Royal College of Obstetricians & Gynaecologists

Guidance on the engagement of long-term locums in maternity care in collaboration with NHS England, Scotland and Wales

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Introduction

The RCOG has developed this guidance on the engagement of locums in maternity care in collaboration with the NHS. The guidance outlines roles and responsibilities for healthcare providers, healthcare organisations and individual doctors undertaking locum positions within the NHS. It has been approved by NHS England, Wales and Scotland.

For the purposes of this guidance, a locum refers to a doctor who:

- Is placed by a locum agency or a locum bank to work in a healthcare organisation
- Directly engages with healthcare organisations for short-term work.
- Is a doctor in training who undertakes locums outside their training

In this guidance a long-term locum is one where the placement is for longer than two weeks duration. This is an opportunity for doctors to obtain the evidence they require to meet the criteria for a Certificate of Eligibility for Locums (CEL) outlined in the Royal College of Obstetricians and Gynaecologists' Guidance on the Engagement of Short-Term Locums in Maternity Care.

Locum doctors do not have to provide a CEL for a long-term locum position.

Background

Comprehensive guidance for healthcare providers, locum agencies and individual locum doctors has been produced by NHS England. The RCOG and the NHS strongly recommend that healthcare organisations engaging locum doctors should use this practical guidance to support those individuals and ensure they comply with recommended processes such as pre-employment checks and appropriate induction.

- Supporting organisations engaging with locums and doctors in short-term placements
- Supporting locums and doctors in short-term placements

Recent high-profile cases in maternity care have highlighted the need for adequate support and supervision of locums who enter the workplace. These individuals face the challenge of providing excellent clinical care but without the knowledge of the organisation or familiarity with the staff with whom they will work.

Currently there are widespread shortages of suitably qualified obstetricians and gynaecologists who can safely undertake the role of senior resident doctor out-of-hours with indirect supervision from a consultant who is non-resident.

Rota gaps amongst doctors are present in 83% of obstetric units at any one time (Blotkamp 2019). These are due to a combination of sickness, parental leave and a shortfall in the number of allocated trainees from HEE/NES/NIMDA/NHS Wales training programmes due to out of programme activity and attrition.

Where possible, healthcare providers encourage the use of internal locums so that the service is provided by staff already working within the unit. However, in order to comply with junior doctor contract rules and to prevent trainees, SAS and locally employed doctors from working excessive hours, external agency locums are often required. These locum doctors have not always worked in the unit previously. Therefore, appropriately robust recruitment processes and assessment of their skills and knowledge, with structured feedback and support, are required before they are released to work independently. This is to ensure there is no compromise in patient safety and quality of care.

Responsibilities of the healthcare provider

The responsibilities of the healthcare provider are outlined in the NHSE guidance but are reproduced here for ease of reference.

A healthcare provider which engages the locum doctor is responsible for (at the point of placement):

- Verifying that GMC registration and licence to practise, HPAN, identity, language, health clearance and other checks have taken place, or undertaking these if this cannot be verified
- Ensuring that it is aware if any doctors placed with them have GMC conditions or undertakings on their registration and that they will be able to work within these restrictions
- Accurately representing to the locum doctor and locum agency (where relevant) which skills and competencies are required in the position for which the doctor is being engaged
- Providing suitable induction to the doctor to enable them to carry out the work they are being engaged to do (including appropriate IT system login/access, buildings/departmental access and the process for escalating concerns)
- Completing the required end of placement/exit report and peer/colleague feedback for the doctor
- Integrating the doctor into their governance structure in a manner appropriate to the nature and duration of the placement
- Supporting the doctor's appraisal preparation
- Agreeing with the doctor and at the discretion of the doctor's responsible officer to provide annual appraisal for the doctor if appropriate to do so (in light of the nature and duration of the doctor's placement), to the standard of the 'Medical Appraisal Guide' (NHS England 2014), along with 'Guidance on supporting information for appraisal and revalidation' (GMC 2018). NHS England GPs' appraisals are organised through NHS England local teams
- Notifying the doctor and locum agency (where relevant) if any significant information of note arises in relation to the doctor's practice during their placement (and/or the doctor's responsible officer if the agency is not the doctor's designated body)

- Agreeing with the locum agency or NHS England local team (where relevant) whether any necessary investigation is carried out in the organisation
- Including quality elements within the service level agreement (if applicable) with the locum agency to facilitate the above 2.

Specific requirements for healthcare organisations engaging with locums in maternity services who undertake the role of senior resident doctor out-of-hours.

The RCOG has been working across all nations to agree more extensive guidance and recommendations for locum placements. This guidance has been agreed and signed off by NHS England, NHS Wales and NHS Scotland. It recommends that all maternity providers should have a written policy and standard operating procedures for the employment of locum medical staff which includes a process for monitoring compliance/effectiveness.

These should include:

- Ensuring that the locum doctor's Curriculum Vitae is reviewed by an appropriately qualified O&G consultant (or equivalent). The lead clinician should pay particular attention to the skills and experience of the doctor
- Checking that appropriate pre-employment checks have been completed
- Discussion between the locum doctor and the lead clinician about clinical capabilities on appointment or prior to starting employment
- Arrangement of appropriate departmental induction with a senior member of staff (preferably a consultant) on the commencement day
- Access to all IT systems, guidelines and training completed on commencement day
- A named consultant to support the locum (this could be the clinical lead, rota lead or college tutor depending on the circumstances and length of the locum attachment)
- Arrangement of supernumerary or directly supervised clinical duties enabling assessment of skills prior to undertaking clinical duties with indirect supervision, especially out-of-hours
- Review of suitability for the post based on multidisciplinary feedback
- Feedback to the locum doctor and to the employing agency regarding the locum's performance

Guidance for departments on supernumerary or directly supervised clinical duties prior to indirect supervision

The guidance on what might constitute appropriate supervision or assessment of skills will vary depending on the service configuration. Services vary both with the number of tiers in their middle grade rota and the seniority of staff on those rotas.

Where a locum doctor works out-of-hours without resident senior support

If a locum doctor is to be employed on the senior tier of a middle grade rota or on a single tier middle grade rota, where the consultant is non-resident out-of-hours, the performance of the locum doctor should be reviewed and assessed prior to allowing them to work out-of-hours. This may be undertaken by assigning them to work in a supernumerary capacity alongside a consultant on the wards and in theatre. Educational tools (OSATs, NOTSS) are available to aid assessment if required and would also assist the locum in obtaining the evidence to gain a Certificate of Eligibility for Locums. It would be appropriate for more challenging caesarean sections and instrumental deliveries to be assessed as well as management plans on labour ward or the antenatal and postnatal ward. Balancing the requirements of the out-of-hours gynaecology service should also be considered as part of the wider professional judgement of the doctor. These activities could be undertaken out-of-hours provided there is direct consultant supervision. It should be noted that the clinical capabilities outlined in the core curriculum can help support consultants making these judgements.

There should be an active decision made that the locum doctor is suitable to undertake indirectly supervised shifts, based upon multidisciplinary feedback. This should be fed back to the individual doctor and documented. The timescales to reach this decision will vary dependent on the skills and experience of the locum doctor.

As part of this sign off, the locum doctor should be given clear instructions about clinical scenarios when a consultant should be informed and when it would be mandatory to call a consultant in from home. This should include the clinical scenarios detailed in Appendix 1 and any other situations identified by the unit.

Where a locum doctor works out-of-hours with resident senior support

For locum doctors working on the junior tier of a two-tier system or where there is a resident consultant on-call, the locum doctor should be paired with a senior specialty trainee (ST6/7) or consultant to work under direct supervision initially before being assigned to work in the different ward areas. There should be an active decision made, based upon multidisciplinary feedback, that the locum doctor is suitable to undertake indirectly supervised shifts but with a senior resident doctor immediately available. This decision should be fed back to the individual doctor and documented. As part of this sign off the locum doctor should be given clear instructions about clinical scenarios when a consultant should be informed and when it would be mandatory to call a consultant in from home.

Clinical Supervision

Appropriate clinical supervision and support is at the heart of safe care for women, babies, and their families. In all units, policies for appropriate supervision and escalation should be in place and clearly understood by all staff, not just locum doctors.

Units must agree under what circumstances a consultant must be informed about activity within their unit and where consultant presence is mandatory. The trigger lists in Appendix 1 detail the clinical scenarios in which the RCOG recommend that the consultant is either informed or should attend in person while on-call.

Locum doctors who are known to the unit from previous periods of employment and are known to be competent to work on the appropriate tier can commence work without the period of supervision outlined above.

Locum doctors should be supported in achieving the competencies required for completion of the Certificate of Eligibility for Locums (CEL) if they wish to be able to carry out short-term locums in the future.

In all cases, if locum doctors are deemed unsuitable for the work after due consideration, then feedback should be given to the doctor in person and to the agency. If they are not deemed to be suitable, they can then be given a period of notice.

Monitoring of compliance/effectiveness

The RCOG/NHS recommends that units monitor compliance with this guidance.

The following is a simple tool which can be adapted for local use and retained as evidence of a robust process of assessment for all locum appointments. This could be completed by the lead consultant with support from a medical administrator

Compliance	Completed Y/N	Date
Locum doctor CV reviewed by consultant lead prior to appointment		
Discussion with locum doctor re clinical capabilities by consultant lead prior to starting or on appointment		
Departmental induction by consultant on commencement date		
Access to all IT systems and guidelines and training completed on commencement date		
Named consultant supervisor to support locum	Name:	
Supernumerary clinical duties undertaken with appropriate direct supervision		
Review of suitability for post and OOH working based on MDT feedback		
Feedback to locum doctor and agency on performance		

References

1. 1. Blotkamp A, NMPA Project Team. *National Maternity and Perinatal Audit: Organisational Report 2019*. London: RCOG; 2019.

Appendix 1

Clinical scenarios in which the RCOG recommends that the consultant should be informed or attend in person whilst on-call.

Situations in which the consultant MUST ATTEND
GENERAL
In the event of high levels of activity e.g a second theatre being opened, unit closure due to high levels of activity requiring obstetrician input
Any return to theatre for obstetrics or gynaecology
Team debrief requested
If requested to do so
OBSTETRICS
Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary
Caesarean birth for major placenta praevia / abnormally invasive placenta
Caesarean birth for women with a BMI >50
Caesarean birth <28/40
Premature twins (<30/40)
4th degree perineal tear repair
Unexpected intrapartum stillbirth
Eclampsia
Maternal collapse e.g septic shock, massive abruption
PPH >2L where the haemorrhage is continuing and Massive Obstetric Haemorrhage protocol has been instigated
GYNAECOLOGY
Any laparotomy

Situations in which the consultant must ATTEND unless the most senior doctor present has documented evidence as being signed off as competent. In these situations, the senior doctor and the consultant should decide in advance if the consultant should be INFORMED prior to the senior doctor undertaking the procedure.
GENERAL
Any patient in obstetrics OR gynaecology with an EBL >1.5litres and ongoing bleeding*
OBSTETRICS
Trial of instrumental birth
Vaginal twin birth
Caesarean birth at full dilatation
Caesarean birth for women with a BMI >40
Caesarean birth for transverse lie
Caesarean birth at <32/40
Vaginal breech birth
3rd degree perineal tear repair
GYNAECOLOGY
Diagnostic laparoscopy
Laparoscopic management of ectopic pregnancy

** This includes women in early pregnancy. Consultants should be informed earlier than 1.5 litres if the woman is haemodynamically unstable, has a low body weight, has a low starting haemoglobin, if there is a rapid rate of bleeding or if there are other complexities regarding her care. Should the consultant choose not to attend in person, there should be a full discussion regarding resuscitation of the patient and ongoing management. This should be documented along with the reasons why the consultant has not attended.*