

Supporting organisations engaging with locums and doctors in short- term placements

**A practical guide for healthcare providers,
locum agencies and revalidation
management services**

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Description	This guidance is for any individual or organisation engaging with locum and short-term placement doctors, who often do not have easy access to systems or structures in place to support their CPD, appraisal, revalidation and governance. This guidance highlights ways they may be supported to provide safe provision of healthcare as a valuable part of the workforce.
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Supporting organisations engaging with locums and doctors in short-term placements: A practical guide for healthcare providers, locum agencies and revalidation management services

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Prepared by:

- **Ruth Chapman**, Associate Medical Director (Revalidation) and Regional Appraisal Lead, NHS England London Regional Team
- **Mark Cohen**, Professional Standards Team, Medical Directorate (central), NHS England

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Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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1. Purpose of this guidance

This guidance is directed towards medical directors, responsible officers, those with governance responsibility for doctors' practice (in a place where the doctor is working), appraisal leads and human resources personnel engaging with doctors who locum or work within health organisations for short-term placements.

It should also be of interest to other bodies with direct involvement in this area or with any of the above groups, such as the Care Quality Commission (CQC) regarding inspections and approved framework agreement operators for the provision of agency/temporary staff to the NHS.

Working in this short-term way has specific challenges. These doctors often do not have in place easy access to systems or structures to support their continuing professional development, appraisal, revalidation, and governance. It is hoped that this guidance, along with the accompanying guidance 'Supporting locums and doctors in short-term placements: A practical guide for doctors in these roles' (NHS England 2018), will highlight ways that these doctors may be supported to provide safe provision of healthcare as a valuable part of the workforce.

For the purposes of this guidance, a locum refers to a doctor who is either placed by a locum agency/GP chambers, or a locum bank to work in a healthcare provider organisation or directly engages with healthcare organisations or GP practices for short-term work, and a doctor in a short-term placement is one who is an employee of the organisation for a short, fixed term.

There may also be doctors in training who work as locums outside their training programme and who are therefore connected to Health Education England (HEE) as their designated body.

At the end of this document there are useful resources and references to be used as appropriate.

Organisations, including healthcare providers, GP practices and locum agencies, may tailor this guidance for their own corporate requirements to assist their own locum and short-term placement doctors, or use it as it is. This guidance aims to promote a standardised approach to working with locum and short-term placement doctors across primary and secondary care and in all sectors. It is hoped that it will act as a benchmark as models of care and systems develop over time.

Background

Locums and doctors in short-term placements are an essential part of the work force, contributing to patient care and safety.

There is no evidence available to suggest that locums or doctors in short-term placements put patients more at risk compared to other doctors in more substantive posts. However, there have been a number of significant events relating to individuals presenting themselves as locums where appropriate pre-employment checks were not carried out. These incidents have led to some concern about doctors who work as peripatetic locums, the governance arrangements around them and their connections to designated bodies and responsible officers.

There is a risk that, due to the peripatetic nature of this part of the workforce, some locums and doctors in short-term placements may not be embedded within a strong clinical governance system to support both their clinical practice and continuing professional development. This can include issues such as the absence of induction, not knowing how to escalate concerns, and being placed in challenging environments or untested models of care.

Sir Keith Pearson was commissioned by the General Medical Council (GMC) to produce an independent report '[Taking revalidation forward: Improving the process of relicensing for doctors](#)' (GMC January 2017). This highlighted concern about the 'rigor of appraisal and revalidation' for locums as well as issues around the connection of doctors taking on short-term placements. Sir Keith's report also suggested the need to reduce the burden and improve the experience of appraisal for doctors in general. This should involve improved organisational systems and doctors' access to them.

The Medical Profession (Responsible Officer) Regulations 2010, amended 2013, define the designated body's and responsible officer's statutory obligations towards their connected doctors – including doctors who are working as locums.

Information about the Responsible Officer Regulations

[The Medical Profession \(Responsible Officers\) Regulations 2010](#)

[The Medical Profession \(Responsible Officers\) \(Amendment\) Regulations 2013](#)

[NHS Improvement took steps in 2016 to cap secondary care locum costs, by producing a set of 'agency rules' for trusts.](#) One of these stated that healthcare organisations are required to procure all agency staff from approved framework agreements. These frameworks specify how locum agencies should act with respect to pre-employment checks of locums and doctors in short-term placements based on [standards defined by NHS Employers](#).

In October 2016 NHS England convened a group of stakeholders to discuss issues relating to this group of doctors. The result of this discussion was the agreement of the following set of working principles for doctors, locum agencies, and healthcare providers. These have been tested and refined through conversations with all three groups:

A locum, or a doctor working in a short-term placement, is responsible for:

- Complying with specific GMC requirements for registration and licence to practise including identity, language and other checks for remaining on the medical register
- Complying with any GMC warnings, conditions or undertakings. They must not put them self in a position where they are unable to comply with restrictions on their practice. They should inform the organisation about any restrictions before they start work so that the organisation can support them to practise within the restrictions
- Complying with pre-employment processes including identity, language, Healthcare Professionals Alert Notices (HPANs), health clearance and other

checks when starting with a new healthcare provider. These checks should be completed prior to any shifts being commenced

- Participating in the induction processes of organisations where they work
- Accurately representing their skills and competencies
- Accruing supporting information about their individual medical practice, including end of placement/exit reports and peer/colleague feedback from placements
- Knowing who their responsible officer is, who they are accountable to and who they should report to
- Providing relevant information about their professional practice to their locum agency (where relevant) and any organisations where they work
- Participating in annual whole scope of practice medical appraisal
- Engaging in the governance system of the organisations where they work as well as those of their designated body (including engaging with the responsible officers, or clinical governance leads of both)
- Engaging with revalidation and the processes that support it
- Adhering to the requirements of [Good Medical Practice \(GMP\) \(2013\)](#) and the GMC, including the requirement to have adequate and appropriate indemnity/insurance cover for the work that they do
- Engaging with processes to investigate and address any concern about their practice or the systems in which they work

A locum agency is responsible for:

(some of these points are less applicable for GP locums)

- Appointing a responsible officer (if it is a designated body), or a clinical governance lead and providing them with resources. The locum agency must tell their doctors who the responsible officer is and inform them of any fees relating to the appraisal and revalidation process
- Undertaking pre-employment checks including GMC requirements for registration and licence to practice, identity and language, health clearance and other checks for any doctor joining, such as HPANs. **These checks should be completed prior to any shifts being commenced**
- Ensuring it is aware of any doctors who have GMC conditions or undertakings on their registration and that they are only placed in roles where they will be able to work within those restrictions
- Having processes to monitor the doctor's practice in relation to the work they are being supplied to do, including end of placement/exit reports and peer/colleague feedback from the doctor's placements
- Sharing information of note relevant to the doctor's intended work with any organisation to which the doctor is being supplied, **in advance of a placement** if known, or as it arises

- Accurately representing the skills and competencies of a locum doctor to the engaging organisation
- Ensuring the provision of annual appraisal to the standards of the [‘Medical Appraisal Guide’ \(NHS England 2014\)](#) for the doctor, whether through the agency or in an organisation where the doctor is undertaking a placement. NHS England GPs’ appraisals are organised through NHS England local teams
- Coordinating feedback and other information such as end of placement/exit reports and peer/colleague feedback and sharing it with the doctor for appraisal, professional development, and the maintenance of records of such processes
- Receiving information about, and responding to, any potential concerns about the doctor’s practice, coordinating any investigative process required as a result and agreeing where this should be situated, whether in the agency or in one or more of the organisations where the doctor has worked (including speaking to the NHS England local team (if appropriate), or the GMC Employer Liaison Advisor (ELA) for advice on whether any concern meets GMC thresholds). The doctor should be kept informed of the process
- Providing a governance framework for doctors, whether or not the doctor’s prescribed connection is to the agency. This includes such things as having a programme to support the doctor’s professional development in a manner appropriate to the nature and duration of the placement and provision of supporting information for appraisal, as described in the NHS England document [‘Improving Inputs to Medical Appraisal’ \(NHS England 2016\)](#)
- Having processes for monitoring connections of doctors and ensuring they are up to date
- Having processes for ensuring doctors’ appraisals take place annually and that appraisal systems are quality assured

A healthcare provider which engages the locum doctor is responsible for (at the point of placement):

- Verifying that GMC registration and licence to practise, HPAN, identity, language, health clearance and other checks have taken place, or undertaking these if this cannot be verified
- Ensuring that it is aware if any doctors placed with them who have GMC conditions or undertakings on their registration and that they will be able to work within these restrictions
- Accurately representing to the locum doctor and locum agency (where relevant) which skills and competencies are required in the position for which the doctor is being engaged
- Providing suitable induction to the doctor to enable them to carry out the work they are being engaged to do (including appropriate IT system login/access, buildings/departmental access and the process for escalating concerns)

- Completing the required end of placement/exit report and peer/colleague feedback for the doctor
- Integrating the doctor into their governance structure in a manner appropriate to the nature and duration of the placement
- Supporting the doctor's appraisal preparation
- Agreeing with the doctor and at the discretion of the doctor's responsible officer, to provide annual appraisal for the doctor if appropriate to do so (in light of the nature and duration of the doctor's placement), to the standard of the ['Medical Appraisal Guide' \(NHS England 2014\)](#); along with ['Guidance on supporting information for appraisal and revalidation' \(GMC 2018\)](#). NHS England GPs' appraisals are organised through NHS England local teams
- Notifying the doctor and locum agency (where relevant) if any significant information of note arises in relation to the doctor's practice during their placement (and/or the doctor's responsible officer if the agency is not the doctor's designated body (see Appendix Ai for a suitable template to use))
- Agreeing with the locum agency or NHS England local team (where relevant) whether any necessary investigation is carried out in the organisation
- Including quality elements within the service level agreement (if applicable) with the locum agency to facilitate the above

2. Roles, connections, professional responsibilities, and the nature of the organisation

Every doctor has a professional duty to maintain fitness to practise. This includes working within their skills and competence, keeping up to date and engaging with the appraisal and revalidation process. It is also important that they adhere to any steps taken to manage performance concerns that may have been raised about their practice or to address risks to patient care related to their health.

The governance network around a doctor can vary in scale and complexity, depending on the number of places where they work and the nature of these organisations.

Doctors only have one designated body and one responsible officer.

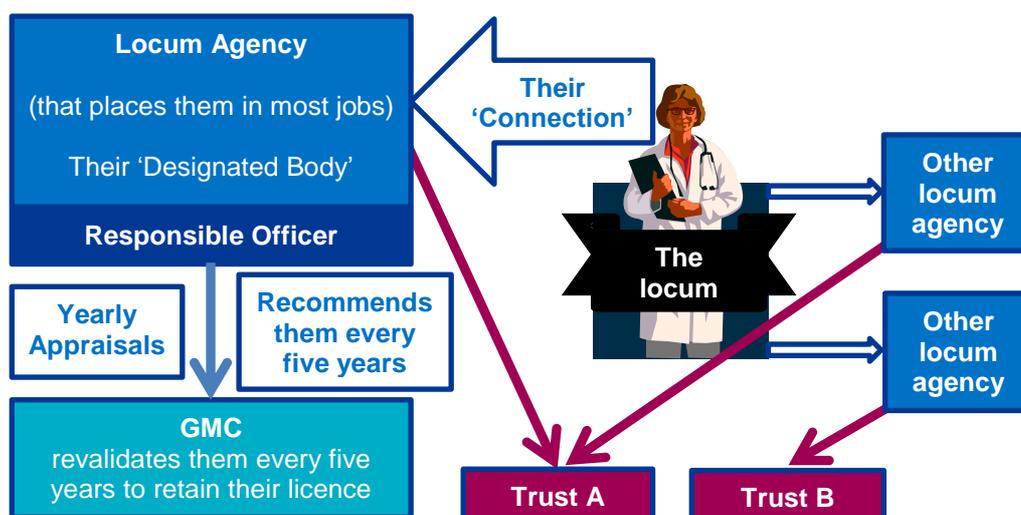
Secondary care and private sector locums

The designated body of a locum or short-term placement doctor working in secondary care will usually be one of the following, as defined by the Responsible Officer Regulations:

- A locum agency which places the doctor within a provider setting (NHS or private) to carry out their clinical duties. The doctor connects to the locum agency that places the doctor in work the most over the last twelve months, even if they are registered with or have worked for more than one locum agency over that year

- A NHS England local team – a small number of locum or short-term placement doctors who are not GPs may connect to one of these local teams (for example, they may work through a locum agency which is not a designated body)
- A NHS trust, where the doctor carries out most of their clinical practice even though they may also do some locum work in addition to this. (There are also an increasing number of regionally based locum provider banks placing locums, although working in this way does not necessarily lead to a connection to a trust)
- Health Education England, if the doctor is currently on a training programme

The relationships a secondary care locum doctor may have with organisations



General Practitioners

NHS GP locums are required to be on the [National Performers List](#) and therefore their prescribed connection is to NHS England (as their designated body). Their responsible officer is the responsible officer of the NHS England local team in the area where the doctor carries out most of their clinical work, or if their work is spread equally across a number of local team areas, their responsible officer is the one for the local team nearest their home address, as registered with the GMC. Many GP locums work freelance engaging with GP practices directly for employment, others sign up to an agency to arrange placements and some work within GP chambers and may use online platforms. GPs working solely in the private/non NHS sector will connect to a private sector designated body/locum agency.

Approved practice settings

Doctors who are new to the register, or are returning after a significant break (for example, from working in some other parts of the world), may have an Approved Practice Setting (APS) requirement on their registration. They will need to connect to a designated body with a responsible officer. They cannot work independently and freelance as a locum. [More information about APS can be found on the GMC website.](#)

How to find a doctor's designated body

The [GMC online connections tool](#) will help you find your designated body.

The Responsible Officer and those with governance responsibility

A designated body is required to nominate or appoint a responsible officer according to the rules set out in the Responsible Officer Regulations. Responsible officers have statutory duties in relation to doctors with whom the designated body has a prescribed connection. These include:

- Ensuring that proper identity and other pre-employment checks are in place
- Ensuring regular appraisals of connected doctors
- Managing concerns about a doctor's fitness to practise
- Monitoring conditions or undertakings imposed or agreed with the GMC
- Making a recommendation to the GMC about the doctor's revalidation, normally every five years

Often the responsible officer is also the medical director of the organisation. Designated bodies are required to have good governance systems which support the responsible officer in the discharge of their statutory role.

The term '*person with governance responsibility for the doctor's practice in a place where the doctor is working*' in this paper refers to a person in a setting other than the doctor's designated body.

For example, if a secondary care doctor works only as a locum connected to locum agency A (and has performed most of their work in the previous calendar year through locum agency A), their prescribed connection will be to locum agency A and the responsible officer of locum agency A will be their responsible officer. If that doctor is placed and undertakes sessions in an NHS trust, the trust medical director (who may also be the responsible officer for the trust) is the 'person with governance responsibility for the doctor's practice' in the trust. An individual doctor may relate to a number of such persons depending on their scope of practice.

If a GP locum works in a number of practices, or a GP chambers, the person with governance responsibility for their practice where they work as a locum is likely to be a partner/clinical lead in each setting during each placement. **Therefore, a partner/clinical lead in every GP setting should be specifically nominated to oversee clinical governance for locums and monitor their practice, for example, reviewing significant events and complaints.** It is good practice for GP practices to include locums and doctors in short-term placements in any governance and educational meetings that the practice has. Any concerns about a locum should be raised with the doctor in the first instance. Significant concerns or information of note should be escalated by the practice, or GP chambers to the GP's responsible officer (whose team manage those on the National Performers List), or the GMC as appropriate (see Appendix Ai for a suitable template to use for this communication).

A person with governance responsibility for a doctor's practice has a duty to cooperate with the doctor's responsible officer in addressing a concern about the doctor's practice. The information flows which support this, along with how information about a doctor should be appropriately shared, when and by whom, are

described in the guidance [‘Information flows to support medical governance and responsible officer statutory function’](#) (NHS England 2016).

Information on designated bodies, the responsible officer and clinical governance roles

More information can be found on the [GMC](#) and [NHS England](#) websites.

Joining a new locum agency

When a doctor registers with a new locum agency, that agency must establish whether the doctor’s **prescribed connection** is transferring to them.

If it is, then the previous responsible officer must pass information about the doctor’s practice, including appraisal outputs and any information of note, to the doctor’s new responsible officer in the new agency. The new responsible officer can also request this information from the previous responsible officer and the doctor.

If it is not, then the new agency should notify the doctor’s responsible officer to inform them that the doctor has joined their service. This is so that the doctor’s responsible officer is kept informed of the doctor’s full scope of practice, and is also able to share any information of note that might exist in relation to the doctor’s practice with the doctor’s new agency.

A number of templates exist to communicate this information already, including the established and widely used [‘Medical Practice Information Transfer \(MPIT\) form’](#) (NHS England 2013).

However, more up to date, concise and practical email templates can be found in Appendix A.

These templates may be used to communicate this information (whichever is most appropriate, depending on the information to be relayed):

- [The ‘e- Medical Practice Information Transfer \(e-MPIT\) form’](#) (see [Appendix Ai](#))
- [The ‘Notification to responsible officer of new locum engagement form’](#) (see [Appendix Aii](#))
- The original [‘Medical Practice Information Transfer \(MPIT\) Form’](#) (NHS England 2013) and its [Abbreviated template for email use](#) (see [Toolkit 5, page 49 of ‘Information flows to support medical governance and responsible officer statutory function’](#) (NHS England 2016)) may also be used to share information between responsible officers, but are longer templates.

When details of the new designated body are not immediately available, they can be stored and shared once the doctor’s connection to the new organisation is known.

3. Pre-employment checks

When a locum or a doctor in a short-term placement is recruited, a number of pre-employment checks are made to verify their identity and that they are compliant with

all the competency requirements of their given role. Locum agencies are expected to conform to [NHS Employers employment check standards](#).

If an organisation outsources pre-employment checks they must still be quality assured for compliance to the standards.

The usual checks that should be made are:

- Identity and right to work check and visa status if relevant, for example, the visa sponsor and how many hours a locum can work under the terms of the visa
- [GMC registration and licence check](#) including whether the doctor has any live warnings, conditions or undertakings
- The National Performers List information (if relevant)
- Any additional restrictions on practice and identification of adequate support if relevant
- HPAN notices
- Disclosure and Barring Service (DBS) checks - always enhanced checks
- Specialty qualifications or evidence that they have the appropriate skills and competencies for the placement
- Occupational Health checks relevant to the given role (for example, bloodborne virus health clearance including hepatitis B vaccination/immunity)
- Mandatory and statutory training in line with role (for example, safeguarding and cardiopulmonary resuscitation (CPR))
- Language checks
- Indemnity or insurance checks

A GP locum may **engage directly with GP practices** providing their credentials to the practice manager themselves. This may also now be done by sharing links to internet platforms. [The CQC provides GP practices with guidance about ensuring the suitability of GP locums including those employed through locum agencies](#).

Doctors have a responsibility under '[GMP](#)' (GMC 2013), to **declare any restrictions** previously placed on their practice to locum agencies and any organisations where they carry out medical work, including where they see patients independently. They should make these declarations before they start working in any new placement.

The pre-employment checks are made prior to the placement, but a doctor should also be asked to provide **photographic identification** (original passport or UK driving licence) at the start of their shift. This may be shown to the senior doctor/other clinician or manager on at the time of the shift and confirmation that it has been checked should be documented for purposes of an audit trail.

Healthcare Professionals Alert Notices (HPANs)

The National Clinical Assessment Services (NCAS), part of NHS Resolution, issues HPANs. The HPAN alert notice system is a process by which NHS bodies and others can be made aware of a registered healthcare professional whose performance or conduct gives rise to concern that patients or staff may, in future, be at risk of harm from inadequate or unsafe clinical practice or from inappropriate behaviour (NHS Employers, 2006). An NHS body may also request the issue of an alert notice where there are reasonable grounds to believe that a person may falsely present themselves as a healthcare professional and may seek work in that capacity.

HPANs are usually used whilst the regulator is considering concerns and provides an additional safeguard during the pre-employment checking process. NCAS will consider all appropriate requests and these can be made by locum agencies by using the form on the NCAS website or by contacting the HPAN team using the following email address: hpan@resolution.nhs.uk.

Once the HPAN has been authorised, copies are distributed electronically to the requester, Chief Medical Officers of Northern Ireland, Scotland, Wales and all responsible officers in NHS England regions, the regulator and to the practitioner it relates to. It may also be sent to any NHS body, or other organisation, which provides services to an NHS body. NHS organisations in England can check for HPANs on the NCAS webcheck service on the NCAS website but they need access to NHS.net secure email. Locum Agencies cannot directly access webcheck but can email NCAS direct to check whether an individual is subject to an active HPAN. Active HPANs are reviewed by NCAS at least every six months and earlier if they receive new information.

Information on Health Professional Alert Notices (HPANs)

[NHS Employers](#)

[National Clinical Assessment Service \(NCAS\)](#)

Occupational Health

It is important that all doctors comply with any relevant health checks requested of them by employers and that they declare any health issues that they have that might affect patient care.

The GMC gives clear guidance around this. [GMP \(2013\) Domain 2 – Safety and Quality](#) states:

'If you know or suspect that you have a serious condition that you could pass on to patients, or if your judgement or performance could be affected by a condition or its treatment, you must consult a suitably qualified colleague. You must follow their advice about any changes to your practice they consider necessary. You must not rely on your own assessment of the risk to patients' and 'you should be immunised against common serious communicable diseases (unless otherwise contraindicated).'

When healthcare workers are appointed to the NHS, employers are responsible for ensuring that standard healthcare checks are carried out for all new healthcare workers, including testing for bloodborne viruses (BBVs), such as hepatitis B, hepatitis C and HIV, for anyone carrying out exposure-prone procedures.

Information on occupational health

[NHS Employers guidance on work health assessments](#)

['Bloodborne viruses in healthcare workers: health clearance and management' Public Health England \(October 2017\)](#)

4. Induction

When a doctor registers with a locum agency, it should conduct its own compliance and induction process to help the doctor understand the clinical governance standards it operates to and how it will support them in their placements. This should also include an explanation of appraisal and revalidation processes, should the agency become the doctor's designated body. This is less applicable to GP/primary care locum agencies acting purely as a booking service.

The locum agency is responsible for liaising with trusts for any specific training that might be required. For example, some trusts have their own policies on deep vein thrombosis prevention or guidelines on the use of chaperones. In these cases, as some training requirements are trust specific, the trust should pass on their policies to the locum agencies so that they may be shared with the locum doctor before they are placed and only after they have confirmed that they have read and understood the trust specific policies.

It is also good practice for an organisation/healthcare provider engaging with a locum or a doctor in a short-term placement to provide an induction pack on or before arrival, providing appropriate information and involving additional training where necessary. Whilst this should be suitably tailored to the nature and duration of the placement, it also needs to be recognised that induction needs to be sufficient to support safe care as much in one session as for longer placements.

When doctors arrive at their place of work as a locum or doctor in a short-term placement, the organisation should provide them with adequate information to allow them to access the systems required to carry out their sessions safely.

At times, organisations need to recruit a locum out of normal working hours and at very short notice. To help mitigate any risk associated with this situation, maintain robust governance processes and ensure the doctor is supported as they should be, the organisation should have in place a plan for a shortened induction process which covers essential areas, but allows for quick and safe integration into the work environment.

Induction on a placement should include:

- A locum induction pack
- Access codes for appropriate buildings/departments
- IT systems passwords, codes and/or Smart cards including the ability to order investigations and a unique prescribing number for GPs, when available
- Access to guidance on appropriate local clinical pathways and protocols
- For short-term placement doctors, enrolment on to the organisation's induction programme (**examples of induction programmes** for [primary care locums](#) **can be found in Appendix Bi** and [secondary care locums in Appendix Bii](#))

As part of employment contract agreements, many healthcare organisations already require doctors to complete a number of online modules of **mandatory training** in addition to basic life support face-to-face training (which should include defibrillator training) annually. Where possible, doctors should be allowed to attend good standard basic life support training within the provider/trust setting.

These online modules might typically include the following topics:

- Information governance/data protection
- Adult and child safeguarding
- Equality and diversity
- Health and safety
- Infection control
- Counter fraud, bribery and corruption
- Conflict resolution
- Manual handling

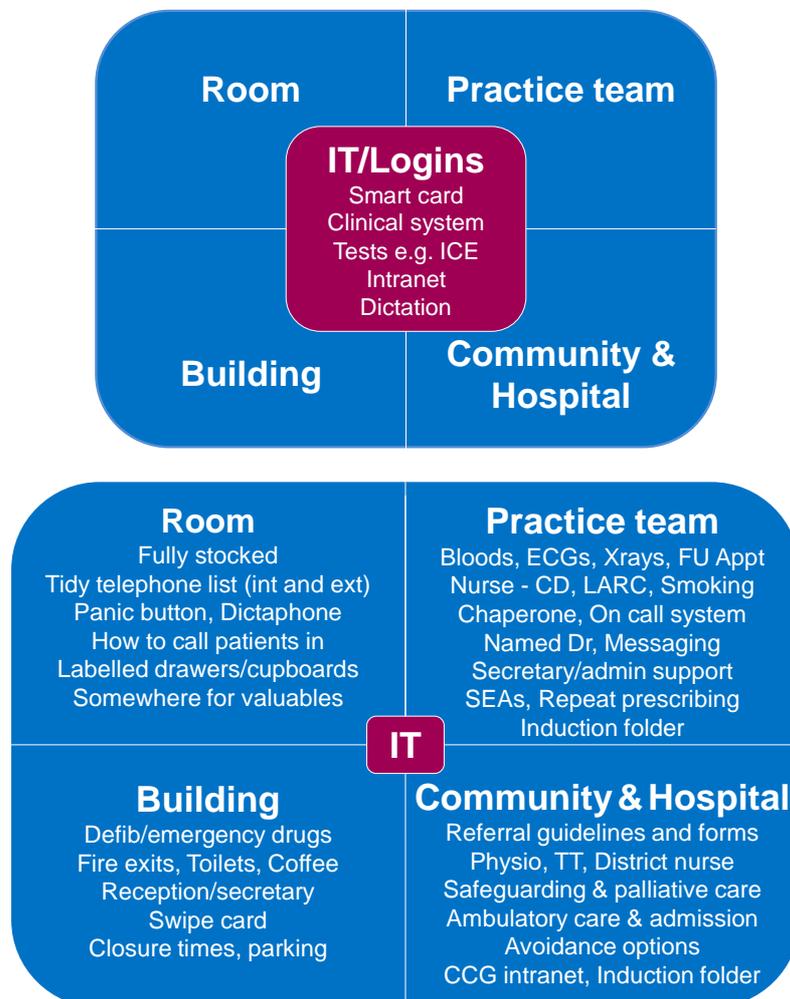
Some locum agencies and places of work require doctors to complete required mandatory training before actually being placed. Induction at a place of work is more likely to cover specific issues related to working in that environment or setting.

Organisations are also encouraged to support doctors in obtaining an NHS.net secure email address if they do not already have one, or an alternative secure email address if working outside the NHS.

If a placement is extremely short and a doctor's time at one particular organisation is limited, it may not always be practical or possible to achieve all of the above under induction (for example, attending a one/two day induction programme). However, organisations should still ensure that they provide doctors with sufficient access and information to be able to perform their role as effectively and safely as possible.

GP induction requirements, including those mentioned above, may be divided into the four areas below:

Domains of practice locum induction



(Paula Wright – sessional GP)

Information on induction packs for GPs

[Practice induction packs, CQC](#)

[Standard Practice Information Portal, National Association of Sessional GPs](#)

5. Appraisal, continuing professional development and supporting information

All doctors should plan to have one annual whole scope of practice appraisal that must reflect all the roles and places they have worked during that year. It is important that the doctor identifies their whole scope of practice so that they can make sure that their supporting information covers all aspects of their work/roles over the last year, not just where they are placed at the time of their appraisal. Their supporting information must cover any work they do in:

- Clinical (including voluntary work) and non- clinical (including academic) roles
- NHS, independent sector and private work

They should not be expected to list the details of every placement in that year. For example, as a GP they would not have to list every GP practice and time that they worked if there are many placements, however they should highlight the practices where they worked the most.

Organisations should support locum and short-term placement doctors with the appraisal process whenever possible.

The doctor's designated body should request that the doctor shares the most recent and previous appraisal documentation (or Annual Review of Competence Progression (ARCP)). The doctor's responsible officer will usually review the appraisal outputs, but is entitled to see the full appraisal documentation, including previous appraisals, in order to consider a full and balanced picture towards the doctor's revalidation recommendation. It is not essential that all the appraisals reviewed by the responsible officer prior to recommendation have to have been carried out by the doctor's current designated body.

Once locums and doctors in short-term placements are 'under notice' for revalidation recommendation by the responsible officer, i.e. it is four months until their revalidation recommendation date, they should not change their designated body (unless required under the Responsible Officer Regulations). This is good practice and should reduce deferrals and promote consistency of revalidation recommendation decisions as the current responsible officer reviewing the appraisal portfolio will have a better knowledge of the doctor.

Other agencies that the doctor registers with and places where the doctor works may request to see a copy of the doctor's most recent appraisal outputs/summary report, and/or other information relating to the doctor's practice such as the doctor's full scope of practice, to support clinical governance processes. This is not a GMC requirement but may be a cooperative arrangement with the doctor or can be mandated within the contract of engagement between the doctor and the organisation in question.

Appraisal outputs include:

- Personal development plan
- Summary of appraisal discussion
- Appraisal statements

What supporting information do doctors need?

[The GMC has guidance on what supporting information you must provide for your appraisal and revalidation.](#)

A designated body will have its own approach to scheduling appraisals for its doctors. For example, some responsible officers will expect doctors to have the appraisal in the same appraisal month every year. A designated body will need to be able to take a flexible approach to a locum or short-term placement doctor whose appraisal due date falls within the period during which the doctor is working in the organisation, even when this differs from the organisation's usual approach.

Ideally, a doctor should have the same appraiser for no more than three consecutive years and the designated body/agency should arrange this for the doctor. To avoid any appearance of bias or conflict of interest, it is good practice that a doctor does not appoint their own appraiser or know their appraiser on a personal or close-working basis. A responsible officer must be assured of, and have confidence in, the quality of both the appraiser and the appraisal. If they do not, then they may feel unable to accept the appraisal as being satisfactory and may request for the appraisal to be conducted again under terms that meet their assurance requirements.

Sometimes a provider organisation such as a hospital trust, where a doctor is placed, may support a doctor's appraisal by allocating a trust appraiser to them. Some locum agencies have a contractual term which requires providers to support appraisal processes for locums being placed for over three months:

Refer to the ['Medical Appraisal Logistics Handbook' \(NHS England 2015\)](#)

Some locum agencies and healthcare provider organisations will use their own appraisal IT system to record a doctor's appraisal. Otherwise, the doctor can prepare and record their appraisal using the [NHS England 'Medical Appraisal Guide \(MAG\) Form'](#), which includes guidance on how to complete it and provides the template for other toolkits including commercially available packages.

Due to the peripatetic nature of locum and short-term placement doctors, it is important that they retain personal copies of all their appraisals. This is particularly important if they are registered with multiple agencies and their designated body and responsible officer transfers from one organisation to another. Even though a doctor's designated body/locum agency may hold and transfer this information appropriately on behalf of a doctor, it is also the responsibility of all doctors to keep a record of all their appraisal information.

Information relating to how a doctor can prepare for their appraisal

[‘Medical Appraisal Guide \(MAG\): A guide to medical appraisal for revalidation in England’ \(NHS England 2014\)](#)

[‘Simplifying appraisal preparation for doctors – a statement to doctors from responsible officers in England’ \(NHS England, AMRC, BMA June 2017\)](#)

[‘Improving the inputs to medical appraisal’ \(NHS England 2016\)](#)

[‘Doctor’s medical appraisal checklist’ \(NHS England June 2016\)](#)

Specialty-related appraisal guidance that may also be helpful

From your specialty college and the [Academy of Medical Royal Colleges](#)

[GPC Guidance on appraisal for sessional GPs](#)

[RCGP appraisal and revalidation mythbusters](#)

Developing appraisers

Attention should be made to developing appraisers so that they understand the challenges faced by locums and doctors in short-term placements although they should feel confident appraising any doctor, whatever their role. The appointment of an appraisal lead for a group of appraisers is key to their development and quality assurance. This guidance and the accompanying guidance ‘Supporting locums and doctors in short-term placements: A practical guide for doctors in these roles’ (NHS England 2018), should be highlighted to appraisers who are appraising locums and doctors in short-term placements.

It is a responsible officer’s responsibility to ensure that appraisers and appraisals are quality assured. If using appraisers from outside the organisation, the responsible officer must be assured that the appraisals are of good quality and provide the information required for revalidation recommendation purposes. Refer to [‘The GMC protocol for making revalidation recommendations: Guidance for responsible officers and suitable persons’ \(5th edition GMC March 2018\)](#)

All appraisers should have relevant continuing professional development which is often obtained through an annual one-to-one review session with their appraisal lead; and holding quarterly/six monthly collective appraiser workshops, led by an appraisal lead. Such workshops allow appraisers to anonymously raise and discuss issues/queries and share experiences and learning. Similarly, appraisers could be further supported by having access to an appropriate online group chat forum to query issues with their peers/fellow appraisers.

Feedback from locum and doctors in short-term placements should be sought after their appraisal and quality assurance of appraisers should be carried out. For reference to further appraiser development and quality assurance resources please see both the NHS [‘Quality assurance of appraisal guidance notes’ \(NHS England 2016\)](#); and the [‘Medical appraisal policy’ \(NHS England 2015\), Annex J: Routine appraiser assurance tools including the ASPAT.](#)

Technology-assisted appraisal (for example, Skype)

It may be helpful to have a technology-assisted appraisal remotely for a number of reasons including the geographical distance between the doctor and the appraiser/designated body. As video technology continues to evolve and becomes a more stable and quality medium, more appraisal discussions are being conducted in this way each year.

However, it is still considered best practice to have at least two face-to-face appraisals within a five year cycle, particularly for the first appraisal in a cycle, or with a new appraiser, or for the last appraisal prior to the revalidation recommendation. The appraisal discussion between the doctor and the appraiser is an important part of the doctor's development and conducting it face-to-face may improve communication and the rapport they establish with the appraiser. As technology improves further, this may become less of a concern and technology-assisted appraisal may offer additional benefits. If a doctor would prefer, or specifically requests to have a face-to-face appraisal, this should be accommodated.

When a technology-assisted appraisal takes place, it is essential that the appraiser is able to establish sufficient proof of identity from the doctor, before the discussion begins. The technology must function adequately without interrupting the flow of the appraisal discussion. The use of technology-assisted appraisal should be agreed with your responsible officer in advance and will need approval by the organisation to ensure that it meets the organisation's security and governance standards as well as maintains confidentiality. Appraisal by telephone/audio only would not normally be considered appropriate, nor an acceptable method of appraisal.

Guidance on the use of technology-assisted appraisal

['NHS England Medical Appraisal Logistics Handbook' \(NHS England November 2015\)](#), page 25, Topic 8.

Continuing professional development (CPD)

All doctors are responsible for their own CPD covering the scope of their practice as outlined above. Doctors in short-term placements should be informed of opportunities to access educational sessions at their place of work. This may occur during or outside contracted sessions, depending on the terms of their engagement. The attendance at GP practice meetings, educational events or other multidisciplinary team meetings during a placement has to be balanced with the provision of care for which they are employed. CPD may occur through learning and reflection on various activities (including self-directed learning groups, which might be via secure online platforms) and from feedback.

Organisations should ensure that all clinicians, regardless of duration of placement, have access to essential policies, and resources provided to support standards of clinical practice. Appropriate professional contact between peers should also be encouraged and where possible facilitated.

Organisations are actively encouraged to support locum and short-term placement doctors by providing relevant information held by the organisation that may contribute to CPD such as clinical governance data, learning events analysis, quality improvement activity, significant events and complaints.

GP locums should be given access to Clinical Commissioning Group (CCG) run educational sessions, including cardio-pulmonary resuscitation and safeguarding training, along with routine circulation of updates relating to new national and local guidance as well as initiatives within their CCG.

Quality improvement activity

Often, locum and short-term placement doctors' quality improvement efforts have to be focused on their own personal practice. This limits the value of audit as a model for quality improvement activity. Organisations are encouraged to allow appropriate access to systems including patient data, outside of working shifts to enable them to complete work for their appraisal portfolio.

Examples of quality improvement activity include:

- Case reviews
- Reviews of clinical outcomes and national audit data such as, Health Quality Improvement Partnership (HQIP) for secondary care doctors
- A quality improvement data exercise or audit (group or personal)
- Prescribing, record keeping or referral audit/review

In addition, any activity that results in an improvement in practice may be included.

Information on quality improvement activity

For further information relating to quality improvement activity and other supporting information please see:

[‘Doctor’s medical appraisal checklist’ \(NHS England June 2016\)](#)

[Guidance on supporting information for appraisal and revalidation \(GMC 2018\)](#)

[Healthcare record standards \(Royal College of Physicians\)](#)

[RCGP appraisal and revalidation mythbusters](#)

Patient and colleague feedback

[Patient and colleague feedback to meet the GMC’s requirements for supporting information](#) may be gathered during placements, although it is recognised that there may be some difficulties if doctors are working for just a short period of time in an organisation. However, the feedback may be collected over time and should be from as many placements as possible covering their scope of practice. The colleagues asked to give feedback may not have worked with the doctor for long and so their views may be based on a limited encounter with them. The doctor may need to ask for colleagues’ email contact details during the placement to facilitate gathering this feedback. They should also be encouraged to request feedback from colleagues within the locum agency or chambers (where relevant).

The doctor’s written reflection, relating to the feedback received, should be insightful with an understanding of how the way a locum works might affect feedback given. Locum doctors should be encouraged to start collecting their patient and colleague feedback questionnaires in good time within the revalidation cycle (such as in the year prior to the revalidation recommendation year) to ensure that it meets the GMC requirements and so that the doctor can reflect on and discuss it at the appraisal.

Doctors should also be encouraged to reflect on any other relevant feedback (other than that collected with questionnaires) which may be received throughout the revalidation cycle, such as letters and emails (anonymised for their appraisal portfolio) or relevant organisational feedback.

Case studies – patient feedback

GMC case studies about locum doctors collecting patient feedback may be found here:

[Patient feedback case studies \(GMC\)](#)

Compliments, complaints and significant events

A doctor can reflect and learn from any positive and negative significant events and compliments. They should be encouraged to include this learning in their appraisal portfolio.

If a doctor is named in a complaint, significant event or serious untoward incident/patient safety incident, then **they should be:**

- Informed in a timely manner of the complaint
- Given access to the medical records
- Allowed to contribute to the official response to the patient after consulting their medical defence organisation
- Informed of ongoing outcomes of this response in a timely manner
- Able to meet with the complainant to resolve the issue if necessary
- Given access to the related documentation for their appraisal

Organisations should have IT systems in place for safe storage and access to the documentation relating to these events. Multidisciplinary and system learning should take place and locum and short-term placement doctors should be encouraged to attend this learning whenever possible. All team members should reflect on the discussion and outcome of this learning which may be evidenced and submitted in appraisal portfolios.

The locum or short-term placement doctor's responsible officer should be notified of the outcome of these events by the organisation (see Appendix Ai for a suitable template to communicate this). If there are significant concerns, information must be shared straight away – see: ['Information flows to support medical governance and responsible officer statutory function' \(NHS England 2016\)](#).

Probity and health declarations

The appraisal probity statement should be completed by all doctors; suspensions, exclusions, restrictions, undertakings or investigations listed if present, with reflection. A declaration that the doctor has appropriate and adequate indemnity covering their scope of practice should be made. The health statement should be signed by the doctor and they should include any references to occupational health assessments or other health issues that may affect their work.

Locum agencies and healthcare providers should ensure that doctors are not placed in an environment that might lead to a breach of any restrictions or conditions.

End of placement/exit forms

At the end of the placement it is good practice for locum or short-term placement doctors to obtain feedback from a senior clinical colleague/peer in the form of an end of placement or exit form/report. A number of templates already exist, for example the 'End of Assignment Assessment Report' from the Crown Commercial Service framework.

However, a more up to date, concise and practical email template - [an 'e-Medical Practice Information Transfer \(e-MPIT\) form'](#) - can be found in [Appendix Ai](#), which can be used to communicate this information.

It is particularly important for organisations to support locum and short-term placement doctors in obtaining feedback on completion of a placement. The exit form provides feedback to the doctor and, where relevant, their locum agency relating to their clinical work in that placement. This may be to simply state that there have been no concerns, or to highlight good practice, but could also be a prompt to suggest opportunities for further development. This feedback can be used as supporting evidence for a doctor's annual appraisal.

Ideally, this feedback will be collected and collated using an electronic template, such as the e-MPIT form. The doctor or the locum agency (where relevant) may make this request after the placement but it is good practice to collect such feedback before the doctor leaves the setting.

Doctors may retain copies of their exit forms and provide them to new locum agencies at registration as on-going referencing. In some places the exit form is incorporated into the doctor's timesheet, creating a mechanical link between compliance and payment.

Currently, the exit form response rate from healthcare providers is extremely low. This reduces the doctor's opportunity to reflect on the positive or negative nature of such feedback and to include any relevant areas in their personal development plan for the future. It is hoped that the use of the e-MPIT form ([Appendix Ai](#)) may help improve, ease and speed up this process, particularly for senior clinicians in giving feedback. In the future, it may also be possible to facilitate electronic feedback from the doctor to the organisation as well.

The ['Generic medical in-post review template' page 38 of 'Improving the inputs to medical appraisal' \(NHS England 2016\)](#) may also be used to gain feedback from a colleague. This form is particularly helpful if the doctor has worked in one setting for three to four weeks, or as a regular locum there.

These templates encourage collecting evidence from different places of work and therefore the doctor's full scope of practice. The feedback discussed above should be reflected on and submitted as evidence in the doctor's appraisal portfolio.

6. Clinical Governance and responding to concerns

Quality assurance

It is a reality that the provision of temporary locum and short-term placement clinicians by locum agencies is a commercial business in a competitive market. It can

be challenging to operate in this environment when **commercial interests must be balanced against strong clinical governance processes**. Locum agencies and revalidation management services should always ensure that they set strong, robust clinical governance standards to provide assurance relating to clinicians in this part of the work force, quality of care and the protection of patients.

Some locum agencies appoint responsible officers who carry out this role for a number or designated bodies. There is a risk that the responsible officer may have less direct involvement in the locum agency systems and with the board or governing body as a result. It may also be the case that a responsible officer is not always the medical director or clinical lead for the designated body. If this is the case, there should be strong lines of communication between the organisation, medical director and the responsible officer for good governance. The responsible officer should have direct access to the designated body's board or governing body which must provide adequate resource to the responsible officer so that they may execute their statutory function. The responsible officer should provide regular reports to the board/governing body relating to the appraisal, revalidation and governance systems of the organisation. If the responsible officer is not supported by the board or governing body in their role then escalation to the higher level responsible officer would be appropriate.

Responsible officer governance responsibilities also include appropriately sharing information and systematically responding to queries with a documented and securely stored IT audit trail about a doctor when raised – see: [‘Information flows to support medical governance and responsible officer statutory function’ \(NHS England 2016\)](#). Those that do not risk action being taken under the quality assurance processes set out below including those set by the CQC, NHS England and framework operators.

Trusts/healthcare providers are regarded as responsible by the **CQC** for clinical governance around the locum doctors they engage with under the [‘well led’ domain](#), and organisations may wish to bear in mind that CQC inspection teams may take into consideration the performance of organisations against the standards set out in this guidance.

The NHS England Regional Medical Director/Higher Level Responsible Officer (HLRO) also seeks assurance from all designated bodies and responsible officers around clinical governance systems in relation to locums and doctors working in short-term placements through the process of a **Higher Level Responsible Officer quality review**, which includes a visit to the designated body, carried out by the regional revalidation team.

Trusts/healthcare providers should ensure they only contract with and receive locum and short-term placement doctors from a locum agency that is on one of NHS Improvement's **approved framework agreements**, or from a locum agency that sub-contracts with a locum agency that is on one of these frameworks.

Trusts/providers of healthcare often need to recruit a locum doctor at very short notice to fill a vacancy and the pressure to do so sometimes results in them dealing with agencies that are not on the framework. However, to assure quality and clinical governance standards of agency staff, and to protect patients, trusts/providers should always try to avoid this option. If it is necessary to engage with agencies that are not

on an approved framework agreement, then it is particularly important that the checks outlined above are carried out.

Audits of agencies which have signed up to framework agreements are carried out against the criteria set out by NHS Improvement. **Framework agreement operators** should also audit the performance of their organisations against the standards set out in this guidance, particularly in checking that locum agencies are conducting appraisal and revalidation, and responding to concerns appropriately.

Information on approved framework agreements for the provision of agency staff

[NHS Improvement – NHS agency staff: rules and price caps](#)

Performance issues and concerns

Doctors working as locums and in short-term placements should still be integrated into the organisation's **governance systems** in a manner appropriate to the nature and duration of the placement to support a consistent and safe standard of care. They should be made aware of escalation processes.

It is good practice for **secondary care consultants** when handing over patients to other consultants at the end of a shift, to ensure that they hand over information about any locum doctors in the same way. For example, who they are and if they require any additional support or supervision.

As mentioned previously, locums and short-term placement doctors should be given **access to information** held about any complaints, significant events and serious untoward incidents that they have been involved in where they work. They should also be offered the opportunity where appropriate to comment on such events. This allows them and others to reflect and learn. These events should also be shared with their responsible officer.

If a performance issue arises, the doctor is obliged to engage with any processes responding to the concern. They, and the person with governance responsibility for their practice in the place where they are working, should notify the locum agency or GP chambers (where relevant) if any information of note arises in relation to their practice during or following their placement and/or their responsible officer if the agency is not their designated body. The person with governance responsibility for their practice in the place where they are working and their responsible officer will decide whether any necessary investigation is carried out in the organisation, although the doctor's responsible officer should take overall responsibility and oversight of the process of investigation and managing concerns.

In the case of a secondary care locum, the trust/provider in which the incident occurred should, if appropriate, refer the case to the doctor's responsible officer. They also have the ability to refer directly to the GMC, although the GMC may signpost them back to the doctor's responsible officer after an initial assessment of the matter. The doctor should engage with such processes and comply with any conditions or restrictions, as well as any remediation. They should also be advised to take advice from their defence organisation and to seek additional appropriate support while the process takes place.

Significant **concerns, conditions or restrictions to the doctor's practice** must be shared by the doctor with any locum agency they register with as well as any place that they work. The doctor's designated body's responsible officer should also share this appropriately with any organisations where the doctor is working.

Information on responding to concerns

['Maintaining high professional standards in the modern NHS' \(DH 2005\)](#)

[Responding to concerns \(NHS England\)](#)

Indemnity and insurance

The GMC states that 'a doctor must have adequate and appropriate insurance or indemnity in place'. This means that medical defence organisations or insurers must be informed by the doctor when their scope of practice or the number of sessions worked changes, so that they are fully indemnified for the work that they do. If medical indemnity or insurance is purchased abroad then the doctor should be able to demonstrate that it is comparable in cover (with a similar minimum pay out) to indemnity and insurance offered in the UK. The level of continuing indemnity and insurance cover after a doctor retires or stops working clinically should also be considered.

In addition the GMC can:

- Check that any doctor practising in the UK has adequate and appropriate insurance or indemnity cover
- Remove a doctor's licence to stop them from practising altogether, if they learn that they do not have adequate and appropriate insurance or indemnity or if they fail to give the GMC the information they ask for
- Refuse to grant a licence to a doctor if they cannot assure the GMC that they will have the adequate and appropriate insurance or indemnity by the time they start practising in the UK

Some secondary care locums rely on trust indemnity and do not have additional personal cover. However, this is not recommended because these locums are not covered for legal representation under trust indemnity if they come before a GMC tribunal – they would need to either represent themselves or self-fund legal representation in this situation.

If a doctor is required to travel in the community as part of their work, for example carrying out home visits or working across sites, then they also need a valid driving licence and business cover within their car insurance. As a GP they must ensure that their indemnity or insurance covers any out of hours or extended access work that they do. If in doubt they should be encouraged to seek advice from their indemnity or insurance provider.

Adequate and appropriate indemnity or insurance is a doctor's personal responsibility and it should be declared in a doctor's appraisal. The organisation and responsible officer has a duty of care to both patients and the doctors and may check that they have appropriate and adequate indemnity.

Information on indemnity and insurance

Further guidance from the GMC on [Insurance indemnity and medico-legal support](#).

Sharing of information

A new cultural appreciation by doctors, locum agencies and engaging organisations that the above responsibilities are required to protect patients will increase commitment to action, in particular engaging with new processes for the provision and sharing of information, as set out in [‘Information flows to support medical governance and responsible officer statutory function’ \(NHS England 2016\)](#). Locum agencies and providers are encouraged to develop stronger relationships so that agreed standards may be developed and used routinely when engaging with locums and doctors in short-term placements: [Information Sharing Principles, GMC](#).

It is important that when concerns arise about a doctor, all relevant parties share information appropriately. For example, trusts/providers should always feedback to a locum agency if they are not happy with a locum or short-term placement doctor, otherwise the agency is unable to deal with the issue and the doctor is unable to address any required changes in their behaviour, attitude or skills. Consequently, doctors with development needs will continue to move around the system without action being taken, putting patients and colleagues at risk. It is important that concerns are shared in this way rather than just a decision made to terminate a contract early, or not to employ the locum in question in the future.

Where a contract/placement is terminated early, the doctor and their responsible officer should be informed of the reasons why and, if this does not happen, the doctor’s responsible officer should chase this up with the employing organisation as a matter of routine.

The [‘e-MPIT form’ \(Appendix Ai\)](#) and the [‘Notification to responsible officer of new locum engagement’ \(Appendix Aii\)](#) are concise templates for sharing information in this way.

The original [‘Medical Practice Information Transfer \(MPIT\) Form’ \(NHS England 2013\)](#) and its [Abbreviated template for email use \(see Toolkit 5, page 49 of ‘Information flows to support medical governance and responsible officer statutory function’ \(NHS England 2016\)\)](#) are also suitable for sharing information between responsible officers/organisations about doctors, but are longer templates.

The use of the above templates also promote the sharing of significant information such as complaints, significant events and serious untoward incidents, between a person with governance responsibility for the doctor’s practice in a place where the doctor is working and the doctor’s responsible officer – securely emailed directly to the responsible officer if necessary.

Occasionally, locum or short-term placement doctors fail to turn up for their shifts without sufficient notice (without a valid reason). This can put patients at risk. Responsible officers are also encouraged to feed this back to the doctor and locum agency responsible officer (where applicable) as it could raise questions about their fitness to practise and adherence to the standards of Good Medical Practice or be an indicator of other issues which need to be addressed.

If organisations fail to share relevant information of note appropriately, this may be escalated as an issue of concern to the Regional GMC Employer Liaison Advisor (ELA) and the relevant regional NHS England Higher Level Responsible Officer.

7. Conclusion

This guidance is intended to lead to safer patient care, improved support and a more rewarding experience for locums and doctors in short-term placements, along with strengthened governance processes – managed by those who engage with this important sector of the medical workforce. Much of the suggested practice that it contains is good practice for engaging with all doctors. The short-term and peripatetic nature of the work undertaken by this group of doctors, and the cross-organisational boundaries across which information must flow, create a challenge to develop and implement governance processes that are sufficiently slick and efficient to ensure patient safety and clinician support in a pragmatic and productive way. Meeting this challenge will have significant impact on governance processes in general as well as in this important context.

8. Appendices

Appendix Ai – e-Medical Practice Information Transfer (e-MPIT) form

This template can be copied and pasted into an email. It should be used by responsible officers, clinical governance leads and/or senior clinicians engaging with locum doctors and doctors in short-term placements to **communicate information of note** to the doctor, the doctor's responsible officer and/or the doctor's locum agency.

It can also be used as an **end of placement/exit form** to simply state that there have been no concerns, or to highlight good practice, but could also be a prompt to suggest opportunities for further development. This could be used by the doctor as supporting evidence towards their annual appraisal and revalidation recommendation.

To:	[DOCTOR'S RESPONSIBLE OFFICER OR DELEGATE]
Cc:	
Subject:	CONFIDENTIAL: e-MPIT form – Re: [NAME OF DOCTOR] GMC Number: [GMC NUMBER] Date(s) of placement: [DATE(S)] Placement: [LOCATION AND NATURE OF PLACEMENT]

Dear [DOCTOR'S RESPONSIBLE OFFICER OR DELEGATE]

Please find below a completed medical information transfer form in relation to the doctor and placement defined above, for your information and action as appropriate.

Yours sincerely,

[SENDER'S ADDRESS BLOCK]

[DELETE THIS INSTRUCTION AND THE OPTIONS WHICH DO NOT APPLY]

1. Information of note relating to the Doctor's practice

I have no information of note to share.

I have the following information for the Responsible Officer to note or take action:

2. Supporting documentation

No supporting documentation to describe / share.

Supportive information is attached.

3. Communication with the Doctor

The doctor is copied in.

I have shared this information with the doctor by another means.

I am not sharing a copy of this information with the doctor. I understand the doctor can request to see the information shared in this message, and in all but the most exceptional circumstances is entitled to do so.

This form is sent in keeping with the regulations and guidance set out in the original published MPIT form (<https://www.england.nhs.uk/medical-revalidation/ro/info-docs/mpit-form/>).

Appendix Aii – Notification to responsible officer of new locum engagement

This template can be copied and pasted into an email. It should be used by organisations (for example and where appropriate: GP practices, locum agencies, trusts) to notify the doctor's responsible officer that the doctor has joined their service. This is so that the doctor's responsible officer is kept informed of the doctor's full scope of practice, and is also able to share any information of note that might exist in relation to the doctor's practice with the doctor's new agency/placement.

To:	[DOCTOR'S RESPONSIBLE OFFICER]
Cc:	
Subject:	CONFIDENTIAL: Notification to responsible officer of new locum engagement of [DR FIRSTNAME LASTNAME], GMC No: [GMC NUMBER]

Dear [RESPONSIBLE OFFICER]

Dr [LASTNAME] is taking up a new position as [POSITION] at [ORGANISATION] and has verified that that you are their responsible officer. I am writing to let you know this so that you can update your information about their scope of practice.

Our [POSITION], [TITLE NAME] (copied in), is the person with governance responsibility for all doctors in their work at [ORGANISATION]. Their mobile is [0123 456 789]. If, whether now or in the future, you have any enquiries to make in relation to this doctor, or any information of note to share about their practice in relation to patient safety please address these to [TITLE NAME].

Information of note about the doctor's practice

In the process of applying for this position the doctor has declared the following:

- Information of note to share about their practice: Yes / No
- Details:

If the doctor answered 'No' this specifically means they have indicated that they are not referred to the GMC, are not subject to GMC conditions or undertakings, and are not subject to any local restrictions on their practice.

If this declaration is at variance with any information which you hold please let me know as soon as possible.

Communication with the doctor. Dr [LASTNAME] is copied into this message.

Appendix Bi – Example of a Clinical Commissioning Group (CCG) induction day for GPs (trainees and locums)



New doctor induction events

Short presentations on how to get things done in N. Tyneside.

14.00 Introduction

Clinical Chair, NHS North Tyneside Clinical Commissioning Group

Welcome. Introduction to the CCG and what it does, the health needs in North Tyneside and how the CCG is working to address them and an overview of service developments, which will be explored in more detail in the sessions following.

14.30 Urgent Care

GP Village Green Surgery, Wallsend and Medical Director NTCCG

How to access urgent care for patients – services for extended access to primary care services and how to keep your patients out of hospital if possible.

15.00 Medicines management and community resources

Pharmacist Practitioner, Collingwood Health Group

CCG prescribing policies, improving prescribing practice and making best use of community resources for medicines management.

15.30 TEA

15.45 Community falls service and Care Plus frailty service

GP commissioning fellow, NHS North Tyneside CCG

Review of the new community falls service and services for patients with frailty.

16.15 End of life

GP Collingwood Surgery, clinical lead for end of life care

End of Life pathways in NT. Use of the Deciding right documents and GP Palliative care templates and registers

14.00 Planned Care

GP Village Surgery, Wallsend

Primary care is under increased pressure to evaluate/refine elective referrals to hospitals. The CCGs are working together with trusts to improve this interface. The session will provide insight into current progress and new pathways/service provision for some of the specialities across North Tyneside including the referral management system and value-based commissioning.

14.30 Mental health

Executive Partner at Collingwood Health Group

Freelance consultant and North Tyneside CCG clinical lead in Patient Centred care

What is available for patients with mental health problems in North Tyneside, which service is most appropriate and how to make best use of them.

15.00 Chronic pain

Executive Partner at Collingwood Health Group

Freelance consultant and North Tyneside CCG clinical lead in Patient Centred care

How to help your patients with chronic pain and reduce the use of opiate painkillers.

15.30 TEA

15.45 Mental Capacity Act and adult safeguarding

Adult safeguarding team

A quiz of general adult safeguarding themes covering government policy and legislation, the Mental Capacity Act(MCA), Domestic Abuse and Domestic Homicide Reviews(DHR), best interest decision making and how to share concerns to the relevant agencies

16.15 Child safeguarding

Child safeguarding team, North Tyneside

A quiz of general child safeguarding themes covering National and Local cases, Government Policy and Legislation, different types of abuse, recognition and how to make a referral if you have a concern.

16.45 Evaluation and final questions

Appendix Bii – Example of a NHS trust induction day programme:



University Hospitals of
Derby and Burton
NHS Foundation Trust

Day 1

Time	Day 1 Activity
8.00 – 8.30	Registration and Trust ID badge
8.30 – 8.45	Welcome / introduction
8.45 – 9.15	Welcome to our organisation
9.15 – 9.45	Meet our people
9.45 – 10.15	Understand our patients
10.15 – 10.45	Market place & refreshments
10.45 – 11.30	Human factors
11.30 – 12.30	Fire
12.30 – 13.00	Lunch
13.00 – 14.00	Dementia awareness
14.00 – 15.30	Prevent (Wrap 3)
15:30 – 16:00	IT training services

Day 2

Time	Day 2 Activity
8.20 – 8.30	Introduction to day 2
8.30 – 9.30	Blood product theory
9.30 – 10.30	ANTT & hand hygiene
10.30 – 11.15	Mental Capacity Act
11.15 – 12.00	Falls prevention
12.00 – 12.30	Lunch
12.30 – 14.30 14.30 – 16.30	Group 1 Resus + patient handling
12.30 – 14.30 14.30 – 16.30	Group 2 Patient handling + resus

Appendix C – Useful resources

Abbreviated Medical Practice Information Transfer (MPIT) template:

Please use the following link to page 50 of:

'Information flows to support medical governance and responsible officer statutory function' NHS England, August 2016, found here:

<https://www.england.nhs.uk/medical-revalidation/ro/info-flows/>

Generic medical in-post review template:

Please use the following link to page 38 Appendix B of 'Improving the inputs to medical appraisal' NHS England 2016, found here:

<https://www.england.nhs.uk/medical-revalidation/appraisers/improving-the-inputs-to-medical-appraisal/>

Mandatory training / Core Skills Frameworks – Skills for Health:

<http://www.skillsforhealth.org.uk/services/item/146-core-skills-training-framework>

GP resources:

<http://www.rcgp.org.uk/training-exams/practice/revalidation/mythbusters-appraisal-and-revalidation.aspx>

<http://www.nasgp.org.uk/spip>

<https://www.cqc.org.uk/content/nigels-surgery-58-practice-induction-packs>

<https://www.cqc.org.uk/content/nigels-surgery-50-gp-locums>

<https://www.nesg.org.uk/appraisal-revalidation>

<https://www.nasgp.org.uk/appraisalaid/2-appraisal-quality-improvement-activities-qia/>

GP locum resources related to complaints and significant events:

<https://www.nasgp.org.uk/appraisalaid/6-complaints/>

<https://www.nasgp.org.uk/appraisalaid/3-significant-event-analysis-sea/>

GP locum resource relating to feedback:

<https://www.nasgp.org.uk/faqs/spip-toolkit-exit-feedback-locum-practice/>

YouTube GP resources:

<https://youtu.be/dMEL7QpipZo>

A guide to GP locum induction and support:

<https://youtu.be/QAyeUxr32kw>

For practice managers:

Part 1:

<https://youtu.be/phoqQUrn9s0>

Part 2:

<https://youtu.be/phoqQUrn9s0>

Further advice for locum GPs:

<https://www.bma.org.uk/advice/employment/appraisals/appraisal-tips-for-sessional-gps>

<https://www.nasgp.org.uk/appraisalaid/5-colleague-feedback/>

'With SUPPORT from practices locums can provide HOPE' BMA blog 2016:

https://www.bma.org.uk/connecting-doctors/the_practice/b/weblog/posts/with-support-from-practices-and-vision-from-ccqs-locums-can-provide-hope-for-general-practice

Appendix D – References

'The Skipton House Expert Group Statement on Locum and Short-Term Doctors' (NHS England May 2017):

(please request via england.revalidation-pmo@nhs.net)

'Simplifying appraisal preparation for doctors – a statement to doctors from responsible officers in England' NHS England, AMRC, BMA June 2017:

<https://www.bma.org.uk/advice/employment/appraisals/useful-appraisal-resources>

'Improving the inputs to medical appraisal' NHS England 2016:

<https://www.england.nhs.uk/medical-revalidation/appraisers/improving-the-inputs-to-medical-appraisal/>

'Doctor's medical appraisal checklist' NHS England, June 2016:

<https://www.england.nhs.uk/medical-revalidation/doctors/doctors-medical-appraisal-checklist/>

'Medical Appraisal Guide: Model Appraisal Form' (MAG V4.2) NHS England 2016:

<https://www.england.nhs.uk/medical-revalidation/appraisers/mag-mod/>

'Information sharing principles' GMC 2018:

<https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/the-responsibilities-of-responsible-officers-and-designated-bodies-in-preparing-for-revalidation/information-sharing-principles---purpose-and-context>

The National Performers List:

<https://www.performer.england.nhs.uk/>

Taking revalidation forward: improving the process for relicensing for doctors' Sir Keith Pearson's report (Jan 2017):

https://www.gmc-uk.org/-/media/documents/taking-revalidation-forward---improving-the-process-of-relicensing-for-doctors_pdf-68683704.pdf

'Information flows to support medical governance and responsible officer statutory function' NHS England, August 2016:

<https://www.england.nhs.uk/medical-revalidation/ro/info-flows/>

'NHS England Medical Appraisal Logistics Handbook' NHS England, November 2015:

<https://www.england.nhs.uk/medical-revalidation/ro/ma-handbook/>

'Good Medical Practice' GMC 2013:

https://www.gmc-uk.org/guidance/good_medical_practice.asp

Responding to concerns (NHS England):

<https://www.england.nhs.uk/medical-revalidation/ro/resp-con/>

'Maintaining high professional standards in the modern NHS' DH 2003:

http://webarchive.nationalarchives.gov.uk/20130123204228/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103586

Healthcare Professionals Alert Notices (HPANs):

NHS Employers:

<https://www.nhsemployers.org/your-workforce/recruit/employment-checks/professional-registration-and-qualification-checks/copy-of-alert-notice-system>

National Clinical Assessment Service (NCAS):

<https://www.ncas.nhs.uk/about-ncas/alert-notices/>

Healthcare Professionals Alert Notices Directions 2006:

http://webarchive.nationalarchives.gov.uk/+http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_4140332

The National Health Service Litigation Authority Directions 2013:

<https://www.gov.uk/government/publications/nhs-litigation-authority-directions-2013>

Appendix E – Contributors

Simon Bennett	Director of Business & Operations - Medical Directorate	NHS Improvement
Vicky Banks	Associate Medical Director Revalidation, Quality & Appraisal Lead	NHS England (South)
Julie Bullock	Director	Healthcare Licensing Support Ltd
Susi Caesar	Medical Director for Revalidation	Royal College of General Practitioners
Ruth Chapman	Associate Medical Director, Revalidation & Regional Appraisal Lead	NHS England (London)
Mark Cohen	Project Manager, Professional Standards Team, Medical Directorate	NHS England (National)
Maurice Conlon	Clinical Advisor, Professional Standards Team, Medical Directorate	NHS England (National)
Ros Crowder	Deputy Director (Revalidation), Medical Directorate, South Region	NHS England (South)
Ray Field	Revalidation Lead, Medical Directorate, London Region	NHS England (London)
Richard Fieldhouse	Chair	National Association of Sessional General Practitioners
Kirsty Foster	National Infection Service	Public Health England
Ian Grant	Responsible Officer	Healthcare Licensing Support Ltd
Jenny Kirk	Project Manager, Professional Standards Team, Medical Directorate	NHS England (National)
Kit Latham	locum doctor	
Daniel McAlonan	Head of Regulation, Education & Training	British Medical Association
Helen McGill	Medical Director & Responsible Officer	NHS Professionals
Mark Sanderson	Deputy Regional Medical Director, Midlands & East Region	NHS England (Midlands & East)
Tracie Spires	Head of Quality & Compliance	Athona Recruitment Ltd
Kirstyn Shaw	Principal Employer Liaison Adviser	General Medical Council
Nigel Sturrock	Executive Medical Director	Derby Teaching Hospitals NHS FT
Paul Twomey	Joint Medical Director, North Region (Yorkshire and the Humber)	NHS England (North)
Elizabeth Tysoe	Employer Liaison Advisor, London Region	General Medical Council
Lindsey Westwood	Head of Revalidation	General Medical Council
Paula Wright	Sessional GP	
Pallant Medical Chambers		
Yorkshire Medical Chambers		

