Key messages

Using locum doctors in hospitals

AUDIT SCOTLAND

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June 2010

Key messages

Background

1. Locum doctors are doctors of any grade or specialty who provide temporary staffing 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 such as sickness absence or sudden, unexpected vacancies in substantive posts.

2. 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 locum doctors, and many doctors carry out locum work in addition to their substantive post.

3. NHS boards need to have systems in place for appointing and managing locum doctors to avoid unnecessary expenditure and risks to patient safety. By using locum doctors well, NHS boards can save money and improve service delivery.

4. It is preferable for NHS boards to fill gaps in their medical staffing rotas by using internal cover rather than more expensive locums provided by private agencies. Internal locums are usually paid nationally-set rates and are directly employed by NHS boards. Using agency locums is potentially higher risk than using internal locums in terms of ensuring patient safety as agency locums may be unknown to the board.

Our audit

5. 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.

6. 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.

7. We analysed quantitative and qualitative data collected from NHS boards and the Golden Jubilee National Hospital. We also interviewed a range of key stakeholders and staff at a sample of NHS boards.[1]

Key messages

1 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.

8. In 2008/09, NHS boards spent at least £20 million on internal locums and £27 million on agency locums. Expenditure on locums has more than doubled in real terms since 1996/97. Although total locum expenditure has remained static in real terms over the past three years, expenditure on agency locum doctors has increased by five per cent. Only six NHS boards (Ayrshire and Arran, Forth Valley, Greater Glasgow and Clyde, Orkney, Shetland and Western Isles) reduced their overall expenditure on locum doctors between 2006/07 and 2008/09.[2]

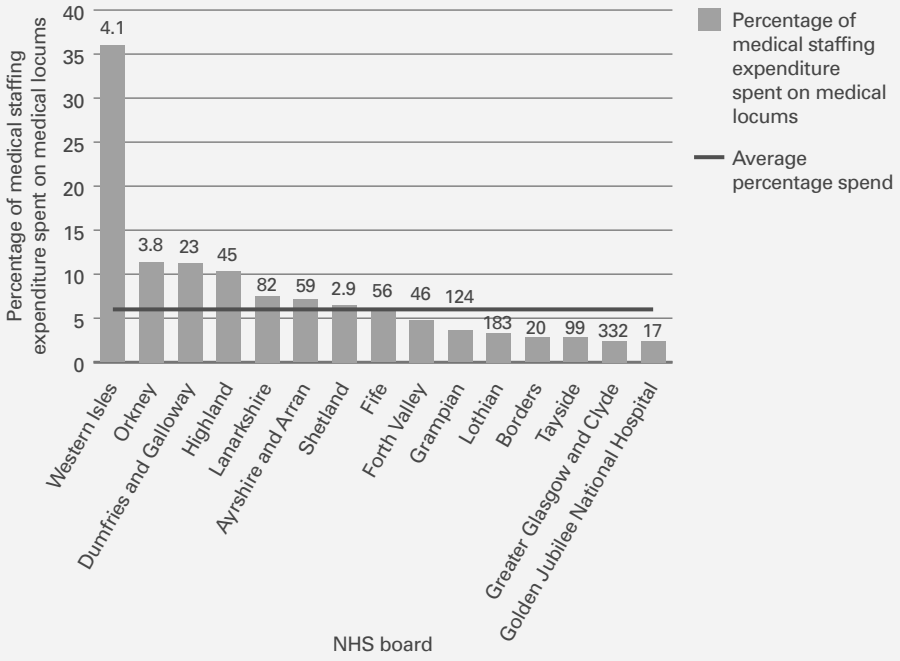
9. Expenditure on locum doctors in Scotland accounted for 4.3 per cent of total medical staffing expenditure in 2008/09. This varies from 2.4 per cent in NHS Greater Glasgow and Clyde and Golden Jubilee National Hospital to 11.4 per cent in Orkney and 36 per cent in Western Isles (Exhibit 1). By reducing the percentage spent on locum doctors to the national average, the NHS could save around £6 million a year.[3] 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 reducing expenditure on locum doctors by improving procurement procedures, and more generally, managing workforce planning better.

1 NHS Grampian, Greater Glasgow and Clyde, Highland and Lanarkshire. Stakeholders interviewed were the Scottish Government Health Directorates, National Procurement (a division of NHS National Services Scotland), the General Medical Council and NHS Education for Scotland.
2 This excludes expenditure from NHS Highland as data were only available for 2008/09. This is due to the financial system being replaced in 2008.
3 Savings calculated using the national median level.

Exhibit 1

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 NHS NSS Information Services Division (ISD).
2. The average is calculated using the median percentage spend.

Source: Audit Scotland, 2010

10. To make savings it is essential to have accurate and detailed information, including information on how much is being spent on locum doctors and the reasons for using them. NHS boards' information on locum doctors is inconsistent and not all boards hold detailed information on reasons for using locum doctors, and patterns of use of locum doctors.

11. Where information does exist, much of it is held at departmental level and it is not always collated or analysed for management purposes. All NHS boards except Ayrshire and Arran, and Lanarkshire still use paper records to store some information. This makes it difficult for NHS boards to understand the factors driving expenditure on locum doctors; to target areas where they could be more efficient; and to benchmark their performance with other NHS boards. Only six NHS boards have performance indicators in place to monitor the use of, or expenditure on locum doctors and only two (Grampian and Highland) have performance targets in place.

12. National Procurement set up a national contract for agency locums in 2004 to standardise pay rates and reduce the costs of using agency locums. Agency locums cost more than internal locums because they have higher hourly rates and there are additional commission costs. Internal pay rates range from £11 to £64 per hour (depending upon grade and time of shift) compared to £34 to £87 per hour for a national contract agency.

13. In 2006, the Scottish Executive instructed NHS Boards to use only the two agencies in the national contract.[4] However, NHS boards continued to use non-contract agencies and expenditure on non-contract agency locums increased from 31 per cent of overall agency expenditure in 2006/07 to 33 per cent in 2008/09 (see paragraphs 29 to 31 in the main report for more information).[5]

14. The national contract lapsed in May 2009 and NHS boards have been responsible for negotiating their own rates since then. 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. It is likely that other NHS boards are paying higher rates for locum doctors than before the contract lapsed (see paragraphs 33 to 36 in the main report for more information). A new national contract came into place in June 2010.

2 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.

4 *HDL (2006) 39 Use of national contracts*, Scottish Executive Health Department, 2006.
5 Base is nine NHS boards and Golden Jubilee National Hospital.

15. Based on data from seven NHS boards, requests for agency locums more than doubled between 2006/07 and 2008/09 from around 3,700 requests to around 8,200 requests. Limited information across the NHS means it is not possible to identify the level of demand for internal locums.

16. Agencies' ability to meet demand for locum doctors fell from 83 per cent of all requests filled in 2006/07 to 71 per cent in 2008/09.[6] This varies across the country from 100 per cent of all locum requests filled in NHS Shetland and Western Isles in 2008/09 to 61 per cent in NHS Fife. In terms of specialties, pathology had the highest fill rate in 2008/09 (90 per cent) and surgical specialties had the lowest (56 per cent). Obstetrics and gynaecology and ophthalmology have experienced the greatest decline in fill rates since 2006/07, falling by 28 per cent.

17. When NHS boards cannot procure locum doctors then other doctors within the team have to cover the workload; senior staff, such as consultants, cover the work of junior colleagues; or the service may be reduced.

18. NHS boards report that demand for agency locum doctors has increased due to the full implementation of the 48-hour week European Working Time Directive (EWTD) for medical staff, and increasing numbers of hard-to-fill vacancies. Vacancies in trainee 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 do exist (see paragraph 25 in the main report for more information).[7]

19. Planned absence is a key reason for requesting locum doctors. Good practice states that locum doctors should mainly be used for unplanned absences rather than planned leave.[8] However, evidence from seven NHS boards shows that a significant percentage of requests for locum doctors in 2008/09 were to cover vacancies and planned absences, including annual leave and study leave. Requests to cover vacancies in 2008/09 ranged from 23 per cent of all requests in NHS Western Isles to 100 per cent in Golden Jubilee National Hospital. Requests to cover planned leave ranged from 12 per cent in NHS Dumfries and Galloway to 45 per cent in Greater Glasgow and Clyde.[9]

3 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.

20. The use of locum doctors creates potential risks to patient safety, particularly where locums are unknown to the board. For example, a lack of adequate supervision could lead to inappropriate treatment of patients (Exhibit 2, overleaf). It is the responsibility of NHS boards to manage these risks.

21. NHS boards are responsible for ensuring that pre-employment checks are carried out when appointing agency locum doctors, but agencies can carry out some of these checks on their behalf. All NHS boards have a formal checklist setting out the documents that should be received when employing locum doctors, but only eight set out within their locum policy who is responsible for each element of the appointment process. This means 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.

22. Only five NHS boards have a corporate induction policy relating to locum doctors. Our sample of NHS boards reported that induction for short-term locums tends to be basic and that they are less likely to receive induction than longer-term locums.

23. Although the majority of NHS boards undertake performance reviews of locum doctors, only five NHS boards have a corporate policy setting out how locums should be assessed and the procedures for acting on this information. The majority of feedback provided by NHS boards is verbal and only a few NHS boards report consistent use of written assessment forms to record performance.

24. Where poor performance is reported to agencies, NHS boards do not always receive feedback on any action taken. There is also no mechanism to share performance information with other NHS boards or agencies.

6 Based on information provided by NHS Dumfries and Galloway, Fife, Greater Glasgow and Clyde, Lanarkshire, Orkney, Shetland and Western Isles.
7 NHS Education for Scotland.
8 *Code of practice in the appointment and employment of locum doctors, NHS Circular: PCS(DD)1998/1*, the Scottish Office, January 1998.
9 Planned leave includes annual leave, study leave and maternity leave.

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 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.

Exhibit 2

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	
• 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	• Inappropriate use on grounds of experience, qualifications, immigration status, fatigue or health status • Appointment of bogus doctors
Induction and supervision	
• Absence of formal arrangements • Limited induction of locum doctors • Lack of proper supervision	• Poor continuity of care • Improper or unauthorised action by locums • Inappropriate treatment of patients
Performance management	
• Unclear line management structure • Inadequate reporting of poor performance • No records maintained of appraisals	• Poor performance not detected • Unsatisfactory medical locum reappointed • Poor locum doctors able to escape sanctions by moving between NHS boards

Source: Accounts Commission, 1998

The Scottish Government and National Procurement should:

- identify national performance indicators for NHS boards to use to benchmark performance in relation to locum doctors[10]
- 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.

10 National Procurement is part of NHS National Services Scotland and is responsible for implementing and managing the national locum agency contract.

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