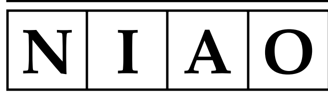
The use of locum doctors by Northern Ireland Hospitals

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
1 July 2011



Northern Ireland Audit Office

Report by the Comptroller and Auditor General for Northern Ireland

The use of locum doctors by Northern Ireland Hospitals

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This report has been prepared under Article 8 of the Audit (Northern Ireland) Order 1987 for presentation to the Northern Ireland Assembly in accordance with Article 11 of that Order.

K J Donnelly
Comptroller and Auditor General

Northern Ireland Audit Office
1 July 2011

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Abbreviations

A&E	Accident and Emergency
AHP	Allied Health Professional
BSO	Business Services Organisation
DHSSPS	Department of Health, Social Services and Public Safety
ENT	Ear, Nose and Throat
EWTD	European Working Time Directive
GMC	General Medical Council
GP	General Practitioner
HR	Human Resources
HSC	Health and Social Care
IT	Information Technology
LDA	Locum Doctors' Association
NIAO	Northern Ireland Audit Office
NIMDTA	Northern Ireland Medical and Dental Training Agency
NHS	National Health Service
PASA	Purchasing and Supply Agency
RMMLS	Regionally Managed Medical Locum Service
RQIA	Regulation and Quality Improvement Authority
RST	Revalidation Support Team
SAI	Serious Adverse Incident
SHO	Senior House Officer
USA	United States of America

Executive Summary

Executive Summary

Introduction

1. Properly-managed use of locum doctors allows Health and Social Care (HSC) Trusts to respond flexibly and efficiently to varying activity levels and to cover short-term absences or vacancies. However, in order to safeguard the quality of patient care, Trusts must not only control costs but must take steps to reduce the clinical risks associated with locum doctors who may be unfamiliar with their colleagues, their surroundings, the patients under their care, or with local procedures and practice.

2. This report examines the use of locum doctors in hospitals across Northern Ireland. It considers whether the Department of Health, Social Services and Public Safety (the Department) and Trusts have developed a planned approach to controlling and managing the supply of and demand for locum doctors. The report also explores the safety and quality issues associated with the use of locum doctors.

On average, Trusts spend around 8 per cent of total medical staffing expenditure on locum doctors

3. In the four years to 31 March 2011, Trusts spent over £100 million covering doctor shortages in hospitals. In 2010-11 alone, locum costs amounted to £22.5 million, almost 8 per cent of all medical staffing expenditure. Within the Western Trust the percentage was more than double this rate (at 17 per cent). If it were possible for all Trusts to maintain locum costs within the regional average, this might yield potential savings of £5 million each year. Local circumstances may make this challenging to achieve but Trusts should be capable of making savings by more effective management of the demand for locums and improving purchasing procedures.

Better information on the use of locum doctors is needed to identify where efficiency can be improved

4. The quality of management information used across the Health and Social Care sector varies considerably and, as a result, it can be difficult to obtain an overall picture of locum doctor activity and costs. Costs relating to locums employed through recruitment agencies are routinely identified. However, information on the use and cost of internal locums (i.e. doctors employed within Trusts working hours additional to those stated in their contract) to cover gaps in rotas is not captured in the same way. In order to manage the use of locum doctors effectively and make savings, Trusts need accurate and comprehensive summary information on how much is being spent on locums, the grades and specialties being used and the type of locum – internal or agency. Monitoring expenditure in this way may help Trusts to target areas where they could be more efficient in their use of locums and to benchmark locum use locally and against other United Kingdom comparators.

Managing the demand for locum doctors could be improved

5. Consultant medical staff workforce complements are fixed by Trusts in collaboration with the Health and Social Care Board. In relation to junior doctors, the Northern Ireland Medical and Dental Training Agency (NIMDTA) is responsible for the recruitment of doctors in training. Trusts have no authority to permanently appoint junior doctors to fill posts which create gaps in rotas.

6. Demand for locum doctors is mainly driven by the need to provide a safe and effective service where there are hard-to-fill vacancies and where medical staff are required to comply with the 48-hour week European Working Time Directive (EWTD). Periodic reviews of the medical workforce, produced by the Department, provide a high level overview of likely staffing needs but are not designed to identify gaps at medical specialty level. We acknowledge that the Department has commenced work aimed at addressing how it can strengthen planning and intelligence at medical specialty level.

7. It is important for Trusts to have the key management information available locally to inform decisions. Therefore Trusts should develop strategies to improve their understanding and management of demand for locum doctors. Trusts should use a standard system for recording the reasons why employing locum doctors was deemed necessary; the grade and specialty involved; the type of locum (internal or agency); and the time and duration of shift. Trust managers should then use this information to improve workforce planning arrangements.

Improved procurement could lead to more efficient use of locum doctors

8. According to Trust procedures, only when the options of cover by medical teams or the appointment of internal locums have been exhausted will Trusts grant approval to approach external recruitment agencies. All Trusts have contracts in place with a number of agencies, through the Business Services Organisation (BSO), for the supply of locum doctors. Trusts told us that where the contracted agencies are unable to provide locums, they will move outside the contract.

9. In order to further generate efficiency savings and reduce clinical risk, we consider that Trusts need to explore and adopt better practice in the procurement of locum hours by improving collaboration and partnership working. Towards this end, we acknowledge that Trusts are taking steps to develop a regionally-managed medical locum service for Northern Ireland. When in place, the regional service should enable the Trusts to plan locum use more effectively and to demonstrate that locums are being used appropriately. In addition, the risk to patient safety of locum doctors could be reduced if all locums available under the service received appropriate inductions and had their performance fully assessed.

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Improvements need to be made to assure the quality of locum doctors

10. Controlling the scale and cost of locum use is only part of the challenge. Perhaps more important, is the duty to provide safe, effective and quality care to patients. Trusts must address their responsibility to ensure that locums are competent to undertake the duties required of them. While each of the Trusts has procedures in place for procuring locum doctors, Internal Audit has identified several instances where checks to ensure the competence of locum doctors had not been undertaken or were not properly documented and where Trusts' arrangements with agencies supplying locums exposed them to risk.

11. In 2006, the Department introduced *Interim Arrangements for the Appraisal of Locum Doctors*. These arrangements required that all locum episodes should be subject to a standard performance review assessing the clinical skills of the locum. However, a review in 2008[1] indicated that, in certain areas, there was a significant shortfall in the number of consultants (and possibly locums) appraised; that there were no formal systems for the review and performance management of appraisers; and that there was little evidence of the evaluation of training or of the outcomes of the appraisal process. A more recent series of reviews in 2010[2] reported improvement overall but noted that Trusts do not always receive end of placement reports from locum agencies or previous employers and that not all Trusts have systems in place to provide exit reports for all locum doctors. The need for Trusts to maintain records of the performance of individual locums will become even more important as the General Medical Council (GMC) moves forward with a process of revalidation where a doctor's licence to practice will be reissued every five years subject to the satisfactory assessment of their fitness to practise. The Department told us that it is preparing for revalidation.

12. While the detailed aspects of the employment of locum doctors are, in practice, delegated to staff within the specialty requiring cover, each of the Trusts operates a central accountability system through which senior doctors (Associate Medical Director/Clinical Director level), are accountable for the demand and the associated safety and quality issues. It is important that compliance with such procedures is monitored and that action is taken to improve compliance where necessary.

13. There are no systems and safeguards in place to enable a Trust to routinely identify whether a locum doctor has exceeded the safe level of hours set under the European Working Time Directive. Long working hours can place risks on the health and performance of the locums and can affect the safety of patients in their care. While *Good Medical Practice*[3] requires individual doctors to be responsible for their own work, in our view, in the interests of patient safety, Trusts need to establish systems to enable them to control and monitor the total number of hours worked by each locum doctor. We

1 The Regulation and Quality Improvement Authority (RQIA) Review of Medical Consultant Appraisal, August 2008
2 The Regulation and Quality Improvement Authority (RQIA) Review of HSC Trust Readiness for Medical Revalidation, December 2010
3 Good Medical Practice – Framework for Assessment and Appraisal, The General Medical Council, November 2006

acknowledge that the current regional discussions and scoping exercise on the potential to develop a regional locum service cites this as a potential benefit.

14. In the Department's view, locum doctors provide an entirely satisfactory service in the vast majority of episodes in which they are employed. However, given the weaknesses we identified in the arrangements for managing the work of locums, we believe that the Trusts and the Department need to routinely monitor the performance of locum doctors. Trusts told us that their management information systems have the capacity to provide information on a doctor-specific basis, although some alterations to the way in which data is recorded may be required to specifically identify locums.

Part One:
Introduction and Background

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Introduction and Background

1.1 In Northern Ireland, the Department of Health, Social Services and Public Safety (the Department) is responsible for improving the health and social well-being of the people of Northern Ireland. Part of its responsibilities involve ensuring the provision of appropriate health and social care services, both in clinical settings (such as hospitals and General Practitioners' (GPs') surgeries) and in the community through nursing, social work and other professional services.

1.2 In recent years, the health and social care sector has been subject to major structural reforms[4]. On 1 April 2007, five integrated Health and Social Care Trusts replaced 18 of the 19 Trusts (see Appendix 1). The remaining Trust, the Northern Ireland Ambulance Service Health and Social Care Trust, stayed in place. Other changes within the sector have included the creation of the Health and Social Care Board (HSC Board), five Local Commissioning Groups, the Business Services Organisation (BSO), the Patient and Client Council and the Public Health Agency.

1.3 Management of hospital services falls to the five Health and Social Care Trusts. There are currently 39 hospitals in Northern Ireland. Of these, 13 provide acute hospital services while the remaining 26 provide either community-based services[5] or mental health services. The reporting structures for hospital services since 1 April 2007 are set out in Figure 1 below.

1.4 Northern Ireland hospitals provide a wide-ranging programme of care to patients. Some hospitals operate 24 hours each day, 365 days a year (acute and mental health hospitals). Others provide care within specified periods (community hospitals). Hospitals can only maintain crucial services where they ensure that appropriate numbers of doctors are available for each shift.

1.5 In recent years, an increasing number of doctors have elected to work fewer hours, reflecting broader community preferences for balancing work and private life. In addition, new immigration laws have led to a decline in the number of international medical graduates and the European Working Time Directive (EWTD) has introduced restrictions on the number of hours doctors can work. These changes have made it difficult for hospitals to ensure that the optimal number of doctors is available to cover shifts at all times.

1.6 Where a hospital has insufficient numbers of doctors available to provide the required services, it will either:

a. pay existing staff (internal locums) to cover the additional hours;

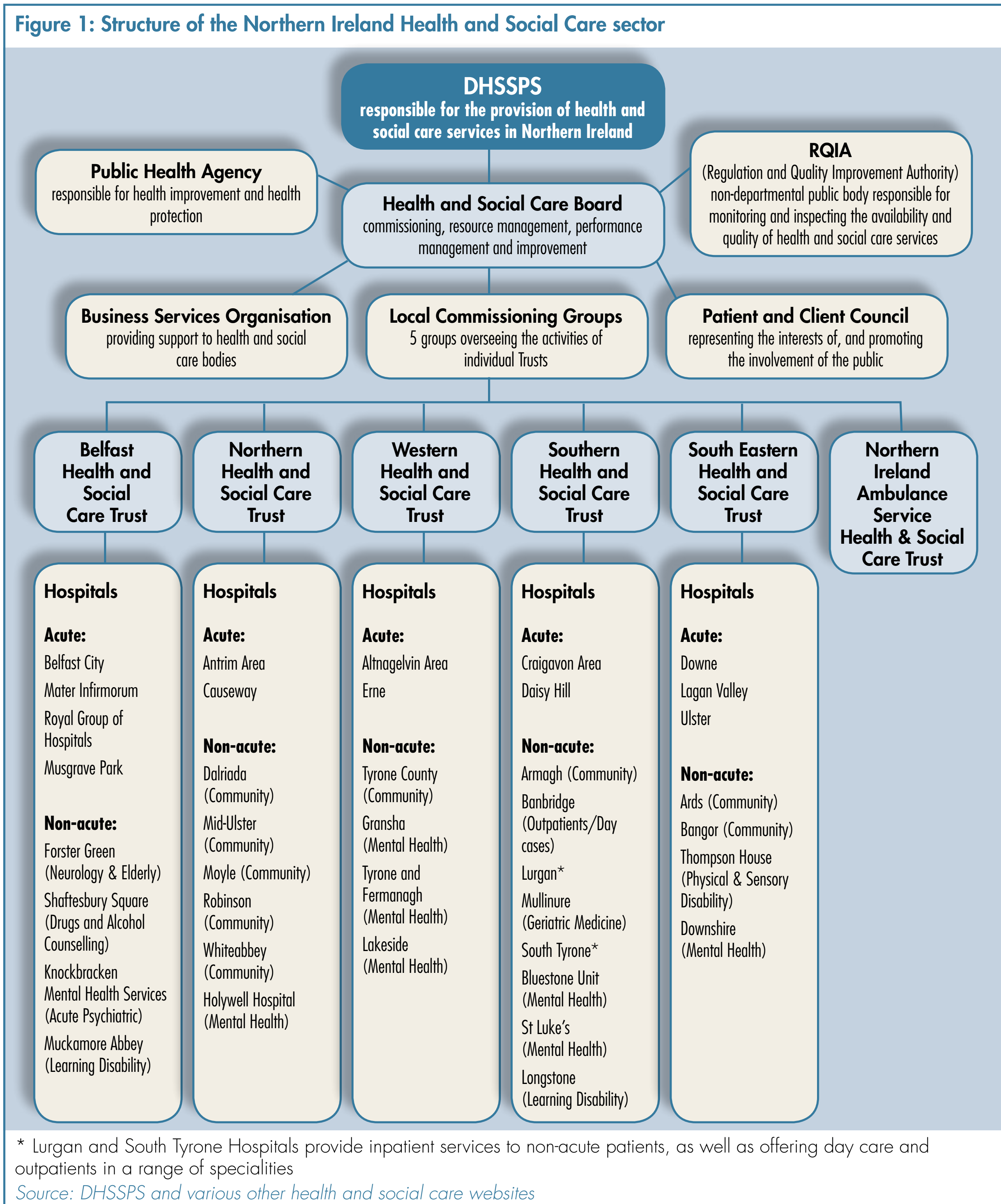
b. recruit additional (temporary) staff where the post is to last several months; or

c. where neither (a) or (b) is feasible or successful, approach an external agency to provide staff (agency locums).

4 The structural reforms primarily reflected changes required through the Review of Public Administration and to address the findings of the Appleby Review.

5 A list of Northern Ireland hospitals is included at Appendix 2.

Figure 1: Structure of the Northern Ireland Health and Social Care sector



* Lurgan and South Tyrone Hospitals provide inpatient services to non-acute patients, as well as offering day care and outpatients in a range of specialities

Source: DHSSPS and various other health and social care websites

Part One:
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Locum doctors are used in Northern Ireland hospitals to ensure continuity of care for the patient

1.7 '*Locum*', from the Latin phrase *locum tenes*, refers to a person who temporarily fulfils the duties of another. A '*locum doctor*' is a professionally-qualified, medical practitioner temporarily covering for staff shortages or unexpected peaks in workload. Locums assist in hospitals in two key areas. For instance, they can provide short-term shift cover for doctors who are temporarily unavailable for work, or they can be appointed on a longer term basis to fill vacant posts or as cover for staff on extended absence, such as maternity leave.

1.8 There will always be a need for locum staff to cover periods of sick or maternity leave, to overcome shortages in the number of doctors in training within some specialties and, increasingly, to compensate for the desire of staff to work more flexible hours. However, Trusts acknowledge that effective planning can help control the extent to which locums are required.

1.9 Doctors providing locum services are either Trust employees working outside their normal hours or are supplied by Locum Agencies.

- *Internal Locums* – Hospitals use their own internal staff as locums. Staff are used to cover absences and are normally remunerated at nationally agreed rates as specified in Departmental circulars. The Department has acknowledged, however, that since these rates are substantially lower than the rates available to Agency locums, internal locums often refuse the additional hours unless an increased rate is offered. Apart from the Belfast Trust, the other four Trusts told us that internal locums often barter for rates above those approved by the Department.

- *Agency Locums* – There are currently nine Locum Agencies in Northern Ireland who supply locum doctors to hospitals. These Agencies recruit doctors from within the Northern Ireland Health and Social Care sector, indeed many of the staff supplied by these Agencies are already working for Trust hospitals. The payment rates, although in line with agreed contract rates, tend to be significantly higher than the salaries paid to hospital staff. For example, rates for some of the larger Agencies range between £31 to £72 per hour compared against substantive post rates of between £26 to £31 per hour.

We had difficulty obtaining details of the total locum spend across Trusts

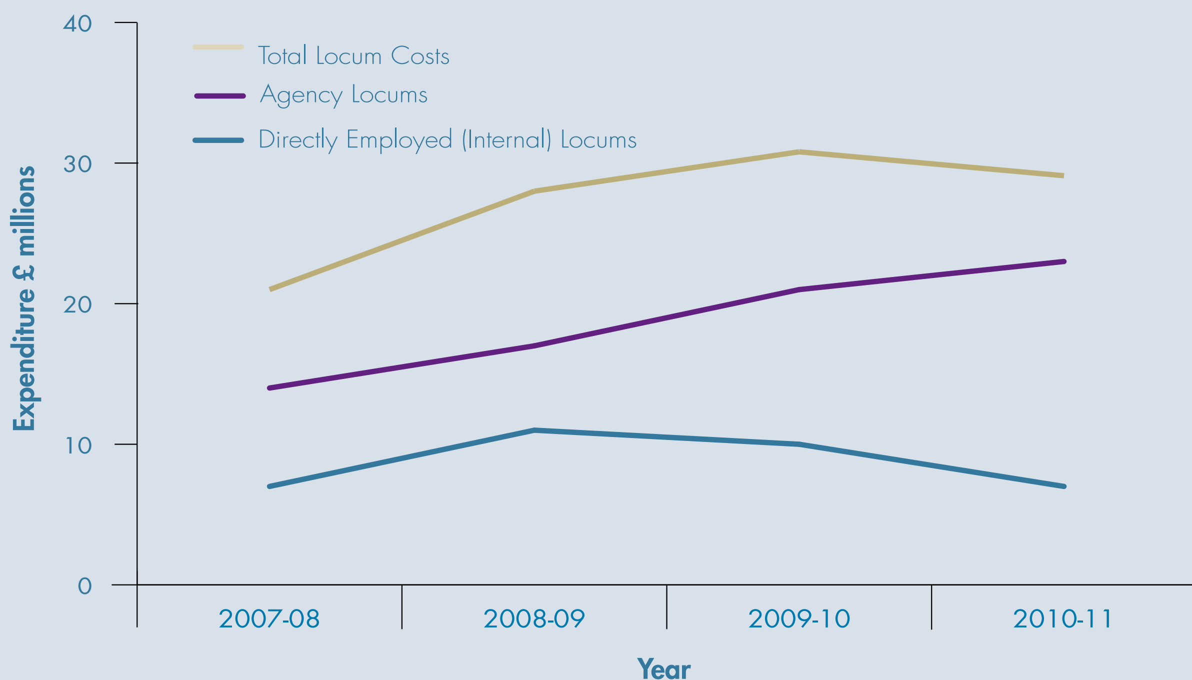
1.10 At the outset of our audit, we asked each Trust to provide details of the total payments made in respect of locum doctors. Information on payments to external agencies (for agency locums), has been collected by the Department's Workforce Planning Unit since October 2006 and was, therefore, readily

available. Information on the value of payments to internal locums proved more difficult to obtain. Throughout our audit, individual Trusts told us that it was not possible to extract this information from their management information systems.

1.11 Some time later, during the latter stage of the reporting process, the Department provided the information we had previously requested (see Appendix 3[6]). The Department told us that the information could be extracted from the management information systems of Trusts, albeit with some interrogation of systems.

1.12 Figure 2 below shows locum doctor expenditure within Northern Ireland Trusts over the period from 1 April 2007 to 31 March 2011. Overall, in the four year from 2007 to 2011, Northern Ireland Trusts paid £109 million to cover staff shortages. Expenditure on agency locums rose steadily over the period from almost £14 million in 2007 to £22.5 million in 2010-11. Since 2007, the cost of agency-supplied locum doctors has amounted to just under £74 million for providing locum doctors to Trusts. Over the same period, Trusts paid just over £35 million to internal staff for hours worked over and above their contracted hours.

Figure 2: Total Locum Expenditure within Northern Ireland hospitals over the period 2007-2011



Source: Department

6 We have not undertaken any validation work to assess the accuracy of the cost information provided to us by the Department.

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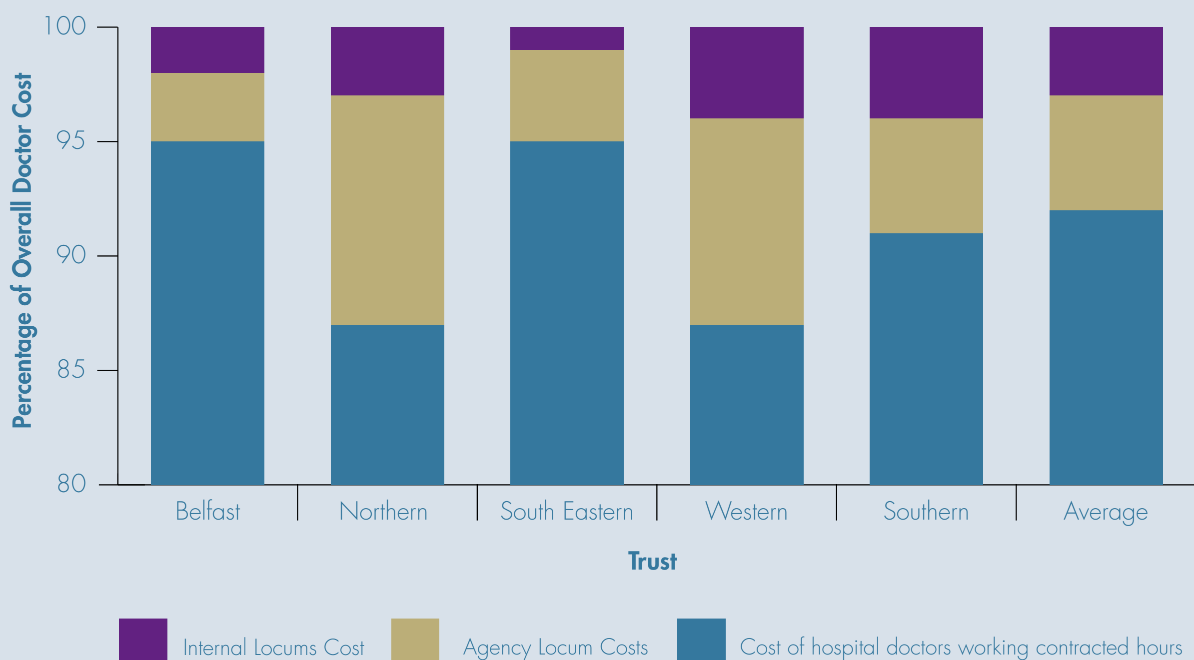
Introduction and Background

1.13 Figure 3 shows (in percentage terms) the level of locum expenditure compared to payments to permanent doctors for contracted hours. The majority of expenditure (around 92 per cent) in 2010-11 relates to payments to doctors for their contracted hours within the Trust.

1.14 On average, 8 per cent of overall spend on employing doctors within hospitals relates to the use of locums - 6 per cent of this being paid to external agencies. A 2010 report by Audit Scotland[7] identified that locum expenditure in Scottish NHS Boards in 2008-09 accounted for 4.3 per cent of medical staffing expenditure.

1.15 If it were possible for all Trusts to maintain locum costs within the regional average of 8 per cent, this might yield potential savings of £5 million each year. Theoretically, this would involve all Trusts minimising the use of locum doctors by deploying a more optimal number and mix of permanent doctors. In practice, however, we recognise that for some Trusts this is not easy. For example, the Western and Northern Trusts have faced difficulties in recruiting staff in some specialties and grades. Despite the pressures to use locums created by such a strategic workforce issue, Trusts, in our view, should be capable of generating savings by more effective management

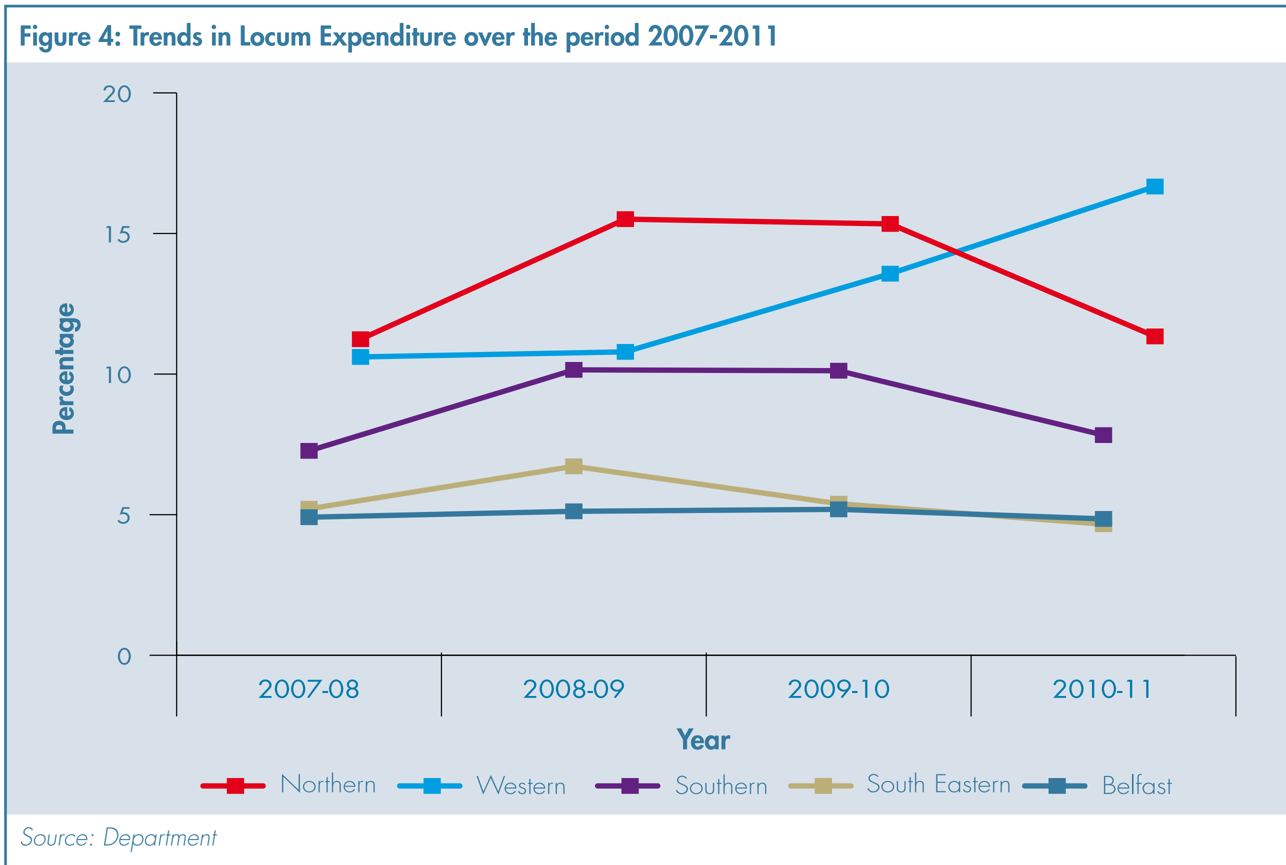
Figure 3: Percentage split of total NI hospital doctor costs between contracted hours, Agency locums and internal locums over the period 2007-2011, by Trust



Source: Department

7 Using Locum Doctors in Hospital – Audit Scotland June 2010

Figure 4: Trends in Locum Expenditure over the period 2007-2011



Source: Department

of the demand for locums and improving procurement procedures, particularly around the payment of premium rates to locum doctors.

1.16 Further analysis of the figures from Trusts each year (Figure 4 above) sheds some light on the specific difficulties faced by Trusts. Locum expenditure within the Belfast Trust has remained fairly constant over the four year period to 31 March 2011 at around 5 per cent of the overall cost of hospital doctors. Levels within the South Eastern Trust also remained relatively constant at around 5 per cent, apart from a slight increase in 2008-09 which saw the locum level rise to just under 7 per cent.

1.17 The percentage of locum expenditure within the Southern Trust had been higher, with the average for the four years of around 9 per cent. However, this has fallen in the last three years and now stands at just under 8 per cent.

1.18 Percentage levels in the Northern Trust and the Western Trust have been the highest over the four year period. Within the Northern Trust, the level stood at almost 16 per cent in 2008-09, although levels have fallen in each of the subsequent years.

1.19 Within the Western Trust, on the other hand, the percentage of locum use

Part One:
Introduction and Background

has risen steadily over the four years from almost 11 per cent in 2007-08 to nearly 17 per cent in 2010-11 as the Trust becomes more reliant on locums to maintain services. The 2010-11 level within the Western Trust (of almost 17 per cent) is the highest for any Trust over the four years examined. The Western Trust had always placed reliance on International Medical Graduates (IMGs) and the recent changes to immigration laws has resulted in this disproportionate use of locum cover.

The use of locums must be monitored carefully if the cost and quality of care is to be maintained

1.20 Locum doctors provide cover at all levels in medical specialties across Northern Ireland's hospitals. Although most medical and health and social care personnel agree that the use of locum doctors within hospitals provides flexibility, the practice also creates specific challenges. For instance, following our previous report on acute hospital services in 1993[8], the Public Accounts Committee at Westminster[9] concluded that, while there was a recognised need for locum doctors to be used on occasions:

".....the Department must monitor carefully the quality of service provided in such situations on a regular basis so as to assure itself that quality of care is not being compromised."

1.21 A subsequent report by us[10] in 2007 highlighted the circumstances surrounding the employment of a locum consultant radiologist who was paid £240,000 for work during the period 2003-04. A permanent staff member would have cost approximately £71,000. When the permanent post was finally advertised, the locum did not apply. The report also identified a series of weaknesses which existed in the management of locum doctors (and agency nursing staff) such as:

- inadequate Trust guidance on agency/locum staff engagement procedures;
- failures to use formal contracts;
- the appointment of staff from non-contracted agencies; and
- weaknesses in vouching procedures.

1.22 On the basis of these findings, the Comptroller and Auditor General made a commitment in his report to undertake a separate review *".....into the use of locum doctors, with particular focus on the effectiveness of management arrangements in this area."*

1.23 The cost of temporary staffing has also been the focus of attention in the National Health Service in Great Britain. In December 2005, the Department of Health listed *"managing temporary staffing as a major source of efficiency"*[11]

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8 *Department of Health and Social Services: The Provision of Acute Hospital Services in Northern Ireland*, NIAO, 4 November 1993

9 *Department of Finance and Personnel, Memorandum on the 12th and 13th Reports from the Committee of Public Accounts*, Session 1993-94, Cm 2555, London, HMSO

10 *Financial Auditing and Reporting: 2003-04 and 2004-05, Combined General Report on the Health Sector by the Comptroller and Auditor General for Northern Ireland, NIAO,* NIA 66/06-07, 6 July 2007

11 *A National Framework to Support Local Workforce Strategy Development*, Department of Health, December 2005

as one of its ten high impact workforce changes. While findings such as these support the case for a detailed study of locum use and costs, there are also potentially more important issues concerning clinical risk and standards of patient care.

1.24 Trusts take advantage of the flexibility that using locum doctors affords so that they can ensure that services are safely maintained and that they can address the clinical risks of failing to fill gaps in doctors' rotas. If the doctors appointed are competent in all respects to do the work required, they will provide the same quality of care as a doctor in a permanent post. However, the circumstances under which locum doctors are appointed and carry out their duties may pose certain risks. For example, where a locum is brought in on a short-term basis, their induction may be limited. Their lack of familiarity with the Trust working environment and other staff can create a risk to patient safety. Further, their limited stay on a ward raises concerns over the continuity of care.

1.25 Trusts have acknowledged that it would be preferable to have a more robust 'bank' of locum staff, who progress through a formal training update programme, on an annual basis. With this in mind, Trusts are engaging with each other with a view to developing a regionally-managed locum system (see paragraph 2.16).

This report considers the effectiveness of Trust controls over the use of locum doctors in hospitals

1.26 This Report considers the effectiveness of management arrangements over the use of locum doctors by Trusts;

- Part 2 examines the arrangements in place to manage the demand for locum doctors; and
- Part 3 considers the arrangements in place for safeguarding the quality of care provided to patients.

More detail on our methodology is set out at Appendix 4.

Part Two:
Managing the demand for locum cover

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Managing the demand for locum cover

Workforce planning in the health service attempts to balance the availability of suitably-qualified medical staff against patient needs

2.1 Workforce planning provides organisations with an opportunity to identify trends and anticipate shortfalls in staffing levels. Medical workforce planning is a complex process. In Northern Ireland, the exercise consists of a major review of services every three years and involves several organisations, notably the Department, the Medical School at The Queen's University of Belfast, the Trusts and the Northern Ireland Medical and Dental Training Agency[12]. The objective of medical workforce planning is to balance the availability of suitably-qualified medical staff against patients' needs.

The latest Review of the Medical Workforce was published in 2010

2.2 In April 2010, the Department published its latest Review of the Medical Workforce[13]. The purpose of the review was to provide comprehensive, current information on the medical professional group in Northern Ireland to be used by the Department to forward-plan training over a five to ten year period[14].

Changes to the hospital environment have had an impact on the availability of staff

2.3 The environment in which hospital services are delivered has gone through a period of substantial change. This has impacted on the availability of staff and therefore on the need to use locums if crucial services are to be delivered. Given the complicated interplay between workforce planning at the regional level and individual Trusts' overall medical staffing arrangements, inevitably the supply of trained doctors will not always match demand. Where demand for clinical services outstrips medical workforce supply, key services may have to be withdrawn. For instance, during September 2009, the obstetrics and gynaecology service at the Erne Hospital was suspended for two weeks due to a gap in the service provision created by a lack of junior doctors. In 2010, Accident and Emergency services at the Whiteabbey and Mid-Ulster Hospitals were closed and transferred to Antrim Area Hospital for a number of reasons[15]. One reason was the loss of senior clinical staff at the former two locations and the impact this could have on the quality of clinical outcomes.

2.4 Primary responsibility for planning staffing needs in relation to service delivery rests with the employer – as does succession planning. This is done at Trust level, and the results provided to

12 The Northern Ireland Medical and Dental Training Agency is responsible for funding, managing and supporting postgraduate medical and dental education within Northern Ireland. It is responsible for the organisation, development and quality assurance of Postgraduate Medical and Dental Education and for the delivery and quality assurance of Continuing Professional Development for general, medical and dental practitioners.
13 The 2010 Review related to 2008 while the previous review, published in 2006, related to 2005.
14 The 2010 Workforce Planning Review related to the ten year period from 2008.
15 Other reasons for the closure included the absence of critical care facilities and a paediatric service at Whiteabbey Hospital, the lack of access at either hospitals to acute surgical inpatient services, the absence of intensive care units at both sites; and the limitations modern technologies in cardiology have placed on cardiologists' ability to cover two sites simultaneously out-of-hours.

the Department, so that regional gaps/shortages/trends can be identified and remedial action taken. The regional position is an overall summary which cannot replace close planning in relation to service needs. The Department told us that work is currently underway to prompt improvements in this area.

2.5 Several factors have contributed to the limited availability of suitably qualified staff across the health and social care sector as follows:

a. **Changes to the immigration rules:** In February 2008, a new points-based immigration system was introduced setting out the conditions under which overseas doctors could qualify for entry to work in the UK. The new regulations restrict the numbers of overseas doctors eligible to work in the UK.

b. **Introduction of the European Working Time Directive (EWTD):** The EWTD was introduced in Northern Ireland in 1998 to protect the health and safety of workers by introducing minimum rules for rest periods, leave entitlements, length of working week and night work (additional information on the implications of the Directive is set out at Appendix 5). From August 2004, the legislation limited junior doctors' working hours to 58 per week. This was further reduced to 56 hours per week from August 2007 and to 48 hours from August 2009[16].

c. **Individual specialty and location preferences of staff:** Hospitals located outside Belfast often experience difficulty attracting and retaining staff. Small, rural sites can struggle to consistently provide adequate cover for patients. Within these hospitals, the loss of even one member of staff (through sick leave, resignation or other reason) can have a major impact on the ability of the site to maintain its services. Inevitably this puts pressure on remaining consultants and staff and makes their positions less attractive.

d. **Flexibility of working hours and early retirements:** Doctors of both sexes are increasingly electing to work fewer hours during their career and to retire early. This reflects broader community preferences for balancing work and private life but places pressure on Trusts as experienced staff are available for a reduced period of time.

e. **Change in the female to male ratio of students:** An increasing number of females are choosing medicine as a career. The current female to male ratio among medical students at Queen's University, Belfast is almost 60:40[17]. This will ultimately impact on the composition of the workforce - over the last two years female representation has increased by 3 per cent and, in future years, this is expected to rise. The employment of additional females can place further

16 Research undertaken by the Department in 2008 identified that despite the potential imposition of heavy penalties, non-compliance with EWTD is high across the five Northern Ireland Health and Social Care Trusts. The research identified that levels of compliance could be significantly improved by the implementation of internal measures by each of the respective Trusts.

17 QUB Medical School Data – January 2009 - Female to male ratio is 57:43

Part Two:
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pressure on Trusts where cover is required for periods of maternity leave.

2.6 The Department told us that it has taken steps to address the shortage of junior doctors. In 2005, funding was provided to increase the number of medical students. The extent to which these additional graduates reduce the use of locums will depend on their chosen career location and their choice of specialty.

2.7 While locum appointments are intended to fill gaps resulting from the unavailability of permanent doctors, there is evidence that the local supply of locums is also becoming a concern. The Department recently drew attention to the high costs of bringing in doctors from outside Northern Ireland to provide cover in Accident and Emergency departments, commenting that, in some cases, temporary replacement doctors were being paid almost three times more than staff doctors[18]. Trusts need to be able to demonstrate that such practice is an appropriate and cost effective use of resources in the longer term.

Management information is insufficient to enable effective monitoring and control of the use of locums

2.8 Individual Trusts collect information, to varying degrees, on the usage and costs of locum doctors and report this to management periodically. However, the information collected is not comprehensive nor is it brought together in a systematic manner to provide the basis for analysing the most appropriate way to use locums throughout the Trusts. Failure to collate and analyse comprehensive management information makes effective strategic planning and control of locums very difficult. The ability of Trusts to plan strategically and work flexibly becomes increasingly important, if they are to address medical workforce changes.

2.9 The Trusts told us that it is essential that information is available to assist in planning and use of locums. The Trusts see great merit in the development of a regional management information system which would be managed by a dedicated resource and would ensure that information is collated consistently across the region. This would also facilitate regional monitoring of activity and trends and inter-trust comparisons, providing greater opportunity for managing the use of locums holistically across the service.

The 2010 Workforce Planning Review was completed in the absence of detailed information on speciality training

2.10 If the use of locum doctors is to be effectively planned, it is essential to have good quality information on likely staffing difficulties within the sector. The workforce planning review published in September 2006[19] indicated potential staffing shortfalls in the following specialties (see Appendix 6 for further detail):

- anaesthetics;
- community paediatrics;

18 Information was extracted from an article which appeared in the Irish News on 2 April 2010.
19 Review of Workforce Planning for the Medical Profession, September 2006

- orthopaedics;
- psychiatry; and
- radiology.

2.11 The next Workforce Planning Review, published in 2010, states that *"...detailed specialty planning will be required to address specialty specific training and recruitment needs"*. While the Department told us that planning for all specialties had been completed before April 2009, the Review team would not have had all of this information at the time of its fieldwork. In our view, to be most effective, it is important that workforce planning should be based on an analysis of the staff numbers and grades that are needed so that both training requirements and service needs are met. It is only when such plans are agreed that Trusts will be in a position to consider how their dependence on locums might be reduced.

2.12 In order to maximise use of the workforce planning we recommend that, for all subsequent exercises, specialty planning is commissioned and undertaken in sufficient time to enable detailed analysis prior to publication of the ten-year Workforce Planning Review.

Using locum doctors can create considerable financial risks

2.13 There can be considerable financial risks in appointing locum doctors. Trusts are charged with ensuring that they have sufficient substantive posts to meet foreseen service demands, including planned absences. The Department told us that Trusts must balance this requirement against their statutory obligation to break-even each year. The use of locums is generally only permissible to cover temporary absences (such as maternity absence) from substantive posts. Locum appointments are expected to be preceded by an assessment of the relative cost-effectiveness and viability of engaging additional permanent staff as opposed to engaging locum staff. The Department assured us that each Trust reviews the relative merits of each case and assesses cost-effectiveness before making decisions.

2.14 We examined Internal Audit reports on the use of locums produced since 2005. These made a number of comments in relation to payments made to locum agencies[20]:

- it was often difficult to verify the rates paid to external agencies because specific locum grades were not recorded on the documentation;
- instances were identified where Trusts were using locums registered with Agencies which do not have a contract with Trusts. In these cases, Trusts were negotiating payment rates on an ad-hoc basis;
- it was noted that existing Trust medical employees were also registered with locum Agencies (on occasion more than one agency). In these cases,

20 It is not possible to quantify the actual extent of non-compliance identified by Internal Audit due to the summary nature of their reports.

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Trusts are paying higher rates to their own employees through external recruitment agencies; and

- instances were repeatedly identified by Internal Audit where the rates paid for locum work were in excess of the Department's agreed remuneration rates. In addition, other occasions were highlighted where Trusts, needing a shift covered at the last minute, negotiated payments rates with locums rather than offering the rates stipulated by the Department (see Case Example 1). The Department confirmed that in order to fill gaps in rotas to maintain safe and effective services it is sometimes necessary to negotiate higher rates than those recommended in Departmental guidance. The management information held by the Department and Trusts is not sufficiently detailed to allow identification of the proportion and value of locum payments which exceed stipulated rates.

2.15 Given the current drive for delivering efficiency savings across the health and social care sector, Trusts must take action to control costs when engaging locum doctors. Drawing on the experience of the National Health Service (NHS) in England, we have set out in Figure 5, two examples of good practice which have been developed and implemented by participating teams (full details are provided at Appendix 7). Each example has a positive impact on productivity, improves efficiency and generates cost-savings[21]. In particular, the collaboration of hospitals and Trusts, applying agreed standards and rates, has been shown to contribute to more cost-effective use of medical locums. A number of Trusts working together have greater leverage with external agencies, and economies of scale can deliver more competitive agency rates. Additionally, collaboration across Trusts enables the sharing of good practice and learning.

Case Example 1

In one instance, an Internal Locum Consultant had been paid a remuneration rate arbitrarily determined by the Clinical Directorate rather than that specified in Departmental guidance. The Consultant was paid a total of £1,500 (£500 per 3-4 hour session). We estimate that had a doctor in a substantive post undertaken the work, the likely cost would have been around £100 to £125 for each 3-4 hour session). It was also noted that payment for one session was disallowed by Finance since it had been paid before.

21 The good practice examples have been taken from the NHS Employers publication *"Controlling the use of temporary staff through large scale workforce change"*.

Figure 5: Summary of Good Practice Purchasing Initiatives identified by NHS Employers

Issues similar to those identified in our report were identified in hospitals across UK Trusts as follows:

- the use of agencies outside those outlined in the national framework were regularly being used;
- individual departments were developing and using their own suppliers and procedures for booking locums;
- absence of (or limited) central control over expenditure on temporary staff;
- an absence of useful intelligence on medical locum usage and spend;
- insufficient checking of invoices for medical locums episodes; and
- a number of positions relied on high-cost medical locums to fill vacancies, and these had not been reviewed for some time.

A range of potential solutions were generated and piloted to address these issues as follows:

- use of a consortium of trusts with shared goals and commitments, to drive down agency costs through combined spending power;
- development of a master vendor network allocating responsibility for supplying temporary staff to a single supplier;
- introduction of protocols and improved financial controls over the booking of medical locums;
- direct phone calls to agencies from wards were banned, the phone number was blocked through the switchboard and out-of-hours bookings were done through on-call executive directors;
- use of centralised booking arrangements (for all medical staff) through one source within individual Trusts;
- improved management information to allow managers to control the use of temporary staff more effectively;
- review of rota-planning arrangements; and
- posts which tended to rely heavily on agency locums were re-advertised, NHS locums were favoured over agency locums and agency locums were encouraged to transfer to NHS contracts.

Various benefits were secured through these initiatives including:

- ability to secure more favourable rates and better sharing of good practice through collaborative working;
- increased spending power, greater leverage in driving down costs, improved service to Trusts and the provision of improved management information from the supplier;
- improved monitoring of the use of locums;
- release of considerable clinical staff time by use of administrative staff to arrange locum bookings and a single supplier; and
- improved staff morale by increasing fill rates on shifts.

Actual savings were secured as follows:

- In one Trust, the use of the master vendor system reduced spend on medical locums (nursing and medical) by just over £2 million each year.
- In that Trust, the introduction of a centralised booking system released savings of around £0.8 million.
- Within another Trust, the introduction of improved procedures reduced the use and cost of medical locums by over £278,000 per month, equating to an estimated annual saving of over £3.3 million per year.

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2.16 Given the success of these examples in the NHS, it is encouraging to note the recent decision in Northern Ireland to take steps to introduce a Regionally Managed Medical Locum Service for Northern Ireland (see Appendix 8). We also welcome assurances from the Business Services Organisation that it has taken steps to improve collaborative working and improve purchasing arrangements.

2.17 Trusts across the United Kingdom experience similar problems managing locum costs. Successful pilots in Trusts across the United Kingdom generated substantial savings and this could be replicated within Northern Ireland Trusts. We recommend that Trusts keep up to date with developments elsewhere in the United Kingdom and explore the success or otherwise of the various initiatives undertaken as a means of identifying improved practices.

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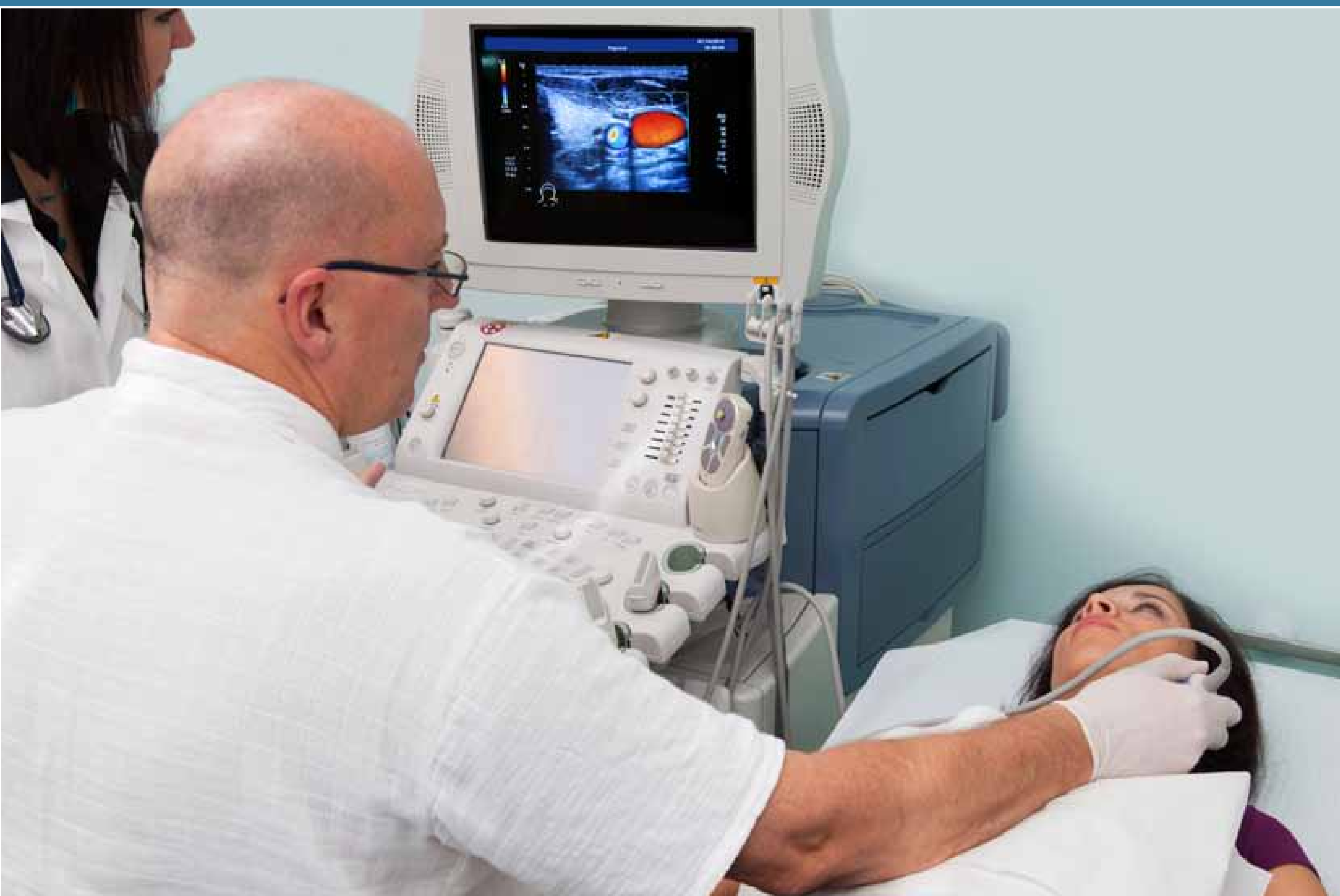

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Trusts and the Department must manage risks to provide safe, high-quality care to patients

3.1 As demand for locums increases and pressure on workload grows, Trusts and the Department must ensure that, along with controlling costs, doctors appointed on a locum basis are competent to undertake the duties required of them. Risk management, therefore, is increasingly important in ensuring that Trusts provide a safe and high quality service to patients. Patients are entitled to expect appropriate staffing levels and professional competence. The use of locum doctors both averts and contributes to the risk, by enabling hospitals to maintain appropriate staffing levels even though this might involve appointing doctors with less experience or skills than those they are replacing.

3.2 There can be other potential risks for the healthcare system in engaging locums: lack of continuity of care; or lack of familiarity with a hospital and its procedures. In addition, there can be significant potential disadvantages for doctors who choose to work on a locum basis, for example, the lack of ongoing education from patient follow-up; and the absence of mentor and peer support or inadequate supervision of adherence to conditions of the EWTD (see paragraph 2.5b).

3.3 The presence of risk is not an argument against the use of locums, but those making the decisions need to be able to identify, measure and control the degree of risk involved. The corporate governance structures within the health and social care sector require the Management Boards of individual Trusts to evaluate internal controls and report the results to the Department. In relation to staffing, the Human Resources (HR) Controls Assurance Standard[22] sets out key criteria and contains guidance on how Management Boards should establish whether systems are sound. One of the stated criteria of the HR Standard is to ensure that all staff are recruited and employed in accordance with relevant statutory employment legislation and any other relevant requirements.

Locum doctors provided to Trusts by external agencies are not regulated by the Regulation and Quality Improvement Authority

3.4 The Regulation and Quality Improvement Authority (RQIA)[23] is responsible for the regulation of a wide range of health and social care services including Nursing Agencies which provide temporary registered nurses, health visitors, and midwives to the health and social care sector. However, its remit does not extend to Agencies providing locum doctors.

3.5 We understand that arrangements in Scotland and Wales also exclude the regulation of locum agencies. In England, unless the locum agency has a direct role in managing or directing the care then it is exempt from regulation.

22 HSC Controls Assurance Standard – Human Resources (latest version April 2009)

23 RQIA is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services.

3.6 Although we note that the current regulation arrangements in Northern Ireland mirror those elsewhere in the United Kingdom, in our view, external agencies supplying locum doctors should be subject to the same regulation as nursing agencies. We recommend that the Department considers extending RQIA's role to cover external agencies supplying locum doctors to Trusts. For maximum benefit, the Department should consider liaising with the other regions in the United Kingdom with a view to developing a joined-up approach to such regulation.

The Code of Practice in Locum Doctor Appointment and Employment was introduced in Northern Ireland in 1998 and sets out key controls for the use of locums

3.7 It is the clear responsibility of Trusts to ensure that all doctors they employ are competent, appropriately qualified, experienced and capable of undertaking the duties required of them. To assist Trusts, in July 1998, the Department introduced The Code of Practice in Locum Doctor Appointment and Employment.

3.8 The Code was developed by the Locums Working Group which was commissioned by the Chief Medical Officer in England because:

"… the health service, the medical profession and the Health Departments all expressed concerns over the quality of some locum doctors and the apparent ease with which some unsatisfactory doctors are sometimes able to move between locum posts within the Health Service …"

The Code sets out the required pre-employment checks for each locum episode

3.9 The guidance outlines key checks to be completed prior to the appointment of locum doctors and required monitoring and recording of the quality of each locum episode. The Code clarifies that all locum appointments should comply. It reminds Trusts that, as employers, they have ultimate responsibility for pre-employment screening, whether or not the locum doctor has been supplied by an agency. The objective of the guidance is to safeguard the quality of patient care. As an additional control, in line with Departmental guidance, Trusts are required to use only locums supplied by contracted Agencies.

3.10 Following a decision to appoint a locum doctor, each Trust has responsibility for determining the most suitable applicant. Locum appointments should be made with the same care as substantive appointments. Prior to offering the appointment, Trusts are responsible for ensuring that the locum doctor:

- has the requisite qualifications and experience to undertake the work;
- is not subject to reservations about the standard or competence in previous employment;

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- identifies and provides a written report from their most recent locum employer and/or relevant references;
- has been subject to a formal health assessment and has signed a health declaration form; and
- discloses details of any convictions – spent or otherwise.

3.11 In practice, where Agency locums are used, pre-employment checks are completed by the Agency. Internal locums, as Trust employees, will already have been appointed using procedures for substantive posts.

We identified several weaknesses in procedures for employing locums from external agencies

3.12 As well as examining a sample of 30 locum appointments within the Belfast Trust, we reviewed previous internal audit reports on the use of locums produced since 2005. We found evidence of problems with the way in which checks on locum doctors have been conducted[24]:

- in one Trust, Agencies had not been required to provide written confirmation that pre-employment checks had been completed;
- in one Trust, qualification checks were made on an informal basis, increasing the risk of inappropriate and possibly under-qualified staff being used;
- some Trusts used non-contracted Agencies to provide staff. This raises issues relating to the quality and safety of service where assurance is limited that appropriate validation checks have been completed. The Department told us that, where contracted agencies are unable to provide appropriate staff, Trusts have no option but to use non-contracted Agencies; and
- some Trusts had failed to carry out any audit of locum Agencies for a number of years. Under contractual arrangements, Trusts have the right to conduct an audit of the external agency at any time, to ensure it complies with its pre-employment vetting obligations. Such audits should include checks that the locum doctor registered with the Agency has the necessary qualifications/experience/skills for the post, has a satisfactory health assessment, and proper job references. As such they give assurance to Trusts that Agencies are providing properly vetted locums. We understand that no audits have been performed since the inception of the new Health Trusts in April 2007.

3.13 It is a matter of concern that Trusts on so many occasions did not comply with the approved procedures for employing locums from external agencies. In many cases, Internal Audit's concerns resulted in an assessment of "partial" or "limited" assurance.

24 Again, it is not possible to quantify the actual extent of non-compliance identified by Internal Audit due to the summary nature of their reports.

3.14 We recommend that all Trusts comply with the existing procedures for employing locum doctors from external agencies. For all locum appointments, Trusts must be satisfied that appropriate vetting of applicants has been undertaken. In the absence of appropriate vetting, Trusts risk compromising patient safety and may face serious financial consequences if claims for clinical negligence were to result from an inappropriate appointment.

3.15 Trusts also need to carefully weigh, and fully address, the added risks of using locums, especially where doctors are new to the hospital, are unfamiliar with colleagues, the patients under their care and local procedures and practices. We recommend that Trusts review their induction arrangements for locum staff to protect patient safety.

The Code sets out procedures for assessing the quality of service for each locum episode

3.16 In addition to pre-employment checks, Trusts need to have procedures in place to ensure that the quality of service is assessed for each locum episode. In October 2006, the Department introduced *Interim Arrangements for the Appraisal of Locum Doctors in Trusts*. This enhances guidance contained in the 1998 Code of Practice (paragraph 3.7). The requirements of the guidance are set out in Figure 6.

3.17 In August 2008, RQIA conducted a *Review of Medical Consultant Appraisal*. As part of the review, Trusts were asked to supply information on the percentage of consultant locums who had not been appraised during the period 1 April 2006 - 31 March 2007. RQIA noted in the report that

Figure 6: Appraisal of Locum Doctors

- where a locum doctor is employed for less than one week he/she should be supplied with a suitable reference or 'statement of satisfactory employment'
- where a locum doctor is employed for periods of more than one week but less than six months and cannot be included in routine appraisal processes, an end-of-placement report, which shows that there are no significant unresolved concerns about the doctor's fitness to practise, should be completed
- if the locum post is for more than six months duration, the doctor should be appraised as part of the routine appraisal process
- where the locum doctor is employed via an Agency and appraisal of doctors is part of the services provided by that Agency, the employer should ensure that appropriate standards and quality assurance mechanisms are in place to ensure robust appraisal mechanisms and pre-employment checks.

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the methodology led to limitations in the quality of information supplied by the Trusts. The review methodology was not conducive to in-depth analysis nor did it allow examination of the implementation of policies and procedures. The views of appraisers and appraisees were not sought. Therefore, the analysis of the effectiveness of the consultant appraisal system is limited. Results are contained at Figure 7.

Figure 7 – Percentage of Locum Consultants not Appraised

Trust	% locums not appraised
Belfast	Information not supplied
Northern	42%
Southern	43%
South Eastern	Information not supplied
Western	Information not supplied

Source: RQIA

3.18 Only two Trusts supplied the required information. For these Trusts, a significant percentage of locum consultants had not been appraised. Reasons given for non-appraisal included:

- changes in medical personnel as a result of the restructuring within the health sector had adversely affected the completion of appraisals;
- loss of momentum as a result of the delay in finalising arrangements for revalidation of hospital doctors (see paragraph 3.27 below);
- doctors appraised but paperwork not returned to Human Resources;
- posts not filled permanently and high turnover of locum staff; and
- sick leave.

3.19 In addition to the apparent low incidence of locum appraisal, RQIA identified a number of other concerns with the medical appraisal system, including:

- there was little evidence submitted that Trusts carry out an annual audit of medical appraisal systems. In the main, Trusts described an aspiration to meet good appraisal criteria; and
- only one Trust (the Southern Trust) indicated it had a process in place to review the skills of appraisers. RQIA concluded from its analysis of information from Trusts, that there appeared to be no formal process for review and performance management of appraisers, and little evaluation of the effectiveness of the appraisal discussion.

3.20 In a more recent review in 2010[25], RQIA concluded that there was strong commitment in all Health and social care sector Trusts in Northern Ireland to ensuring effective appraisal systems are in place and that there has been good progress towards preparing for revalidation. However, specifically in relation to locums, the review team observed that Trusts were not always receiving end of placement reports from

25 In 2010, RQIA worked with the General Medical Council, the NHS Revalidation Support Team (RST), Quality Improvement Scotland and the Healthcare Inspectorate Wales to pilot a approach for independently reviewing medical revalidation procedures within Trusts.

locum agencies or previous employers and that not all Trusts had systems in place to provide exit reports for all locum doctors. The review team considered that it would be useful to standardise arrangements across Northern Ireland and recommended a review of the systems for gathering and sharing locum doctor information to ensure that these can support revalidation.

3.21 Failure to carry out locum doctor appraisals in a consistent and rigorous way and to regularly audit appraisal procedures is a serious breach of clinical governance. At the conclusion of every locum appointment, in line with best practice, the Trust specialty engaging a locum doctor should prepare a brief standardised return to the clinical director, providing feedback on performance and highlighting any concerns. Trusts also need to have procedures in place to ensure that appraisers, who are key to the process, are selected, trained and supported appropriately.

3.22 The planned move towards a new system of revalidation as a means of assessing the performance of staff providing health care to patients is a positive step. We welcome the assurance that all HSC Trusts in Northern Ireland are committed to ensuring effective appraisal systems are in place and have made good progress towards preparing for revalidation. However, we note the recommendations of the review team that work is required in relation to the appraisal of locum doctors. We recommend that the Department addresses the review team's concerns in relation to locum doctors as a matter of urgency.

The limitations of existing management information can create difficulties for Trusts attempting to verify compliance with the requirements of the European Working Time Directive (EWTD)

3.23 The Department told us that, compliance with the EWTD (see paragraph 2.5) has contributed to the need to employ locums. However, we found that the management information systems in place do not facilitate monitoring of the number of hours worked by internal locums. By implication this therefore precludes identification of the number of hours rest taken by internal locums. A crucial element of the EWTD is the need for doctors to take a minimum of 11 hours rest in any 24 hour period. While it is up to individual doctors to behave in a professional manner, it is also appropriate to have systems in place to ensure that locum doctors do not work excessive hours. Although Trusts must ensure that the staff whom they employ do not breach the terms of the EWTD, where a doctor chooses to work additional hours in another Trust, it can be difficult for individual Trusts to monitor continued compliance with the Directive.

3.24 According to research undertaken by the Department in 2008[26], non-compliance with the EWTD was high across the five

26 Research was undertaken by the Department's Implementation Support Group in August 2008

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Northern Ireland Health and Social Care Trusts despite the potential imposition of heavy penalties. The research identified that the average level of compliance with the Directive across Trusts was 40 per cent.

3.25 The Department told us that a more recent self-reporting exercise undertaken in October 2010[27] indicated that the level of compliance was 77.5 per cent. The exercise identified that non-complaint posts were mainly in specialties such as Medicine, Surgery, Obstetrics and Gynaecology, Psychiatry and Paediatrics where solutions remain difficult.

3.26 We acknowledge the improvement that the Trusts have made in the rate of compliance with the EWTD. We also recognise the difficulty faced by Trusts and doctors in complying with the Directive while seeking to meet the demands of hospital services. However, failure to meet the requirements of EWTD could result in the imposition of significant financial penalties by the European Union, or more seriously, could compromise the health and safety of doctors and patients. It is important, therefore, that Trusts work closely together and with the Department to agree what needs to be done to support compliance.

The Confidence in Care programme, introducing revalidation of all licensed doctors, is intended to improve the quality of patient care

3.27 The 2007 White Paper *Trust Assurance and Safety* has positioned appraisal as the cornerstone of a programme of revalidation. When the programme is fully implemented, every doctor who wishes to practise (either as a substantive staff member or as a locum) will be required to hold a license and will be required to participate in revalidation. Revalidation is the process by which doctors will demonstrate that their knowledge is up to date and that they are fit to practise.

3.28 Under the process, each doctor will maintain a five-year portfolio for review against standards (set by the General Medical Council) at an annual appraisal. This approach aims to ensure more consistent clinical governance and the fairer assessment of doctors' medical practice against standards. It is important to note that the Locum Doctors' Association[28] has expressed concern over the ability of locum doctors to collate enough evidence of practice to warrant revalidation.

3.29 We welcome the plans to move towards a new system of revalidation as a means of assessing the performance of staff providing health care to patients.

27 The Board Liaison Group (BLG) within the Health and Social Care Board acts in an advisory capacity to Trusts, the HSC Board and the Department to help develop EWTD non-compliance solutions. The BLG estimated the October 2010 level of compliance with the EWTD on the basis of the results of a self-reporting exercise across the Trusts.

28 The LDA is a trade union which was founded in June 1997 and represents hospital locum doctors.

3.30 When revalidation is fully operational, its success will depend to a large extent on the robustness of Trust arrangements and the quality of challenge exercised by Trusts where there is any evidence of lack of compliance. In the period prior to the introduction of revalidation, we recommend that Trusts introduce interim arrangements to assess the performance of hospital locums.

Where Trusts do not undertake the required pre-employment checks, complete appraisals for each locum episode or enforce compliance with the EWTD, there is a risk that patient safety will be compromised

3.31 During our audit we found evidence that pre-employment checks and appraisals are not completed for all locum episodes. We also noted from research undertaken by the Department that Trusts were not complying with the requirements of the EWTD. These are important controls designed to provide assurance that patients receive quality care. While we acknowledge that the Department has introduced clinical and social care governance and risk management processes across the health and social care sector, in our view the failure to comply with key controls increases the risk that care is not of sufficient quality.

3.32 In an attempt to establish whether locum doctors pose a greater clinical risk than their counterparts in substantive posts, we examined the records held by the Department[29] for evidence as to whether the incidence of serious adverse incidents involving locum doctors was higher than those involving only permanent staff. We found however, that the Department's records did not consistently record whether the doctor involved was employed permanently or was a locum.

3.33 The Department told us that such a review of serious adverse incidents would not produce an objective assessment of locum performance. While the Department accepts that, as a result of treatment, some patients may suffer some form of harm, may complain or may seek compensation, it told us that even where it is clear that an adverse event has occurred, it is not always an indication of the poor performance of staff. Rather, adverse events can arise as a result of systems or procedural failures as well as because of human error.

3.34 The Department advised us that the Supporting Safer Services Report[30] is designed to share the learning from the Serious Adverse Incident Reporting System. The 2007 Report, for example, details the issues, identified by HSC organisations for learning, in the areas of recruitment and training. This included guidance on induction for all newly appointed staff (whether substantive or locum) and arrangements to ensure locums are familiar with Trust protocols and procedures.

3.35 While the lack of detailed information on the extent to which locums were involved in reported serious adverse incidents prevented comprehensive analysis, we

29 Serious Adverse Incident Reporting Arrangements transferred from the Department to the HSC Board (working in close partnership with the Public Health Authority and RQIA) with effect from 1 May 2010.

30 DHSSPS (2006 and 2007) Supporting Safer Services: Analysis of Serious Adverse Incidents

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were able to identify some cases where locums provided unsatisfactory care to patients. In our view, these illustrate the potentially very serious consequences of failing to operate pre-employment, appraisal and EWTD controls effectively. Failings reported in these cases involved unprofessional behaviour, breaches of departmental medical policies and practice and an inability to perform the work. Case Examples 2-4 below provide some indication of the impact of poor locum performance on patient care and safety.

Case Example 2

Following concerns, a review of examinations performed by a locum consultant radiologist was undertaken. The review identified "serious failure in standards in breast screening assessment". In total, 44 cases required urgent re-assessment. Of these, eight women were diagnosed with breast cancer. The locum radiologist was suspended from clinical practice pending disciplinary procedures. As a result of these findings the Health Minister commissioned an independent governance investigation by RQIA. In March 2006, RQIA concluded that:

- chronic shortages of radiologists contributed to the circumstances which led to the locum working in a degree of isolation, without peer support;
- concerns over the clinical competence of the locum radiologist were not raised or discussed with the individual; and
- management's decision to continue providing breast screening services despite concerns over the competence of the consultant radiologist was flawed.

Case Example 3

Concerns were raised about the quality of MRI scans undertaken by a locum radiologist during the period April 2007 to October 2007. The locum had been employed for four years, until June 2007.

The accuracy of 620 scans undertaken by the locum radiologist was independently assessed by an accredited medical company. Half of the independent assessments differed substantially from the locum's results. In each of these cases, patient records were reviewed to ensure the validity of diagnosis and, where necessary, patients were recalled.

Case Example 4

In June 2008 a locum consultant obtained a post. After a few months his colleagues expressed concern about some aspects of his gynaecological practice. After discussions with the Medical Director and Human Resources, he was suspended from gynaecological work but continued in obstetric practice at the hospital. Subsequently, further issues were raised and, following discussion, his contract was terminated.

An exercise by the Chief Executive of the Trust identified 25 patients who were having treatment which may not have been of a sufficient standard. These patients were offered a revised treatment plan. The doctor in question was in his first year of consultant practice. The Trust has decided to develop an induction programme for new consultants.

3.36 The need for Trusts to use locum doctors to maintain crucial services in Northern Ireland hospitals is not disputed. We accept that a very large number of locums provide quality cover. However, the weaknesses in procedures identified across Trusts in relation to pre-employment checks, appraisal processes and regulation of locums and the consequent increase in risk exposure means that it is all the more important that the Department should routinely monitor the performance of locum doctors.

Appendices

Appendix 1:
Structure of Northern Ireland Health and Social Care Trusts

Current Trust	Trusts prior to 1 April 2007
Belfast Trust	Belfast City Hospital Trust Greenpark Trust Mater Hospital Trust North and West Belfast Trust Royal Group of Hospitals Trust South and East Belfast Trust
Northern Trust	Causeway Trust Homefirst Community Trust United Hospitals Trust
South Eastern Trust	Down Lisburn Trust Ulster Community and Hospitals Trust
Southern Trust	Armagh and Dungannon Trust Craigavon Area Hospital Craigavon and Banbridge Community Trust Newry and Mourne Trust
Western Trust	Altnagelvin Trust Foyle Trust Sperrin Lakeland Trust

Appendix 2:
Health and Social Care Hospitals in Northern Ireland

ACUTE:	
1.	Altnagelvin Area Hospital
2.	Antrim Area Hospital
3.	Belfast City Hospital
4.	Causeway Hospital
5.	Craigavon Area Hospital
6.	Daisy Hill Hospital
7.	Downe Hospital
8.	Erne Hospital
9	Lagan Valley Hospital
10.	Mater Infirmorum Hospital
11.	Musgrave Park Hospital
12.	The Royal Group of Hospitals: – Royal Jubilee Maternity Service; – Royal Dental Hospital; – Royal Belfast Hospital for Sick Children; – Royal Victoria Hospital.
13.	Ulster Hospital

Non Acute:	
14.	Ards Community Hospital
15.	Armagh Community Hospital
16.	Banbridge – (Outpatients and Day cases)
17.	Bangor Community Hospital
18.	Bluestone Unit (Mental Health)
19.	Dalriada Hospital (Community)
20.	Downshire Hospital (Mental Health)
21.	Forster Green Hospital (Non Acute – Neurology & Elderly)

Appendix 2:
Health and Social Care Hospitals in Northern Ireland

Non Acute (Continued):	
22.	Gransha Hospital (Mental Health)
23.	Holywell Hospital (Mental Health)
24.	Knockbracken Mental Health Services (Acute Psychiatric)
25.	Lakeview Hospital (Mental Health)
26.	Longstone (Learning Disability)
27.	Lurgan - Non-Acute Inpatients, Day Care and Outpatients
28.	Mid Ulster Hospital
29.	Moyle Hospital (Community)
30.	Muckamore Abbey (Learning Disability)
31.	Mullinure (Geriatric Medicine)
32.	Robinson Hospital (Community)
33.	Shaftesbury Square Hospital (Drugs & Alcohol, Counseling)
34.	St Luke's Hospital (Mental Health)
35.	South Tyrone - Non-Acute Inpatients, Day Cases, Day Care and Outpatients
36.	Thompson House (Physical & Sensory Disability)
37.	Tyrone County Hospital (Community)
38.	Tyrone & Fermanagh Hospital (Mental Health)
39.	Whiteabbey Hospital

Appendix 3:
The Cost of Agency and Internal Locums in Northern Ireland 2007-08 to 2010-11

	2010/11						
HSC Trust	**Agency Locum £ million**	**Internal Locum £ million**	**Total Locum Costs £ million**	**Cost of permanent doctors working contracted hours £ million**	**Total Doctor Costs £ million**	**Agency Locum costs as % of Total Medical costs £ million**	**Total Locum costs as % of Total Doctor costs £ million**
Belfast	5.6	1.8	7.4	145.3	152.7	3.67%	4.85%
Northern	4.0	2.0	6.0	46.9	52.9	7.56%	11.34%
South Eastern	1.8	0.5	2.3	47.1	49.4	3.64%	4.66%
Western	7.9	1.1	9.0	45.0	54.0	14.63%	16.67%
Southern	3.2	1.2	4.4	51.8	56.2	5.69%	7.83%
Total	**22.5**	**6.6**	**29.1**	**336.1**	**365.2**	**6.16%**	**7.97%**

	2009/10						
HSC Trust	**Agency Locum £ million**	**Internal Locum £ million**	**Total Locum Costs £ million**	**Cost of permanent doctors working contracted hours £ million**	**Total Doctor Costs £ million**	**Agency Locum costs as % of Total Medical costs £ million**	**Total Locum costs as % of Total Doctor costs £ million**
Belfast	5.5	2.6	8.1	148.0	156.1	3.5%	5.19%
Northern	5.4	2.7	8.1	44.7	52.8	10.23%	15.34%
South Eastern	2.2	0.5	2.7	47.4	50.1	4.39%	5.39%
Western	5.1	1.9	7.0	44.6	51.6	9.88%	13.57%
Southern	2.4	2.5	4.9	43.5	48.4	4.96%	10.12%
Total	**20.6**	**10.2**	**30.8**	**328.2**	**359.0**	**5.74%**	**8.58%**

Appendix 3:
The Cost of Agency and Internal Locums in Northern Ireland 2007-08 to 2010-11

	2008/09						
HSC Trust	Agency Locum £ million	Internal Locum £ million	Total Locum Costs £ million	Cost of permanent doctors working contracted hours £ million	Total Doctor Costs £ million	Agency Locum costs as % of Total Medical costs £ million	Total Locum costs as % of Total Doctor costs £ million
Belfast	4.5	2.9	7.4	137.0	144.4	3.1%	5.12%
Northern	4.9	2.7	7.6	41.4	49.0	10.00%	15.51%
South Eastern	2.4	0.7	3.1	43.0	46.1	5.21%	6.72%
Western	3.3	1.9	5.2	43.0	48.2	6.85%	10.79%
Southern	1.9	2.8	4.7	41.6	46.3	4.10%	10.15%
Total	**17.0**	**11.0**	**28.0**	**306.0**	**334.0**	**5.09%**	**8.38%**

	2007/08						
HSC Trust	Agency Locum £ million	Internal Locum £ million	Total Locum Costs £ million	Cost of permanent doctors working contracted hours £ million	Total Doctor Costs £ million	Agency Locum costs as % of Total Medical costs £ million	Total Locum costs as % of Total Doctor costs £ million
Belfast	3.6	2.9	6.5	126.0	132.5	2.7%	4.91%
Northern			4.7	37.1	41.8	11.24%	11.24%
South Eastern	1.4	0.8	2.2	40.0	42.2	3.32%	5.21%
Western	2.4	2.3	4.7	39.6	44.3	5.42%	10.61%
Southern	1.5	1.4	2.9	37.0	39.9	3.76%	7.27%
Total	**13.6**	**7.4**	**21.0**	**279.7**	**300.7**	**4.52%**	**6.98%**

Appendix 4: Audit Methodology

This report considers the arrangements in place across Trusts to manage the demand for locum doctors and those for safeguarding patient safety.

Our report focuses on the use of locum doctors by acute and community hospitals but does not extend to the use of GP locums in the primary care sector.

At the outset of the audit we wrote to the Department outlining our interest in the following areas:

- the expenditure incurred in each of the acute and community hospitals in Northern Ireland;
- the usage of locum doctors within Trust hospitals;
- the workforce planning methodologies operated by Trust hospitals;
- the extent of Trust compliance with locum pre-employment procedures; and
- the quality of appraisal procedures in place to assess the performance of locum doctors.

We undertook a range of interviews with key personnel within each Trust.

Information provided to us by individual Trusts in relation to the cost of internal locums was limited. The information was subsequently requested from Trusts by the Department. Following the request from the Department, Trusts carried out some interrogation of their management information systems and provided the information required. Given the time taken for the Department to produce the cost information, it was not possible for us to undertake any validation work to assess the accuracy of the information contained in the Trust spreadsheets.

We examined various Departmental policies relating to the employment, monitoring and appraisal of locum doctors in hospitals and we reviewed relevant Internal Audit work across the Trusts.

We also reviewed the detail of those Serious Adverse Incidents which involved locum doctors.

Appendix 5:
Implications of the EU Working Time Directive

The European Commission introduced the Working Time Directive to Northern Ireland in 1998 to work alongside member states employment laws. It is primarily designed to safeguard workers rights by putting a limit on the number of hours that should be worked each week. Some groups of workers were initially excluded from these regulations, however from August 2004 the provisions of the Directive have begun to be applied to doctors in training in the UK. Legislation limited junior doctors working hours to a 58 hour week, with strict arrangements for rest requirements. From August 2007 the working week was further limited to 56 hours of work per week until the full implementation of the directive in August 2009, limiting the working week to 48 hours.

In the past, hospitals used junior doctors extensively for medical cover during unsocial hours. The consensus of all Northern Ireland's Trusts was that the progressive implementation of the Working Time Directive has had, and will continue to have, profound effects on the delivery and continuity of medical care, and on doctors in training. There is a large degree of pressure now to provide extra cover (including using locums) to ensure junior doctor working hours and rota patterns are compliant with the Directive. Consultants reported that they have had to provide more service cover during unsocial hours, thus reducing availability during the day and in turn requiring further expansion of consultant numbers.

Appendix 6:
Medical Demand and Supply Problems Identified by the Department

Review of Workforce Planning for the Medical Profession (September 2006)

Speciality	Demand and Supply Problems
Anaesthetics	There are a large number of unfilled posts in Northern Ireland and there is a need for increased consultant numbers.
Ear, Nose and Throat (ENT)	Concern was expressed at the uneven geographic distribution of ENT consultants relative to the population served. Earlier retirements are predicted for the future and there are increases in levels of maternity leave, family leave and requests for part-time working, attributed to a high ratio of females in this area. Increased demand for ENT services was resulting from GPs not being adequately trained in ENT. It was estimated that at least 30% of outpatients do not need to be seen, resulting in a large number of unnecessary referrals clogging out-patient lists.
Medical Paediatrics	There is a high female to male ratio within Paediatrics and it is likely that there will be an increased demand for flexible working patterns. Due to the high level of on-call requirement, it is predicted that many consultants will not work much past the age of 55. Peripheral hospitals are facing difficulties in filling posts. For example, the Erne hospital has had to recruit increasing numbers of non Northern Ireland trained doctors who only intend to remain in post for a short period of time.
Community Paediatrics	Significant depletion of the workforce is predicted given the age profile of the current workforce and expected retirements within the next 10 years. The majority of Trusts have had difficulty recruiting staff over recent years. A need was identified to increase training at both undergraduate and postgraduate level.
Neurology	Findings from the Association of British Neurologists has highlighted shortages of neurologists in Northern Ireland : - in the USA there is one consultant per 20,000 of population - in Northern Ireland there is one consultant per 100,000 of population - there are fewer consultant neurologists per head of population in Northern Ireland than in many other parts of the United Kingdom.
Oncology	The demographic trends within Northern Ireland mean that there will be a greater number of people aged 70 years plus and therefore a higher frequency of cancer incidents. There will be greater demand for oncology consultants in the future. The Workforce Plan identified haematology as under-resourced. The Department is working to the Royal College of Physicians recommendation of one consultant per 250 patients. The USA ratio is one consultant per 100 patients.

Appendix 6:
Medical Demand and Supply Problems Identified by the Department

Speciality	Demand and Supply Problems
Ophthalmology	Ageing population is a significant factor for Ophthalmology. The Royal College of Ophthalmologists have recommended one consultant per 50,000 to 70,000 of population. Northern Ireland currently sits at one consultant per 100,000 of population and would need to increase from 23.5 to 30 to meet this ratio. The retirement age of consultant Ophthalmologists has decreased by 2-3 years over recent years. In addition there is a high number of females within the speciality, with an increased desire to work part-time, thereby creating demands for extra staff.
Orthopaedics	An ageing population once again creates greater demand for Orthopaedic services. Northern Ireland sits as a region within the UK with the lowest Consultant orthopaedic numbers per head of population. The Workforce Plan identified a shortage of 40% from the target number of consultants.
Pathology	Pathology is perceived as a less attractive speciality than others with not enough trainees coming through the system.
Community Care	The Plan identified supply issues at Trust level and continuing recruitment difficulties were reported in the west of Northern Ireland.
Psychiatry	The Plan estimated that approximately 120 consultants will be required over the next few years. There is a higher proportion of female staff which impacts on workforce levels with higher levels of breaks of employment due to caring responsibilities. The European Working Time Directive is having an impact on the ability of the profession to provide night cover due to the relatively small size of the workforce.
Radiology	There is a greater demand for radiology services and there is a significant workforce deficit. It is estimated that there will be 80 consultant vacancies over the next 10 years.

Appendix 7:
Good Practice Examples identified from the NHS Employer's publication "Controlling the use of temporary staff through large scale workforce change"

Example 1: Kingston Hospitals NHS Trust

Kingston Hospital is an acute general hospital serving a population of around 320,000 in south-west London. It faces similar pressures to many city centre hospitals in high demand (it has one of the highest levels of day surgery in the country) and a transient workforce.

Issues identified

- a high expenditure on medical locums across the trust, notably senior house officers (SHOs) in the Accident and Emergency (A&E) department
- agencies outside those outlined in the NHS Purchasing and Supply Agency (PASA) national framework were regularly being used
- excessive delays in the running of Criminal Records Bureau checks were causing potential recruits to be lost to other employers
- lack of appropriate authority levels in the booking of medical locums - bookings were not challenged or vetted
- lack of central control in booking medical locums and controlling expenditure - each department was using its own suppliers and procedures for booking
- lack of useful intelligence on medical locum usage and spend.

Aims

- to develop a master vendor system in collaboration with other trusts
- to reduce spend on medical and Allied Health Professional (AHP) agency staff.

Implementation

- established a consortium with other trusts with shared goals and commitments, to drive down agency costs through combined spending power
- piloted the use of a preferred agency (master vendor) in A&E to assess the impact on expenditure and further develop the concept to roll out across the trust
- established protocols for booking locums and measuring compliance against expenditure/use.
- established financial controls for booking of medical locums (for example, higher line of authority for 'requesting' signature and for 'authorising payment' signature)
- centralised booking arrangements through one source within the trust- and combined this with the operation for booking nurse bank staff
- developed the Harlequin IT system (already used for the nurse bank) and introduced it for managing medical locum and AHP bookings
- improved management information on medical locum use to allow managers to audit and query use of medical locums more effectively

Appendix 7:
Good Practice Examples identified from the NHS Employer's publication "Controlling the use of temporary staff through large scale workforce change"

- recruited staff booked through the agency onto the trust bank
- educated the coordinators of rotas and rota planning.

Improvements delivered:

Collaborative working
The trust negotiated with external agencies in collaboration with three other trusts. As well as securing more favourable rates, trusts shared good practice with each other and enhanced their project work.

Developing a master vendor
In collaboration, the trust developed a master vendor network across the strategic health authority to provide a preferred supplier for nursing agencies (and later for other staff groups). The increased spending power of four trusts provided greater leverage in driving down costs, improving the service to the trust and, in addition, the supplier was able to provide valuable management information on use. The master vendor guarantees to fill vacancies requested (against an agreed fill rate) and will contact secondary agencies if unable to fill the shift themselves. In addition, because they can rely on a guaranteed income from the trust, the supplier is able to justify providing dedicated staff support for dealing with the trusts needs. As a result of these changes the spending on agency nurses was reduced from approximately £2.8m to around £1.0m per annum - a saving of £1.8m for the trust across the year.

From January 2006 the first 'true' master vendor agreement started, with a single supplier for nursing, medical and AHPs. This gave a further reduction of 26 per cent, which equates to £260,000 per annum across the trust.

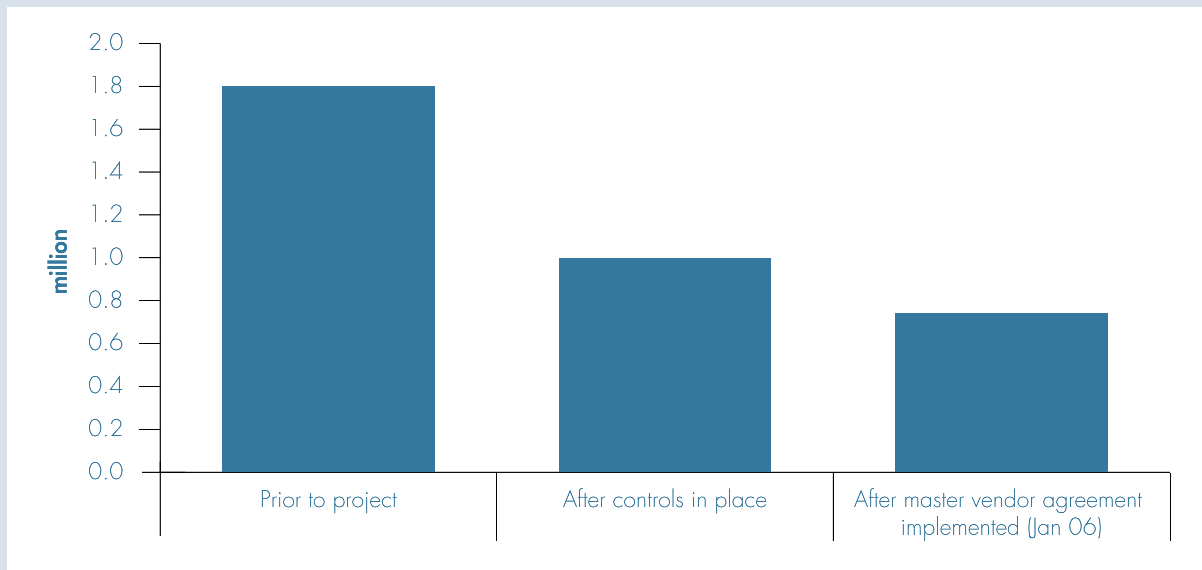
Management control for medical locums and AHPs
The trust introduced tighter controls on the authorisation for booking temporary staff and changed the culture of acceptance for the need for a booking. Bookings are now centralised through a single function and the trust has developed its Harlequin IT system to manage medical locum and AHP bookings. Agency spend on these staff groups reduced from £1.8m per annum to less than £1.0m.

Clinical and administrative staff
By having a single point of contact and a single external supplier (rather than more than 20 agencies), clinical staff saved considerable time on booking shifts. Clinical time previously spent contacting five or six agencies to secure a booking is now saved by contacting the master vendor only. Since the master vendor pays secondary agencies and then invoices the trust for all costs, this saves administrative time in processing multiple invoices. In addition, the management information that the master vendor was able to provide saved on administrative time for the trust.

Improving working lives

It is an identified factor that shift fill rates have a marked effect on staff morale. When staff are expected to deliver services in a shift with a reduced number of staff on duty, morale often falls as a result. The master vendor scheme set up guarantees a 90 per cent fill rate for the trust and this rate has in fact been bettered since the scheme was introduced. This led to increased staff morale.

Kingston Hospital. Annual spend on medical locums and Allied Health Professionals 2005-06



Example 2: East Kent Hospitals NHS Trust

East Kent Hospitals NHS Trust is one of the largest hospital trusts in England, with five hospitals and several outpatient facilities. The trust has undergone a major service reconfiguration programme involving extensive builds at three of its sites.

Issues identified

- the trust had a rising spend on medical locum usage
- some locums were supplied through high-cost agencies and outside of the PASA framework
- there was a lack of control in some directorates with consultants booking their own medical locums without authorisation
- there was little or no checking of invoices for medical locums once submitted for payment
- a number of positions relied on high-cost medical locums to fill vacancies, and these had not been reviewed for some time.

Appendix 7:
Good Practice Examples identified from the NHS Employer's publication "Controlling the use of temporary staff through large scale workforce change"

Aims
- to centralise locum booking arrangements in directorates, with the exception of A&E, anaesthetics and radiology, with effect from 1 September 2005
- to review each high-cost agency locum with a view to identifying the best way to reduce costs by one or a combination of actions

Implementation

Locum booking
A revised policy for employment of locum medical staff was approved by the clinical management board and was implemented on 1 September 2005. Bookings were centralised through a reporting mechanism to a single point of contact. Bookings are now made for clinical care only and must be capable of clinical justification.

Direct phone calls to agencies from wards were banned, the phone number was blocked through the switchboard and out-of-hours bookings were done through on-call executive directors. These on-call directors adhered to a strict protocol in line with a new booking policy agreed at board level. Administrative guidance notes were issued to all staff for implementing the new policy and unique reference numbers were issued to each authorised booking - only invoices bearing this number were passed for payment.

The job plans of substantive doctors were analysed and locums were not authorised where the trust's own doctors were duty-bound to provide cover.

The core project team reviewed, studied and acted on issues raised on a fortnightly basis to the end of the project. This was especially important in the early phases.

Individual high-cost agency locums
Each high-cost locum placement was reviewed and a strategy to reduce cost was adopted. Posts that had relied on agency locums for several months were re-advertised and NHS locums favoured over agency locums. Agency locums were encouraged to transfer to NHS contracts. NHS Professionals was sought as a cheaper alternative if the trust was unable to make substantive appointments.

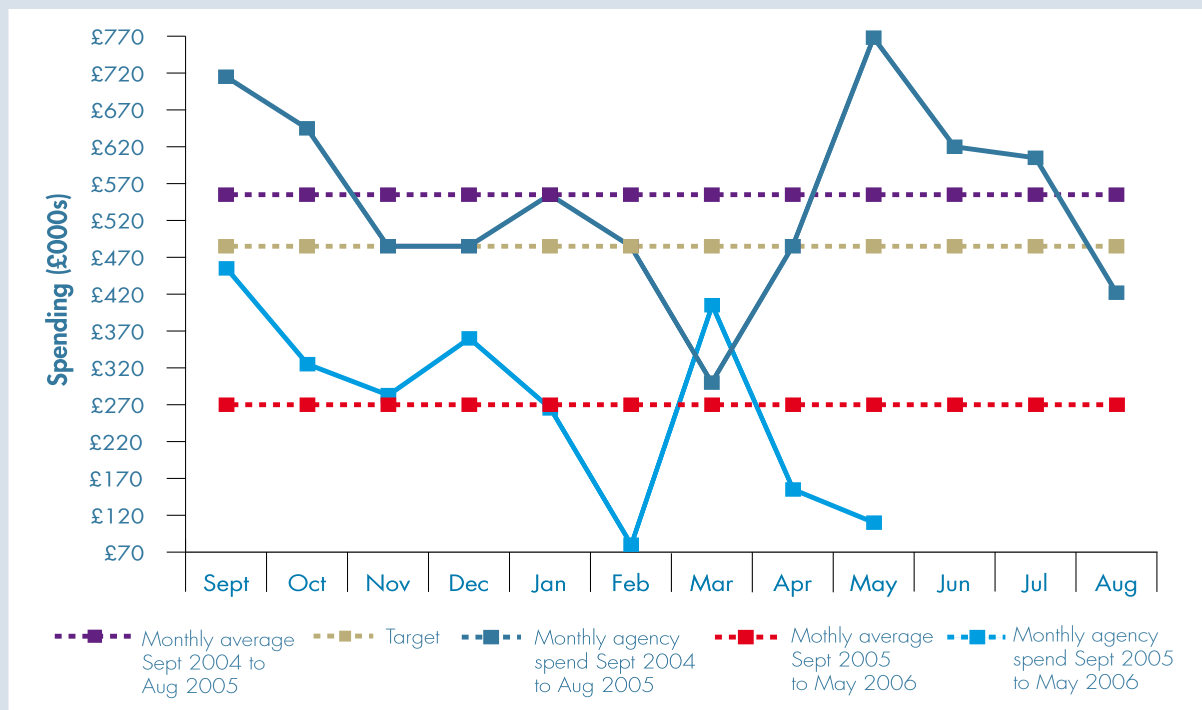
Annual and study leave periods were imposed for locums where prospective cover arrangements applied. Invoices were carefully scrutinised to ensure hours worked and claimed were consistent with the original hours booked with the agency, and costs were capped to the rates agreed under the agency framework agreement.

Data on locum usage was collected and analysed and a fortnightly review carried out. Directorates with high usage were targeted for intervention and action plans with each directorate were agreed.

Improvements delivered

- decrease in both use and overall spend on medical locums since September 2005, when changes were first implemented. Previous year's average monthly costs were £548,400 (September 2004 to August 2005)
- the target to reduce expenditure to £490,000 per month was bettered. Spend reduced to under £270,000 per month (September 2005 to May 2006) - a saving of over £278,000 per month
- if this saving were sustained across the year, it would equate to an annual saving of over £3.3 million for the year (see graph)
- the trust identified seasonal fluctuations and can now plan to cover any known and predictable demand (such as medical examinations).

East Kent Hospitals NHS Trust: monthly spend on medical locums 2005/06



Appendix 8:
Regionally Managed Medical Locum Service for Northern Ireland

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

Individually HSC Trusts have been taking forward initiatives to seek to more effectively manage the use and expenditure associated with locum doctors. This project presents an opportunity to pool the collective inputs of Trusts and the BSO to develop a regionally co-ordinated and managed approach to locum cover within the context of shared services.

Discussions have taken place across the HSC on how to regionally tackle the increasing spend on Locums. The outcome of these conversations was the formation of a Human Resource led Regional Medical Locum Group comprising representatives from each Trust (usually the medical HR or relevant recruitment staff) to take this forward.

The Regional Medical Locum Group has produced a plan to address the escalating agency Locum spend which reflects the need for a coordinated regional approach to the management of locum doctors. In the short term the immediate action is the establishment of a regional database to record the details of locum doctors, pre-employment checks, shifts worked, any identified performance issues etc.

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

In the longer term this project also provides a vehicle to support the processes associated with the management of revalidation of medical locums and the discharging of the Responsible Officer function for locum doctors who are not employed on a full-time basis by a Trust i.e. career locums. The purpose of revalidation, when it is introduced (current projections are mid-2012), will be to assure patients and the public, employers and other healthcare professionals that licensed doctors are up to date and are practising to the standards defined by *Good Medical Practice*[31].

The development of the responsible officer role (which was implemented in NI in October 2010) is part of wide ranging regulatory reform set out in the White Paper *Trust, Assurance and Safety*[32]. In Northern Ireland, these reforms are being taken forward through the DHSSPS *Confidence in Care* programme.

The terms of reference for the Regionally Managed Medical Locum Service (RMMLS) have been informed by the Medical Locum Regional Working Group and reflect the streaming and priority of activities to be undertaken. The terms of reference under each of the project workstreams are set out below.

Workstream 1 – Development of the Regional Locum Registration Process and Database (Timescale-Short Term)

- Define the strategy, scope and operational requirements/arrangements of the central medical locum registration process and database.
- Develop the governance, accountability and administration arrangements for same.

31 Good Medical Practice – Framework for Assessment and Appraisal, The General Medical Council, November 2006
32 Trust, Assurance and Safety: The Regulation of Health Professionals in the 21st Century: TSO, February 2007

- Secure funding for development of the central database.
- Agree the hosting organisation and the operational framework for the Regional Locum Registration process and Database
- Design the specification in terms of content, operational requirements and capabilities of the registration system and database, together with the practical access arrangements in accordance with data protection requirements.
- Commission the construction of the system.
- Produce the operational registration process and database with accompanying mechanisms for feedback and review to continually ensure service improvement.
- Plan implementation arrangements ensuring that both locums joining the scheme and the Trusts using the scheme are clear on operational arrangements, have access to information on operational arrangements, have access to operational instructions and a 'helpdesk' facility (likely to be one for each Trust initially).
- Commence the phased registration of Locums.
- 'Go live' with the regional locum database.

Workstream 2 – Shared Service Model for Employment and Management of Locums and service provision to the HSC stakeholders (Timescale-Medium Term)

- Develop the operational model to support the management of locums under the umbrella of BSO, Shared Services ensuring that there is clarity regarding the employment arrangements of medical locums including all related issues (such as safeguarding checks, payment etc) and how Trusts will access, use and pay for this service.
- Develop the governance, accountability, and performance management arrangements for the proposed shared services model for the management of locums
- Develop and seek approval for the business case for the provision of shared services for locum doctors
- Implement the model for shared services for locum doctors

Workstream 3 – Development of Regional Contract for the Provision of Locum Services from Agencies (Timescale-Medium Term)

- The BSO will work with Trust colleagues in the group towards the development of a single regional contract with Agencies through which agency locum services can be secured (should the required locum cover not be available via the Shared Service for locums). This will involve the development of a draft contract and the associated content of same.

Workstream 4 – Revalidation/RO Support for Locums (Timescale-Medium/Long Term)

- In conjunction with the DHSSPS *Confidence in Care Programme* develop and implement the arrangements to support the discharge of Responsible Officer functions for those locum doctors not employed by a Trust

Appendix 8:
Regionally Managed Medical Locum Service for Northern Ireland

- In conjunction with the DHSSPS *Confidence in Care Programme* develop and implement the arrangements to support revalidation (including appraisal) for those locum doctors not employed by a Trust

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Title	Date Published
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