Medical Xpress

Working arrangements for locum doctors pose significant patient safety challenges, finds study

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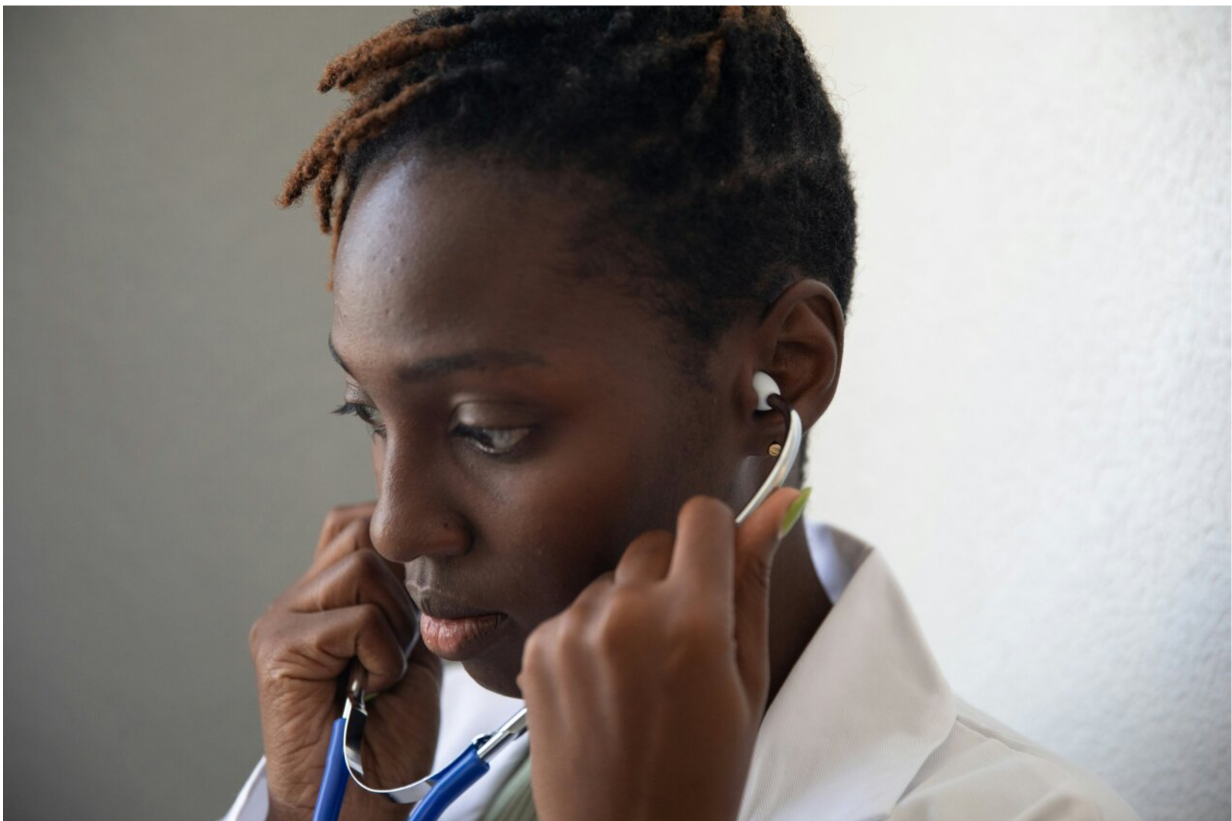

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Working arrangements for locum doctors pose significant patient safety challenges for the NHS in England, although there are opportunities to

be grasped too, finds qualitative research involving a broad spectrum of health professionals, published online in the journal *BMJ Quality & Safety*.

NHS leaders need to rethink how these professionals are engaged, supported, and used, while health care organizations and locums themselves need to reflect on whether their practices provide a collective approach to patient safety and quality of care, conclude the researchers.

Locum doctors are a vital resource that enable health care organizations to deliver care by flexing capacity and covering staffing gaps, and the need for them is expected to increase given the projected increase in the NHS vacancy rate, say the researchers.

But despite longstanding concerns among policymakers, health care providers, professional associations, and professional regulators about the implications of locum working for quality and safety as well as cost, there is limited good quality empirical research to substantiate these concerns, they add.

In a bid to build on the evidence base, the researchers looked at how locum working arrangements might impact quality and safety and the implications of locum working for patients, locums, and health service organizations in primary and secondary care in the NHS in England.

They carried out semi structured interviews and focus groups with 130 people between March 2021 and April 2022. Participants included locums, patients, permanently employed doctors, nurses, and other health care professionals with governance and recruitment responsibilities for locums across NHS primary and secondary health care organizations in England.

The responses were divided into common themes, the first of which was

familiarity with an organization and its patients and staff, which was seen as essential to delivering safe care.

Locums described how they often worked in unfamiliar environments, sometimes with minimal induction and varying levels of support. Unfamiliarity, lack of access to, or other restrictions on computer systems, policies, procedures and buildings meant that they weren't always able to do their job safely, productively, or effectively, they said.

The balance and stability of services reliant on locums were perceived to be at risk of destabilization and lacking leadership for quality improvement.

Locums were less likely to be involved in team and organizational development. They recognized that having "an NHS run by locums" was detrimental to quality and safety, and departments that were disproportionately dependent on them were often perceived to lack clinical leadership and direction which meant that quality improvement was slower or less likely to happen.

And the discrimination and exclusion experienced by locums were detrimental to morale, retention, and patient outcomes.

Most locums described negative behaviors and attitudes from staff and some patients, which affected their involvement, inclusion, and experiences in organizations. Negative perceptions of competency and safety meant that locums were often stigmatized, with ethnicity and gender further worsening discrimination.

Locums were viewed as practicing defensive medicine as a result of their perceived increased vulnerability and low levels of support. And locums recognized that they were likely to be scapegoated if things went wrong; some described being more likely to practice defensively as a result.

Locums also felt they were more vulnerable to criticisms of their clinical competence and disempowered to make decisions. Other staff felt that some locums were simply avoiding work and evaded responsibility for patients by pushing work onto others or into the future.

Clinical governance arrangements often didn't adequately cover locum doctors. Responsibility for involving them in performance feedback, supervision, educational opportunities, appraisal, and quality improvement was unclear.

While some organizations included locums in their governance activities, others regarded locum work as transactional–where the locum was there merely to provide a finite service. Where complaints arose, the doctor had often moved on and was unaware of the concerns.

"Our findings provide some profound and concerning insights for patient safety and quality of care. The ways in which locums were recruited, inducted, deployed and integrated, and supported by organizations undoubtedly affected quality and safety," write the researchers.

"Our findings indicate that regardless of their level of experience, it was unlikely that locum doctors would be able to function optimally in unfamiliar environments; and organizations who had poor supportive infrastructure and governance mechanisms for locums were less likely to deliver high-quality safe services," they add.

"Our findings are a call to action for organizations to take stock of how they engage, support and work with locums, and ask both locums and organizations to reflect on whether their practices support a collective approach to patient safety and quality of care," they conclude.

In a linked editorial, Professor Richard Lilford of the University of Birmingham, comments that the evidence presented by the study

"suggests that locum doctor arrangements are unkind and unfair, and potentially harmful to patient safety," and that "the life of the locum is a difficult and lonely one"

He suggests some potential solutions, based on the premise that locum services are essential. "There nevertheless seems to be a good case for bearing down on the market and strongly encouraging all posts to be filled with non-locum staff—less money spent on locum doctors with more money for the substantive posts."

"Inspection processes could monitor the use of medical locums and nudge hospital managers to model their workforce requirements to find the optimal balance between substantive and temporary posts," he adds.

"Because locums find it hard to adapt to different procedures and protocols, organizations could be incentivized to standardize," he suggests. A bespoke induction when locums join a clinical service and awareness raising among other staff of the sorts of issues locums face could help to tackle the isolation and discrimination they face, he says.

Routine structured feedback to locum agencies and feedback from the doctors themselves about the organizations and teams in which they work could also prove invaluable learning points for all concerned and enhance patient safety, he adds.

But change won't happen by itself, he acknowledges. "I recommend that, in England and beyond, design groups should be formed including policymakers, service managers, local agency managers and public contributors to develop a set of workable solutions for subsequent piloting, careful evaluation, and later implementation," he writes.

The study findings "should not be simply curated among the voluminous safety literature. [They] should be considered as a call to action by senior

policy makers," he advocates.

More information: Locum doctor working and quality and safety: a qualitative study in English primary and secondary care, *BMJ Quality & Safety* (2024). DOI: 10.1136/bmjqs-2023-016699

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