

**BMA**

# Locum GP handbook



British Medical Association  
[bma.org.uk](http://bma.org.uk)



# Contents

<b>Aims of the handbook</b> .....	<b>3</b>
What is a locum GP and who engages locums? .....	3
Becoming a locum.....	4
Requirements for working as a locum GP.....	5
Ways of working as a locum .....	7
<b>Locuming after GP training</b> .....	<b>10</b>
Getting started as a locum and finding locum work .....	10
Becoming an employer.....	12
Confidentiality and the General Data Protection Regulation (GDPR) .....	12
Equipment.....	13
Taxation and accounts.....	14
Finding an accountant .....	15
Negotiating fees.....	15
Invoicing .....	17
The NHS occupational pension scheme – general information .....	17
Seniority pay .....	19
Death in service benefits.....	19
Insurance, maternity, adoption, parental and sick provisions .....	19
Maternity Allowance.....	20
Taking out insurance .....	20
<b>Modes of locum work</b> .....	<b>22</b>
Working as a short term locum.....	22
Working as a fixed term locum.....	22
<b>Professional considerations for locums</b> .....	<b>26</b>
<b>Reducing the risks of locum GP work</b> .....	<b>32</b>
Working in an unfamiliar environment .....	32
Agreeing terms of work.....	33
Record keeping.....	33
Dealing with complaints .....	34
Prescribing and repeat prescribing.....	34
<b>Avoiding professional isolation and building networks</b> .....	<b>37</b>
Problems with professional isolation .....	37
<b>Representation of locum GPs</b> .....	<b>39</b>
National representation.....	39
The BMA (British Medical Association).....	39
BMA general practitioners committee .....	39
Sessional GPs subcommittee of the GPC.....	39
Local representation.....	39
LMCs (Local Medical Committees) .....	39
BMA support to individual members .....	41
<b>For locums and providers</b> .....	<b>42</b>
The contract for services.....	42
Timetable of work .....	42
Definition of work to be undertaken .....	42
Additional and enhanced services .....	43
Definition of contractor responsibilities.....	44
Definition of locum responsibilities.....	44
Termination of the contract for services (for self-employed locums).....	45
Termination of employment (for employed doctors).....	46

<b>For providers .....</b>	<b>47</b>
Reimbursement available to practices for locums .....	47
Recruiting locums .....	47
Provider responsibilities.....	48
Locum GP induction.....	50
The induction drill .....	50
The induction pack.....	51
<b>Working through platforms and locum banks .....</b>	<b>52</b>
<b>Sources of further information.....</b>	<b>54</b>
<b>Appendix 1 - Employment status – Key factors.....</b>	<b>55</b>
<b>Appendix 2 – Template GP locum induction pack for practices .....</b>	<b>56</b>
<b>Appendix 3 – Legal structures .....</b>	<b>62</b>
Partnerships.....	62
Limited liability partnerships (LLPs).....	65
Private companies limited by shares .....	66

# Aims of the handbook

The BMA Locum GP handbook has been produced as one of the many benefits available to BMA members, providing advice and guidance on all aspects of GP locum work. It should be useful for:

- locum GPs
- those intending or about to become locum GPs
- practices and other providers who engage the services of locum GPs.

This handbook is relevant to all four UK countries. Where there are national variations in policy and practice, these are noted.

## What is a locum GP and who engages locums?

### What is a locum GP?

A locum GP is defined as one who temporarily takes the place of another GP. Locums are usually self-employed and are sometimes also referred to as freelance GPs.

A self-employed locum GP has a **contract for services** rather than a 'contract of service', which would be the case for a salaried GP. Locum GPs can operate in many different ways including as sole traders, by joining a locum agencies or a web-based platform, as part of formal partnerships or other group arrangements (eg 'chambers'). Locum GPs are usually\* self-employed and paid fees for their work. Being self-employed they would not expect to receive the same benefits as permanent contracted GPs (eg holiday pay, sick pay, maternity/paternity pay) but this should be factored in when determining locum fees. As with other self-employed workers, they will not have income protection, unless they take out their own personal insurance.

The way that locum GPs undertake their work varies widely:

- some provide cover for a specified fixed-term period (eg to cover for maternity leave)
- some provide services to practices on an ad-hoc basis
- some provide a range of services
- some provide specific services.

Working as a GP locum has become more popular as a specific career choice to support a portfolio career and to provide a better work-life balance, rather than traditionally being used to remain practicing while between more substantive posts (when new to an area, post-retirement etc).

Practices commonly engage self-employed locums to cover long-term absence owing to sick leave, maternity leave or sabbaticals. In these cases the locum may be offered fixed term employment. Increasingly locums are also used to cover sessions while practice based GPs work outside the practice. GPs with specific skills such as minor surgery can be contracted by practices to work in that particular field.

### Who engages locums?

Locum agreements can be made between locum GPs and a variety of different parties: GMS, PMS, APMS practices, private/non-NHS practices, and out of hours providers.

### Determining your employment status

Employed and self-employed GPs are normally distinct in terms of their contractual arrangements and responsibilities and rights in relation to their employers and contractual providers. It is vital for locum GPs and practices to give serious consideration to this, as the distinction can become blurred between a locum GP and a salaried GP when a locum is in a practice on a long-term basis or when a locum is working through an agency.

---

\* But see 'determining your employment status' for exceptions

For tax and national insurance contribution purposes, there is no statutory definition of a contract of service (employment) or of a contract for services (self-employment). Case law relating to tax and employment status provides a number of key characteristics which can assist to determine an individual's employment status as employed or self-employed, as neither the length of a particular engagement nor the presence or absence of a contract of service can determine employment status on their own. Some of the characteristics to be considered can be found in appendix 1. It is important to note that employment status is not a matter of personal preference, or how the relationship is referred to by the locum and the provider, but depends upon what actually happens in practice. As no single factor alone can determine an individual's employment status, a holistic overview of the engagement is required to determine your status. It is also worth noting that an individual's employment status can change over time as the relationship progresses and changes.

For a general guide as to whether your work is likely to be regarded as employment or self-employment, see the [HMRC's guidance](#) and [Employment Status Indicator](#).

A locum's employment status has wide ranging implications financially (taxation, national insurance and pensions), contractually and legally. For employees, their employer would be expected to calculate their pension and National Insurance contributions and to be responsible for remitting the employee's income tax payments to HMRC under PAYE. Employees would also have their salary, leave and sickness entitlement, etc. detailed in their contract. Self-employed locums, on the other hand, are responsible for accounting to HMRC for their own tax and NIC liability. However, changes to the intermediaries legislation means that locums working through personal service companies (PSC), in certain circumstances are not liable, please see further guidance [here](#).

Practices and locums must ensure that any long-term or regular work undertaken is properly treated as either self-employed or employed work. **Both parties are advised to take advice on this matter from the BMA and accountants.**

It is perfectly possible for an individual to do locum work under separate contracts in both an employed and self-employed capacity at the same time. An example would be working for a practice as a salaried GP part of the week and being a locum for the remainder of the time.

## Becoming a locum

### Is locum work for you?

GPs take on locum work for a wide variety of reasons. Sometimes locum work is actively chosen as part of a portfolio career (where a GP takes on a number of different types of job eg medical politics, medical journalism, research or teaching etc) and/or to work around family commitments. Some newly 'retired' GPs choose to do locum work to keep up some medical practice. Locuming can also be a good way to try out different types of working environments before committing to a salaried or partnership post.

For other GPs, locum work is taken on as an interim measure while actively looking for longer-term positions. In any case, the unique characteristics of working freelance as a locum presents both advantages and disadvantages.

Advantages of locum work	Disadvantages of locum work
<ul style="list-style-type: none"> <li>– a potentially high degree of autonomy over working hours and place of work</li> <li>– a chance to work in a variety of different environments</li> <li>– work can be taken on around other professional and/or family commitments</li> <li>– you can choose to take breaks from working, for example to travel or pursue other projects</li> <li>– working commitments are more rigidly defined and do not involve the managerial concerns that partners have</li> <li>– locuming is one way to make your name known locally and may put you in a stronger position when more permanent or alternative leadership posts become available</li> <li>– by negotiating pay, dealing with invoicing and sorting out taxes locums learn small business skills useful in running a practice or working in commissioning</li> <li>– you should not need to negotiate with colleagues if you want time off at busy periods such as Christmas</li> <li>– you may find that it is easier to move to another area to work and live than it would be as a partner</li> </ul>	<ul style="list-style-type: none"> <li>– locums can become or feel isolated from other doctors (see <a href="#">Avoiding professional isolation</a>)</li> <li>– locum GPs are sometimes excluded from formal and informal information cascades and locality networking</li> <li>– CPD and appraisal opportunities need different consideration in locum work (see <a href="#">Professional considerations for locums</a>)</li> <li>– it can be harder to keep up to date with certain aspects of practice eg chronic disease management, baby clinics, updating computer skills</li> <li>– you need to adjust to different work places quickly, and you will need to ensure a good induction where you work</li> <li>– you may have to work with a lot of different computer systems and you will need to ensure that you have an individual log-in in each place of work.</li> <li>– locuming can carry potential risks owing to poor induction, not being familiar with the patients, fewer chances for handover and case discussion (see <a href="#">Reducing the risks of locum work</a>)</li> <li>– you can miss out on patient continuity in short term jobs</li> <li>– locums must normally organise their own invoicing, accounts and pensions, unless working for an agency or employing an accountant to do this for them</li> <li>– uncertainty of income – if opportunities are in short supply locally you may face periods without work or long journeys to jobs</li> <li>– locuming can involve working at antisocial times such as bank holidays, Christmas etc when locum work is more readily available</li> <li>– no employee benefits eg sickness, maternity, study or annual leave, unless working for an agency</li> </ul>

### Requirements for working as a locum GP

Locum GPs are fully qualified GPs and therefore have the same training and qualifications as the medical providers for whom they provide services. Locums must be included on the GMC's GP Register. To work as a GP, the locum's name must also be on the Performers List in the country in which he/she wishes to work.

As for other self-employed workers, the European Working Time Directive Regulations do not apply to locum GPs.

### GMC GP Register

Check that you are included on the GMC's GP Register by contacting the GMC directly or visiting [www.gmc-uk.org/doctors/register/LRMP.asp](http://www.gmc-uk.org/doctors/register/LRMP.asp). If your name is not already included then you should apply for this. It is a free of charge service.

### GMC licence to practise

In 2009, the GMC introduced the licence to practise. All doctors registered with the GMC were asked to confirm that they wished to be licensed. Those who responded positively received written confirmation from the GMC; the GMC is not issuing a licence certificate. The licence will need to be renewed, and this will be on a five-yearly basis following revalidation.

### Performers List

Locum GPs must apply to be on the national Performers List of England, Wales or Northern Ireland. In Scotland, rather than a national performers list, each Health Board operate their own list. However, since June 2016, GPs in Scotland applying to the performers list can, with a single application, elect to be included on every Health Board list. You can be on more than one national list in the UK at a time, which can be useful if you are working on a border. You cannot practice in a country if you are not registered on the relevant list.

You are encouraged to apply well in advance of the start date of your work. Applying for the Performers List can be time consuming. This is particularly so as you will need a disclosure and barring service (DBS) check or equivalent (except that in Scotland the need for this is not obligatory). There is no set time, but generally if you have had a DBS check in last three years, then this should be accepted, however it is still best to check.

To join a Performers List in order to become a locum GP, an application must be made to the relevant national body. Further information and application forms can be found below.

- England <http://pcse.england.nhs.uk/performer-list/>, policy and procedures <https://www.england.nhs.uk/joint/>
- Wales <https://www.walesdeanery.org/specialty-training/general-practice/gp-trainees/medical-performers-list>
- Scotland [http://www.sehd.scot.nhs.uk/pca/PCA2016\(M\)04.pdf](http://www.sehd.scot.nhs.uk/pca/PCA2016(M)04.pdf)
- Northern Ireland <http://www.hscbusiness.hscni.net/services/1813.htm>

You can appeal if your application is refused or if you are subsequently placed under conditions, unless a mandatory refusal applies (eg if you have been convicted of a serious crime). For further details about appealing, please contact the BMA for individual advice.

Once you are on a Performers List, there are certain criteria with which you are required to comply, including:

- work in that area on at least one occasion during a 12-month period (see below)
- undertake an annual NHS appraisal
- inform NHS England or the Health Board of any change of contact address
- inform NHS England or the Health Board of any material changes to the information provided in the application
- cooperate with an assessment by the National Clinical Assessment Service (NCAS) when requested to do so
- supply a DBS certificate or equivalent if requested with reasonable cause.

Failure to meet these requirements could result in you being removed from the list and therefore ineligible to work as a GP (unless re-included or subsequently included on another list).



**Performers List requirements: minimum requirements**

It is a requirement of remaining on a Performers List that a GP must undertake some NHS GP work in the area during a 12-month period. The BMAs interpretation of the regulations is that provided the GP undertakes some work (even just one session per annum), then they should not be removed from the list.

If it is suggested that you will be removed from a list due to insufficient GP work being undertaken, contact the BMA as a matter of urgency. The BMA can assist in helping to resolve this.

Undertaking a very limited amount of work can be detrimental if it prevents you keeping fully up to date and maintaining your skills. This could also have an adverse impact on your appraisal and revalidation, while appraisal is based on the scope of your work, being unable to maintain skills could have an adverse impact on revalidation.

It is unlawful to discriminate or penalise GPs who take breaks from work for maternity leave, even where this means failing to attain the minimal annual working requirements.

You should inform NHS England or the Health Board of any upcoming maternity leave and discuss with the RO or appraisal lead any deferment or other arrangement required regarding your appraisal while on maternity leave.

**Ways of working as a locum**

There are different ways of setting yourself up for work as a locum. For example, you can choose to operate as a sole trader (self-employed), or as part of a 'chambers' or you can join an agency. If you are working as a self-employed GP, your agreement with practices will be a 'contract for services', rather than a 'contract of service', which would be the case if you were an employee.

Locums should consider taking separate legal advice about the various options available.

**Working as a sole trader**

The intention of a sole trader is to work in a self-employed capacity, which involves more administration but also more independence than employment through an agency. However, beware that an intention to operate in a self-employed way is not sufficient to guarantee that your work will be viewed in this way.

Some locums choose to set up a partnership framework to organise their work. This can be an appealing option for locums who want to work with family members, perhaps using a spouse for administrative management.

**Working for a locum agency**

Some GPs find locum work through agencies, though this is less common than for hospital-based locum work. If you choose to work through an agency, the agency (or agencies) you are registered with will contact you with work that meets your specifications. If you are interested in the job they will put you in touch with the provider. While you are working you would then normally provide details of the hours worked to the agency which will pay you and charge the provider for the hours worked plus a fee or commission for itself.

You should be aware that if you are supplied through an agency, you may be viewed as being employed by the agency, rather than self-employed. In this case, the agency would have to operate PAYE and account for Class 1 National Insurance Contributions. Agency pay is not pensionable under the NHS pension scheme because you are regarded as working for the agency and not for the NHS. You need to be aware of IR35 when working for an agency, please see our guidance [here](#).

### Joining a web based platforms

Web-based platforms are becoming more prevalent among locums. A doctor can join up to one of these websites for a fee and they will be connected with employers. They 'connect' a locum with an employer, so the doctor is not considered to be employed through this platform, and therefore the locum is still considered to be working for the NHS through this 'connector'. This has the advantage that the work will remain pensionable in the NHS scheme.

### Joining 'chambers'

Some locums form a 'chambers' in order to share administrative costs while maintaining more autonomy than an agency affords. There are a number of GP locum chambers already established across the UK and the BMA has produced specific guidance about setting up or joining a chambers, please follow this [link](#) for further information.

### Pros and cons of different ways of working

	Pros	Cons	Other considerations
Working as a sole trader	<p>Most straight-forward approach to self-employed locuming</p> <p>Provides maximum independence</p>	<p>You will carry the administrative burden alone</p>	<p>If you employ any staff to help you, you must ensure you comply with employment law</p> <p>Be certain that any work you undertake is correctly designated and treated as self-employment, rather than employment</p>
Working for a locum agency	<p>Will help find work</p> <p>Can considerably reduce the administration involved in locum work</p>	<p>May limit your freedom to contact practices yourself in the future</p> <p>Agency pay is not pensionable under the NHS pension scheme</p> <p>You will not be able to offset so many expenses against your tax bill.</p>	<p>You could probably be considered an employee of the agency.</p>
Establishing a partnership	<p>Allows you to work with other locums or with family members in a relatively straight forward legal structure.</p> <p>Could work better for tax purposes in some circumstances</p>	<p>More complicated legally and financially than being a sole trader</p>	<p>See <a href="#">Appendix 3 – Legal structures</a></p>

Joining chambers	<p>May reduce some of the risks involved in setting out alone</p> <p>Will probably provide economies of scale for admin/accounting etc</p> <p>If operating under a legal structure which makes the chambers a single organisation, could increase your bargaining power vis a vis providers.</p>	<p>Cons depend on the arrangements and legal structure in place.</p> <p>Will probably lose some independence.</p> <p>You will probably have to pay the chambers something or they will subtract a proportion of your fee.</p> <p>Setting up chambers can be time consuming.</p>	<p>Particularly important to ensure that you do not breach Competition law. See <a href="#">Appendix 3</a>.</p>
------------------	--	---	---

## Locuming after GP training

For many newly qualified GPs, locum work will be the first job taken after qualifying. Locuming after GP training can provide a good opportunity to experience different types of practice. A locum can get experience working in different areas (eg inner cities and suburbia, rural or remote, large corporate practices or very small practices). Locum work might also encompass expedition medicine, ship doctoring or posts abroad. By undertaking a variety of jobs, newly qualified GPs can build experience and hone their preferences. Locuming in a new region or town is also one way to find out which practices would be desirable for more permanent posts.

If you want to start locuming after GP training, you are advised to prepare early (see 'Getting started as a locum' as below). Most well organised practices and agencies will book their cover well in advance so start networking early, perhaps three months ahead. Do as much paperwork as possible while you are still training. Networking during training, for example by attending local meetings, can also help to secure appointments.

Consider starting work in the area you know. Too many changes at once might be daunting so consider checking with local practices or even your current practice whether they need any cover. Practices are more likely to take on doctors they know. In the case of an unfamiliar practice, you might want to ask other doctors what they know about it before committing to work there. You should also join a local sessional GP group as this is a good way to maintain contacts and assist with finding work.

### Getting started as a locum and finding locum work

Starting out as a locum can be daunting. This table provides some tips on starting out and finding work.

#### Getting started

Decide in which area(s) you want to work

This will probably be an area where you have previously worked or where you trained. It is helpful to understand the needs of the population and the local health economy. A working knowledge of computer systems used locally is also an advantage.

Consider how you want your career to develop and what you want to gain from your locuming positions so you can plan accordingly.

This will help to determine whether you apply for short or long term positions and how you define your role. An advantage of being a locum is the increased opportunity to decide how work is balanced against other interests and personal commitments.

Ensure you are on the Performers List

All practicing GPs must be on a Performer's List in the country in which they work. Ideally this should be in the area where most of their work is done. The Performers List is also important for helping to organise appraisals.

Make contact and develop a good relationship with the local area team/Health Board. Ensure you find out how to access the appraisal system and appraisal policy. It is also advisable to be on the relevant CCG and LMC mailing list.

Prepare a business card, your standard terms of engagement, a CV and possibly a website

Think about the minimum amount you require to charge to cover your professional expenses.

It is a requirement that you hold full MDO indemnity that covers all types of work that you undertake and that you keep your indemnity provider informed of any changes to your work, sessions worked per week and the type of work you do. Check your providers' definition of a session too to avoid over or under paying. Some providers may be willing to arrange breaks in cover for any long periods that you may not be working. There are two different types of indemnification, for further information please follow this [link](#).

Network locally (see [Avoiding professional isolation and building networks](#))

Maintain a single folder with all your necessary documents:

- CV
- letter confirming entry on a Performers List
- indemnity insurance
- JCPTGP/PMETB/CCT (or equivalent) references and letters of competence
- Hep B status.

Keep electronic copies of all of these documents to hand to email if needed. Failure to do this quickly can mean losing out on work to others. References may need to be verified by the engaging practice as the CQC may check that these references are being verified.

Before accepting work, get as much information as possible about the practice, its staff and systems. Consider developing a checklist of key facts to find out about (eg is it single handed? Which computer system is used? What is the usual appointment times, duration of appointments, is it a book on the day system and usual surgery length as well as are home visits usual or expected? Is the practice over multiple sites?)

Ensure jobs come with clear terms of contract or terms and conditions regarding fees, hours or number of patients to be seen, home visits, extended hours etc all this should be clarified in a formal written contract or in writing (see [The contract for services](#)). It is acceptable to use email to do this, provided it is sufficiently clear that both parties have agreed to the terms.

Develop standardised invoices and receipts. Consider using software to generate all your superannuation forms automatically.

## Finding work

Plan ahead for your locum jobs. Most providers will want to book a couple of months in advance particularly for peak holiday times. Some locums tend to arrange their work such that leave is taken in off peak periods eg January or September/October.

Join your local Sessional GP Group (see [Local Sessional GP Groups](#)). These provide general support to locum GPs and sometimes also hold vacancy information.

Look for work advertised through local sessional groups, and national publications such as the BMJ, Pulse and GP.

Get details of and look for work with local out of hours providers and any other GP-led services provided outside practices.

Consider joining a locum agency or chambers to get work through this channel. Doing so will not necessarily preclude you taking on freelance work as well.

## Becoming an employer

As well as engaging the services of accountants, locums sometimes employ part time staff to help them run their business. This might for example involve employing a family member or spouse part time to take bookings and do secretarial work. If you employ help you must ensure that you comply with employment law (including, among other things, pay, conditions, leave and termination of employment). You must issue employees with a written statement setting out certain key terms and conditions of employment within two months of the commencement of their employment. It is also your responsibility to ensure your employees have the right to work in the UK. You will need to deduct and account to HMRC for tax and National Insurance Contributions for employees earning over the threshold. If you are employing a spouse or family member speak to an accountant to make sure that the employment is justifiable and cannot be classed as tax evasion. Contact the BMA's dedicated Employers Advisory Service for further advice on employment of staff.

## Confidentiality and the General Data Protection Regulation (GDPR)

All doctors must follow GMC guidance on Confidentiality when using or sharing patient information: <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/confidentiality> The GDPR does not make any fundamental changes to the this guidance.

It is unlikely that salaried doctors will be 'data controllers' for the purposes of the GDPR. A data controller is a person or organisation that decides why and how personal data are processed.

All organisations must have data protection policies and procedures in place in order to meet their legal obligations under GDPR, for example, managing subject access requests, reporting data breaches and staff training. Salaried doctors must follow their local policies and procedures.

Many breaches of confidentiality occur inadvertently. Some practical tips which all health and care staff can use to help ensure that confidential information is protected at all times include:

- Don't share password logins or smartcards and don't leave terminals unattended when logged in
- Don't leave paper records unsupervised where they might be accessed inappropriately
- Don't download confidential information onto unencrypted portable devices such as USB sticks
- Know who to talk to in your organisation if you are unsure, for example, your Caldicott Guardian or an experienced colleague
- Avoid discussing cases in public places if the patient can be identified

Dame Fiona Caldicott, the National Data Guardian for Health and Social Care has established seven key principles for health and care staff to guide how they use and share confidential information:

### Principle 1 – Justify the purpose(s) for using confidential information

Every proposed use or transfer of personal confidential data within or from an organisation should be clearly defined, scrutinised and documented, with continuing uses regularly reviewed, by an appropriate guardian.

### Principle 2 – Don't use personal confidential data unless it is absolutely necessary

Personal confidential data items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).

### Principle 3 – Use the minimum necessary personal confidential data

Where use of personal confidential data is considered to be essential, the inclusion of each individual item of data should be considered and justified so that the minimum amount of personal confidential data is transferred or accessible as is necessary for a given function to be carried out.

**Principle 4 – Access to personal confidential data should be on a strict need-to-know basis**

Only those individuals who need access to personal confidential data should have access to it, and they should only have access to the data items that they need to see. This may mean introducing access controls or splitting data flows where one data flow is used for several purposes.

**Principle 5 – Everyone with access to personal confidential data should be aware of their responsibilities**

Action should be taken to ensure that those handling personal confidential data - both clinical and non-clinical staff – are made fully aware of their responsibilities and obligations to respect patient confidentiality.

**Principle 6 – Comply with the law**

Every use of personal confidential data must be lawful. Someone in each organisation handling personal confidential data should be responsible for ensuring that the organisation complies with legal requirements.

**Principle 7 – The duty to share information can be as important as the duty to protect patient confidentiality**

Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.

**Equipment**

As a locum you will typically need, as a minimum:

- a computer with appropriate software eg Excel, a bookings database
- a personal email address
- a mobile phone
- use of a car which should be insured for business use. Ensure that your car insurance includes a courtesy car in the event that you are unable to use your own
- basic medical equipment (see below)
- insurance for all of your equipment
- in rural areas, a supply of basic medicines and controlled drugs. These can be issued to you by a pharmacy on a private prescription. Controlled drugs should be stored securely and their use should be recorded in a log book in accordance with the [Misuse of Drugs Act \(1971\)](#) and [The Misuse of Drugs Regulations 2001](#).

Expect to carry some of your own medical equipment and desk aids to jobs. The equipment provided by practices for you may vary from job to job. For ease, you may, for example choose to carry:

Suggested medical equipment:

- stethoscope
- ophthalmoscope/otoscope
- sphygmomanometer
- thermometer
- urine pregnancy tests
- tape measure
- pulse oximeter
- tourniquet
- disposable gloves
- peak flow meters
- cBNF (available as a smart phone application)
- guidelines and protocols to use as aide memoirs.

## Drugs

Practices will usually have an emergency bag which can include an oxygen cylinder. This should be available to the locum to use for home visits, however, they may choose to have their own bag if they prefer. Important to ensure that all items are kept up to date. The drugs carried will vary from locum to locum. Those working in urban areas for example may carry less because they have easier access to drugs when they need them. Sometimes practices will have bags of the most widely used drugs ready for use by locums. The Drug and Therapeutics Bulletin has published guidance on drugs for the doctor's bag.

## Taxation and accounts

Unless working for an agency, you need to organise your own accounts and pay tax and national insurance contributions on your income. Self-employed locum GPs should be registered with HM Revenue & Customs as a business and the profits of the business subject to schedule D income tax. You will need to pay two classes of National Insurance:

- Class 2 National Insurance contributions – a few pounds a week which enable you to receive Incapacity Benefit, Maternity Allowance, State Pension etc. These are collected through self-assessment which is part of tax return in January and July, Class 2 are due to be scrapped in April 2018.
- Class 4 contributions – collected with your tax return and applied as a percentage of your income over a threshold, which is charged annually.

You will be sent a tax return form by HM Revenue & Customs or you can complete it online. Always do this on time to avoid fines.

As a self-employed tax payer you can claim some of your expenses as a deduction against income. You may be able to claim tax relief against the following things:

- computers and printers (you should get accountancy advice on dealing with these capital expenses)
- car and fuel, road tax, insurance, service and repairs, AA/RAC membership etc course fees and books
- internet access and website
- telephone costs, both mobile and landline, though you will need to state what proportion is business use
- consumables such as paper and disposable covers
- a portion of your home expenses such as utilities and rates if you use your home as an office – getting your accountant to agree a figure with HMRC may help avoid capital gains liability
- study materials, courses, conferences etc (including related accommodation and subsistence costs)
- accommodation and subsistence costs when away from home for work.

Not all costs are tax deductible for schedule D income tax purposes. The treatment of capital and revenue expenses against income tax for self-employed doctors must be in accordance with current UK taxation law and professional advice should be sought where necessary. Further information is available from HM Revenues and Customs or from an accountant. Some locums hire an accountant, others will do their own tax returns, particularly if their income is straight-forward. If you are hiring an accountant, check that they know how to deal with locum work. HM Revenues & Customs provides guidance on completing self-assessment tax returns.

Dealing with taxation and accounts – key points:

- register with HM Revenue & Customs as a business
- consider setting up a business bank account. This will help to keep your work accounting separate from your personal finances
- read through the [Working for Yourself the Guide](#) webpages on the HM Revenue & Customs webpages
- keep good records for taxation purposes to avoid paying more tax than necessary
- invoice promptly for the sake of your own cash flow and the NHS pension scheme. An invoice template will make this easier



- include the Locum A form with your invoice for pension purposes
- make sure you keep a mileage log to claim tax relief for travel to and from work as well as for home visits etc If you are self-employed your place of business will usually be your home office so travel between home and the practice is likely to be considered a legitimate business expense
- keep a list of claimable expenses such as the cost of equipment, your doctor's bag, stationery, memberships, indemnity insurance, work mobile phone etc
- consider using spreadsheets to keep track of how many sessions you have worked, mileage, earnings, superannuation payments, expenses, who has paid, invoices sent etc
- consider hiring an accountant, particularly if you work across a number of organisations
- put money aside during the year to cover your tax and National Insurance costs
- request monthly receipts and annual statements from the PSCE in England, LHB in Wales, PSD in Scotland and HSC Pension Service in Northern Ireland for your files.

Please note that the BMA (including the GPC) does not provide any form of tax advice, including advice on direct or indirect taxation and National Insurance Contributions to its members as part of its membership offer.

The BMA advise that locum GPs should get individual tax advice, from specialists in dealing with medical self-employed doctors.

### Finding an accountant

Accountants can help you with book keeping, annual tax returns and if you are working through a company, can help with filing accounts with Companies House.

It is important to select an accountant who is right for you. It is worth asking prospective accountants if they have experience dealing with medical and specifically with GP locum work. Some accountants specialise in work for medical organisations.

The following websites are a good starting place for doctors wishing to find an accountant:

The Institute of Chartered Accountants of England and Wales [www.icaew.co.uk](http://www.icaew.co.uk)  
 Association of Chartered Certified Accountants [www.accaglobal.com](http://www.accaglobal.com)  
 Chartered Institute of Management Accountants [www.cimaglobal.com](http://www.cimaglobal.com)  
 Association of Independent Specialist Medical Accountants <http://www.aisma.org.uk/>

When choosing an accountant it is important to establish the cost, who will be looking after you and the services offered by the accountant or accountancy firm. Prospective accountants should be happy to explain the level of access their business will have to the data produced.

### Negotiating fees for locum work

The BMA cannot advise locums how to set a fee and neither the BMA nor the GPC can offer guidance on levels of fees because of competition law. The Competition Act 1998 prohibits "agreements between undertakings, decisions by associations of undertakings and concerted practices which prevent, restrict or distort competition within the UK or are intended to do so, and which may affect trade within the United Kingdom".

#### It is illegal to agree or fix your rates with other locums

The rate for locum work is a matter for negotiation between the locum and the practice.

There are essentially two approaches to defining the service the locum offers in relation to a fee.

- A time-based approach, whereby a set fee is agreed for a specified number of hours of work. This could be calculated on a per hour, per session, per day or per week basis.

Where this approach is used, it is important that you agree the appropriateness of the time period given for the work that you are required to complete and what that work is expected to include. Ensure that you build in time for paperwork, processing results or other duties specified as appropriate at the end of the session. It is also important to ensure that the fee per hour for any additional work is clearly stated in advance.

- A workload-based approach, whereby a fee is agreed for a set number of appointments/visits, regardless of the time worked. An advantage for the provider is that there is a guarantee of work covered and the practice is not penalised if the locum runs behind (as may occur using a time-based approach to fees). Under a workload-based fee arrangement, the locum would not normally charge an additional per hour fee if the agreed workload took longer than expected, except in exceptional circumstances, such as where a patient is sectioned under the Mental Health Act. If you choose to work in this way, ensure you factor in sufficient time, especially when working in two different practices in one day. Also be aware that visits, particularly to elderly patients and where admissions need to be arranged, can take a significant amount of time.

As a general guide, locums and practices need to consider the following factors when agreeing fees:

- session length and content. Standard sessions, based on the model contract for salaried GPs, comprise four hours and 10 minutes of work. As the definition of a session can vary, the length of a 'session' should be clarified and agreed in advance, together with the expected consultation rate
- the full range of clinical and non-clinical work being contracted and the intensity of this work. In addition to agreeing a basic fee for each session or for the work undertaken, it may be appropriate to specify:
  - an hourly rate, for shortened sessions and sessions that overrun
  - an extended hours rate
  - a rate for additional work – ie work carried out in addition to that which is defined within the agreement as being expected within a session
  - details of fee arrangements for private work – for example, whether it will be done in lieu of standard appointments and visits, or in addition to the agreed work (in which case a fee will need to be agreed and set out in the agreement) or not done at all
  - a fee for on-call work.

The locum's fee may take into account their medical experience, the demand for and supply of locums locally, clinical skills, knowledge of the practice and area, professional expenses (eg professional indemnity, GMC, BMA, NASGP and RCGP membership, equipment and business costs) and your CPD as well as appraisal and revalidation. When setting a rate you should consider how much you will be left with at the end of the year after paying tax, NICs and pension contributions and how much you will have to work to earn the amount you judge necessary to live on and to cover the costs of any private income protection. If you are self-employed, you will not be entitled to the same statutory employment rights as an employee would be (such as sick leave, paternity leave etc.) so this should be taken into account too.

Locums working on a fixed-term period (for example to cover maternity leave) basis may be asked to offer some form of discount on their normal rates in exchange for security of tenure of work. Where this is the case, you should consider whether extra work requested will be priced at the usual or discounted rate. There is no obligation to reduce the rate for long term work which will, after all, probably involve additional administrative work.

The agreement for services should also include:

- details of the time period within which the fees should be paid. This should usually be within 28 calendar days to allow completion of your pension forms. Under late payment legislation, you would have the right to charge interest on an overdue account. For more information see the [Business Link website](#)
- arrangements for travel reimbursement and accommodation, particularly when working a long way from home. You can set your own mileage rate to reflect the costs associated with running your car

- a range of cancellation charges for where a session is cancelled by the practice at short notice and the income has been lost.

Covering all eventualities in your fee schedule will reduce the need for discussing your terms and rates on the job. You can frame your terms more positively by focusing on what your fee does include. Email communication is sufficient.

### Invoicing

It is good practice to formally contact providers once a booking has been made. This will also give you a chance to confirm your rates, any expenses to be met by the provider and the work that has been agreed. The provider should be asked to confirm that they are happy with your terms.

After the work has been completed, or at appropriate intervals in a longer job, you can issue an invoice setting out the time worked, your rate, itemised extras if appropriate, the total due and details for payment of the bill. Locum work is not VAT rated so there is no need to charge VAT.

Payment would usually be expected within 28 days of the date of the invoice. If you are not paid by a practice, this will most likely be owing to administrative error or oversight. Usually a second invoice followed by a polite phone call will produce results. BACS payment may also facilitate payment if you are willing to provide your bank details. You are entitled under the Late Payment of Commercial Debts (Interest) Act 1998 to make a late payment surcharge which should be outlined in your original agreement and in the invoice. If any issues with payment arise, we would suggest contacting your LMC as a first step as they can mediate. Should a provider refuse to pay you can take them to the Small Claims Court (please follow this [link](#) for further information), report them to NHS England/Health Board and, if you feel it is necessary, to the GMC. For advice on non-payment of fees please contact the BMA.

### Pensions

#### Locums and the NHS Pension Scheme

Locum GPs may join the NHS pension scheme (NHSPS) for NHS freelance GP locum work provided they:

- are on the Performers List and working as an individual
- are deputising for or providing additional services to an NHS GP or GP practice on a temporary basis (this can include work for an out of hours provider, as long as it is an NHS pension scheme Employing Authority, which would then be pensioned on the GP SOLO form as type 2 practitioner work)
- be performing appraisal work under a contract for services and
- apply not more than 10 weeks after commencing any period of freelance GP locum work enclosing the GP locum forms A (one from each practice recording sessions and pensionable income, countersigned by the practice) and B (one per month as an overall summary), the locum's scheme contributions, and the employer's scheme contributions as obtained from the practice.

Locums in the NHS pension scheme are members on the same basis as self-employed GPs, and not on the same basis as salaried 'officers'. GP Locums are afforded 'Locum Practitioner' Scheme status and are only able to pension periods of actual work undertaken.

Locums can pension essential services, additional services, enhanced services, dispensing services, out of hours services, commissioned services (such as CCG work) and collaborative services under existing regulations. They are not entitled to pension non-NHS work such as cremation forms.

Since 1 April 2013, GP practices in England and Wales have become responsible for the employer's pension contributions of the locums they engage. These payments had, until then, been made by PCOs. There has been no change to the arrangements in Scotland and Northern Ireland, where employer's pension contributions for locum GPs remain the responsibility of PCOs. The employer's contribution rate is 14.3% in England and Wales, 14.9% in Scotland and 16.3% in Northern Ireland. From 1 April 2017 the employer

contribution rate in England and Wales will increase to 14.38% to reflect the cost of administering the NHS pension scheme moving from the Department of Health to employers.

The funding for GMS practices is being transferred into global sum payments. The Department of Health stated that it is for NHS England to decide how locum employer pension contributions will be funded for PMS and APMS practices.

All practices have a statutory responsibility for funding the employer contributions. However, the administrative process is such that locums themselves must collect and pass on the employer contribution for any pensionable income to their local area team at the same time as they pay their own contributions. The Department of Health expects locums to invoice practices with a separate charge for the employer's pension contribution, on top of their fee.

Locum Forms A and B have been updated with a separate box for the employer's contribution. The forms are available on the [NHS Business Services Authority website](#). A helpful guide to completing the forms can be found [here](#).

Locums working through an agency or doing a lot of locum work for non NHS Pension Authority providers may wish to consider private pension arrangements to supplement any NHS pension, they should seek independent financial advice prior to doing so.

The process for making NHS payments pensionable will be as follows.

- The employer's contribution (based on 90% of the fee paid to the locum) must be paid to the locum along with the fee.
- Locums themselves must forward the payment to the local area team along with their own contribution. In England, forms and cheques should be sent to PCSE (further information available [here](#)). In Wales, forms and cheques should be sent to, and made payable to, the Local Health Board.
- 'GP Locum Form A', which validates that a locum has worked for a practice, should be used. The form includes a statement to say that the locum wishes to pension the income and to show the amount of employer's contribution paid.
- Deadlines for payment apply – the locum is required to send the cheque, accompanied by the form, by the 7th day of the month following the month in which the income was earned. Locums must pension work within 10 weeks of commencing the work.
- 'GP Locum Form B' (a record of all locum work undertaken and recognised in that month) is also required.
- If a Locum is undertaking other kinds of pensionable work (such as work for the CCG) they are also required to complete the Type 2 self-assessment form. If CCG work is undertaken on a contract for services (self-employed basis) then it is pensioned on a practitioner basis. If it is undertaken on a contract of service (employed basis) then it is pensioned on an officer basis and a Type 2 self-assessment form will not be relevant.

Locums must pass on the employer's pension contribution to the local area team/health board or PCSE in England. Failure to do so could result in legal action. A locum cannot advise a practice that they wish to pension earnings then change their mind and retain the employer contribution. If a locum changes their mind the employer contribution must be returned to the practice.

Locums in England must now submit their pension contributions to PCSE, for further information, please follow this [link](#) to guidance on their website.

Locums must show the employer's contribution as a separate charge on their invoices. It is important that invoices clearly show the rate and amount of the employer's contribution.

Some locums choose to list mileage as a separate fee on their invoices and others include it as part of the total fee. The total amount entered into Box 1 on the locum A form, whether this is inclusive of mileage expenses or not, will be used to calculate pensionable income.

It is possible for a doctor working exclusively as a locum to treat as pensionable pay income earned from only certain contracts as a locum. Unlike other scheme members, locums do not have to pension all of their income if they do not wish to. This option only applies to doctors who work solely as locum GPs. However it is not possible for a locum to pension only part of their fee for a particular piece of work, they must either pension the full amount or none for each contract worked.

We would expect that that the decision to not pension the income for a contract would only be a preferred option for locums near to the end of their careers, particularly former partners who have chosen to become locums to reduce their work commitment before retirement, or for tax reasons (if they are close to exceeding either the Annual Allowance or the Lifetime Allowance), and not for any other purposes.

Locum GP BMA members with questions about their pensions should contact the BMA Pensions Department. If a locum BMA member has concerns about issues related to the pension changes, for example non-payment or late payment of fees, they must contact the BMA's First Point of Contact advice service.

Always keep careful pensions records. Request monthly receipts and annual statements from the PSCE in England, LHB in Wales, PSD in Scotland and HSC Pension Service in Northern Ireland for your files.

### The NHS occupational pension scheme – general information

On 1 April 2015 a new NHS Pension Scheme was introduced which covers all transitioning and new NHS employees. Some members are entitled to remain in the 1995 or 2008 Sections until retirement through the Scheme's Protection arrangements. The content of this website is being updated in stages to reflect these changes. More information about the 2015 Scheme arrangements can be found [here](#).

### Seniority pay

Locums are not entitled to seniority pay. Seniority payments are being phased out and no more GPs will be admitted to the seniority system.

### Death in service benefits

If a doctor dies in service, whilst contributing to the NHS Pension Scheme, a life assurance lump sum and, in most cases, enhanced widow/widower/registered civil partner/nominated partner pensions and children's pensions become payable.

Full information on these benefits can be found on the BMA website (please follow [this link](#)). Locum GPs are only covered for the death in service lump sum payment during periods of contracted work. This means they are not covered between jobs or while they are on leave. However, other forms of benefit may be available depending on the locum's circumstances. Please refer to the BMA Death Benefits factsheet for more information. You may wish to consider getting death in service insurance to ensure that you are covered.

### Insurance, maternity, adoption, parental and sick provisions

If you are self-employed, the full range of employment rights protecting salaried GPs will not apply to you. The terms of the contract are those agreed with the provider. This means you will bear the risk of not having any income if you fall ill, have unfilled sessions or take leave.

If you are self-employed you will have been paying Class 2 National Insurance contributions which will entitle you to receive basic state benefits such as incapacity benefit but you should always make sure you have savings to fall back on if work dries up for a while or in case you cannot work. You may also want to consider taking private insurance and/or income protection, please follow this [link](#) for more information on the BMA's private insurance offers or seek independent financial advice.

### Maternity Allowance

If you are self-employed and become pregnant, you may be eligible to receive MA (Maternity Allowance). The MA pays a standard weekly rate (currently £139.58) or 90 per cent of your average gross weekly earnings (before tax), whichever is the smaller. MA is paid for a maximum period of 39 weeks and can begin from 11 weeks before your due date. For further information see the Department for Work and Pensions publication Maternity benefits: technical guidance <https://www.gov.uk/government/publications/maternity-benefits-technical-guidance/maternity-benefits-technical-guidance>

You should inform NHS England or the Health Board of any upcoming maternity leave and discuss with the RO or appraisal lead any deferment or other arrangement required regarding your appraisal while on maternity leave.

### Taking out insurance

If you are working as a self-employed locum, it is essential to fully understand the risks to your income, and that of any of your dependants should you be unable to work through illness, or indeed, in the event of your death.

In the event of an illness or accident resulting in an inability to continue working in the short, medium or long term, a self-employed locum is not entitled to any sick pay benefits from the NHS or the GP practice for which they are working. These are risks that can be addressed from a financial perspective with careful forward planning.

You should consider how long you could maintain a reasonable standard of living without any regular income. Income protection is something that should at least be considered to ensure that if you become ill or have an accident, you are not left in an untenable situation and unable to pay for everyday necessities, mortgage or loan repayments etc. Income Protection is designed to give you peace of mind and can replace a significant percentage of your income. The cover is determined at the outset and is payable after a specified 'deferred period'. The deferred period can be set to match your own personal requirements, and is normally set to reflect the level of your personal savings. This is then matched to how long you could maintain your standard of living and pay your bills utilising your savings should your income cease. The deferred periods available are normally 4, 13, 26 or 52 weeks.

If you have dependants it is also very important to consider the financial implications that would be brought about by your death. Depending on the type of locum work you are doing there is every probability that you will still be entitled to be a member of the NHS Pension Scheme, but this is not guaranteed. The scheme provides valuable benefits to its members but it is still vital that you confirm that these are enough to meet the requirements of your family. If you are employed by an agency, or another non NHS source then it is unlikely that you will benefit from maintaining your membership in the scheme and it is even more important therefore to consider the implications. As a word of caution even whilst working for an NHS body if you are a freelance GP and not working consistently, there is a risk that, on the day of your death, if you are not working, your family may not be entitled to any death in service lump sum (see [Death in service benefits](#)).

BMA Services can put members in touch with companies that offer income protection and life insurance policies or you can take out your own.

BMA Services at AWD Chase de Vere has a dedicated team of financial advisers, each with specialist knowledge of the medical profession, and in particular the NHS Pension Scheme and its associated benefits. They are able to combine a full understanding of your specific life stage and professional needs. They are also totally independent which means that they search the whole financial services market to find financial solutions, which they then tailor to your exact needs. Your AWD Chase de Vere adviser works for you and to your agenda.

If you feel you could be affected by any of the areas discussed above and would like to speak to an independent financial adviser to discuss your own personal circumstances and needs then please contact us on AWD Chase de Vere on 0345 609 2008.

The first meeting with an adviser is without charge or obligation. This gives you the opportunity to get to know your AWD Chase de Vere adviser and for your adviser to begin to understand your financial needs and priorities. Your adviser will discuss and agree with you how you will pay for your advice before moving to the next stage. Your adviser may charge you a fee, receive commission, or use a combination of both and you will be fully aware of any commitment on your part before you choose to proceed and incur any costs.

## Modes of locum work

### Working as a short term locum

Working in short term posts has very different pros and cons to long term work, most of which are discussed at length in this handbook eg variety and flexibility on the plus side but also perhaps professional isolation and greater risks inherent in moving between unfamiliar practices etc. More jobs results in more administration, including invoicing and pension forms. Taking short term posts also reduces income stability.

At-a-glance: advantages and disadvantages of short-term locum work

<b>Advantages</b>	<ul style="list-style-type: none"> <li>Opportunity to experience a range of different working environments</li> <li>More flexibility in choosing when you work</li> <li>Working for a portfolio of practices expands your network and makes it more likely you will be able to find new work</li> <li>Work is more likely to be on your terms eg without additional administration.</li> </ul>
<b>Disadvantages</b>	<ul style="list-style-type: none"> <li>Less opportunity to get involved in work related to practice management</li> <li>Less opportunity to become involved in continuing care and chronic disease management.</li> <li>Less stability of income</li> <li>Likely to involve fewer activities relevant to CPD eg development of practice policies, audits etc</li> <li>Additional challenges at appraisal time, for example, reduced access to multi-source feedback.</li> <li>Fewer opportunities to acquire references based on longer term relationships</li> <li>Harder to do monthly pension returns</li> <li>Requires additional networking, invoicing etc</li> <li>Have to work in a number of unfamiliar practices, increasing medico-legal risk, especially where you have to work with numerous different computer systems.</li> </ul>

### Working as a fixed term locum

Locum engagement can be for a clearly defined duration (as is the case when covering a sabbatical or maternity leave) or open-ended (for example if covering sick leave). The contract may therefore be a fixed-term contract and specify an end date or operate on a rolling basis. Locums are sometimes contracted to work for a single practice for six months or a year, creating a fairly long-term and relatively stable working relationship.

**When working in long-term posts, you must be mindful of potential changes to your employment status. See [Determining your employment status](#).**

Taking on a locum position in a single practice for several months can confer a range of advantages for you and also for colleagues and patients. Typically, a long term locum will be expected to cover the same work as the person they are replacing including a share of administrative work. For some, the chance to experience more of the management of the practice and become more involved in the lives of the patients is an appealing prospect. Those hoping to hold more permanent roles within a practice can experience involvement in practice meetings. There may also be more opportunity in a long-term locum post to get involved in activities like drawing up policies and protocols, demonstrating team work and training, carrying audits and significant event analyses or working on patient feedback and surveys. The work you do might typically involve repeat prescriptions, management



of laboratory results and incoming letters and reports. Long-term locum posts can lead to appointment to a more permanent post within a practice.

Locums engaged in long-term positions have more stable incomes and more certainty in their working lives than those engaged on a more ad hoc basis. Working for a single practice long term and becoming a more integral part of the team will also tend to make it harder to dictate workload. Blurring the distinction between locum help and long-term team membership can lead to ambiguity on both sides. To avoid disagreements arising when taking on long-term contracts consider explicitly setting out the duties you want to undertake and the hours you wish to work. You will also need to factor in your need for holidays, which if you are working as a self-employed locum, will remain in your control. (See [The contract for services](#) section.) In any case, the practice and locum are urged to contact the BMA for individual advice on their positions.

Long-term locums are strongly advised to have a written contract. Both locums and practices should give some consideration to break-clauses and notice periods in the contract and agree notice periods for taking leave (which, for locums who are self-employed, must be determined by the locum).

Locums working on a long term basis sometimes offer some form of discount on their normal rates in exchange for security of tenure of work. Where this is the case, you should consider whether additional duties requested will be priced at the usual or discounted rate. There is no obligation to reduce the rate for long term work which will, after all, probably involve additional responsibilities and administrative work.

If you are offered long term work, you may be presented with the option of taking on a fixed term salaried position. A salaried contract reduces the administrative burden for the locum and provides additional security of income, though you will lose the autonomy of self-employment you will gain benefits associated with employment rights. If you are going to be working in a post for six months or more, we would advise you to take a salaried post, ideally using the BMA's model contract or terms no less favourable (which is mandatory for salaried employment in GMS practices and in PMS practices who have signed a contract since June 2015). Further details can be found in the [BMA's Salaried GP handbook](#).

At-a-glance: advantages, disadvantages and considerations for long-term locum work

#### Advantages

- More opportunity to get involved in practice development and clinical and educational meetings
- Chance to develop relationships with patients and provide some continuity of care
- Greater stability of income
- Regular working environment (maybe a set room) and sometimes regular hours
- Role may involve more activities related to management activity eg development of practice policies, audits etc
- Opportunity to acquire references based on longer term relationships and possibly including activities related to practice management
- May lead to a permanent position as a partner or salaried GP (though there is no guarantee of this)
- Less complicated to do monthly pension returns
- Fewer challenges at appraisal time, for example, carry out patient surveys

<b>Disadvantages</b>	<p>Potential blurring of distinction between locum and partner/ salaried. You could lose your self-employed status</p> <p>Greater pressure to 'muck-in' rather than have clear boundaries to your workload</p> <p>GP work may extend locum responsibility beyond that desired</p> <p>Practice may come to rely on the locum</p> <p>Less flexibility for the locum once engaged in a long-term arrangement</p> <p>Working in a single practice over a long period of time limits networking opportunities</p> <p>At the end of the job you will have to re-establish yourself as a freelance locum with other practices</p>
<b>Considerations</b>	<p>If your job lasts for more than six months the provider will be liable for paying the cost of the employer's pension contribution (see <a href="#">pensions chapter</a> for more detail)</p> <p>Be sure to give consideration to your employment status (See <a href="#">Determining your employment status</a>).</p>

### Out of hours work

Locum work can take place out of hours. Some locums do out of hours work as part of a portfolio of different jobs. Others will work predominately in out of hours settings.

Here are some points you might want to consider if you are thinking about taking on out of hours work:

- what are the arrangements for home visits? Does the work require a driver's license? Will a driver be provided? Are travel expenses reimbursed?
- are support mechanisms in place that will facilitate feedback on your work? Is there any kind of in house appraisal of performance or support for evidence in your NHS appraisal?
- are induction and educational sessions provided by the out of hours employer that address the issues specific to out of hours work?
- look at the prescribing protocols, referral protocols, communication with patients' usual GPs, home visiting and telephone triaging
- ask what performance management statistics the organisation uses and what access you will have to these. Organisations usually include productivity related statistics but some out of hours organisations also assess a selection of consultations. Is there a requirement to get to appointments within a prescribed time?
- pay attention to the duration of shifts and breaks during the shift. What opportunities are there for rest and what is the policy on sleeping?

You need to consider the same issues as you would when drawing up terms and conditions for in hours work, though you should allow for antisocial hours, the different intensity of the work and any management of other staff when setting your rates. Ensure you are fully aware of the work you will be expected to do.

Insist on an induction before starting out of hours work. It may well involve an unfamiliar computer system.

If the out of hours provider is an NHS Employing Authority, the work will be pensionable.

NHS Education for Scotland has published guidance on appraisal evidence for out of hours doctors <http://www.appraisal.nes.scot.nhs.uk/i-want-access-to/toolkits/ooh-gp.aspx>

### Working in a single-handed practice

Single-handed and small practices usually offer plenty of opportunities for short-term locum work as partners are not available to cover short-term absence.

Locuming in a single handed practice can be a very different experience to locum work in a larger practice. If you are covering for a single-handed practitioner, you are very likely to have to take on all of the GP's normal work including on-call, repeat prescriptions, results, management and visits. This increases the medico-legal risks involved and probably the time you will have to commit to the work. The work will be more isolated than usual and you are less likely to be able to discuss cases or consult with a colleague who might know the patient better. You are also less likely to have immediate access to someone with better knowledge of local services, protocols or pathways. Your rate for covering the level and type of work should reflect this. As there are fewer people around to check things while you work it is more important than ever to insist on a good induction before commencing a period of work there (see [Locum GP induction](#)). It is also more important than ever to join local locum groups for support.

If you are thinking about taking on work in a single-handed practice, consider what work you will be required to do, such as if this is a caretaking arrangement for which you are being engaged.

# Professional considerations for locums

## Appraisal and revalidation

Revalidation is a legal requirement of all practising doctors in the UK to demonstrate that their knowledge and skills are up-to-date. The revalidation cycle occurs over 5 years, with an appraisal taking place annually. This is a valuable opportunity for learning and facilitated reflection and to identify areas for improvement.

The guidance on appraisal and revalidation in this chapter should be read in conjunction with [GMC](#) guidance, BMA [general appraisal and revalidation guidance](#) and [RCGP](#) specific GP guidance.

For the reasons outlined below, some locum GPs are likely to find appraisal and revalidation particularly challenging. Locum GPs are not normally in a position to take paid time for appraisal, so need to ensure that their fees are set in such a way to allow them to invest the necessary regular time in all appraisal and revalidation activities to maintain their standards without running into financial hardship. The onus is on locums to ensure they maintain professional standards and their fees should take into account the time and expense of these activities.

## Preparing for the appraisal

Your appraisal portfolio should normally include:

- supporting information
- a description of the scope and nature of work (including any significant changes or circumstances). This should cover all roles and positions in which you have clinical responsibilities and any other roles for which a licence to practise is required including work for voluntary organisations, work in private or independent practice and managerial, educational, research and academic roles.
- previous personal development plans and summaries of the appraisal discussion for each year in the current revalidation cycle
- a commentary on achievements, challenges and aspirations.

## Supporting information

You will keep a portfolio which will contain information collated over the five-year cycle from appraisals and the six areas of supporting information for their appraisal which are:

- continuing professional development (CPD)
- quality improvement activity (QIA)
- significant events (SE)
- patient feedback
- colleague feedback
- review of complaints and compliments.

[RCGP guidance](#) recognises that appraisal has become more onerous than intended with regional variation and inconsistency. The 2016 revisions to this guidance aim to ensure that the effort to engage in appraisal does not become disproportionate in a way that detracts from patient care.

The RCGP guidance on supporting information guides appraisers to retain 'a supportive and developmental focus on quality maintenance and improvement through your personal and professional development without a major increase in workload'.

National guidance can be found under the following links:

- England can be found [here](#) and [here](#)
- Scotland can be found [here](#)
- Northern Ireland can be found [here](#)
- Wales can be found [here](#).

## Continuing professional development (CPD)

You are responsible for keeping up to date through CPD which covers the whole scope of your practice. In your appraisal the RCGP recommends that you demonstrate engagement with at least 50 CPD credits, on average, per twelve months of work, irrespective of the number of sessions worked. The number of credits expected at an appraisal following a career break (such as maternity or sickness) are adjusted to reflect the time spent in work (proportional to the appraisal year).

The previous option to double the credits claimed for each hour of CPD has been phased out from 31 March 2016, however the guidance encourages GPs to claim CPD credits for reflection on impact from learning arising from QIAs, feedback, SEAs, complaints and compliments.

### Keep evidence of your CPD

“One credit is ‘one hour of learning activity demonstrated by a reflective note on the lessons learned and any changes made.’” RCGP guidance

The RCGP recommends that GPs keep a structured learning log (‘including date, title, time taken, key lessons learned and reflection on impact on practice or any changes made as a result of learning’) as evidence and discourages the additional effort that many GPs currently spend on uploading certificates except where these pertain to ‘mandatory’ training defined by the employing or contracting organisation.

You will be expected to show a range of learning methods over a five year cycle. The latest RCGP guidance emphasises the importance of learning with colleagues outside of your place of work. For sessional GPs, participation in learning groups (also known as CPD groups) are a good example of this, alongside formal taught courses, lectures or locality ‘protected learning time’ events. Where it has not been possible to meet the various recommendations for CPD a reflective note is necessary to explain this and outline plans to address this where appropriate.

## Quality improvement activity

The RCGP recommends that you ‘demonstrate the ability to review and learn from your medical practice by reflecting on representative quality improvement activities (QIA) relevant to your clinical work every year, with a spread of QIAs across all of your scope of work over a five year cycle’.

In the past this has meant two SEAs each year and a clinical audit in a five year cycle. In the current RCGP guidance no fixed number of QIAs is specifically recommended. The guidance builds on the recent trend towards greater flexibility and recognises that some forms of QIA may be difficult to achieve in some circumstances, for example true peripatetic locum work.

### Forms of QIA

The guidance also recommends that you should choose QIAs which are representative and appropriate to your scope of work. QIAs can take many forms such as:

- large scale national audit
- formal audit
- review of personal outcome data
- small scale data searches
- information collection and analysis (Search and Do activities)
- plan/do/study/act (PDSA) cycles
- significant event analysis (SEA) reflective case reviews
- outcomes of reflection on your formal patient and colleague feedback survey results, Significant Events and Complaints’.

You are encouraged to submit good quality examples with appropriate reflection, making clear your personal involvement without the need to be involved in data collection. Where organisational, regional or national outcome data is provided you can provide a reflection on what this means about your personal performance and your response or actions.

Where you employ specific clinical skills such as minor surgery, joint injections, cervical smears and IUCD/IUS insertions, a log of personal outcome data with reflection would be a suitable example.

### **Clinical audit and review exercises**

Clinical audit, although an established tool for systems quality improvement, has long been an area that many sessional GPs can find problematic because of their limited influence over practice systems, lack of support with searches, and lack of managerial influence, as well as problems accessing records when working peripatetically. For this reason it is accepted that clinical audit may not always be feasible or relevant to the sessional GP's role or responsibilities.

Locum GPs may appropriately focus quality improvement efforts on areas of personal practice for example:

- record-keeping
- referrals or investigations
- prospective case based condition reviews
- random case analysis or review of telephone triage outcomes
- prescribing.

Ideally you need to demonstrate change in your practice linked to learning points arising from these review exercises. Case reviews are one way to demonstrate that such changes are subsequently incorporated into practice. You should aim to document these using a suitable structured template which incorporates reflection and learning points.

### **Significant events**

This is an area where the latest RCGP guidance (2016) has slightly changed. It is important to understand the difference between 'GMC level' significant event analyses (SEAs; also known as serious untoward incident or significant event audits) and those SEAs routinely undertaken in primary care. The former (GMC level SEAs) refer to incidents where significant harm could have or did come to a patient or patients. Most GPs will not have a serious untoward incident to report and should make a declaration to this effect at the appraisal.

The GMC consider the type of SEA routinely undertaken in primary care to be a quality improvement activity (QIA) and these can be submitted as an example of QIA and there is no longer any minimum number of these to be submitted each year.

The difference between GMC level SEAs and other SEAs is also clarified in the [RCGP SEA toolkit](#).

You must however declare all GMC level SEAs in which you have been personally named or involved. You will need to include an analysis of each of these using a standard pro-forma after discussion with colleagues including reflections and actions going forward.

You also need to demonstrate your awareness of how SEs are captured (and how you would report them) in the organisations within which you work, across the whole of your scope of work.

GP significant events are normally discussed at practice meetings, however where sessional GPs are not invited to participate in these (contrary to best practice and GPC recommendations) it is acceptable to discuss significant events in a practitioner group or self-directed learning group. Where this is not possible the event can be discussed during the appraisal meeting itself after appropriate reflection on a suitable template.

### **Patient feedback**

Patient feedback is a GMC requirement and presents challenges for many sessional GPs, especially locums. However, the following tips should help.

- Experience has shown that completion of patient surveys often takes longer than expected and patient response rates, particularly for locum GPs, are lower than

average. It may be necessary to sample over a range of practices. For these reasons it is worth planning several months ahead, particularly if this is your last appraisal before revalidation.

- You need to use a tool which complies with [GMC guidance](#) but the RCGP no longer specifies which tool you should use.
- It is best practice to ask practice staff to distribute and collect questionnaires, something which locum GPs may wish to include in their locum agreement with the practice. Where this is not possible locums may have to do this without help. Locums who do this may wish to consider a deposit box for the completed questionnaires, as GMC guidance recommends that you do not have access to individual completed responses, with analyses being carried out by the questionnaire provider or an independent third party. Further information about this is provided in the [GMC's guidance on questionnaires](#).
- It is known from [GMC pilots](#) that patient satisfaction ratings are higher for doctors classed as the 'usual doctor': a feature which can disadvantage locum GPs. If you are a locum it is therefore important to choose a questionnaire provider which has locum specific benchmarks (and several do). This will make the results more relevant and meaningful to you.
- Prison GPs will also face particular challenges in gaining patient feedback, as shown by the RCGP secure environments revalidation pilot.
- Doctors working in an out of hours (OOH) centre where the predominant consultation method is telephone consultations or home visits may not be able to use the more widely available tools and so should be able to expect appropriate flexibility from their appraiser, appraisal lead and RO who should be able to advise on suitable alternatives as they evolve. Some OOH providers collect individual performance data and provide feedback which may be available for use in the appraisal.

### Colleague feedback

Colleague feedback can also present challenges, and this is especially true for locum GPs who, due to the peripatetic nature of their work and frequently not able to participate in team meetings, can have much more limited contact with colleagues at any one time.

Things to remember.

- Experience has shown that completion of colleague surveys often takes longer than expected. This is because it takes time for colleagues to get to know you and you may need to collect feedback across several practices as you rotate through them. You may need to ask your survey provider to extend the response period to several months to allow you to collect feedback (and the relevant number of responses) over a longer period of time. An important part of the process is filling in your own self-assessment forms as part of the colleague and patient surveys, so allow yourself adequate time to do this.
- You need to ensure that the feedback includes colleagues from all your roles (ie the whole scope of practice), however the RCGP guidance now offers greater flexibility over the choice of survey tool. For clinical colleagues you can choose any GMC compliant tool, however for non-clinical colleagues you can choose from a wider range to select the most useful tool for that non-clinical role.
- If you are a locum GP, you should consider a GMC compliant clinical survey tool that has locum-specific benchmarks (such as locums, out of hours doctors, and similar).
- You will need to reflect on the results of both the patient and colleague survey, ideally using one of the structured forms provided as part of the survey tool, and you will need to consider what learning needs have arisen when you come to agree your Personal Development Plan (PDP).
- The latest RCGP guidance suggest that you reflect on some of the many other sources of feedback from your patients, including compliments, annually at your appraisal as patient groups have raised concern that a formal survey on a five yearly basis does not provide a sufficient 'patient voice'. Informal comments can be captured and submitted accompanied by adequate reflection remembering to ensure that submissions must not include patient identifiable data.

## Review of complaints and compliments

Feedback is often provided by patients (and others) by way of complaints and compliments – this should also be reviewed as part of the appraisal process.

Things to remember.

- A complaint is 'a formal expression of dissatisfaction or grievance. It can be about an individual doctor, the team or about the care of patients where a doctor could be expected to have had influence or responsibility.'
- Complaints should be considered as another type of feedback, allowing you to review and further develop your practice and to make improvements. [The RCGP revalidation guide](#) provides an outline of the elements to be covered when considering complaints.
- As with significant events, complaints are normally discussed at practice meetings. Sessional GPs may not be invited to participate in these. Nevertheless, as part of this process a practice should inform the sessional GPs of a complaint directed at them and invite the sessional GP to take part in such discussions. It is therefore important that you highlight in your terms of engagement the need to be informed promptly about complaints or concerns and the importance of having the opportunity to respond to these. [Read our guidance on locum GP agreements](#)
- As GPs we tend to concentrate on complaints and not on the compliments we receive. You should bring any compliments you have received to the appraisal, as these are just as important.

## Other items

You may be asked by your responsible officer to bring specific information to the appraisal, such as routine clinical governance information provided by your organisation, or the outcomes of an investigation or complaint. It is important to comply with such requests to ensure that you share your reflections on these items with your appraiser, and this can be captured in appraisal summary.

## Appraisal interview and output

The discussion, which normally takes between 1 and 2 hours, explores the evidence that the locum GP has submitted and considers the development needs of the individual.

The discussion is confidential although there may be circumstances in which the appraiser must share information with others in line with their professional duties where issues of patient safety are raised for example.

When in doubt the appraiser or the doctor may wish to discuss this with the appraisal lead, responsible officer or nominated deputy.

At the end of the appraisal, the locum GP and appraiser should:

- agree a new personal development plan. The plan should contain a list of personal objectives with an indication of the period of time in which items should be completed and how completion should be recognised. The personal development plan represents the main developmental output and it may be appropriate to combine this plan with any objectives arising from job planning and from other roles so that the doctor has a single development plan
- agree a written summary of the appraisal discussion, including an overview of the supporting information and the extent to which the supporting information relates to all aspects of the doctor's scope and nature of work. It should also include the key elements of the appraisal discussion itself. It may also be helpful for the appraiser to record a brief agreed summary of important issues for the doctor in that year to ensure continuity from one appraiser to the next
- your appraiser will also make a series of statements to the responsible officer that will, in time, inform your revalidation recommendation. They should discuss this with you.



### Complaints about performance

If any formal complaints have been lodged against you, the appraiser should be made aware of this prior to appraisal. Such complaints should continue to be investigated in the normal way and outside the appraisal process.

### Concerns about performance

Appraisal, for any performer, is not designed to identify concerns. However, during the appraisal discussion or following a review of appraisal documentation, concerns may become apparent. The appraiser has a professional responsibility to protect patients and to take appropriate action where a colleague's conduct, performance or health may be presenting a risk to patients. Where an appraiser has identified such a concern, they are required to report this to their Responsible Officer who has a statutory duty to take appropriate action. That action may be supportive, for example, where the concerns relate to health, or may require further investigation.

If serious concerns about performance are raised, the salaried GP should immediately contact their medical defence organisation and the BMA for advice and possible representation.

### Appeal mechanism

If during or following the appraisal you have concerns about the appraiser, the way the appraisal is or was conducted or the outcome of the appraisal, you should take the following steps:

- in the first instance, raise the concerns with the appraiser
- if concerns still remain, raise these with the senior clinician/clinical governance lead who should try to find an informal resolution to the problem through discussion and mediation
- if the problems cannot be resolved by taking the above steps, ask for the senior clinician/clinical governance lead or the chief executive to convene a panel meeting to consider this further.

### Sources of further information

Most designated bodies have their own local procedure and guidance, which should tie in with the nationally agreed system, for dealing with NHS GP appraisal. You should therefore contact your designated body for details of this procedure.

BMA – [FAQ – what should I do if there is a conflict of interest](#)

England – [Appealing against appraiser allocation](#)

Scotland – [How do I change Appraiser on SOAR](#)

Northern Ireland – [Appraisal issues relevant to HSCB – GP appraisal complaints and appeals](#)

Wales – [Revalidation Support Unit: GP Appraisal and CPD Complaints and Disputes Policy](#)

# Reducing the risks of locum GP work

**Locums must ensure that they have full medical protection through a medical defence organisation and should update the organisation immediately with any changes in working patterns or specialist work.**

Any clinical work has risks of adverse outcomes: missed diagnoses, misunderstandings, complaints, delays and so on. Keeping your clinical skills and knowledge up to date, reflecting on your performance and analysing adverse events or 'near misses' are all key to reducing these risks. Locum GP work can have features that can make adverse outcomes more likely. This chapter addresses the specific risks associated with locum work and ways to reduce them.

The specific additional risks for locum work are:

- working in unfamiliar environments, sometimes in poorly stocked rooms or without adequate induction. Practices can rely heavily on 'organisational memory' for ensuring that practice members understand procedures and protocols and the roles of different members. GPs not established within a practice will often not have access to this
- requests to participate in signing repeat prescriptions without full knowledge of the practice's prescribing policy or the roles and competencies of the various practice members who are also involved
- working with unfamiliar computer systems
- being unfamiliar with referral processes to local services or for safeguarding, which can give rise to unwanted clinical outcomes or complaints
- potential misunderstandings about agreed terms of work, especially regarding the amount and type of work covered by the locum duty
- prejudices against locums and a lack of established relationships with patients can contribute towards a lower threshold for complaints
- working in isolation from other doctors with resulting difficulty in obtaining advice, for example about practice or local procedures
- poor access to education through being excluded from mainstream locality or commissioner-based educational events and mailshots.

## Working in an unfamiliar environment

It is easy to confuse the arrangements of one surgery with another leading at best to inconvenience and at worst to complaints or adverse health outcomes. Even within the same locality, processes vary between practices. Responsibilities fall on both the practice and the locum to ensure everything runs smoothly. An induction should be provided by the practice or requested by the locum where this is not done automatically. For specific advice on practice induction, see [Locum GP induction](#).

It is good practice before any locum assignment to ensure you arrive early to introduce yourself to staff and ensure you have all the necessary equipment in your room (see [The induction drill](#)). Additionally, you will want to ensure you have a suitably equipped doctor's bag, local maps and a supply of the practice's prescription pads or arrangements for electronic prescribing before you leave for house visits.

It is particularly important that you take time to familiarise yourself with the computer system. You might consider requesting training prior to starting the job but at a minimum you should leave yourself enough time before your first session to get used to it. Some systems will not work or give full access without a smart card linking to the spine. It is essential that as part of the induction these arrangements are clarified. Medical defence organisations advise that it is essential that locums have their own personal login at each surgery (not a generic login shared by all locums at the surgery). Only in this way can clinical work be audited, attributed and where necessary defended.

Expect to take some of your own basic equipment on jobs (see [Equipment](#)). For practices which don't provide a good induction as standard, the lists in [Locum GP induction](#) can provide a guide to the questions you should ask at the beginning of your first locum session.

Consider whether to accept 'on call' duties in practices you are not familiar with and where you have short bookings. Always check that there is an identified individual on call before accepting work if you do not wish to cover on call yourself, and ensure that what you have agreed to is included in your locum agreement (guidance on locum agreements can be found [here](#)).

### Agreeing terms of work

Managing time well is a critical skill for a locum, as working under pressure just compounds the risk of mistakes. You and the practice must be realistic about the workload that can be achieved in the time available and outline this in your locum agreement, especially if you are unfamiliar with the practice. Too commonly practices make assumptions that all GPs work in the same way. Agreeing a job plan and setting out the type and timing of activity can help to avoid misunderstandings.

### Record keeping

If you have only been booked for a few sessions you may not be there to follow patient care through to its conclusion, or to explain your actions to peers if things do not go as well as they should. It is therefore especially important to document very clearly a structured contemporaneous record of the clinical encounter, including any advice to patients about when to return (safety netting). Leave a written or computer note, ideally electronically tagged in the patient records (eg EMIS practice note) of any outstanding tasks. If you cannot get back to the surgery after doing a visit, phone to have the secretary put the details on the computer for you, checking that it will be communicated to the appropriate recipient.

**Record keeping is always important however, for the locum doctor the importance is even greater due to the potential lack of continuity of care.**

You should insist on having the patient's records – especially for home visits for patients with chronic and long term illnesses with complex care pathways including terminally ill patients. If conducting a home visit on behalf of a paperlight practice, ask a member of staff of the practice to print off the patient record so that all information on consultations, medications and so on, is to hand while conducting the consultation with the patient. Once the home visit is completed, the locum GP should ensure to write up the visit for the patient's record, and in the case of not returning to the practice, that the report is emailed securely to the practice manager to be added to the patient record. You should also ensure the practice provides you with a list of QOF codes and that you know where they are displayed on the system.

You may not be available to sign dictated referrals, so if tapes are wiped or lost this can be very serious. Practices will have different mechanisms for processing these, it is worth discussing this with practice staff in advance to ensure procedures are followed. Secretaries can check that there are tapes to match all entered READ codes. Alternatively all referrals or tapes can be logged by GPs in a secretary's book at the point when tapes are handed over. If you make a referral either typed or dictated it may be helpful to perhaps provide a list to the practice manager at the end of your surgery to ensure that the referrals are not lost and can be followed up.

For cases involving child protection, risk of suicide or terminal illness it is a good idea to also have some sort of face to face or at least verbal handover with other doctors so that there is better continuity of care. Detailed recording of all communication is particularly essential here.

## Dealing with complaints

Complaints and litigation will sometimes occur in medicine. One of the top five reasons for complaints is poor communication with patients. All doctors can reduce the risk of complaints and litigation by using good communication skills and by taking time to listen and explain treatment to patients.

Locums are particularly vulnerable to complaints because they:

- are less well known to the patient
- are often given inadequate or no induction by practices
- are less familiar with practice policies and systems including the computer system
- may be faced with patient notes in an unfamiliar format
- have less exposure to feedback
- can be exposed to misunderstandings about agreed terms of work
- are sometimes met with prejudice from staff and patients.

All the risks of locum work outlined above can also contribute to the likelihood that you will face complaints at some point. Following the advice in this chapter on working in an unfamiliar environment, agreeing terms of work and recording keeping will help reduce the risk of complaints.

Your terms and conditions of engagement should include a requirement that you will be kept informed about and fully involved in responding to any complaints received against you.

If you find yourself the subject of a complaint you should:

- ask to be kept informed of the complaint in a timely fashion
- have access to medical records relevant to the complaint
- be given the opportunity to acknowledge the complaint if you have not already done so
- be given the opportunity to respond or contribute to the response
- have the opportunity to consult your defence organisation.

If you are involved in a complaint process, you may find it helpful to seek the support of local peers, perhaps through a local locum group. The BMA advise all members to contact our advisors if a complaint is made against you, follow this [link](#) for contact information.

## Prescribing and repeat prescribing

You should take the usual precautions to guard against prescribing errors (see the GMC guidance *Good Practice in Prescribing Medicines*). Also, keep up to date with guidance from the British National Formulary and the National Institute of Health and Clinical Excellence in England and Wales and be aware of local prescribing policies and guidance. You should also keep an eye out for safety alerts usually cascaded via local commissioners and also available via the MHRA (Medicines and Healthcare products Regulatory Agency) [website](#) (follow this [link](#) to sign up for alerts).

- It is crucial that you familiarise yourself with each practice's prescribing policy.
- If you prescribe on the recommendation of staff without prescribing rights you must ensure you are satisfied that the prescription is appropriate.
- Be very wary of signing repeat prescriptions if you do not know what training staff have or what sort of protocols they work to.

Acute prescribing is usually more straightforward for locums than repeat prescribing or prescribing on the recommendation of other staff but you still need to learn to use the practice's IT system and ensure you are familiar with the practice's prescribing policies and protocols. Be aware of any hospital only or named person prescribing protocols and that drugs prescribed by specialists may not appear in the patient's notes. If in doubt and the drugs are not immediately necessary, and if there is no one else to consult, you should consider whether, in your professional judgement, it may be better to err on the side of caution.

Repeat prescribing carries particular risks for locum GPs. Locums are frequently asked to sign repeat prescriptions and in many cases will not know the patient's history. Yet the person who signs the prescription is the one who will be held legally accountable should something go wrong, even if it is a repeat prescription. This means that great care should always be taken when repeat prescribing. The GMC's Good Practice in Prescribing Medicines states that before signing a repeat prescription, you must be satisfied that it is safe and appropriate to do so and that secure procedures are in place to ensure that:

- the patient is issued with the correct prescription
- each prescription is regularly reviewed so that it is not issued for a medicine that is no longer required
- the correct dose is prescribed for medicines where the dose varies during the course of the treatment.

This GMC guidance can seem challenging if you are expected to sign repeat prescriptions for a practice with which you are not particularly familiar. You might want to state explicitly in your contract for services that you are not available to sign repeat prescriptions during short term bookings. This will help to protect you against clinical risk and also avoids the inevitable time pressures associated with familiarising yourself with repeat prescription protocols and establishing that each prescription is appropriate. In longer term jobs you have a better opportunity to satisfy yourself that the review mechanisms for prescriptions are robust but you may still want to negotiate allocated time for signing prescriptions.

The MPS (Medical Protection Society) recommends the following steps be followed if you were not the original prescriber:

- where possible, try and arrange for repeat prescriptions to be signed by a doctor who sees the patient regularly
- set time aside for signing repeats, allowing time to check the patients' records
- make sure acute prescriptions do not get mixed in with the repeat prescribing pile
- check prescriptions in a quiet location where full concentration can be devoted to the task
- if you are uncertain about a particular prescription, do not feel pressured into signing it simply because there are a pile of requests waiting. The notes should be available for you to refer to.\*

The MPS also suggests that if you are unsure about a prescription you should:

- check the details of the drug if you are unfamiliar with it
- check the patient's medical record and contact them if necessary
- discuss it with a colleague
- pass the prescription back to a doctor in the practice who knows that patient best
- ask the patient to make an appointment.

If you are unsure whether or not you want to take on repeat prescriptions within a particular practice, you might want to ask the practice some of the following questions to determine the level of risk in the system:

- are there any non-medical prescribers? Who can add medications to the repeat prescribing screen (eg pharmacists, nurse practitioners)?
- what are the processes for monitoring disease-modifying antirheumatic drugs?
- does the practice do its own warfarin monitoring?
- are drug allergies coded?
- does the practice have in place an adequate system for systematic review of repeat medications? Do all repeat medications have review dates?
- are medications 'linked' to clinical problems?
- are there systems for alerting you to stop repeats which are only required for defined periods eg Warfarin?
- what percentage of patients are compliant with reviews?
- is there an audit trail for non-repeat scripts issues and who has authorised them, or when they were last refused?
- how are hospital discharge medications added to the record? By a doctor, pharmacist, receptionist?

Patients will occasionally present problems for which you need further information. If you cannot get hold of a colleague, you could:

- have a few reference books readily available such as the Oxford handbooks of clinical medicine and of general practice and the BNF and local formulary guidelines.
- access information online with an ATHENS password for the National Electronic Library for Health. This will permit access to all sorts of excellent online resources, databases, eg PUBMED, 'Clinical Evidence' and even some full text journals. GPs can sign up to [Univadis](#) for free and have free access to GP notebook which can be a useful resource to GPs.

# Avoiding professional isolation and building networks

## Problems with professional isolation

The locum GP role can be an isolated one for a number of reasons. Some of these are outlined below.

- Starting work as a GP locum can often coincide with a reduced network of support. For example, a GP could have just finished their training scheme or moved to a new area.
- The support that comes with being an established, practice based GP is often not present for the locum; locums may have less opportunity to establish relationships with work colleagues, and might have less access to helpful support mechanisms such as deanery contacts, LMC contacts, and mentorship. Locum GPs should ensure that they are signed up to the LMC and that their contact information is up to date.
- Locums often do not always have the same formal and informal opportunities for discussing their clinical work with colleagues. This means that they miss out on the benchmarking of standards against peers that these meetings offer, exposing the locum to a greater risk of underperforming. Clinical discussions allow GPs to place their own clinical behaviours and standards in the context of that delivered by their peers. Locum GPs should ensure that their contact details are held by deanery tutors if present in the area, the LMC, the local RCGP faculty, a SGP group, any network federation who employ locums to cover work for the contracts that they hold, and often post-training the learning sets stay together.
- Locum GPs often miss out on important information cascaded down from PCOs, LMCs and deaneries – for example, information about educational opportunities or clinical services. Such information is often passed down through practices rather than to individual GPs and therefore often does not reach locums without a practice base. This leaves many locum GPs unaware of educational opportunities and other developments in their area. The BMA's sessional GP subcommittee is working to ensure that information is cascaded to locums more effectively. If a locum GP works regularly at a practice they can ask if they can be added to the distribution list to receive local information.

## Potential solutions

There are a number of ways in which you can limit this isolation and its potential impact.

- Join your local Sessional GP group. A list of these can be found on the BMA website (follow this [link](#)). Many groups also have their own website. Each operates slightly differently but most offer the opportunity to meet other locums and therefore develop a network of support. Some have educational meetings, and even offer information about locum vacancies. If a sessional GP group does not exist in your area you could consider setting one up (see box below).
- Make yourself known to the local deanery tutor and the educational facilitator at your PCO. Some deaneries have dedicated tutors for sessional GPs, while in others the tutors are generic and should be prepared to help all kinds of GPs. You should ask both the PCO and deanery tutor whether they can add your email address to their distribution list for educational events.
- Register your details with your local LMC and ensure you are on their mailing list or listserver. The role of LMCs is discussed more fully in the Representation chapter, but part of their role is to keep GPs up to date with developments in the local area. You can find a full list of LMCs on the [BMA website](#).
- Join an SDLG (self-directed learning group). See [Continuing professional development](#).
- Find out whether your PCO, LMC or deanery runs a local mentoring scheme.
- Contact your PCO to obtain relevant information on how to access appraisal. You should be provided with a list of appraisers and any local appraisal policies (much of this may be available via the PCO's website).
- Make sure you are on the mailing list for local hospital and CCG GP educational events.
- Keep an eye out for the GPC sessional GPs subcommittee newsletter which is sent to all BMA members registered as a sessional GP and cascaded to all LMCs. This will help to keep you up to date with political and professional developments.
- Overseas doctors may wish to join an organisation like BiDA or BAPIO to aid networking.

Membership can also count towards CPD.

- Consider using internet forums to chat to other locums and doctors, for example there are many facebook groups, doctors.net or NASGP
- Attending local clinician meetings and discussion groups can help raise your profile and keep you up to date with local developments. Locum GPs should ensure that their contact details are held by deanery tutors if present in the area, the LMC, the local RCGP faculty, an SGP group, any network federation who employ locums to cover work for the contracts that they hold, and often post-training the learning sets stay together.
- Ensure you receive:
  - urgent public health alerts that are cascaded via practices by signing up to receive them by email
  - the Primary Care Bulletin from the Department of Health. Follow this [link](#)
  - the NICE e-newsletter. Register [here](#).
- Out of hours work can also provide good opportunities for networking.

### Local sessional GP Groups

#### Tips on setting up a local sessional GP group

1. Use your local LMC to make initial contact with local sessional GPs.
2. Recruit volunteers to help run the group.
3. Consider holding meetings on a fixed day of the month and in a set location.
4. Think about combining the group's meetings with educational events. This may require some liaison with the local GP tutor for sessional GPs.
5. Build a website. This will diminish administrative work in the long run and helps to disseminate information.
6. Forge links with the local vocational training scheme, the local deanery and its GPs tutors.

A list of local sessional GP groups can be found [here](#).



# Representation of locum GPs

## National representation

### The BMA (British Medical Association)

The BMA is the professional association of doctors in the UK and is registered as an independent trade union to represent doctors both locally and nationally. Officially recognised by the Doctors and Dentists Review Body, the Government and NHS Employers, the BMA has sole negotiating rights for all GPs contracted by the NHS under national agreements, irrespective of whether or not they are members. It is also recognised by many employers of doctors practising in other fields.

### BMA GPC (general practitioners committee)

The BMA GPC UK represents all NHS GPs. It consists of approximately 90 members from across the UK. The GPC has sole negotiating rights with the Department of Health for all GPs working under the GMS (General Medical Services) contract. The GPC is also consulted on issues concerning the whole of the GP profession.

There are also national General Practitioners Committees for England, Scotland, Wales and Northern Ireland. As a result of devolution the committees negotiate directly with their respective governments on issues affecting general practice in their countries.

The GPC has representatives on other BMA committees, including BMA Council (the central executive of the BMA), as well as maintaining relations with external organisations.

Details about the GPC (UK) and national GPC election procedures are available on the [BMA website](#).

There are three main routes to become a GPC representative:

- via a regional seat
- via LMC or BMA's annual representative meeting, or
- via the sessional GPs subcommittee.

### Sessional GPs subcommittee of the GPC

The sessional GPs subcommittee is a democratic body and represents all salaried and locum GPs throughout the UK. It has been in existence since 1997 and was previously known as the Non-principals subcommittee. It deals with issues that affect all types of sessional doctors. It has grown in strength and has achieved a great deal since its inception. Further information can be found on the sessional GP subcommittee [here](#), this includes key issues and links to further guidance. Information on the representatives on the subcommittee is available [here](#).

## Local representation

### LMCs (Local Medical Committees)

LMCs in England, Wales and Northern Ireland are recognised in statute as the local representative body of GPs, including salaried GPs. They are therefore recognised to negotiate with their PCO.

### Scotland: LMCs and Area Medical Committees

In Scotland the situation differs. Scottish LMCs only represent local GPs on matters relating to their remuneration and conditions of service. Local GP negotiation with the Scottish PCOs on the general operation and funding of primary care services is undertaken by the AMC (Area Medical Committee) of the PCO and the AMC's GP subcommittee. The AMC's GP subcommittee is made up of GP members.

### Role of LMCs for locum GPs

All LMCs throughout the UK are able to influence GPC policy through the annual conference of LMCs and through their direct liaison with GPC members and secretariat. LMCs provide a professional advisory and supportive role to their local GPs, including supporting locum GPs with any difficulties they experience with a PCO they are engaged with.

They can, for example:

- offer support for entry to the performers list
- support locum GPs experiencing difficulties with their contract or practice, possibly helping to mediate between the parties
- ensure that PCOs, deaneries and GP tutors are aware of locum GPs' educational needs and the need to disseminate relevant information to these local doctors
- liaise with PCOs to ensure proper funding and support is available for appraisal
- ensure that, where applicable, locums are involved in elections to boards and executives
- occasionally organise educational and inter-professional events.

### Representation of locum GPs on LMCs

A locum GP may need to contribute to the levy to join the LMC. There is local variation but the fees are usually nominal. If you work in more than one area and it is not immediately obvious which LMC to join, you could join the LMC which covers the PCO where you are on the performers list, or you could join the LMC that you feel best represents where you work.

You should ensure you are on the LMC's mailing list. LMCs often try hard to contact locum GPs in their area, to let them know about the LMC and its work, but it is often difficult for them to obtain accurate contact details for locum GPs. If you do not hear from your LMC, it is quite likely that they simply do not know that you are working in the area or, if they do know, they do not know how to get in touch with you. Contact your LMC to let them know that you are working in their area, and that you would like to join the LMC.

One of the best ways to make sure that your voice is heard within your LMC is to stand for election to its committee or board. As democratic organisations, they are best able to represent members' interests if members of all groups become actively involved in the running of the LMC.

Each LMC is an independent organisation so there are many different committee structures, and different ways to get elected. Ways that you could be elected to your LMC's main committee include:

- direct election – most LMCs are divided into regional constituencies, and all LMC members within that regional constituency can vote for the GP they want to represent them
- to a seat reserved for sessional GPs – some LMCs, aware that sessional GPs find it difficult to get elected in direct elections, reserve a number of seats in which only sessional GPs are allowed to stand for election and vote
- co-option – some LMCs regularly assess the diversity of their membership, and co-opt additional members to represent an under-represented group of doctors
- to a sessional GPs subcommittee – some LMCs have subcommittees that focus on specific areas. If your LMC has a sessional GPs subcommittee, they may be looking for additional members.

Contact your LMC to see what options are open to you in your area. You can find your LMC's contact details on the [BMA's website](#).

For further information on Sessional GPs and LMCs working together, please follow this [link](#).

**Membership of the BMA is distinct from that of the LMC. You are strongly advised to join your LMC to access their services and ensure that your interests are represented.**

### **BMA support to individual members**

Individual expert advice and support on employment contractual matters is available to BMA members.

For locum GP members this includes an employment contract checking service as well as advice on their terms and conditions of service and pension matters arising from the operation of an employment contract. The BMA also provides representation at grievance hearings and disciplinary hearings and, where appropriate, before employment tribunals and the civil courts.

GP members who are employers can obtain advice on drawing up contracts of employment for staff, including terms and conditions of service and pension matters from the BMA employer advisory service. They can also receive advice and representation on matters arising out of the day-to-day operation of the employment relationship with staff.

#### **Contacting our advisers**

The BMA is here to provide you with free, comprehensive, impartial and authoritative advice on a huge range of employer and employee related matters.

For advice and information, please call a BMA adviser on 0300 123 1233 between 8.30am and 6.00pm, Monday to Friday except UK-wide bank holidays. You can also webchat live with an adviser or email your query anytime.

Members should always contact an adviser in the first instance. Your enquiry will be dealt with efficiently by our team of specially trained and experienced advisers.

To access these benefits you must be a BMA member or at least one partner in the practice must be a BMA member.

# For locums and providers

## The contract for services

The BMA recommends that when locum GPs are engaged by practices the parties use a written agreement that sets out the terms of engagement. Practices vary considerably in the way they are organised, and in terms of what is considered a standard working day. Using a written agreement ensures that both parties' expectations are clearly set out and should help to create a successful working relationship. There is also the added benefit of ensuring that the locum is working within their range of experience.

The locum agreement is normally made between the locum and the practice manager or someone with delegated authority to negotiate (deputy manager). However, receptionists should also be made aware of the exact terms of the agreement (though not necessarily the financial arrangements), particularly in relation to agreed workload. To reduce the time which can potentially be involved in drawing up an agreement, many locums will have a standard personalised one which they offer in the first instance and which can be subject to small adaptations to suit the practice if mutually desirable.

The content of any locum agreement will be subject to negotiations between the locum and the contractor. Email should allow efficient and effective liaison between the parties to ensure that there is a clearly-worded finalised agreement in writing, which has been signed and dated by both parties, before the locum starts work. Locums should and often will avoid accepting bookings without clear written terms.

The main things that should be covered by a locum agreement are:

- fees (see [Negotiating fees](#))
- timetable of work
- definition of core work
- additional and enhanced services
- definition of contractor responsibilities
- definition of locum responsibilities
- arrangements for termination of the agreement.

The BMA can check members' locum contracts. If you wish to use this service send your contract to the BMA well before accepting its terms.

## Timetable of work

The agreement could include, among other things, specific details about:

- the number of sessions that will be worked per week
- the start and finishing times each day
- where on-call duties apply, the time until which the locum will be available by phone if not at the surgery. This could all be included in the form of an easy-to-use timetable within the agreement
- details of the number of appointments expected to be completed during a day
- appointment length
- visits and the cut off time for notification of routine visits (ie from what time visits would be considered the responsibility of the on-call doctor, or what the agreed cut off time is for that specific locum bearing in mind that they may have work booked elsewhere for the afternoon).

Consideration should also be given as to whether the locum is prepared to accept extra appointments or not during the course of the working day.

## Definition of work to be undertaken

The agreement should include a definition of the work that the locum will be expected to carry out. A locum aspiring to deliver a high standard of care must allow reasonable time for consultations and the tasks arising from these such as prescribing and referrals. The locum might want to specify how many patients they will see per hour or per session, how much time they need protected for administration and how many breaks they require. The

agreement could include a general definition of the locum's core work as well as a more specific list of the work that might be undertaken in addition to basic duties (for example, telephone consultations, repeat prescribing, completing private or benefit reports etc). The agreement might specify that additional work undertaken will be subject to your agreement on the day. Unfamiliarity with practice systems and unforeseen circumstances can make it difficult to agree additional work in advance.

The non-clinical work that is included in the locum's fee should be specified. For short-term placements, this is likely to include arranging referrals and investigations and it may be helpful to specify 'referrals and investigations arising directly from own caseload'. The procedure used for referrals should be detailed, for example whether a dictaphone is available and whether there is assistance for Choose and Book referrals. These factors should be considered when estimating the time required to complete the work. A modified clinical workload may be negotiated to factor in time for additional paperwork or repeat prescriptions. Bear in mind that a newly qualified GP will work very differently to a locum who has just retired from 20 years in a practice. Just because other GPs see 24 patients in a surgery does not mean the locum can or should do this, in an unfamiliar environment.

There are some areas that frequently prove contentious and should be addressed explicitly (either inclusion or exclusion):

- dealing with nurse queries
- dealing with queries from patients who have not been seen by the locum
- telephone triage outside of agreed surgeries
- signing prescriptions on behalf of other practitioners such as nurses
- otherwise supervising nurses or nurse practitioners
- chaperone provision for intimate examinations
- defining what the on-call duties are
- the cut off point for notification of home visits
- whether any private work (medical certificates, reports, insurance examinations etc) will be undertaken and what proportion of payment will be retained by the locum. As private work pays more per hour than NHS work, it is quite common to be paid for private work separately
- what happens to fees incidental to seeing patients eg MHA sectioning fees
- whether the locum will sign prescriptions and whether this will be just repeat prescriptions (for patients who have been reviewed within their required review date, subject to seeing the repeat prescribing policy) or also non-repeat requests.

For longer-term placements:

- whether the locum will deal with incoming results and correspondence. If necessary, an adjustment should be made to the normal workload to reflect the additional time required and/or the fee should be adjusted accordingly
- whether the 'paperwork' share is only that linked to the locum's own caseload and that of the doctor the locum is replacing, or whether it is done on the basis of a set 'share' of the overall workload of the practice.

### Additional and enhanced services

The agreement should clarify whether there is an expectation to undertake work associated with Additional and Enhanced services, including LESs (local enhanced services) or DESs (direct enhanced services).

As with the definition of core work, if additional and enhanced services are to be carried out, the agreement should specify what services will be undertaken – for example, minor surgery or IUDs. Following discussion between the locum and the contractor, details should be specified in the agreement and specific fees detailed.

### Definition of contractor responsibilities

There are a number of examples of basic responsibilities that may be outlined within the agreement including:

- provision of a personal computer login username and password and, if appropriate, a brief training session on the system used, activation of smart card for Choose and Book for that practice and login access to ICE to allow direct requests of xrays and tests
- provision of an induction folder and information (see [Locum GP induction](#))
- access to computer and medical records outside of consulting time for audit purposes
- payment of fees within a stated time period (late payment may incur an additional fee)
- signing pension form A promptly (see [Practice responsibilities](#))
- supplying adequate/appropriate equipment and drugs
- prompt notification of any complaints and patient feedback
- providing an adequate notice period for cancelled sessions.

Additional issues that may be referred to in the agreement include the possibility of the locum attending practice clinical and educational meetings (and whether this will be paid or time in lieu given if over and above agreed working hours) and being able to work in the same consulting room when working in a practice over a longer period.

### Definition of locum responsibilities

A clear statement should be made by the locum that written original evidence of the following will be provided for the practice to make and keep a photocopy:

1. inclusion on a medical performer's list
2. medical indemnity.

The agreement must make clear that the locum is undertaking the work in a self-employed capacity and undertakes to meet any National Insurance Contributions, income and any other taxes arising from the income. The locum will be expected to provide either an invoice for payment or a receipt. For longer-term placements, the locum and contractor may wish to agree a notice period for taking leave or making changes to availability. A self-employed locum would however still be expected to control his or her own annual leave. Restrictions on the locum's freedom to take leave could affect their employment status with consequences for national insurance contributions etc.

Where locums choose to set up and operate through a limited company or other form of intermediary, rules known as 'IR35' (or 'intermediaries' rules) may apply. From 6 April 2017, new IR35 rules will come into force for public sector bodies who engage a worker via an intermediary, such as a limited company or PSC (personal service company).

Under the new rules, responsibility for deciding whether IR35 applies will move from the individual worker's personal service company to the public sector body, agency or third party paying them. This means that public sector bodies, including GP practices, will be responsible for deducting tax and NICs from any payments made to the intermediary where they consider IR35 to apply.

The new rules may mean that GP practices take a risk-averse approach and decide to apply IR35 to all locums who use intermediaries. IR35 rules only apply to tax and NIC, so there won't necessarily be any change to a locum's employment status in terms of their statutory rights. Further information on IR35 can be found [here](#).

### Arrangements for termination of the agreement

Arrangements for the termination of the agreement made should be included, particularly if the locum is engaged by the contractor on a longer-term basis. Where such arrangements are outlined within an agreement, they will often include the following:

- details of how the parties can decide to terminate the agreement ie by mutual agreement, or by providing a certain length of notice (acceptable to the locum and the contractor)
- if the agreement is terminated by the contractor and the agreed period of notice is not given, details of the fee claimable by the locum (for example, this fee could be based on

the difference between the notice actually given and notice that should have been given according to the terms of the agreement)

- a clause stating that the agreement can be terminated if its terms are breached by either party.

It is considered bad practice to commit to locum work only to leave it if a better job is offered.

### Termination of the contract for services (for self-employed locums)

This section applies to self-employed locums and to the providers that engage them.

A contract for services usually ends on completion of the task, by notice or if the terms of the contract are breached.

Locums who are told that their services are no longer required during their contract period should contact the BMA immediately. Similarly, providers considering ending a locum GP's contract should contact the BMA as a matter of urgency. These services are only available to BMA members.

There are various ways in which a locum's contract for services may be terminated. Some of these may give rise to a legal claim:

- termination by mutual agreement
- termination by the locum
- ending of a fixed term contract
- termination by the provider with notice
- termination by the provider without notice
- termination due to frustration.

#### Termination by mutual agreement

If the locum and provider agree that the contract for services should end, then there will normally be no redress for either party. This includes if the provider persuades the locum to leave through a financial incentive.

#### Termination by the locum

If a locum wishes to terminate the contract, the notice period to be given should be that which is outlined in the contract for services.

#### Ending of a fixed term contract

A fixed term contract is one which terminates on either:

- a specific date or after a specified amount of time
- the completion of a particular task
- the occurrence (or non-occurrence) of an event.

If a fixed term contract is terminated prematurely then payment in lieu of lost wages may be available.

#### Termination of the contract with notice

The length of notice needed to terminate an agreement should be included in the contract for services. If the agreement is terminated without the requisite notice, the contract may stipulate that a fee will be claimed by the locum – for example based on the difference between the notice actually given and the notice that should have been given according to the terms of the agreement.

The locum may be paid in lieu of notice where this is provided for in the contract for services or otherwise agreed between the parties

#### Termination without notice

If the agreement is terminated without the notice provided for in the contract, this will constitute a breach of contract, for which the locum can seek damages.

The locum can expect their contract to be terminated forthwith if:

- the locum's name is removed or suspended from the Medical Register (except under section 30(5) of the Medical Act 1983 – whereby medical practitioners who have been written to at a certain address by the Registrar but no answer has been received from that address for six months are erased from the Medical Register)
- the locum's name is removed or suspended from the relevant Performers List
- the locum commits any gross or persistent breaches of his/her obligations under the employment contract
- the locum is guilty of illegal substance abuse or habitual insobriety.

### Termination due to frustration

Frustration of a contract occurs when either it is impossible for the contractual obligation to be performed, or the circumstances (such as sickness or imprisonment) would render the contract substantially different from that envisaged by the parties at the time of the contract being entered into.

If the contract is frustrated then there is no requirement for the locum to be given notice of the termination. However, it can be difficult to prove that the contract has been frustrated since factors need to be taken into account, such as the locum's role and duties, the need for work to be done, etc. Further advice on this should be sought from the BMA.

### Termination of employment (for employed doctors)

If you are working in a post with a salaried GP contract (contract of service), the rules on termination of employment are different. For full information on your rights as a salaried GP, please refer to the [BMA's Salaried GP handbook](#).



## For providers

### Reimbursement available to practices for locums

In some circumstances, under the SFE (Statement of Financial Entitlements) a GMS practice is entitled to apply to its PCO for locum reimbursement. For more detail on the conditions for doing this please follow this [link](#) for the 2013 version, and this [link](#) to access the 2015 amendments.

In all cases, in so far as possible, practices are advised to receive approval from their PCO in advance of needing a locum and to seek confirmation of the level of reimbursement available from the PCO.

It is expected that PMS practices will have the benefit of locum reimbursement included in their contract for services with the PCO. It is important for the practice to check this contract, including the extent and level of locum reimbursement available. Practices should contact the BMA for advice if the contract with the PCO is unclear.

### Recruiting locums

Locums can be found through locum agencies or chambers, from locum banks coordinated by Local Medical Committees (LMCs) or local sessional GP groups or in some cases through training schemes or out of hours organisations. Most GP locums are freelance and find work through local knowledge and contacts. You might also choose to advertise your vacancy in a professional publication, use a web-based platform or to use locums you have used in the past.

When advertising for a locum you should include as much information as possible about the normal surgery length and workload. Include information about the computer system used, the number of surgery sites and whether the work includes on call or special clinics. The position will be more attractive if you are able to offer some flexibility over surgery start times and booking intervals to suit the locum's working style, experience and other commitments. As most locums are self-employed you may need to be flexible about the fee and willing to negotiate (see [Negotiating fees](#)).

Using email to communicate with prospective locums helps to capture the discussion and ensure that a record is kept of the arrangements. For this reason it is good practice to confirm any booking in writing (eg by email) promptly. You should ask if the locum has written terms of engagement or try to include as much as possible in advance in writing (see [The contract for services](#)).

On the first day of their engagement, give locums clear directions for getting to the surgery and gaining entry to the building if it will be locked when the locum arrives. Ensure that someone is available to meet the locum before the first surgery to give them an induction (see [Locum GP induction](#)). If the locum needs to be inducted before the reception desk is open and phone lines switched on, ensure they have been given a suitable alternative contact phone number to use should they need directions or be delayed.

### Best practice tips when engaging locums

Providers quickly gain a reputation amongst locums for being good or bad to work for. If you want to remain attractive to locums when you need them, you should bear the following in mind:

- adhere to the agreed terms of engagement and workload with adequate time built in for longer appointments. If you want the locum to take on additional work, check with them first (they may be unable to extend their session owing to prior commitments)
- pay fees promptly
- make sure you sign pension forms promptly
- be friendly and helpful and ensure other staff are too
- make sure you have a good settling in and induction procedure
- do not make assumptions about the way the locum will work. Remember that practices work in very different ways. What is normal in your practice may be unfamiliar to the locum. Ways of working which are acceptable to one practice or locum may be unacceptable to others (eg with regard to repeat prescribing practice)
- help to support appraisal and the locum's continuous improvement. For example:
  - inform the locum what your procedure is for reporting significant events
  - inform him or her promptly of any complaints, compliments or feedback of which he or she is a party
  - invite him or her to clinical or educational meetings specially CPR or safeguarding children training which can be difficult to access outside of practices
  - consider including the locum (if they wish) in any patient surveys or multisource feedback exercises
  - ask locums about their experience working with you to help you improve
  - allow the locum to return and audit their work eg by reviewing the outcome of referrals made.

### Provider responsibilities

The provider is responsible for checking that the locum is a GP (ie has a JCPTGP certificate), with medical indemnity, up to date DBS check, registered with the GMC and on a local Performers List. The practice should also check a locum GP's references, the CQC may check on this during an inspection. Registration with the GMC can be checked at [www.gmc-uk.org/doctors/register/LRMP.asp](http://www.gmc-uk.org/doctors/register/LRMP.asp). This is the best way to make sure that registration is current.

Practices should be satisfied of the locum's self-employed status and be aware of the potential for a regular, long-term locum to gain employment rights. This also has implications for, among other things, pension administration and contributions (see below). **It is your responsibility as an engager to correctly determine the employment status of your workers.** You should bear in mind that an individual's employment status can change over time as the relationship progresses. Independent, professional tax advice should be taken if either party has any doubts as to the locum's taxable status.

Providers are responsible for any negligent acts of locums providing cover for them to the extent that these acts are related wholly to the services that are being provided and not to something that is outside the remit of what is expected of the locum in the ordinary course of providing those services. It is fully incumbent on providers to maintain the appropriate insurance cover including any negligence of locums providing contracted services.

In addition to these basic requirements, practices have a responsibility to the locum and to the patients to provide the locum with a decent practice induction (see [Locum GP induction](#)).

More specific responsibilities of the practice may be outlined in the locum's contract for services (see [The contract for services](#)).

### Locum GPs and pensions – practice responsibilities

If a GP practice employs or engages a GP on a regular basis (eg 1 session per week, for 8 months) the GP is regarded as 'GP Performer/type 2 Practitioner' under the statutory NHS Pension Scheme Regulations. It is the practice's responsibility in law to collect the employee contributions from the GP and to forward these (along with the employer contributions) to PCSE. In reality (and as with GP Providers) the contributions are in fact top sliced from the monthly global sum payments by PCSE.

It is not for a practice to determine if a GP working at the practice is a GP Locum or a GP Performer. Only the Secretary of State (ie the NHS Pensions Division) can determine this in accordance with the statutory NHS Pension Scheme Regulations. The fact that a GP may not have a contract of employment with a practice will not prevent them from being viewed as a performer/type 2 practitioner and not as a locum.

As this is a complex area, the NHS Pension Agency has recently agreed with the BMA and Department of Health the following:

1. If from the outset it is clear that the locum will be engaged for more than six months at the practice, the GP will be a type 2 practitioner and the practice will be responsible for the cost of the employer's superannuation from day one.
2. If from the outset it is clear the fee based GP will be engaged for less than 6 months at the practice, they are a GP locum in pension terms from day one. If the locum works beyond 6 months without break they are then considered a type 2 practitioner from that point on for pension purposes.
3. If it is not known how long the GP will be engaged for they are a GP locum in pension terms, however once their engagement hits the six month mark, they will become a type 2 practitioner going forward for pension purposes.

We would expect this principle to apply across the UK.

It is important that providers are clear on their responsibilities with regard to pensions because:

- Where a practice withholds contributions it is acting in breach of the statutory NHS Pension Scheme Regulations and section 49 of the Pensions Act 1995.
- If that practice is a GMS practice it is also acting in breach of the statutory GMS SFE (Statement of Financial Entitlement). The SFE has penalty clauses including giving the local commissioner powers to withhold monies it pays to the practice if any part of the SFE has not been complied with.
- The budget agreed between the commissioner and the practice includes all scheme contributions except those in respect of GP locums. If that practice is not forwarding these contributions on to the NHS Pensions Division they have to consider if any foul play has occurred especially if the Providers are increasing their own profits and therefore their own pensionable pay.
- There are provisions under NHS Pension Scheme regulations T5 and T6 to withhold monies from a GP Provider's pension benefits if there has been an act of crime, negligence, or fraud.
- Section 70 of the 2004 Pensions Act states that the NHS Pensions Division has a legal duty to report any breaches of the law on pensions to the Pensions Regulator. Breaches can attract hefty fines, of up to £5,000 in the case of an individual and up to £50,000 in any other case.
- The NHS Pensions Division also have a duty to inform the Business Services Authority, at NHS Counter Fraud Services, if they believe that fraud may have taken place in the NHS. NHS Counter Fraud has already investigated several Practices who are allegedly breaking the law.

Please contact the BMA pensions department on 0300 123 1233 if you require further guidance in this matter.

GP locums are required to pay over their pension contributions, to their PCO/PSCE, within 10 weeks of having commenced the locum work. If payments are made outside of this period, the PCO/PCSE is able to decline the payment and the GP locum will not be able to pension the period of work in question.

### Locum GP induction

Practices differ widely, and locums cannot be expected to offer a good standard of service if they are not provided with essential information about how the practice operates. This means having both an induction drill and a reference induction pack. Providing a good induction is an important guard against adverse events. It will also make work a more enjoyable experience for the locum. Locums will soon learn to avoid practices which do not provide a supportive environment.

### The induction drill

A long term locum could be given protected paid time for a thorough induction at the start of the post. This might be stipulated contractually and is a worthwhile investment. When a locum is only with a practice for a short time, a long induction is impractical but most locums will allow time before starting work to brief themselves and check that the room is adequately stocked. Practices should make sure that someone is available during this time to help the locum and provide a short induction. Ensure that the locum is familiar with the computer system before they turn up for work. A short induction check list will help to ensure that the most important points are covered. This checklist should be reviewed periodically by the practice.

For example, before the locum starts his or her first session:

- Show the locum around the practice. Orientation within the practice should cover:
  - codes to any keypad operated doors which the locum will need to use location of panic button, emergency box, nebuliser ECG machine if appropriate as well as resuscitation trolley, fire exits, toilets, tea/coffee and where other staff can be found.
- Show locum to their room. In the consulting room show the locum:
  - how to call patients in
  - how to obtain an outside line
  - how to login in to computer (windows and clinical system, and any document viewer) as well as ICE (Integrated Clinical Environment) software and authorisation for Choose and Book smartcard
  - the practice directory of phone numbers (reception, secretary, consulting rooms, nurses etc)
  - how to use practice intranet
  - how to print a prescription or the electronic transfer of prescriptions
  - the system for dictation
  - where they can obtain information on the computer on local referral pathways, especially fast-track services and their eligibility criteria.
- Show the locum where they can find or who they should ask for:
  - stationery: fit notes, FP10 pad and computer script supplies, letterhead, envelopes, blood forms, x-ray forms
  - referral forms
  - maps of any new estates which are not included in commercially available A to Z
  - essential equipment: BP machine, peak flow meter, msu bottles, emergency drugs
  - dictaphone and tape
  - the locum induction pack.
- Ensure the locum knows who the lead GP on call is that day and who they should call with any problems.
- Ensure that the locum has everything they need prior to the start of surgery. Practices should try to place locums in a single room during the course of their work for the practice and should avoid relocating the locum during the day.

### The induction pack

It is considered good practice to have an induction pack which is specific to the practice. This is recommended as part of practice risk management, good practice in personnel management and is recommended by medical defence organisations. It should be small and concise and be kept up to date. It is also one of the parameters contributing to assessments of quality made during inspections by the CQC (Care Quality Commission). Training practices are required to have induction folders for trainees. If your practice has one for this purpose you may wish to make it available to locums.

Enquiries into major critical incidents consistently highlight poor communication and teamwork as causal factors. Induction packs therefore have a major role to play in preventing critical incidents. They will also increase job satisfaction for locums and most importantly, by reducing variation amongst clinicians, ensure that your patients receive consistent standards of service. Patients can become very frustrated when given incorrect information by locums about how to request repeat prescriptions, how to find out results or how to book certain types of appointments. In the absence of adequate induction information provided by the practice, the locum's surgery can be punctuated by a constant stream of telephone queries between the locum and receptionists (and other staff) disrupting everyone's work.

The induction pack will help to ensure that your locum will:

- use 'in house' services appropriately and follow correct procedures eg bloods, dietician, contraception (IUDs), minor surgery
- use external local services appropriately eg local cancer pathways, chest pain clinics, and any services which are peculiar to your area (eg hospital appointments booked by patients)
- refer acute admissions to the correct service/hospital without undue delay or confusion
- work effectively with the primary care team
- communicate with the right person for each problem in a timely fashion
- follow practice protocols (eg repeat prescribing protocols)
- document care in a format which will fit with quality measurements/targets in the practice
- follow the practice prescribing incentive scheme
- know where in the practice they can access information (local guidelines, recent urgent public health alerts or cascades).

There is a strong case for creating this as an electronic document. This will allow you to insert file paths and hyperlinks (thus making the document more manageable), which will make it easy for the locum to search for necessary information and will make it easier for you to keep up to date. If folders are not available electronically they should be properly indexed so they are easily accessible. Practices may wish to use the practice intranet to hold standard forms and protocols.

A template induction pack for tailoring to your own practice can be found in [Appendix 2](#).

# Working through platforms and locum banks

This guidance outlines the potential benefits and disadvantages of working through locum banks and platforms compared with working freelance.

Freelance working has increased across the UK and in the GP workforce. It offers locums flexibility and the opportunity for increasing their working participation for example supplementing another more regular role, although pre-employment checks required by CQC can be off-putting for employers.

Agencies, chambers, and the newer technological intermediaries - called 'platforms'— can match workforce supply and demand and make it easier for employers to hire pre-vetted labour on a casual basis. NHSE has recently set aside funding to invest in this model, which it describes as "[flexible staff pools](#)".

We outline the potential benefits and disadvantages of working through locum banks and platforms compared with working freelance.

## What are locum banks?

A locum bank is a service that is usually provided by an NHS organisation. It links practices to freelance GPs without the cost and burden of finding locums and carrying out pre-employment checks. Although these services generally charge practices a fee, it can be less costly than using an agency.

Locum banks may also develop preferential arrangements with certain platforms – for instance, they might negotiate a block contract for a reduced fee for practices that use the platform.

## What are web-based locum platforms?

Web-based locum platforms, are profit based intermediaries which can connect practices and freelance locums across a wide geographical area. They provide features like automated confirmation of bookings with integrated terms and conditions, credentials storage like DBS checks, diary management and invoicing.

In practice-facing platforms, the practice sets the work and fee, although the freelancer can challenge or negotiate the terms and fee. On the other hand, locum-facing platforms allow the freelancer to set their own working terms, workload, and fees – including cancellation terms.

## Benefits of working via locum banks or platforms over working freelance

Possible benefits of working through locum banks or platforms include:

- Connecting with a larger number of practices and sessions. Extended access hubs often only advertise via online platforms, for instance.
- Finding work more easily due to increased visibility, especially if you have just moved or are newly qualified.
- Easier administration through:
  - Automated invoices and superannuation forms.
  - Customization, like filtering available sessions by distance from home, computer systems, days, work types, terms and conditions.
  - An online calendar of availability which can be viewed and sometimes booked directly by practices with different levels of locum control. Some bookings are subject to a date-by-date acceptance by the locum; other platforms allow locums to select practices which can book available slots directly and without further confirmation.
- The ability to track mileage, income, and expenses for ease of accounts and tax returns.
- The ability to submit pre-employment check documents to a single cloud-based link, which removes the need to update them or re-supply these to each new practice.
- Support in chasing payments. In some instances, payment is guaranteed by the platform.

### Risks and disadvantages of working via platforms and banks

You may not be able to negotiate your price independently due to fixed session fee setting by locum banks. Containing locum costs is often a driver for locum banks.

- Some locum banks standardise their terms and conditions without allowing the freelancer to set their own terms. If this is the case in your area, review the terms and conditions carefully to ensure you are satisfied with them. Common areas of concern are around cancellation notice and fees.
- Working via platforms and banks could place locums in challenging settings, for example poorly organized, under-doctored, high turnover practices which they might not voluntarily have accepted work in.
- Booking sessions via a platform may sometimes limit the relationship a locum has with a practice. For example, it is important you are given the opportunity for a proper induction to familiarise yourself with local policies and systems.
- By nature, locum work can be more medico-legally risky and it is important that you feel you can access support in the practice you are working in.
- The amount of investment in peer association and education can be highly variable between banks or platforms. Locum work can be isolating, so educational and pastoral support are essential.

### What to consider before working for a locum bank, flexible working pool or online platform

- Is it a practice-facing or locum-facing intermediary?
- Does it have a block contract with the local federation or CCG/ local market dominance? It is important that freelance locums retain the option to book work outside the platform.
- Are fees set by the locum or the practice? Do fees state clearly whether they inclusive or exclusive of superannuation payments?
- Does it allow you to define your terms and conditions, for each work environment i.e. what is included in your fee and whether this is practice specific, your cancellation terms, etc.? As a locum you want to be able to define the fees and terms which you offer as a self-employed worker regardless of the platform which does the matching.
- What feedback data is collected about you, where is it held and for how long? How is the data collected, benchmarked and actioned? Does the platform measure your performance based on any of these metrics?
- What happens if there is a complaint or a concern about your performance? Are there processes in place to ensure you have adequate access to adequate access to medical records, information about the complaint, the opportunity to contribute to the response if necessary after accessing professional advice from an MDO ?
- Does the platform enable you to have a voice or participate with others?
- What minimum requirements are there on practices to offer, for example, locum packs, individual logins, induction, etc.
- What educational support is available?

# Sources of further information

**British Medical Association**

[www.bma.org.uk](http://www.bma.org.uk)

**BMA Local Medical Committees**

[Local medical committees](#)

**General Medical Council**

[www.gmc-uk.org](http://www.gmc-uk.org)

**HM Revenues and Customs**

[www.hmrc.gov.uk](http://www.hmrc.gov.uk)

**Medical Defence Union**

[www.the-mdu.com](http://www.the-mdu.com)

**Medical Protection Society**

[www.medicalprotection.org](http://www.medicalprotection.org)

**Medical and Dental Defence Union of Scotland**

[www.mddus.com](http://www.mddus.com)

**National Association of Sessional GPs**

[www.nasgp.org.uk](http://www.nasgp.org.uk)

**Royal College of General Practitioners**

[www.rcgp.org.uk](http://www.rcgp.org.uk)



## Appendix 1 – Employment status – Key factors

Factor	Indication of employment	Indication of self-employment
The measure of control over the individual's work	Subject to management and supervision by the practice	No supervision once overall assignment agreed.
Extent of integration in the business	Integral part of business of employer	Assignment is incidental to activities of the practice
Provision of equipment (especially major items)	Equipment is provided to the locum	The locum provides any equipment needed
The length of engagement	A long-term engagement	A short-term engagement covering a specific assignment
Acceptance of work offered	Required to accept work	Not obliged to accept work offered
Work routines	Required to work specific hours and attend a place of work on a regular basis	Free to work as and when the individual wishes, as long as the assignment is performed
Remuneration	Paid at set regular intervals (for example, weekly or monthly)	Remuneration on a fee basis or on the basis of the amount of work performed; the individual raises invoices
Responsibility	Unable to profit from sound management of tasks, but has no risk of financial loss from the working relationship	Able to profit from sound management of the assignment, is responsible for own management and investment decisions, and risks financial loss to correct unsatisfactory work
Other work	Restricted to working for one practice at a particular time	Free to undertake work for others
Separate business	Work arrangements have none of the characteristics of a separate business	Has own business address, puts in own capital, which is at risk, and has overheads (for example, premises or employees)
Liability to third parties	Covered by the employer for any damage caused by the work	Responsible for damage caused by the work and has appropriate insurance
Job title	Described as an officer or employee	Described as a contractor, adviser or consultant
Subcontracting or hiring helpers	Cannot subcontract or hire helpers; must provide own services	Can subcontract or use own employees to perform the assignment

## Appendix 2 – Template GP locum induction pack for practices

### GP locum induction pack

Example framework to be customised for your own practice. There is a strong case for creating this as an electronic document. This will allow you to insert file paths and hyperlinks (thus making the document more manageable) and will make it easier for you to keep up to date.

This pack has been developed for  
Practice name  
Address/branch

Last updated:

Scheduled date for review:

Name of practice manager:

This practice is a GMS/PMS/Section 17C/APMS practice with <insert number> patients.  
Is the practice a training practice?

#### Contents

1. Important telephone numbers and practice staff
2. The computer system
3. Practice protocols and local protocols
4. Enhanced services carried out within the practice
5. Ordering investigations, making referrals and arranging treatment
6. Results

### Important telephone numbers and practice staff

Switchboard xxxx

Practice fax number xxxx

For an outside line dial xxxx

Position	Name	Phone number(s)	Notes eg days worked, room number
Practice Manager			
Reception			
Secretaries			
Admin			
Clinical partners		You may want to include surgery, mobile, home numbers	
Salaried Doctors			
Practice nurses			
Treatment room			
Nursing Assistants			
Health Visitors			

	Number(s), including mobile numbers where relevant	Notes
Local district general hospital		
Local tertiary hospital(s)		
Ambulance		
District nurses		
Psychiatrist		
Social worker elderly care		
Social worker mental health act		
Social worker child protection		
Macmillan nurses		
Coroner		
Pharmacies		
Police		

### The computer system

This practice uses <insert name of system>.

If you experience any problems with this system please contact <insert phone number of person who is most likely to be available for login problems etc>.

If the practice uses an ICE (Integrated Clinical Environment) system to send blood requests straight to the hospital and you are not going to give the locum a login for the system, note who will make the ICE requests on the locum's behalf.

Remember to [customise as appropriate, this is an example]

- Enter a problem title for each patient consultation and if it relates to a problem that the patient has presented before, select the problem title from the list of past problems and file it as a review.
- For all chronic diseases file data under T (templates), Y (chronic diseases) and reset a due diary (D).

Insert information on how patients are added to disease registers and the use of READ coding

### Practice protocols and local protocols

#### Practice protocols

This practice has protocols for:

<List your practice protocols and indicate any with which the locum must be familiar>. You could include the most important in the induction pack eg visits, repeat prescribing and referrals. Note where others can be found for reference. The following are only examples.

- Appointment booking – can patients book double appointments?
- Flu vaccination (you should be aware of this between eg October – December)
- Chaperone policy – you can obtain a chaperone by phoning xxxx. Please remember to record in the consultation if a chaperone has been offered and declined/accepted
- Visits - where are visits normally recorded? Who is normally responsible for allocating visits (admin staff, doctor on call or discussed at coffee)? What is the normal cut off time for visits (when they become responsibility of the on call doctors)?
- On call arrangements – Is the day divided up into sections for on call? Where can this rota be found? What is the responsibility of the on call doctor?
- Reporting of adverse or significant events
- Admin – eg preferred Read Codes, internal messaging

- Handover – State what you expect from the locum in terms of handover. Eg In general we would expect the medical record to allow continuity between different members of the team, however we would request you to please inform the doctor on call in person of any issues you have dealt with relating to terminal care, risk of suicide or child protection.

### Prescribing and repeat prescribing protocols

Outline your prescribing practice and repeat prescription policy to show that robust checks and balances exist in the system. Providing this will make it more likely – though not certain – that locums will be willing to sign repeat prescriptions. This information will probably cover the following:

- how are acute/ non repeat requests are dealt with
- how much notice do patients need to give for prescription requests
- are there any non-medical prescribers
- what are the processes for monitoring disease-modifying antirheumatic drugs
- does the practice do its own warfarin monitoring
- are drug allergies coded
- do all repeat medications have review dates, What is the practice procedure for ensuring patients are recalled for a medication review when this it due
- are medications 'linked' to clinical problems
- are there systems for alerting you to stop repeats which are only required for defined periods eg Warfarin
- is there an audit trail for non-repeat script issues and who has authorised them, or when they were last refused
- is there a pharmacist or pharmacy advisor working with the practice
- how are hospital discharge medications added to the record? By a doctor, pharmacist, receptionist
- what are the processes for monitoring DMARDS (not on repeats) – are these medications placed on repeat or are they left as acute and issued only as and when blood results are checked. Are bloods checked by the hospital as well as by the practice?

### Referrals

Please note that this practice has clinicians with special interests in <insert areas as relevant and names of clinicians>.

Please make yourself familiar with the list of services carried out by the practice.

How are referrals handled and prioritised?

How do the doctors liaise with the secretary for referrals eg by electronic message, electronic form on the patient record, dictation into tape (who to give this to, how dealt with, with/without referral log,) dictation into audio files (include login details if needed)?

Use of choose and book. Is it the doctor or secretary/receptionist that uses the choose and book system? Who can help with choose and book if the locum is not trained to use it?

### Local protocols

Protocol topic	Link, website address or where copies can be found in the practice

### Enhanced services carried out within the practice

This practice delivers the following enhanced services:

Service	Notes Name of clinician and times of any special clinics, other information about the service eg approximate number of patients on methadone if substance misuse LES

### Ordering investigations, making referrals and arranging treatment

[The following provides a helpful framework for informing locums how to arrange a wide variety of referrals and treatments. If the practice chooses not to complete the full tables, it should, as a minimum, state which referrals require a form to be filled in and how to organise the most common investigations eg x-ray, bloods and ECGs.]

#### Ordering investigations

The following investigations can be carried out at the practice: <insert list>

Ask the patient to book for these at reception.

Local hospital laboratory collection information:

	Procedure for each test eg fill in form and give form to patient/ give form to reception staff/ ask patient to book in with nurse/ take form directly to local XR department/ test not available directly ...etc (Insert where possible the file path for each referral form or standard letter If forms are set up to self complete from the patients' records, add keystroke instructions on how to open them)
ECG	
X-ray	
Blood tests	
MRI scans eg for prolapsed discs	
Spirometry	
USS abdomen	
USS carotid	
Cardiac Echo	
Open access Endoscopy	
Exercise ECG testing	
On site pregnancy testing eg for ectopics	
Paediatric urine specimens systems	
Faecal Occult blood tests	
Adult MSU	

### Non-urgent referrals

	Referral form or dictated letter? If forms are set up to self complete from the patients' records, add keystroke instructions on how to open them. Note if any type of referral needs to be agreed with a second doctor before being made
Medicine	
Geriatrics	
Psychiatric	
Drug and alcohol	
Paediatrics	
General Surgery	
Vascular	
Orthopaedics	
Urology	
Gynaecology	
Family planning Clinic	
GUM	
Termination of pregnancy	
Antenatal care eg arranging first trimester scan, templates, details of the antenatal clinic	
ENT	
Eyes	
Neurological	
Dermatology	
Rheumatology	
Hospice	
Pain Clinic	

### How to arrange other treatments

Specific form? Dictated letter? Available in practice? Insert where possible the file path for each referral form or standard letter. If forms are set up to self complete from the patients' records, add keystroke instructions on how to open them

Minor operations

IUD fitting: routine and emergency

Depo contraception injection

Dietician
Physiotherapy
Chiropodist
Booking with Midwife for antenatal care
Diabetic clinic
Wart clinic
Counselling
Smoking cessation counselling

If you are still unsure of the appropriate referral route for your patient you can ring <xxxx> or /and send a practice note to <xxxx> to ensure appropriate action is taken. Please do not rely on verbal messages. We will endeavour to provide prompt advice but where this is not possible please leave us written instructions of the service you need your patient to access and we will ensure this is actioned or passed on to another clinician for action if we have been unable to assist you in completing this yourself during your time with us.

### **Results**

Which results are sent via the computer system and how this happens?

How are results auctioned or labelled for action?

How other results reach clinicians?

When can patients phone for results?

### **Index**

Insert an index if the document is not available electronically

## Appendix 3 – Legal structures

This Appendix contains detailed information on the different business structures through which locums might choose to work. For the majority of locum GPs, who typically work as sole traders or for agencies, this section will not be relevant. Those locums forming a partnership or thinking of setting up chambers as a separate legal entity should read this section carefully. This Appendix does not cover public limited companies or companies limited by guarantee as they are unlikely to be used to organise locum work.

The BMA does not recommend one type of business structure over another. Suitability will depend on the individual aims and needs of the organisation. You are advised to read this explanatory guidance and, where relevant, discuss the various options with potential business partners before seeking more detailed professional advice. Independent lawyers and accountants are best placed to judge whether a particular arrangement is appropriate to your individual or organisation's needs.

For help finding an accountant see [Finding an accountant](#).

It is critical to seek good legal advice from the outset to avoid serious legal problems. The Law Society ([www.lawsociety.org.uk](http://www.lawsociety.org.uk)) can put businesses in touch with local solicitors or with a solicitor with experience in the relevant area. Alternatively, good solicitors can sometimes be found through personal recommendation.

BMA Law offers legal services to members at discounted rates. For more information see <https://www.bma.org.uk/advice/work-life-support/your-finances-and-protection/legal-advice-and-services>

The advice of a solicitor and an accountant will be vital for new businesses. In addition businesses may wish to engage the help of other professionals such as IT specialists, marketing agents and business consultants or advisers.

### Partnerships

#### What are partnerships?

Under the Partnership Act 1890, a partnership is defined as 'the relationship which subsists between persons carrying on a business in common with a view of profit'.

In England, Wales and Northern Ireland a partnership is not an entity distinct from its individual partners. The partnership itself cannot acquire rights, incur obligations or hold property. The rights and liabilities of a partnership are the collection of the individual rights and liabilities of each of the partners. Partnerships are, therefore, used to share the risks, costs and responsibilities of being in a business. Each partner is self-employed and takes a share of the profits. Usually each partner shares in the decision making.

In Scotland a partnership does have a corporate existence and the restrictions on partnerships described above for the other parts of the UK do not apply.

Partnerships are formed where a group of self-employed individuals wish to come together to do business with a view to profit while sharing liability.

#### The legal basis

The Partnership Act 1890 sets out the interests and duties of partners. A written partnership agreement may legitimately vary the rights and obligations of partners as implied by the Partnership Act 1890 (or by the general law), but the rights and obligations of the Partnership Act 1890 will apply in the absence of any contrary provision.



### Advantages of partnerships

- subject to low regulation – it is not necessary to file an annual report
- flexibility – partnerships have a more flexible internal structure than limited companies
- they are governed by agreement rather than by a memorandum or articles of association.

### Disadvantages of partnerships

- partnerships require the highest degree of trust because partners are jointly and severally liable for their own and each other's actions, for example, if one partner commits the partnership to incur a debt of £10,000, the partners may be sued jointly for the recovery of that debt, or any one partner may be sued individually for the whole debt (even though he or she was not the partner who entered into the contract).
- a stable partnership is reliant on a good written agreement – the agreement will govern the business relationship between partners. Partnerships with inadequate or out-of-date agreements and partnerships at will (those without a written agreement) are a very unstable basis for a business relationship.
- partnerships have no access to capital markets through selling shares – partners typically raise money for the business out of their own assets and/or with loans.

### Membership

An incoming partner should expect to contribute to the partnership a share of the capital. It is possible to have 'sleeping' partners who contribute money to the business but are not involved in running it. The partnership agreement should deal with how any departing partner's share will be realised and valued.

The partnership as a whole should normally pay for any practice staff employed, accountancy, stationery, bank charges, telephones etc, and such expenses should be paid or allowed for before profits are distributed.

The partnership agreement needs amending every time there are changes in the partnership. Failure to do this is often the main reason for the agreement becoming ineffective.

### How to form a partnership

On formation, each member of the partnership needs to register as self-employed. All the arrangements and undertakings between partners or prospective partners should be on a strict business footing. Verbal assurances offer no security and should be avoided. It is best that a partnership is conducted under a written agreement governing the business relationship between the partners. The agreement defines the rights, liabilities and responsibilities of the partners in the business.

Every partnership agreement should be the result of detailed consideration by all the partners and intended partners. A clear statement of the terms to be included should be referred to the partnership's legal advisers so that an agreement can be prepared. Individual partners may also want to take their own, independent legal advice. It is essential that the partnership agreement is kept up to date, particularly when there are changes to the membership of the partnership. Any change in the constitution of a partnership should be dealt with under the terms of a partnership agreement. Otherwise, a partnership at will could arise, with all its disadvantages.

To regulate medical partnerships properly, and to avoid dispute, partnerships should have a signed, up-to-date, regularly-reviewed, written partnership agreement (which may, depending on the specific terms, be in the form of a deed) where all applicable terms are accurate and precisely defined.

It is important that partnership agreements are drawn up in accordance with the wishes of the partners. Nevertheless, partnership agreements do tend to follow a prescribed pattern and include a number of clauses which are common to all. Strictly speaking, many of these 'standard' clauses are not necessary either because the rights or obligations they assign are prescribed by the Partnership Act 1890 or, in the case of others such as an obligation to

be just and faithful in all dealings with one's partners, they are always implied. Partnership agreements are not intended to define all the rights and obligations of the partners but should govern the most important elements.

Certain items should be included in every partnership agreement. These are as follows:

- date of the document
- name and title of partnership
- partnership's address
- definitions
- the nature of the business
- date of commencement and the duration
- the capital
- premises
- expenses and their allocation
- income
- division of profits
- attention to the affairs of the partnership
- tax liability
- engaging and dismissing staff
- power to make decisions
- holidays, sabbatical leave, study leave, adoptive leave
- leaving the partnership, voluntarily or involuntarily
- lengthy incapacity
- retirement and death
- defence society
- arbitration
- banking
- accounts
- pensions
- suspension
- termination of the partnership.

This list is not exhaustive but includes those items which relate particularly to medical partnerships.

### Records and accounts

Partnerships are responsible for maintaining proper books and there will be a requirement for all the partners to sign the annual accounts once approved. The partnership and each individual partner must make annual self-assessment returns to HMRC (HM Revenue & Customs). One partner should be nominated to file a Partnership Tax Return with HMRC and his/her responsibilities should be clearly defined in the partnership agreement. The partnership must also keep records showing income and expenses. As a matter of good practice, prospective partners should be given reasonable access to the books and accounts of the practice, including provision for them to make the accounts available in confidence to their own accountants for the purposes of taking advice.

### Tax and national insurance

Partners are self-employed and taxed on their share of the partnership's profits. Partners need to pay fixed-rate Class 2 national insurance contributions and Class 4 national insurance contributions, although they may seek deferment of one or more of these if they have other employment, and may be exempt if they are over retirement age. With the present arrangements for HMRC tax assessment it is particularly important that partners decide how personal expenses are to be dealt with, ie claimed through the partnership accounts or on a personal expenses claim by individual partners. Specialist advice should be sought from an accountant, preferable one with expertise in advising medical partnerships. Members of partnerships are individually liable for personal taxation.

BMA Law offers a partnership drafting and checking service .

<http://www.bmalaw.co.uk/service/partnerships/>

## Limited liability partnerships (LLPs)

### What are LLPs?

An LLP is a body corporate – a separate legal entity distinct from its members. This means that locums working in an LLP could have a set rate for their work. An LLP can form a legal relationship in its own right and will continue in existence despite any change in membership.

LLPs can hold property, employ people, enter into contracts, sue or be sued and are the subject of their own debts and liabilities. LLPs are liable for the debts they incur up to the full extent of their assets but members otherwise have limited personal liability. LLPs do not have directors or shareholders, though in many cases there are designated 'precedent partners' who undertake the same sort of work that a company secretary would do eg filing accounts, administration and general day to day management. Precedent partners have additional responsibilities and should be declared on the form which is submitted to Companies House. LLPs must use the suffix 'LLP' after their company name.

LLPs are not partnerships in the true sense and are quite close in concept to limited liability companies in so far as liability incurred by one partner does not inevitably bind another partner.

### The legal basis

LLPs were introduced by the Limited Liability Partnerships Act 2000 and are governed by the LLP Regulations 2001 along with the Companies Act 2006 and the Financial Services and Markets Act 2000 (provisions on insolvency).

There is no legal obligation for LLPs to have an agreement and agreements for LLPs are not filed at Companies House. It is however very wise to have one in place. In the absence of a written agreement, default provisions will apply.

### Membership

Any legal 'person' can be a partner in an LLP, including companies registered under the Companies Act 2006, unless disqualified.

An LLP must have at least two members and two or more members of the LLP must be identified as 'designated members'. Designated members have a statutory duty to undertake certain tasks on behalf of the other partners. They are subject to penalties for failure to comply with their statutory tasks which include:

- signing accounts
- sending accounts to the registrar
- appointing and removing auditors
- notifying the registrar of membership changes
- conduct of the annual return
- removing the LLP from the register (where appropriate).

If the LLP does not specify any designated members when it registers, then all its members will be treated as such.

Members normally share both the responsibilities of running the business and the profits that it makes. LLP members usually raise money out of their own assets and/or loans and all members have certain duties to the LLP, including the duty to act in the interests of the entity. Members must avoid conflicts of interest and are prohibited from making secret profits. Exactly how additional rights and responsibilities are defined and divided depends on the LLP's partnership agreement, which also regulates the relationship between members. Although members of LLPs enjoy limited liability, they are still liable for wrongful, fraudulent or negligent trading.

### Advantages of LLPs

- Ability to set rates for locums involved.
- Limited liability – the main advantage of an LLP over a traditional partnership is that members' liability is limited to the amount of money they have invested in the business and to any personal guarantees they have given.
- Flexibility – LLPs have a flexible internal structure in the same way that partnerships do, as opposed to the more rigid structure of a limited company. They are governed by agreement rather than by a memo or articles of association.

### Disadvantages of LLPs

- LLPs are more complicated and costly to set up and run than ordinary partnerships – they have to meet many of the same requirements as limited companies.
- Reporting requirements including annual returns – operating under an LLP brings a number of extra running costs. As with a company, financial information about the business has to be made publicly available. LLPs are required to maintain proper accounting records and prepare and deliver audited annual accounts to Companies House. An annual return must also be made giving key details of the LLP and its members.
- LLPs need to be governed by an agreement – members of LLPs should draw up a formal agreement setting out the relationship between partners and detailing all the usual areas covered by partnership agreements such as capital, division of profits and decision making. Although there are some default provisions in cases where there is no formal written agreement, LLPs do not have straightforward default options such as those set out in the Companies Act tables.
- Legal uncertainty – LLPs are governed by a developing area of law and many issues remain legally untested.
- If limited companies come together to form an LLP there may be tax complications by virtue of their association – if treated as associated, the corporation tax allowance may be divided between the companies involved in the LLP.
- NHS Pension Scheme – the NHS pension scheme extends only to doctors and staff employed by or providing services to an 'NHS Pension Scheme Employing Authority'. If you work through an LLP you are unlikely to be eligible for the NHS pension scheme.

### Taxation and national insurance

Members are taxed on their share of profits and pay tax and national insurance contributions according to their business structure (an individual will pay national insurance contributions and income tax, a limited company member will pay corporation tax). Specialist advice must be sought, especially where limited companies wish to join LLPs.

### When are LLPs a good option?

Although there are relatively few LLPs in England (compared to, say, limited companies), LLPs often appeal to professionals because they combine limited liability with a partnership ethos. Large firms of solicitors or accountants who have offices spread over several countries often operate under LLPs so that liability incurred by a partner in one country does not inevitably bind others.

An LLP is an unlikely choice for a traditional GP partnership which, by virtue of its size and the nature of its business transactions, is generally well served by the traditional partnership model. However it may be more appealing to groups of locums as it allows a single rate to be set for work without falling foul of competition law.

### Private companies limited by shares

#### What are private companies limited by shares?

Private companies limited by shares are the most common vehicle for company formation. Private companies limited by shares must include the suffix 'Limited' or 'Ltd' as part of their company name. Any profit made by a company limited by shares is divided according to the shareholding. Shareholders may be individuals, other companies or, in Scotland only, partnerships.

The fundamental attribute of incorporation is the creation of a corporate personality – the ‘company’ – which is distinct from the legal personality of its members and can create its own legal relationships with third parties. This means that private companies limited by shares can own property, employ staff and enter into contractual relationships. It also means companies limited by shares can set fees for locum work without falling foul of competition law.

Finance typically comes from shareholders, borrowing and retained profits. The liability of members is limited to their share capital or amounts unpaid on shares and members are not by virtue of their membership in a company personally bound by the legal relationships of the company as they would be in a partnership. Members, who will often also be directors, may be subjected to unlimited liability if they act fraudulently, negligently, beyond the scope of the company’s power, or if they continue to trade when it is obvious to them that the company is insolvent.

Private companies limited by shares are formed when a group of private individuals wish to form a business, with a view to profit, using their own contributions as capital while protecting their personal wealth. In the case of locum GPs, providers could contract with the company for locum services as they would with an agency.

### The legal basis

Private companies limited by shares are governed by the Companies Act 2006.

Advantages of private companies limited by shares:

- would allow a group of locums to work with set rates
- limited liability – members’ personal wealth is protected
- private companies are flexible – they are subject to less exacting regulation than public companies
- easy to set up
- possibility of sole directorship – it is possible for private companies limited by shares to operate with only one director.

Disadvantages of private companies limited by shares:

- must be floated by members’ own capital (or their debt) – the law assumes that the working capital of private companies limited by shares will be contributed by its members to some extent
- requirements to share information – company directors have a personal responsibility for making information about the capital structure, management and activities of their companies available both to the members of the company and to the general public
- accounts and other statutory details must be filed annually.

### Tax and national insurance

Private companies limited by shares pay corporation tax and must make an annual return to HMRC. Company directors are treated as employees of the company and must pay Class 1 national insurance contributions as well as income tax on their salaries. This means that if operating through a company limited by shares, a locum would lose his or her self-employed status.





**British Medical Association**

BMA House, Tavistock Square, London WC1H 9JP

[bma.org.uk](http://bma.org.uk)

© British Medical Association, 2021

BMA 20210256