Department of Finance and Personnel Memorandum on the Fourth Report from the Public Accounts Committee Mandate 2011-2015

The Use of Locum Doctors by Northern Ireland Hospitals

Presented to the Northern Ireland Assembly by the Minister of Finance and Personnel

8 May 2012

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Glossary of Abbreviations

BSO Business Services Organisation

DHSSPS Department of Health, Social Services and Public Safety

EWTD European Working Time Directive

GMC General Medical Council

HSC Health and Social Care

RMMLS Regionally Managed Medical Locum Service

DEPARTMENT OF FINANCE AND PERSONNEL MEMORANDUM DATED 8th MAY 2012 ON THE 4th REPORT FROM THE PUBLIC ACCOUNTS COMMITTEE MANDATE 2011-2015

Fourth Report

Department of Health, Social Services and Public Safety

The Use of Locum Doctors by Northern Ireland Hospitals

Recommendation 1

The Committee recommends that each Trust, in agreement with the Department, determines the optimal split between permanent staff and locums and benchmarks actual locum use against this each year. Adherence to the optimal split offers the potential for Trusts to generate financial savings.

The Department of Health, Social Services and Public Safety (DHSSPS) accepts this recommendation and will determine, in agreement with each Trust, an optimal split between permanent staff and locums. DHSSPS will then put in place monitoring arrangements to assess the percentage use of locum staff against the medical staffing complement. This information will be used to measure adherence against the optimal level each year, in order to assess the potential to generate financial savings. Where there is potential to generate financial savings, DHSSPS will work with Trusts to realise these savings and ensure value for money.

Recommendation 2

In the absence of basic management information, Trusts are not well positioned to manage their use of locums effectively. While the Committee welcomes the Department's assurances that the new Regionally Managed Medical Locum Service (RMMLS) will address the current deficiencies in management information and will allow increased use of substantive staff to cover vacancies, it is concerned that the plans surrounding its implementation are beginning to slip. The Committee recommends that, as a matter of urgency, Trusts implement actions to capture basic information on all locum episodes in order to improve their ability to manage and oversee the use of locums.

DHSSPS accepts this recommendation but would wish to assure the Committee that Trusts do already collect detailed management information on the use of locums. However, DHSSPS will work further with Trusts to identify the common basic information required on all locum episodes that would be considered necessary to improve their ability to manage and oversee the use of locums.

DHSSPS welcomes the Committee's acknowledgement that the new Regionally Managed Medical Locum Service (RMMLS) will address deficiencies in management information and work has progressed to pilot the RMMLS across Trusts. DHSSPS will seek assurances and regular updates from the Business Services Organisation (BSO) to ensure that this project is progressed with sufficient vigour and an implementation timetable will be agreed.

A demonstration of finalised IT system build is currently scheduled for May 2012 and recruitment activities are planned for May/June to source the required system administration support. Current plans are for the pilot to launch in August 2012 to coincide with junior doctor rotations and it is anticipated that first locum placements via RMMLS will have taken place by the end of September 2012.

Recommendation 3

The Committee recommends that all future workforce planning exercises shall include a detailed analysis of demand and activity levels by medical specialty in order to reduce the need for unplanned locum appointments.

DHSSPS accepts this recommendation. The detailed analysis of activity and demand is primarily a matter for Trusts and other service providers in determining the adequacy of their current workforce and consequently their ability to best deal with short term vacancies. This analysis has, in turn, relevance to the medium to long term workforce planning exercises undertaken by DHSSPS as it will provide the detail upon which specialty planning can be considered. In meeting this recommendation, DHSSPS will require the Trusts and other service providers

to detail their workforce needs and thus improve the workforce planning function overall in both the short and longer term. This should then help to reduce the need for unplanned locum appointments.

Recommendation 4

The Committee notes that the Department has produced a formal estimate of the savings it expects to achieve through implementation of the Regionally Managed Medical Locum Service. The Committee recommends that the Department establish the service as a matter of urgency and expects that the Department provide a progress report on what has been achieved by September 2012.

DHSSPS accepts this recommendation and can confirm that the RMMLS will be established as a matter of urgency.

Work has progressed to pilot the RMMLS across Trusts and current plans are for the pilot to launch in August 2012. It is anticipated that first locum placements via RMMLS will have taken place by the end of September 2012.

DHSSPS will provide the Committee with a progress report of what has been achieved by September 2012.

Recommendation 5

The Committee welcomes the Department's acceptance of the need for stringent controls in the appointment of locums. The Committee recommends that the Department issue immediately to Trusts the planned reminder about complying fully with the relevant checks prior to appointing a locum doctor. In addition, the Committee recommends that Trusts develop a monitoring schedule which will allow them to identify the level of compliance with the controls in place for locum appointments and to take action where deficiencies are identified.

DHSSPS accepts this recommendation and agrees there must be stringent controls in the appointment of locums. DHSSPS can confirm that it wrote to all Trusts in November 2011 reminding them of the importance of collecting and retaining evidence that the requisite checks have been undertaken before a locum can be offered an appointment. In addition, DHSSPS will ensure that Trusts put in place audit arrangements to ensure that there is compliance with the pre-employment requirements.

Also as recommended, DHSSPS will seek assurances from all Trusts that pre-employment checks are effective and will ask Trusts to develop a schedule which will allow the Trusts and the Department to monitor the level of compliance with the controls in place for locum appointments and to take corrective action where deficiencies are identified.

Recommendation 6

In the Committee's view, given the risk to patient safety, it is not sufficient for Trusts to rely solely on doctors to verify their compliance with the EWTD. In order to protect the interests of patients, the Committee recommends that the Department ensures Trusts have effective arrangements in place for monitoring the total number of hours worked by each doctor, whether in substantive employment or working as a locum. In addition, this process should measure not only hours worked but that rest breaks are being achieved, and/or adequate compensatory rest provided.

DHSSPS notes this recommendation. Trusts monitor the hours worked by doctors within their substantive posts, and where locum cover is being provided by doctors who are already employed by that Trust, difficulties in monitoring compliance against the European Working Time Directive (EWTD) should not arise. However, Trusts would find it impossible to ascertain the hours worked by a locum doctor in other Trusts in the days and weeks leading up to any temporary employment with the Trust. The responsibility remains with the doctor or with a contracting agency and to reinforce this message DHSSPS will ask BSO to write to all contracting agencies, seeking their assurance that doctors engaged in locum work are fully aware of their responsibilities under EWTD.

DHSSPS would assure the Committee however that Trusts are committed to working within EWTD limits and do their utmost to ensure compliance. Compliance is monitored and where rotas do not comply, efforts are made to address this through planned rota changes or identification of alternative working patterns.

It is also important to note that all doctors, whether in permanent employment or working in a locum capacity, must act in accordance with the regulations laid down by the General Medical Council (GMC). Doctors are required by the GMC document, Good Medical Practice to be responsible for their own safety to work and to use judgment in not overstretching themselves.

Good Medical Practice also sets out the general principles and values on which good practice is founded; these principles together describe medical professionalism in action. The guidance is addressed to doctors, but it is also intended to let the public know what they can expect from doctors.

Within Good Medical Practice, doctors must demonstrate:

- **Good clinical care** – doctors must provide good standards of clinical care, must practise within the limits of their competence, and must ensure that patients are not put at unnecessary risk.
- **Maintaining good medical practice** – doctors must keep up to date with developments in their field, maintain their skills and audit their performance.
- **Relationships with patients**– doctors must develop and maintain successful relationships with their patients**,** by respecting patients' autonomy and other rights.
- **Working with colleagues –** doctors must work effectively with their colleagues.
- **Teaching and training** – where doctors have teaching responsibilities they must develop the skills, attitudes and practices of a competent teacher.
- **Probity** – doctors must be honest and trustworthy.
- **Health** – doctors must not allow their own health condition to endanger patients.

Recommendation 7

The use of "off-contract" agencies creates additional patient safety risks. The Committee recommends that the use of such agencies must be limited to exceptional circumstances only and that, where they are used, Trusts must put procedures in place to ensure that the performance of such agencies at least matches the service standards and prices available from contracted agencies.

DHSSPS accepts this recommendation and would wish to assure the Committee that "off-contract" agencies are only used in exceptional circumstances, and that the standards applicable to engaging locums from contracted agencies also apply to non-contract agencies.

There are occasions however, when non-contracted agencies have to be used to source doctors in a particular specialty. This is not done lightly or as a first port of call for Trusts. There are robust processes in place in all Trusts to obtain permission at the highest level before this type of expenditure can be authorised. In these instances it is the difference between sustaining a service and taking the decision to close the service on a temporary basis on the grounds of patient safety.

DHSSPS will write to Trusts to remind them that 'off-contract' agencies should be used only in exceptional circumstances and of the importance of value for money in the appointment of locums from non-contract agencies.

Recommendation 8

The Committee recommends that the Department insists on full compliance with the controls in place within Trusts for logging concerns about the performance of locum doctors.

DHSSPS accepts this recommendation and will write to Trusts reminding them of the need to fully comply with the systems and controls in place within Trusts for logging concerns about doctor's performance.

Current controls for logging concerns about the performance of all doctors are laid out in a Departmental Circular which was issued in 1998. It details the process for the issue of alert letters where there are concerns about medical staff that are under investigation by their Health and Social Care (HSC) employer. The objective of the alert letter system is to protect patients by ensuring that information about doctors who have been dismissed or are under suspension is disseminated as appropriate. DHSSPS will examine how compliance with these controls could be integrated into the existing Trust/Department accountability mechanism.

In addition, as part of the Confidence in Care programme which was established in 2008 to implement recommendations for reform in relation to regulation of healthcare professionals, DHSSPS guidance covering the reporting of doctor's performance will be reviewed. The Confidence in Care programme is due to complete by December 2012.

Recommendation 9

The Committee recommends that, in future, all adverse incident reports concerning a doctor's performance should specify the nature of the doctor's employment. This information should then be used to monitor the number of adverse incidents which involve locum doctors and to compare against adverse incidents involving doctors in substantive posts.

DHSSPS accepts this recommendation. DHSSPS will issue a Policy Guidance Circular to all HSC organisations, advising that where any adverse incident report identifies the actual clinical or professional performance of a clinician or practitioner as a possible contributory cause of an adverse incident, then the employment status of that person should be recorded in the appropriate investigatory report following the adverse incident report.

This information will then be used to monitor and compare the number of adverse incidents where the clinical or professional performance of a substantive or locum clinician or practitioner was a contributory factor. DHSSPS will require the HSC Board to report regularly, as appropriate, on such comparisons to them.

However, it should be pointed out that it is not practically possible, or indeed, meaningful to identify and record, on every adverse incident (including serious adverse incident) report, the employment status of every clinician or practitioner, locum or otherwise, who may have had some relevant involvement in the circumstances surrounding the adverse incident reported.

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