

# briefing

APRIL 1999

## Cover Story

### The Use of Locum Doctors in NHS Trusts

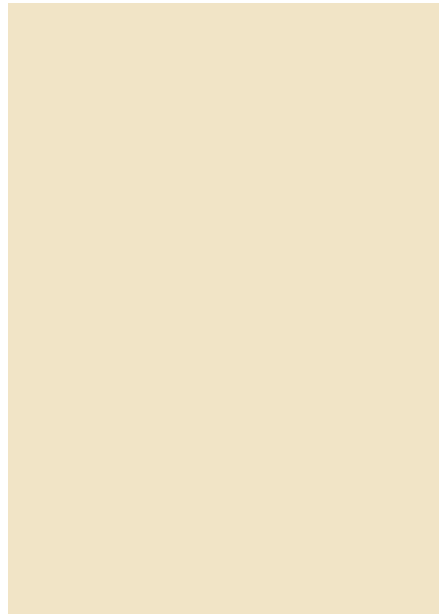
#### Locum doctors provide an important patient service in NHS trusts...

- on a typical day 3,500 locums are employed in hospitals in England and Wales, at a cost of £214 million in 1996/97
- nearly every trust uses locum doctors
- locums are often needed to provide important continuity of service when posts are vacant or when permanent staff are absent
- the majority of locum episodes are entirely satisfactory

#### ...but there are occasional concerns about the quality of care provided...

- trusts' arrangements for appointing and reviewing the performance of locum doctors are in some cases weak
- locum doctors work in unfamiliar surroundings, often with insufficient induction and low levels of both supervision and support
- it is difficult for locums who have not held permanent posts for some time to keep their technical ability and education up to date

#### ...and unnecessary costs are being incurred.



- financial controls over payments to locum agencies often do not meet basic standards
- after making allowances for geography and status, there remains significant variation in the use of locums between trusts
- locum use could be reduced through better management of permanent medical staff. For example, significant savings may be achieved through greater use of internal cover
- many trusts do not establish effective contracts or get the best deals from the locum agencies that they use

#### Improving the quality of locum doctors requires action at a national level...

- a system of accreditation is needed to assure the quality of the locum pool, and to provide help and advice to locums who have not held a permanent post for over two years
- performance review for all locums, as outlined in the NHS Executive's *Code of Practice in the Appointment and Employment of HCCHS Locum Doctors*, needs to be implemented consistently across the UK

#### ...but there is much that trusts can do locally to improve standards and reduce costs.

- the NHS Executive's *Code of Practice* should be implemented in full
- all trusts should appoint a senior doctor to take an overall lead and managerial accountability for the quality of locums employed
- trusts should establish effective partnerships with a limited number of locum agencies to secure best value for money for all concerned.



# Introduction

1. On a typical day, there are around 3,500<sup>I</sup> doctors working as locums in NHS trusts in England and Wales. They are needed for a variety of reasons [EXHIBIT 1].

2. Nearly all trusts of all types use locum doctors. In 1996/97, trusts in England and Wales spent £2.8 billion on medical staff. Of this, £104 million (49 per cent) was spent on locums who were recruited directly by trusts (mainly to cover vacancies), and £110 million (51 per cent) was paid to private locum agencies (mainly to cover short-term absence).

3. Locum doctors provide a vital service to the NHS, and where they are competent in all respects to do the work required, they provide the same standard of care as a doctor in a permanent

post. But problems may arise if they are not familiar with their surroundings and with local procedures and practice. Many locum appointments are for very short periods [EXHIBIT 2], and where locums are covering short-term absence, they are likely to work out of hours without direct monitoring or supervision.

4. These concerns led the Chief Medical Officer to convene a working party to find ways of improving the management of locums and assuring the quality of their work. In 1997, the NHS Executive's *Code of Practice in the Appointment and Employment of HCHS Locum Doctors*<sup>II</sup> was issued as guidance to trusts on the appointment, management and performance review of locums.

5. The efficient and effective management of locum doctors comprises three main elements:

- reducing the need for locums by establishing the right numbers and mix of permanent medical and clinical staff;
- when locums are needed, the quality of the work they do must be assured; and
- the cost of locums should be minimised without compromising quality.

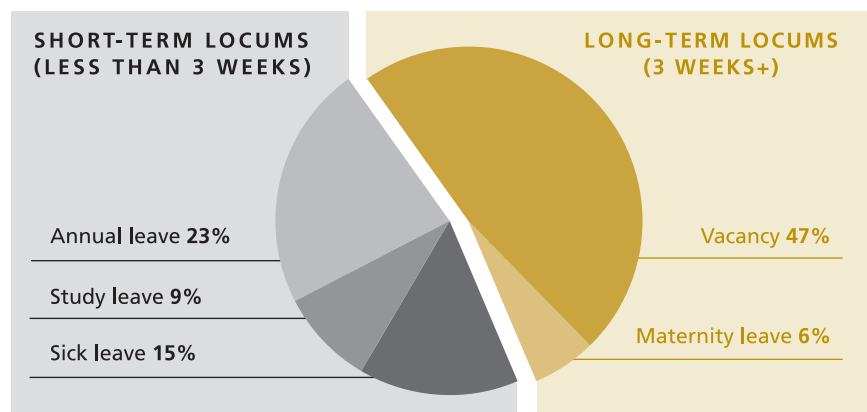
I 2,450 whole time equivalents.

II Circulated in England under cover of EL (97) 48 and DGM (97) 68 in Wales.

## EXHIBIT 1

### Reasons for expenditure on locums

Locums are used for a variety of reasons.



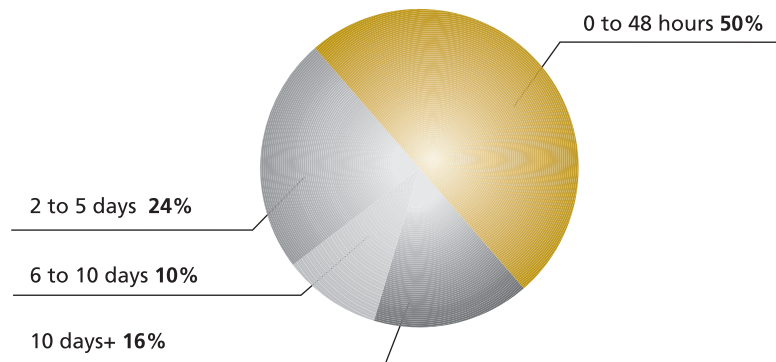
Note: N = £6.019m – analysis of locum expenditure at seven trusts.

Source: Audit Commission research sites

## EXHIBIT 2

**Duration of locum episodes**

About half of locum appointments are for less than two days.



Note: 4,896 episodes at 11 trusts.

Source: Audit Commission research sites

## Reducing the need for locums

6. Any shortfall between a trust's permanent medical staff and its service needs will increase the pressure to employ locums. Some of the factors affecting workload planning are outside trusts' control, but are often exacerbated by ineffective *local* management of locums. For example, some trusts needlessly spend money on short-term locum cover for planned leave even though full prospective cover by permanent staff has been negotiated and agreed [EXHIBIT 3, overleaf].

7. National medical workforce planning is notoriously difficult, due to the long lead times and changing service needs. Nevertheless, some trusts could

reduce their use of locums through better local medical workforce planning. This involves working with the regional postgraduate dean and the local medical workforce advisory group to ensure that both training requirements and service needs are met. Once such plans are agreed, trusts can reduce their dependence on locums by:

- providing full prospective cover for the planned leave of permanent doctors (as long as New Deal hours are maintained);
- arranging doctors' work to enable the provision of cross-cover between complementary specialties

in accordance with guidelines from the appropriate Royal Colleges;

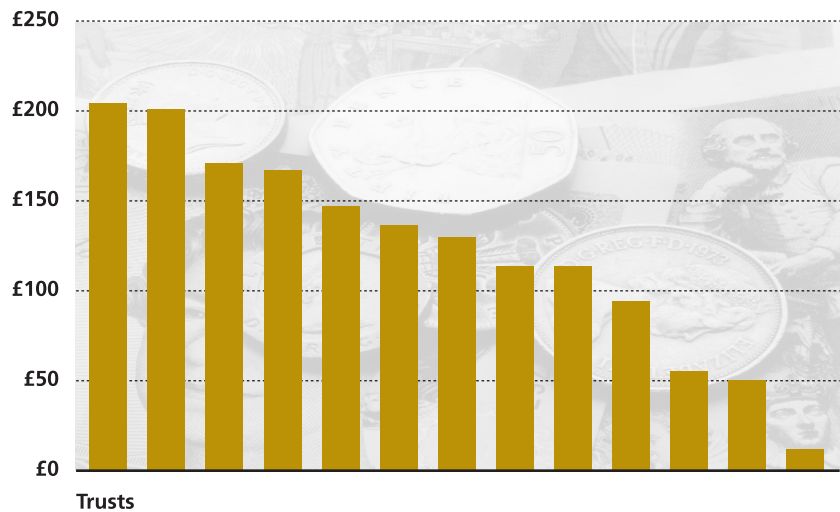
- introducing flexible working arrangements to help recruit and retain permanent members of staff;
- ensuring that recruitment procedures are streamlined so that vacant posts are filled as quickly as possible; and
- ensuring effective team working among all healthcare professionals so that permanent doctors are not undertaking inappropriate duties.

## EXHIBIT 3

**Saving opportunities identified in trusts that use locums to cover planned leave**

Money could be saved by trusts that continue to use short-term cover planned absence in specialties with adequate prospective cover.

Saving opportunities (£000)



Source: Audit Commission research sites

## Assuring the quality of locums

### At a national level

8. Although there is a widely held view that locum doctors are of lower quality than permanent staff, there is little evidence either to confirm or disprove the point. However, adverse events involving locums were reported by directors of personnel in the 35 per cent of trusts that responded to an Audit Commission survey. The problems ranged from minor irritations, such as arriving late, to serious or critical adverse incidents.

9. There are two main reasons why locum doctors may pose a clinical risk to patients. Firstly,

an Audit Commission survey of locum doctors found that eight out of ten respondents did not hold permanent posts elsewhere, and that one in five had not held a permanent post for over two years [EXHIBIT 4]. These doctors will find it extremely difficult to keep their technical skills and knowledge up to date as they are not attached to any recognised training scheme. And, secondly, locum doctors may pose a clinical risk because the circumstances under which they are appointed and carry out their duties are often less than ideal.

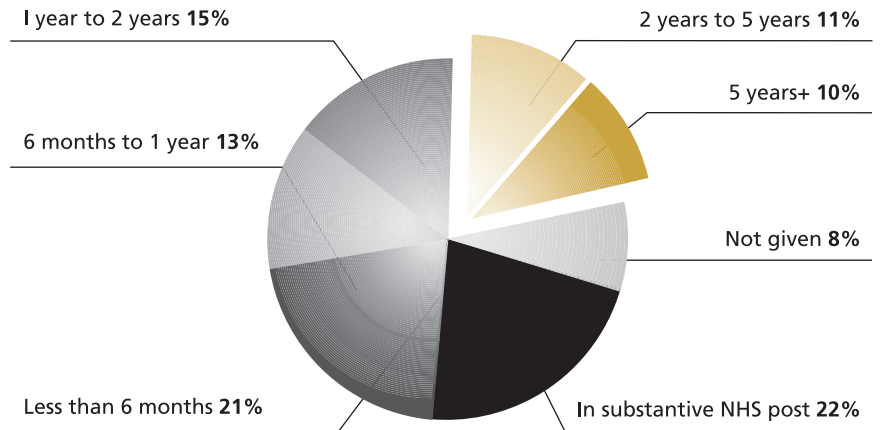
10. Assuring the quality of the national locum pool is not

straightforward because, unlike other areas of medicine, no organisation has overall responsibility. To address this problem, a high-level working party should be established to consider the development of an accreditation system for locum doctors who have not held a permanent post during the previous two years. The aims of such a system would include reviewing locums' continuing professional development and medical education; assessing their performance review records; and providing access to careers guidance.

## EXHIBIT 4

**Time since locum doctors held a permanent post**

One-fifth of locums have not held a permanent NHS post during the previous two years.



Note: N = 130. This analysis is based on a low (32 per cent) response rate.

Source: Audit Commission research sites

**At a local level**

**11.** As long as uncertainties about the overall quality of the locum pool persist, it is important for trusts' own controls to be robust. Many of the detailed aspects of the appointment and employment of locums are dealt with at a specialty level. But given the shortcomings and breaches of standards observed in the appointment, induction, supervision and performance review of locums, all trusts should appoint a senior doctor at medical director or associate medical director level to take an overall lead and managerial accountability for ensuring the quality of locums employed. Alternatively, there may be merit in appointing two separate

senior doctors to this role; one with responsibility for the quality of locum consultants, and the other for locums covering trainee posts. These two groups of locums present different problems and such an arrangement would spread the workload.

**Appointment**

**12.** Many of the checks needed to ensure the competence of locum doctors are not undertaken [EXHIBIT 5, overleaf]. Making all the necessary checks is especially important for locum consultants who, once appointed, practice with full clinical autonomy. When a locum is required at short notice, trusts have to place considerable reliance on the agencies that supply them. But many trusts expose themselves

to risk by failing to establish properly specified contracts and effective relationships, and by using a large number of agencies.

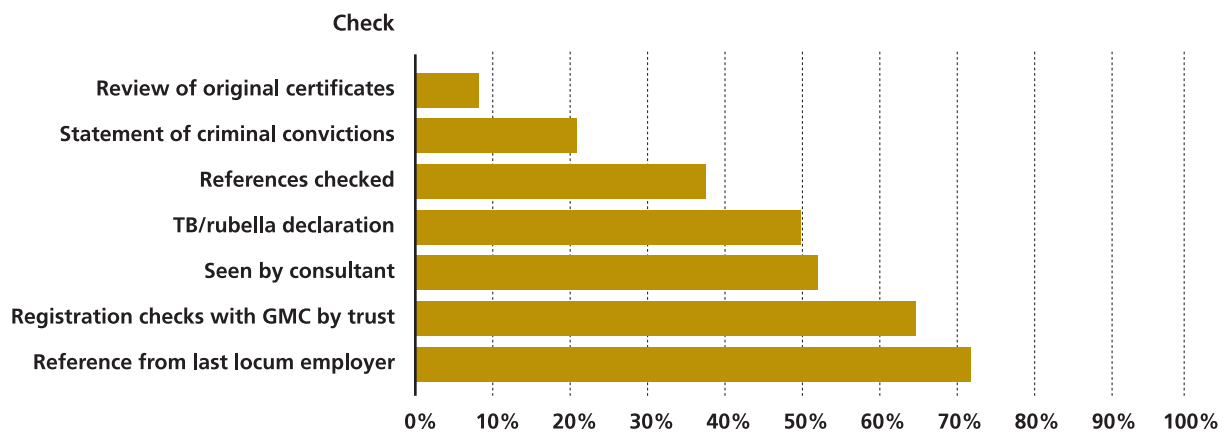
**Induction**

**13.** Any member of staff is likely to perform below their best if they are unfamiliar with their surroundings. This is especially true of locums who have never worked at a particular hospital before. Yet arrangements for the induction of locum doctors are inadequate at about half the trusts in England and Wales [EXHIBIT 6, overleaf], and significantly worse than for doctors in permanent posts. The proper induction of locums is an important and obvious safeguard against clinical risk.

EXHIBIT 5

**Checks undertaken before appointing locums**

Many important checks are not undertaken.



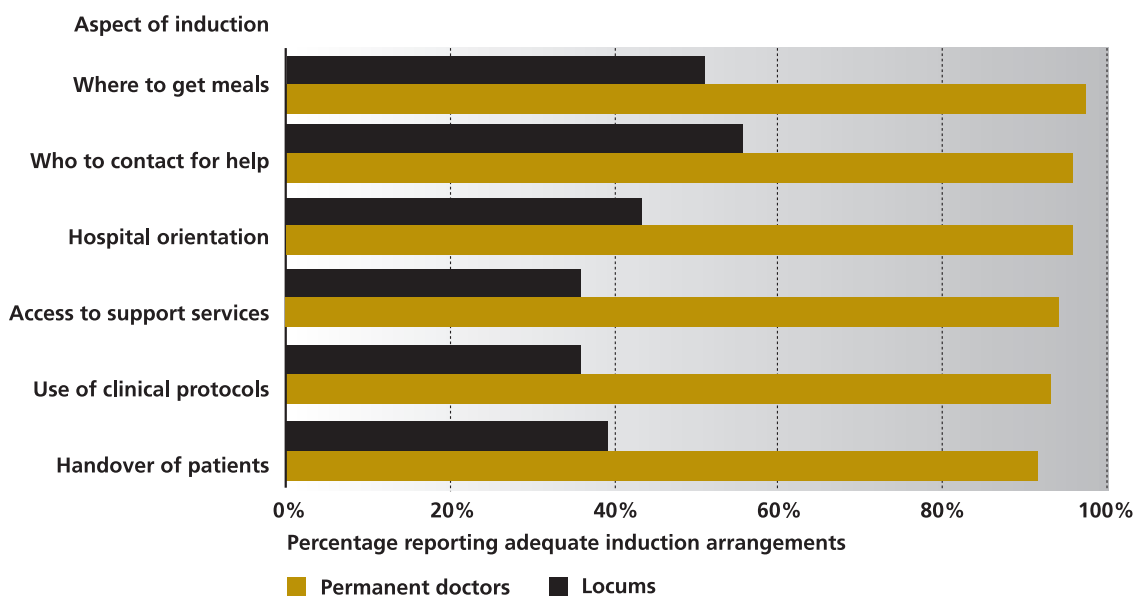
Note: N = 181 (locum episodes).

Source: Audit Commission

EXHIBIT 6

**Induction provided to new doctors – personnel directors’ views**

Trusts fail to provide consistent standards of induction to locum doctors.



Note: N = 240.

Source: Audit Commission survey of directors of personnel

### Supervision

14. Locums are often employed to cover posts or periods of time where direct supervision is not the norm. Only 52 per cent of directors of personnel surveyed felt that their trust provided adequate monitoring of the work of locum consultants. Medical directors, working closely with clinical directors, should provide a reasonable level of oversight of

the work of locum consultants who do not meet the criteria for permanent appointment to the grade. In general, locums who are unknown to the trust should work unsupervised only if they have been deemed competent by an appropriate consultant.

### Performance review

15. Despite the requirement of the *Code of Practice* that trusts should

have introduced arrangements for performance review by December 1997, only 36 per cent of the directors of personnel surveyed in June 1998 reported that this had been done. A comprehensive performance review system for locums is essential to ensure that problems in clinical performance are detected and addressed at an early stage.

## Minimising the cost of locums

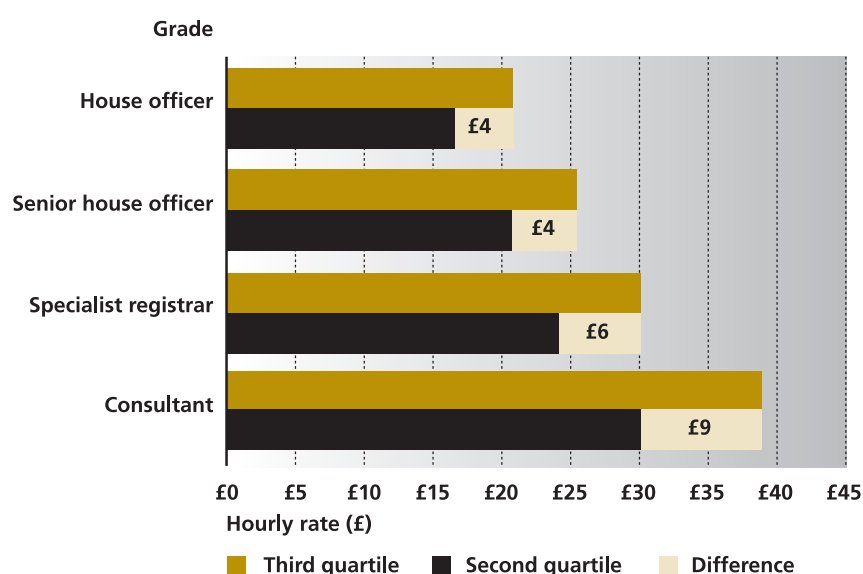
16. There is wide variation in the hourly rates charged by agencies for locum doctors. This suggests that there is considerable scope for trusts to achieve savings by negotiating better deals with agencies [EXHIBIT 7].

17. To minimise agency costs on trusts' behalf, NHS Supplies has established a national contract for medical locums that sets a level of agency commission and service standards. Six trusts were visited that were not using the national contract, and had not sought competitive tenders for the medical locum agency services. At these trusts, average savings opportunities of £30,000 (about 10 per cent of their expenditure on agency locums) were identified.

EXHIBIT 7

### Hourly rates paid by trusts for agency locums

There is a wide variation in the hourly rates paid by trusts to agencies for different grades of locums.



Note: N = 240 (data quoted show inter-quartile range).

Source: Audit Commission survey of personal directors

18. Money can be wasted through error or fraud. However, controls over payments to agencies are applied inconsistently, exposing many trusts to the risk of financial loss [EXHIBIT 8]. Internal audit has an important role to play and should undertake sample checks on payments for locums as part of their cyclical audit plans.

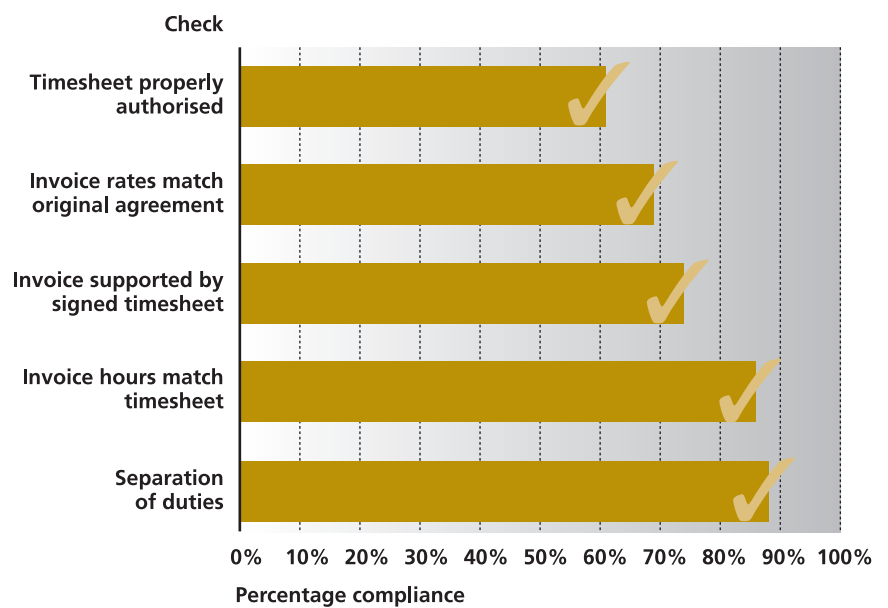
## Next steps

19. During the audit year 1998/99, many NHS trusts in England and Wales will receive a local report from their external auditors about their use of locum doctors. Having completed their reports, auditors will in future years review the progress made by trusts towards achieving better value for money.

EXHIBIT 8

### Controls over payments

Controls over payments to agencies are applied inconsistently.



Note: N = 206.

Source: Audit Commission research sites

If you want to know more: the full national report, **Cover Story: The Use of Locum Doctors in NHS Trusts** looks at all these issues in more detail and includes background information, case studies and specific guidance.

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