

Using locum doctors in hospitals



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Auditor General for Scotland

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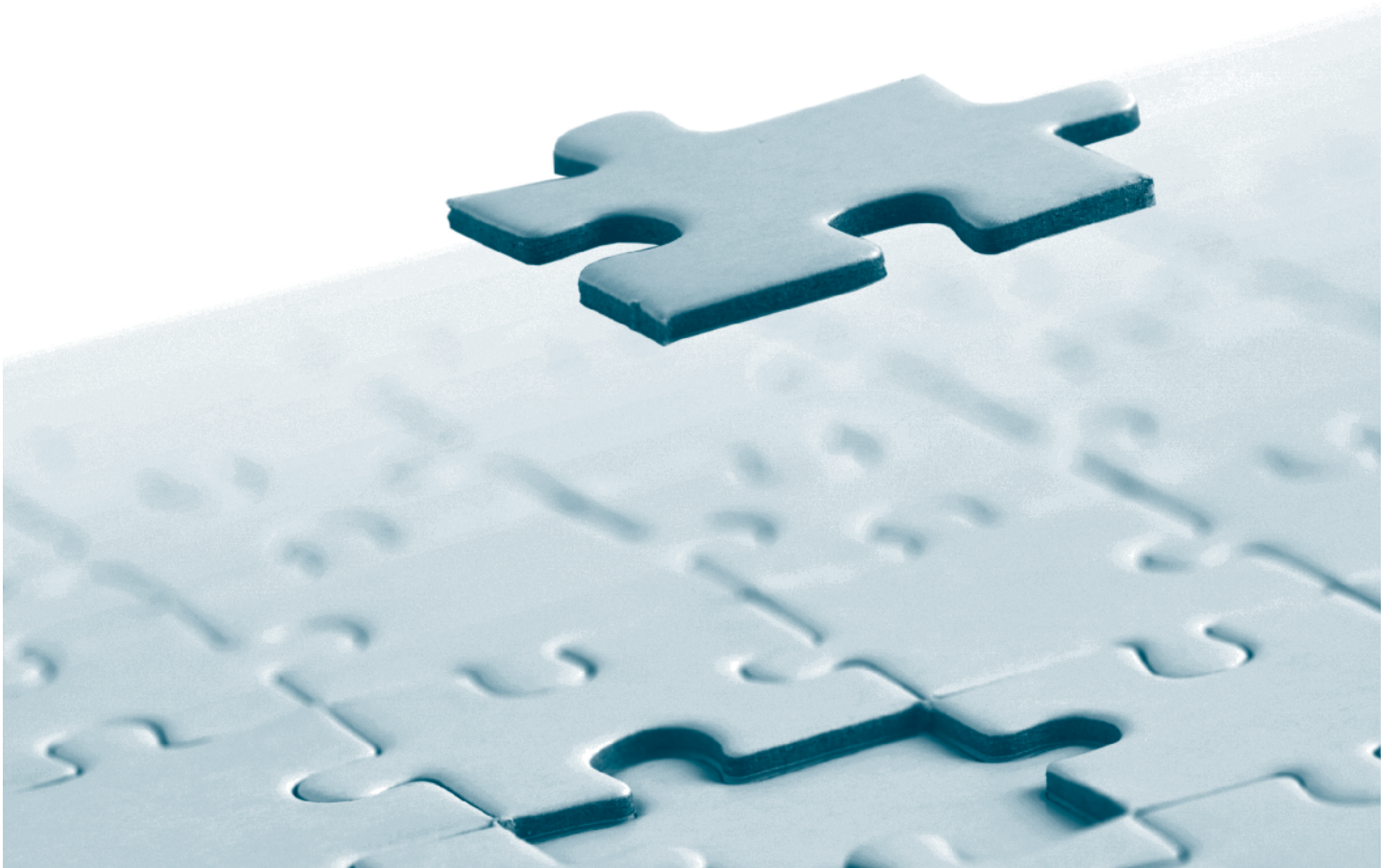
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Summary



The NHS could save around £6 million a year by some boards reducing expenditure on locum doctors.



Introduction

1. The NHS provides care for patients 24 hours a day, 365 days a year. To help provide good quality care, hospitals need to ensure there are appropriate numbers of staff, such as doctors, at work. When there are not enough doctors available to provide the required level of care and maintain service delivery, NHS boards will seek to cover these gaps. One of the ways this can be done is by using locum doctors.

2. Locum doctors are doctors of any grade or specialty who provide temporary cover at any time in acute and community hospitals. They can be used to cover:

- planned gaps in staffing caused by vacancies, maternity leave and annual leave
- unplanned gaps in staffing caused by sickness absence or sudden, unexpected vacancies in substantive posts.

3. The number of locum doctors working in hospitals in Scotland is unknown. This is because there are no local or national databases of doctors working as locums, and many doctors carry out locum work in addition to their substantive post.

4. NHS boards can use internal locums or agency locums to fill gaps in medical staffing cover:

- Internal locum doctors are those already employed by an NHS board. These can be doctors carrying out locum shifts in addition to their substantive post, often for very short-term gaps, or doctors directly recruited by the NHS board to provide cover for longer-term gaps, such as vacancies. Internal locum doctors are paid directly by the NHS board at set national rates.

- NHS boards can also employ locum doctors from agencies. These may be doctors who already work in the NHS, either in the same NHS board or another, or doctors who are not currently employed by the NHS and may come from another UK country or from outside the UK.¹ NHS boards use agency locum doctors to cover both planned and unplanned gaps. NHS boards pay the agency for the locum doctor.

5. There are two types of locum post – a Locum Appointment for Training (LAT) and a Locum Appointment for Service (LAS). If the gap in medical staffing is in a training post, NHS boards can directly recruit a locum to this LAT post and they will receive medical training just like any other junior doctor in a substantive training post. These tend to be for periods from three to 12 months. NHS boards can also appoint a locum doctor to a LAS post. This is a post at any grade or specialty where no training is offered. LAS appointments can be used to cover both unplanned, often short-term gaps, such as sickness absence, and longer-term planned gaps such as vacancies. NHS boards use both internal and agency locum doctors to cover LAS posts.

6. The cost of using agency locums is generally higher than for internal locums. The decision on the type of locum cover required is based on factors such as clinical risk, the length of time the locum is needed, the type of position that needs to be filled and the availability of locums.

7. If NHS boards do not have appropriate systems in place for appointing and managing locum doctors, this can cause unnecessary expenditure and can create risks to patient safety. By using locum doctors efficiently and effectively, NHS boards can save money and

improve service delivery. Control over the additional costs of using locum doctors is particularly important in the current economic climate.

About our audit

8. We examined how efficiently and how safely NHS boards are using locum doctors in hospitals. We analysed the reasons why NHS boards are using locum doctors and how much they are spending on them. We also assessed whether NHS boards have appropriate arrangements in place for ensuring patient safety when using locum doctors.

9. Our report focuses on the use of locum doctors in acute and community hospitals. We did not examine the use of GP locums in the primary care sector.

10. We analysed quantitative and qualitative data collected from NHS boards and the Golden Jubilee National Hospital. We also interviewed a range of staff at four NHS boards (Grampian, Greater Glasgow and Clyde, Highland and Lanarkshire), the Scottish Government Health Directorates (SGHD), National Procurement (part of NHS National Services Scotland), the General Medical Council (GMC) and NHS Education for Scotland (NES). In addition, we undertook an online survey of doctors who have worked as locum doctors in NHS boards in the past two years. See [Appendix 2](#) for full details of the methodology.

11. We have highlighted specific issues for non-executive NHS board members to raise within their boards. These focus on efficiency and patient safety issues (see [Appendix 4](#) and *Issues for non-executive NHS board members* on our website).

¹ The number of locum doctors from outside the UK who are working in Scottish hospitals is unknown as this information is not collected centrally by NHS boards or the Scottish Government.

12. This report is in three parts:

- **Part 1** examines the extent to which NHS boards are using locum doctors efficiently.
- **Part 2** considers how NHS boards are managing the demand for locum doctors.
- **Part 3** assesses whether NHS boards are using locum doctors safely.

Key messages

- NHS boards spent approximately £47 million on locum doctors in 2008/09, 4.3 per cent of overall medical staffing expenditure. This is approximately double the amount spent in 1996/97 in real terms. The NHS could save around £6 million a year by some boards reducing their expenditure on locum doctors to the national average. Local circumstances may make this challenging to achieve but all NHS boards should be capable of making savings by improving procurement procedures and, more generally, managing workforce planning better.
- Demand for agency locum doctors has increased since 2006/07 but the ability of agencies to meet requests has fallen. Demand for locum doctors is mainly driven by wider workforce planning issues such as increasing numbers of hard-to-fill vacancies and the full implementation of the 48-hour week European Working Time Directive for medical staff. Most requests for agency locum doctors are to cover vacancies and planned absence, such as annual leave and study leave. There is no information available for internal locum doctors.

- The employment of locum doctors presents potential risks to patient safety and it is the ultimate responsibility of NHS boards to ensure these risks are minimised. NHS boards need to manage these risks better. Arrangements for pre-employment checks are not always formalised and there is a risk that checks may not be completed at all times. Induction arrangements for locum doctors are variable. In addition, feedback on performance is mainly verbal with written assessments undertaken infrequently. There are no formal mechanisms in place for sharing information about individual locums between NHS boards and agencies.

Key recommendations

NHS boards should:

- collect, and hold electronically in an easily accessible and collated format, the following information relating to expenditure, demand and use of locum doctors:
 - grade and specialty
 - type of locum (internal or agency)
 - time of shift and duration
 - reason why locums were needed and used
- analyse and report performance information and develop strategies to reduce expenditure on, and minimise demand for, locum doctors. Performance information should be benchmarked with other NHS boards

- ensure they have a corporate policy, setting out when locum doctors can be used and procedures for procuring locum doctors. Compliance with the policy should be monitored and action taken to improve compliance where necessary
- develop corporate policies relating to pre-employment checks, induction, supervision and performance management of locum doctors and ensure these are implemented across the organisation.

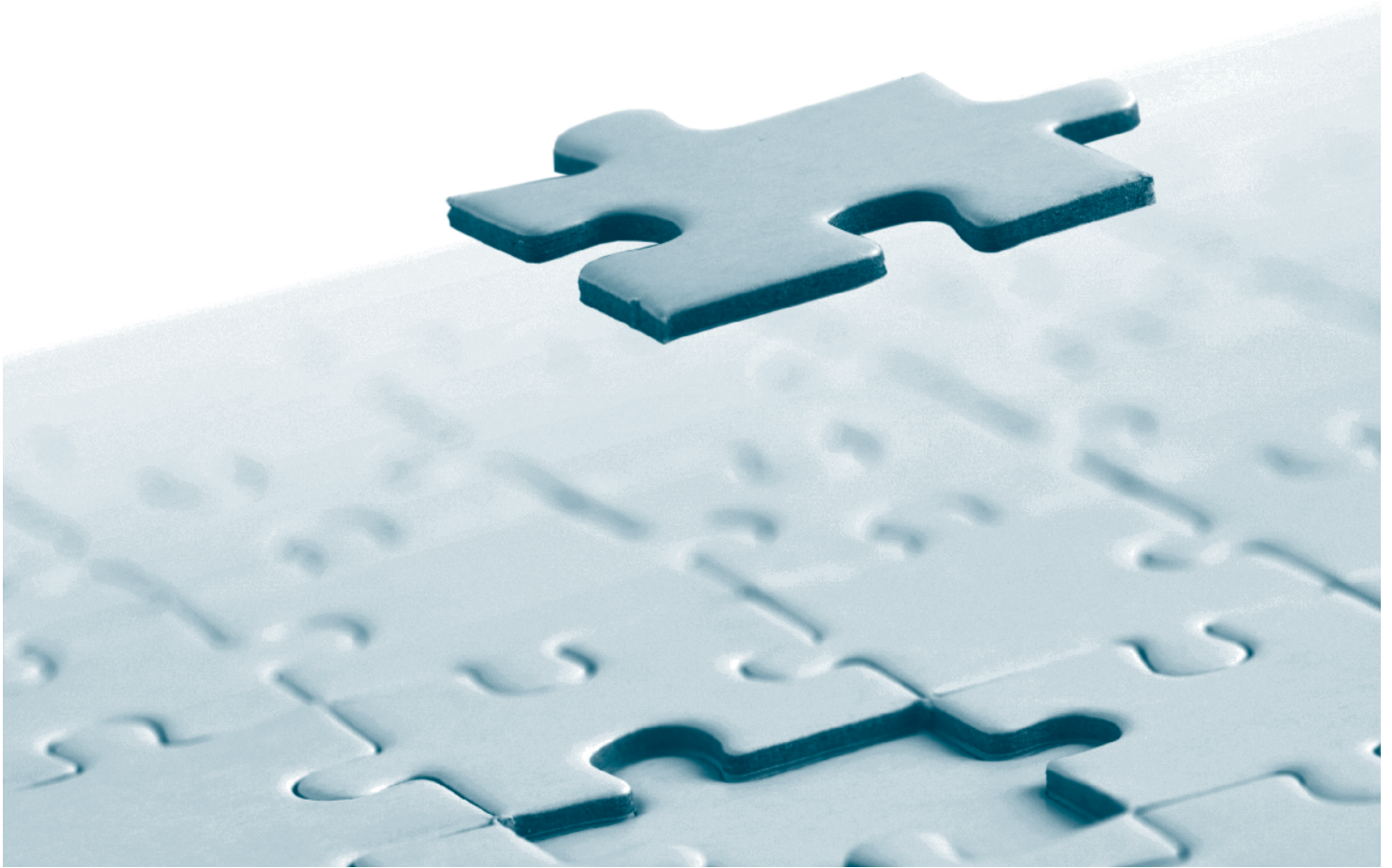
The Scottish Government and National Procurement should:²

- identify national performance indicators for NHS boards to use to benchmark performance in relation to locum doctors
- monitor the performance of national contract agencies in meeting NHS boards' requests for locum doctors and take appropriate action where performance falls below agreed levels.

The Scottish Government should:

- update the national *Locum Code of Practice* and develop performance measures to assess NHS boards' compliance with the Code. The *Locum Code of Practice* should specify arrangements for reporting poor performance.

Part 1. Using locum doctors efficiently



NHS boards need better information to identify where savings can be made.



Key messages

- NHS boards spent approximately £47 million on locum doctors in 2008/09, 4.3 per cent of all medical staffing expenditure. This is approximately double the amount spent in 1996/97 in real terms. Although overall expenditure has not risen in the past three years, expenditure on agency locums continues to increase. The NHS could save an estimated £6 million a year by some boards reducing their expenditure to the national average.
- In 2008/09, around 65 per cent of locum expenditure was on consultants. Medical, surgical, and psychiatry specialties accounted for the majority of locum expenditure. But the amount spent on locum doctors, at which grade and in which specialty varies across NHS boards.
- Although NHS boards hold some information on the costs of locum doctors, it is neither comprehensive nor held in a consistent format by all boards. This makes it harder for NHS boards to identify where savings could be made.
- The introduction of a national contract for agency locums in 2004 did not reduce expenditure on more expensive non-contract agencies and the contract lapsed in 2009. A new national contract did not come into place until June 2010.

Expenditure on locum doctors is increasing

13. In 2008/09, NHS boards spent at least £47 million on locum doctors, 4.3 per cent of all medical staffing expenditure.^{3,4} In real terms, this is approximately double what was spent by health bodies in 1996/97 (£16.9 million).⁵ Although total locum expenditure has remained static in real terms since 2006/07, expenditure on agency locums increased by five per cent.⁶ There is only partial expenditure information collected centrally in other UK countries so it is not possible to compare locum expenditure in Scotland with the rest of the UK.

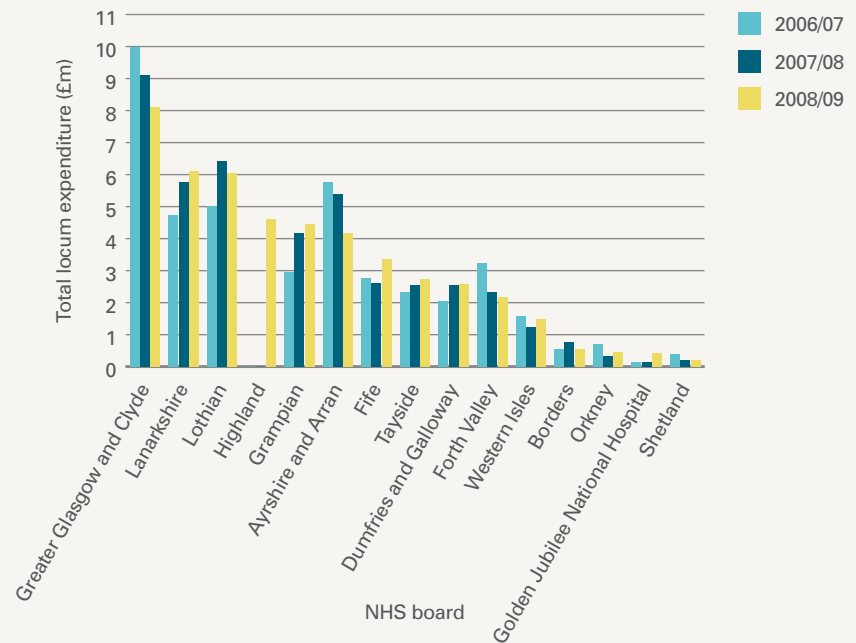
14. Expenditure on locum doctors increased in real terms in seven NHS boards and Golden Jubilee National Hospital over the past three years (**Exhibit 1**). Six NHS boards – Ayrshire and Arran, Forth Valley, Greater Glasgow and Clyde, Orkney, Shetland and Western Isles – reduced their overall expenditure on locum doctors over the same period but only NHS Forth Valley and Greater Glasgow and Clyde reduced expenditure on both internal and agency locums.⁷

15. Agency locums account for the majority of expenditure on locum doctors. In 2008/09, 57 per cent of expenditure was on agency locums (£27 million) compared to 43 per cent

Exhibit 1

Total expenditure on locum doctors 2006/07–2008/09 by NHS board in real terms

Expenditure on locum doctors increased in the majority of NHS boards between 2006/07 and 2008/09.



Note: NHS Highland could only provide locum expenditure for 2008/09.

Source: Audit Scotland, 2010

3 Due to inconsistencies in the way NHS boards record expenditure on internal locums, it is only possible to estimate total expenditure on locum doctors. Expenditure figures exclude VAT as this could be reclaimed on agency locum expenditure until the end of 2008/09 financial year. See Appendix 2 for more detail.

4 NHS Highland's medical staffing expenditure is based on ISD data which includes expenditure on dental staff.

5 1996/97 was the year of the last national audit on locum doctors, *Doing the rounds: The use of locum doctors in Scotland's hospitals*, Accounts Commission, July 1998.

6 This excludes expenditure from NHS Highland as it could only provide expenditure for 2008/09. This is due to the financial system being replaced in 2008.

7 Ibid.

(approximately £20 million) on internal locums. The percentage spent on agency locums has increased from 50 per cent of all expenditure in 1996/97 and in the past three years, expenditure on agency locums has increased at a faster rate than internal locum costs.^{8,9}

Using locum doctors more efficiently could potentially release about £6 million a year

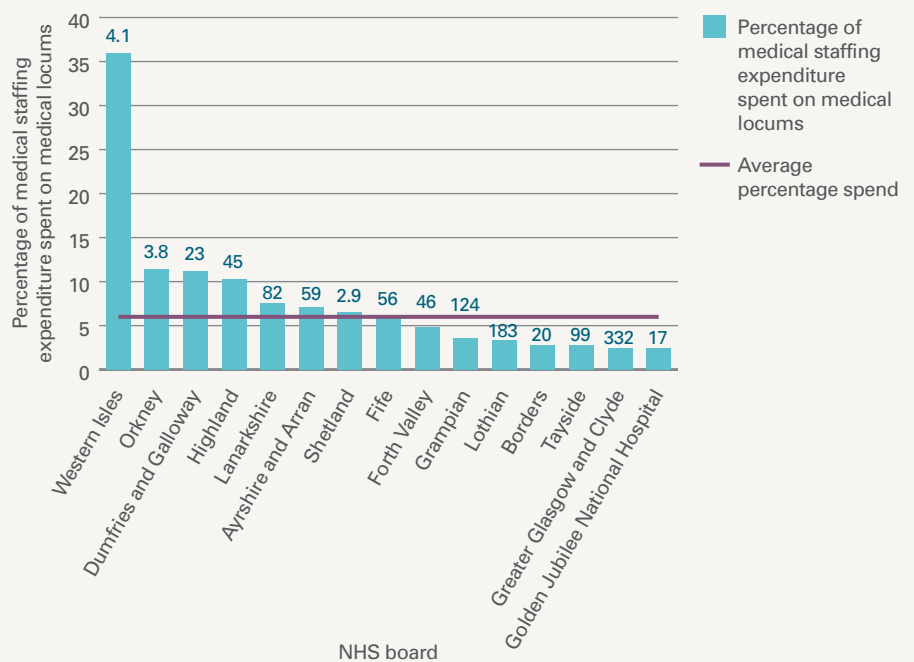
16. Expenditure on locum doctors varies across Scotland, from 2.4 per cent of total medical staffing expenditure in Greater Glasgow and Clyde and Golden Jubilee National Hospital to 11.4 per cent in Orkney and 36 per cent in Western Isles (Exhibit 2).¹⁰ Rural and island NHS boards have a higher percentage spend on locum doctors than other NHS boards (see paragraph 25 for more information).

17. We estimate that NHS boards with higher locum doctor costs could save the NHS an estimated £6 million per year if they reduced their costs to the national average.¹¹ We recognise that for some NHS boards this may be difficult, for example, rural and island NHS boards such as Western Isles and Highland face difficulties in recruiting staff in some specialties and grades. Reducing expenditure on locum doctors in these boards may require further consideration of how acute services are delivered in these areas. All NHS boards, however, should be capable of making savings on locum doctors by improving procurement procedures, and more generally, managing their workforce planning better to minimise demand for locum doctors. The *NHS Scotland Efficiency and Productivity Programme: Delivery Framework* identifies temporary staffing costs as a potential area for savings to be made.¹² A national working group has been established to examine this area

Exhibit 2

Percentage of NHS boards' total medical staffing expenditure spent on locum doctors, 2008/09

Rural and island NHS boards generally spend a bigger percentage of their expenditure on locum doctors than other NHS boards.



Notes:

1. The total medical staffing expenditure for 2008/09 is listed above each column in £ millions. NHS Highland's medical staffing expenditure is based on medical and dental staff expenditure data from ISD.
2. The average is calculated using the median percentage spend.

Source: Audit Scotland, 2010

and is due to report in July 2010. Part of this work is the development of guidance for NHS boards on ways in which they can minimise expenditure on locum doctors.

NHS boards need better information to identify where savings can be made

18. To make savings it is essential that NHS boards have accurate and detailed information, including why locum doctors are being requested, how much is being spent on them,

the grades and specialties being used and the type of locum used – internal or agency. Our previous report on locum doctors in 1998 found that in the past NHS boards held limited information on locum doctors.¹³

19. Most NHS boards now have basic information on locum doctors such as expenditure by grade and specialty but they are less likely to know why locum doctors are being requested, the length of each locum episode or the shift times that locums are requested for (Exhibit 3, overleaf).

8 *Doing the rounds: The use of locum doctors in Scotland's hospitals*, Accounts Commission, July 1998.

9 This excludes expenditure from NHS Highland as it could only provide expenditure for 2008/09.

10 Medical staffing expenditure for NHS Highland is based on medical and dental staff expenditure from ISD.

11 Savings calculated using national median level.

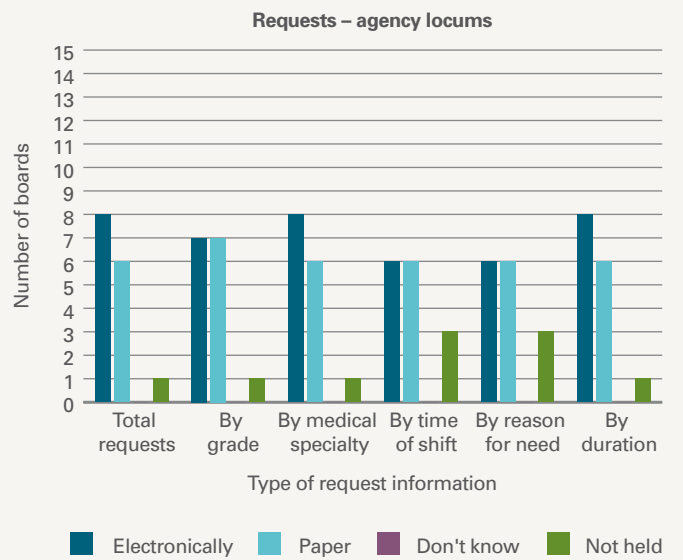
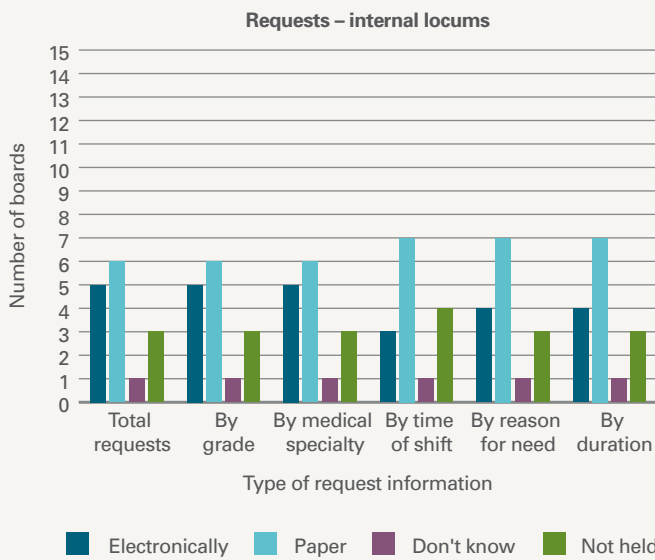
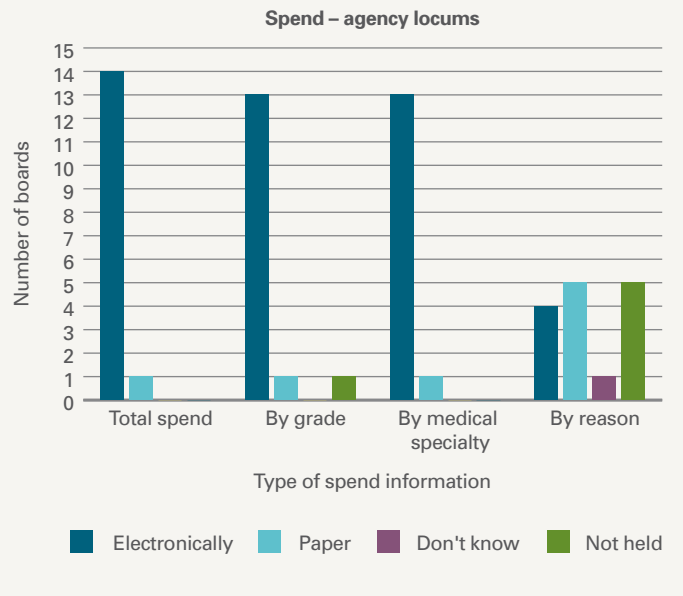
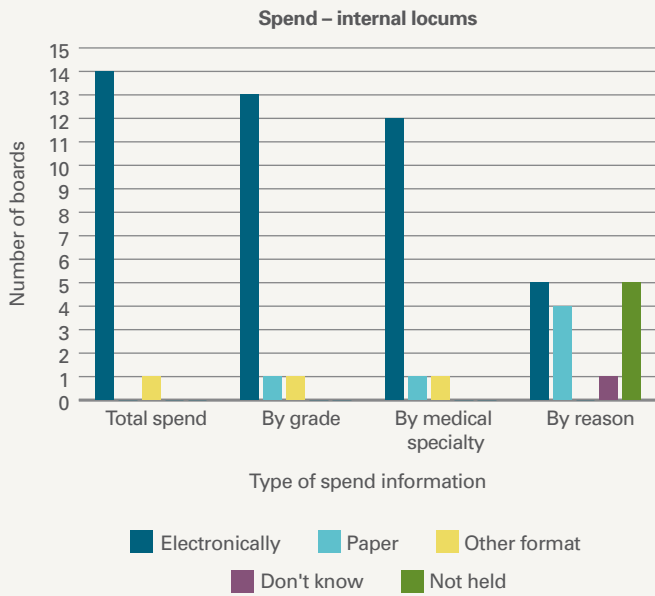
12 *NHSScotland Efficiency and Productivity Programme: Delivery Framework June 2009*, Scottish Government, 2009.

13 *Doing the rounds: The use of locum doctors in Scotland's hospitals*, Accounts Commission, July 1998.

Exhibit 3

The type and format of information held by NHS boards on use of locum doctors

A minority of NHS boards hold information on locum requests electronically.



Notes:

1. Base for spend: 13 NHS boards and Golden Jubilee National Hospital. Western Isles did not respond to spend by specialty.

2. Base for requests: 14 NHS boards and Golden Jubilee National Hospital.

Source: Audit Scotland, 2010

NHS boards hold more information on agency locum doctors than internal locum doctors.

20. All NHS boards except Ayrshire and Arran, and Lanarkshire still use paper records to store at least some information and this makes it more difficult and time-consuming to collate and monitor the information. There is no link between the types and format of information that NHS boards hold and the amount they spend on locum doctors. However, NHS boards need to have this information if they are to understand the factors driving expenditure on locum doctors and to target areas where they could be more efficient.

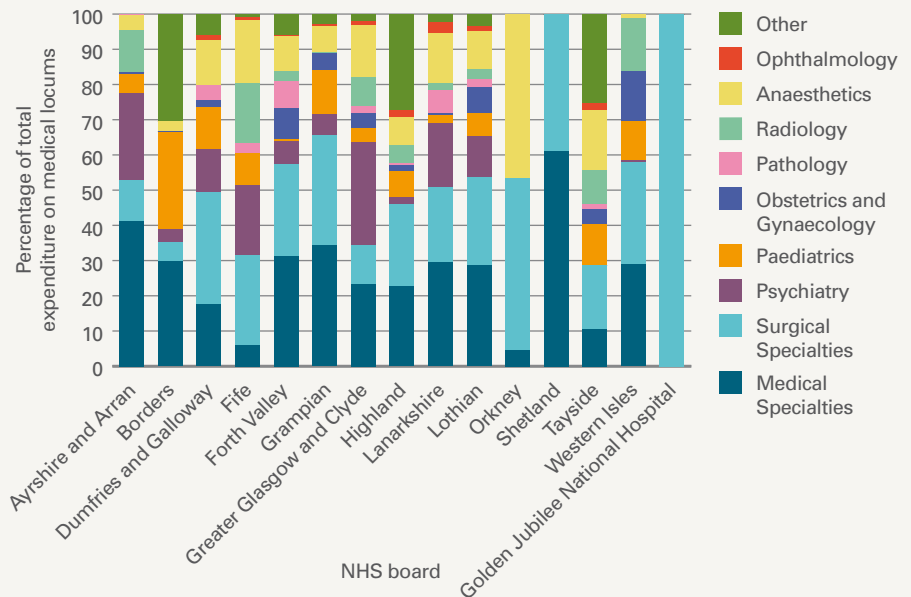
21. Half of NHS boards provide management information on locum expenditure, mainly on a monthly basis, to service managers or lead clinicians in service departments.¹⁴ Only NHS Forth Valley and Golden Jubilee National Hospital, however, provide management information on locum demand and locum use to service departments on a monthly basis.¹⁵ Half of NHS boards also do not report information on demand for, or use of, locum doctors to the senior management team or the chief executive. This means it may be difficult for service managers, and more senior management, to monitor locum trends in demand and use and identify actions to minimise demand.

22. Only six NHS boards (Dumfries and Galloway, Fife, Greater Glasgow and Clyde, Lanarkshire, Lothian and Tayside) have performance indicators in place to monitor the use of, or expenditure on, both internal and agency locum doctors and only two NHS boards (Grampian and Highland) have performance targets

Exhibit 4

Locum doctor expenditure by specialty by NHS board, 2008/09

Medical specialties, surgical specialties, and psychiatry account for the majority of expenditure in specialties.



Note: NHS Lothian agency expenditure by specialty is only from Medacs locum agency. It does not include expenditure from other agencies used by the board.

Source: Audit Scotland, 2010

in place. NHS boards need to collect information which is comparable across all NHS boards to benchmark their use of locum doctors and identify actions to reduce expenditure. There is no link between NHS boards which have performance indicators or targets and the amount they spend on locum doctors.

Expenditure by specialty and grade varies across the NHS

23. We have analysed the limited available information to try to identify where money is spent on locums and why. For almost all NHS boards the majority of locum expenditure is in

three specialties – medical, surgical, and psychiatry (Exhibit 4).¹⁶ However, the percentage of total locum expenditure spent on locum doctors in each specialty varies across the NHS.¹⁷ For example, in 2008/09, the percentage spent on locum doctors in anaesthetics varied from nothing in NHS Shetland and Golden Jubilee National Hospital to 47 per cent in NHS Orkney. The largest increase in locum doctor expenditure was in pathology with a real terms increase of around 230 per cent, from £300,000 in 2006/07 to £1 million in 2008/09.¹⁸

¹⁴ NHS Dumfries and Galloway and Greater Glasgow and Clyde did not respond.

¹⁵ Ibid.

¹⁶ Medical specialties are: Accident and Emergency, Allergy, Audiological Medicine, Cardiology, Clinical Genetics, Clinical Pharmacology & Therapeutics, Dermatology, Endocrinology & Diabetes Mellitus, Gastroenterology, Genito-Urinary Medicine (GUM), Geriatric, Infectious Diseases, Medical Oncology, Neurology, Neurophysiology, Nuclear Medicine, Occupational Medicine, Paediatric Cardiology, Palliative Medicine, Pharmaceutical Medicine, Public Health Medicine, Rehabilitation, Renal Medicine, Respiratory Medicine, Rheumatology. Surgical specialties include: Cardiothoracic surgery, Ear, Nose and Throat surgery, Neurosurgery, Oral & Maxillofacial, Orthopaedic & Trauma, Paediatric, and Plastic surgery.

¹⁷ NHS Lothian agency expenditure by specialty is only expenditure from Medacs locum agency. It does not include expenditure from other agencies it uses.

¹⁸ This excludes expenditure by specialty from NHS Highland as it could only provide expenditure for 2008/09. For 2006/07, this excludes NHS Lanarkshire Community Health Partnership expenditure as this could not be provided by specialty.

24. Although locum doctors at consultant grade accounted for only seven per cent of the total number of locum episodes in 2008/09, NHS boards spent 65 per cent of their locum expenditure on locum consultants in 2008/09.^{19, 20, 21} The percentage spent varied from 22 per cent in NHS Shetland and 48 per cent in Tayside to 77 per cent in Highland and 97 per cent in Western Isles. The percentage of expenditure by grade also differs between internal and agency locums. Junior doctors in specialist training years one and two make up a higher percentage of agency locum expenditure (12 per cent) than expenditure on internal locums at this grade (four per cent).²² If NHS boards had better information on why locum doctors are being used by grade and specialty then they could establish reasons for differences in expenditure and determine what action is needed to make improvements and savings.

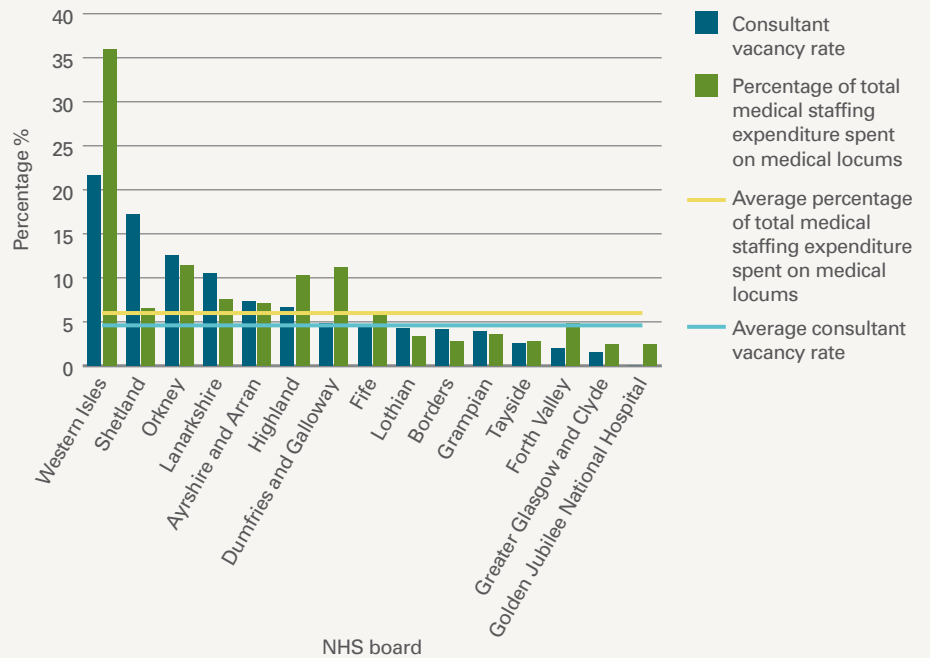
NHS boards with a high level of vacant consultant posts spend more on locum doctors

25. All NHS boards that spend more than the national average on locum doctors also have vacancy rates for consultants that are higher than the national average (Exhibit 5).²³ This may be expected given that consultants account for the majority of locum expenditure (paragraph 24). For example, at September 2008, NHS Western Isles had a consultant vacancy rate of 22 per cent, compared to the national average of 4.6 per cent, and spent 36 per cent of its total medical staffing expenditure on locum doctors.²⁴

Exhibit 5

Consultant vacancy rates compared to expenditure on locum doctors by NHS board, 2008/09

NHS boards that spend a higher percentage on locum doctors also tend to have high consultant vacancies.



A national contract for agency locums did not reduce expenditure on non-contract agencies

26. In 2004, National Procurement set up a national contract for locums with three agencies at agreed pay and commission rates.²⁵ The contract aimed to reduce variation in the locum costs being paid by NHS boards and to improve the quality of locum

agencies and agency locum doctors. The contract expired in May 2009 and a new national contract was not established until June 2010 (see paragraph 33).

27. The hourly rates which NHS boards paid for locum doctors at April 2009 can be grouped into three main categories (Exhibit 6):

19 Number of episodes is based on eight NHS boards (Borders, Dumfries and Galloway, Fife, Greater Glasgow and Clyde, Lanarkshire, Orkney, Shetland and Western Isles) and Golden Jubilee National Hospital.

20 A locum episode is one discrete job of locum cover which could last any prescribed length of time.

21 Expenditure by grade is based on 12 NHS boards and Golden Jubilee National Hospital. NHS Forth Valley and Greater Glasgow and Clyde could not provide a full breakdown of expenditure by grade. NHS Lothian agency expenditure by grade is only expenditure from Medacs locum agency. It does not include expenditure from other agencies it uses.

22 Base is 11 NHS boards and Golden Jubilee National Hospital. NHS Forth Valley, Grampian and Greater Glasgow and Clyde could not provide a breakdown of expenditure by specialty training grades. NHS Lothian agency expenditure by grade is only expenditure from Medacs locum agency. It does not include expenditure from other agencies it uses.

23 Average for both expenditure and consultant vacancy refers to the median level.

24 *Workforce Census 2009*, ISD, 2010. GP practice vacancies have been removed.

25 One of the agencies in the national contract, Corinth International, went out of business in 2005 leaving two agencies - Medacs and Reed. National Procurement is a division of NHS National Services Scotland.

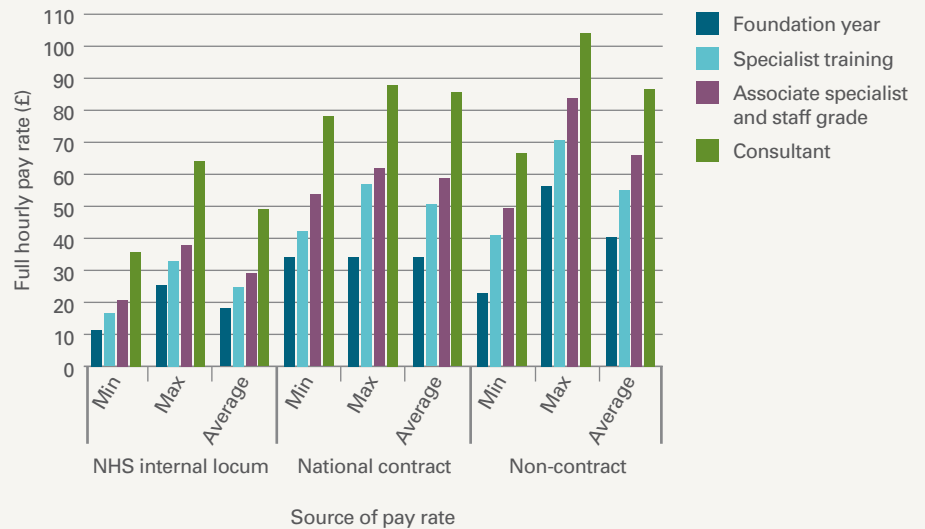
- Internal locums where pay rates are nationally set. These range from £11 to £64 per hour depending upon grade and time of shift.²⁶
- Agencies in the national contract with agreed hourly rates and commission rates. The rates range from £34 to £87 per hour depending upon grade and specialty and they include a 12 per cent commission rate.²⁷
- Agencies outside the national contract can negotiate their own rates. The rates can range from £22 to more than £104 per hour depending upon grade and specialty. The average commission rate is 23 per cent and can range from 14 per cent to more than 30 per cent.²⁸

28. The four NHS boards where we conducted fieldwork stated that locum agencies frequently try to negotiate rates higher than those set out above and NHS boards may have to pay these to secure a locum doctor. However, data on the actual hourly rates being paid by NHS boards to agencies are not easily available, therefore, it is not possible to identify the differences in the hourly rates being paid by NHS boards. The hourly rate of an agency locum doctor can depend upon factors such as location – rural and island NHS boards can find it more difficult than other NHS boards to attract locum doctors and so may have to pay more; the level of demand nationally for certain grades and specialties – higher demand means hourly rates can be higher; and the availability of locum doctors – the fewer locum doctors available means hourly rates can be higher.

Exhibit 6

Locum doctor hourly rates at April 2009

Internal cover is the least expensive option for procuring locum doctors.



Notes:

1. NHS internal rates are based on nationally set NHS medical locum rates (see footnote 26) at April 2009.
 2. Contract rates are based on Scottish national contract rates at April 2009.
 3. Non-contract rates are based on English national contract rates at April 2009 (see footnote 28).
- Source: Audit Scotland, 2010

29. In 2006, the Scottish Executive instructed NHS boards to use only the contract agencies.²⁹ However, expenditure on non-contract agencies increased slightly from 31 per cent of total agency expenditure to 33 per cent between 2006/07 and 2008/09.³⁰ There is wide variation across NHS boards, from 94 per cent of agency expenditure spent on non-contract agencies in NHS Tayside in 2008/09 to Golden Jubilee National Hospital which did not use any non-contract agencies.

30. The four NHS boards where we conducted fieldwork stated that the increase in expenditure on non-contract agencies has been a combination of more use of non-contract agencies to meet demand that could not be met by the contract agencies, and increasing hourly rates for non-contract agency locums. Limitations in available data, however, mean that it is not possible to fully identify the reasons why expenditure on non-contract agencies has increased.

²⁶ Internal NHS rates are based on nationally set pay rates. See Appendix 2 for more detail.

²⁷ These figures are for the previous national contract and include VAT.

²⁸ The hourly rates are based on a sample of ten commonly used agencies not included in the Scottish national contract. Hourly rates include VAT.

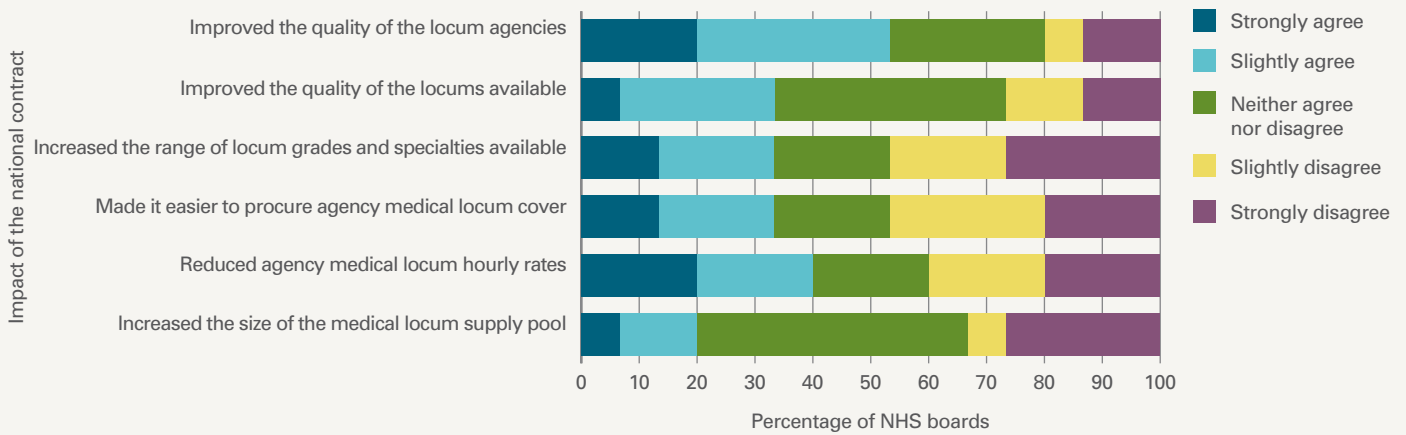
²⁹ HDL (2006) 39 Use of national contracts, Scottish Executive Health Department, 2006.

³⁰ Base is nine NHS boards and Golden Jubilee National Hospital. NHS Dumfries and Galloway, Highland, Shetland and Western Isles could not provide these data; Greater Glasgow and Clyde is not included as they could only provide an agency expenditure breakdown for acute services. For 2006/07, NHS Lanarkshire Community Health Partnership expenditure is not included as they could not be provided by agency.

Exhibit 7

NHS boards' attitudes towards the impact of the national contract

The views of NHS boards are mixed towards the impact of the national contract.



Note: Base: 14 NHS boards and Golden Jubilee National Hospital.

Source: Audit Scotland, 2010

31. National Procurement monitored and recorded any savings NHS boards made through the implementation of the previous national contract but it undertook no other benefits analysis. Although National Procurement stipulated that agencies must carry out pre-employment checks and that NHS boards should ensure that they are carried out, the contract contained no performance standards or targets relating to the performance of the contract agencies. National Procurement monitored whether NHS boards were complying with the contract but did not undertake any work, either with contract agencies or NHS boards, to establish why NHS boards were increasing their expenditure on non-contract agencies, or to reduce their reliance on non-contract agencies.

32. NHS boards' attitudes towards the benefits of the previous national contract are mixed (Exhibit 7). More than half consider that the contract improved the quality of locum

agencies, but attitudes are split on whether the national contract increased the range of locum doctors available from different grades and specialties and made it easier to procure agency locum cover (five NHS boards agree to both statements compared to seven that disagree for both statements).

The end of the national contract led to some NHS boards paying higher rates for agency locums

33. The three-year national contract set up in 2004 was extended in 2007 and again in 2008 with the intention of entering into a revised English national contract in May 2009.³¹ However, National Procurement reports that changes to the hourly rates included in the English contract made this too expensive for Scottish health boards and this led to the national contract lapsing in May 2009 without a replacement. Formal notice of the end of the national contract was not issued to NHS boards until just before

the end of the contract and no formal guidance was issued by National Procurement to support NHS boards in managing the transition to revised local arrangements.

34. NHS boards were responsible for setting up their own local agreements for agency procurement at the end of the national contract. Only five NHS boards (Dumfries and Galloway, Forth Valley, Greater Glasgow and Clyde, Lanarkshire and Western Isles) and Golden Jubilee National Hospital stated that they renegotiated the same rates with the former national contract agencies at the end of the national contract. All other NHS boards adopted English national contract rates, which are generally higher than Scottish national contract rates had been, or they renegotiated higher rates with Medacs and Reed (Exhibit 8). This means it is likely that some NHS boards are paying higher rates for locum doctors than before the contract lapsed.

31 A national contract with set terms and conditions for locum agencies is in place in England between 2008 and 2011. The contract was made available to Scottish NHS boards to use and contains 55 agencies.

Exhibit 8

Hourly rate arrangements at the end of the previous contract
NHS boards put in place a variety of arrangements at the end of the previous national contract.

	Renegotiated the same framework rates with Medacs and/or Reed	Renegotiated higher rates with Medacs and /or Reed	Use of English framework rates
Ayrshire and Arran			X
Borders		X	
Dumfries and Galloway	X		
Fife			X
Forth Valley	X		
Grampian		X	
Greater Glasgow and Clyde	X		
Highland			X
Lanarkshire	X		
Lothian			X
Orkney			X
Shetland			X
Tayside			X
Western Isles	X		
Golden Jubilee	X		

Source: Audit Scotland, 2010

35. NHS boards in our fieldwork sample reported that since the end of the previous contract, all locum agencies are increasingly trying to negotiate, on a case-by-case basis, higher hourly rates for locum doctors, even where agreed contract rates are in place. This can lead to procurement taking longer and NHS boards paying more for locum doctors.

36. A new national contract came into place in June 2010 which all NHS boards have again been instructed to use. The aim of the new contract is to standardise the rates being paid by NHS boards.

Better procurement could lead to more efficient use of locum doctors

37. Ensuring locum doctors are used appropriately can generate efficiency savings and reduce clinical risk. To do this, it is essential that NHS boards have in place formal policies and procedures for deciding when locums can be used and for procuring that cover. Our previous report highlighted that a range of factors such as clinical need and the cost of procuring cover should be considered when deciding whether to use a locum doctor.³²

38. Nine NHS boards have a policy in place setting out the procedures that should be followed for procuring locum cover, but only five of these policies also set out when it is appropriate to use locum doctors.³³ Although, the majority of NHS boards require a formal agency locum request form to be submitted to the department responsible for procurement, the lack of guidance on deciding the need for locum doctors means that NHS boards cannot always ensure that all options have been fully explored and agency locums are being used as a last resort (Appendix 3). NHS Borders has a policy that sets out when locum doctors can be used and the procedures for appointing and employing locum doctors (Case study 1, overleaf).

39. The majority of NHS boards procure agency locum doctors centrally, either through their human resources or medical staffing departments. Internal locums are usually arranged at either a local departmental level or centrally. Centralisation of agency procurement provides greater quality assurance and consistency, and minimises unnecessary expenditure. This is because NHS boards can ensure that, for example, cheaper contract

32 *Doing the rounds: The use of locum doctors in Scotland's hospitals*, Accounts Commission, July 1998.

33 NHS Lothian is not included but is developing policies for locum doctor use and procurement. Golden Jubilee National Hospital did not provide documentary evidence.

agencies are always contacted first and that the relevant pre-employment checks are undertaken for any agencies used. Only six NHS boards, however, formally set out the procedures that should be used for procuring agency locum doctors out-of-hours (ie, when the central department is not staffed, generally in evenings, nights and weekends and procurement is done at a departmental level). This means that the benefits gained from central procurement, such as reduced expenditure, may not always be realised. NHS Greater Glasgow and Clyde has formal policies and procedures in place across the organisation to ensure that agency locum doctors are used only when necessary (Case study 2). Staff interviewed at the board feel this has contributed to the decrease in expenditure on locum doctors over the past three years.

40. In all NHS boards, except Forth Valley (where use is decided at consultant level), budget holders or senior management authorise the use of, and expenditure on, locum doctors. This means the cost of locum doctors, and the impact this may have on service budgets, should always be considered when decisions are taken on the use of locum doctors.

41. All NHS boards that responded have checks in place to minimise fraudulent payments for locum doctors.³⁴ These include checking that the doctor attended their shift, the number of hours worked and the pay rate is as agreed upon procurement.

Case study 1

The efficient use of locum doctors – NHS Borders

NHS Borders' *Appointment of locum medical staff: Procedure and protocol* sets out guidelines for deciding the need for locum doctors with the aim of minimising their use. The policy is based on good practice guidelines, including the 1998 Accounts Commission report *Doing the rounds* and the national *Code of practice in the appointment and employment of locum doctors*.

The policy aims to provide management and medical managers with a clearer understanding of how and when suitable arrangements should be put in place in the event of planned or unplanned absence of medical staff of all grades.

Actions set out in the policy aimed at ensuring locum doctors are used only when necessary include:

- All medical staff should give six weeks' notice of leave therefore providing sufficient notice to consider cover arrangements other than locums.
- When planning for leave and responding to urgent unplanned absence situations, consultants and other medical staff are asked to:
 - review ongoing commitments and consider rescheduling non-urgent work
 - reallocate work to other available colleagues
 - redistribute available resource within the clinical team to avoid cancellation of 'essential workload'.
- In general, locums will not be appointed to cover planned/predictable leave. This includes prospective cover leave for holidays, exams and study leave.
- Where longer notice is given, eg maternity leave, locums will be appointed by open advertisement. The Medical Staffing team should be informed at least 12 weeks before the expected date of leave to ensure the recruitment process can be managed within the timescales.
- Internal cover is encouraged as much as possible where this will not cause a breach in the contractual working arrangements for the doctor providing the cover.

Source: *Appointment of locum medical staff: procedure and protocol*, NHS Borders

Case study 2

Procurement procedures in NHS Greater Glasgow and Clyde

Procurement of agency locum doctors is centralised with identified roles and responsibilities for the appointment of agency locum doctors.

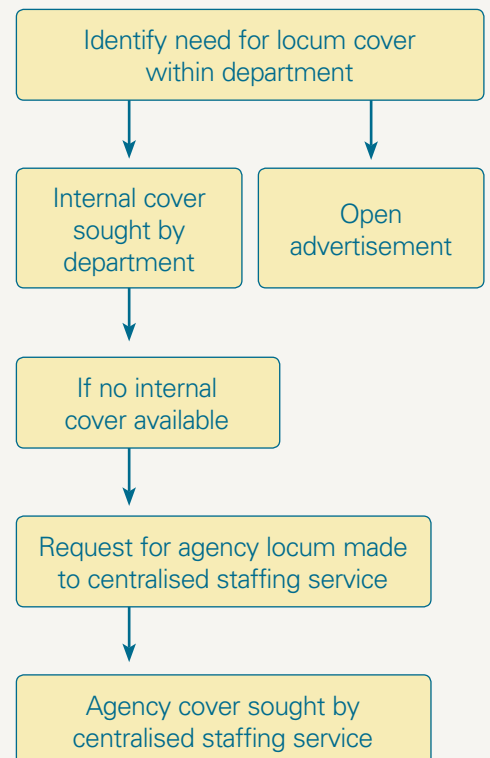
There are procedures in place for appointing locum medical staff. Minimal use of locum doctors is encouraged through effective planning for study and annual leave, including a six-week minimum notice period for requested leave.

Minimal use of agency locums is also encouraged with use of internal cover or direct recruitment of locum doctors by external advertisement. This aims to limit agency locum use only to gaps of unavoidably short notice or where internal cover is not available.

Where no internal locum cover is available, a request form for an agency locum doctor can be submitted to medical staffing. Authorisation from a consultant or authorised manager is needed for the request.

Procurement is then undertaken by an identified member of staff who works centrally in medical staffing. All communication with the locum agencies is done centrally and all relevant paperwork (such as pre-employment checks) is also handled centrally.

Source: NHS Greater Glasgow and Clyde



Recommendations

NHS boards should:

- collect, and hold electronically in an easily accessible and collated format, the following information relating to expenditure, demand, and use of locum doctors:
 - grade and specialty
 - type of locum (internal or agency)
 - time of shift and duration
 - reason why locums were needed and used
- analyse and report performance information and develop strategies to reduce expenditure on, and minimise demand for, locum doctors. Performance information should be benchmarked with other NHS boards

- ensure they have a corporate policy setting out when locum doctors can be used and procedures for procuring locum doctors. This should set out the steps involved in deciding when a locum doctor should be used and the level of sign-off required for agreeing locum doctor use. Compliance with the policy should be monitored and action taken to improve compliance where necessary
- monitor their use of the new national contract for locum agencies and produce an action plan for ensuring levels of use of the contract are maintained and improved where necessary.

The Scottish Government and National Procurement should:

- monitor the level of NHS board compliance with the national contract for locum agencies and take appropriate action where compliance falls below agreed levels
- identify national performance indicators for NHS boards to use to benchmark performance in relation to locum doctors.

Part 2. Managing the demand for locum doctors



Demand for agency locum doctors
is increasing.



Key messages

- Available information indicates that demand for agency locums has increased since 2006/07, but the ability of agencies to meet requests has fallen. Information is not available to assess levels of demand for internal locums.
- Demand for locum doctors is mainly driven by wider workforce planning issues. These include increasing numbers of hard-to-fill vacancies in NHS boards and decreased availability of junior doctors to cover gaps due to the full implementation of the 48-hour week European Working Time Directive.
- Hospitals mainly use locum doctors to cover vacancies and planned absence, such as annual leave.
- NHS boards and the Scottish Government are undertaking a range of actions to try to minimise demand for locum doctors. These include increased advertising for overseas doctors and the use of locum banks.

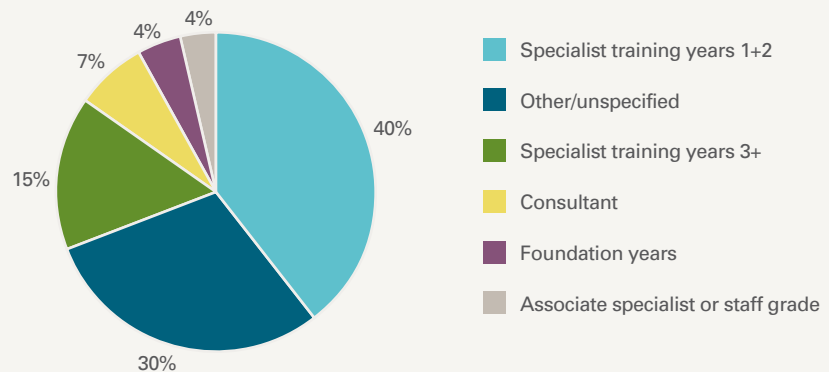
Demand for agency locum doctors is increasing

42. Based on data from seven NHS boards, requests for agency locums doubled between 2006/07 and 2008/09 from around 3,700 requests to around 8,200 requests.³⁵ As discussed in [Part 1](#) of the report, there is limited information available on locum doctors and it is not possible to identify the level of demand for internal locums.

Exhibit 9

Agency locum doctor requests by grade, 2008/09

Demand for agency locum doctors differs by grade, with most requests being for doctors in specialist training years one and two.



Note: Base is eight NHS boards (Borders, Dumfries and Galloway, Fife, Greater Glasgow and Clyde, Lanarkshire, Orkney, Shetland and Western Isles) and Golden Jubilee National Hospital.

Source: Audit Scotland, 2010

43. Junior doctors in specialist training years one and two were the most requested grade of agency locum in 2008/09, making up 40 per cent of all requests ([Exhibit 9](#)).³⁶ Demand varies across the country, with rural and island NHS boards more likely to request locum doctors at consultant grade than other grades, in line with their higher than average consultant vacancy rates.

Demand is mainly driven by wider workforce planning issues

44. National workforce planning policies and individual boards' overall medical staffing arrangements affect demand for and use of locum doctors. Any shortfall between an NHS board's permanent medical staff and its service needs will increase the pressure to appoint locum doctors. The key policy changes in relation to medical staff that are influencing the way NHS boards plan for and deliver their services are:

- the move to a service provided by trained doctors rather than doctors in training. The Scottish Government is reducing the number of training posts available between 2010 and 2013 with the aim of increasing the use of doctors who have completed training to provide services. The SGHD believes that this will provide greater stability and less uncertainty in filling medical rotas and that it will free up consultant time, with fewer junior doctors requiring training and supervision. It is unclear what the financial and service implications will be for NHS boards, although the SGHD, through its national workforce planning, is projecting an over-supply of medical staff in the coming years
- an increase in the amount of training for junior doctors (introduced by the Modernising Medical Careers scheme) coupled

³⁵ Seven NHS boards provided this information – Dumfries and Galloway, Fife, Greater Glasgow and Clyde, Lanarkshire, Orkney, Shetland, Western Isles.

³⁶ Eight NHS boards provided this information (Borders, Dumfries and Galloway, Fife, Greater Glasgow and Clyde, Lanarkshire, Orkney, Shetland and Western Isles) and Golden Jubilee National Hospital.

with the full implementation of the 48-hour week European Working Time Directive (EWTD) from August 2009.^{37, 38} This means junior doctors now have less working hours available to work additional shifts as an internal locum

- changes to immigration rules introduced by the UK Government in 2008. These changes introduced stringent rules for the use of non-EU doctors by the NHS, and reduced the time non-EU doctors are able to work in the country from an unlimited period of time to two years.

45. Our previous report found that workforce planning issues, such as staff shortages and decreased availability of junior doctors due to changes to training arrangements,

were contributing to increasing demand for locum doctors. Workforce planning issues are still key factors as to why demand for locum doctors has increased in recent years (Exhibit 10):

- The majority of NHS boards consider that unfilled vacancies in substantive posts are a key contributing factor in rising demand for locum doctors. Vacancy rates in junior doctor posts arising from the annual recruitment exercise were 16 per cent in 2008 and 14 per cent in 2009 and although consultant vacancies have decreased over the past three years, NHS boards are finding it increasingly difficult to fill the vacancies that exist.³⁹
- The introduction of annual national recruitment under the Modernising

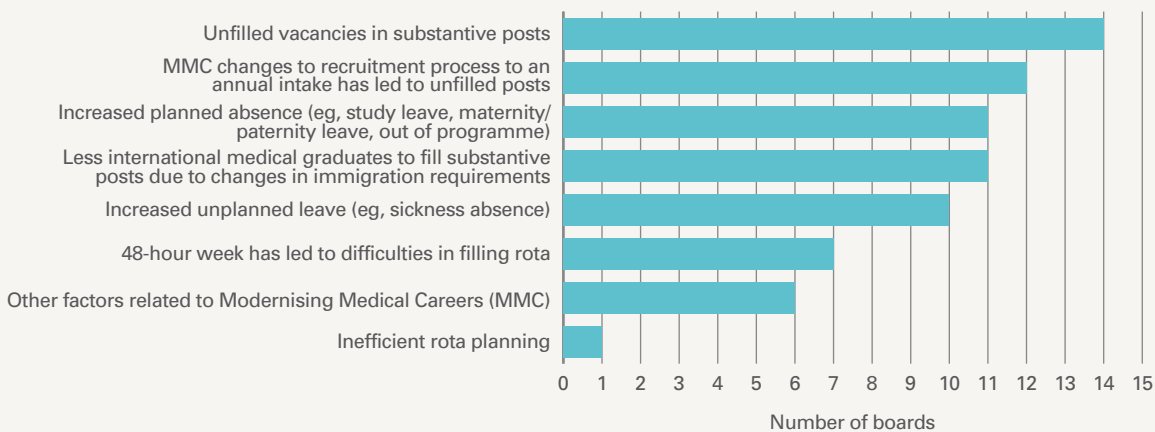
Medical Careers scheme means junior doctor vacancies can only be offered as locum posts until the next annual recruitment round. Vacancies could be advertised throughout the year under the previous system. One in six training posts have not been filled through the annual recruitment exercise over the past two years, placing pressure on NHS boards to fill gaps.⁴⁰

- A reduction in the availability of junior doctors to provide internal cover due to the need to fully implement the 48-hour working week European Working Time Directive.⁴¹ Until the mid-1990s, it was generally easier for hospitals to cover temporary shortages internally by requiring doctors to work longer shifts.⁴² This is no

Exhibit 10

Reasons for demand for locum doctors

NHS boards highlight a number of factors contributing to the demand for locum doctors.



Notes:

1. Base: 14 NHS boards and Golden Jubilee National Hospital.

2. Out of Programme leave is an extended period of absence from their training post (often a year) for which junior doctors can apply to NHS Education for Scotland to gain wider medical experience. This is often undertaken outside the UK.

Source: Audit Scotland, 2010

37 The Modernising Medical Careers scheme (now known as Scottish Medical Training in Scotland) was introduced across the UK in 2007. It established a new system of recruitment and training in postgraduate medical education.
 38 The European Working Time Directive introduced Working Time Regulations in 1998. This introduced a number of entitlements for public sector workers such as a limit on the numbers of hours that can be worked in a week to 48 hours. The introduction of the 48-hour week in the NHS was done in stages with final implementation in August 2009.
 39 Annual recruitment vacancy data, NHS Education for Scotland; *Workforce Census 2009*, ISD, 2010.
 40 Ibid.
 41 Four NHS boards (Ayrshire and Arran, Borders, Fife and Lanarkshire) received partial exemptions from the full implementation of the directive in certain specialties. These exemptions allow junior doctors to work 52-hour weeks rather than 48-hour weeks for up to two years.
 42 *Doing the rounds: The use of locum doctors in Scotland's hospitals*, Accounts Commission, July 1998.

longer possible as junior doctors now have fewer working hours available. There is no national information to assess the impact of EWTD on the number of working hours available.

- 55 per cent of junior doctors are female, compared to 51 per cent three years ago. This makes planning for maternity leave an increasingly important part of workforce planning for NHS boards.⁴³

46. Guidance for the NHS in England sets out the key points for NHS bodies to consider when assessing options for filling gaps in medical staffing.⁴⁴ This includes the need for early planning and ensuring all options for filling vacancies are examined including using international recruitment and changing working patterns. There is no Scottish equivalent of this guidance.

Most requests for locum doctors are to cover planned absences

47. The *Locum Code of Practice* states that locum doctors should mainly be used for short-term unplanned absences, such as sickness.⁴⁵ In 2008/09, 69 per cent of agency locum requests were for less than two days.⁴⁶ NHS boards mostly request agency locum doctors to cover vacancies and planned absences, including annual leave and study leave (Exhibit 11).

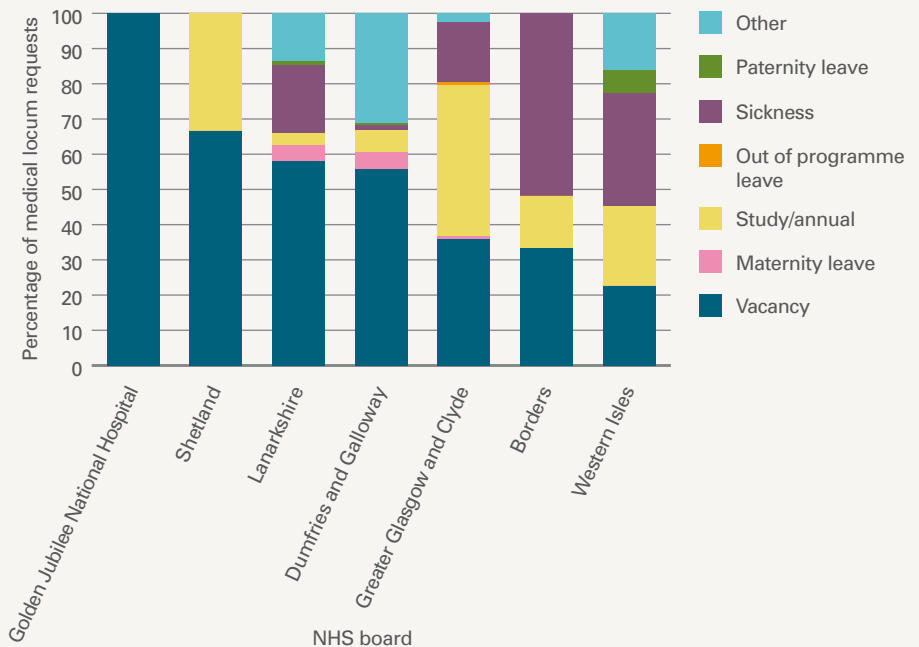
48. Our previous report found that using locum doctors to cover planned leave was often a result of a failure to:

- coordinate 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 rotation

Exhibit 11

Reasons for requesting an agency locum doctor, 2008/09

Most requests for agency locum doctors are to cover vacancies and planned absence.



Note: Out of Programme leave is an extended period of absence from their training post (often a year) for which junior doctors can apply to NHS Education for Scotland to gain wider medical experience. This is often undertaken outside the UK.

Source: Audit Scotland, 2010

- ensure that alternative cover is arranged.⁴⁷

49. The length of notice period required for annual leave and study leave among medical staff in our four sample NHS boards varied from no prescribed period to two months. Rearranging rotas at short notice to cover gaps created by planned leave can be difficult so NHS boards may be using locum doctors unnecessarily to cover these gaps. Difficulties in procuring internal staff to cover gaps (caused by factors such as those described in paragraph 45) may also mean NHS boards have to use locum doctors. Better information on why locum doctors are being used will enable NHS boards to identify areas for improvement.

Supply has not kept pace with the growth in demand for agency locum doctors

50. There has been a decline in locum agencies' abilities to meet requests for locum doctors over the past three years. Based on data from seven NHS boards, the percentage of requests to agencies that they were able to fill (known as the 'fill rate') fell from 83 per cent in 2006/07 to 71 per cent in 2008/09.⁴⁸ Fill rates in 2008/09 varied across the country from 61 per cent of locum requests filled in NHS Fife to 100 per cent of requests in NHS Shetland and Western Isles. There is no information available about demand for internal locum doctors.

⁴³ *NHS Scotland Workforce Statistics 2009*, ISD, 2010.

⁴⁴ *Managing Gaps in Medical Staffing*, NHS Employers, 2008.

⁴⁵ *Code of practice in the appointment and employment of locum doctors*, *NHS Circular: PCS (DD) 1998/1*, The Scottish Office, January 1998.

⁴⁶ Five NHS boards and Golden Jubilee National Hospital provided this information: Borders, Dumfries and Galloway, Fife, Shetland, Western Isles. Lanarkshire provided some duration data but this could not be collated.

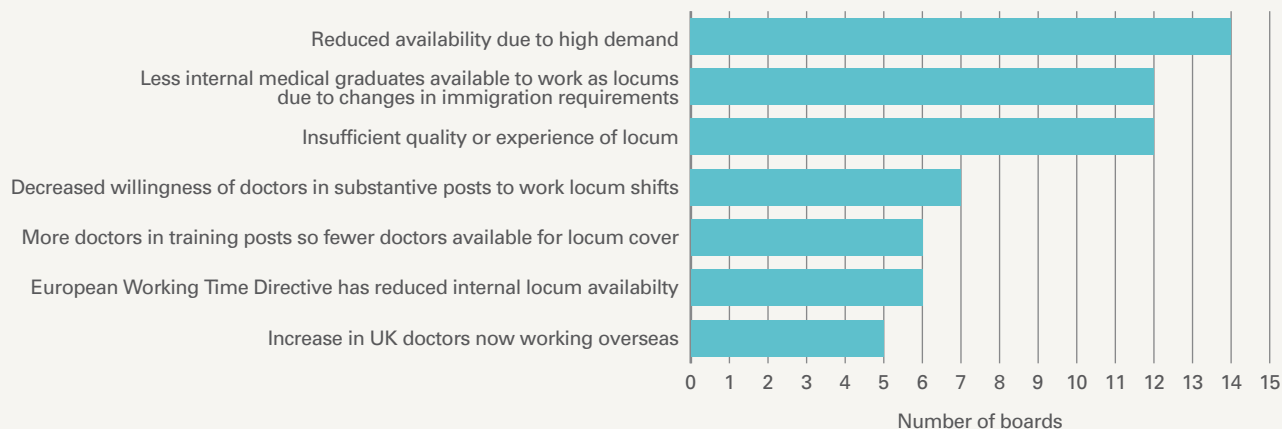
⁴⁷ *Doing the rounds: The use of locum doctors in Scotland's hospitals*, Accounts Commission, July 1998.

⁴⁸ The seven NHS boards that provided data for 2006/07 to 2008/09 were Dumfries and Galloway, Fife, Greater Glasgow and Clyde, Lanarkshire, Orkney, Shetland and Western Isles. For 2006/07, this excludes NHS Lanarkshire Community Health Partnership data as this could not be provided.

Exhibit 12

Reasons why it can be difficult to get agency locum cover

NHS boards highlighted a number of factors as contributing to problems getting agency locum doctors.



Note: Base: 14 NHS boards. Golden Jubilee National Hospital reported they did not have difficulty getting agency locums.

Source: Audit Scotland, 2010

51. Only 39 per cent of requests for locum doctors in foundation years one and two and 59 per cent of requests for specialty training years one and two were filled in 2008/09.⁴⁹ This compares to 68 per cent and 83 per cent in 2006/07 respectively. Pathology had the highest fill rate of all specialties in 2008/09 (90 per cent) and surgical specialties had the lowest (56 per cent).⁵⁰ Obstetrics and gynaecology and ophthalmology have experienced the greatest decline in fill rates since 2006/07 falling by 28 per cent. When locum doctors cannot be procured, then other doctors within the team have to cover the workload; senior staff, such as consultants, sometimes cover the work of junior colleagues; or the service is reduced.

52. There are a number of reasons why NHS boards have difficulty filling requests for agency locum doctors (Exhibit 12). These include

the full implementation of the EWTD reducing the availability of junior doctors to work as locums, and changes to immigration rules in 2008 making it more difficult for non-EU doctors to work in the country.

The NHS is trying to minimise demand for locum doctors

53. NHS boards are trying to minimise demand for locum doctors by actions such as improving absence management and increasing advertising for overseas doctors to fill vacancies (Exhibit 13). The majority of NHS boards have taken action to improve absence management of medical staff and most now have formal absence management policies that relate to medical staff. Ten NHS boards reported increasing advertising for overseas doctors to fill substantive posts. One way of doing this is through the Medical Training Initiative

(MTI) which allows non-EU doctors to work in the United Kingdom for two years. This scheme has been used successfully by some NHS boards to fill vacancies.

54. The Scottish Government Health Directorates (SGHD) are also working with NHS boards to examine setting up locum doctor banks. Nurse banks have been used successfully over the past few years by NHS boards to minimise agency spend. Using bank nurses instead of agency nurses means NHS boards have a greater degree of control over the cost and quality of the nurses used. This is because bank nurses are NHS employees recruited and trained by the NHS who are paid national rates. Learning from nurse banks can be transferred to the management of locum doctors (Exhibit 14). The use of locum doctor banks would allow NHS boards to plan their use

49 The seven NHS boards that provided data for 2006/07 to 2008/09 were Dumfries and Galloway, Fife, Greater Glasgow and Clyde, Lanarkshire, Orkney, Shetland and Western Isles.

50 Surgical specialties include Cardiothoracic surgery, Ear, Nose and Throat surgery, Neurosurgery, Oral & Maxillofacial, Orthopaedic & Trauma, Paediatric, Plastic surgery.

Exhibit 13

Actions to reduce demand for locum doctors

NHS boards are implementing a range of actions to try to reduce demand for locum doctors.



Note: Base: 14 NHS boards and Golden Jubilee National Hospital.

Source: Audit Scotland, 2010

of locum doctors better and ensure they are being used appropriately by having a central point of procurement checking requests are appropriate. Risks to patient safety created by the use of locum doctors can also be minimised as NHS boards could ensure that all locum doctors in a bank receive appropriate inductions and performance assessment. NHS Lothian is currently expanding its nurse bank to include medical staff to cover internal locum doctor shifts ([Case study 3, overleaf](#)).

Exhibit 14

Assessment of the National Nursing and Midwifery Workload and Workforce Planning Programme

A number of elements of the Programme helped NHS boards reduce nurse agency spend.

As a result of the 2003 Audit Scotland report *Planning ward nursing: legacy or design?*, the Scottish Executive established the National Nursing and Midwifery Workload and Workforce Planning Programme in 2005 to take forward actions with NHS boards to reduce reliance on nurse agencies and maximise use of nurse banks.

An assessment of the programme found that reductions in agency spend had been achieved by:

- an unprecedented level of scrutiny on agency use with leadership and ownership from nurse directors through to frontline staff in NHS boards, supported by a nationally coordinated approach
- the introduction of escalation and authorisation policies for nurse agency
- improved intelligence and reporting at national and local levels on agency use
- the development of single NHS board banks including a focus on improving the efficiency and effectiveness of banks
- the introduction of board IT systems and infrastructure that supports the sharing of intelligence on bank and agency usage from clinical level upwards.

Source: *Progress on reducing use of nurse agency in NHS Scotland*, Agenda Paper for NHS Board Chief Executives' Business meeting, 2009; *Planning ward nursing: legacy or design?*, Audit Scotland, 2003

Case study 3

Proposed NHS Lothian Staff Bank Model

Doctors are recruited to the bank and become employees of NHS Lothian if they are not one already. The bank keeps up-to-date details of their grade, experience, training and development needs, and performance.

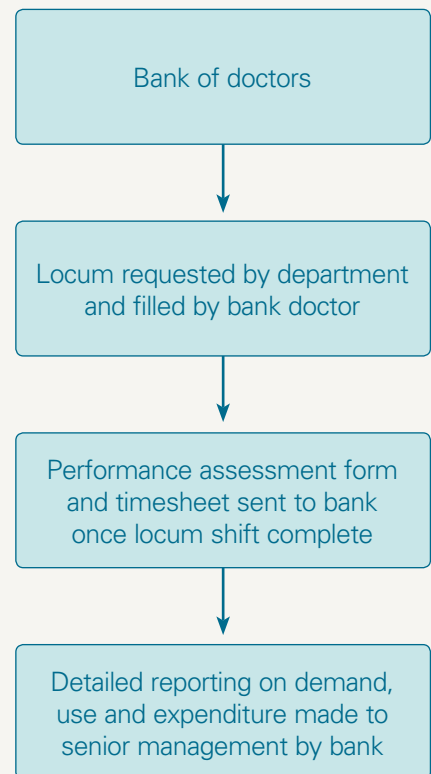
When departments need a locum doctor they first request a bank locum before a request goes to an agency. The department is required to state why it needs a locum and sign-off accountability lies with a senior member of staff. Information on why a locum has been requested; location; date, time, and length of shift; specialty; and grade are recorded electronically.

A performance assessment form is completed by the department for each locum and kept in an electronic format by the bank. Any performance issues raised are investigated by the bank and an action plan developed and carried out.

All timesheets and pay rates are routed through the bank and then to payroll.

The bank reports information to relevant senior management on expenditure, demand and use.

Source: NHS Lothian



Recommendations

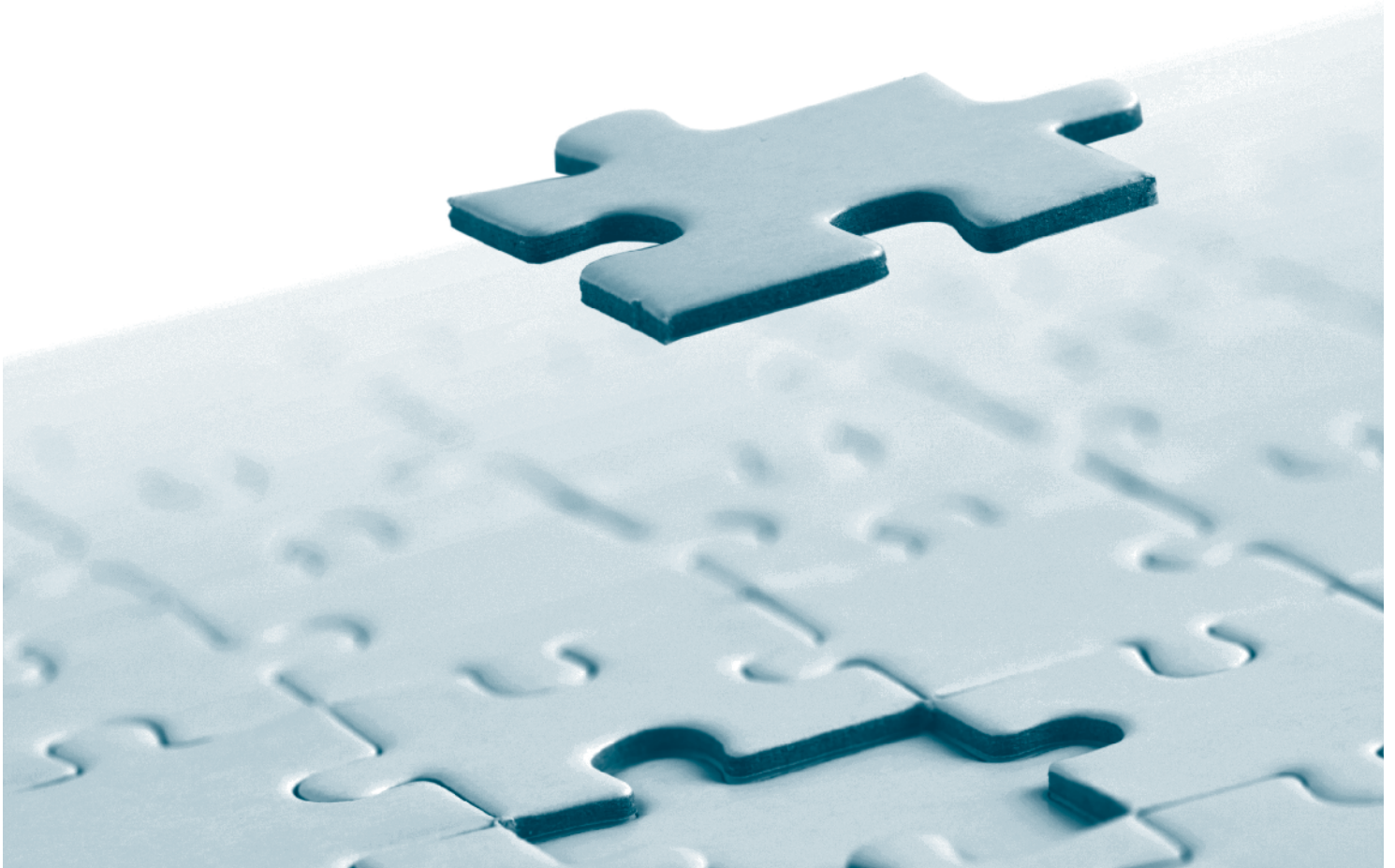
NHS boards should:

- reduce the use of locum doctors for annual leave and study leave by ensuring planned leave is factored into rota planning and that rotas are large enough to be re-organised to try to minimise demand for locums.

The Scottish Government should:

- progress work to identify ways to minimise demand for locum doctors and reduce reliance on agency locums. This may include the development of regional locum doctor banks
- monitor the performance of national contract agencies in meeting NHS boards' requests for locum doctors and take appropriate action where performance falls below agreed levels.

Part 3. Ensuring patient safety



Using locum doctors creates potential risks to patient safety which boards must manage.



Key messages

- Using locum doctors creates potential risks to patient safety which NHS boards must manage. Using agency locums is potentially higher risk than using internal locums as agency locums may be unknown to the NHS board and the necessary pre-employment checks may not be carried out directly by the NHS board.
- Arrangements for pre-employment checks are not always formalised, and there is a risk that checks may not be completed at all times.
- Arrangements for induction and supervision are, in the majority of NHS boards, decided locally. Few NHS boards have corporate policies and procedures for induction and supervision of locum doctors so levels of induction and supervision can be variable.
- Performance management arrangements for locums are not well developed. Feedback is mainly verbal and written assessments are undertaken infrequently. There are no formal mechanisms in place for sharing information between NHS boards and agencies.

Using locum doctors creates potential risks to patient safety

55. Locum doctors help NHS boards minimise risk by enabling hospitals to maintain appropriate staffing levels but their use also creates potential risks to patient safety. Risks are likely to be higher when locum doctors are unknown to the department or hospital and this is more likely with agency locums. *Doing the rounds* identified three stages where risks can occur – the appointment of locum

Exhibit 15

Risks to patient safety of using locum doctors

Using locum doctors presents a number of potential risks to patient safety.

Risk stage	Risk to patient safety
Vetting appointments	
<ul style="list-style-type: none"> • Inadequate screening of short-term locum doctors • Reliance on agency vetting • No checks on hours worked in relation to 48-hour week • No record of checks carried out 	<ul style="list-style-type: none"> • Inappropriate use on grounds of experience, qualifications, immigration status, fatigue or health status • Appointment of bogus doctors
Induction and supervision	
<ul style="list-style-type: none"> • Absence of formal arrangements • Limited induction of locum doctors • Lack of proper supervision 	<ul style="list-style-type: none"> • Poor continuity of care • Improper or unauthorised action by locums • Inappropriate treatment of patients
Performance management	
<ul style="list-style-type: none"> • Unclear line management structure • Inadequate reporting of poor performance • No records maintained of appraisals 	<ul style="list-style-type: none"> • Poor performance not detected • Unsatisfactory medical locum reapointed • Poor locum doctors able to escape sanctions by moving between NHS boards

Source: Accounts Commission, 1998

doctors, induction and supervision, and performance management (Exhibit 15).⁵¹

56. In order to minimise the risks of appointing locum doctors, a *Code of Practice in the appointment and employment of locum doctors* (the Code) was introduced in Scotland in 1998.⁵² The Code covers issues such as the need for adequate checks to be carried out before locum doctors are employed and for assessment forms to be completed for locum doctors. The SGHD has recently issued guidance reminding NHS boards of the Code but compliance

is not monitored by the SGHD or by NHS boards.⁵³

57. The Scottish national contract for agency locum doctors also sets out employment standards that agencies should adhere to although under the previous contract, National Procurement did not undertake any audits of the agencies to check standards were being met. There are no nationally agreed standards that non-contract agencies are expected to meet. In all cases, it is the ultimate responsibility of NHS boards to ensure risks are minimised.

⁵¹ *Doing the rounds: The use of locum doctors in Scotland's hospitals*, Accounts Commission, July 1998.

⁵² *Code of practice in the appointment and employment of locum doctors*, NHS Circular: PCS (DD) 1998/1, The Scottish Office, January 1998.

⁵³ *CEL 2010 (08) Use of temporary medical staff*, Scottish Government, March 2010.

58. There are national standards covering clinical governance and risk management in the health service in Scotland and these are assessed by NHS Quality Improvement Scotland (NHS QIS).⁵⁴ These include reviewing the strategic policies and arrangements in place for issues such as pre-employment checks and performance management of staff. NHS QIS does not assess specific performance in appointing and managing locum doctors.

59. It is not possible to establish whether locum doctors pose a greater clinical risk than their counterparts in substantive posts. When doctors are suspected of being unfit to practise, the GMC can investigate. Seven per cent of GMC investigations relate to locum doctors with addresses in Scotland but because the size of the locum population is unknown it is not possible to say whether this percentage is higher than for doctors in substantive posts.⁵⁵ The Central Legal Office also investigates complaints against doctors but does not record whether doctors were working as locums at the time of the incident.

Arrangements for pre-employment checks are not always formalised

60. NHS boards are responsible for ensuring that the locum doctors they employ are fit to practise and have the right experience and skills for the role. As many internal locums are already employed by their NHS board and so will have been appointed using procedures for substantive posts, the key area of risk is agency locums who may be unknown to the NHS board. There are national pre-employment guidelines setting out what checks NHS boards should undertake when employing new staff and these apply to locums.⁵⁶ These include checking GMC registration and

occupational health certificates. The *Code of Practice in the appointment and employment of locum doctors* also sets out a similar checklist of pre-employment checks to be undertaken.⁵⁷

61. All NHS boards have a checklist setting out the documents that should be received when employing locum doctors, but only eight formally set out within their locum procurement policy who is responsible for each element of the appointment process.⁵⁸ This means that if procurement is undertaken by someone unfamiliar with existing working practices, such as in the evening, night or weekend where procurement may be done at a department level, there is a risk that not all checks will be completed if there is no formal policy. Only three NHS boards (Borders, Greater Glasgow and Clyde and Highland) specifically state in their locum procurement policies the pre-employment checks that need to be completed and the documents that must be seen before appointing locum doctors out-of-hours.

62. The House of Commons Health Committee recently highlighted the issue of ensuring doctors from outside the UK speak English well enough to properly carry out their duties.⁵⁹ This is also an area of potential risk for NHS Scotland when using agency locum doctors. Both the previous and current national contracts for agency locum doctors state that locum agencies are responsible for assessing how well their locum doctors speak English and that evidence of this should be included in doctors' CVs. Ultimately, it is the responsibility of NHS boards to ensure the locum doctors they are appointing are able to speak sufficient English to carry out their

role appropriately and NHS boards need to ensure they are carrying out this check.

It is not possible to check the total number of hours worked by locum doctors

63. Under the European Working Time Directive doctors should work no more than 48 hours per week. NHS boards keep records to show their substantive staff comply with this, but there are no processes in place to check the number of hours worked by locum doctors. This is due to difficulties in tracking the hours worked by locums, who may work in a number of different workplaces during a week. Like the NHS in England and Wales, NHS boards rely instead on professional self-regulation by doctors. This creates potential risks to patient safety if locum doctors are working when tired as a result of working too many hours.

Induction and supervision arrangements are not formalised in the majority of NHS boards

64. Induction is important for a number of reasons. It helps to ensure that locum doctors have adequate knowledge of the patients in their care and that they are aware of local working practices, such as how to order tests, in order to work safely. In 1998, few NHS bodies had formal induction policies for locum doctors.⁶⁰ This is still the case, with only five NHS boards having a corporate induction policy relating to locum doctors.

65. The type of induction provided by NHS boards depends upon the length of the locum appointment. Locum doctors appointed to cover longer-term gaps such as vacancies tend to receive the standard corporate

54 *National Clinical Standards*, NHS QIS, 2008.

55 Although locum doctors may have an address in Scotland, they may not be working in Scotland. This means it is not possible to say exactly how many GMC investigations relate to locum doctors working in Scotland.

56 *PIN guidelines*, Scottish Government, 2008.

57 *Code of practice in the appointment and employment of locum doctors*, NHS Circular: PCS (DD) 1998/1, The Scottish Office, January 1998.

58 NHS Lothian is not included but has a policy in draft.

59 *The use of overseas doctors in providing out-of-hours services*, House of Commons Health Committee, 2010.

60 *Doing the rounds: The use of locum doctors in Scotland's hospitals*, Accounts Commission, July 1998.

induction given to those filling substantive posts. Induction for locum doctors covering shorter-term gaps such as sickness absence tends to be basic and less frequently undertaken. The majority of NHS boards do not formally set out the type of induction that should be given to locum doctors. A survey of a small number of locum doctors highlighted differences in the quality of induction received.⁶¹ This compares to longer-term locum training posts where only 12 per cent rated their induction as poor.⁶²

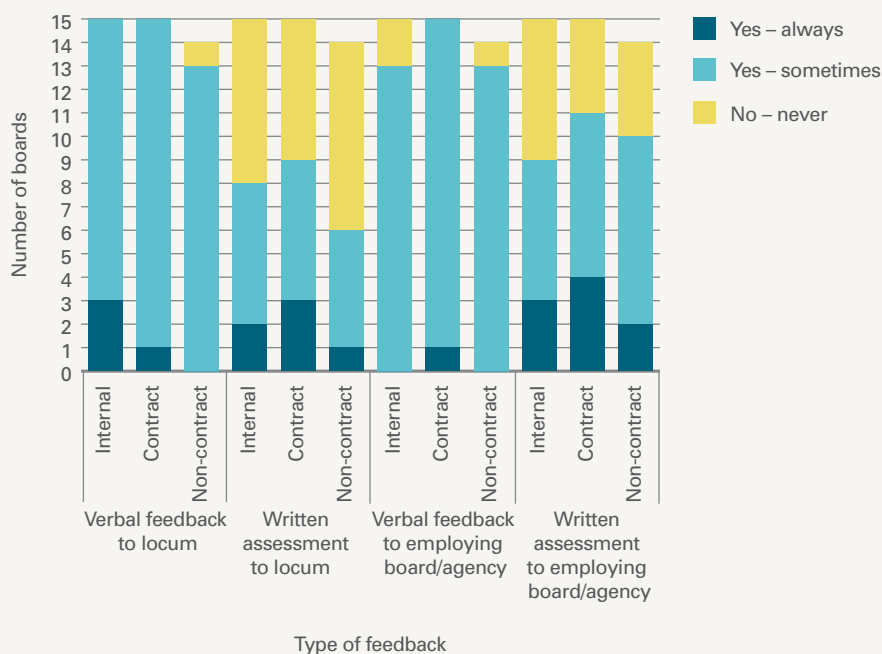
66. It is particularly important that locum doctors are provided with their own IT password. This enables them to prescribe and order tests for patients. In three of our sample NHS boards, locum doctors are not always assigned their own passwords and there is a risk they are sharing them with other doctors. This is against GMC guidelines and if problems occur, it can be difficult for NHS boards to clearly identify who may be involved.

67. If locum doctors are unknown to the staff they are working with it is important that there are clear procedures in place to supervise them and for staff to raise any concerns they may have. Only four NHS boards (Borders, Fife, Greater Glasgow and Clyde, and Highland) have a formal policy on the supervision of locum doctors. In our sample of NHS boards, local departments are responsible for supervision arrangements with junior doctor locums generally supervised by the lead consultant. Locum doctors at consultant grade may not be formally supervised if a senior colleague is not available. Our small survey of locum doctors indicated there may be differences in the level of supervision received by locum doctors.⁶³

Exhibit 16

Type of feedback provided by NHS boards to locum doctors

NHS boards generally provide locum doctors with verbal feedback on their performance.



Notes:

1. Base: 14 NHS boards and Golden Jubilee National Hospital.
2. Golden Jubilee National Hospital did not provide a response for non-contract locum doctors.

Source: Audit Scotland, 2010

Performance management arrangements for locum doctors are not well developed

68. Assessing the performance of locum doctors is an important element in ensuring patient safety. Only five NHS boards have a corporate policy relating to performance management of locum doctors that sets out how they should be assessed and the procedures for acting on this information.⁶⁴ The national *Locum Code of Practice* states that written assessments should be completed at the end of every locum episode.⁶⁵ However, feedback to locum doctors is primarily verbal rather than written with few

NHS boards reporting consistent use of written assessment forms (Exhibit 16). This is similar to the situation we found in 1998.⁶⁶

69. NHS boards report serious performance incidents to the GMC. However, for issues that do not merit GMC referral, there are no formal mechanisms for NHS boards to report performance issues to the employing agency or to other NHS boards and for this information to be acted upon. Evidence from our sample of NHS boards shows that if boards have concerns with agency locum doctors, they may terminate the contract and contact the employing agency. Often NHS boards do not receive feedback from the agency on any action taken.

⁶¹ Base: 35 locum doctors. See Appendix 2 for further details on the methodology.

⁶² *Annual Survey of Junior Doctors 2009*, Postgraduate Medical Education and Training Board, 2010.

⁶³ Base: 35 locum doctors. See Appendix 2 for further details on the methodology.

⁶⁴ NHS Lothian is not included but has a policy in draft.

⁶⁵ *Code of practice in the appointment and employment of locum doctors*, NHS Circular: PCS (DD) 1998/1, The Scottish Office, January 1998.

⁶⁶ *Doing the rounds: The use of locum doctors in Scotland's hospitals*, Accounts Commission, July 1998.

70. All doctors are required by the GMC to have an annual appraisal to assess their performance. There are no arrangements in place at NHS boards or at a national level to ensure all locum doctors receive an annual appraisal. Our survey of a small number of locum doctors indicated that locum doctors do not always have an annual appraisal.⁶⁷ All doctors now require a licence to practise and this will be reissued every five years upon a satisfactory assessment of their fitness to practise (known as revalidation). Performance management and appraisal procedures at NHS boards need to be improved if this is to work successfully. Currently it may be difficult for locum doctors to collate enough evidence of practice for their revalidation.

Recommendations

NHS boards should:

- develop corporate policies relating to pre-employment checks, induction, supervision and performance management of locum doctors and produce an action plan for ensuring these are implemented across the board. They should also develop a monitoring schedule to check policies are being implemented
- collect centrally, in an electronic format, performance information from locum doctor assessment forms and record any action undertaken
- ensure there is a system for providing IT passwords to each locum doctor used.

The Scottish Government should:

- update the national *Locum Code of Practice* and develop performance measures to assess NHS boards' compliance with the Code. The *Locum Code of Practice* should specify arrangements for reporting poor performance
- develop measures for identifying clinical governance complaints against locum doctors so that it can monitor this area at a national level.

Appendix 1.

Project advisory group members

Audit Scotland would like to thank the members of the project advisory group for their input and advice throughout the study.

Member	Organisation
Dr Rob Gray	Consultant, NHS Greater Glasgow and Clyde
Helen Kelly	Human Resources Director, NHS Forth Valley
Andrew McCreadie	Assistant Director of Finance, NHS Fife
John Nicholls	Deputy Director Health Workforce Planning and Development Division, Scottish Government Health Directorates
Danny Rankin	Service Manager, NHS Lanarkshire
Professor Bill Reid	Postgraduate Dean, Deanery of Postgraduate Medicine, South-East Deanery, NHS Education for Scotland
Dr Alan Robertson	Junior Doctor, NHS Tayside; Chair of BMA Scottish Junior Doctor National Committee
Raymond Rose	Head of Medical Staffing, NHS Greater Glasgow and Clyde
Dennis Rowe	Head of Procurement, NHS Lothian
Andrew Sokell	Senior Commodity Manager, National Procurement, NHS National Services Scotland

Note: Members of the project advisory group sat in an advisory capacity only. The content and conclusions of this report are the sole responsibility of Audit Scotland.

Appendix 2.

Audit methodology

We examined how efficiently and safely NHS boards are using locum doctors in hospitals. We analysed the reasons why NHS boards are using locum doctors and how much they are spending on them. We also assessed whether NHS boards have appropriate arrangements in place for ensuring patient safety when using locum doctors.

Our report focuses on the use of locum doctors in acute and community hospitals. We did not examine the use of GP locums in the primary care sector.

In the audit we analysed quantitative and qualitative data collected from NHS boards and the Golden Jubilee National Hospital. A data request was sent out to all NHS boards and the Golden Jubilee National Hospital requesting data on expenditure on internal and agency locum doctors; demand and use of agency locum doctors; performance management information such as the types of information held on locum doctors; and clinical governance information such as the type of locum performance assessments undertaken.

All NHS boards and the Golden Jubilee National Hospital returned the data request although the majority could not complete all sections as the data requested were either not held or were not held in an easily accessible format.

We also requested and examined policies relating to locum doctors from all NHS boards and the Golden Jubilee National Hospital, such as locum doctor procurement policies and induction and supervision policies. We also examined national policies and guidance, both Scottish-specific and from other UK countries, relating to locum doctors.

Four NHS boards were selected as sample sites to investigate issues further. The NHS boards (Grampian, Greater Glasgow and Clyde, Highland and Lanarkshire) were selected to represent a mix in terms of size, geography and cost. At these sites, we interviewed a range of staff including service managers, general managers, finance staff and medical staffing managers. Fieldwork was limited in NHS Lanarkshire as we were not able to carry out all the interviews within the required timescales.

We also interviewed staff at National Procurement, General Medical Council, NHS Education for Scotland and the Scottish Government Health Directorates.

To examine the views of doctors working as locums, we also undertook a short online survey between December 2009 and January 2010 of doctors who have worked as a locum doctor in the NHS in the past two years. The survey contained demographic questions and questions relating to their experiences of working as a locum. A link to the

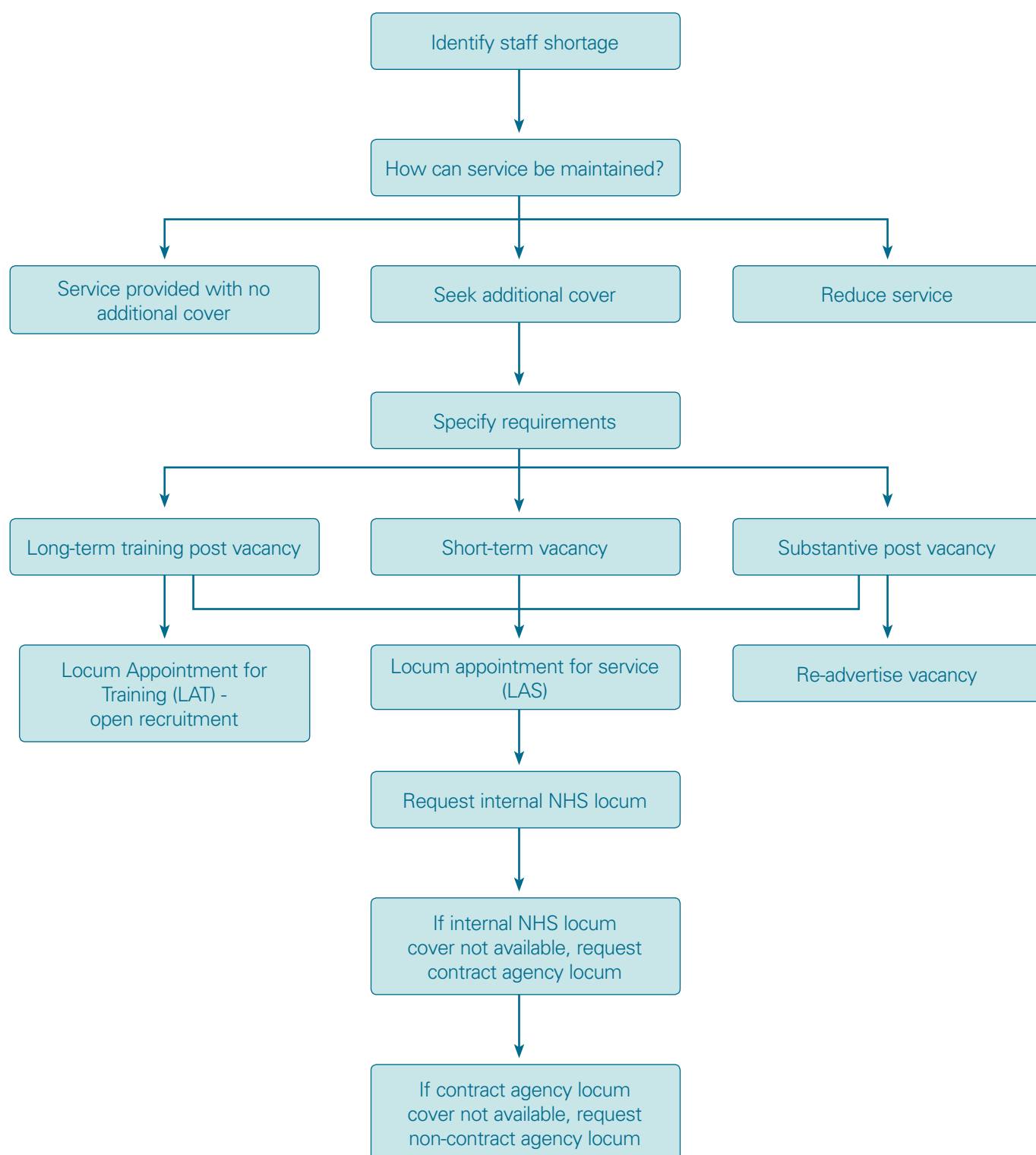
survey with an explanatory email was sent out to all doctors registered with Reed locum agency. The email and link was provided by us to National Procurement which acted as an intermediary with Reed which then sent it out. Information on the survey and the survey link was also included in the December 2009 issue of the BMA Scottish Junior Doctor newsletter sent out to all junior doctors in Scotland. Unfortunately, the response rate was only 35 doctors.

Expenditure figures for 2006/07–2008/09 on locum doctors ([see Part 1](#)) exclude VAT. Nine boards provided expenditure with VAT removed. VAT for the remaining boards was removed by Audit Scotland at 17.5 per cent.

Hourly rates for internal locum doctors ([Exhibit 6](#)) were based on the following: Doctors in Training – *PCS(DD)2009/03: Pay and conditions of service remuneration of hospital medical and dental staff and doctors and dentists in public health medicine and the community health service*; Associate specialist and staff grade medical locum hourly pay rate obtained from Scottish Standard Payroll System, with out-of-hours rates derived at time and one-third; Consultant medical locum hourly pay rate derived from substantive consultant salary scale *PCS (DD)2009/02: 2004 Consultant contract increases to national salary scales and fees and allowances for 2009/10*, with out-of-hours rates derived at time and one-third.

Appendix 3.

Good practice flowchart for identifying need for locum doctors



Appendix 4.

Self-assessment checklist for NHS boards

The last column in the checklist can be used to record sources of evidence, supplementary comments to support your assessment or highlight areas of interest.

Issue	Assessment of current position					Comment to support or explain your statement
	No – action needed	No – but action in hand	Yes – in place but needs improving	Yes – in place and working well	Not applicable	
Is the board collecting information on expenditure, demand for, and use of locum doctors to understand why, and in which areas, locums are being used? Is this information held electronically in an easily accessible format?						
Is the board analysing and reporting performance information on expenditure, demand and use of locum doctors to appropriate management level?						
Has the board developed a strategy to reduce expenditure on, and minimise demand for, locum doctors? Has this been implemented?						
Is the board benchmarking performance information with other NHS boards?						
Does the board have a corporate policy setting out when locum doctors can be used and the procedures for procuring locum doctors? Is compliance with this policy monitored and actions set out to improve compliance where necessary?						
Does the board monitor its use of the new national contract for locum agencies? Is there an action plan for ensuring levels of use of the contract are maintained and improved where necessary?						

Issue	Assessment of current position					Comment to support or explain your statement
	No – action needed	No – but action in hand	Yes – in place but needs improving	Yes – in place and working well	Not applicable	
Is the board reducing the use of locum doctors for annual leave and study leave by ensuring planned leave is factored into rota planning? Are rotas large enough to be re-organised to try to minimise demand for locum doctors?						
Does the board have corporate policies relating to pre-employment checks, induction, supervision and performance management of locum doctors? Is there an action plan for ensuring these are implemented across the board? Does the board have a monitoring schedule to check these policies are being implemented?						
Does the board collect centrally, in an electronic format, performance information from locum doctor assessment forms and record any action taken to ensure risks to patient safety are minimised?						
Does the board have a system for providing IT passwords to each locum doctor used?						

Using locum doctors in hospitals

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