Dear Colleague

CODE OF PRACTICE IN THE APPOINTMENT AND EMPLOYMENT OF LOCUM DOCTORS

Summary

1. This letter introduces the Code of Practice in the Appointment and Employment of Locum Doctors. The Code, which has recently been issued in England, recommends a structured approach to the quality control of employment and usage of locum doctors and dentists within NHS hospitals. A copy is at Annex 1.

2. The existing guidance states that medical qualifications should be checked and references sought when employing locum doctors and dentists. There are, however, 4 main weaknesses in locum employment which have been identified as follows:

   • over-dependence by hospitals on locums;
   • lack of rigour on the part of some employers in applying existing guidance;
   • poor standard of appraisal and referencing of locums;
   • locums acting up and beyond their training competence, particularly locum consultants working unsupervised and with full clinical autonomy.

Further, pre-employment checks may be ignored if cover is needed at short notice and the use of commercial locum agencies often results in a lack of clarity on where responsibilities reside for these important checks. This is a long-standing problem which so far has proved intractable and unsatisfactory locums are sometimes able to obtain work in Trusts and Health Boards.

3. In view of these problems, the Locums Working Group (LWG) was commissioned by Sir Kenneth Calman (CMO England) to examine ways of improving the quality control of hospital locum doctors and dentists. Its membership was widely drawn from the service, the profession and representatives of

LOCUMPPCS
locum agencies. The Scottish Office Directorate of Human Resources had observer status on
the Group.

4. The LWG identified flaws in the present system of referencing locum doctors and
recognised the importance of assessing their professional competence for the benefit of
subsequent employers. The Group considered that one solution to these problems was to
provide Trusts and Health Boards with quality service and advice and to ensure good practice
without being too prescriptive or unrealistic. The Group’s report, published in January 1995
following a consultation exercise, attracted widespread support and the Code of Practice in
the Appointment and Employment of Locum Doctors is designed to implement its
recommendations.

5. The Code is, therefore, framed in terms of good practice in locum employment by
recommending:

- minimum standards in relation to locum appointments which would establish a national
  benchmark standard for locum appointments;

- final standards towards which Trusts and Health Boards are asked to work in the light of
  local resources and priorities and which would be introduced over a period of time.

While these criteria have our support, the profession had concerns over what they saw as
inroads into consultants’ time. These concerns have been met to some extent by accepting
that it may not always be practicable to appraise a short-term locum. In these circumstances,
the locum should be well known to the employer or have recent good references secured and
examined by a locum agency.

6. Among the main action points in the Code are the following:

- Trusts should put in place appropriate arrangements in the event of unsatisfactory work
carried out by a locum doctor;

- Trusts should introduce a structured assessment form to provide references for locum
doctors based on the suggested formats at Annex B to the Code;

- Trusts should agree working arrangements with locum agencies to ensure that locums meet
the minimum standards (see Annex A to the Code);

- Trusts should review their personnel procedures to ensure that steps are taken in good time
to fill posts falling vacant to eliminate the unnecessary use of locums.

The Code thus tightens appointment procedures and provides criteria for a national
benchmark to help eliminate unacceptable locums whilst giving Trusts and Health Boards the
ability to meet the appointment standards in a flexible way without imposing undue resource
pressures. It aims to establish a pool of good quality, reliable locums on which Trusts and
Health Boards can draw with confidence.
Action

8. Trusts and Health Boards are asked to:

- ensure that copies of the Code are available to all those engaged in recruiting, employing or supervising locums;

- introduce the recommendations as soon as practicable.

Yours sincerely

[Signature]

GERRY MARR
Director of Human Resources
CODE OF PRACTICE IN THE
APPOINTMENT AND EMPLOYMENT OF
LOCUM DOCTORS

THIS CODE OF PRACTICE SETS HIGH STANDARDS WHICH THE SERVICE
WILL NEED TO ACHIEVE OVER A PERIOD OF TIME. SOME OF THESE
STANDARDS ARE INTENDED FOR IMMEDIATE ADOPTION. TRUSTS AND
HEALTH BOARDS ARE URGED TO WORK TOGETHER TO
ATTAIN THESE STANDARDS AS QUICKLY AS IS REASONABLY
PRACTICABLE.
MAIN ACTION POINTS

1. Trusts using locum agencies should check that the agencies have copies of the Code.

   **Timing**

   **By October 1997**

2. Trusts, or other NHS employers where appropriate, should put in place arrangements which, in the event of unsatisfactory work by a locum doctor, enable them to consider whether:

   a) the doctor should be employed by them again;

   b) in the case of an agency doctor, the locum agency should be informed;

   c) in the case of a junior doctor, a report should be sent to the postgraduate dean;

   d) a report should be sent to the GMC.

   **Timing**

   **By December 1997**

3. Trusts should introduce a structured assessment form to provide references for locum doctors. A shorter form may be used for appointments of less than a week, unless the locum's work was unsatisfactory. The factors which may need to be considered are covered by the suggested formats at Annex B to the Code.

   **Timing**

   **By January 1998**

4. Trusts and health authorities should discuss the use of and need for locums to maintain patient services, and should agree a strategy for locum appointments based upon the Code of Practice.

   **Timing**

   **By January 1998**

5. Trusts should agree working arrangements with locum agencies to ensure that locums meet the minimum standards agreed with health authorities. (See Annex A to the Code)

   **Timing**

   **By February 1998**
6. Trust Medical Directors, working closely with Clinical Directors, should arrange, were practicable, for the appropriate level of oversight of the work of locum consultants who do not meet the criteria for substantive appointment to this grade.  

7. Trusts should review their personnel procedures to ensure that steps are taken in good time to fill posts falling vacant, eliminating unnecessary use of locums.  

8. Trusts should ensure that locum doctors meet the more demanding criteria for the grade in which they are to work as soon as is practicable (see Annex A to Code).  

By February 1998  

As soon as is practicable  

Over a period of time to be agreed with health boards
1 - INTRODUCTION

1. This Code of Practice originates from the recommendations of the Working Group on Locum Doctors\(^1\), which was set up in December 1993 to advise the Chief Medical Officer on ways to improve quality control of hospital locum doctors in the NHS. The Code sets out guidelines on the appointment of locum doctors.

2. All locum appointments, whether made directly or through NHS or private locum agencies, should comply with the Code. Employers should subscribe to the Code because they have the ultimate responsibility for pre-employment screening, whether or not the locum doctor has been supplied by an agency. They should not use locum agencies that do not also subscribe to the Code. Health Authorities (Health Boards in Scotland) and GP Fundholders should include in contracts with NHS Trusts an assurance that any locum doctor appointments will comply with the Code.

3. This Code of Practice sets high standards which the service will need to achieve over a period of time. Some of these standards are intended for immediate adoption. Health authorities and trusts are urged to work together to attain these standards as quickly as is reasonably practicable.

4. Examples of two types of assessment form are offered at Annex E, with full structured assessment for locum appointments of a week or more, or where there are concerns about a locum’s performance.

2 - DEFINITION OF A LOCUM

1. A doctor in locum tenens is one who is standing in for an absent doctor, or temporarily covering a vacancy, in an established post.

2. Locum doctors should not be appointed where there is no substantive post to be covered. The only exception to this general rule is that locum consultants may be appointed to provide bridging arrangements during an interim period when services are being reorganised locally.

3 - REASONS FOR AND USE OF LOCUMS

1. Trusts (and DMUs in Scotland) should consider carefully the relative cost-effectiveness of engaging permanent and locum staff. Ideally, there should be sufficient substantive posts within the unit to meet foreseen service demands, including planned absences.

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\(^1\) Membership of the Working Group comprised representatives of the medical profession (The Joint Consultants Committee, the Central Consultants and Specialists Committee, the Junior Doctors Committee and the Conference of Colleges), the General Medical Council, the Overseas Doctors Association and the Federation of Recruitment and Employment Services Ltd (FRES). Also a Postgraduate Dean, a Regional Medical Manpower Manager, a Medical Staffing Officer, a Trust Chief Executive, a Trust Personnel Director and observers from the territorial Health Departments.
2. Employers will wish systematically to identify the career intentions, including retirement, of their medical staff. Where it is known that a post is to fall vacant, steps to make a substantive appointment should be taken sufficiently early to avoid unnecessary locum appointments. Staff absences, at both junior and senior levels, should be carefully managed to avoid needless overlap.

3. Locum doctors are an important asset to the NHS and make a valuable contribution to it. However, the appointment of a locum should be a temporary measure of limited duration. A substantive appointment to the post should be made as quickly as possible. A vacant post should not be filled over a substantial period of time by means of a series of short-term locum appointments. Long-term locums should not be used.

4. Where there is a foreseeable absence, locum cover should be arranged in good time.

5. Senior managers within trusts (and DMUs in Scotland) should ensure that the use of locums is never a matter of routine, but is always justified in the light of service need with reference to quality assurance and standards and to risk management. They should give full support to medical staffing officers in implementing this policy. Senior managers also have responsibility for determining how service requirements are to be met if a locum of sufficient quality cannot be appointed.

4 - STANDARDS AND CONDITIONS FOR APPOINTMENT AND EMPLOYMENT OF LOCUMS

1. Locum doctor appointments should be made with the same care as for a substantive appointment. All locum doctors should meet the criteria for the post to which they are to be appointed (see Annex A).

2. Locum doctors must be properly qualified and experienced for the work they are required to undertake. This should include an understanding and experience of the legal context for medical practice appropriate to the post (for example, the application of the Mental Health Act 1983 or the Mental Health [Scotland] Act 1984 in psychiatric practice).

3. Employers should not engage locums who are currently the subject of reservations about standards or competence of previous performance, or who are unwilling to provide their most recent report.

4. Locums should not be engaged to provide only overnight or weekend cover unless all the necessary checks (including professional references) have been conducted, either by the hospital or by a locum agency which subscribes to this Code. Or unless the locums are already well known to the employing trust, for example, through having recently been permanent members of staff.
5. Locum service should not normally be recognised for training purposes. Where educational approval is given for training in a locum post, this should always be secured prospectively and never retrospectively. Educational approval should not be sought for appointments of less than 3 months’ duration in a single post.

5 - EMPLOYMENT REFERENCES

1. Locum doctors should sign a statement identifying their most recent locum employer and, wherever possible, should provide a written report from that employer. If it is not practicable to provide a written report, verbal references should be taken from the most recent locum employer or the locum agency (Agencies should have procedures in place to supply such references). This should be followed by a written reference if appropriate.

2. The statement signed by the locum doctor should also give details of any proceedings by the GMC which are pending in his or her name.

3. A locum who is in a substantive post elsewhere, or has been in such a post within the last two years, should also supply a reference from that employer. Current employers of a doctor in a training grade who is undertaking a locum placement elsewhere will wish to ensure that the placement will not cause a breach in the controls on hours set out in the New Deal on Junior Doctors’ Hours.

4. At the end of the locum episode, the medical staffing officer should ensure that a reference is completed by a senior clinician (for example, consultant or clinical director) or by the medical director. A structured report form (Annex B) is offered as a suggested format. Trusts may wish to adopt their own local report styles based on either the short or long format. The long format is unlikely to be appropriate for most locums of a short duration. Trusts may wish to adopt a different approach to reporting arrangements for different locum grades for example those in locum consultant posts and those in locums training grade posts. The report should be counter-signed by the locum doctor, who may add written comments if desired. The locum doctor should retain a copy of this report for use as a future reference. It should be the responsibility of the medical director to support the medical staffing officer in ensuring that the referencing system operates smoothly within the hospital.

5. If, exceptionally, it will not be possible to assess and reference the doctor (because the appointment is very short and no senior staff will be present), the

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1. See "A Guide to Specialist Registrar training" March 1998 for the conditions under which a Locum Appointment - Training (Annex B) is appropriate.

2. "You must protect patients when you believe that a colleague’s conduct, performance or health is a threat to them...... Your comments about colleagues must be honest and you must be able to back them up......the safety of patients must come first at all times.”

locum doctor should if at all possible already be well known to the employer, or have recent, good references secured and examined by a locum agency.

6 - HEALTH DECLARATIONS

1. Before a doctor's first locum appointment, or when first registering with a locum agency, the doctor should undergo a formal health assessment. This assessment should be carried out by an Occupational Health Department. Locum doctors should have dated documentary evidence of this health assessment.

2. Locum doctors should have documentary evidence of the immunisations and tests that they have had, along with the results and dates. This should be provided by an Occupational Health Department which has knowledge and experience of these matters and their implications.

3. At the start of each locum episode, the doctor should sign a declaration that he/she feels well; has the mental and physical capacity to undertake the work; believes that he or she does not have any medical or physical infirmity which may pose a risk to patients or other staff; is not taking or awaiting medical treatment; and believes that he or she is not carrying any infection which could pose a risk to patients. A health declaration form is provided at Annex C. Even for very short or unexpected locum appointments, it should be possible to provide supplies of the declaration form at the point where the locum doctor will first report for duty at the hospital.

4. If the locum doctor is due to arrive when no-one in the Medical Staffing office is on duty, there must be adequate arrangements (perhaps through a locum agency) for the necessary documentation to have been received and examined. Employers should also have in place a reliable system for receiving the doctor, checking his identity and ensuring that this documentation is complete.

7 - CRIMINAL CONVICTIONS

1. At the start of each locum episode, the locum doctor should provide a statement of any criminal convictions (Annex D). Under the Rehabilitation of Offenders Act 1974 (Exceptions; Order 1975, applicants for locum medical posts are not entitled to withhold information about convictions which for other purposes are 'spent',

*other than, for example, medication for a well-controlled condition such as asthma, hay fever or diabetes*
8 - CHECKLISTS OF RESPONSIBILITIES

EMPLOYERS

Employers should:

1. Check the doctor’s identity, preferably by means of documentation such as a passport which bears a photograph. *

2. Check that the locum doctor is registered with the General Medical or Dental Council by inspecting the original certificates and/or by telephoning the GMC or GDC to confirm the registration. This is now a 24 hour service, available daily throughout the year.*

3. Check that no GMC proceedings concerning the doctor are pending or that the doctor has not been suspended, or is able to practise only under prescribed conditions.

4. Check the doctor’s medical qualifications, again by inspecting the original certificates. *

5. Check that, where necessary, the doctor holds current membership of a medical defence organisation.*

6. Check the doctor’s eligibility to work in the UK. Where there is doubt and the doctor is a non-EEA national, the doctor should be asked to obtain a letter from the Home Office confirming his/her immigration status. Full details about the employment of overseas doctors in the UK are contained in Health Circular HC(FP)185:14 (a revised version of this circular is expected to be issued in spring 1997). In Scotland: NHS Circular 1985(GEN)26. *

7. Ensure that the doctor is suitably qualified and experienced for the work to be undertaken.*

8. Take up and examine the necessary references from the locum doctor (see section 5 above). *

9. Ensure that the doctor:

   a. has documentary evidence, dated within the last two years, of the pre-employment health assessment by an Occupational Health Department;

   b. has an up-to-date certification of immunisation from an Occupational Health Department and that this meets the requirements of HSG(93)40(see note 1), its addendum EL(96)77, and any local requirements;
c. completes a form of Health Declaration (Annex C) and statement of Criminal Convictions (Annex D) before taking up the locum appointment.

(1) In Scotland, the letter dated 18 August 1993 from Mr G A Anderson and Dr E R Kendall entitled “Protecting Health Care Workers and Patients from Hepatitis B”

10. Ensure that educational approval for the appointment is secured in advance if the locum posting is to be recognised for training purposes.

11. In the case of a doctor with Limited Registration, check that the registration is valid for the work to be undertaken.

12. Seek to ensure that the locum placement will not cause the doctor in a training grade to breach the controls on hours set out in the *New Deal on Junior Doctors’ Hours.*

13. Provide induction for the locum doctor, appropriate to the post and the length of the appointment.

14. At the end of the locum episode of two weeks or more, the medical staffing officer should ensure that a structured report form (such as that suggested at Annex B) is completed by a senior clinician or the medical director. Employers should attempt if at all possible to complete reports on locums employed for shorter periods, especially where their performance has been unsatisfactory. If the locum has been engaged through an agency, the medical staffing officer must always send a copy of the report to the agency. Reports showing serious shortcomings in the locum’s performance should be copied to the GMC where appropriate. For doctors currently in training, postgraduate deans should receive copies of any report where significant shortcomings are identified. Medical staffing officers should retain all reports for seven years.

15. Employers who find that any locum doctor’s services are of an unacceptable standard should complete as much as possible of a full structured assessment form (such as that at Annex B) for that doctor, whatever the length of the locum episode.

16. Review the appointment if, exceptionally, the locum doctor is still in post after 6 months (3 months in Scotland). Locum consultant appointments are not subject to the full procedure used for substantive appointments, which are detailed in the NHS (Appointment of Consultants) Regulations 1996 (SIno 701). However, wherever possible, employers should try to appoint as

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*Information about the disclosure of criminal proceedings of those with access to patients may be found in HC 96/9. In Scotland: NHS Circular 1987/02/06.

*You must protect patients when you believe that a colleague’s conduct, performance or health is a threat to them....Your comments about colleagues must be honest and yet must be able to back them up....The safety of patients must come first at all times.*

locum consultants doctors who hold, or have held, posts of consultant status, or else who have completed specialist training (or who hold accreditation in the appropriate specialty). In any event there should always be careful assessment of the candidates by an appointments committee with at least two professional members, one in the specialty concerned. Locum appointments should be restricted to an initial period of six months and any extension beyond that period should be subject to a satisfactory review by the employer in consultation with the relevant college. In all cases locum consultant appointments should be limited to a maximum period of one year.

17. **Employers using a locum agency should ensure that the agency subscribes to this Code of Practice. Ultimate responsibility for conducting checks on locum doctors rests with the employer. If the routine checks are delegated to an agency, there must be a clear understanding between the two parties so that no checks are overlooked.**

Employer responsibilities marked with an asterisk * may, with all due care, be delegated to a locum agency with whom the employer has contracted. In this case, employers should check, as often as they consider necessary, that their required procedures are being carried out.

Employers should ensure that agencies are clear about the qualifications and experience required for each post. They may also need to assist agencies with access to Occupational Health Services and criminal records checks. Agencies may not be aware of notices that have been issued to the NHS about doctors who have been suspended.

**HEALTH AUTHORITIES, HEALTH BOARDS IN SCOTLAND AND NORTHERN IRELAND, COMMISSIONING AGENTS AND GP FUNDHOLDERS**

Should:

1. Consider the extent of locum usage by trusts when setting quality standards.

2. Include in contracts with trusts an assurance that locum doctor appointments will meet agreed standards based upon this Code of Practice.

3. Monitor locum usage and any associated quality problems as a part of quality standards control.

4. Tell trusts of any problems so that they can take appropriate action.
MEDICAL EMPLOYMENT AGENCIES

Both NHS and independent employment agencies should:

1. Meet the standards set out in this Code of Practice.


3. Ensure that, on first registering with the agency, all doctors:
   a. undergo a formal health assessment at an occupational health department, and obtain dated documentary evidence of this assessment;
   b. provide current documentary evidence of the immunisations and tests that they have had, along with the results and dates. This should be provided by an occupational health department;
   c. provide a statement of criminal convictions (Annex D);
   d. provide a valid criminal records clearance form, or undergo a police check where necessary.

4. Undertake the appropriate checks listed above as employer responsibilities where the agency is acting on the employer’s behalf. There must be a clear understanding and agreement between the two parties so that no checks are overlooked.

5. Secure copies of assessment reports on locum doctors they have placed, retaining these for as long as good business practice dictates; and consider whether a doctor who has been the subject of poor reports should remain on the agency’s books.

6. Where questions arise about a series of reports from one unit (whether concerning the same or several different doctors), take the matter up with the senior management of that unit.
LOCUM DOCTORS

Locum doctors should:

1. Produce their original certificates for the employer or locum agency to see to confirm the details of their Registration, medical qualifications and membership of a medical defence organisation where necessary. Produce work permits where applicable.

2. Provide their most recent locum reference (Section 5) and sign a statement that the most recent employer is correctly identified. The statement should also identify any GMC proceedings which are pending. Where they are also in substantive employment, a reference from the substantive employer should also be provided. If a locum is due to arrive outside normal working hours, he should hand these references to the person who receives him, for transmission to the appropriate Clinical Director the following day.

3. Ensure that any locum work undertaken does not entail exceeding national limits on contracted hours or actual hours of work set out in the New Deal on Junior Doctors' hours.

4. Provide dated documentary evidence of their health assessment; and of the immunisations and tests that they have had.

5. Complete a Health Declaration (Annex C) and Statement of Criminal Convictions (Annex D) at the start of each locum episode.

6. In the case of a doctor with Limited Registration, ensure that any locum work undertaken is within the terms of the registration, and does not damage his/her training interests.

7. Cooperate with the medical staffing officer and the senior clinician reporting on him or her to ensure that the report is completed in a timely manner.

8. Countersign the completed report at the end of the locum appointment, making written comments if desired.

9. If he or she disagrees with the contents of a report, contact the medical director.
CRITERIA FOR APPOINTMENT TO THE VARIOUS LOCUM GRADES

Locum doctors should be suitably qualified for the work required of them. The pay of a locum doctor may sometimes exceed the national pay rate for the grade in which he or she is employed. However, the work expected of and the responsibilities allocated to the locum doctor should not exceed the doctor's training and competencies.

The standards presented below are the minimum standards for early adoption. Health authorities and trusts should work together to attain the higher standards recommended by the Locums Working Group. These are identified in italics to the right of the page.

CAREER GRADE LOCUMS

Consultant

Employers should bear in mind that a doctor appointed as a locum consultant will work without supervision and with full clinical autonomy. Great care should therefore be exercised in making these appointments. They should usually be short-term. Ideally the individual should be registered as a specialist with the GMC and either have held a substantive NHS consultant post or equivalent honorary post in a relevant specialty for at least one year; or have equivalent service overseas. A review by the employing body in consultation with the relevant College must be held at 6 monthly intervals (3 monthly intervals in Scotland) if the locum is still in post and where, exceptionally, a long-term locum appointment is unavoidable. In all cases, locum appointments should be limited to a maximum period of one year.

Locum consultants should have full registration with the General Medical Council (GMC)\(^\text{1}\). Employers should satisfy themselves that any doctor to be appointed as a locum consultant has the knowledge, skills, attributes and experience necessary to discharge the responsibilities of a consultant. If the most suitable candidate for the locum post does not fully meet these criteria, then the Medical Director, working closely with the Clinical Director, should arrange for the appropriate level of oversight of the locum’s work. If necessary, the employer should consider engaging a locum in a non-consultant career grade to help cover the service need.

Wherever possible, the appointment committee for a locum consultant should include two members of the medical profession, one of whom should be from the discipline concerned. One professional committee member

\(\text{1 Full Registration: Most "career grade" doctors would have full registration to able to practice without restrictions; though some may have limited registration.}\)
should be sought from the appropriate Royal College or, in Scotland, the National Panel of Specialists. In an emergency, the Medical Director could take responsibility for interviewing a potential candidate.

Locum consultants may not participate in teaching and training except where such activity has been clearly defined and approved by the relevant clinical tutor.

**FINAL STANDARD:** Locum consultants should be registered as a specialist with the GMC in an appropriate specialty and be adequately experienced to undertake unsupervised independent clinical practice.

**Associate Specialist**

Locum associate specialists must have full registration with the GMC and must have worked for a minimum of 4 years in the registrar or staff grade, at least two years of which have been in the relevant specialty.

**Staff Grade**

Locum Staff Grades should have full registration and at least three years’ full time or equivalent hospital service at SHO or higher grade, including adequate experience in the relevant specialty.

**Clinical Assistant (Part-time Medical Officer; paragraph 9- appointments).**

The locum should have full registration, relevant experience in the specialty and may be a local general practitioner who is able to offer a limited sessional commitment.

Similar principles should be applied to other career grades, e.g. Senior Clinical Medical Officer, Clinical Medical Officer, Hospital Medical Practitioner.

**TRAINING GRADE LOCUMS**

**Specialist Registrar (SpR)**

The appointment of locum Specialist Registrars should follow the procedures set out in "A guide to Specialist Registrar training" (March 1996). Such posts may be either Locum Appointments - Service (LASs) or Locum Appointments - Training (LATs).

Doctors applying for appointment to a LAS must demonstrate qualifications and experience to a level allowing them to provide a service to patients of a quality comparable to a substantive SpR in that placement. Employers
should be sought from the appropriate Royal College or, in Scotland, the National Panel of Specialists. In an emergency, the Medical Director could take responsibility for interviewing a potential candidate.

Locum consultants may not participate in teaching and training except where such activity has been clearly defined and approved by the relevant clinical tutor.

**FINAL STANDARD:** Locum consultants should be registered as a specialist with the GMC in an appropriate specialty and be adequately experienced to undertake unsupervised independent clinical practice.

**Associate Specialist**

Locum associate specialists must have full registration with the GMC and must have worked for a minimum of 4 years in the registrar or staff grade, at least two years of which have been in the relevant specialty.

**Staff Grade**

Locum Staff Grades should have full registration and at least three years' full time or equivalent hospital service at SHO or higher grade, including adequate experience in the relevant specialty.

**Clinical Assistant (Part-time Medical Officer: paragraph 94 appointments)**

The locum should have full registration, relevant experience in the specialty and may be a local general practitioner who is able to offer a limited sessional commitment.

Similar principles should be applied to other career grades, e.g. Senior Clinical Medical Officer, Clinical Medical Officer, Hospital Medical Practitioner.

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Doctors applying for appointment to a LAS must demonstrate qualifications and experience to a level allowing them to provide a service to patients of a quality comparable to a substantive SpR in that placement. Employers
should ensure that applicants are vetted and interviewed by at least one doctor who is qualified to sit on an SpR appointment committee.

SHOs applying for appointment to a LAT should have completed the necessary SHO experience and gained the minimum College requirements for entry to the SpR grade.

Registrar and Senior Registrar

Where a placement occupied by a senior registrar must be filled by a locum, a locum Specialist Registrar should be appointed, again following the procedures set out in "A guide to Specialist Registrar training" (March 1996). If a placement occupied by a registrar needs to be filled by a locum, this should generally be done by a locum SpR. Locum registrar appointments can be made temporarily for those posts which are occupied by registrars who have not, for any reason, entered the SpR grade during transition.

Senior House Officer (SHO)

Locum SHOs should have full or limited registration with the GMC and at least 6 months' postgraduate experience in the relevant or associated specialty.

FINAL STANDARD: Locum SHOs should have full or limited registration with the GMC and at least 12 months' postgraduate experience in the relevant or an associated specialty.

House Officer

Doctors covering for House Officers should have full, limited or provisional registration and at least six months' experience in a recognised medical or surgical specialty.

Exceptions

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* Limited Registration: Certain training grade doctors will not be eligible for full registration, but will have limited registration. They will be issued with certificates that specify the conditions under which they may practice. These conditions include a time limit, may place restrictions on the grade in which a doctor can work and may exclude a doctor from working in certain departments or specialties. No doctor working outside the conditions of his registration is practising illegally.

* Provisional Registration: Grants to practitioners to work only in resident posts in hospitals or institutions which are approved for the purpose of pre-registration service.
The above appointment criteria may be waived only in the following circumstances:

**Acting Up**

Acting up to a higher grade within a unit or rotational training scheme is permissible in certain circumstances. For example, a specialist registrar judged to be within six months of the award of a Certificate of Completion of Specialist Training could act up as a locum consultant. Acting up must be supported by the trainee’s supervisor or college advisor. The doctor must be sufficiently experienced to carry out the duties of the locum appointment and appropriate supervision arrangements should be made.

**Moving across**

Doctors may move across within a unit or rotational training scheme to provide locum cover in another specialty in which they have previous experience.

**Consultants who have left or retired**

Recently retired doctors who have previously been Consultants of good standing in the discipline within the same employing body may be employed as locums without the full appointments procedure.

*The Joint Consultants’ Committee of the BMA has suggested that the term “acting consultant” might be applied to doctors who fall into this category. Trusts may wish to consider this and to offer views at the policy review stage.*
REPORTS ON LOCUM DOCTORS

Written assessment reports/references on locum doctors should be prepared at the end of each locum episode. They should be completed by the consultant or other senior doctor responsible for the supervision of the locum doctor. In the case of a locum consultant, the report should be completed by the Clinical Director or by a doctor acceptable to that Director.

"You must protect patients when you believe that a colleague's conduct, performance or health is a threat to them. Your comments about colleagues must be honest. The safety of patients must come first at all times."

Extract from *Good Medical Practice, Guidance from the GMC, October 1995*.

THE ASSESSMENT FORMS WHICH FOLLOW MAY BE REPRODUCED LOCALLY
SUGGESTED FORMAT FOR ASSESSMENT
OF LOCUM APPOINTMENTS OF LESS THAN ONE WEEK

DOCTOR’S NAME: .................................. GMC No. ................

GRADE (This post): .....................

SPECIALTY: ....................

PERIOD: .................................. UNIT: ..............

THE DOCTOR’S PERFORMANCE IN THIS LOCUM POST HAS BEEN *:

GOOD ........................................

AVERAGE ....................................

POOR .........................................

UNSATISFACTORY ** ........................

** In the event of unsatisfactory work by a locum doctor, please complete the full structured assessment form.

WOULD YOU EMPLOY THIS DOCTOR AS A LOCUM IN THE HOSPITAL AGAIN? *

YES/NO

* Please tick as appropriate

Comments by reporting doctor:
DOES THIS DOCTOR HAVE ANY TRAINING NEEDS THAT YOU HAVE IDENTIFIED

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

NAME OF REPORTING DOCTOR:...........................................

Signed.......................... Date.................................

STATEMENT BY LOCUM DOCTOR

I have seen the above assessment report and I agree/disagree * with its contents. If you disagree with the contents you should tell the medical director.

Signed............................ Name in CAPITALS.........................

Comments by locum doctor (if desired).

* Please delete as appropriate
# ASSESSMENT OF LOCUM APPOINTMENTS OF ONE WEEK OR LONGER

**DOCTOR'S NAME:**

**GMC No:**

**GRADE (This post):**

**SPECIALTY:**

**PERIOD:**

**UNIT:**

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<th>Please tick the appropriate boxes:</th>
<th>Above Average</th>
<th>Average</th>
<th>Below Average</th>
<th>Unacceptable</th>
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<td><strong>CLINICAL SKILLS</strong></td>
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<td>1. History taking</td>
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<td>2. Physical examination</td>
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<td>3. Investigations and diagnosis</td>
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<td>4. Judgement and patient management</td>
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<td>5. Practical skill</td>
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<td><strong>KNOWLEDGE</strong></td>
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<td>6. Basic science</td>
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<td>7. Clinical</td>
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<td><strong>ATTITUDES</strong></td>
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<td>8. Reliability</td>
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<td>9. Leadership and initiative</td>
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<td>10. Administration</td>
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<td>11. Time keeping</td>
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<td><strong>RELATIONSHIPS</strong></td>
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<tr>
<td>12 a) Colleagues</td>
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<tr>
<td>12 b) Patients</td>
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<td>12 c) Other staff</td>
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<td>12 d) Communication skills</td>
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<td><strong>PERSONAL QUALITIES</strong></td>
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<td>13. Appearance</td>
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<td>14. Integrity</td>
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<tr>
<td>15. Manners</td>
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</tbody>
</table>
DOES THIS DOCTOR HAVE ANY TRAINING NEEDS THAT YOU HAVE IDENTIFIED?

Comments by reporting doctor:

NAME OF REPORTING DOCTOR.............................

Signed.................. Date..................

STATEMENT BY LOCUM DOCTOR

I have seen the above assessment report and I agree/disagree* with its contents.
I have also seen the guidance notes on the completion of the assessment report.

Signed............... Name in CAPITALS..............

Statement by locum doctor if desired:

* Please delete as appropriate
NOTES ON COMPLETION OF THE ASSESSMENT MATRIX

Tick only one box in each row of the matrix. These guidelines may help in assessing the performance of the locum doctor. To be graded **above average** or **average** the locum’s performance must be consistent with that of doctors in substantive appointments at the grade. Reports showing serious shortcomings in the locum doctor’s performance should be copied to the GMC.

<table>
<thead>
<tr>
<th></th>
<th>Above average</th>
<th>Average</th>
<th>Below average</th>
<th>Unacceptable</th>
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<tbody>
<tr>
<td><strong>CLINICAL SKILLS</strong></td>
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</tr>
<tr>
<td>1. History taking</td>
<td>Precise, perceptive, comprehensive, well documented.</td>
<td>Usually complete, orderly &amp; systematic.</td>
<td>Often incomplete, inaccurate and poorly recorded.</td>
<td>Frequently incomplete, inaccurate and poorly recorded.</td>
</tr>
<tr>
<td>2. Physical examination</td>
<td>Through. Accurate. Recognises &amp; elicits physical signs.</td>
<td>Usually elicits correct signs. Recognises most significant findings.</td>
<td>Lacks basic skills and misses some signs. May misinterpret signs.</td>
<td>Lacks basic skills. Frequently misses signs and or misinterprets them.</td>
</tr>
<tr>
<td>3. Investigations and diagnosis</td>
<td>Investigations almost always appropriate in relation to differential diagnosis. Excellent or interpretation. Excellent diagnostician. Excellent clinical memory.</td>
<td>Investigation usually appropriate. Good knowledge or interpreting tests relevant to the specialty. Competent clinician. Good knowledge with orderly logical approach to differential diagnosis.</td>
<td>Investigations may be inappropriate and are frequently unnecessary, expensive. Unable to interpret some tests. May fail to interpret symptoms and signs correctly.</td>
<td>Investigations incorporate or incompetent. Fails to interpret tests correctly. Often fails to interpret symptoms and signs correctly.</td>
</tr>
<tr>
<td>4. Judgement and patient management</td>
<td>Excellent clinician who is aware of his/her limits. Excellent ward and/or outpatient management.</td>
<td>Relate &amp; communicate.</td>
<td>Sometimes unreliable &amp; uninterested.</td>
<td>Often unreliable &amp; uninterested. Fails to grasp the significance of findings or take appropriate action. Fails to notice complications and act appropriately. Fails to recognise limitations &amp; to seek advice when needed.</td>
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<tr>
<td>5. Practical skill</td>
<td>Shows outstanding practical ability</td>
<td>Competent</td>
<td>Clumsy or rough. Can have difficulty in even the simplest procedures</td>
<td>Clumsy and rough. Often has difficulty in even the simplest procedures</td>
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<tr>
<td><strong>KNOWLEDGE</strong></td>
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<tr>
<td>6. Basic science</td>
<td>Comprehensive and up to date knowledge and understanding of the basic science of the speciality. Widely read.</td>
<td>Adequate and up to date fund of knowledge. Relates this satisfactorily to patient care.</td>
<td>Reasonable though perhaps dated knowledge. Not always applied approximately.</td>
<td>Uninterested. Does not read the literature. Fails to apply basic science knowledge to clinical problems.</td>
</tr>
<tr>
<td>7. Clinical</td>
<td>Comprehensive and up to date knowledge and excellent application. Widely read.</td>
<td>Satisfactory knowledge for dealing with common disorders. May fail to &quot;spot the rarity&quot; but learns from experience.</td>
<td>Lacks appropriate knowledge or ability to apply it. May fail to learn from experience.</td>
<td>Lacks basic and essential knowledge. Unable to learn from experience.</td>
</tr>
<tr>
<td><strong>ATTITUDES</strong></td>
<td></td>
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<tr>
<td>10. Administration</td>
<td>Well prepared &amp; organised. Adapts to the hospital’s management policies.</td>
<td>Well prepared &amp; organised. Conscientious. Can be left confidently to deal with routine admin.</td>
<td>Often behind or neglects routine admin.</td>
<td>Cannot be bothered or slapdash.</td>
</tr>
<tr>
<td>RELATIONSHIPS</td>
<td>Willing to accommodate the working methods of the clinical team.</td>
<td>Good rapport</td>
<td>Fails to fit in with seniors, peers or juniors</td>
<td>Uninterested</td>
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<tr>
<td>--------------</td>
<td>---------------------------------------------------------------</td>
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</tr>
<tr>
<td>Colleagues</td>
<td>Able to deal with problems in the team.</td>
<td>Trusted</td>
<td>Does not try to fit in with colleagues and may even undermine them</td>
<td></td>
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<tr>
<td></td>
<td>Excellent colleague who fits in well.</td>
<td>Easy to work with</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Able to fit in with existing team</td>
<td></td>
<td></td>
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<tr>
<td>12 b) Patients</td>
<td>Inspires confidence Establishes excellent rapport.</td>
<td>Sound caring attitude.</td>
<td>Does not put people at their ease</td>
<td></td>
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<tr>
<td></td>
<td>Patients delighted to be looked after by him/her.</td>
<td>Can allay patient fears. Takes time</td>
<td>Lacks empathy</td>
<td>Does not mean well, Rude.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Trusted by the patient</td>
<td></td>
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</tr>
<tr>
<td>12 c) Other staff</td>
<td>Inspires envy and enthusiasm.</td>
<td>Sound and professional yet approachable. Treats others with respect &amp; is respected in return</td>
<td>Careless of others. May generate rather than solve problems</td>
<td>Rude and arrogant likely to cause problems</td>
</tr>
<tr>
<td>12 d) Communication skills</td>
<td>Excellent communication. Establishes rapport with patients.</td>
<td>Good communication skills.</td>
<td>Poor command of local language</td>
<td>Very poor command of local language</td>
</tr>
<tr>
<td></td>
<td>Encourages and enhances mutual understanding.</td>
<td>Listens well &amp; explains well in appropriate language</td>
<td>Irritate and confusion easily misunderstood</td>
<td>Unintelligible</td>
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<tr>
<td></td>
<td></td>
<td>Gives clear instructions</td>
<td>Does not listen or understand</td>
<td>Inarticulate</td>
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<td></td>
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<td></td>
<td>Confuses patients with unnecessary technical terms</td>
<td>Inarticulate or struggle</td>
</tr>
<tr>
<td>13. Appearance</td>
<td>Smart, appropriately dressed. Good personal hygiene.</td>
<td>Tidy, appropriate dress. Normal personal hygiene.</td>
<td>Unlucky or inappropriate dress</td>
<td>Other scrutiny. Generally poor personal hygiene</td>
</tr>
<tr>
<td>14. Integrity</td>
<td>Excellent.</td>
<td>Good.</td>
<td>Just acceptable</td>
<td>Suspect honesty or morals</td>
</tr>
<tr>
<td>15. Manners</td>
<td>Always considerate and polite. Generally good. Considerate.</td>
<td>Tactless. Sometimes rude</td>
<td>Rude or not at all polite</td>
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</table>
In Confidence

HEALTH DECLARATION

To be completed at the start of each locum episode

I ATTACH documentary evidence from ............ (name of) Occupational Health Department of the
immunisations and tests that I have had, together with the results and dates.

I DECLARE THAT:

1. I am feeling well.

2. I have the mental and physical capacity to undertake the work required of me
   as a locum ................................ at ..............................................

3. I am not ovulating.

4. I believe that I do not have any medical or physical infirmity which may pose a risk to
   patients or other staff.

5. a. I am not taking or awaiting medical treatment.
   b. I am taking the following medication...........................................

Please delete/compleate as appropriate

6. I believe that I am not carrying any infection which could pose a risk to patients.

7. I understand my responsibility (set out in "Duties of a doctor: Guidance from the General
   Medical Council") to have all the necessary tests if I think I have or am carrying a serious
   communicable condition, and to act on the advice of a suitably qualified colleague about
   necessary treatment and/or modifications to my clinical practice. I also understand that I
   must take and follow advice from a consultant in occupational health or another suitably
   qualified colleague if my judgement or performance could be significantly affected by a
   condition or illness.

Signature..................................Date..............................

Name in CAPITALS..................................................

GMC Number..............................................
In Confidence

STATEMENT OF CRIMINAL CONVICTIONS

1. Please list any criminal convictions and dates below. As a doctor, any criminal convictions you may have may not be treated as "spent" under the Rehabilitation of Offenders Act 1974. You are therefore required to declare all criminal convictions or cautions. The information you give will be treated in confidence and taken into account only where the offence is relevant to the post for which you are applying.

2. Do you have any criminal proceedings pending against you?

   YES / NO

   If yes, please give details.

Signed........................................Date......................

Name in CAPITALS..............................................

GMC Number.................................

GMC Number.................................

/cont....
STATEMENT OF CRIMINAL CONVICTIONS

1. Please list any criminal convictions and dates below. As a doctor any criminal convictions you may have may not be treated as "spent" under the Rehabilitation of Offenders Act 1974. You are therefore required to declare all criminal convictions or cautions. The information you give will be treated in confidence and taken into account only where the offence is relevant to the post for which you are applying.


Signed...........................................Date..............

Name in CAPITALS...........................................

GMC Number...........................................

2. Do you have any criminal proceedings pending against you?

YES / NO

If yes, please give details.................................


Signed...........................................Date..............

GMC Number...........................................
3. Police Check

Unless you are able to provide your criminal record convictions records clearance form, it may be necessary to request a police check to ensure that you do not have a criminal record that would affect your suitability for medical work. Please complete the form below, or provide a clearance certificate stating that you have been the subject of a criminal convictions check within the last 12 months and that you have no convictions preventing you from working as a doctor.

Name in full....................................................

Maiden name [where applicable]............................

Date of birth.................................Place of birth....................

Present address.................................................................

..................................................................................

..................................................................................

Since [date] ........................................

Previous addresses in last 4 years (including dates):

..................................................................................

..................................................................................

..................................................................................

..................................................................................

I hereby give..............................................permission to undertake a police check on my behalf. I understand that refusal could prevent further consideration of my application.

Signed.........................................................Date.....................

Name in CAPITALS.............................................................

GMC Number..............................................
SUMMARY OF EXISTING GUIDANCE

1. All locum appointments should comply with the guidance to employers contained in EL(89)P/148, EL(92)53, EL(92)841, HCG(96)242 and HSG(92)403 and its addendum issued under EL(96)77. This guidance is summarised below.

2. The following pre-employment checks should be carried out on prospective locum doctors:
   a. employers should check that the doctor is registered with the GMC, and should check his medical qualifications. For both purposes, the original certificates should be inspected;
   b. employers should also check whether the doctor's registration is affected by any decision of the GMC which has been notified to them in confidence by means of circulars from the NHS Executive;
   c. references should be sought from previous employers, at least one of which should relate to relevant employment in the preceding 12 months. In Wales, references must include one from the most recent appointment;
   d. employers should consider what health checks are required in the light of the guidance for substantive staff appointments;
   e. employers should check that the doctor is eligible to work in the UK in the post on offer;
   f. the doctor should declare any criminal offence (unless the work required will not normally involve patient contact);
   g. where the locum post involves substantial access to children, a police check should be undertaken;
   h. employers should consider whether the doctor's aggregate commitments would be unreasonable, or if the locum placement would not otherwise be in the interests of the service;

1 In Wales: DGM (89)99 and the letter of 14 September 1992 from Mr D H Jones
In Scotland: SHHD DGM (1990)2
In Northern Ireland: HSS(TC2)19/92

2 In Wales: Para 32 of WHC(83)23
In Scotland: NHS MEL(1993)62
In Northern Ireland: HSS(TC2)19/92

3 In Wales: PSM9312
In Scotland: The letter of 18 August 1993 from Mr G A Anderson and Dr R E Kendall
In Northern Ireland: HSS(MD)4/94
i. employers should obtain brief details, including the nature of duties and hours of work, of any NHS appointments that the doctor will hold concurrently with the locum placement;

j. wherever practicable, the doctor should be interviewed by a senior member of the medical or dental staff of the hospital before, or within 24 hours of, commencing the placement;

3. Employers using locum agencies are still responsible for ensuring that the necessary pre-employment checks have been carried out:

k. employers using locum agencies must satisfy themselves that the agency has suitable procedures for recruiting and placing doctors. These must include ensuring that the prospective locum is registered with the GMC, has the required qualifications and experience for the post on offer, is supported by suitable professional references, and is eligible to work. Employers should check as often as they consider necessary that these procedures are being carried out.

l. employers must also undertake their own checks on prospective locums. In particular, they should satisfy themselves that the doctor is registered with the GMC and that the registration is not affected by any GMC decision. They should also, where practicable, arrange for the doctor to be interviewed by a senior member of the medical staff before, or within 24 hours of commencing, the locum placement.

4. The guidance on consultant appointments, HSG(96)22, draws attention to locum appointments. It is important that employers have satisfactory procedures in place to ensure that locum consultants are of adequate standard. Employers need, wherever possible, to appoint doctors who hold or have held, posts of consultant status, or else doctors who have completed specialist training or who hold accreditation a CCST in the appropriate specialty. In any event, there should always be careful assessment of candidates by an appointments committee with at least 2 professional members, one in the specialty concerned.

5. It may be necessary to waive this requirement in cases where a locum is urgently needed, but there should always be some professional involvement in the appointment of a locum consultant. Where the locum is not known to the professional staff in the hospital, he should be seen by at least one of the hospital's consultants before he is engaged. It is important that references are obtained for all locum appointments, irrespective of the short-term nature of the post.

6. HSG(93)40³, and its addendum issued under EL(96)77, also refers to locum doctors. The guidance is designed to protect patients against the risk of acquiring Hepatitis B from infected healthcare workers. It asks that doctors performing “exposure prone procedures” should be immunised, and their response to the vaccine checked. Locum staff should have adequate documentation demonstrating compliance with this guidance.
SUMMARY OF RECOMMENDATIONS OF THE LWG REPORT

While this Report focuses on the quality of hospital locums, we recommend that any implications for the primary care sector arising from our work should be considered by the UK Health Departments as appropriate. (Recommendation 1)

Reducing Dependence on Locums

While there will always be a need for some locums, there are intrinsic shortcomings with this method of providing a service and we believe there is a need to reduce the dependence of hospitals on locums. We therefore recommend that:

- Trusts should carefully consider the relative cost-effectiveness of engaging permanent and locum staff; (Recommendation 3)

- the use of a locum should never be a matter of routine; that locum use should always be justified in the light of service need, quality assurance and risk management; and that Trusts should assign a high priority to their quality assurance strategies:

  long-term locums should not be used: neither should a vacant post be filled over a substantial period of time by means of a series of short-term locum appointments. (Recommendation 15)

- there should normally be sufficient substantive posts within the unit to meet the foreseen service demands, including planned absences; (Recommendation 2.1)

- as far as possible, posts should be filled by staff in substantive appointments who have undergone the full normal appointment procedures. Any necessary locum appointments should be short-term, and a substantive appointment to the post should be made as quickly as possible; (Recommendation 2.2).

- health authorities should consider the extent of locum usage by trusts when setting quality standards. (Recommendation 18.1)

Responsibilities of Employing Bodies

It is the clear responsibility of senior management, and in particular the Chief Executive and Medical Director of a Trust, to ensure that all doctors including locums whom they employ are of adequate quality. They must also ensure that the doctors are capable of undertaking the work required of them. We therefore recommend that:

- Medical Staffing Officers should be given the full support of senior clinical and
managerial staff in seeking to maintain high quality standards for locum doctors, even if this means a locum position cannot be filled. Local management will then determine how service requirements will be met. (Recommendation 5)

- appropriate induction for all newly appointed junior staff including locums should be provided and recognised as important. Appropriate induction should also be available for career grade locums, including locum consultants. Induction should be financed by the employing body. (Recommendation 6.1)

- employers or agents of locums should satisfy themselves that, in the case of doctors with Limited Registration in the UK, the registration is valid for the work to be undertaken within their unit. (Recommendation 8.2)

Immediate Steps

We believe that there are a number of steps that should be taken immediately to improve locum quality and ensure that doctors in training are aware of the implications of locum work for them. We therefore recommend that:

- the current guidance to employing bodies should be consolidated into a single document, incorporating also the expected revised guidance on the appointment of locum consultants. This should be issued at the earliest opportunity. (Recommendation 9)

- locum service should not normally be recognised for training purposes. We recommend that the educational approval for training in such posts should always be secured prospectively and never retrospectively. (Recommendation 7)

- doctors with Limited Registration in the UK should ensure that any locum work undertaken is within the terms of their Registration and does not damage their training interests. (Recommendation 8.1)

Existing good practice in placing locums appears to be effective in minimising problems. We believe that quality standards would be improved across the board if this good practice were universally applied and that this could best be achieved via a Code of Practice. We have therefore prepared such a Code and recommend that:

- employers who are recruiting locum doctors directly should adhere to the Code of Practice. (Recommendation 17.1)

- all locum agencies, whether in the public or private sector, should agree to adhere to the high standards set out in the Code of Practice. Employing bodies should not use agencies that do not apply these standards and subscribe to the Code of Practice. (Recommendations 10 and 17.2)

- health authorities should include in contracts with NHS Trusts an assurance that locum doctor appointments will comply with the Code of Practice. (Recommendation 18.2)
the standards for appointment to the various locum grades set out in the Code of Practice should be universally and rigorously applied: (Recommendation 20)

the following should not be appointed as locum doctors:

- those who do not meet the appointment criteria set out in the Code of Practice, unless they are "acting up" or "moving across" within a unit or rotational training scheme to provide short-term cover for an unforeseen absence; (Recommendation 21.1)

- those who are currently the subject of reservations about standards or competence of previous performance; (Recommendation 21.2)

- those who are unwilling to provide their most recent structured appraisal report and are also unwilling to identify their most recent locum employment; (Recommendation 21.3)

- those doing only overnight or weekend cover, unless the doctor is already well known to the employing unit or unless all the necessary checks have already been conducted and appropriate induction given; (Recommendation 21.4)

- those junior doctors in established posts for whom the locum service would entail their exceeding their contracted hours unless the locum employment is within their own unit and time off is to be given in lieu. (Recommendation 21.5)

Reporting on locum doctors is an area in some disarray. We believe that the introduction of a fair and open structured appraisal system would identify problems and help prevent bad locum doctors from simply moving on to other locum posts. We therefore recommend that

- a system of fair and open structured reporting be introduced for locum doctors, using the appraisal form and reporting procedures we describe. The report should be signed by the senior doctor who has written it, and also by the locum doctor who should indicate agreement, or otherwise, with its contents; (Recommendation 11)

- a locum doctor should ideally provide a written report from the most recent locum employer before beginning a new episode of locum employment. If this is not practicable, verbal references should be taken from the most recent employer. The locum should be required to sign a statement that the most recent employer is correctly identified; (Recommendation 14.1)

- a locum who is in a substantive post elsewhere, or has been in such a post within the last 2 years, should also supply a reference from that employer; (Recommendation 14.2)
We believe that there should be ways of identifying bad locums and taking steps to counteract the concomitant problems; and that this necessarily involves a personnel function at a level above that of individual employers. We therefore recommend that:

- there must be a personnel function at a level above that of individual employers. With the proposed changes in the organisation of the NHS, this function might best be undertaken by the NHS Executive; (Recommendation 19)

- locum doctors who are found to be unsatisfactory should be identified and reports sent to:
  - the Postgraduate Dean who may offer counselling and/or recommend further training; however there may be financial implications which need to be addressed; (Recommendation 12.1)
  - the NHS Executive to inform the alert system (see next section); (Recommendation 12.2)
  - the GMC, if appropriate; (Recommendation 12.3)

- an "untoward incident" procedure should be set up to facilitate earlier detection of potential problems in each employing body. Reports should be made in writing and through a single channel in that Trust which is known to all involved in locum employment. This would normally be the Medical Director and/or Chief Executive. Serious cases should be notified to the NHS Executive and, where appropriate the GMC. (Recommendation 15.2)

Longer Term Measures

The above measures should improve locum quality but this could be further enhanced by the introduction of a number of measures in the longer term. Some of these require more knowledge than is presently available. We therefore recommend that:

- accurate data on locum demand, supply and usage should be collected over a twelve month period from a representative sample of trusts in the UK. (The data should include all locum episodes, whether arranged internally, by direct recruitment or through an agency; and should also include "acting up" or "moving across" within a unit.) Any issues identified from this work should be addressed, initially by the Health Departments. (Recommendation 4)

- We recommend that the research into the best way to provide locums with induction, which SCOPME have identified as being necessary, should be undertaken; (Recommendation 6.2)

- an alert system should be set up and operated centrally by the NHS Executive on behalf of the United Kingdom as a whole:
  - information from reports on unsatisfactory locum doctors should be
available on request to employing bodies (in both the NHS and the private sector) and to locum agencies. (Recommendation 13.1)

✦ employing bodies and locum agencies should be informed of the setting up of an alert system: (Recommendation 13.2)

✦ if legislation presently in force should be deemed to prevent the operation of an alert system, the Health Ministers should consider introducing the necessary legislative changes: (Recommendation 13.3)

There are a number of options which offer improved security and a more formal reporting system. We recommend that:

✦ at least in the short to medium term, a logbook system be introduced to increase security. The logbook might be based upon the structured appraisal forms that we have recommended; a pilot study should be mounted before the scheme is introduced nationally: (Recommendation 15.1)

✦ a feasibility study should be mounted into the use of plastic data cards, electronic smartcards and other electronic data options: (Recommendation 15.2)

✦ in the longer term, consideration should be given to the introduction of a data card, smartcard or other electronic data storage and retrieval system, depending on the outcome of the feasibility study. (Recommendation 15.4)

General

We recommend that our Report and the Code of Practice be subject to a period of consultation and should then be published. (Recommendation 23)