

Care Services Improvement Partnership 

National Institute for  
**Mental Health in England**  
NATIONAL WORKFORCE PROGRAMME

## **A Practical Guide for Handling Consultant Vacancies**

## **FOREWORD**

This practical guide to managing vacancies for psychiatrists (consultants and other grades) has been developed by Peter Kennedy and Stephen Humphries.

It deliberately takes a broad approach to filling vacancies in the context of New Ways of Working and workforce reform.

It forms part of a national initiative to reduce the costs and use of locums and to improve their quality when used. It was tested and endorsed by mental health medical directors, chief executives, human resources and other personnel working with the Locum Psychiatry Collaborative Group.

We hope it will prove useful to Medical and HR Directors, Medical Staffing Managers and others.

A handwritten signature in black ink that reads "Roslyn Hope". The signature is written in a cursive, flowing style.

**Roslyn Hope**  
**NIMHE National Workforce Programme**

## FACTS AND FIGURES

### Consultants - not as scarce as they seem

1. In 2005 there were 3399 established consultant psychiatry posts in England
2. Estimates of vacancy rates vary between 7 and 18per cent.
3. Variation in vacancy rates ranged from 1 in 6 to 1in 29 across SHAs\*
4. There has been a very substantial increase in new consultant posts in the last 5 years to staff new services such as Crisis Resolution, Home Treatment, Assertive Outreach and Early Intervention. The output of CCT holders has not been sufficient to keep pace, hence the vacancy rates have been slow to come down in response to a variety of recruitment and retention initiatives.

### Locums – potentially more problems than solutions

5. Locums may be less committed to local service development and there is strong anecdotal evidence that they use more beds.
6. Locums can be a major cause of financial deficits that divert money from service developments
7. College standards for the appointment of locums are rarely achieved.

### Recruitment - improving

8. A collaborating cluster of trusts in the North West:-
  - Accepts locums only from agencies that are compliant
  - With defined standards required for an appointment
  - At pay rates substantially reduced from the £80 - £100 an hour that was being charged before the collaborative started.
  - So several trusts saved around £1 million p.a. (Appendix A).
  - And now most SpRs are seeking substantive posts
9. Some medical directors are eliminating the need for locums by creative planning (Appendix B)
10. Recruitment is improving with the international recruiting and expansion of medical schools.
11. ***Agency supplied locum hours worked were halved between 2004 and 2006\*\**** .

## SHORT TERM SOLUTIONS TO VACANCIES

### Give yourself time

12. Give yourself as much time as possible by encouraging doctors to give as much warning as possible of their intention to leave.
13. Immediately the intention is signalled carry out an 'exit interview' to understand the reasons and whether there is action that could be taken to retain the leaver.
14. Promote the idea that the trust and its consultants are willing to consider job changes like reduced or no 'on call' to retain older consultants considering early retirement.

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\* & \*\* Detailed survey reports available from: [pasamedloc@pasa.nhs.uk](mailto:pasamedloc@pasa.nhs.uk)

### **The people you know**

15. Contact all retired consultants in the area and find out under what conditions each might consider coming back to work part time or as a short term locum. Keep an up to date contact list.
16. Carry out 'career planning interviews' with all SpRs after 6 months and repeat annually to ascertain what attracts or detracts each from continuing to work in the trust as an SpR and the conditions under which each would consider taking a locum consultant post or better still an established consultant appointment. Keep an up to date record.

### **Creative cover**

17. Remember, in both the old and new consultant contracts, there is a requirement for consultants to cover absent colleagues when practicable, for example in the case of sickness absence. (Appendix C).
18. Consider whether a consultant might agree to cover a larger area of responsibility with more support from other staff?
19. Consider whether consultants might club together as a team and agree a functional split of duties to cover the vacancy.
20. Consider all available staff, medical and non medical. Can a consultant or consultants cover a vacancy by having a network of other professions triaging cases and only engaging the consultant as a true consultant on the more complex cases (see below under new ways of working)?

### **Incentivise**

21. Have a clear policy agreed for additional remuneration of a consultant covering extra work due to a vacancy<sup>\*\*\*</sup>.
22. *Exhaust all other possibilities before going to a locum agency*, recognising that the high costs of locums provides a lot of possibilities for cheaper and safer options, that reward existing staff without abusing their goodwill, and without the disadvantages of having to work with a higher paid and potentially less committed colleague.
23. If you do use an agency locum take particular care that the locum is not working more hours or doing more on-call than is budgeted for – other staff making demands on a consultant may not realise the cost implications.

## **CONTROLLING THE QUALITY AND COSTS OF LOCUMS.**

### **Club together**

24. All MH trusts across three SHAs clubbed together and agreed standards and rates for the appointment of any locum. NHS Professionals acting for the trusts deals with only those agencies that have agreed to meet these conditions. Fewer agencies are now operating in the area. Locums are made available to trusts through NHS Professionals at short notice and at rates no higher than £50 per hour, at that time. (Appendix A example)

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<sup>\*\*\*</sup> Examples available from Christine Vize : [Christine.vize@nhs.net](mailto:Christine.vize@nhs.net)

25. There is a national drive led by DH and NIMHE/CSIP to encourage this kind of collaboration in other SHAs. Expert help in setting up such arrangements will be facilitated through NHSEmployers, working with NHSProfessionals and co-ordinated through a national collaborative group led by Roslyn Hope (NIMHE/CSIP) and Ron Shields (chief executive, Northampton Trust on behalf of the National Mental Health Partnership Group of Trusts).
26. The NHS Purchasing and Supply Agency (PASA) is responsible for the negotiation and management of a national framework agreement for the supply of medical locums. Within the agreement all locum agencies are audited and then selected on the basis of quality and value for money. Where the NHS is unable to meet a locum requirement internally or through NHS Professionals only those agencies working within the PASA Framework Agreement should be used.

### **Maintain your standards**

27. Many trusts consider the appointment of an agency locum to be such a quality and governance risk to patients that any appointment must be vetted and approved at the highest level by the medical director. Even when both the agency and NHS Professionals have made it clear that a doctor does not meet agreed standards of the collaborating cluster, appointments have sometimes gone ahead when only the approval of a junior manager has been required in a 'friday night emergency'. At the very least it is recommended that a procedure is agreed for high level early scrutiny when a candidate has not provided clear evidence of meeting the trust's standards for appointment.
28. It is recommended that any locum appointment should be short term and time limited whilst better options are being pursued. It is essential that telephone references are sought for locums who are not known.

## **USING THE POTENTIAL OF NEW WAYS OF WORKING**

### **Use new guidance**

29. There is now commitment from RCPsych., BMA, DH, NIMHE/CSIP, and the GMC to support a change in role whereby the consultant focuses on complex cases, has a smaller case load, and is available to advise other professionals when asked. The Joint Guidance on Employment of Psychiatrists (DH 2005) describes this approach in detail.
30. Where there are significant vacancy rates and posts difficult to fill, one option to consider alongside that of replacing an existing consultant is that of looking at redesigning all consultant roles, shifting to New Ways of Working throughout the service (examples in the final report DH 2005) and potentially providing a higher level of consultant input to teams with possibly a smaller number of consultants. This approach though is not a way of cutting consultant numbers or encouraging managers to look at cheaper options for staffing services. It may be harder to do this in smaller Trusts, but mergers are creating a critical mass of consultants where this approach can be used.
31. New GMC guidance on 'medical responsibility' to support consultants and other professions in this change is now published (Appendix D). Coroners are being educated about the new limits on the responsibilities of consultants.

### **Involve people**

31. First, set up a process involving consultants and other professions in workforce planning with the early agenda focusing on alternatives to locums by redistribution of work and new ways of working.
32. Second, obtain commitment of the trust board by seeking approval of an employer's policy that supports clinical staff in adopting NWW.
33. Third, arrange visits to trusts with successful role models already working in this way.

### **Grasp opportunities**

34. Necessity being the mother of invention – use vacancy crises as opportunities to make an immediate shift to NWW with promises of careful evaluation and earlier review if there are problems.
35. Pilot a planned whole sector shift to NWW involving staff who are ready for change, to convince more conservative elements.

## **CREATING THE CAPABILITY FOR CONTINUAL CHANGE.**

### **Like diamonds – change is forever**

36. Convince everyone of the obvious need for continual change in working practices to cope with the constantly changing configurations of services and organisational structures. In the past there has been plenty of the latter but with such inertia with respect to the former that opportunities may have been reduced for improving working lives, or the quality of the services patients experience.

### **Develop leaders at all levels**

37. Give priority to development of multi-disciplinary team leaders, clinical and service directors, and the medical director. The need for excellent leadership at all levels will be more and more important to achieve what Charles Handy defines as the essence of effective leadership: *“To combine the aspirations and needs of the individuals with the purposes of the larger community to which they belong”*.

### **Thinking far ahead**

38. The medical director needs to be anticipating what will be required in 5 to 10 years time, carefully devising the workforce plan, and preparing everyone for its implementation in good time. A medical director who is preoccupied with the urgent (filling a vacancy) rather than the important (forecasting and planning for scarcity) will be failing in the core responsibilities of the job - to make sure that clinical work can be delivered efficiently and safely within budget.

**NOV 10 2006**

## APPENDIX A

### THE NORTH WEST COLLABORATION OF TRUSTS TO CONTROL THE QUALITY AND COSTS OF LOCUMS

Over the past 3 years, the 9 mental health trusts in the North West have collaborated on managing the use of locums, particularly at consultant grade. The collaboration was endorsed by the Strategic Health Authorities and has strong local leadership. A time limited task group of Medical Directors, Finance Directors and Human Resources Directors from each trust, and representatives of NHS Professionals (NHSP) established common standards for a unified approach.

A plan was formulated to take advantage of the new locum consultant contract and to use NHSP as the prime supplier of locums. An hourly rate of £50 was agreed as an appropriate amount for consultant locums at that time and also the standards required for engaging agencies and appointing locum doctors. The possibility of large numbers of locum consultants leaving the region in search for higher paid work elsewhere did not occur. Most existing locums have remained within the trusts and taken trust contracts. The approach has been well received by consultants in the region. Specialist registrars within the region are now keen to find substantive consultant posts locally.

During this period the trusts have employed International Fellows who have provided excellent care for the duration of their 2 year contract. Additionally, a number of specialist registrars have acted up for 3 months in their final year of training, and this is an initiative strongly supported by the Deanery.

#### OVERALL BENEFITS

The initiative has undoubtedly led to better working relationships between the different mental health trusts. The task group continues to monitor progress. Governance arrangements for medical staff have improved, and the use of NHSP as a prime supplier has helped set higher standards for agencies and locums. The financial benefits of the collaboration have been very significant – several trusts have saved around £1 million in medical staffing costs.

**David Fearnley**  
**Medical Director,**  
**Mersey Care NHS Trust**

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## APPENDIX B

### THE SUFFOLK APPROACH TO RECRUITMENT

When I took over as MD in 2003 we had 14 locum consultants out of 38 posts and had held back two new posts because we knew we would be unable to fill them. In 2006 we 42 consultants in post with two locums for maternity leaves, plus a five-year fixed term locum in PLD. My overspend has gone down from £1.1 million to less than £0.1 million. In the same time we have expanded our training posts from 21 to 28.

This is what we did:

- (i) I put together a Medical Staffing Strategy that got Board approval. This was based on the need to continue and expand medical training posts and to keep consultant jobs within do-able limits. Being active in training shows potential applicants that we are a forward-thinking Trust and to grow our consultants of the future. It also included a clear plan of how many consultants we needed at minimum and the practical effect of not having them. The strategy included interesting data on cost-per-consultation for medics and other clinicians. Doctors are invariably cheaper due to faster throughput and shorter appointments.
- (ii) Job descriptions were contained to the old College norm sizes by being brutal with what you do and do not expect doctors to have to do.
- (iii) All heroism was openly discouraged. Doctors who overwork are a liability to themselves, their families, their patients and their employers. We need doctors who work shorter smarter hours.
- (iv) We made it everybody's business to pull on every contact they have ever had, in order to fill posts that once filled would reduce the collective burden.
- (v) We never haggled about salaries. The deal on the table was the deal that was on offer. The new consultant contract made this easier but we had already started doing it before that arrived. Doctors who will only come to work for you if you pay them more will go elsewhere when they get a bigger offer. We need loyalty to the organisation and its local community, not loyalty to a bank balance. That said, such straightforward dealing works both ways and where a consultant has a fair claim to better pay or conditions it is important to be fair and to deliver.
- (vi) Never appoint someone who is not up to the job, even when you are desperate.

- (vii) When good people are coming to look at one of your posts be clear that you would like them to meet all the people who will be important to their professional lives in the next few years. Make those people available to them. Encourage applicants to ask all their most testing questions about what is wrong with current services and reply with honest assessments of where you are, where you intend to be, why and how. Above all, never lie.

**Tim Webb**  
**Medical Director**  
**Suffolk Mental Health Partnership NHS Trust**

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## APPENDIX C

### **NHS Employers Consultant Contract – Frequently Asked Questions. Cover for colleagues absent through sickness**

**Q Before the introduction of the 2003 contract, consultants in our Trust would normally automatically cover for a colleague's absence through sickness.**

Some of those who have taken up the 2003 contract are now questioning whether they have any obligation to continue to work in this way. There is acceptance of the need to cover the emergency aspect of work long enough for the Trust to employ a locum (perhaps 48 hours), but beyond this some are of the view that these additional duties are not part of a consultant's contracted work and should be separately remunerated. As the work covered is not specified in their agreed Job Plans, these consultants are now asking for payment at an enhanced additional rate, equivalent to agency locum rates of pay. How should we deal with the requests for additional payment?

**A** Schedule 2.3 of the Terms and Conditions contains a specific obligation that consultants are expected “ in the normal run of their duties to deputise for absent consultant or Associate Specialist colleagues so far as is practicable, even if on occasions this would involve interchange of staff within the same employing organisation. This does not include deputising where Associate Specialists are on a rota with doctors in training.”

This is not a new requirement. It is expressed in almost identical terms to the obligation that arises from paragraph 106 of the 'old' contract Terms and conditions. There is, therefore, a continuing general obligation to provide cover where practicable.

Some Trusts have put in place a policy to cover this matter, an approach we would endorse. In the absence of such a policy we would offer the following guidance.

Employers and consultants are encouraged to come to agreement locally on what is deemed to be practicable, what the proposed cover entails and establish that the work is of a suitable nature to be covered by the consultant. In establishing suitability, due regard must be given to a doctor's duty to recognise and work within the limits of their professional competence. It may be necessary to agree re-arranged duties for one or more consultants in the short term in order to provide adequate cover.

In terms of remuneration, obviously is not possible to schedule PAs for unexpected absences into a prospective Job Plan. There are a number of ways of addressing the issue of compensation for additional work. The 2003 contract is sufficiently flexible that the length of the working day (or week) is not expected to be the same week in, week out. It may be possible to re-arrange, by agreement, duties flexibly so that a consultant providing additional cover for an absent colleague can take time off in lieu later.

Duties may be rearranged temporarily so that, for example, extra Direct Clinical Care PAs are worked to cover the absence, with Supporting Professional Activities PAs time shifted to be taken at a later, more convenient date perhaps in lieu of Direct Clinical Care PAs at that time. Alternatively, or in addition, thought may be given to a temporary reallocation of specified responsibilities (with enhanced supervision as necessary) to an Associate Specialist or specialist registrar.

In the longer term, the question of additional remuneration may arise, including in respect of the On Call Availability Supplement (if the rota frequency has increased) and PAs for on call work undertaken. These may need to be re-calculated. The formula for circulation and payment is that contained within the Terms and Conditions. Schedule 16.4 of the Terms and Conditions anticipates changes in rota frequency, which may require a change in On Call Availability Supplement. Schedule 5 deals with recognition for work arising from on call duties, while Schedule 13 deals with payment for Additional PAs.

In summary, cover for an unexpected absence is not 'extra-contractual', but is a contractual obligation for consultants, whether on the 'old' contract or the 2003 contract. The practicability of providing such cover should be determined locally by agreement. Compensation for the additional work should be in accordance with the applicable contract.

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## APPENDIX D

### GMC REVISED GUIDANCE

*The Standards and Ethics Committee, working with the Department of Health and the Royal College of Psychiatrists, has prepared the following advice to explain how the guidance on delegation and referral in Good Medical Practice applies to consultant psychiatrists working in multi-agency teams.*

#### **Accountability in multi-disciplinary and multi-agency mental health teams**

Consultants' roles and responsibilities are developing and changing. They vary according to both the specialty and the type of healthcare environment in which they are provided. Changing working practices, such as multi-disciplinary and multi-agency team work, and changes in the range of skills and competencies of other healthcare practitioners, present a number of opportunities as well as challenges in providing safe and effective care. Many of the issues are best resolved by clarity between consultants and their employing organisation about appropriate roles and responsibilities. Consultants should raise with their employing bodies any issues where ambiguity or uncertainty about responsibilities may arise. Consultants also need to be clear about the expectations of the GMC. All doctors are accountable to the GMC for their conduct and the decisions they take. Good Medical Practice (2001) sets out the principles which should underpin their professional work and against which their conduct may be judged. Good Medical Practice does not try to address, in detail, all the circumstances in which doctors may work. This guidance explains how the principles in Good Medical Practice apply for doctors working in multi-disciplinary or multi-agency mental health teams.

- Doctors should be competent in all aspects of their work including: reviewing and auditing the standards of the care they provide; training and supervising colleagues; and managing staff and the performance of the teams in which they work where and when they have direct line management responsibility.
- Doctors should do their best to ensure that the systems in which they are working provide a good standard of care to patients. Where doctors cannot be satisfied, nor take steps to resolve problems, they should draw the matter to the attention of their trust or other employing or contracting body.
- To these ends, doctors should establish clearly with their employing or contracting body both the scope and the responsibilities of their role. This includes clarifying: lines of accountability for the care provided to individual patients; any leadership roles and/or line management responsibilities that they hold for colleagues or staff; and responsibilities for the quality and standards of care provided by the teams of which they are a member. This is particularly important in circumstances in which responsibility for providing care is spread between a number of practitioners and/or different agencies.
- Doctors are not accountable to the GMC for the decisions and actions of other clinicians.
- This means that if a consultant delegates assessment, treatment and care to a more junior doctor, the consultant is not accountable to the GMC for the decisions or actions of the junior doctor but the consultant is responsible for ensuring that the junior doctor is appropriately trained, experienced and supervised. Psychiatrists can delegate the care of those patients for whom they agree to take responsibility. But many psychiatrists work in systems that are not based on referral of patients to a specific consultant. Instead, the multi-disciplinary teams of which they are a member may provide health and social care services to a substantial number of patients. Referrals are made directly to such teams and decisions about allocation to an appropriate professional are made according to the teams' policies. In these teams, the responsibility for the care of the patients is distributed among the clinical members of the team. Consultants retain oversight of a group of patients who are allocated to their care and are responsible for providing advice and support to the team. They are not accountable for the actions of other clinicians in the team. However, in accordance with paragraph 2, they must do their best to ensure that arrangements are in place to monitor standards of care, and to identify potential or current problems. They should notify their employer about any unresolved concerns or problems.