ACTION

Code of Practice

In the Appointment and Employment of HCHS Locum Doctors

August 1997

NHS
Executive

Purpose of this document

To provide guidelines and to set standard for the appointment and assessment of HCHS locum doctors in order to safeguard the quality of patient care.

ACTION

Matters requiring action

Author	**Carmel Sheriff, Human Resources Directorate, Quarry House, Leeds**
Further copies from	**NHS Executive Responseline 0541 555 455**
Catalogue number	**96CC0003**
Date of issue	**August 1997**

THIS CODE OF PRACTICE SETS HIGH STANDARDS WHICH THE SERVICE WILL NEED TO ACHIEVE OVER A PERIOD OF TIME. SOME OF THESE STANDARDS ARE INTENDED FOR IMMEDIATE ADOPTION. HEALTH AUTHORITIES AND TRUSTS ARE URGED TO WORK TOGETHER TO ATTAIN THESE STANDARDS AS QUICKLY AS IS REASONABLY PRACTICABLE

MAIN ACTION POINTS	*TIMING*
1. Trusts using locum agencies should check that the agencies have copies of the Code.	***By October 1997***
2. Trusts, or other NHS employers where appropriate, should put in place arrangements which, in the event of unsatisfactory work by a locum doctor, enable them to consider whether: (a) the doctor should be employed by them again: (b) in the case of an agency doctor, the locum agency should be informed; (c) in the case of a junior doctor, a report should be sent to the postgraduate dean; (d) a report should be sent to the GMC.	***By December 1997***
3. Trusts should introduce a structured assessment form to provide references for locum doctors. A shorter form may be used for appointments of less than a week, unless the locum's work was unsatisfactory. The factors which may need to be considered are covered by the suggested formats at Annex B to the Code	***By January 1998***
4. Trusts and health authorities should discuss the use of and need for locums to maintain patient services, and should agree a strategy for locum appointments based upon the Code of Practice.	***By January 1998***
5. Trusts should agree working arrangements with locum agencies to ensure that locums meet the minimum standards agreed with health authorities. (See Annex A to the Code)	***By February 1998***
6. Trust Medical Directors, working closely with Clinical Directors should arrange, where practicable, for the appropriate level of oversight of the work of locum consultants who do not meet the criteria for substantive appointment to this grade.	***By February 1998***

7.	Trusts should review their personnel procedures to ensure that steps are taken in good time to fill posts falling vacant, eliminating unnecessary use of locums.	***As soon as is practicable***
8.	Trusts should ensure that locum doctors meet the more demanding criteria for the grade in which they are to work as soon as is practicable (see Annex A to Code).	***Over a period of time to be agreed with health authorities***

NOTE: Locum doctors should already demonstrate compliance with HSG(93)40 "Protecting Health Care Workers and Patients from Hepatitis B, and its addendum issued under EL(96)77

1 – INTRODUCTION

1. This Code of Practice originates from the recommendations of the Working Group on Locum Doctors[1], which was set up in December 1993 to advise the Chief Medical Officer on ways to improve quality control of hospital locum doctors in the NHS. The Code sets out guidelines on the appointment of locum doctors.

2. All locum appointments, whether made directly or through NHS or private locum agencies, should comply with the Code. Employers should subscribe to the Code ***because they have the ultimate responsibility for pre-employment screening, whether or not the locum doctor has been supplied by an agency*.** They should not use locum agencies that do not also subscribe to the Code. Health Authorities (Health Boards in Scotland) and GP Fundholders should include in contracts with NHS Trusts an assurance that any locum doctor appointments will comply with the Code.

3. This Code of Practice sets high standards which the service will need to achieve over a period of time. Some of these standards are intended for immediate adoption. Health authorities and trusts are urged to work together to attain these standards as quickly as is reasonably practicable.

4. Examples of two types of assessment form are offered at Annex B, with full structured assessment for locum appointments of a week or more, or where there are concerns about a locum's performance.

2 – DEFINITION OF A LOCUM

1. A doctor in *locum tenens* is one who is standing in for an absent doctor, or temporarily covering a vacancy, in an established post.

2. Locum doctors should not be appointed where there is no substantive post to be covered. The only exception to this general rule is that locum consultants may be appointed to provide bridging arrangements during an interim period when services are being reorganised locally.

3 – REASONS FOR AND USE OF LOCUMS

1. Trusts (and DMUs in Scotland) should consider carefully the relative cost-effectiveness of engaging permanent and locum staff. Ideally, there should be sufficient substantive posts within the unit to meet foreseen service demands, including planned absences.

[1] Membership of the Working Group comprised representatives of the medical profession (The Joint Consultants Committee, the Central Consultants and Specialists Committee, the Junior Doctors' Committee and the Conference of Colleges), the General Medical Council, the Overseas Doctors Association and the Federation of Recruitment and Employment Services Ltd (FRS). Also a Postgraduate Dean, a Regional Medical Manpower Manager, a Medical Staffing Officer, a Trust Chief Executive, a Trust Personnel Director and observers from the territorial Health Departments.

2. Employers will wish systematically to identify the career intentions, including retirement, of their medical staff. Where it is known that a post is to fall vacant, steps to make a substantive appointment should be taken sufficiently early to avoid unnecessary locum appointments. Staff absences, at both junior and senior levels, should be carefully managed to avoid needless overlap.

3. Locum doctors are an important asset to the NHS and make a valuable contribution to it. However, the appointment of a locum should be a temporary measure of limited duration. A substantive appointment to the post should be made as quickly as possible. A vacant post should not be filled over a substantial period of time by means of a series of short-term locum appointments. Long-term locums should not be used.

4. Where there is a foreseeable absence, locum cover should be arranged in good time.

5. Senior managers within trusts (and DMUs in Scotland) should ensure that the use of locums is never a matter of routine, but is always justified in the light of service need with reference to quality assurance and standards and to risk management. They should give full support to medical staffing officers in implementing this policy. Senior managers also have responsibility for determining how service requirements are to be met if a locum of sufficient quality cannot be appointed.

4 – STANDARD AND CONDITIONS FOR APPOINTMENT AND EMPLOYMENT OF LOCUMS

1. Locum doctor appointments should be made with the same care as for a substantive appointment. All locum doctors should meet the criteria for the post to which they are to be appointed (see Annex A).

2. Locum doctors must be properly qualified and experienced for the work they are required to undertake. This should include an understanding and experience of the legal context for medical practice appropriate to the post (for example, the application of the Mental Health Act 1983 or the Mental Health (Scotland) Act 1984 in psychiatric practice).

3. Employers should not engage locums who are currently the subject of reservations about standards or competence of previous performance, or who are unwilling to provide their most recent report.

4. Locums should not be engaged to provide only overnight or weekend cover unless all the necessary checks (including professional references) have been conducted, either by the hospital or by a locum agency which subscribes to this Code. Or unless the locums are already well known to the employing trust, for example, through having recently been permanent members of staff.

5. Locum service should not normally be recognised for training purposes[2]. Where educational approval is given for training in a locum post, this should always be secured prospectively and never retrospectively. Educational approval should not be sought for appointments of less then 3 months' duration in a single post.

5 – EMPLOYMENT REFERENCES

1. Locum doctors should sign a statement identifying their most recent locum employer and, wherever possible, should provide a written report from that employer. If it is not practicable to provide a written report, verbal references should be taken from the most recent locum employer or the locum agency (Agencies should have procedures in place to supply such references). This should be followed by a written reference if appropriate.

2. The statement signed by the locum doctor should also give details of any proceedings by the GMC which are pending in his or her name.

3. A locum who is in a substantive post elsewhere, or have been in such a post within the last 2 years, should also supply a reference from that employer. Current employers of a doctor in a training grade who is undertaking a locum placement elsewhere will wish to ensure that the placement will not cause a breach in the controls on hours set out in the ***New Deal on Junior Doctors' Hours.***

4. At the end of the locum episode, the medical staffing officer should ensure that a reference is completed by a senior clinician (for example, consultant or clinical director) or by the medical director[3]. A structured report form (Annex B) is offered as a suggested format. Trusts may wish to adopt their own local reports based on either the short or long format. The long format is unlikely to be appropriate for most locums of a short duration. Trusts may wish to adopt a different approach to reporting arrangements for different locum grades for example those in locum consultant posts and those in locums training grade posts. The report should be counter-signed by the locum doctor, who may add written comments if desired. The locum doctor should retain a copy of this report for use as a future reference. It should be the responsibility of the medical director to support the medical staffing officer in ensuring that the referencing system operates smoothly within the hospital.

5. If, exceptionally, it will not be possible to assess and reference the doctor (because the appointment is very short and no senior staff will be present), the

[2] But see "A Guide to Specialist Registrar Training" (March 1996) for the conditions under which a Locum Appointment – Training (LAT) is appropriate.

[3] "you must protect patients when you believe that a colleague's conduct, performance or health is a threat to them….. . Your comments about colleagues must be honest and you must be able to back them up …… . The safety of patients must come first at all times".
Extract from "Good Medical Practice", Guidance from the GMC, October 1995

locum doctor should if at all possible already be well known to the employer, or have recent, good references secured and examined by a locum agency.

6 – HEALTH DECLARATIONS

1. Before a doctor's first locum appointment, or when first registering with a locum agency, the doctor should undergo a formal health assessment. This assessment should be carried out by an Occupational Health Department. Locum doctors should have dated documentary evidence of this health assessment.

2. Locum doctors should have a documentary evidence of the immunisations and tests that they have had, along with the results and dates. This should be provided by an Occupational Health Department which has knowledge and experience of these matters and their implications.

3. At the start of each locum episode, the doctor should sign a declaration that he/she feels well; has the mental and physical capacity to undertake the work[4], believes that he or she does not have any medical or physical infirmity which could pose a risk to patients or other staff; is not taking or awaiting medical treatment and believes that he or she is not carrying any infection which could pose a risk to patients. A health declaration form is provided at Annex C. Even for very short or unexpected locum appointments, it should be possible to provide supplies of the declaration form at the point where the locum doctor will first report for duty at the hospital.

4. If the locum doctor is due to arrive when no-one in the Medical Staffing Office is on duty, there must be adequate arrangements (perhaps through a locum agency) for the necessary documentation to have been received and examined. Employers should also have in place a reliable system for receiving the doctor, checking his identity and ensuring that this documentation is complete.

7 – CRIMINAL CONVICTIONS

1. At the start of each locum episode, the locum doctor should provide a statement of any criminal convictions (Annex D). Under the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975, applicants for locum medical posts are not entitled to withhold information about convictions which for other purposes are "spent".

[4] Other than, for example, medication for a well-controlled condition such as asthma, hay fever or diabetes

8 – CHECKLISTS OF RESPONSIBILITIES

EMPLOYERS

Employers should:

1. Check the doctor's identity, preferably by means of documentation such as a passport which bears a photograph *

2. Check that the locum doctor is registered with the General Medical or Dental Council by inspecting the original certificates and/or by telephoning the GMC or GDC to confirm the registration. This is now a 24 hour service, available daily throughout the year *.

3. Check that no GMC proceedings concerning the doctor are pending or that the doctor has not been suspended, or is able to practise only under prescribed conditions.

4. Check the doctor's medical qualifications, again by inspecting the original certificates *.

5. Check that, where necessary, the doctor holds current membership of a medical defence organisation. *

6. Check the doctor's eligibility to work in the UK. Where there is doubt and the doctor is a non-EEA national, the doctor should be asked to obtain a letter from the Home Office confirming his/her immigration status. Full details about the employment of overseas doctors in the UK are contained in Health Circular HC(FP)(85)14 (a revised version of this circular is expected to be issued in spring 1997). In Scotland: NHS Circular 1985 (GEN) 26. *

7. Ensure that the doctor is suitably qualified and experienced for the work to be undertaken. *

8. Take up and examine the necessary reference from the locum doctor (see Section 5 above).

9. Ensure that the doctor:*

   (a) has documentary evidence, dated within the last 2 years of the pre-employment health assessment by an Occupational Health Department:

   (b) has an up-to date certification of immunisation from an Occupational Health Department and that this meets the requirements of HSG(93)40 (see Note 1), its addendum EL(96)77 and any local requirements;

(c) complete a form of Health Declaration (Annex C) and statement of Criminal Convictions (Annex D) before taking up the locum appointment[5] .

(1) In Scotland, the letter dated 18 August 1983 from Mr G A Anderson and Dr R E Kendell entitled "Protecting Health Care Workers and Patients from Hepatitis B"

10. Ensure that educational approval for the appointment is secured ***in advance*** if the locum posting is to be recognised for training purposes.

11. In the case of a doctor with Limited Registration, check that the registration is valid for the work to be undertaken. *

12. Seek to ensure that the locum placement will not cause the doctor in a training grade to breach the controls on hours set out in the ***New Deal on Junior Doctors' Hours.*** *

13 Provide induction for the locum doctor, appropriate to the post and the length of the appointment.

14. At the end of the locum episode of 2 weeks or more, the medical staffing officer should ensure that a structured report form (such as that suggested at Annex B) is completed by a senior clinician or the medical director[6]. Employers should attempt if at all possible to complete reports on locums employed for shorter periods, especially where their performance has been unsatisfactory. If the locum has been engaged through an agency, the medical staffing officer must always send a copy of the report to the agency. Reports showing serious shortcomings in the locum's performance should be copied to the GMC where appropriate. For doctors currently in training, postgraduate deans should receive copies of any report where significant shortcomings are identified. Medical staffing officers should retain all reports for 7 years.

15. Employers who find that any locum doctor's services are of an unacceptable standard should complete as much as possible of a full structured assessment form (such as that at Annex B) for that doctor, ***whatever the length of the locum episode.***

16. Review the appointment if, exceptionally, the locum doctor is still in post after 6 months (3 months in Scotland). Locum consultant appointments are not subject to the full procedure used for substantive appointments, which are detailed in the NHS (Appointment of Consultants) Regulations 1996 (SI No 701). However, wherever possible, employers should try to appoint as locum consultants doctors who hold, or have held, posts of consultant status, or else who have completed specialist training (or who hold accreditation in the

[5] Information about the disclosure of criminal background of those with access to children may be found in HC(88)9. In Scotland: NHS Circular 1989 (GEN) 22.

[6] "You must protect patients when you believe that a colleague's conduct, performance or health is a threat to them….. . Your comments about colleagues must be honest and you must be able to back them up….. . The safety of patients must come first at all times.

Extract from "Good Medical Practice" Guidance from the GMC, October 1995

appropriate specialty). In any event there should always be careful assessment of the candidates by an appointments committee with at least 2 professional members, one in the specialty concerned. Locum appointments should be restricted to an initial period of 6 months and any extension beyond that period should be subject to a satisfactory review by the employer in consultation with the relevant college. In all cases locum consultant appointments should be limited to a maximum period of one year.

17. ***Employers using a locum agency should ensure that the agency subscribes to this Code of Practice. Ultimate Responsibility for conducting checks on locum doctors rests with the employer. If the routine checks are delegated to an agency, there must be a clear understanding between the 2 parties so that no checks are overlooked.***

Employer responsibilities marked with an asterisk * may, with all due care, be delegated to a locum agency with whom the employer has contracted. In this case, employers should check, as often as they consider necessary, that their required procedures are being carried out.

Employers should ensure that agencies are clear about the qualifications and experience required for each post. They may also need to assist agencies with access to Occupational Health Services and criminal records checks. Agencies may not be aware of notices that have been issued to the NHS about doctors who have been suspended.

HEALTH AUTHORITIES, HEALTH BOARDS IN SCOTLAND AND NORTHERN IRELAND, COMMISSIONING AGENTS AND GP FUNDHOLDERS

Should:

1. Consider the extent of locum usage by trusts when setting quality standards

2. Include in contracts with trusts an assurance that locum doctor appointments will meet agreed standards based upon this Code of Practice

3. Monitor locum usage and any associated quality problems as part of quality standards control

4. Tell trusts of any problems so that they can take appropriate action

MEDICAL EMPLOYMENT AGENCIES

Both NHS and Independent Employment Agencies should:

1. Meet the standards set out in this Code of Practice.

2. Comply with the Employment Agencies Act 1973 and the Code of Conduct Regulations for Employment Agencies and Employment Businesses 1976 (SI no 715).

3. Ensure that, on first registering with the agency, all doctors:

   (a) undergo a formal health assessment at an occupational health department, and obtain dated documentary evidence of this assessment;

   (b) provide current documentary evidence of the immunisations and tests that they have had, along with the results and dates. This should be provided by an occupational health department;

   (c) provide a statement of criminal convictions (Annex D)

   (d) provide a valid criminal records clearance form, or undergo a police check where necessary.

4. Undertake the appropriate checks listed above as employer responsibilities where the agencies acting on the employer's behalf. **There must be a clear understanding and agreement between the 2 parties *so that no checks are overlooked.***

5. Secure copies of assessment reports on locum doctors they have placed, retaining these for a long as good business practice dictates; and consider whether a doctor who has been the subject of poor reports should remain on the agency's books.

6. Where questions arise about a series of reports from one unit (whether concerning the same or several different doctors), take the matter up with the senior management of that unit).

LOCUM DOCTORS

Locum Doctors should:

1. Produce their original certificates for the employer or locum agency to see to confirm the details of their Registration, medical qualifications and membership of a medical defence organisation where necessary. Produce work permits where applicable.

2. Provide their most recent locum reference (Section 5) and sign a statement that the most recent employer is correctly identified. The statement should also identify any GMC proceedings which are pending. Where they are also in substantive employment, a reference from the substantive employer should also be provided. If a locum is due to arrive outside normal working hours, he should hand these references to the person who receives him, for transmission to the appropriate Clinical Director then following day.

3. Ensure that any locum work undertaken does not entail exceeding national limits on contracted hours or actual hours of work set out in the ***New Deal on Junior Doctors' hours.***

4. Provide dated documentary evidence of their health assessment; and of the immunisations and tests that they have had.

5. Complete a Health Declaration (Annex C) and Statement of Criminal Convictions (Annex D) at the start of each locum episode.

6. In the case of a doctor with Limited Registration, ensure that any locum work undertaken is within the terms of the registration, and does not damage his/her training interests.

7. Cooperate with the medical staffing officer and the senior clinician reporting on him or her to ensure that the report is completed in a timely manner.

8. Countersign the completed report at the end of the locum appointment, making written comments if desired.

9. If he or she disagrees with the contents of a report, contact the medical director.

ANNEX A

CRITERIA FOR APPOINTMENT TO THE VARIOUS LOCUM GRADES

Locum doctors should be suitably qualified for the work required of them. The pay of a locum doctor may sometimes exceed the national pay rate for the grade in which he or she is employed. However, the work expected of and the responsibilities allocated to the locum doctor should not exceed the doctor's training and competencies.

The standards presented below are the minimum standards for early adoption. Health authorities and trusts should work together to attain the higher standards recommended by the Locums Working Group. These are identified in italics to the right of the page.

CAREER GRADE LOCUMS

Consultant

Employers should bear in mind that a doctor appointed as a locum consultant will work without supervision and with full clinical autonomy. Great care should therefore be exercised in making these appointments. They should usually be short-term. Ideally the individual should be registered as a specialist with the GMC and either have held a substantive NHS consultant post or equivalent honorary post in a relevant specialty for at least one year; or have equivalent service overseas. A review by the employing body in consultation with the relevant college must be held at 6 monthly intervals (3 monthly intervals in Scotland) if the locum is still in post and where, exceptionally, a long-term locum appointment is unavoidable. In all cases, locum appointments should be limited to a maximum period of one year.

Locum consultants should have full registration with the General Medical Council (GMC)[7]. Employers should satisfy themselves that any doctor to be appointed as a locum consultant has the knowledge, skills, attributes and experience necessary to discharge the responsibilities of a consultant. If the most suitable candidate for the locum post does not fully meet these criteria, then the Medical Director, working closely with the Clinical Director, should arrange for the appropriate level of oversight of the locum's work. If necessary, the employer should consider engaging a locum in a non-consultant career grade to help cover the service need.

Wherever possible, the appointment committee for a locum consultant should include 2 members of the medical profession, one of whom should be from the discipline concerned. One professional committee member should be sought from the appropriate Royal College or, in Scotland, the National Panel of Specialists. In an emergency, the Medical Director could take responsibility for interviewing a potential candidate.

[7] Full Registration: Most "Career Grade" doctors would have full registration, ie able to practice without restriction: though some may have limited registration.

Locum consultants may not participate in teaching and training except where such activity has been clearly defined and approved by the relevant clinical tutor.

FINAL STANDARD: Locum consultants should be registered as a specialist with the GMC in an appropriate specialty and be adequately experienced to undertake unsupervised independent clinical practice.

Associate Specialist

Locum Associate Specialists must have full registration with the GMC and must have worked for a minimum of 4 years in the registrar or staff grade, at least 2 years of which have been in the relevant specialty.

Staff Grade

Locum Staff Grades should have full registration and at least 3 years' full time or equivalent hospital service at SHO or higher grade, including adequate experience in the relevant specialty.

Clinical Assistant (Part-time Medical Officer: paragraph 94 appointments)

The locum should have full registration, relevant experience in the specialty and may be a local general practitioner who is able to offer a limited sessional commitment.

Similar principles should be applied to other career grades, eg Senior Clinical Medical Officer, Clinical Medical Officer, Hospital Medical Practitioner.

TRAINING GRADE LOCUMS

Specialist Registrar (SpR)

The appointment of locum Specialist Registrars should follow the procedures set out in *"A Guide to Specialist Registrar Training"* (March 1996). Such posts may be either Locum Appointments – Service (LASs) or Locum Appointments – Training (LATs).

Doctors applying for appointment to a LAS must demonstrate qualifications and experience to a level allowing them to provide a service to patients of a quality comparable to a substantive SpR in that placement. Employers should ensure that applicants are vetted and interviewed by at least one doctor who is qualified to sit on an SpR Appointment Committee.

SHOs applying for appointment to a LAT should have completed the necessary SHO experience and gained the minimum college requirements for entry to the SpR grade.

Registrar and Senior Registrar

Where a placement occupied by a senior registrar must be filled by a locum, a locum specialist registrar should be appointed, again following the procedures set out in *"A Guide to Specialist Registrar Training"* (March 1996). If a placement occupied by a registrar needs to be filled by a locum, this should generally be done by a locum SpR. Locum registrar appointments can be made pro tem for those posts which are occupied by registrars who have not, for any reason, entered the SpR grade during transition.

Senior House Officer (SHO)

Locum SHOs should have full or limited registration[8] with the GMC and at least 6 months' postgraduate experience in the relevant or associated specialty.

FINAL STANDARD: Locum SHOs should have full or limited registration with the GMC and at least 12 months' postgraduate experience in the relevant or an associated specialty

House Officer

Doctors covering for House Officers should have full, limited or provisional [9] registration and at least 6 months' experience in a recognised medical or surgical specialty.

[8] **Limited Registration**: Certain training grade doctors will not be eligible for full registration but will have limited registration. They will be issued with certificates that specify the conditions under which they may practise. These conditions include a time limit, may place restrictions on the grade in which a doctor can work and may exclude a doctor from working in certain departments or specialties. Any doctor working outside the conditions of his registration is practising illegally.

[9] **Provisional Registration**: Granted to practitioners to work only in resident posts in hospitals or institutions which are approved for the purpose of pre-registration service.

EXCEPTIONS

The above appointment criteria may be waived ***only*** in the following circumstances:

Acting Up

Acting up to a higher grade within a unit or rotational training scheme is permissible in certain circumstances. For example, a specialist registrar judged to be within 6 months of the award of a Certificate of Completion of Specialist Training could act up as a locum consultant[10]. Acting up must be supported by the trainee's supervisor or college advisor. The doctor must be sufficiently experienced to carryout the duties of the locum appointment and appropriate supervision arrangements should be made.

Moving Across

Doctors may move across within a unit or rotational training scheme to provide locum cover in another specialty in which they have previous experience.

Consultants who have left or retired

Recently retired doctors who have previously been consultants of good standing in the discipline within the same employing body may be employed as locums without the full appointments procedure.

[10] The Joint Consultants' Committee of the BMA has suggested that the term "acting consultant" might be applied to doctors who fall into this category. Trusts may wish to consider this and to offer views at the policy review state.

ANNEX B

REPORTS ON LOCUM DOCTORS

Written assessment reports/references on locum doctors should be prepared at the end of each locum episode. They should be completed by the consultant or other senior doctor responsible for the supervision of the locum doctor. In the case of a locum consultant, the report should be completed by the Clinical Director or by a doctor acceptable to that Director.

> ***"You must protect patients when you believe that a colleague's conduct, performance or health is a threat to them……. . Your comments about colleagues must be honest …….. . The safety of patients must come first at all times. "***
>
> Extract from ***Good Medical Practice***, Guidance from the GMC, October 1995

THE ASSESSMENT FORMS WHICH FOLLOW MAY BE REPRODUCED LOCALLY

SUGGESTED FORMAT FOR ASSESSMENT OF LOCUM APPOINTMENTS OF LESS THAN ONE WEEK

DOCTOR'S NAME:……... **GMC NO** ……

GRADE *(This post)**:*** ……

SPECIALTY: ……

PERIOD: …… **UNIT:** ……

The Doctor's performance in this locum post has been*:

GOOD: ……

AVERAGE: ……

POOR: ……

UNSATISFACTORY:** ……

In the event of unsatisfactory work by a locum doctor, please complete the full structured assessment form

Would you employ this Doctor as a locum in the hospital again?*

Yes/No

**Please tick as appropriate*

Comments by Reporting Doctor:

Does this Doctor have any training needs that you have identified?

……
……
……
……
……
……

Name of Reporting Doctor: ……..

Signed ……..... **Date** ……

STATEMENT BY LOCUM DOCTOR

I have seen the above assessment report and I agree/disagree* with its contents.
If you disagree with the contents you should tell the Medical Director.

Signed: ……

Name in CAPITALS: ……

Comments by Locum Doctor *(if desired)*

**Please delete as appropriate*

ASSESSMENT OF LOCUM APPOINTMENTS OF ONE WEEK OR LONGER

DOCTOR'S NAME: ..... **GMC NO** ..... **GRADE** *(this post)*.....

SPECIALTY: ..... **PERIOD:** ....**UNIT:** .....

Please tick the appropriate boxes:	**ABOVE AVERAGE**	**AVERAGE**	**BELOW AVERAGE**	**UNACCEPTABLE**
CLINICAL SKILLS				
1. History Taking				
2. Physical Examination				
3. Investigations and Diagnosis				
4. Judgement and Patient Management				
5. Practical Skill				
KNOWLEDGE				
6. Basic Science				
7. Clinical				
ATTITUDES				
8. Reliability				
9. Leadership and Initiative				
10. Administration				
11. Time Keeping				
RELATIONSHIPS				
12 a) Colleagues				
12 b) Patients				
12 c) Other Staff				
12 d) Communication Skills				
PERSONAL QUALITIES				
13. Appearance				
14. Integrity				
15. Manners				

Does this Doctor have any training needs that you have identified?

……

……

……

……

……..

Comments by Reporting Doctor:

NAME OF REPORTING DOCTOR: ……..

Signed …….. **Date** ……..

STATEMENT BY LOCUM DOCTOR

I have seen the above Assessment Report and I agree/disagree with its contents. I have also seen the Guidance Notes on the completion of the Assessment Report.*

Signed ……

Name in CAPITALS ……..

Statement by Locum Doctor *(if desired)*

**Please delete as appropriate*

NOTES ON COMPLETION OF THE ASSESSMENT MATRIX

Tick only one box in each row of the matrix. These guidelines may help in assessing the performance of the Locum Doctor. To be graded *average* or *above average* the Locum's performance must be consistent with that of doctors in substantive appointments at the grade. Reports showing serious shortcomings in the Locum Doctor's performance should be copied to the GMC.

	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE	UNACCEPTABLE
CLINICAL SKILLS				
1. History Taking	Precise, perceptive, comprehensive, well documented	Usually complete, orderly and systematic.	Often incomplete/ inaccurate and/or poorly recorded	Frequently incomplete, inaccurate and poorly recorded
2. Physical Examination	Thorough, accurate, recognises and elicits physical signs	Usually elicits correct signs. Recognises most significant findings	Lacks basic skills and misses some signs. May misconstrue signs	Lacks basic skills. Frequently misses signs and/or misinterprets them
3. Investigations and Diagnosis	Investigations almost always appropriate in relation to differential diagnosis. Excellent at interpretation. Excellent diagnostician. Excellent clinical memory.	Investigations usually appropriate. Good knowledge on interpreting tests relevant to the specialty. Competent clinician. Good knowledge with orderly logical approach to differential diagnosis.	Investigations may be inappropriate and are frequently unnecessarily expensive. Unable to interpret some tests. May fail to interpret symptoms and signs correctly.	Investigations inappropriate or incomplete. Fails to interpret tests correctly. Often fails to interpret symptoms and signs correctly.
4. Judgement and Patient Management	Excellent clinician who is aware of his/her limits. Excellent ward and/or outpatient management.	Reliable and conscientious. Competent under pressure. Seeks advice appropriately. Good awareness for complications.	Sometimes unreliable and uninterested. May fail to grasp significance of findings or take appropriate action. May under or over react to emergencies. May fail to notice complications and/or act appropriately. May fail to recognise limitations and to seek advice when needed.	Often unreliable and uninterested. Fails to grasp significance of findings or take appropriate action. Often under or over reacts to emergencies. Fails to notice complica-tions and/or act appropriately. Fails to recognise limitations and seek advice when needed.
5. Practical Skill	Shows outstanding practical ability.	Competent.	Clumsy or rough. Can have difficulty in even the simplest procedures.	Clumsy and rough. Often has difficulty in even the simplest procedures
KNOWLEDGE				
6. Basic Science	Comprehensive and up to date knowledge and understanding of the basic science of the specialty. Widely read.	Adequate and up to date fund of knowledge. Relates this satisfactorily to patient care.	Reasonable though perhaps dated knowledge. Not always applied appropriately.	Uninterested. Does not read the literature. Fails to apply basic science knowledge to clinical problems.
7. Clinical	Comprehensive and up to date knowledge and excellent application. Widely Read	Satisfactory knowledge for dealing with common disorders. May fail to "spot the rarity" but learns from experience.	Lacks appropriate knowledge or ability to apply it. May fail to learn from experience.	Lacks basic and/or essential knowledge. Unable to learn from experience.

	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE	UNACCEPTABLE
ATTITUDES				
8. Reliability	Highly dependable and conscientious.	Dependable. Does not need reminding. Conscientious in patient care.	Occasionally unreliable. Forgets to do things (possibly to the detriment of patients).	Frequently unreliable. Likely to fail to do things (possible to the detriment of patients).
9. Leadership and Initiative	Excellent team leader with great ability to motivate others. Shows initiative. Always takes responsibility.	Competent but lacks inspiration. Gives clear instructions. Usually shows initiative and takes responsibility.	Needs pushing and may fail to show initiative.	Very limited. Gives confusing instructions. No initiative.
10. Administration	Well prepared and organised. Adapts to the hospital's management policies.	Well prepared and organised. Conscientious. Can be left confidently to deal with routine admin.	Often behind or neglects routine admin.	Cannot be bothered or slapdash.
11. Time Keeping	Punctual and reliable. Will always contact the unit to warn of a problem.	Usually on time. Usually contacts the unit to warn of a problem.	Often late to the unit and to clinics. May not warn of a problem.	Frequently late to the unit and to clinics. Often fails to warn of a problem.
RELATIONSHIPS				
12 a) Colleagues	Willing to accommodate the working methods of the clinical team. Able to defuse problems in the team. An excellent colleague who fits in well.	Good rapport. Trusted. Easy to work with. Able to fit in with existing team.	Fails to fit in with seniors, peers or juniors.	Uninterested. Does not try to fit in with colleagues and may even undermine them.
12 b) Patients	Inspires confidence. Establishes excellent rapport. Patients delighted to be looked after by him/her.	Sound, caring attitude. Can allay patient fears. Takes time. Trusted by the patient.	Does not put people at their ease. Lacks empathy.	Does not mean well. Rude. Patients do not want him/her as their doctor. Increases patient anxieties.
12 c) Other Staff	Inspires loyalty and enthusiasm.	Sound and professional, yet approachable. Treats others with respect and is respected in return.	Careless of others. May generate rather than solve problems.	Rude and arrogant. Likely to cause problems.
12 d) Communica-tion Skills	Excellent communicator. Easily establishes rapport with patients. Encourages and enhances mutual understanding.	Good communication skulls. Listens well and explains well, in appropriate language. Gives clear instruction.	Poor command of local language. Inarticulate and confusing; easily misunderstood. Does not listen or understand. Confuses patients with unnecessary technical terms.	Very poor command of local language. Unintelligible, inarticulate. Minimal explanatory skills. Fails to listen or understand. Can appear indifferent and/or patronising.
PERSONAL QUALITIES				
13. Appearance	Smart, appropriately dressed. Good personal hygiene.	Tidy, appropriate dress. Normal personal hygiene.	Untidy or inappropriate dress	Often scruffy. Generally poor personal hygiene.
14. Integrity	Excellent	Good	Just acceptable	Suspect honesty or morals
15. Manners	Always considerate and polite.	Generally good. Considerate.	Thoughtless, sometimes rude.	Rude and/or arrogant.

ANNEX C

In Confidence

HEALTH DECLARATION

To be completed at the start of each locum episode

I ATTACH documentary evidence from …….. *(name of)* Occupational Health Department of the immunisations and tests that I have had, together with the results and dates.

I DECLARE THAT

1. I am feeling well.

2. I have the mental and physical capacity to undertake the work required of me as a Locum

   …… at ……

3. I am note overtired.

4. I believe that I do not have any medical or physical infirmity which may pose a risk to patients or other staff.

5. (a) I am not taking or awaiting medical treatment.

   (b) I am taking the following medication ……..

   Please delete/complete as appropriate

6. I believe that I am not carrying any infection which could pose a risk to patients.

7. I understand my responsibility (set out in Duties of a Doctor: Guidance from the General Medical Council") to have all the necessary tests if I think I have or am carrying a serious communicable condition and to act on the advice of a suitably qualified colleague about necessary treatment and/or modifications to my clinical practice. I also understand that I must take and follow advice from a consultant in Occupational Health or another suitably qualified colleague if my judgement or performance could be significantly affected by a condition or illness.

Signature ……..

Date ……

Name in CAPITALS ……..

GMC Number ……..

ANNEX D

In Confidence

STATEMENT OF CRIMINAL CONVICTIONS

1. Please list any criminal convictions and dates below. As a doctor any criminal convictions you may have may not be treated as "spent" under the Rehabilitation of Offenders Act 1974. You are therefore required to declare all criminal convictions or cautions. The information you give will be treated in confidence and taken into account only where the offence is relevant to the post for which you are applying.

……
……
……
……
……

Signed …… **Date** ……..

Name in CAPITALS ……

GMC Number ……

2. Do you have any criminal proceedings pending against you?

YES/NO

If yes, please give details: ……
……
……
……
……

Signed …… **Date** ……

GMC Number ……..

3. Police Check

Unless you are able to provide you criminal record convictions records clearance form, it may be necessary to request a Police Check to ensure that you do not have a criminal record that would affect your suitability for medical work. Please complete the form below, or provide a clearance certificate stating that you have been the subject of a criminal convictions check within the last 12 months and that you have no convictions preventing you from working as a doctor.

Name in full ……

Maiden Name ……
(where applicable)

Date of Birth ……..

Place of Birth ……

Present Address ……

……

……

Since *(date)* ……

Previous addresses in last 4 years *(including dates):*

……

……

……

……

I hereby give ……permission to undertake a Police Check on my behalf. I understand that refusal could prevent further consideration of my application.

Signed ……**Date** ……..

Name in CAPITALS ……

GMC Number ……