Healthcare People podcast, brought to you by NHS Professionals

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Looking after locums: why doctors locum and the support they need to work safely

Hello, I'm Jamie Garnett from NHS Professionals, and welcome to Healthcare People. This is the podcast where we talk about everything health and care workforce: the challenges, the opportunities, and the future. In this series, we'll discuss the workforce pressure points for NHS trusts and integrated care systems and look at where positive change is possible.

This episode features Dr. Helen McGill, Medical Director at NHS Professionals. We'll be talking about the ways we support locum doctors to deliver safe and high-quality medical care.

Welcome and medical career overview

JG: Helen, welcome to the Healthcare People podcast. I'm delighted to see you today. And I can safely say we have a doctor in the house. You've had a very diverse career in medicine. So can you give us a quick overview of your professional journey to where you are today?

HM: Happy to do so. I came to medicine a little bit late because I did dentistry first. And I was training to be a maxillofacial surgeon and then had a career change and decided that wasn't for me. I actually trained as a GP and did a lot of work in emergency department at the same time. And I worked in primary care as a general practitioner in a busy city sort of GP surgery. I did a lot of work. During the old days people possibly will remember that I did PCG PCT CCG, and then I got to a certain stage I thought I needed to change.

I saw an advert for responsible officer role with NHS Professionals. And I applied for that role, didn't know what it was, didn't know what the responsible officer was at the time, and did a lot of research. That was back in 2011, really when the responsible officer role started with the introduction of the regulations and the revalidation processes. That's when I started working at NHSP and I've been there since then. The workload has increased to begin with, we had nine connected doctors and now we've got nearly 360 connected doctors. It started off with one day a week and now I work four days a week and I love it.

Doctor appraisal and revalidation

JG: That's great to hear. And obviously with the appraisals and revalidation process, you know, evidence is absolutely key to that. So there must be a huge amount to co-ordinate and work with the doctors themselves to manage that and to make sure they've got everything that they need?

HM: It’s fairly well defined because it's regulated by the regulations which are part of the medical act. The whole appraisal revalidation process is quite formulaic, but the doctors are different. You have to accommodate processes to support the doctors and we clearly we work with locum doctors, and sometimes they are in different situations, they're not always in a stable working sort of situation. We tailor our processes to support them as a specific group to meet their professional obligations and the GMC requirement to have an annual appraisal and revalidation.

We try to hold hands. We get a lot of doctors come to us who are new to the country, have no experience of the concept of revalidation. We get a lot of junior doctors that join us who have just come through foundation training, again, who have been very, I wouldn't say spoon fed, it's the foundation training. They have a slightly different sort of process for their annual

appraisal. And they come to us and we help them understand what they need to do. And we help deliver that process for them and we support them. And I think we do that very well.

Doctor heal thyself: learning how to support doctors

JG: Did you ever feel that you as a doctor needed more support when you worked on the frontline? And if so, what kind of support did you need?

HM: I think the support you need varies with the level of experience that you've got. Junior doctors possibly need, probably do need more support and guidance. And the support can be in very many different facets. It's not just all about educational support, it can be mentorship, career development, dealing with personal issues. The support is quite a difficult question because the support is multifaceted. And we have a very heterogeneous group of doctors and…we have a big flux of doctors that join the organization and leave the organization. Every day we learn about our doctors, we learn about their issues.

From my point of view, the support I needed may be clinical support. If you had a clinical issue that you wanted to discuss with a colleague or personal issue that you wanted to discuss, I think doctors do find that quite difficult, because they tend to sort of be used to looking after people. They're not always the best at seeking help and support. So yeah, I think it varies with your role. It varies where you are, it varies what you're doing. And it varies the level at which you're doing it.

JG: I think it's obviously well known that people turn to doctors for a whole range of support throughout their lives. But the idea that doctors themselves will need different levels of support during their careers is perhaps not so well known to those outside health care. For example, we've seen doctors' mental health come much more into the spotlight since the pandemic. Do you agree that we don't tend to think of doctors as people in need of support themselves? And if so, why not?

HM: It's very complex, isn't it? I think doctors themselves find it difficult to reach out for support. We're sort of trained to be very, how can I say…to deal with emergency situations, to deal with chronic conditions, to deal with stress, to absorb those things for your patients. It's sometimes very difficult to recognize if you need to reach out for help as an individual, and then it's very difficult to know where to reach out for help. I think it's getting better with the younger generation. I'm a bit of an old dinosaur. So, you know, we were sort of, you just get your head down, and you do the work. And you know, nobody has emotional problems.

I think it is better now, but I think it's still difficult for doctors, because it may be seen as a sign of frailty, or it may be seen a sign of weakness. And I don't think people always have their ears open to listening to what doctors are saying all the time to hear. If there are issues, we give them that opportunity in the appraisal process. We use a form in the appraisal process that has a specific section about wellbeing, it was really designed coming out of COVID. There are a lot of issues that arose during the pandemic, particularly with the workforce that I work with, who were quite severely impacted in the ability to work for various reasons.

We do have a section in our appraisal process that looks at impact of those things, and what help people need and how can we support them. There's a limit to what we can do - we can signpost people in the right direction, we do have support structures, but sometimes it's just giving people the opportunity to open up and discuss issues in a safe space that sometimes it's the most useful for individuals who've come to that situation. And if you've got the right sort of a place, they'll be able to pick up on those vibes and encourage people to talk about those things.

JG: And do you think that development will continue? There is much more discussion about, for example, mental health. Do you think that's a good thing for doctors?

HM: I don't think it's a bad thing. I think it's really difficult because doctors are used to the doctor/patient relationship. And so it's difficult for them to be put in the patient role. And to switch that sort of psychology, that mentality, into the receive rather than transmit mode, so to speak. I think there's a bigger awareness. Now, I think there is a generational difference. The way junior doctors work now may be different than the older generations. So I do think there's an awareness there. And there has to be a process whereby there's a freedom to express those feelings that a doctor may have, without having any stigma attached to it. But I do think that those things are getting better.

Support for international doctors

JG: We work with a lot of international doctors. What kinds of support do international Doctors need specifically, if any? Are there any differences?

HM: There's a lot of work being done on this. And [Professor] Mala Rao from Imperial [College London] did a lot of work with NHS England, which I was involved in, to on acclimatization and induction of overseas doctors because, I mean, who understands how the NHS works? You know, it's a complicated work environment. There are complicated relationships within a work environment. And I think sometimes doctors need support into soft landing into the NHS to learn that it is appropriate to ask for help. It is appropriate to say I can't do this, it is appropriate to say I need help because I can't deal with 10 people at the same time. Go and get help.

And I think sometimes it may be that there are differences in how things are done, and attitudes to addressing seniors or juniors, that people need permission to say, it's all right to say, I haven't got the bandwidth to deal with three acute situations at the same time - call for help. Because it may be that it's seen as a sign of weakness if you call for help, but actually, it's a weakness if you don't call for help. A lot of it is giving people permission to say, hands up, I'm out of my depth, I need some help, can you teach me how to do this? Can you get me some help?

So I think there are very subtle differences. I think the core knowledge is very similar. I deal a lot with UK citizens who studied medicine in Europe. And there are differences in their training to UK training, which we can quickly support in bridging the gap. And we do that I think very efficiently. But I think it's maybe acknowledging those differences, recognizing those differences, and giving people permission to be different. You know, you're bringing a skill, you're bringing your experience, goodness me, you've probably had masses more clinical experience than a lot of UK doctors. But at the same time, how we operate, how we work has sort of tribes within the hospital. Maybe that's what they need support with, that we try to help them with.

NHS Professionals and the locums we work with

JG: Turning to the kind of work that we do with doctors in the NHS. And just for context, can you first briefly describe the types of doctors that we work with the most? At NHS Professionals we work with locums, but can you just kind of quantify that group a little bit?

HM: It’s a very heterogeneous group working across all specialties at all levels, across all geographical locations in the country. We are based in one particular spot in the country, we are not on site to support those doctors, so whatever we do is done at arm's length. And we rely on the Trusts to support the doctors when they're in post doing locum work as much as

possible. We've got overseas doctors, I think probably about 40% of all our connected doctors…we get a lot of UK doctors…we have more doctors working through NHS Professionals than are connected to us because a lot of doctors will have be working substantively somewhere else and they choose to do some extra sessions.

The connected doctors are a high flux group of people. I think we have something like 350 doctors connected to us every year, and 350 doctors disconnect with us. So it's quite difficult to form, not meaningful relationships, but long-term relationships, with those doctors. But that's the nature of what the doctor wants to do. They come into the local workforce. They either leave the country or they get to substantive posts, they get training posts. It is a very transient community of doctors.

Why doctors choose to locum

JG: What have we learned? What have you learned about why people become locums?

That's the $64 million question, isn't it? Really, there are lots of reasons… how they come to us the locums, some of them have been in training posts. And they just decided they want a change in career. They don't know what that change is going to be, so they opt out of training and they come. Everybody needs to earn an income. They come and work through NHS Professionals as locums for a time. We get junior doctors who've just completed foundation training, who maybe didn't get the training post or the training number they wanted, or don't quite know what sort of specialty they want to go into, so they'll step aside and maybe take 12 months. And that's happened a bit more because pre-COVID a lot of doctors used to go, post foundation, go off to Australia, do some work there, go around the world. And now people are staying at home a bit more. That's my impression anyway. So we get those very junior doctors who are trying to earn an income haven't yet decided what route they want to take. A lot of the international medical graduates come and work through us because they do find it difficult sometimes to get substantive posts. There are lots of reasons…everyone's different. I bet we could look at all [our] doctors and they all have different reasons.

Support for locums

JG: What do you think the key challenges are facing locums in your experience and what are they reporting back to you? What kinds of support do they need as a group?

HM: That's quite a complex question. I have been involved in work with NHS England developing support programs for local doctors. A lot of it can be - at the risk of being a bit controversial maybe - attitudes towards locums and how they land and how they're supported and how they are sometimes excluded from career development opportunities, from networking opportunities. We pick a lot of things up for these doctors where they go into a Trust, ‘it's just the locum’, you know, ‘they're learning more from me, they should be able to do it.’ In a nice environment, and I think most places are like this, they would be met, they would have a mini induction into the environment in which they would be working, they'd be shown where…the blood testing equipment was, how to escalate things…some locums tend to be in a position for quite a long time. They can work for 10 years as a locum in the same Trust, get on perfectly well and forget they’re locums.

I've had other locums, I've read the appraisals…I had one locum who was working in the emergency department at night time on permanent nights and never met another doctor. So clearly that isn't tip top, you know, and clearly, that can be corrected. It doesn't mean anybody at the Trust knew that was happening. It just came up at an appraisal, and we managed to discuss that situation with the medical director and the clinical director at the

Trust. That doctor was then included in the multidisciplinary team meetings and the learning sessions and was put into different sort of safe clinical environments and not in that isolated position. You get best practice and you get not so best practice. And I don't think there's a sort of generic identity to what that practice is. There is advice that's available on how to treat locums. And how locums should actually treat…how they arrive. We have a code of behavior from our doctors. And it's, you know, you turn up on time, you don't have any mobile phone. It's just common sense stuff. But you know, it's probably about mutual respect really.

Patient safety and locum capabilities

JG: What do you think are the most effective ways for both of us at NHS Professionals, but also the Trusts that locums working with, to provide them with that support? I mean, you just hinted at this idea of and this concept of belonging. So even if you're there for only a month, you want to feel like part of a team. Is that part of it?

HM: There's a vulnerability to locums because it's quite a transient lifestyle. Potentially, you don't know where your next locum shift is coming from, you could be replaced by substantive doctor anytime. But actually, trusts really do depend on filling gaps within rotas using locums. For me, the most important thing would be that the locum is well prepared for what they're going to be asked to do. So they have all the prerequisite qualifications and experience, but also for us to put the right locum in the right place, we need to have information on what the role they're going into would entail. The more information you can get on the situation, this is what we would expect this doctor to do at this level…You can look at that all the college frameworks, you can have an idea in your own head about what would be expected, but each Trust may have idiosyncratic things or different roles. It's good, from the supportive point of view, for the locums to know, okay, I'm going to this Trust, this is what's expected of me. And actually, for the locum to be honest and say, I don't think that's for me. You don't want people being put into situations where they're completely out of their depth, or unsupported, or don't know the escalation routes, don't know who to turn to for help.

We have a process which is unique to NHS Professionals that I developed…called the Medical Advisory Group, which is a group of senior clinicians we consult across a whole range of specialties across the country. If a doctor comes to us, we will - I don't hold all the truth scrolls, you know, I'm not a surgeon or a physician or cardiologist or pediatrician - we will actually send that CV…the doctor will say, I want to work as a consultant in paediatrics, so we will send that CV to one of our members of the Medical Advisory Group who will look at the CV, look at the references and say, actually this doctor should only be working at ST2 level, not a consultant. You have to have that sort rebalance reality check. That's where we take on the responsibility of saying to the doctor, you can work for us, but you will only work for us at this level, because that's where we believe your capabilities and competencies lie.

As an organization, we can hold our heads up and say, we have validated this doctor to work at this level, we've assured ourselves they have this level of experience. Now, that doesn't mean the doctor stays put at that level. If they work for us for a time and then they gain more experience, we can re-evaluate that and put them up to a higher level. I think that's the quid pro quo of the locum and the doctor and the Trust working together where they…we've got as much information on the doctor, we've got as much information on the role, and we can match that safely. The bottom line is patient safety so you can actually put people into the appropriate role.

JG: It sounds like that relationship with the medical directors is absolutely critical?

HM: Yes, critical. From my point of view is me building relationships with medical directors across the country. And it's not that you're on the phone all the time to them, it's just they hopefully trust me so that if I find out and say, you know, I'm just not happy with what's happening here, and we have a discussion, they go 'completely agree Helen, or you've lost the plot, Helen'. There's a mutual respect that I'm not trying to interfere in how your Trust works, I'm really trying to quality assure what we do for you and make sure that your patients are safe.

What do doctors care about the most?

JG: I wondered if you could single out the one thing that the doctors that you work with, in your experience, need above all else. The one thing that can make the biggest difference to their performance and overall wellbeing? What do they care about the most?

HM: I think insight - insight from us as an organization into how we can support them, the level at which we can support them, the extent to which we can support them. Insight from the Trust about what their needs are, what the best way [is] of getting the best staff to the locums by being very supportive, giving them learning opportunities. Treat them like your own doctors, don't treat them like a different tribe. And for the doctors to have insight that they have responsibilities in meeting their professional requirements and in going into Trust and behaving professionally, which they will do, but going in and having insight into their limitations and insight into having the power and the personal resilience and the strength to put their hands up and say that's not appropriate. This is outside my bandwidth for working.

JG: And if that's achieved, what is the chief benefit of that?

HM: Safe patients, and doctors working within their range of competencies and capabilities. There's always going to be locums, people like working as locums. But I would like to be able to support locums, who want to go down that route, into substantive roles where they have stability. Whether they have structured support in a location that is going to develop them through a different route is very difficult from a career developmental point of view for a locum, you require a lot of experience. You require a lot of practical skills if you're working as a locum, but you don't have a career structure. If I could say anything it would be yes, you're always going to need people to come in and pick up the workload when somebody is off sick, somebody is on maternity leave, you haven't recruited or any of the whole range of reasons why. But actually, to reduce the total number of locums and enable people to work safely and happily and have fulfilment from what they do - that's what my dream would be."

JG: Helen, thank you very much for your time, it was fascinating talking to you today.

HM: Thank you.

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