Sherwood Forest Hospitals
NHS Foundation Trust

TITLE: Providing Emergency Cover for Junior Colleagues commonly known as "Acting Down"

Document Category:	**PEOPLE DIRECTORATE**
Document Type:	**PROCEDURE**

Keywords:	

Version:	Issue Date:	Review Date:
5	25th September 2025	01/09/2027

Supersedes:	4		
Approved by (committee/group):	Joint Local Negotiating Committee	**Date Approved:**	18/09/25

Scope/ Target Audience: (delete as applicable and/ or describe)	**Medical Workforce**
Evidence Base/ References:	N/A
Lead Division:	Corporate
Lead Specialty/ Department: (Or Division if 'divisionally' owned)	People Directorate
Lead Author: (position/ role and name)	Head of Medical Workforce
Co-Author(s): (position/ role and name if applicable)	
Sponsor (position/ role):	Executive Director of People

Name the documents here or record not applicable (these are documents which are usually developed or reviewed/ amended at the same time – ie a family of documents)	
Associated Policy	N/A
Associated Guideline(s)	N/A
Associated Pathway(s)	N/A
Associated Standard Operating Procedure(s)	N/A
Other associated documents e.g. documentation/ forms	N/A

Consultation Undertaken:	Joint Local Negotiating Committee
Template control:	V3 April 2024

Amendments from previous version(s)

Version	Issue Date	Section(s) involved (author to record section number/ page)	Amendment (author to summarise)
4	15/09/2022	Whole document	• Amendments to terminology
5	18/09/2025	Whole document	• Minor changes to terminology • Amendment to section 4.2 to acknowledge change from Waiting List Initiative payment to extra duty payment.

CONTENTS

1 INTRODUCTION/ BACKGROUND

The purpose of this procedure is to have a mechanism in place where there is a requirement for a member of medical staff, at a senior level, to “act down”. This can be due to an emergency or immediate crisis. It requires the senior doctor to undertake the duties usually performed by a more junior member of staff.

2 AIMS/ OBJECTIVES/ PURPOSE (including Related Trust Documents)

“Acting Down” should be the exception rather than the rule and all attempts to avoid the necessity for it should be made. The Trust recognises that acting down places an increased burden of stress on that individual and can lead to one member of staff trying to perform two key roles simultaneously which can affect delivery of the service. The Trust also recognises that, under their current terms and conditions of service, Consultants, Specialists, Associate Specialists or Specialty Doctors are not contractually obliged to act down, or to be compulsorily resident on-call to cover the duties of more junior medical staff, except in the most extraordinary and unforeseeable circumstances. The aim of this procedure is therefore to outline the actions that should be taken to minimise the need for senior medical staff to undertake both roles simultaneously and outline the remuneration/compensation arrangements for individuals who do.

“Acting Down” is the term used to refer to situations where a Consultant, Specialist, Associate Specialist or Specialty Doctor, normally as a result of an emergency or an immediate crisis, is required to undertake duties usually performed by a more junior member of medical staff. It does not apply to duties which a clinician undertakes as part of their normal workload but which a more junior member of staff may be competent to undertake.

3 ROLES AND RESPONSIBILITIES

The procedure was developed by the Head of Medical Workforce and a sub-group of the JLNC and approved by the JLNC.

Clinical Managers with support from rota co-ordinators would ascertain where acting down is required, they would discuss this and agree a way forward with senior doctors within the specialty.

This procedure will be reviewed by the Trust Joint Local Negotiating Committee (JLNC) in line with the review date.

4 PROCEDURE DETAILS (including Flowcharts)

4.1 Consultants, Specialists, Associate Specialists or Specialty Doctors are usually requested to act down owing to a shortage or absence of resident doctors. The majority of such absences or shortages are known well in advance.

Resident doctors are required to give a minimum of six weeks' notice of any requested annual or study leave and where required internal cover should be arranged and co-ordinated by the Clinical Manager and supported by the rota co-ordinator to ensure adequate levels of cover are provided.

Resident doctors participate in rotas, which contractually require them to prospectively cover the annual leave and study leave of their colleagues who participate in the same rota. Clinical Managers should ensure they have arrangements in place for the management of these rotas. There should also be a mechanism for identifying at the earliest opportunity any problems, which could result in additional cover being necessary. Usual practice would be for rotas to be reviewed six weeks ahead to ensure that where the need for additional cover is identified and agreed this is conveyed to rota co-ordinators to organise the cover. (For further information relating to rostering, see the Good Rostering Guide May 2018)

Some specialties encounter difficulties in recruiting to their agreed quota of resident doctor posts. Clinical Managers should again ensure that mechanisms are in place to identify potential problems at the earliest opportunity, enlisting the support of rota co-ordinators to try and make temporary arrangements for cover with bank medical staff where there are difficulties.

Although most of the leave can be planned well in advance, there will be occasions where absences occur at very short notice because of unforeseen circumstances such as sickness, domestic crisis, or the failure of a doctor to arrive on shift. Inevitably absences occurring in these situations are much more difficult to manage, however, there are certain measures which can be put in place to assist in the management of these situations.

Clinical Managers and rota coordinators should ensure, as part of the induction process, that resident doctors are fully aware of the procedures for booking all types of leave, reporting sickness absence, the people they should report sickness absence to, and the need for the absence to be reported at the earliest opportunity. This then maximises the amount of time the Clinical Manager, with the assistance of the rota co-ordinator where applicable, has to find appropriate locum cover if necessary. In this situation, the appropriate Consultant, Specialist, Associate Specialist or Specialty Doctor should be informed of the position and advised of the attempts being made to find cover. This allows the Consultant and Clinical Manager the maximum notification of a potential problem.

The failure of a doctor to arrive on shift is often discovered outside of 9.00 a.m. – 5.00 p.m. Monday to Friday. There may also be other absences which are notified outside of these hours, for example the resident doctor who is due to start work at 9.00 a.m. on Saturday morning but falls ill during Friday night are by far the most difficult situations in which to find alternative cover.

In these circumstances the on-call Consultant for the specialty concerned should be informed at the earliest opportunity and their advice sought.

Whilst it is the responsibility of the on-call Manager rather than the on-call Consultant to obtain suitable medical cover, the on-call Consultant would be expected to support the on-call Manager to obtain cover.

If all options have been exhausted and no locum cover arrangements can be made, it may be necessary to ask a Consultant, Specialist, Associate Specialist or Specialty Doctor to provide emergency cover. Whenever possible the clinician should be given a minimum of four hours' notice of a potential problem to allow them to start to make contingency plans. It does, however, need to be recognised that this will not always be possible; for example, if a locum fails to turn up or a resident doctor is taken ill during a period of duty. In these situations, a request made for a clinician to act down may be made by the Executive Director on call known as gold on call with the support of the senior clinician on duty for the service.

It is recognised that the Consultant on-call for the specialty concerned is the ultimate judge of whether a department can continue to operate safely. Any decision to close a department, however, must take account of the implications for the patients, staff, and any knock-on effect for other Trusts, together with an assessment by the Consultant as to whether they are able to provide safe cover. If the impact or risk of closing a department is greater than keeping the department open then it cannot be closed. If potential problems are identified during Monday to Friday between 9am and 5pm and an alternative being considered is the closure of the department this must be discussed with the Chief Executive and/or Chief Medical Officer. Out of hours this should be discussed with the Executive Director, who will be gold on-call.

Consultant, Specialist, Associate Specialist or Specialty Doctor Staff will not be required to agree to provide cover unless it is as the result of an unforeseen event, the alternative to which is the closure of the department which would put the wellbeing of patients at significant risk. In this situation the consultant-in-charge recognises that they have the legal responsibility for a patient admitted under their care or the delegated responsibility for the patient admitted to the care of Consultant colleagues if participating in an on-call rota. If any Consultant does not believe they can safely provide this cover they must speak to their colleagues and escalate the matter so that discussions can take place and appropriate arrangements can be made.

The Consultant, Specialist, Associate Specialist or Specialty Doctor who agrees to act down will cover both roles. In these situations, the senior clinician and gold on call should review the situation and agree as to how a safe and effective service can be delivered, if necessary, help and support from other colleagues, nursing staff and/or staff from neighbouring Trusts will be obtained by gold on call.

In circumstances where a Consultant, Specialist, Associate Specialist or Specialist Doctor is asked to act as second on-call where a colleague is acting down and as a result is called excessively or called in, the Trust will offer time off in lieu to compensate for this.

4.2 Consultants, Specialists, Associate Specialists and Specialty doctors acting down between 9am and 5pm (or during their normal working hours if different to this) will not receive additional remuneration or compensation. Depending on the circumstances, there may be a need to obtain additional support from colleagues or in extreme circumstances, reduce clinics/theatre lists. Should there be a requirement to stay beyond the normal finishing time to complete work/see patients, due to acting down, this should be documented in the Acting Down form (Appendix 1) and an extra duty claim form completed which can be obtained from the Rota Coordinator.

If a Consultant, Specialist, Associate Specialist or Specialty Doctor provides cover for a junior colleague for a period between 5pm and 9am or at a weekend (unless this forms part of their standard programmed activities in the job plan) and is required to be on call from home they will be entitled to time off in lieu or an extra duty payment for the period of cover provided. If the doctor is called in to the hospital or is required to be resident on call, during this period of on-call they will be entitled to a disturbance allowance which will be equivalent to the escalated extra duty payment for the shift. This should be documented in the Acting Down Form (Appendix I) and an extra duty claim form completed which can be obtained from the Rota Coordinator.

Following a period of acting down, the doctor must submit the above forms to the rota coordinator/Divisional Administrator. The pattern of acting down will be regularly monitored and reviewed. More detailed investigations will be held where there appears to be a pattern of ‘avoidable’ incidents of acting down.

4.3 Where, as a result of acting down, a doctor is required to be resident on-call between 5.00 p.m. and 9.00 a.m. to participate in a shift system within this time or if on-call from home and spends more than three hours (including travelling time) at the hospital after midnight, they will be entitled to have their clinical commitments cancelled the next day in the interests of patient safety.

Doctors must satisfy themselves that they are safe to continue with their normal duties the following day where they have been acting down the previous night.

5 EDUCATION AND TRAINING

Training on the application of this procedure will be provided to ensure that the minimum requirements of the procedure are met.

6 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (e.g. verbal, formal report etc) and by who)
Monitoring to be carried out of the application of the procedure.	Heads of Service, Service Directors and Divisional Chairs would be responsible for reviewing the application of the procedure with the support of the Head of Medical Workforce	Audit to be undertaken of the instances of acting down	Annually	Heads of Service, Service Directors Divisional General Managers and Divisional Chairs would be responsible for reviewing the results.

7	**EQUALITY IMPACT ASSESSMENT** (please complete all sections of form)

Equality Impact Assessment (EIA) Form (Please complete all sections)

EIA Form Stage One:

Name EIA Assessor: Rebecca Freeman		**Date of EIA completion: 25th September 2025**
Department: People Directorate		**Division: Corporate**
Name of service/policy/procedure being reviewed or created: Providing Emergency Cover for Junior colleagues commonly known as Acting Down		
Name of person responsible for service/policy/procedure: Rebecca Freeman		
Brief summary of policy, procedure or service being assessed: This policy outlines the process to go through where there is a requirement to provide cover for a junior colleague, a process known as acting down. Decisions to act down are made in collaboration with the Clinician on call and the Duty Manager involving other colleagues as deemed necessary.		
Please state who this policy will affect: Medical Workforce **(Please delete as appropriate)**		
Protected Characteristic	**Considering data and supporting information, could protected characteristic groups' face negative impact, barriers, or discrimination? For example, are there any known health inequality or access issues to consider? (Yes or No)**	**Provide a brief summary of what data or supporting information was considered to complete this assessment?** **The policy has been considered together with a recollection of the instances of acting down.**
Race and Ethnicity	None	

Sex	None	Equal and appropriate opportunities are offered to Clinicians to act down where required. All other avenues are considered prior to requesting an individual to act down. A person-centred approach is taken to determine if additional support is required in addition to the acting down plans, considering multi professional colleagues. Where a Clinician has needed to act down during a busy night, consideration needs to be given to cancelling activity the following day in the interests of patient safety.
Age	None	
Religion and Belief	None	
Disability	None	
Sexuality	None	
Pregnancy and Maternity	None	
Gender Reassignment	None	

Marriage and Civil Partnership	None	
Socio-Economic Factors (i.e. living in a poorer neighbour hood / social deprivation)	None	

If you have answered 'yes' to any of the above, please complete Stage 2 of the EIA on Page 3 and 4.

What consultation with protected characteristic groups including patient groups have you carried out?

Consultation has taken place with the JLNC. Discussion has also taken place with individuals who have acted down.

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

None

On the basis of the information/evidence/consideration so far, do you believe that the policy / practice / service / other will have a positive or negative adverse impact on equality? (delete as appropriate)

Positive			Negative			
High	**Medium**	**Low**	**Nil**	**Low**	**Medium**	**High**
			X			

If you identified positive impact, please outline the details here:

The policy promotes good practise to give due consideration to acting down, only using that option as a last resort if no other options available.

Protected Characteristic	Please explain, using examples of evidence and data, what the impact of the Policy, Procedure or Service/Clinical Guideline will be on the protected characteristic group.	What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening.	Please outline any further actions to be taken to address and mitigate or remove any in barriers that have been identified.
Race and Ethnicity	None	N/A	N/A
Gender	None	N/A	N/A
Age	Where a Clinician has needed to act down during a busy night, should the clinician feel unable to work following day, alternative arrangements will need to be made in the interests of patient safety. See section 4.3	N/A	N/A
Religion	None	N/A	N/A
Disability	None	N/A	N/A
Sexuality	None	N/A	N/A
Pregnancy and Maternity	None	N/A	N/A

Gender Reassignment	None	N/A	N/A
Marriage and Civil Partnership	None	N/A	N/A
Socio-Economic Factors (i.e. living in a poorer neighbour hood / social deprivation)	None	N/A	N/A

EIA Form Stage Two:

Signature: *I can confirm I have read the Trust's Guidance document on Equality Impact Assessments prior to completing this form*
Date: **25.09.2025**

APPENDIX 1

ACTING DOWN BY CONSULTANT, ASSOCIATE SPECIALIST AND SPECIALTY DOCTOR MEDICAL AND DENTAL STAFF

This form should be completed whenever a Consultant, Specialist, Associate Specialist or Specialty Doctor has had to undertake duties which should have been performed by medical trainees or other junior medical staff

Staff Details

Full Name:

Grade: Consultant / Specialist / Associate Specialist / Specialty Doctor * please delete

Specialty:

Acting Down Event

Date(s) of cover:

Time(s) duties were undertaken:

On-Call Hours (Unpredictable Work)

Number of Hours unpredictable on-call

- **7am to 7pm:**
- **7pm to 7am (include all hours at weekend or bank holiday)**

Time spent in the Hospital/Trust:

Time spent on call from home:

Nature of duties undertaken:

Individual being covered

Name:

Grade/Role:

On-call status during this period

Were you due to be on call during this period? YES / NO * please delete

Arrangements made for remuneration/time off in lieu

Amount to be paid (if applicable): £

Date for TOIL (if applicable):

Signatures

Clinicians Signature	
Full Name	
Date	

Divisional General Managers Signature	
Full Name	
Date	