examine the wider arrangements for medical staff planning to meet the needs of the NHS in Scotland. Where shortages do exist, we found that the status and location of a hospital may affect its ability to attract recruits. On the whole, the main teaching centres tend to fare better than small community or district general hospitals. These hospitals have sometimes had to adopt novel measures in competing for potential recruits (exhibit 7).

Exhibit 7: Examples of local recruitment initiatives

- Vacancies advertised outwith UK and Europe
- Use of professional recruitment agencies for advice on strategy and head-hunting
- Refurbishing doctors' accommodation and social facilities to make them more attractive to potential recruits
- Information packs developed with staff assistance describing the advantages of the hospital for training and work experience
- Doctors' groups established to liaise with job candidates and promote the professional and social benefits of the hospital and surrounding area
- Internet used to market the trust and advertise vacant posts
- Visits and placements arranged to foster links with students and other potential recruits.

Source: auditors' reports

Planned use of locums

Not all locum placements in vacant posts are due to recruitment difficulties. Locums are often employed for other reasons: for example, as a stopgap until a new doctor is recruited and takes up post. Locum appointments also offer flexibility when trusts are developing or restructuring services.

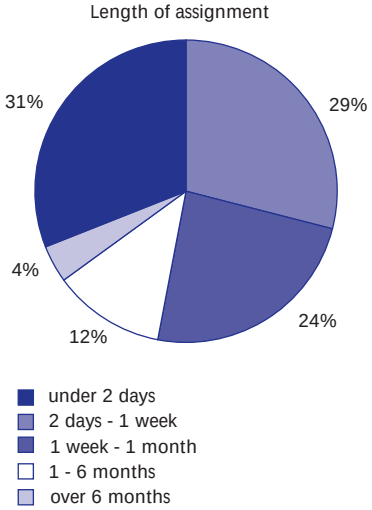
However, trusts should be wary about using locums as a deliberate policy. For junior doctor posts, they risk losing funding by the postgraduate dean if a vacancy is not filled substantively within three months. The latest guidelines from the NHS Management Executive also caution against the long-term use of locums. No firm

time limit has been set, but open-ended appointments should be avoided, and contracts should not extend beyond six months other than in exceptional circumstances (such as providing cover for maternity leave).

Information provided by locum agencies suggests that a significant number of assignments (around one in six) last longer than three months. At the top of the scale, around 4% of contracts extend beyond six months (exhibit 8).

Exhibit 8: Locum use by length of placement

Most agency locum appointments are for less than one week



Source: Accounts Commission survey of agencies

Clearly, where a hospital is unable to make a substantive appointment due to a lack of suitable candidates, it has little choice but to bring in a locum for medium to long-term cover. In doing so, however, managers and clinicians have to weigh the benefits of maintaining services at their existing level with the risk of entrusting the care of patients to a doctor who may, by definition, fall short of the stringent requirements for the post. The Locums Working Group emphasised the risks involved and argued strongly against any lowering of professional standards other than as a temporary measure to be reversed at the earliest opportunity.

Working practices

Vacancies represent the single most common reason for locum use, but the second significant cause is gaps caused by the working and training arrangements for junior doctors. This area has been the subject of major reform in recent years, some aspects of which have undoubtedly added to staffing pressures at trusts, with a knock-on effect on locum costs.

The pressures operate in two directions: first, through restrictions imposed in the hours which junior doctors are allowed to work; and second, by the introduction of a more intensive training programme which involves additional study commitments - and therefore less time on the job - in the short-term.

The training of doctors in hospital is overseen by regional postgraduate deans. It follows the apprenticeship model and may take as long as 15 years to complete, though this period is likely to be greatly reduced under the new arrangements. There are three main stages:

- general clinical training, involving a year's postgraduate experience (in at least two branches of medical practice) leading to full registration as a doctor
- basic specialist training (or general professional training) during which the doctor develops the wide range of general and basic specialist skills appropriate to his or her chosen career path
- higher specialist training leading to accreditation as a specialist (or to an 'exit' qualification) at which stage a doctor is regarded as ready to accept consultant responsibilities.

In effect, a hospital fulfils two key functions in the NHS: providing clinical care and training clinical staff. This twin role has considerable implications for managing hospital services:

- it directly affects the majority of doctors, two-thirds of whom are in training
- training and supervision requirements are major considerations in decisions about the skill mix and deployment of medical staff
- the apprenticeship model means that junior doctors provide a high proportion of clinical services as part of their training
- junior doctors' salaries are not met directly by trusts but are funded through training contracts with the postgraduate deans.

Training also plays a significant part in the recruitment process. In particular, most hospitals experience a considerable turnover of junior doctors every year as they move between jobs to gain experience and progress through the training system. The exercise is co-ordinated nationally, with senior house officers changing jobs during the first week of February and August each year.

The requirements of training may increase the use of locums in several ways:

- to provide back-up to the six-monthly intake of junior doctors if all posts cannot be filled in time
- as replacements for doctors on exam or study leave: in particular, some doctors may save up their study leave entitlement and take it all at once before moving jobs, thus adding to the hospital's difficulty in ensuring continuous cover around February and August
- junior doctors themselves may seek short-term locum work as a means of supplementing their training.

However, hospitals and doctors need to be aware that locum work may not be recognised for training purposes. Few short-term appointments carry any recognised training entitlement, and consequently do not count towards a doctor's specialist grade programme. For the hospital, there is the prospect that the postgraduate dean will withdraw funding of training posts which are not substantively filled after three months, leaving the trust to meet the full cost of any locum fees.

Changes in doctor's training

At national level, there have been two major initiatives on training in the current decade which have affected locum use:

- the *New Deal* for junior doctors
- the Calman report on training.

The New Deal

The New Deal, which was published in 1991, constitutes a formal part of junior doctors' terms and conditions of employment in the NHS. It lays down firm ceilings on contracted hours (72 hours per week) and working hours (56 hours per week) which hospitals must apply to individual contracts.

This reduction in junior doctors' hours added considerably to staffing pressures in hospitals and was clearly a major factor in the sharp rise in locum spending between 1994/95 and 1995/96. Throughout the implementation phase, there were a number of measures to help trusts adjust to the new targets, including:

- access to central funds to create additional posts
- guidance on the management of rotas designed around the standard working week
- encouragement to develop flexible working arrangements for junior doctors, including cross-cover between specialties and reviewing the scope for transferring tasks to other staff groups
- practical advice from local and national implementation groups set up to monitor compliance with targets.

The Calman report

The Calman report was published in 1993, and aims to bring the UK into line with other European Union countries in the training of higher specialists. Specifically, it proposes to:

- reduce the minimum length of postgraduate specialist training to seven years
- introduce a new certificate to make it clear when training is complete
- merge the registrar and senior registrar grades into a single specialist registrar grade.

These proposals will take several years to implement as the old training regime is phased out and the new one phased in. It is still too soon to judge their effect on hospital staffing, but the introduction of a more intensive training programme is likely to generate additional pressures, at least initially.

In the longer term, the new programmes and shorter timescales for training will affect the balance of junior doctors to consultants, with many services becoming consultant-based rather than consultant-led as at present. In turn, this may reduce staff turnover and absence levels associated with current training commitments.

Local studies

The local audits were primarily concerned with one particular aspect of medical staffing, the use of locum doctors. But demand for locums is influenced by wider service considerations. Auditors therefore reviewed current staffing policy and plans, and progress made in implementing recent initiatives and adapting working practices accordingly.

In their reports to trusts, auditors identified three areas which are critical in controlling the use of locums:

- **Rota and shift arrangements** The aim of rota and shift planning is to match staff availability to patient workload, and ensure continuous care around the clock. Where staffing levels allow, they should incorporate provision for prospective cover of planned absences, such as annual and study leave. Auditors reported on several cases where prospective cover was inadequate or had not been properly enforced, resulting in unnecessary locum use.
- **Flexible working practices** Restrictions in working hours and increasing clinical specialisation have made it more difficult for medical teams to cope with fluctuations in workload. The solution advocated in *The New Deal* lies in sharing responsibility for emergency cover between specialties, and transferring tasks from doctors to other staff groups such as nurses. Local audits highlight several initiatives which have contributed to reduced locum costs.

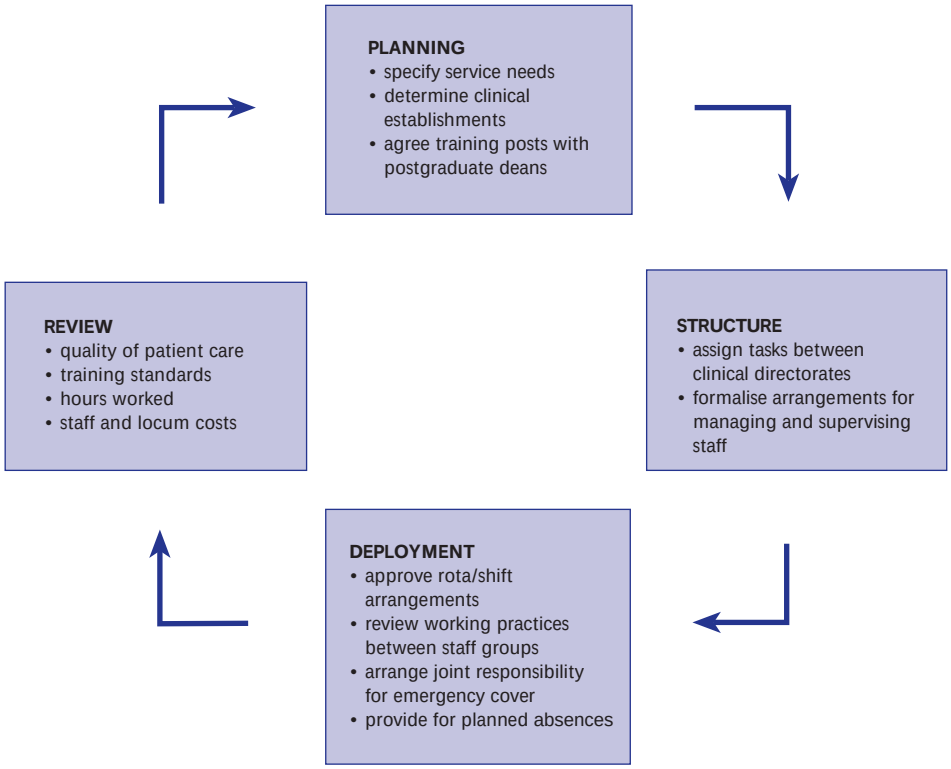
  Case 1: Broadening nurses' roles has reduced doctors' workload

  A nurse-led minor injuries service has been piloted at Arbroath Infirmary. Experienced nursing staff received special training in the treatment of minor injuries, and now provide the first contact for patients. In many cases, the patient does not actually need to see a doctor at any time throughout treatment. It is estimated that up to 60% of patients will be seen solely by a nurse.

- **Monitoring locum requirements** The quality of information on staff workload and locum use varies considerably between trusts. In around a fifth of trusts, auditors were unable to analyse the reasons for locum use because the data were not available. The lack of data meant that some trusts were slow to detect the sharp increase in locum costs in 1995/96, and to explore alternative means of providing clinical cover. Feedback from local audits confirms that improved monitoring is one of the main factors behind the slowing down of cost increases over the last year.

Trusts have been presented with a series of changes in training and service needs. Perhaps most importantly, they need to adopt a co-ordinated strategy for determining the composition and deployment of the medical team (exhibit 9), rather than relying on a series of piecemeal measures. Planning should help to ensure that locum appointments are made only when they are needed to make a positive and cost-effective contribution to the provision of hospital services.

Exhibit 9: A co-ordinated medical staffing strategy



Source: Accounts Commission

3 Appointment and performance

Introduction

Used appropriately, locum doctors are vital to the NHS. They offer hospitals flexibility in dealing with temporary staff shortages or unexpected peaks in workload. Without their support, trusts would have to employ more doctors than necessary, or face disruption to services whenever patient demand exceeds the capacity of the hospital's own staff to deliver.

Locums assist trusts in two key areas. They provide shift cover for doctors who are temporarily unavailable for work, which we have termed short-term use. Long-term locums, on the other hand, are generally appointed to vacant posts which the hospital is having difficulty filling, or as cover for staff on extended absence, such as maternity leave.

Short-term cover

The main function of a hospital is to provide high quality patient care around the clock. This requires a pool of medical staff to be on duty and on-call at all times. Doctors' absences are catered for either by colleagues providing cover for one another, or by recruiting short-term locums.

Locum cover is second best because:

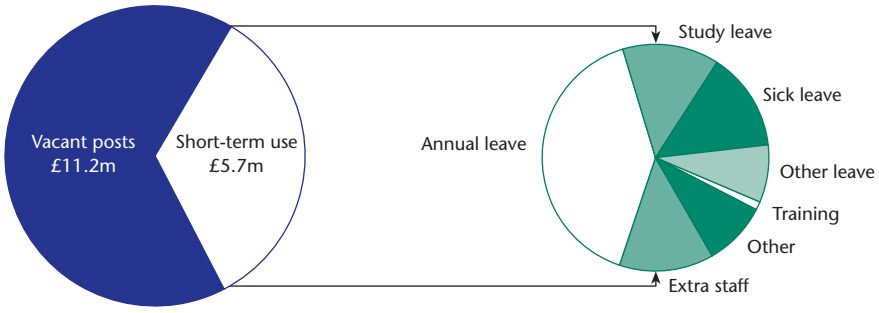
- the competence of locums is often unknown
- a locum doctor may be required to carry out important procedures with minimal supervision in an unfamiliar environment
- locum fees can be expensive compared to other staff costs.

For these reasons, the use of short-term locums should generally be restricted to absences which cannot be predicted in advance, such as sick leave. To this end, doctors' contracts normally include provision for prospective payments requiring them to cover foreseen absences. This is managed through the rota system, which can be arranged to cover routine absence such as annual and study leave provided the number of doctors is sufficient.

In fact, a substantial part of locum costs - amounting to just over £3 million in 1996/97 - was spent on procuring cover for annual and study leave (exhibit 10). This is partly attributable to those specialties and clinical teams where the numbers are simply too small to provide for absences within the rota. But there was also evidence from local audits of locums being used despite the existence of prospective arrangements.

Exhibit 10: Analysis of locum costs by reason for use

Providing cover for planned absence on annual and study leave accounted for 54% (£3.1m) of trusts' expenditure on short-term locums in 1996/97



Source: auditors' reports

The use of locums in these circumstances means that a trust is effectively paying twice for the same service, through the locum fee and in additional payments to its own doctors. Some duplication is inevitable, but it should be restricted to exceptional cases, for example when several doctors are unavoidably absent at the same time.

In practice, however, locum use is often the result of lax management, such as failure to:

- co-ordinate arrangements for annual and study leave
- monitor leave taken by junior doctors, resulting in a high level of accumulated leave at the end of the six monthly rotation
- ensure that prospective cover is being provided where appropriate.

Several trusts have succeeded in reducing locum costs by tightening up control of doctors' leave arrangements (exhibit 11).

Exhibit 11: Management of doctors' leave arrangements

Task:

To minimise the use of locums as cover for planned absence.

Action taken by trusts:

- rotas provide for prospective cover in appropriate cases
- individual contracts specify cover to be provided
- doctors prevented from accumulating leave without prior authority
- all leave subject to approval in advance
- leave arrangements co-ordinated and monitored by Personnel
- agreements between specialties to provide cross-cover in specific cases.

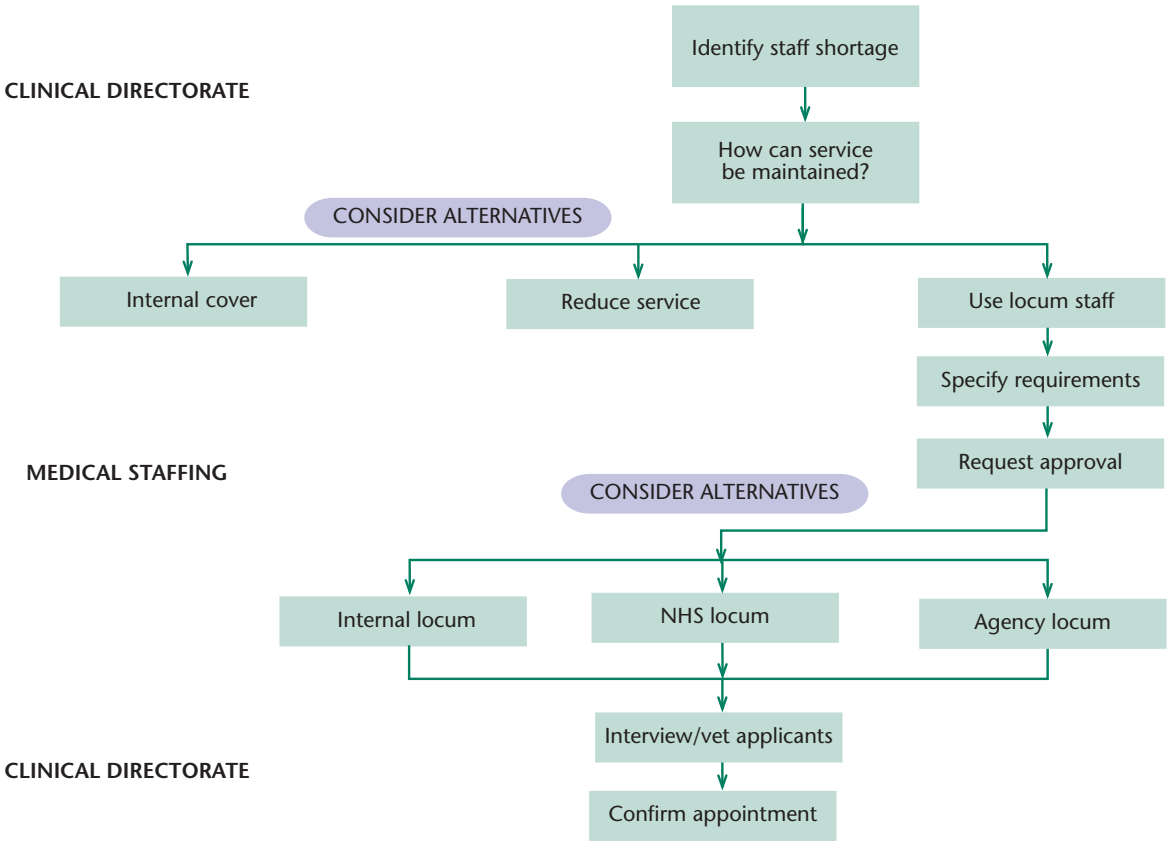
Source: auditors' reports

The need for emergency cover will usually first be identified by the clinical team. In the past, this would invariably have been met directly by the junior doctors within the team, with one or more doctors required to work additional hours to provide cover. However the introduction of limits on working hours has reduced the scope for internal cover, and increased the pressure on clinical directorates to look at other options such as appointing a locum.

There is some evidence from local audits that what were historically flexible arrangements involving the use of the hospital's own staff have been replaced by an equally relaxed approach to the use of locums. This partly explains the escalation in locum costs following the introduction of *The New Deal*.

Ideally, each application for locum use should be subjected to detailed scrutiny, on clinical as well as cost grounds, and assessed against other options in the interests of maintaining patient care. By their nature, gaps in the rota which arise unexpectedly demand a swift, even immediate, response which restricts the available options. In these circumstances, it is vital that the trust has in place clear guidelines on option appraisal and on the procedures to be followed in authorising locum appointments. The key elements of the option appraisal process are illustrated in exhibit 12.

Exhibit 12: Cover for short-term absence - option appraisal



Source: Accounts Commission

At the time of our study few trusts (less than one in three) had any formal arrangements of this kind. However, the situation is improving as more trusts recognise the importance of managing locum use and controlling costs. Several trusts have introduced protocols, along with other practical measures, such as the use of locum request forms, which formally record the justification for and approval of individual appointments.

Long-term cover

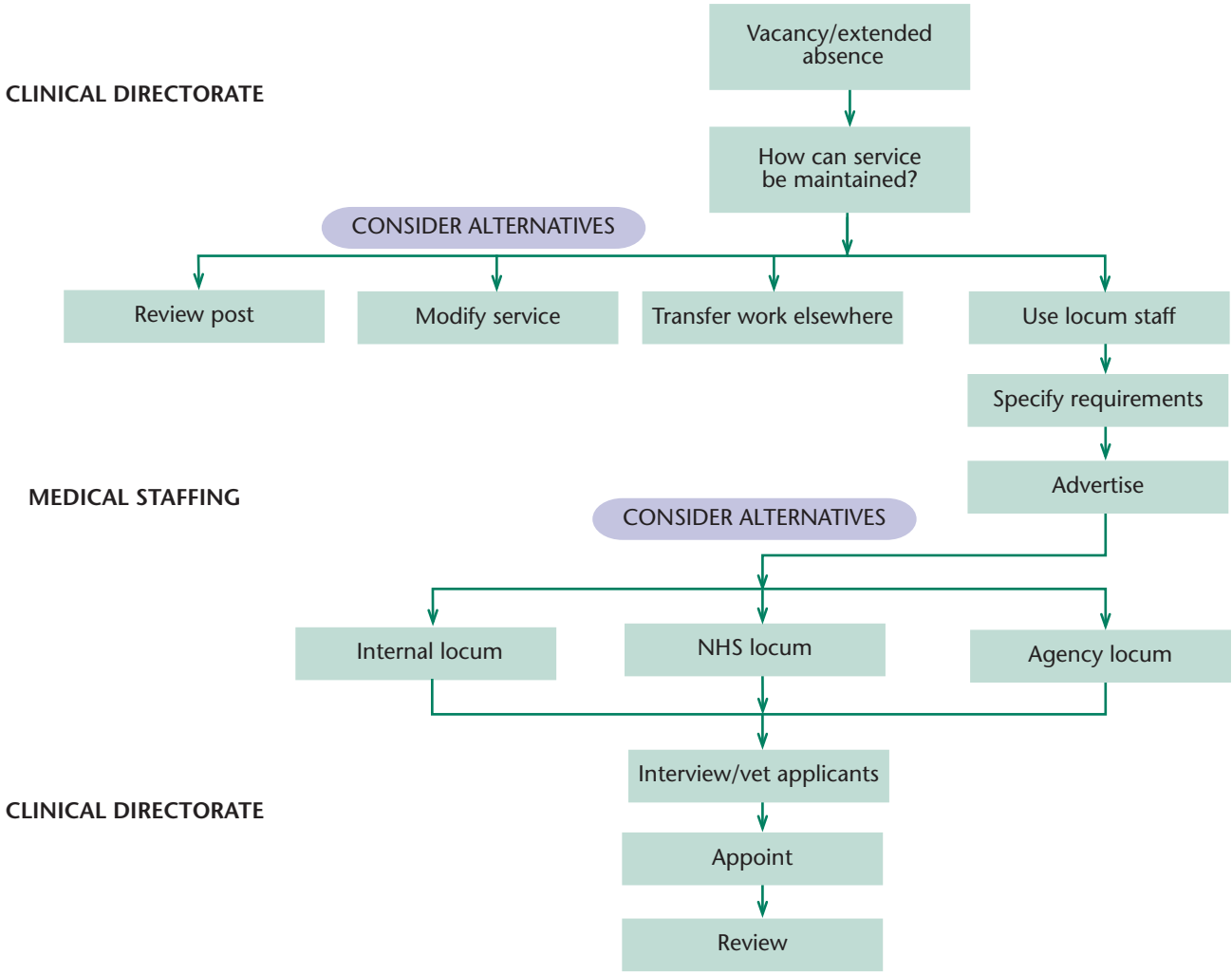
Trusts use long-term locums for two main reasons: first to relieve pressure on the clinical team arising from a vacancy or extended absence; and second, because they are unable to attract a candidate with the appropriate qualifications and experience. The issues surrounding their use are therefore more about standards than costs, particularly where an appointment involves a doctor acting up to a higher grade.

The decision to recruit a long-term locum is a matter for the clinical directorate, which is best placed to weigh up the service interest against the risk of appointing a doctor who is not fully qualified or experienced for the post. The over-riding principle is that such appointments should be temporary and that every effort should be made to fill the post substantively as soon as possible.

Vacancies under this heading fall into two groups - fixed and open-ended. Fixed vacancies include those where a substantive appointment has been made but cover is required until the doctor takes up post, or, for example, where a doctor is on maternity leave. Open-ended vacancies refer to posts which the hospital has been unable to fill. The rule here is that trusts should still appoint a locum for a fixed term (up to six months is the recommended limit).

If a trust does not expect a permanent appointment within that timescale, then it needs to explore more radical measures (exhibit 13). This may include abandoning or regrading the post (if there is an insurmountable recruitment problem), or combining services with a neighbouring trust. The primary consideration is the quality of patient care.

Exhibit 13: Cover for long-term absence - option appraisal



Source: Accounts Commission

Code of Practice

It is the clear responsibility of trusts to ensure that all doctors whom they employ are competent, appropriately experienced and qualified, and capable of undertaking the duties required of them. The *Code of Practice* issued by the Management Executive in January 1998[2] confirmed that these principles apply as much to locum doctors as to permanent staff. It contains detailed guidelines on their appointment and employment by trusts.

The Code covers four key areas:

- **Vetting** There is a well established procedure for ensuring that doctors employed in hospitals are properly qualified and experienced for the role they are required to undertake. This includes checks on medical qualifications and health status, together with appropriate references confirming career history and competence. Details of vetting checks required for locum appointments are listed at appendix 1.
- **Induction** Doctors taking on a new role require basic information, and where appropriate training, on the hospital, the organisation of patient care, and the duties which they have been assigned. The amount of induction required will depend on the length of appointment. As a minimum, locums should be given written information about practices in the hospital and specialty they will work in. This should include details about the tasks they may and may not carry out on their own initiative, and how to get advice and assistance when needed (see appendix 2).
- **Performance appraisal** At the time of our study, there were no guidelines in place for the supervision and appraisal of locums. Most trusts operated an informal system of review and feedback which was not formally recorded. The Code now requires them to introduce a structured assessment form based on the suggested format at appendix 3.
- **Locum agencies** Trusts which use locum agencies must ensure that each agency subscribes to the Code of Practice and complies with the specific responsibilities detailed at appendix 4.

Local audits suggest that the nature and length of a locum appointment have a marked effect on the extent of compliance with the Code. Most long-term posts are subject to conventional recruitment arrangements involving advertisement, interview and vetting of candidates. The procedures are therefore likely to be in line with those for the appointment and employment of medical staff in general.

Short-term appointments are quite different. Often these require urgent action to cover an absence that has arisen unexpectedly. This may involve conducting interviews of prospective locums by telephone, and relying on faxed references and local knowledge to assess their credentials. Much of this work is routed through locum agencies.

Risk management

Risk management is increasingly important in ensuring that trusts provide a safe and high quality service to patients. Patients are entitled to expect that the right number of doctors with the right standards of professional competence are available to provide an acceptable standard of care and supervision. Locums both avert and contribute to risk, by enabling hospitals to maintain appropriate staffing levels even though this might involve appointing doctors with less experience or skills than those they are replacing.

The presence of risk is not an argument against the use of locums, but those taking decisions need to be able to identify, measure and control the degree of risk involved. This is the approach advocated in the report of the Locums Working Group[1], which advised that "*... the use of locums should always be justified in light of the service need with reference to quality assurance and standards, and to risk management.*"

The principles are outlined in the booklet *Risk management in the NHS* which the Management Executive has commended to trusts in Scotland[6]. The section dealing with the use of locum agency staff is reproduced at appendix 6.

Auditors have recommended to trusts that locum appointment procedures should be evaluated as part of their corporate risk strategy. The major concern is safeguarding patients' welfare, but there are also considerable financial risks in appointing unsatisfactory or overworked locums. Examples of some of the detailed issues highlighted in auditors' reports, together with suggested solutions, are listed at exhibit 14.

Exhibit 14: Risk management

Risk from	Risk of	Good practice
Planning and approval		
• Poor monitoring of staff changes/absences	• Unnecessary use of locums	• Staff plan regularly reviewed and updated
• No formal approval of locum use	• Unauthorised use of locums	• Formal policy for locum appointment
• High incidence of emergency cover	• Rushed appointment	• Locum use subject to option appraisal
Vetting		
• Inadequate screening of short-term locums	• Inappropriate use on grounds of experience, qualifications, fatigue or health status	• Agreement on minimum standards of vetting, including checks carried out by locum agencies
• Reliance on agency vetting	• Appointment of bogus doctors	• Agencies liable for calibre of locum
• No checks on hours worked	• Claims for negligence	• Hours checked with locum's home trust
• No record of checks carried out		
Induction		
• Absence of formal arrangements	• Poor continuity of care	• Formal induction policy
• Limited induction of short-term locums	• Improper or unauthorised action by locums	• Written instructions provided in support of oral briefing
• Lack of proper supervision	• Inappropriate treatment of patients	• Contact names supplied for advice and support
Performance		
• Unclear line management structure	• Poor performance not dectected	• Use of formal assessment forms
• Inadequate reporting of poor performance	• Unsatisfactory locum reappointed	• Contact names supplied for advice and support
• No records maintained of appraisals	• Poor locums able to escape sanctions by moving between trusts	• Agreements between trusts for reporting poor performance

Local reports to trusts highlighted the importance of adopting the principles of good practice identified by the Locums Working Group[1], which form the basis of the current Code. The most frequent issues of concern were:

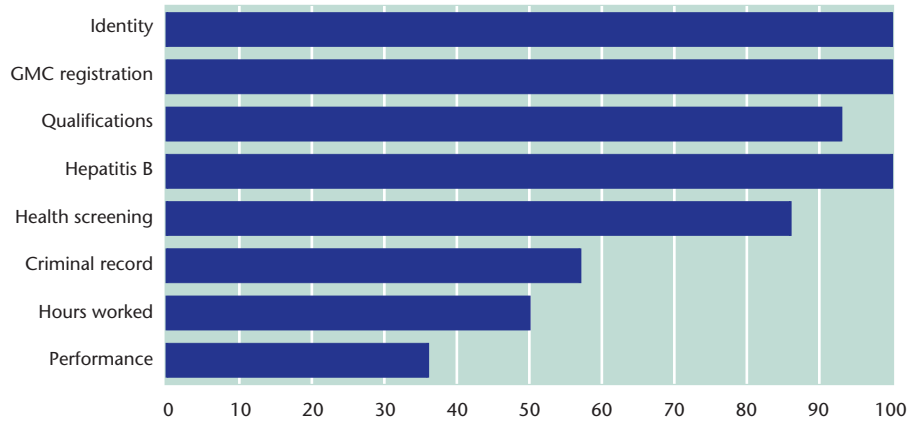
- reliance on agency vetting
- checks on hours worked
- lack of formal induction policy
- reporting poor performance.

Reliance on agency vetting

A major dilemma faced by trusts is that many requests for emergency cover involve overnight or weekend working. In these circumstances, agencies can offer trusts a convenient source of locums. However, the situation can often result in the rushed appointment of a locum who may then be subject only to minimal supervision.

Trusts often assume that agencies have carried out checks on the locums they employ, without ensuring that this is the case. The *Code of Practice* stipulates that a locum should not be engaged unless all necessary checks have been completed or the locum is well known to the trust. There are two separate issues of concern here. First, the range of checks carried out by agencies varies (exhibit 15), with some important checks omitted by a majority of agencies. Second, many agency contracts include a disclaimer for any liability arising from shortcomings in the vetting process.

Exhibit 15: Percentage of locum agencies carrying out specific checks



Source: Accounts Commission survey of agencies

There is no question that responsibility for the suitability of locum doctors rests ultimately with trusts. Under the *Code of Practice*, they may delegate responsibility for vetting checks to agencies. Auditors reported that, while this was common practice in many trusts, only rarely was the basis of the delegation subject to formal agreement between the two parties. Trusts have been advised that there must always be clear understanding about the procedures which have been delegated to agencies and about their contractual liability in the event of any failure to carry out appropriate checks. It is also essential that trusts satisfy themselves that agencies are competent to carry out these tasks (appendix 5).

Checks on hours worked

A common issue in local studies was moonlighting. This refers to doctors who circumvent the controls on junior doctors' hours by taking on extra work as locums at another hospital. Typically, it consists of on-call duties of a few hours or days, and often involves locum agencies which generally have no independent means of checking hours worked.

Even for appointments made directly by trusts, there is invariably no routine system of checking between trusts to confirm a doctor's ability to take on a particular locum assignment, taking account of hours already worked in the relevant period. In fact, many hospitals admitted that they are likely to turn a blind eye to potential abuse of the current ceilings if they need cover badly enough. This is understandable from the hospital's perspective, but it introduces a serious risk that the doctor will be too tired to exercise his or her duties properly - the original reason for limits on junior doctors' hours.

Case 2: Excessive hours worked by a locum

> The personnel manager at a trust received a phone call from a nursing officer complaining that the locum on duty was constantly falling asleep. When interviewed, the locum admitted that he had already worked in excess of 100 hours that week at his own trust, a fact that he had not mentioned on appointment. He was immediately sent home without pay. No action was taken to report the incident to the locum's home trust.

Induction

As for vetting, most trusts have an established procedure for induction of staff to vacant posts which is generally applied to locums and permanent staff. Few trusts, however, had a formal induction policy for appointments at short notice, leaving it largely to the clinical team to adopt their own approach. In their reports, auditors emphasised the need for formal induction which properly reflects the risk of using locums for duties which often receive minimal supervision.

Reporting poor performance

Doctors and managers have a common interest in ensuring that hospitals provide a good standard of practice and care, and that patients are protected from doctors who fail to meet these criteria. These objectives are achieved through appraisal, supervision and training, backed up by formal disciplinary action in extreme cases.

Inadequate performance can be classified in different ways:

- minor failings or mistakes which have no serious consequence but require some additional training or retraining
- more serious problems of unsatisfactory medical care not worthy of disciplinary action
- incidents of serious professional misconduct where the individual should be reported to the appropriate authority.

The first two categories can be difficult for consultants to handle, since most doctors will at some time have made mistakes during their training, and there is an

understandable reluctance to take action which may affect a doctor's future career. If trusts are dissatisfied with a locum's performance, they can simply terminate the appointment. Many trusts admitted that they had taken this option where there was no question of disciplinary action. However, failure to deal with even minor shortcomings may allow the locum to continue to practice without the opportunity to improve, and may place other patients at risk.

4 Sources of supply and costs

Introduction

The main function of a hospital is to provide high-quality patient care around the clock. This requires a pool of medical staff to be on duty and on-call at all times. Absences and vacancies are catered for either by doctors providing cover for one another or by recruiting locums.

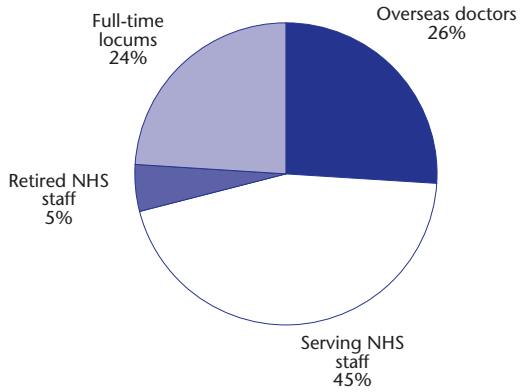
Internal cover is the preferred option, where it can be arranged without wasteful use of professional skills or breaching the rules on working conditions. Locums act as a safety net against unavoidable staff shortages, offering hospitals a practical and convenient means of maintaining services which might otherwise suffer. But their use requires careful consideration:

- locum doctors may be called upon to carry out important procedures with minimal supervision in an unfamiliar environment
- the appointment may involve compromise on experience or qualifications
- locum fees can be expensive compared to the alternatives.

Sources of supply

Just as the reasons for the use of locums vary, so there are several sources which trusts can turn to in filling a locum post (exhibit 16). There is no such thing as a typical locum. They range from working doctors who are looking for a few extra hours to supplement their income, to those who have decided to base their working life around locum placements. In between there is a whole assortment of doctors offering their services, ranging from recently retired consultants, overseas doctors looking for a temporary position in the UK, and junior doctors who are taking a spell out from training to broaden their experience.

Exhibit 16: Recruitment source

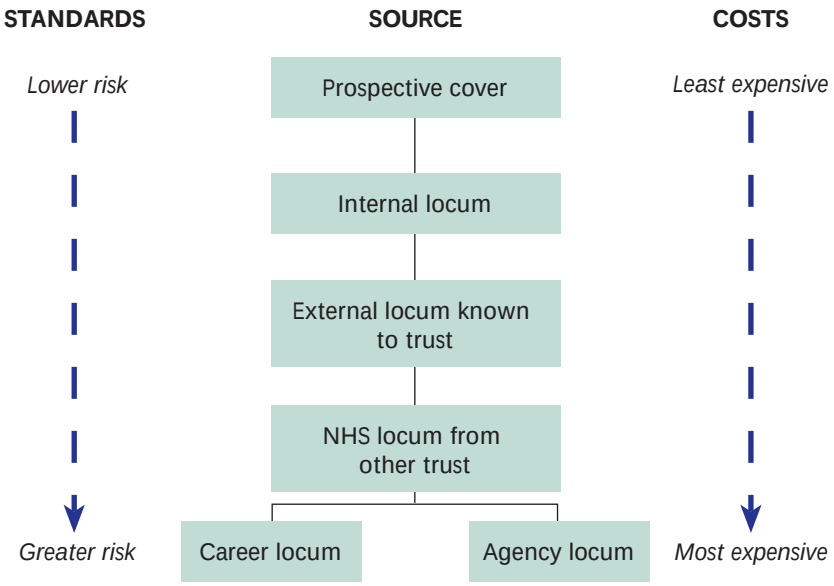


Source: Accounts Commission

For a trust, the ideal arrangement is to appoint as a locum doctor someone whom it knows, whose experience and competence can be directly vouched for, and who in turn is familiar with the working environment. This may be a former employee or someone currently working in the hospital who volunteers for a locum post.

On the whole, doctors who are recruited locally present less risk to standards of patient care than locums who are unknown to the trust prior to appointment (exhibit 17). They are also likely to cost less if they are paid at NHS locum rates or on personal terms which avoid the payment of agency commission.

Exhibit 17: Options for covering a temporary vacancy or absence



Source: Accounts Commission

Locum agencies

Locum agencies operate independently of the NHS. There are well over 50 such agencies in the UK, most of them members of the Federation of Recruitment and Employment Services (FRES). Between 1994/95 and 1995/96 the cost of fees to locum agencies more than doubled, from £4.5 million to £9.4 million. It fell back to £8.5 million in 1996/97, representing 50% of trust spending on locums.

Agencies rely heavily on mailshots and local contacts to generate business. During the course of a year, trusts are likely to receive expressions of interest from as many as 30 or 40 agencies from around the country. This will normally be narrowed down to five or six whose services they use regularly; but a hospital may have to go further afield if there is a shortage of suitable doctors locally.

There is no doubt that agencies make an important contribution in meeting trusts' needs for locums. But the convenience of transferring part of the placement process brings with it certain risks to the trust. For this reason, and because their costs are generally higher, agencies should be used as a last resort when all other practical solutions have been exhausted.

Agency vetting

In many trusts, the demand for locums is outstripping supply from the sources which they have traditionally relied upon to meet their needs. Not surprisingly, new agencies are springing up all the time to meet this demand.

There is evidence that trusts are increasingly being drawn into contacting agencies known to them only through mailshots and adverts in professional journals. If this contact leads to a possible locum placement, it is vital that some form of screening takes place to ensure that both the agency and the locum they intend supplying are legitimate. Failure to do so may expose patients to treatment from an inexperienced or incompetent doctor.

Case 3: Conflict of interest in the management of a locum agency

Staff in a trust's personnel section became suspicious about a locum agency after phone calls from the agency offering cover for particular grades and periods. This seemed to indicate prior knowledge of vacancies and leave absences within a particular clinical directorate.

Subsequent investigation revealed that the agency was owned by an SHO who was working in the directorate as a locum. Furthermore, the doctor concerned had been given responsibility for organising the junior medical staff rota, and was using his position to identify gaps which he could then bid to fill via his agency.

There were fears that he may have manipulated the rota to create vacancies, but this was never proven and there is no evidence that his activities resulted in additional cost to the trust. Nevertheless, this case highlighted weaknesses in the trust's internal procedures:

- the agreement with the agency contained only limited provision for liability and did not safeguard the trust against loss or damages arising out of negligence by the agency
- there was no obligation on the agency or locum to declare a conflict of interest
- the business manager (who controlled the budget) was not consulted about decisions on whether or not to use agencies.

The vetting process might involve:

- obtaining details of the agency's client base and making enquiries of one or two trusts about the standard of service
- carrying out appropriate financial checks
- entering a formal agreement with the agency specifying liability

- examining their arrangements for registering doctors
- assessing the skills of agency representatives to handle the trust's requirements
- confirming membership of a regulatory body such as FRES.

Locum bank

The main advantage offered by agencies is the access provided to a wide pool of prospective locums who can be appointed at short notice. A few trusts are attempting to reproduce this by operating their own pool or 'bank' of doctors who have expressed an interest in locum work (case 4). Traditionally there has been more demand within nursing for a service of this kind, but it is now becoming a feasible proposition at trusts where the use of locum doctors is growing.

Case 4: Operation of a locum bank

> Greater Glasgow Community and Mental Health Services NHS Trust established a locum bank in early 1996. It consists of current and previous employees and is updated every six months. All junior doctors are asked to indicate their willingness to participate in the bank. Those interested complete a form setting out the hospitals and shifts they are able to cover.

Some trusts are reluctant to establish a bank, believing that it will require too much effort to administer. But others have shown that it is possible to operate a service with minimal resources. For example, several trusts maintain informal lists of locums who have worked for them previously and who can be contacted directly for emergency cover. Nor does it have to be a hospital-wide service if the demand for locums is confined to a particular specialty or department - as in the case of Stobhill Trust, which operates a bank solely for casualty doctors in response to staffing shortages within A&E.

Locum banks help to minimise risk as well as cost, by enabling trusts to target locums who are known to be reliable. They are unlikely to satisfy all locum needs, but they should at least make it possible for trusts to reduce dependency on agencies for emergency cover.

Cost of locums

The cost of locum doctors to the NHS in Scotland has increased considerably in recent years. In 1996/97 expenditure by trusts topped £17 million, compared with just £9 million in 1994/95.

However, these figures are not a true measure of the real cost of employing locums. For most long-term locum appointments, for example, there will be compensating savings in the salaries budget from unfilled vacancies. By contrast, trusts have to meet the full cost of providing short-term locum cover: at £6 million, accounting for just over a third of all expenditure on locums in 1996/97. Allowing for higher fees paid to locum doctors compared to salaried staff, and the loss of funding for training posts which filled by locums for more than three months, we estimate that the overall additional cost to the NHS is currently between £8 million and £10 million per year.

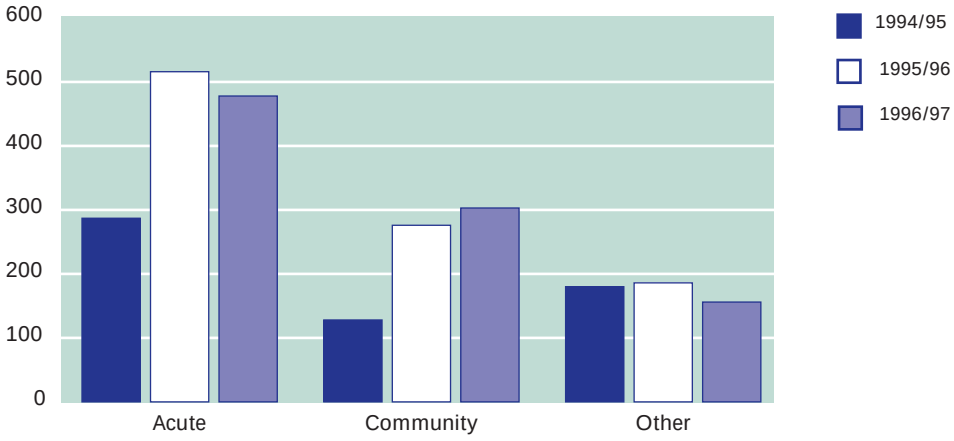
Two factors are mainly responsible for pushing up costs:

- an increase in demand, primarily as a result of initiatives such as *The New Deal* and the Calman report
- deregulation of fees, which came into effect in 1994.

Not every trust has been affected in the same way. On the whole, large teaching hospitals tended to cope better with the impact of *The New Deal* because of a higher ratio of junior doctors able to provide internal cover; while community trusts generally need a lower level of emergency cover than acute trusts. All of this is reflected in variations both in the range of expenditure by individual trusts (exhibit 2) and in the average costs of different categories of trusts (exhibit 18).

Exhibit 18: Average costs by type of trusts

Locum costs averaged £478k per acute trust in 1996/97, compared with £303k for community trusts and £156k for other trusts



Source: auditors' reports

It is worth noting that average spending by acute trusts fell by 7.4% in 1996/97 (down from £516,000 to £478,000). This was partly due to the success of local and national implementation groups in developing internal measures designed to relieve pressure on doctors' workload and achieve compliance with the ceilings on working hours. It also reflects action taken by individual trusts to bring locum costs under control.

Scope for cost savings

Many hospitals were caught out by the initial surge in demand for locums between 1995 and 1996. At that time, few trusts monitored their use of locums systematically. Several trusts have now introduced such arrangements, along with operational policies and formal protocols requiring advance approval of all locum appointments.

In practice, there are two ways of reducing spending on locums. The most effective, in terms of both standards and costs, is to avoid locum use altogether in as many cases as possible, through proper planning of staff movements and rotas. In this

respect, the data collected by auditors shows that £3 million is currently being spent in providing cover for planned absence (exhibit 10). On a conservative assessment of the findings in local reports, we estimate that between 20% and 25% of such appointments could be avoided by better management of doctors' leave arrangements, resulting in potential cash savings upwards of £600,000 a year.

Where locum cover is essential, the aim is then to minimise reliance on costly agencies (exhibit 19).

Exhibit 19: Cost saving measures

Option	Potential saving on agency fee	Possible obstacles
Own/other trust staff at NHS locum rate	Savings dependent on whether appointment involves on-call duties, which are paid as an allowance to NHS staff but at an hourly rate for agency doctors. Savings in such cases can be as high as 50%.	Ceilings on working hours; lack of volunteers
Own/other trust staff at premium rate	A number of trusts are offering NHS staff the rates which they would earn from agency work. By paying direct, they save on agency commission of around 15-20%	Possible conflict with ME guidelines for junior doctors
Locum bank	Savings dependent on whether staff paid at NHS or premium rates, but likely to average at least 10-20% after taking account of management costs	Cost/effort of administering bank arrangements
Tendering for agency services	Many agencies will offer discounts on normal fees if given first refusal on all appointments. Typical saving is 10%	Restricts the practice of instructing several agencies to mount searches at the same time

Source: auditors' reports

Some trusts have achieved quite significant savings by using a combination of these measures. Some, such as the locum bank, require an investment of resources as well as time, but those trusts which have gone down this route confirm that the benefits in terms of control over quality and costs are worthwhile.

There is also an issue around the payment of premium rates which, for junior doctors, must be within the terms approved under national agreements. Some trusts are ignoring this requirement, either through ignorance of it or because they feel that the benefits to the trust were more important. We believe that its continued application should be reviewed if the effect is to reduce the number of doctors volunteering to provide cover internally.

Tendering for agency services is perhaps the most basic of the cost-saving options available to trusts, but auditors reported that around half of the trusts visited had failed to implement this measure. With agency costs totalling £8.5 million a year and average discounts of 10% on offer, we estimate that savings of at least £400,000 are possible from this action alone. Added to the figure of £600,000 mentioned earlier, this would generate cash-releasing savings in excess of £1 million which could be put to use immediately in benefiting patient services.

5 Maintaining the momentum

We embarked on this study in 1996 against a background of rising costs and of the concerns being voiced by some trusts and professional groups about the increasing dependence on locum doctors in maintaining hospital services. This coincided with calls for a code of practice to regulate the use of locums and apply minimum standards to their appointment and employment.

Much has happened since then to allay fears that costs were spiralling out of control. There are signs that the demand for locums has peaked and may even be falling as the pressures on workload and resources generated by *The New Deal* subside. However, many of the clinicians we spoke to believe that this is a temporary respite and that rotas will come under further strain from the latest changes to doctors' training arrangements.

Whatever the implications for service delivery, it is certain that hospitals will be better prepared than before to cope with any upturn in locum demand. Following the local studies, most trusts should have in place by now formal procedures for authorising locum appointments and monitoring out-turn against budgets. These measures will help ensure that variations in levels of routine locum use are promptly detected and investigated, along with other options for providing appropriate cover.

Clinical risk and standards

Controlling the scale of locum use is only part of the equation. Just as vital (if not more so) is the issue of clinical standards and the trust's responsibility for ensuring that locums are competent to undertake the duties required of them. The guidance recently issued by the Management Executive contains a detailed list of action points which are designed to improve control over the quality of hospital locums.

The importance of applying rigorous standards to locum appointments cannot be overstated. While the primary concern is in safeguarding patient care, there is also the prospect of serious financial consequences if claims for clinical negligence were to result from an inappropriate appointment. Trusts need to weigh very carefully, and take steps to address, the added risks from using locums, especially where doctors are new to the hospital or lack the full credentials for a substantive appointment.

Adoption of the new code of practice will go some way towards formalising management responsibilities for locums within trusts, as well as between trusts and agencies in relevant cases. The code includes guidance on performance appraisal but it stops short of implementing *The Locum Working Group's* proposals for logbooks or for a national alert system for sharing intelligence about unsatisfactory locums.

Co-operation between trusts

These are among a number of potential initiatives that would require action to be taken nationally or by several trusts working together. The idea behind a logbook is that it would be carried around by the individual doctor and contain personal and professional details (including a photograph) as well as an independently attested record of performance. It would thus assist the vetting process by:

- protecting trusts against bogus or inadequately qualified doctors
- enabling review of recent employment history, including appointments held and hours worked.

There are doubts however about its practicality. The basic principles involved, which are almost universally recognised as good employment practice, are still quite foreign to the traditional culture within the medical profession, and there are likely to be a major difficulties therefore in guaranteeing that each logbook provides a comprehensive record of performance.

The main purpose of an alert system would be to collate information on unsatisfactory performance and so provide a warning to prospective employers about unqualified or unsuitable doctors. The advantage over a logbook is that it would focus on exception reporting and therefore be less onerous to administer. The Working Group suggested that the NHS Executive might undertake the task on a UK-wide basis.

Clearly issues of this kind are beyond the capability of trusts to deal with individually and so were largely outwith the scope of our review. Auditors did however take the opportunity to canvas views within trusts and found a generally positive attitude in favour of some form of central registration and control. We believe that the Management Executive should consider piloting such as scheme (as recommended by the Locums Working Group) in consultation with trusts.

The Audit Commission is currently engaged upon a similar study of locum use, and initial research indicates that inter-trust co-operation is generally at a more advanced stage in England and Wales with several initiatives underway, such as:

- the establishment of regional banks serving the locum needs of several trusts
- the use of matchbank services which essentially involve the operation of an inter-trust bank by a locum agency for a management fee
- negotiation by the NHS Supplies Agency of national contracts for agency services.

The feedback from trusts which use the national contracts is that they offer significant savings compared with standard fees and we believe that the case for extending the arrangements to Scotland should be pursued by the Management Executive. The full findings from the Audit Commission study on locum use will be published later.

Future programme

This study of locum doctors is the first by the Accounts Commission of staffing and working practices in hospitals. We intend to follow it up with a review of the management and operation of agency and bank nursing which will be carried out at trusts over the course of the next twelve months.

Appendix 1: Vetting of locum doctors

Before a locum doctor takes up post, checks must be carried out to confirm:

1 the doctor's identity, preferably by means of documentation such as a passport which bears a photograph. *

2 that the locum doctor is registered with the General Medical or Dental Council by inspecting the original certificates and/or by telephoning the GMC or GDC to confirm the registration.*

3 that no GMC proceedings concerning the doctor are pending or that the doctor has not been suspended, or is able to practise only under prescribed conditions.

4 the doctor's medical qualifications, again by inspecting the original certificates. *

5 that, where necessary, the doctor holds current membership of a medical defence organisation. *

6 the doctor's eligibility to work in the UK * [Where there is doubt and the doctor is a non-EEA national, the doctor should be asked to obtain a letter from the Home Office confirming his/her immigration status.]

7 that the doctor is suitably qualified and experienced for the work to be undertaken.

8 that the doctor:

   a makes available appropriate references covering recent appointments

   b has documentary evidence, dated within the last two years, of the pre employment health assessment by an Occupational Health Department*

   c has an up-to-date certification of immunisation from an Occupational Health Department and that this meets the requirements of HSG(93)40, its addendum EL(96)77, and any local requirements*

   d completes a form of Health Declaration and statement of Criminal Convictions before taking up the locum appointment*

9 that educational approval for the appointment is secured in advance if the locum posting is to be recognised for training purposes.

10 in the case of a doctor with Limited Registration, that the registration is valid for the work to be undertaken.*

11 that the locum placement will not cause the doctor in a training grade to breach the controls on hours set out in the *New Deal on Junior Doctors' Hours.* *

Responsibility for carrying out vetting checks should be clearly set out in the trust's operating policy. The *Code of Practice* issued by the Management Executive states that those checks above marked with an asterisk may, with all due care, be delegated to a locum agency under contract with the trust. In such cases, trusts should check, as often as they consider necessary, that the required checks are being carried out.

Appendix 2: Locum induction

The following guidelines should apply in developing a formal policy for locum induction:

- Locums should be provided in advance with relevant information about the trust and hospital in the form of an induction pack
- Locums should be given a conducted tour of the department and facilities they will be dealing with
- Locums should be provided with a means of communicating any problems and be aware of how to deal with emergencies beyond their experience
- Essential information about patients should be provided and particular problems discussed at length
- The consultant responsible should meet the locum to establish a relationship, discuss the capabilities and experience of the locum, and confirm the duties required
- The locum should be introduced to other staff and their respective roles explained.

Appendix 3: Performance assessment

The *Code of Practice* sets out new procedures for appraising and reporting on the performance of locum doctors. There are two suggested formats:

- a short assessment for appointments of less than a week (annex A)
- a more structured report for longer appointments (annex B)

Medical staffing officers are required to ensure that the appropriate form is completed by a senior clinician or the medical director at the end of each locum episode.

If the locum has been engaged through an agency, the medical staffing officer must always send a copy of the report to the agency. Reports showing serious shortcomings in the locum's performance should be copied to the GMC where appropriate. For doctors currently in training, postgraduate deans should receive copies of any report where significant shortcomings are identified. Medical staffing officers should retain all reports for seven years.

Employers who find that any locum doctor's services are of an unacceptable standard should complete as much as possible of a full structured assessment form (such as that at Annex B) for that doctor, *whatever the length of the locum episode.*

Annex A

Suggested format for assessment of locum appointments of less than one week

Doctor's name: . . . . . GMC No: . . . . . .

Grade (this post): . . . . . Specialty: . . . . . .

Period: . . . . . Unit: . . . . . .

The doctor's performance in this locum post has been: *

Good *Average* *Poor* *Unsatisfactory* **

** In the event of unsatisfactory work by a locum doctor, please complete the full structured assessment form

Would you employ this doctor as a locum in the hospital again?

Yes/No (Please tick as appropriate)

Comments by reporting doctor:

Does this doctor have any training needs that you have identified?

Name of reporting doctor: . . . . . .

Signed: . . . . . Date: . . . . . .

Statement by locum doctor:

I have seen the above assessment report and I agree/disagree (delete as appropriate) with its contents. If you disagree with the contents you should tell the medical director.

Signed: . . . . . Name in CAPITALS: . . . . . .

Comments by locum doctor (if desired)

Annex B

Suggested format for assessment of locum appointments of less than one week

Doctor's name: . . . . . GMC No: . . . . . .

Grade (this post): . . . . . Specialty: . . . . . .

Period: . . . . . Unit: . . . . . .

Please tick the appropriate boxes		Above average	Average	Below average	Unacceptable
CLINICAL SKILLS					
1	History taking				
2	Physical examination				
3	Investigations and diagnosis				
4	Judgement and patient management				
5	Practical skill				
KNOWLEDGE					
6	Basic science				
7	Clinical				
ATTITUDES					
8	Reliability				
9	Leadership and initiative				
10	Administration				
11	Timekeeping				
RELATIONSHIPS					
12a	Colleagues				
12b	Patients				
12c	Other staff				
12d	Communication skills				
PERSONAL QUALITIES					
13	Appearance				
14	Integrity				
15	Manners				

Does this doctor have any training needs that you have identified?

Name of reporting doctor: . . . . . .

Signed: . . . . . Date: . . . . . .

Statement by locum doctor:

I have seen the above assessment report and I agree/disagree (delete as appropriate) with its contents. If you disagree with the contents you should tell the medical director.

Signed: . . . . . Name in CAPITALS: . . . . . .

Comments by locum doctor (if desired)

Appendix 4: Responsibilities of agencies and banks

Both NHS and independent locum agencies should:

1 Meet the standards set out in this Code of Practice.

2 Comply with the Employment Agencies Act 1973 and the Code of Conduct Regulations for Employment Agencies and Employment Businesses 1976 (SI no 715)

3 Ensure that, on first registering with the agency, all doctors:

   a undergo a formal health assessment at an occupational health department, and obtain dated documentary evidence of this assessment;

   b provide current documentary evidence of the immunisations and tests that they have had, along with the results and dates. This should be provided by an occupational health department;

   c provide a statement of criminal convictions;

   d provide a valid criminal records clearance form, or undergo a police check where necessary.

4 Undertake the appropriate checks listed above as employer responsibilities where the agency is acting on the employer's behalf. There must be a clear understanding and agreement between the two parties ***so that no checks are overlooked.***

5 Secure copies of assessment reports on locum doctors they have placed, retaining these for as long as good business practice dictates; and consider whether a doctor who has been the subject of poor reports should remain on the agency's books.

6 Where questions arise about a series of reports from one unit (whether concerning the same or several different doctors), take the matter up with the senior management of that unit.

Appendix 5: Vetting of locum agencies

Trusts should maintain an approved list of agencies, inclusion in which is subject to the following criteria:

- Confirm the agency has not been convicted of operating fraudulently.
- Assess the trading position and history of the agency and undertake checks accordingly. If the agency is not one of the major agencies vigorous checks should be undertaken on financial background and references should be obtained.
- Ensure that the agency complies with the provisions of the Employment Agencies Act 1973 as amended by the Employment Protection Act 1975.
- Confirm the agency is a member of a regulatory body, such as The Federation of Recruitment and Employment Services Limited (FRES).

- Ensure that the agency subscribes to the Code of Practice in the appointment and employment of locum doctors.
- Evaluate agency procedures for the vetting and registration of doctors and undertake a formal agreement with the agency clearly specifying the obligations and liability of each party in the recruitment and appointment process. Meeting agency representatives should also be considered.
- The skills of the agency representatives to handle trust requirements should be evaluated.

Appendix 6: Risk management

Risk management is an increasingly important activity in ensuring that hospitals provide a high quality, safe service to patients and in minimising the possibility of negligence or loss. The principles are outlined in the booklet *Risk Management in the NHS*, published by the NHS Executive in England and Wales, which was commended to Scottish trusts in Circular MEL 1994(15). The section dealing with the use of locum and agency staff is reproduced here for information:

> There are often occasions when it is necessary to employ temporary staff to cover the absence of permanent staff. This may be done by the use of a 'bank' of staff, by using an agency or by advertising.
>
> Whichever means is used, it is essential that managers check the qualifications and registration of temporary staff who are engaged. The onus is on local managers to ensure that the people they employ are suitably competent to carry out the work which is required, particularly since some posts receive little supervision and are themselves responsible for supervising other staff. It is not enough to think that it is the responsibility of the agency involved. Managers should remember that there are particular dangers involved for temporary staff who do not know the physical area in which they are to work and do not know whom they can ask for advice and support. There is a tendency to pay less attention to scrupulous checking of the credentials of temporary staff, since they will not be there for long. But it takes only one incident to cause major problems for the unit, and it can be argued that more attention should be paid when taking on temporary staff than in the case of permanent staff.
>
> The report of the National Confidential Enquiry into Perioperative Deaths 1990 (CEPOD) found that in 7% of deaths the most senior operating surgeon was a locum; similarly, of those anaesthetists working alone, 9% were locums. In some cases, the locums in both disciplines were 'acting up', but often they admitted personally that they were inadequately trained or out of practice at particular procedures. A review of ***supervision of locum appointments at all grades in these specialties was recommended.***

References

1 *Hospital Locum Doctors*, the Report of the Locums Working Group: a Consultative Document (January 1995)

2 *Code of Practice in the Appointment and Employment of Locum Doctors*, NHS Management Executive Circular PCS(DD)1998/1 (January 1998)

3 *The New Deal: Plan for Action*, NHS Management Executive (1994)

4 *Hospital Doctors: Training for the Future, The Report of the Working Group on Specialist Medical Training (the Calman Report)*, Department of Health (1993)

5 *Is There a Doctor in the House?* Health Director (February 1996)

6 *Risk Management in the NHS*, Management Executive Circular MEL1994(15) (1994)

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