



LOCUM SURGEONS

PRINCIPLES AND STANDARDS



Introduction

Locums are an essential part of life within the NHS. Resources do not allow for staffing levels that would mitigate expected and unexpected periods of absence or higher demand and locum surgeons therefore constitute a valuable section of the surgical workforce.

Patients should be able to expect the same standard of treatment whether this is delivered by a locum or a permanent member of staff.

This document outlines the principles and standards expected both of trusts that engage the services of locum surgeons and locum surgeons themselves.

The College expects locum surgeons to comply with the standards in *Good Surgical Practice*. However, this document provides greater detail on how standards apply to locum surgeons, especially in relation to revalidation.

It is important to note that the management of short-term locum appointments versus long-term locum appointments is quite different. This document highlights these differences where they are relevant.

Who should read this document?

- » Locum surgeons
- » Surgeons with management/supervisory responsibilities to appoint locums
- » Trust human resources staff
- » Locum agencies

Existing guidance

Trusts, locum agencies and locum surgeons should ensure they are familiar with the following guidance:

- » Department of Health. [Locum Consultant Appointments](#). London: DH; 2010.
- » NHS Employers. [The Use of Locums: Advice for Employers](#). Leeds: NHS Employers; 2009.
- » NHS Executive. [Code of Practice In the Appointment and Employment of HCCHS Locum Doctors](#). Leeds: NHS Executive; 1997.

Who should be a locum surgeon?

Locum surgeons should only be engaged to undertake work appropriate to their level of training and experience.

Locums are usually employed because there is pressure on staffing. Therefore, it is important that they have appropriate experience and skills for the grade in which they are employed.

Locum consultant surgeons should be on the specialist register.[†]

The term ‘consultant surgeon’ is well known by patients and carries significant weight. It is important that there is consistency over what it means to be a consultant.¹ For this reason the College standard is that only surgeons on the specialist register (or those within six months of receipt of their Certificate of Completion of Training (CCT) and hence eligible to apply for substantive consultant posts) be appointed to locum consultant positions.

The College is aware that not all locum consultant surgeons that are appointed are on the specialist register or are within six months of obtaining their CCT. However, we would expect this practice to be phased out and for

[†] Prior to 1997 it had been possible to be appointed as a consultant in oral and maxillofacial surgery (OMFS) with only a dental qualification. There was no specialist list of OMFS attached to the dental register. Since these individuals did not hold a medical qualification, they were ineligible for entry to the medical register or its specialist list. Therefore, the [General and Specialist Medical Practice \(Education, Training and Qualifications\) Order 2003 \(statutory instrument 2003/1250\)](#) provided a special exception for any oral and maxillofacial surgeon holding an NHS consultant post prior to 1997 so that he or she could be appointed to a consultant post without being entered on a specialist list. While there were only a small number of consultants who met that criterion, they should be entitled to be appointed as locum consultants despite not having been on the specialist list in OMFS.

the surgeons concerned to seek to obtain a CCT or Certificate of Eligibility to the Specialist Register and for their colleagues to support them in this.

Length of locum appointments

Short-term cover should be covered by existing staff by rearranging rotas.

If possible, it is preferable that surgical cover is provided by surgeons from within the department who are familiar with the hospital, its processes and staff. If this is impossible, surgical departments should seek to develop relationships with locums so that, when their services are required, their familiarity would enable a better and safer performance.

Locum appointments should not be for more than one year.

If there is a need for long-term surgical cover it is far better if surgeons are engaged in substantive posts that provide stability for the department. Locum surgeons should be appointed for no more than 6 months initially with the possibility of a 6 month extension, leading to a maximum appointment term of 12 months.

NHS Executive guidance² advises that consultant locum appointments be made for no longer than six months. Posts may be extended by a further six months subject to a satisfactory review by the trust and in consultation with the College.³ This principle should be extended to all non-training posts.

Many long-term vacancies can be planned, for example vacancies arising from maternity leave, planned sick leave or sabbaticals. In addition, locum appointments that start off as short-term appointments may develop into

long-term appointments, eg if a permanent staff member is taken ill and it becomes clear that there will be a lengthy recovery period. A recruitment process should begin as soon as it is apparent that the appointment will be of a long-term nature.

How should locums be engaged?

Pre-employment checks

The employing trust is responsible for ensuring that pre-employment checks are carried out.

The lead consultant surgeon within a department (or the chosen deputy) should be consulted on the checks to judge for appropriate training, qualifications and experience.

Locum consultant appointments should always have been subject to an assessment in the form of an ‘appointments’ committee by two professional members, one in the specialty concerned.³

Before a locum is engaged a number of checks should be carried out to ensure that the surgeon is suitable to work in the role. Checks should include:[†]

- » immigration rules and regulations
- » fitness to work and immunisations
- » criminal records disclosures
- » professional qualifications
- » appraisal/ revalidation

[†] Based on list provided by Buying Solutions. See <http://www.buyingsolutions.gov.uk/services/ResourcingServices/resourcingsolutionshealth/medicallocums/>

- » training
- » experience.

A consultant surgeon from the relevant specialty should be consulted on the last three of these points to assess the professional suitability of the applicant for the post.

Recent NHS Employers guidance on Criminal Records Bureau (CRB) checks⁴ outlines the requirements for locum doctors. In brief, it states that 'locums [...] should be checked, as a minimum, at least once a year. The employing organisations must obtain written confirmation from the agency that an appropriate check at the correct level has been carried out in that 12-month period.' This check takes the form of a new, enhanced CRB disclosure.

Agencies

Where a locum agency is used it should be either:

- » **NHS Professionals; or**
 - » **an agency that is a member of the National Framework Agreement.[†]**
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If a different agency is used the trust should demonstrate that the agency carries out checks to the same standards as those above.

Trusts may need to rely on agencies to help them source locums. They will also rely on agencies to present candidates that meet the pre-employment checks (although the responsibility for this check still rests with the trust). The Buying Solutions National Framework Agreement provides a service for trusts

[†] The list of Buying Solutions medical locum suppliers can be found here: <http://www.buyingsolutions.gov.uk/categories/Professional/publications/>

to identify agencies that can supply relevant staff and also the assurance that they have been audited by the Buying Solutions audit team

Supervision of locums

All locums must have an induction before they begin work.

The detail of an induction programme will depend on the locum's previous experience of the department and supervision arrangements. However, all locums should be briefed on current issues before starting work.

Locum consultants who are on the specialist register should be mentored by a named senior consultant in the department.

A locum consultant who is not on the specialist register should be supervised by a named consultant.

Non-consultant grade locums should be supervised by a named consultant from within the relevant department.

Medium or long-term locums should be fully integrated into team activities.

In order for locums to be fully effective and for the department to provide a high-quality, safe service locums should be included in team activities including (but not limited to):

- » multi-disciplinary team meetings
- » audit meetings
- » morbidity and mortality meetings

- » educational sessions
- » planning meetings.

Standards of practice for locums

Locum surgeons are expected to practise to exactly the same standards as all other surgeons.

There are various standards documents produced by the College and specialty associations but the most comprehensive collection of professional standards is contained in [*Good Surgical Practice*](#).⁵

This section outlines some of the key areas of [*Good Surgical Practice*](#) that have particular relevance for locum surgeons.

Handover

It is extremely important that locum surgeons who are engaged for short periods of cover understand and follow the local handover protocols in the hospital in which they are working. Locum surgeons are responsible for asking for guidance if they do not know or do not understand the protocols. Surgeons who work with the locum surgeon are responsible for ensuring that the locum is aware of these protocols.

In addition, [*Good Surgical Practice*](#) requires that all surgeons:

- » must arrange safe and effective cover and handover for the assessment, treatment and continuing care of emergency and elective patients for whom they are responsible.
- » must ensure the formal handover of patients to an appropriate colleague following periods on duty.

- » must be aware of protocols for the safe transfer to another unit of emergency patients when the complexity of the patient's condition is beyond the experience of the admitting surgeon or the resources available for his or her proper care.
- » must delegate assessment or emergency surgical operations only when they are sure of the competence of those trainees and staff and associate specialist grades to whom the patient's operative care will be delegated.

Record keeping and post-operative care

Locum surgeons who are engaged for short periods of cover should ensure that their instructions for post-operative care are unambiguous and clearly recorded so that care can be maintained by another doctor after their posting has ended. *Good Surgical Practice* offers some guidance:

Ensure that there are legible operative notes (typed if possible) for every operative procedure. The notes should accompany the patient into recovery and to the ward and should be in sufficient detail to enable continuity of care by another doctor. The notes should include:

- » date and time
- » elective/emergency procedure
- » the names of the operating surgeon and assistant
- » the operative procedure carried out
- » the incision
- » the operative diagnosis
- » the operative findings
- » any problems/complications
- » any extra procedure performed and the reason why it was performed
- » details of tissue removed, added or altered
- » identification of any prosthesis used, including the serial numbers of prostheses and other implanted materials

- » details of closure technique
- » postoperative care instructions
- » a signature.

Continuing professional development (CPD)

Locum surgeons are not exempt from CPD requirements. If a doctor expects to be engaged in locum work then his or her personal development and CPD plans should reflect this. It may be that the locum surgeon's CPD activities relate to a broader range of clinical activities compared with substantive appointments because he or she needs to maintain a broader range of practice in order to obtain locum work.

New techniques

Good Surgical Practice identified new techniques as including 'the introduction of a procedure not previously performed in the trust/organisation'. Locum doctors may have training and experience in a particular technique but this technique may not be a usual procedure for the hospital in which they are placed and the relevant equipment and appropriately trained staff may not be available. When in doubt, a locum should check with his or her supervising surgeon before proceeding.

Working with more junior doctors

Locums may be involved in the day-to-day training of junior doctors under the supervision of an approved educational supervisor or clinical supervisor. Locums should be careful when delegating duties and responsibilities making sure that they only delegate to those specialist trainees and foundation doctors or other doctors whom they know to be competent in the relevant area of practice. If the locum surgeon is not familiar with the competencies of junior staff he or she should get advice from their supervising consultant surgeon or undertake the task personally.

Standards for surgeons working with locum surgeons

Consultant surgeons practising in the same specialty, or the specialty nearest to that of the locum concerned, must ensure that the locum is:

- » fully conversant with the routines and practices of the surgical team;
- » familiar with, and takes part in, the audit processes of the unit;
- » not isolated and knows whom to approach for advice on clinical or managerial matters; and
- » not required or expected to work outside his or her field of expertise.

A locum consultant, not on the General Medical Council specialist register, must be under the supervision of a named substantive consultant in the same specialty. All locum surgeons should be mentored by a more senior member of the department.

Requirements for revalidation

All locums are subject to revalidation.

All locums must have a responsible officer.

According to the responsible officer regulations,⁶ locum surgeons will relate to a responsible officer as follows:[†]

- » If the locum surgeon is employed by an NHS trust that trust will provide a responsible officer and appraisals.
- » If the locum surgeon is not employed by the NHS in any capacity but is employed by NHS Professionals or one of the agencies covered by the Buying Solutions National Framework Agreement then NHS Professionals or the agency will provide a responsible officer.

[†] This is the case for England and Wales. Northern Ireland and Scotland have different arrangements.

- » If neither of these apply, then the responsible officer will be provided by the primary care trust local to where the surgeon lives.†

Responsible officers with responsibility for locum surgeons should read this document and apply the principles and standards when making revalidation decisions.

Responsible officers appointed by locum agencies should be independent from the locum agency board so as to mitigate conflicts of interest.

All locums must have an annual appraisal in every year that they work.

Locums should participate in whole practice appraisal, ie appraisal that covers all the work the locum has done as a doctor in all the places he or she has worked.

Locum surgeons should seek to provide the same kinds of supporting information as all other surgeons for their appraisal. However, it is likely that locum surgeons and their appraisers will need to make pragmatic decisions about what is possible to collect. There is no single method of obtaining supporting information and there will be sufficient flexibility in the final revalidation system to allow for substitutions of suitable supporting information. Depending on the pattern of a locum's work it may not be possible to derive information from trust clinical governance systems for his or her locum postings. It would be sensible to use exit reports as a source of supporting information. Exit reports should be completed at the end of every posting. A sample exit report can be found in the NHS Executive's guidance

† It has been announced that primary care trusts will be abolished. The details of future arrangements are yet to be fully defined.

document *Code of Practice In the Appointment and Employment of HCHS Locum Doctors.*²

The GMC and NHS Professionals⁷ carried out a project using a small sample of locum doctors to identify what challenges revalidation would present. CPD, audit and clinical governance data were identified as the most difficult to generate. The College considers CPD to be a fundamental part of being a professional and the CPD requirements are set at a level that should be achievable by locum doctors in their non-working time.

Further work may be necessary to consider how locum doctors can best participate in audit and obtain clinical governance data. However, all locum surgeons are urged to keep their own records and undertake personal audit and would be expected to participate in any departmental or national audits while undertaking their locum post.

Locums should keep a personal portfolio of supporting information.

The nature of locum work tends to be peripatetic and for this reason locums should keep a personal portfolio. Locums cannot rely on data from employing trusts because this may not be readily available to them. Items of potential supporting information, including end of posting reviews, should be annotated and saved for later use. The College offers an online portfolio for this purpose: www.surgeonsportfolio.org.

Operations performed by locum consultants should be coded under their own GMC number. All locums should be added to the trust's systems. Often there are delays and activity is coded against a substantive consultant; where this occurs, the trust and locum should note this and ensure that retrospective corrections occur.

Further reading and guidance

Medical locums. Buying Solutions. <http://www.buyingsolutions.gov.uk/services/ResourcingServices/resourcingsolutionshealth/medicallocums> (cited 6 April 2011).

Department of Health. [*Locum Consultant Appointments*](#). London: DH; 2010.

Department of Health. [*The National Health Service \(Appointment of Consultants\) Regulations: Good practice guidance*](#). London: DH; 2005.

General Medical Council, NHS Professionals. [*GMC and NHS Professionals Revalidation Project Final Report*](#). London: GMC and NHS Professionals; 2009.

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The Royal College of Surgeons of England. [*An overview of revalidation for surgeons*](#). London: RCS; 2009.

The Royal College of Surgeons of England. [*Good Surgical Practice*](#). London: RCS; 2008.

The Royal College of Surgeons of England. [*Surgical titles in the NHS: Position statement*](#). London: RCS; 2010.

Revalidation. The Royal College of Surgeons of England. <http://www.rcseng.ac.uk/revalidation> (cited 6 April 2011).

List of standards in this document

Employment

Locum surgeons should only be engaged to undertake work appropriate to their level of training and experience.

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Short-term cover should be covered by existing staff by rearranging rotas.

Outside cover should be sought from surgeons familiar with the department.

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References

1. The Royal College of Surgeons of England. *Surgical titles in the NHS: Position statement*. London: RCS; 2010.
2. NHS Executive. *Code of Practice in the Appointment and Employment of HCCHS Locum Doctors*. Leeds: NHS Executive; 1997.
3. Department of Health. *The National Health Service (Appointment of Consultants) Regulations: Good practice guidance*. London: Department of Health; 2005.
4. NHS Employers. *Criminal record checks*. Leeds: NHS Employers; 2010.
5. The Royal College of Surgeons of England. *Good Surgical Practice*. London: RCS; 2008.
6. The Medical Profession (Responsible Officers) Regulations 2010, SI 2010/2841.
7. General Medical Council and NHS Professionals. *GMC and NHS Professionals Revalidation Project Final Report*. London: GMC and NHS Professionals; 2009.



The Royal College of Surgeons of England
35–43 Lincoln's Inn Fields | London | WC2A 3PE
www.rcseng.ac.uk | registered charity no 212808