

Aims of the handbook

Welcome to the BMA's *GP locum handbook*. This has been produced by the BMA as one of the many benefits available to BMA members. We hope both locum GPs and those that engage locum GPs will find this resource helpful.

This handbook is written 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.

Locum GPs

This handbook provides advice on starting out as a locum, setting up your business and establishing a contract for services with a provider. It discusses different types of locum work and contains information for locums on professional considerations such as appraisal and networking. It also explains the representation of locum GPs nationally and locally.

This handbook cannot replace the expert, confidential and individually tailored advice on contractual and financial issues that locum GPs can obtain from the BMA and from their own accountants.

GP providers

This *GP locum handbook* is a valuable tool for GP providers as well as for locums. It provides advice on recruiting locums, outlines your responsibilities and includes tips for good locum induction and advice on how to support your locum to ensure they integrate into the clinical team and provide the best possible care.

GP providers can obtain individually tailored, confidential, advice as a benefit of BMA membership.

For ease of reference, the handbook is divided into chapters primarily intended for locums or those intending to work as locums and chapters intended primarily for providers. Each part contains some information which may be relevant to both.

Where appropriate the text refers to specific chapters elsewhere in the handbook. The chapters on the contract for services and termination of the contract are equally relevant to locums and providers. The chapter on the induction drill, while aimed primarily at providers, is highly relevant to locums too.

To contact the BMA, please email support@bma.org.uk or telephone 0300 123 123 3.

Terminology

This handbook uses the term 'locum' to refer to GPs who temporarily take the place of another GP. These doctors also sometimes describe themselves as "freelance" or "portfolio" GPs reflecting the fact that they are commonly self employed sole traders and have several professional roles in addition to their clinical role. Locum GPs are one type of sessional GP, a term which also includes employed GPs such as salaried GPs and GP retainers. Sessional GP replaces the term 'non-principal', which was used under the old GMS contract to refer to GPs who are not partners. The BMA's own subcommittee responsible for locum and salaried GP issues is known as the sessional GPs subcommittee.

Locum GP: A GP who temporarily takes the place of another GP.

Freelance/Portfolio GP: A self-employed GP, who may have a number of different roles.

Sessional GP: A term used to describe all salaried and locum/freelance/portfolio GPs.

'GP providers' are those who hold a contract with a local health organisation (a Primary Care Trust, Local Health Board etc) to provide primary care services of one sort or another. The contract held could be one of a number of different types including General Medical Services (GMS), Personal Medical Services (PMS)/Section 17C or Alternative Provider Medical Services (APMS). These providers may from time to time engage locum GPs to help deliver primary care services under their contract. Primary Care Organisations (PCOs) or other commissioners may also occasionally engage locums directly, eg to provide GP triage in A&E departments or when temporarily assuming responsibility for the running of a practice in an emergency.

* Freelance GPs and locum GPs are not synonymous. Locums are not always self-employed as the term freelance suggests. Locum GPs may in fact hold fixed term contracts of employment or be employed by an agency.

Feedback

This handbook will be updated over time. Any suggestions on how to improve the handbook or the services provided for locum GP members should be emailed to sessionalgps.gpc@bma.org.uk We welcome your comments.

To help us help you, please remember to keep your **BMA membership and contact details up to date.**

This handbook was correct at the time of going to print. For the most up-to-date version you are advised to consult www.bma.org.uk

'Consider a name badge so patients and staff know who you are and do not just refer to you as "The Locum".'

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. Self-employed locums 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 as sole traders, as part of formal partnerships or other group arrangements (sometimes referred to as 'chambers') or can join locum agencies. Locum GPs are usually self-employed and paid fees for their work. Being self-employed they would not expect to receive any holiday pay, sick pay or maternity pay as an employee would. Some locums choose to take out income protection to cover the income lost during sickness absence. The way that locum GPs undertake their work varies widely: some provide cover for a specified period (eg to cover for maternity leave) while others work in a more ad hoc way, perhaps for different practices on a daily basis. Locum work is sometimes found close to home but can involve long commutes or overnight accommodation. Like other GPs, locums can be found in hugely varied environments including prisons, cruise ships, out-of-hours and immediate care settings.

'I became well known in the area as a locum and so was often contacted to do other things. Over time I found myself working for the police, prison service, local RAF base and private occupational health services to name a few.'

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 provide regular 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.

Locum work allows GPs to keep their hand in when they are between more permanent posts, when new to an area, after qualifying or post-retirement. For others becoming a locum is a decision made to support a portfolio career or to help balance work with family responsibilities.

‘During my time working as a partner I became involved in the Local Medical Committee and soon became Vice Chair and then Secretary. I found that more and more of my time was taken up with political work as I came to be on more and more committees including Scottish GPC. I decided to give up the partnership and go back to locuming as the flexibility of this work allowed me to attend more meetings and do the committee work I wanted to. It has also enabled me to undertake teaching at a local medical school.’

Who engages locums?

Locum agreements can be made between locum GPs and a variety of different parties. From 1 April 2004, locums have been able to work within UK general practice in the following areas: self-employed general medical services (GMS) practice, personal medical services (PMS)/section 17c practice, private/non-NHS practice, PCO-employed practice, out-of-hours providers and alternative primary medical services (APMS).

Determining your employment status

Employed and self-employed GPs are normally quite distinct, work under clearly different contractual arrangements and have different responsibilities and rights vis à vis their employers or contracting providers. The distinction between locum GPs and salaried GPs can however become blurred when a locum is in a practice on a long-term basis or when a locum works through an agency.

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). By itself, the length of a particular engagement does not determine employment status. HMRC advises that what the parties call their relationship, or what they consider it to be, is not conclusive. It is the reality of the relationship that matters. In order to determine the nature of a contract, it is necessary to apply common law principles.

For a general guide as to whether your work is likely to be regarded as employment or self-employment, see the HMRC’s guidance www.hmrc.gov.uk/employment-status/index.htm and Employment Status Indicator www.hmrc.gov.uk/calcs/esi.htm

The difference between being defined as a self-employed locum or defined as a salaried employee has wide-ranging implications financially (taxation, national

insurance and pensions), contractually and legally. In the case of employees, the practice would be expected to pay employer's pension and national insurance contributions and be responsible for remitting the employee's income tax payments to HMRC under PAYE. Employees would also have their salary, leave entitlement, sickness procedures etc detailed in their contract.

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 on a self-employed locum part-time basis while in the same month undertaking ad hoc work organised through an agency on an employed basis.

'If you have never used a particular computer system before, consider going in the day before you start and asking someone to give you a crash course. Also make sure you have your own password so that your consultations cannot be mixed up with anyone else's.'

For locums and those intending to become locums

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) 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 environment 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 present both advantages and disadvantages, some of which will be mitigated if the locum post becomes a long-term position and more akin to a salaried position.

Advantages of locum work	Disadvantages of locum work
<ul style="list-style-type: none"> • a potentially high degree of autonomy over working hours and place of work • a chance to work in a variety of different environments • work can be taken on around other professional or family commitments • you can choose to take breaks from working, for example to travel or pursue other projects • working commitments are more rigidly defined and do not involve the managerial concerns that partners have • locuming is one way to make your name known locally and may put you in a stronger position when more permanent posts become available • by negotiating pay, dealing with invoicing and sorting out taxes, locums learn small business skills useful in running a practice or working in commissioning 	<ul style="list-style-type: none"> • locums can become or feel isolated from other doctors (see 'Avoiding professional isolation'), a particular problem when things go wrong • locum GPs are sometimes excluded from formal and informal information cascades and local networking • CPD and appraisal opportunities need special consideration in locum work (see 'Professional considerations for locums') • it can be harder to keep up to date with certain aspects of practice, eg chronic disease management, baby clinics, updating computer skills • you need to adjust to different work places quickly, not all of which will necessarily provide good inductions

Advantages of locum work	Disadvantages of locum work
<ul style="list-style-type: none"> • you will not need to negotiate with colleagues if you do want time off at busy periods such as Christmas • you may find that it is easier to move to another area to work and live than it would be as a partner 	<ul style="list-style-type: none"> • you may have to work with a lot of different computer systems • locuming can carry potential risks owing to poor induction, not being familiar with the patients, fewer chances for handover and case discussion (see 'Reducing the risks of locum work') • you will miss out on patient continuity in short-term jobs • locums must normally organise their own invoicing, accounts and pensions, unless working for an agency or employing an accountant to do this for them • uncertainty of income – if opportunities are in short supply locally you may face periods without work or long journeys to jobs • locuming can involve working at antisocial times such as bank holidays, Christmas etc when locum work is more readily available • no employee benefits eg sickness, maternity, study or annual leave, unless working for an agency.

'I very much enjoyed being a partner, but being a freelance locum suited me better once my children were at school. I could fit all my work in, in school hours. I was even able to be around for my children when they were at home studying for A levels and did surgeries when they were doing the exams.'

'Not everyone would enjoy working in a different practice every day or half day but I enjoy the variety and also the flexibility. I can choose when and where to work and learned very quickly what to do when I first go to a new practice to enable me to fit in with the working of the practice. I don't have to be involved in all the hassles of running a business: staff problems, partners' squabbles, complaints, missed targets etc. I can see patients and practise as a GP but leave the work at the door when I go home.'

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 of a PCO in the country in which he or she wishes to work.

The European Working Time Directive Regulations do not apply to locum GPs working on a self-employed basis.

GMC GP Register

Check that you are included on the GMC's GP Register by contacting the GMC directly (telephone: 0161 923 6602) or visiting 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 once revalidation is introduced (see Revalidation).

PCO Performers List

Locum GPs must apply to be on a PCO's Performers List. It is recommended that you apply to the PCO in the area where you will be (or are likely to be) doing most of your work. To work in England, Wales and Northern Ireland you can only be on one PCO's Performers List at a time, unless you also wish to work in one of the other three

countries in which case you will need to be on a List there too. In Scotland, GPs are required to be on the Performers List of each Health Board in whose area they wish to work (although following requests from the Scottish GPC, the Scottish Government Health Directorate is currently reviewing this).

If you are moving areas, you can **apply** to be on a new List while still remaining on your current List until inclusion in the new List – but note the point above about only being included on one List at a time in England, Wales and Northern Ireland.

You are encouraged to apply to the PCO 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 an enhanced Criminal Records Bureau (CRB) check or equivalent (except that in Scotland the need for this is not obligatory). If you have previously had such a check, then the PCO should be willing to accept this. However, it is still best to check with the PCO.

To join a Performers List in order to become a locum GP, an application must be made in writing to the PCO (PCOs have their own application forms) including the following:

- full name; sex; date of birth; private address and telephone number
- a declaration that you are a fully registered medical practitioner
- a declaration that you are accredited as a GP, including the date of inclusion
- medical qualifications; professional registration number; date of first registration; where they were obtained (with evidence)
- professional experience separated into experience in general practice, hospital appointments and 'other'. This must include full supporting particulars including chronological details of professional experience (including the starting and finishing dates of each appointment together with an explanation of any gaps between appointments), and an explanation of why you were dismissed from any post
- names and addresses of two clinical references relating to two recent posts, which lasted at least three months without a significant break. Where it is not possible to provide this, you should give a full explanation to the PCO with the names and addresses of alternative referees
- whether you are a contractor (eg hold a contract to provide services with a PCO)
- whether you are an armed forces GP
- whether you have any outstanding application, including a deferred application, to be included in a Performers List or other list (including to a body corporate) and, if so, particulars of that application

- details of any List or equivalent list (including any application in relation to a body corporate) from which you have been removed or contingently removed, or to which you have been refused admission or in which you have been conditionally included, with an explanation as to why
- information about criminal convictions; current or pending criminal investigations
- details of past adverse findings, or current investigations, by regulatory, NHS bodies, employers or partnerships
- consent to a request being made by the PCO to any current or former employer, licensing, regulatory or other body in the United Kingdom or elsewhere, for information relating to a current investigation, or an investigation where the outcome was adverse, to you or a body corporate
- if the PCO finds that the information, references or documentation supplied are not sufficient for it to decide upon the application, such further information, references or documentation as may reasonably be required in order to make a decision
- details of similar information relating to involvement with a body corporate.

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.

Once you are on a Performers List, you are required to:

- work in that area on at least one occasion during a 12-month period (see below)
- undertake an annual NHS appraisal
- inform the PCO of any change of contact address
- inform the PCO 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 by the PCO
- supply an enhanced CRB certificate or equivalent in relation to themselves if the PCO requests this 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 hours

It is a requirement of remaining on a Performers List that a GP must undertake some NHS GP work in the PCO's area during a 12-month period. Some PCOs are interpreting this to mean that a GP must undertake a minimum of one session or one hour (or more) per week. This is a very wide interpretation of the Performers List Regulations, and is not one that is shared by the BMA. Instead, our interpretation is that provided the GP undertakes some work, say one hour per annum, then they should not be removed from the List.

If a PCO suggests 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.

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 requirements for work in that PCT area.

Locuming after the Vocational Training Scheme (VTS)

For many newly qualified GPs, locum work will be the first job taken after qualifying. Locuming after the VTS can provide a good opportunity to experience myriad types of practice. A locum can get experience working in different areas; in inner cities and affluent suburbia, in remote postings, in large corporate practices or in 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 VTS, you are advised to prepare early (see 'Getting started as a locum'). 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. You should be able to apply for

inclusion on a Performers List before you have your Certificate of Completion of Training (CCT) and forward it on to the PCO when you receive it. Networking during training, for example by attending local meetings, can 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.

'Instead of desperately applying for partnerships like everyone else in my trainee year I was unsure whether a partnership in general practice was for me and so made the choice to try locuming first, which at that time was seen as pretty unusual amongst my peers. I sent letters to practices in the area before I finished at my training practice and started getting the work booked in. I finished in my training practice at lunchtime on a Tuesday and started my first locum at 2pm that day in a practice in a village down the road.'

Returning to general practice

Performers List inclusion

Technically if a GP does not work in a PCO area for 12 months, the PCO can remove that GP from its Performers List and should write to the GP to inform them of the removal. Therefore GPs who have been removed will need to re-apply to join a Performers List. Career breaks due to maternity leave should be disregarded by the PCO. (See Performers List requirements: minimum hours for more detail.)

Refresher training

Following guidance agreed between deaneries, a large number of PCOs require GPs who have not been working in general practice for two years or more to undertake a form of refresher training. You can find the Committee of General Practice Education Directors (COGPED) position paper on GP induction, refresher and returner schemes on their website.

The BMA was previously concerned that some PCOs had a blanket policy requiring all GPs who had been out of practice for this period of time to undergo this training.

While we appreciate that there is a need to ensure that returning doctors' skills are up to date, it is unreasonable to presume that every GP who has been out of NHS practice for a certain amount of time will be unable to practice competently.

The BMA has been in discussions with PCOs and deaneries about these concerns, including the level of local funding available to assist returning doctors. For example, discussions are currently under way at deanery level on the method of assessing the need for retraining and the content for a nationally agreed scheme. Nevertheless, at present, the level of support available from PCOs and deaneries, particularly the financial support, continues to differ throughout the UK.

In light of the current situation we advise returning GPs to consider pursuing the following points. This will though depend upon the GP's individual circumstances and the level of support available:

- (a) At the earliest possible date (and ideally well before the intended date of return), you should advise the PCO of your wish to return to NHS general practice, and set out when you last worked and also what you have done to maintain your skills while out of practice.
- (b) The deanery may be able to advise you on how best to approach the collection and formulation of evidence for full inclusion on the Performers List.
- (c) If a PCO is unwilling to include you fully on its Performers List, you should ask the PCO to explain the reasons for this. If the PCO has genuine reasons for considering that refresher training is required, the PCO should be able to give you a 'conditional inclusion' on its List allowing work to be undertaken in a supervised setting. The BMA suggests that you seek a written agreement from the PCO as to when the conditional inclusion will be reviewed, with a view to your name being fully included on the Performers List. For example, requesting a review in three months, on the understanding that this could be shorter depending on hours of work, your previous experience and length of the career break.
- (d) If the PCO gives conditional inclusion, you should find a practice or out-of-hours organisation that is willing to provide you with a supervised setting. It is important to ensure that this is a suitable placement that will meet your needs, and so you may wish to take further advice on this from their deanery and PCO.
- (e) You should discuss with your deanery the possibility of any funding, training and/or careers support that they can offer.

Given the requirements for refresher training, you should think carefully before choosing to take an extended period of time off work. If you are considering an extended career break, seek advice in advance on the impact it will have on your future work.

'Ask for feedback. After your job finishes, think about what went well, what didn't, how the situation could be improved and most importantly whether you want to work there again!'

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

<p>Decide in which area(s) you want to work.</p> <p>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.</p>
<p>Consider how you want your career to develop and what you want to gain from your locuming positions so you can plan accordingly.</p> <p>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.</p>
<p>Ensure you are on the PCO's Performers List and locum list.</p> <p>All practicing GPs must be on a Performers 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. Doctors can only be included on one Performers list in each country. (See 'Requirements for working as a locum GP'.)</p>
<p>Make contact and develop a good relationship with the PCO. Ensure you find out how to access the appraisal system and appraisal policy. Use the PCO intranet if this is an option.</p> <p>Prepare a business card, your standard terms of engagement, a CV and possibly a website.</p>
<p>Ensure you hold full MDO indemnity cover and that you keep your indemnity provider informed of any changes to your work, sessions worked per week and the sort of work you do, eg family planning work. Check your provider's 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 are not working.</p>
<p>Network locally (see 'Avoiding professional isolation and building networks').</p>

Maintain a single folder with all your necessary documents:

- CV
- letter confirming entry on a Performers List
- indemnity insurance
- Postgraduate Medical Education Training Board (PMETB)
- references and letters of competence
- Hep B status.

Keep electronic copies of all of these documents to email if needed. Failure to do this quickly can mean losing out on work.

Before accepting work and preferably before applying, 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 surgery length and visiting rate? Is the practice over multiple sites?

Ensure jobs come with clear terms of contract 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 fine to use email to do this.

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

'Always leave the room tidy.'

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. Be clear about when you intend to take leave as practices are unlikely to book you again if you cancel locum work.

Join your local sessional GP group (see 'Local sessional GP groups'). These provide general support to locum GPs and sometimes also hold vacancy information.

Keep a list of all the practices in the area. Consider making contact with practice managers in the locality by email or telephone and try to build links with practices in which you would particularly like to work. Contact local GPs too as, particularly in small practices, decisions about locums may be taken without the involvement of a practice manager.

Single-handed and small practices usually have more opportunities for short-term locum work.

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, for example in A&E or prisons.

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

'Introduce yourself to nurses and other doctors if you see any.'

Setting up and running your business

Ways of working as a locum

There are different ways of setting yourself up for work as a locum. You can choose to operate as a sole trader or as part of a 'chambers' or you can join an agency. 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. The majority of locums (90% according to a 2010 BMA survey) contract directly with providers for work. Very few operate as part of a chambers organisation.

Sometimes GPs take on fixed term salaried contracts but continue to describe themselves as locum GPs. This sort of arrangement is not dealt with in detail by this book. Those working with salaried contracts should consult the BMA's *Salaried GPs' handbook* for further guidance.

www.bma.org.uk/employmentandcontracts/employmentcontracts/sessional_gps/salariedgpbook.jsp

Working as a sole trader

This is the most common approach to locum work. The intention of a sole trader would be 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 (see 'Determining your employment status').

Establishing a partnership

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. Partnerships are discussed in detail at 'Appendix 4 – Legal structures'.

Working for a locum agency

Some GPs find locum work through agencies, though this is nowhere near as common as it is 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 will probably 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 in theory you work for the agency and not for the NHS.

Joining 'chambers'

Joining other locum GPs to form a 'chambers' is an alternative way of organising locum work. Forming chambers allows locums to share administrative costs, perhaps by jointly employing full-time management staff. This is a way of working long used by barristers. Work could be found for members in much the same way that an agency would place a locum, giving practices the option of reaching several locums with a single call. Being part of a locum group through membership of chambers can also help avoid professional isolation and provide peer support and group education for continuing professional development (CPD). This may be increasingly appealing in the current climate of revalidation and appraisal. In some cases, the chambers arrangement may include administrative support in collecting evidence for appraisal, eg multisource feedback, audits etc.

Chambers can operate in a wide variety of ways and does not imply any particular legal structure. At its most basic, forming a group like this would mean retaining independent contractor status but pooling resources for administrative staff etc. Theoretically, locums could also set up the chambers as a separate legal entity with joint ownership. There are several possible legal frameworks available for this sort of arrangement but this would be an unusual step for locum GPs and could make accounting arrangements very complicated. Making the chambers a single 'undertaking' would mean that the locums within it could have a set rate for their fees without falling foul of competition law. However, this arrangement may entail a risk that the locums are classed as employees rather than independent contractors. Naturally each arrangement would need to be assessed separately.

Setting up locum chambers should only be done with expert legal and accountancy advice. This is particularly important to avoid breaching competition law. Like practice partnerships, any joint ownership should always be based on a formal agreement to avoid acrimonious disputes.

Whatever arrangements are put in place for establishing 'chambers', those involved should understand their legal and tax responsibilities. It is important that locums entering into new business ventures are aware of relevant GMC guidance on, for example, financial interests and advertising as well as relevant law such as competition law.

Pros and cons of different ways of working

	Pros	Cons	Other considerations
Working as a sole trader	Most straight-forward approach to self-employed locuming.	Provides maximum independence. You will carry the administrative burden alone.	If you employ any staff to help you, you must ensure you comply with employment law. Be certain that any work you undertake is correctly designated and treated as self-employment or employment.
Working for a locum agency	Will help find work. Can considerably reduce the administration involved in locum work.	May limit your freedom to contact practices yourself in the future. Agency pay is not pensionable under the NHS pension scheme. You will not be able to offset so many expenses against your tax bill.	You will probably be considered an employee.
Establishing a partnership	Allows you to work with other locums or with family members in a relatively straight forward legal structure. Could work better for tax purposes in some circumstances.	More complicated legally and financially than being a sole trader.	See 'Appendix 4 – Legal structures'.

	Pros	Cons	Other considerations
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 à 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 break Competition Law. See 'Appendix 4'.</p>

'Always tell the receptionist when you leave.'

Becoming an employer

As well as engaging the services of accountants etc on an ad hoc basis, 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 (pay, conditions, leave and termination of employment). You will need to pay 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.

Data Protection Act

If you are going to store data about the providers you work with or about patients, you will need to comply with the Data Protection Act (1998). You will need to take care when storing confidential information and register with the Information Commissioner for a small administrative fee.

Equipment

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

- a computer with appropriate software, eg Excel, a bookings database or Penny Perfect which will do automatic invoicing and pensions forms
- 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, collected as free samples from drug reps or acquired via a practice. 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 (1985).

It can also be helpful to have a fax number or fax to email set up.

Before going to a booked locum try to get your smart card activated for the practice where you are going, where appropriate. This is not always necessary or possible.

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. It is surprising how many of these items can be difficult to find in a badly organised surgery. You may, for example choose to carry:

Medical equipment

- stethoscope
- ophthalmoscope/otoscope
- sphygmomanometer
- thermometer
- glucometer
- urine pregnancy tests (for cases of suspected ectopics)
- tape measure
- pulse oximeter
- tourniquet
- blood taking equipment including vacutainers, needles, syringes, cotton balls, plasters etc
- small portable sharps bin (very small shoe box sizes available)
- venflons and butterflys
- fluorets/flourescein drops
- disposable gloves
- peak flow meters
- some specimen bottles ie for urine, sputum, faeces
- swabs for hvs/skin wounds etc
- BNF (available as a smart phone application)
- guidelines and protocols to use as aide memoirs
- desk aids – peak flow charts, Snellen charts, pregnancy calculator, BMI chart (also available as smart phone applications and on practice computer systems).

Drugs

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.[‡]

Medical equipment for rural work – an insider's perspective

There are some different considerations for selecting your equipment when working in far-flung places.

Perhaps the biggest factor that influences your kit selection is that the ambulance service cover is obviously more limited in rural areas. Generally in rural areas GPs can often be asked to attend as the first healthcare professional or as part of a dual response (ambulance and GP).

Many remote Scottish practices will have a bag of equipment known as a Sandpiper bag. Anyone who takes charge of a bag of equipment for emergencies should familiarise themselves with the contents of the bag; this should be done before they start their clinical duties. You do need to have checked your kit so that you can find things quickly in an emergency.

Be aware that a car boot can quickly become very full when you have an ECG machine, defibrillator, nebuliser, oxygen, diagnostic equipment and other equipment that can be used in emergencies.

In a remote and rural setting factors that affect the selection of drugs to be carried in any doctor's bag will be influenced by the availability of ambulance cover, the proximity and opening times of a pharmacy, and the distance from the nearest hospital.

[‡] Drug and therapeutics bulletin (2005) Drugs for the doctors bag 1 43(9) 65-68
Drug and therapeutics bulletin (2005) Drugs for the doctors bag 2 43(11) 81-83

The equipment and drugs any rural GP will carry will also tend to reflect the location and likelihood of the need to start treatment while waiting for transfer to hospital. Some remote locations will include tenecteplase in their emergency drugs provision. This allows a GP to initiate pre-hospital thrombolysis of a STEMI. The interpretation of the patient's ECG will be needed to make the decision whether to initiate this treatment. In very remote areas it may be difficult to transmit ECG to a CCU for advice.

In the Highlands out-of-hours care shifts can only be undertaken by GPs who can demonstrate that they have a pre-hospital emergency care (PHEC) course or equivalent.

Personal Protective Equipment (PPE). Sturdy shoes and waterproofs are always useful. When considering things to have in the car: it is worth including a pair of wellies and a torch. If you are undertaking a locum shift in a remote single-handed practice you may wish to check in advance that the practice has a stock of gloves that will be the right size for you.

And lastly, if you are someone who relies on your sat-nav, please remember that in rural areas postcodes cover large areas and that the practice should be able to give you a map or describe to you the route to take before you set off on any house calls.

Dr Chris Williams. GP. Medical Education Fellow

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 contributions – a few pounds a week which enable you to receive incapacity benefit, maternity allowance, state pension etc. These are usually collected by direct debit monthly or quarterly. You need to register for this as soon as you start or you may be liable for a fine.

- Class 4 contributions – collected with your tax return and applied to a percentage of your income over a threshold.

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 taxpayer 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 Revenue & 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 Revenue & 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.
- Request a copy of *Working for Yourself the Guide* by HM Revenue & Customs.

- 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 will 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 receipts from the PCT for superannuation contributions each month.
- See the locum fees calculator at Appendix 3 and at www.bma.org.uk/images/locum_calculator_tcm41-158533.xls.

Disclaimer – 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.

Finding an accountant

Accountants can help you with bookkeeping, annual tax returns and, if you are working as part of a more sophisticated business structure, can help with filing accounts with Companies House etc.

Professional associations of certified accountants hold directories of their members. Alternatively, many locums find accountants through personal recommendation. 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 Institute of Chartered Accountants of England and Wales, the Association of Chartered Certified Accountants and the Chartered Institute of Management Accountants all have online facilities for finding an accountant. The following websites are a good starting place for doctors wishing to contact these organisations:

The Institute of Chartered Accountants of England and Wales www.icaew.co.uk
Association of Chartered Certified Accountants www.accaglobal.com
Chartered Institute of Management Accountants www.cimaglobal.com

When choosing an accountant it is obviously 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

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 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. Guidance published by the BMA Professional Fees Committee and developed by the BMA (including the GPC and the GPC Sessional GPs subcommittee) and NASGP is available to BMA members and covers the factors that must be taken into consideration when setting fees. This guidance has been incorporated into this guidebook. The BMA and NASGP have also jointly developed a 'locum fee calculator' to allow locums to calculate on an individual basis their own fee for services provided. This can be found at Appendix 3 and also here www.bma.org.uk/images/locum_calculator_tcm41-158533.xls

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 session, per day or per week basis. Where this approach is used, it is important that you raise any concerns about the appropriateness of the time period given for the work that they are required to complete. Ensure that you build in time for paperwork 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 the best part of an hour.

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 their continuing professional development. When setting a rate you should consider how much you will be left with at the end of the year after paying tax 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.

Locums working on a long-term basis occasionally 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 www.businesslink.gov.uk/bdotg/action/detail?itemId=1073792170&type=RESOURCES
- 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.

A 2010 BMA survey of sessional GPs revealed that 50 per cent of locums were not being paid promptly. If you are not paid by a practice, this will usually 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. Payment would usually be expected within 28 days of the date of the invoice. Should a provider refuse to pay you can take them to the Small Claims Court, report them to the PCO and even, if you feel it is necessary, to the GMC. For advice on non-payment of fees please contact the BMA.

'Make sure you have a break for lunch.'

Pensions

At the time of writing, the government intends to implement major changes to the NHS pension scheme (opposed by the BMA). This chapter sets out current arrangements. Keep up to date with pension changes at www.bma.org.uk/employmentandcontracts/pensions/nhs_pensions_reform/

Locums and the NHS pension scheme

Most GPs are members of the NHS pension scheme (NHSPS). Locum GPs may join the NHS pension scheme for NHS freelance GP locum work provided they:

- are on the Performers List of a PCO
- are deputising for or providing additional services to a NHS GP or GP practice (this can include work for an out of hours provider as long as it is an NHS pension scheme Employing Authority) and
- apply to the host PCO not more than 10 weeks after the end of 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) and the locum's scheme contributions.

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' who are not GPs and have benefits calculated differently. GP locums are afforded 'Locum Practitioner' scheme status. GP locums are only able to pension periods of actual work undertaken. Periods not under contract for services are not pensionable (see also 'Death in service benefits').

Locums can pension essential services, additional services, enhanced services, dispensing services, out-of-hours services, commissioned services and collaborative services under existing regulations. They are not entitled to pension non-NHS work, such as cremation forms, and, under their Locum Practitioner status may not pension work done on behalf of PCOs, such as appraiser work or work for clinical commissioning groups (CCGs) (see below for detail).

The employer contribution for locum GPs working in the NHS is normally paid by the PCO, not the practice. However, where locums are engaged for more than six months the locum becomes a type 2 practitioner and the provider will become responsible for paying the employer's 14 per cent pension contribution (see 'Employer's responsibilities' for more detail).

Locums working through an agency or doing a lot of locum work for non NHS Pension Authority providers should consider private pension arrangements to supplement any NHS pension.

Always keep careful pensions records. Request monthly receipts and annual statements from the PCO for your files.

Pensioning appraiser payments

Locums are not permitted to pension any appraisal fees that they receive under contract for services arrangements with a PCO. If you want any GP appraiser work to be pensionable, you will need to be employed formally (with an employment contract) by the PCO for the appraiser part of your work. In the likely event that your PCO will not provide you with a contract of employment for your appraiser work, you will need to consider whether or not you still wish to undertake the work and/or whether a higher appraiser fee could compensate for the work not being pensionable. If you can persuade the PCO to provide you with a contract of employment for your appraiser work, you will have two concurrent pensionable posts; one as a Locum Practitioner and one as a part time (salaried) Officer.

Pensioning clinical commissioning group work

If a locum GP who is solely freelance receives income from a PCT cluster in respect of clinical commissioning group work this will not be superannuable. As with appraiser payments, if you want clinical commissioning work to be pensionable, you will need to be employed formally for this work (with an employment contract) by the PCT cluster. If this is not an option, you will need to consider whether or not you still wish to undertake the work.

The NHS occupational pension scheme – general information

Membership of the NHS pension scheme is permitted as a special concession by HM Revenue & Customs, and allows partners, salaried GPs and locums (provided that they are in a 'NHS employer' practice) to contribute to the NHSPS.

Since 1 April 2008, the NHSPS regulations have been amended. The NHSPS that existed before 1 April 2008 is known as the 1995 section. Alongside it sits the new scheme created on 1 April 2008, known as the 2008 section. The 2008 section is available for new joiners after 1 April 2008, or rejoiners after 1 October 2008 who have had a break in NHS service for five years or more.

In both the 1995 section and 2008 section the principle on which benefits for GPs is calculated remains the same. GPs in the scheme have benefits based on their total career earnings. Beyond the maintenance of this principle differences exist between the schemes. The main differences are detailed below:

	1995 section	2008 section
Retirement age	60	65
Final salary accrual rate	1/80th	1/60th
GP accrual rate	1.4%	1.87%
Benefits provided	Pension and automatic lump sum	Pension with ability to commute pension for lump sum

Full details on how GP benefits are calculated in both the 1995 section and 2008 section can be found in factsheets available on the pensions pages of the BMA website.

In both the 1995 section and 2008 section, contributions are dependent on earnings. For GPs it is the actual level of income earned that determines the contribution due. The table below details the contribution rate applicable to all members from 1 April 2010.

Pensionable pay	Percentage contribution
£20,709	5%
£20,710 – £69,392	6.5%
£68,393 – £107,846	7.5%
£107,947 +	8.5%

If a GP's pensionable earnings are, for example, £67,000 then the locum will pay a contribution of 6.5 per cent on all of their NHS pensionable earnings. Contributions attract full tax relief. The level of employer contributions is as follows:

England and Wales – from 1 April 2004 – 14%

Scotland – from 1 April 2004 – 13.5%

Northern Ireland – from 1 April 2008 – 15.7%

Non-GP work

While GPs have their benefits calculated based on total career earnings in most instances, periods of work undertaken as a salaried 'officer' (which is not work as a salaried GP, but includes work in hospitals such as a clinical assistant) will be taken into account. This can be done either by treating this service separately and calculating benefits due from it as per the 'officer' method or by incorporating the benefits into their GP pension. This area is complex and reference should be made to the general practitioner factsheet, relating either to the 1995 section or 2008 section, available on the BMA website for more information.

GP work

GP benefits are calculated by totalling uprated (dynamised) GP earnings and multiplying them by 1.4 per cent (1995 section) or 1.87 per cent (2008 section). Members of the 1995 section also receive an automatic lump sum of three times pension which can be increased to the maximum of 25 per cent of the total value of pension benefits by forgoing £1 of pension in favour of £12 of lump sum. While there is no automatic entitlement to a lump sum in the 2008 section, the pension can be commuted at the rate of £1 pension for £12 lump sum up to the maximum of the total value of pension benefits.

All NHS earnings (less expenses) are pensionable for GPs. This includes out-of-hours income performed for a provider that is an NHS employing authority. More details can be found in the BMA pension factsheet for general practitioners.

Earnings cap

Since 1 April 2008 the earnings cap has been abolished in respect of prospective service. The cap previously affected those first joining the NHSPS, or rejoining after a break of more than 12 months, after 1 June 1989. For clarification on whether you are affected by the earnings cap please contact the BMA Pensions Department on telephone: 020 7383 6166/6138.

Pensionable service

Although benefits for GPs are based on total career earnings and not years of service and final pensionable pay, membership of the NHSPS is limited to a maximum of 45 calendar years.

Protection against inflation: index linking

The NHS pension is increased each year in line with the CPI. Increases are paid in April based on the movement in the CPI during the 12 months ending in the previous September.

Improving benefits

It is possible to contribute up to 100 per cent of pensionable income (less that already contributed to the NHSPS) into pension planning and to obtain tax relief. The options available are as follow:

- (a) Unreduced lump sum: available only in the 1995 section, and only necessary for married men with service prior to 25 March 1972. Please refer to the factsheet entitled *Improving benefits (Amended scheme)* available on the BMA website.
- (b) Added years: the facility was only available in the 1995 section up until 1 April 2008 (and for 12 months after for those who registered an interest in making a purchase before 31 March 2008). Half cost added years are still available in the 1995 section for those who meet the relevant criteria to make the purchase.
- (c) Additional pension purchase: since 1 April 2008 the facility has been available in both the 1995 section and 2008 section as a method of improving the annual pension payable. It enables members to purchase additional annual pension benefits in blocks of £250 up to a maximum purchase of £5,000 additional annual pension. Purchases can be made by lump sum or regular deduction and can either enhance member benefits solely or they can also be used to enhance partner benefits. Details of the cost of purchasing these benefits are available in the appendix of the *Improving benefits* factsheet available on the BMA website.
- (d) Additional Voluntary Contributions (AVCs) and Free Standing Additional Voluntary Contributions (FSAVCs): These plans are known as 'money purchase' arrangements and the level of benefits arising from them is dependent on:
 - the amount invested
 - the success of the chosen investment fund
 - the level of annuity (interest) rates prevailing at retirement.

AVCs are an arrangement offered by the NHSPS and allow members to save more for their retirement. They are arranged with external insurance companies who have been selected by the NHS Pensions Agencies as AVC Providers to the NHS. Details of these providers are available in the *Improving benefits* factsheet produced by the BMA Pensions Department and available on the BMA website. FSAVCs may be purchased from any company operating in this field. The advantage of an in-house arrangement, which all occupational pension schemes have, is that commission and administration charges may be lower than for FSAVCs. However, independent financial advice should be sought as to the best method of improving benefits. If you have added years or AVC contributions, remember to account for these on Form B.

Retirement age

While there is no upper age limit on continuing to work as a GP, pensionable NHS service is up to age 75 (assuming the scheme limit of 45 years' maximum calendar service has not been exceeded). GPs can access their benefits in full from age 60 (in the 1995 section) and from age 65 (in the 2008 section).

In order to access benefits GPs need to give four months' notice, to the relevant Pension Agency, of their intention to retire. This is done by obtaining a retirement application form from the practice/PCO and returning it to them at least four months before their intended retirement date. This requirement is in addition and separate to any contractual notice requirements.

Early retirement

There are a number of early retirement options available:

(a) Ill-health retirement

GPs may retire on ill-health grounds if they are permanently incapable (ie up to their scheme's normal retirement age of 60 or 65) of carrying out their NHS duties (Tier 1) or, if additionally they are incapable of carrying out any regular work of like duration to their own (taking account of mental capacity, physical capacity, previous training and previous practical, professional and vocational experience but irrespective of whether or not such employment is actually available) (Tier 2). If the Tier 1 criteria is met no enhancement is added but benefits are payable without reduction for being drawn before the scheme's normal retirement age. If the Tier 2 criteria is met an enhancement is payable of two-thirds of prospective service to the scheme's normal retirement age.

More information on this can be found in the *Ill-health retirement* factsheet available on the BMA website.

(b) Voluntary early retirement

GPs may retire voluntarily from age 50 (1995 section) if certain criteria are met or age 55 (2008 section) with an actuarially reduced pension. More information is available in the *Voluntary early retirement* factsheet for both the 1995 section and 2008 section, available on the BMA website.

Working in the NHS after retirement

Many GPs choose to resume NHS work after retirement. The NHS pension will only be affected if a GP returns to NHS work, prior to attaining the scheme's normal retirement age, having retired on the grounds of ill health or, in the case of an employed 'officer', redundancy. Since 1 April 2008 the scope to reduce the NHS pension on returning to NHS employment following retirement (a process known as abatement) has been significantly reduced. It can only affect the unearned/enhanced portion of any ill health pension (Tier 1 and 2) or, for employed 'officers', redundancy pension.

GPs who retire from the 1995 section and return to work will be unable to rejoin the 1995 section. However, if they retired before the 'choice exercise' (scheduled to start in October 2009) they will be able to join the 2008 section after a period of two years following retirement (assuming that they have not already reached scheme maximum limits of 45 years' calendar service).

GPs who retire from the 2008 section and return to work will be able to rejoin the pension scheme so long as their service does not exceed 45 years. GPs in the 2008 section also have the ability to take partial retirement.

A break of one month is required between retirement and resumed NHS employment, following retirement from the 1995 section. The exception is where a break of one day can be taken as long as work of no more than 16 hours per week is undertaken for the calendar month thereafter.

Following retirement from the 2008 section, a break of one day is sufficient and there is no restriction on the level of work undertaken thereafter.

While GPs need to illustrate genuine retirement by resigning from their partnership/employment where applicable, there is no requirement to come off the Performers List.

Injury benefits

The NHS injury benefits scheme provides benefits to some GPs who suffer a loss of earning ability due to an injury, illness or disease resulting from NHS duties. Details of its current provisions can be found in the *Injury benefits* factsheet available from the BMA website. The Injury Benefits scheme has been reviewed with major changes to be implemented in due course (provisionally from 1 October 2012).

GP locums and GP practice staff are not covered by the current injury benefits scheme. Coverage of GPs under the new scheme is under discussion.

Seniority pay

Locums are not entitled to seniority pay but clinical work as a locum can count as prior NHS service for seniority pay if you later work as a GP partner. You will need to keep good records, including dates, of any locum work that you wish to count towards seniority pay. If you have been keeping records for pensions purposes, this should provide adequate evidence.

For further information on seniority pay see

www.bma.org.uk/employmentandcontracts/independent_contractors/managing_your_practice/focussenioritypay.jsp

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

www.bma.org.uk/employmentandcontracts/pensions/pension_scheme/newnhs_penddeathben.jsp?page=2

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.

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 bear the risk that if you fall ill, have unfilled sessions or take leave you will not get paid.

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 out private insurance.

Maternity allowance

If you are self-employed and become pregnant, you may be eligible to receive maternity allowance (MA). The MA pays a standard weekly rate (£135.45 in 2012) 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 *NI17A – A Guide to Maternity Benefits* www.dwp.gov.uk/publications/specialist-guides/technical-guidance/ni17a-a-guide-to-maternity/

You should inform the PCO of any maternity leave as it can impact on the timing of an appraisal.

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 you should die.

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 be unable to pay for everyday necessities, let alone luxuries. 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 extremely 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 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.

'Get known and liked by the practice managers, they are the ones who will hire you.'

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. Since 12 September 2005 over 7,000 BMA members of all ages and specialties have relied upon their expert knowledge and tailored advisory service.

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 AWD Chase de Vere on 0845 6092008.

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, both invoicing and pension forms. Taking short-term posts also reduces income stability.

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

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

Working as a long-term locum

Locum engagement can be for a clearly defined duration (as is the case when covering a sabbatical) or open-ended (for example if covering sick leave). The contract may therefore 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 a 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 witness 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'.) 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 on a self-employed basis must be determined by the doctor).

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 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 eg control over holidays. Do consider though that the potential benefits of salaried work may be limited if the job is not based on the model contract. 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 (which is mandatory for salaried employment in GMS practices). Further details can be found in the BMA's *Salaried GP handbook*.

www.bma.org.uk/employmentandcontracts/employmentcontracts/sessional_gps/salariedgpbook.jsp

'Be pleasant, even if no one else is, remember you often get asked to work in practices when they are struggling due to illness or bereavement.'

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

Advantages	<ul style="list-style-type: none"> • Might get more thorough practice induction, possibly in paid time • 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, better access to data, opportunities to complete audit cycles and carry out patient surveys
Disadvantages	<ul style="list-style-type: none"> • Potential blurring of distinction between locum and partner/salaried. You could lose your self-employed status • Greater pressure to 'muck-in' rather than have clear boundaries to your workload • GP work may extend locum responsibility beyond that desired. Practice may come to rely on the locum • Less flexibility for the locum once engaged in a long-term arrangement • Working in a single practice over a long period of time limits networking opportunities • At the end of the job you will have to re-establish yourself as a freelance locum with other practices
Considerations	<ul style="list-style-type: none"> • 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 pensions chapter for more detail) <p>BE SURE OF YOUR EMPLOYMENT STATUS (see 'Determining your employment status').</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 licence? 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?
- 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 statistic 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 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

www.scottishappraisal.scot.nhs.uk/appraisal-preparation/ooH-gps.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 a single-handed practice 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.

'Do not work in a practice on your own, that you have never worked in before. If you are likely to be on your own in a practice, make sure there is a nurse there, receptionists do not always know where equipment is.'

If you are thinking about taking on work in a single-handed practice, inform your defence organisation which may have guidance to help you. Ask why locum cover is needed and consider the possibility that a decision might be taken to close the practice or move patients during the locum appointment.

Day-to-day good practice

This handbook contains a wealth of information on operating as a locum. Here are a few extra, less formal, tips from those in the know.

'Consider a name badge so patients and staff know who you are and do not just refer to you as "The Locum".'

'If you have never used a particular computer system before, consider going in the day before you start and asking someone to give you a crash course. Also make sure you have your own password so that your consultations cannot be mixed up with anyone else's.'

'Make sure you have a break for lunch.'

'Ask for feedback. After your job finishes, think about what went well, what didn't, how the situation could be improved and most importantly whether you want to work there again!'

'Be pleasant, even if no one else is, remember you often get asked to work in practices when they are struggling due to illness or bereavement.'

'Dress conservatively.'

'Never criticise the IT. Always work hard at claiming the QOF points unless you are running late.'

'Never gossip about other practices.'

'Always leave the room tidy.'

'Introduce yourself to nurses and other doctors if you see any.'

'Always tell the receptionist when you leave.'

'Do not be a fair weather locum. Sometimes you will have to work hours that may not be convenient for you and practices will appreciate this.'

'Get known and liked by the practice managers, they are the ones who will hire you.'

'Dictate or do your referrals immediately after you have seen the patient. You may not be in the practice again anytime soon so it means they are definitely done!'

'Get income protection as this means you have some income if the worst happens and you are too sick to work.'

'Use Google Bookmarks set up on a Google account so you can readily find commonly needed websites for reference.'

Professional considerations for locums

Continuing professional development (CPD)

CPD is defined in the General Medical Council's *Guidance on continuing professional development*, April 2004 as:

'A continuing learning process that complements formal undergraduate and postgraduate education and training. CPD requires doctors to maintain and improve their standards across all areas of their practice. CPD should also encourage and support specific changes in practice and career development. It has a role to play in helping doctors to keep up to date when they are not practising.'

CPD is essential for all GPs in order for them to keep up-to-date with developments and so to remain fit to practise. CPD activities may include:

- self-directed/private study, ie to keep up to date and/or preparing for a professional exam
- developing and/or updating a personal development plan
- courses
- specific clinical refresher experience
- audit
- practitioner or self-directed learning groups
- PCT protected learning events
- researching clinical queries
- obtaining clinical experience relevant to specific PDP aims
- leadership and/or development activities provided these benefit the GP's personal or skills development
- in-house practice based educational meetings
- other in-house practice based meetings, such as business, practice development and multidisciplinary clinical team meetings.

The balance of these various CPD activities needs to be appropriate to the individual's educational and developmental needs.

Some of these CPD activities are harder for locums to access than they are for other GPs because historically locums have not been invited to attend in-house educational meetings or allowed to access information to facilitate data or evidence collection. This is particularly true for locums working in multiple, short-term jobs. Some of these problems can be addressed by joining a sessional or self-directed learning group (see 'Self-directed learning groups' and 'Local sessional GP groups'). There may be more

opportunities in long-term locum posts to get involved in drawing up policies and protocols, demonstrating team work and training, carrying out audits and significant event analyses or working on patient feedback and surveys.

Audit is particularly difficult for locums because they often cannot access records outside of consulting time, are not around long enough to see changes made and have little influence over practice systems. Despite repeated requests from the GPC, locum GPs still do not have their own prescribing numbers which makes it very difficult for locums to monitor their prescribing patterns. Locums are less likely to be invited to significant event analysis meetings and indeed can be concerned that reporting significant events may be seen as 'whistleblowing' and affect their opportunities of repeat booking at the practice. They also have no 'specific clinical role' to audit and have much less opportunity to effect changes.

Unlike salaried GPs, locums are not normally in a position to take paid time for CPD, however they should ensure that they set their fees in such a way that they can invest the necessary regular time in CPD 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 CPD.

The RCGP has outlined a credit-based system for CPD activity. Under the system, it is normally expected that 50 credits will be accumulated in a year, with 250 credits being accumulated over a five-year revalidation cycle (please see below for further details about revalidation). The credits are attained through both the time spent on the activity (with one hour of activity equalling one credit) and the impact that this activity has on the doctor, his or her patients, and the service. Further details of the scheme can be found at www.rcgp.org.uk/pdf/Credit-Based%20System%20for%20CPD_2nd%20version_110110.pdf

The BMA has concerns that it will be more difficult for locum GPs than other GPs to demonstrate impact as defined in the RCGP guidance. For example, there is often little scope for locums to implement a clinical guideline, change prescribing within a practice, implement a new service change or influence a practice to become a training practice. The BMA has raised these concerns with the RCGP.

Tips for CPD

- Join or organise a self directed learning group (see below)
- Join your local sessional GPs group. This may offer educational opportunities and information about events as well as opportunities for networking.
- Attend local educational events
- Set time aside regularly for CPD and to complete your personal development plan and keep an electronic log of your CPD activities as evidence for revalidation.
- Remember your CPD requirements when drawing up a contract for services. You could for example, ask to be able to participate in practice educational meetings and significant event audit discussions or obtain agreement to consult records to find out the outcomes of your referrals.
- Contact your local deanery tutor to ask to be included in any information cascades or distribution lists relating to education and appraisal.
- Keep your appraisal folder up to date (most available toolkits have this facility)
- If you have not already been informed, check with the appraisal lead in your area as to which toolkit and forms you will be expected to use, as this can change depending on the appraisal policy.
- Take every opportunity to discuss pertinent and relevant cases with doctors you work with
- Make yourself known and ensure you are included on local databases for information cascades and mail outs eg PCO, LMC, Deanery, local hospital postgraduate events, RCGP faculty
- Remember there are lots of excellent online learning sites and apps through which you can carry out CPD if you are isolated and unaware of local educational events or find it difficult to attend either due to childcare arrangements, costs and course fees.

'Get income protection as this means you have some income if the worst happens and you are too sick to work.'

Self-directed learning groups (SDLGs)

Self-directed learning groups are peer groups of GPs which meet for education, peer support and to collect evidence of CPD for appraisal. They do not necessarily have formal leadership or external facilitation and are often non-hierarchical. Commonly meetings take place in members' homes. The group might discuss topics, cases, significant events, journals and audit, or engage in role play. Involvement with a SDLG will help you combat professional isolation and contribution towards peer benchmarking. If you do run into problems or have complaints made against you, the SDLG can provide support.

If you want to set up or join a SDLG you could approach your local sessional GP group or deanery tutors for information and help involving others in your area. The group will work best if it has carefully defined aims, expectations and ground rules from the outset and if these are regularly reviewed to ensure the group continues to function well.

There is a guide for successful self-directed learning groups on the north east employed and locum GPs website
www.nelg.org.uk/media/docs/file83f575f3bb08205a10853e0c5a5402e8.pdf

Appraisal

For the reasons outlined above, some locums, particularly those engaged in ad hoc itinerant work without regular access to colleagues, are likely to find appraisal and revalidation particularly challenging.

NHS appraisal should allow GPs:

- to demonstrate achievements and reflect on overall performance over the previous year in line with the GMC's *Good Medical Practice* guidance
- to obtain feedback on their performance
- to identify any developmental needs so that the necessary training and support can be provided.

All locum GPs must participate in NHS appraisal. It is a requirement of being on a PCO's Performers List that GPs have an appraisal and all GPs must be on a Performers

List to practice. It will also shortly (although in a revised format) be a requirement of revalidation (see below).

Appraisal should normally be undertaken on an annual basis. You should ensure that you have enough notice of the date to undertake the necessary preparation.

Appraisals are organised by PCOs for the GPs on their Performers List. The PCO will arrange for a trained GP appraiser (who should be a practising GP in that locality, unless agreed otherwise by the LMC or national GPC) to conduct the appraisal. The appraiser should not be someone who you know well or where there could be a conflict of interest, for example, your employer or another GP at your practice. Furthermore if you are uncomfortable with the assigned appraiser, you should immediately inform the PCO so that another appraiser can be allocated. The PCO should have a protocol in place to address any concerns.

The NHS appraisal interview is confidential between the appraiser and appraisee, with generally only the main action points arising from the appraisal being reported back to the PCO. The appraisal should be a developmental and formative process, but if the appraiser discovers issues of concern during the interview then the appraiser is required under the GMC's *Good Medical Practice* to take actions to safeguard patient safety, which may include discussing appraisee details with a third party – usually the appraisal lead or medical director/responsible officer.

Pre-appraisal forms

The pre-appraisal forms come in parts. These are slightly different for each country. In addition to the pre-appraisal forms, for a first appraisal GPs are required to prepare an outline personal development plan (PDP) beforehand. Thereafter the PDP is prepared following the outcome of the appraisal. It is recommended that the pre-appraisal statement and supporting information are submitted to the appraiser at least two weeks before appraisal.

You should keep yourself abreast of requirements for supporting information for appraisal and revalidation as published from time to time by the GMC and RCGP and the revalidation support team.

The pre-appraisal forms and model PDP are available electronically
England: www.appraisalsupport.nhs.uk/

Following substantial revisions to the GMC guidance “Good medical practice” the revalidation support team has produced new appraisal forms as the Medical Appraisal Guide (MAG form). This reflects these domains and allows uploading of relevant supporting information. It is expected that this format will be widely adopted.

<http://www.revalidationsupport.nhs.uk/CubeCore/.uploads/PDFForm/MAG/MAGmodelappraisalformv3.pdf>

Wales: <http://gp.cardiff.ac.uk/appraisal>

Scotland: www.scottishappraisal.scot.nhs.uk/

Northern Ireland: www.dhsspsni.gov.uk/public_health-appraisal

A number of online appraisal toolkits are also available, which allow you to store evidence and complete appraisal forms online.

Supporting information for appraisal

The GMC has published guidance on supporting information for appraisal, which also refers doctors to their own Colleges for further guidance.

http://www.gmc-uk.org/doctors/revalidation/revalidation_information.asp

The supporting information that you will need to bring to your appraisal will fall under four broad headings:

- General information – providing context about what you do in all aspects of your work
- Keeping up to date – maintaining and enhancing the quality of your professional work
- Review of your practice – evaluating the quality of your professional work
- Feedback on your practice – how others perceive the quality of your professional work

There are six types of supporting information that you will be expected to provide and discuss at your appraisal at least once in each five year cycle. They are:

1. Continuing professional development
2. Quality improvement activity
3. Significant events
4. Feedback from colleagues

5. Feedback from patients (where applicable)
6. Review of complaints and compliments

The nature of the supporting information will reflect your particular specialist practice and your other professional roles. For example, an appropriate quality improvement activity will vary across different specialties and roles.

The GPC Sessional GPs subcommittee has had concerns that standard for supporting information may disadvantage locums GPs, a view that has been borne out by the several pilots funded by both the RCGP and RST.

http://www.gmc-uk.org/Item_9___Revalidation_Projects_and_Pilots_Annex_C_33221377.pdf

As part of the preparation for revalidation readiness, the RCGP has published its own guide to the revalidation of general practitioners. It has included (in the appendix) several suggestions to ensure locums are able to participate in appraisal in a way that is meaningful to them and not overly onerous.

For example:

- Where audit is not practicable or meaningful, a doctor can carry out a review of their referrals or a condition based review of a series of consultations.
- Where locums are not able to access multidisciplinary meetings to discuss their significant events they can discuss them with their learning group or a colleague.
- Multisource feedback is expected to be a challenge, especially for peripatetic locums. Recent GMC guidance on MSF also states that being a locum caused an adverse bias in the ratings given to locums in the pilots which used MSF:

http://www.gmc-uk.org/Information_for_appraisers.pdf_48212170.pdf

developing appraisal policies, including types of supporting information. If you are asked to submit supporting information which you feel is not appropriate to your role advice may be available from your local appraisal lead, tutors (where they exist) or your LMC.

Appraisal interview

The interview will last about one and a half hours. During this time the GP and appraiser will discuss the pre-appraisal forms and supporting information which the GP has completed and their outline or previously agreed PDP. The aim is to allow the appraisee to review their work, including achievements over the previous year and to consider any areas for further development.

At the end of the appraisal, you and appraiser should aim to agree and sign off the appraisal summary statement, including the agreed PDP for the year ahead, which will be sent in confidence to the PCO chief executive or responsible officer and senior clinician/clinical governance lead. The appraiser should point the appraisee to resources for any learning needs identified

When you are being appraised you should read the appraisal summary statement carefully and only sign it if you agree with its contents. If you cannot agree with it then you should inform the appraiser immediately, and if this cannot be resolved between the two of you the appeal mechanism should be followed.

Complaints about performance

If any formal complaints have been lodged against you, the appraiser should be made aware of this via the pre-appraisal forms. Such complaints should continue to be investigated in the normal way, and outside the appraisal process. If a complaint has been found unjustified then it must be disregarded by the appraiser.

Concerns about performance

If it is identified that some further training is needed, the necessary training should be arranged. If appropriate it should be funded by the PCO. It is most unlikely that serious concerns about a GP's health, conduct or performance would first be raised in an appraisal. However, if the appraiser does have such concerns he or she, as a registered medical practitioner, is obliged under clinical governance procedures to refer this immediately to the PCO senior clinician/clinical governance lead and chief executive or responsible officer or, in extreme cases, to the GMC. When referred to the PCO, it should then take appropriate action. Where appropriate this may include assessment of competence either by the local deanery or referral to the National Clinical Assessment Service (NCAS) for assessment, support and training. If serious concerns about performance are raised the appraisee should immediately contact their medical defence organisation and the BMA for advice and possible representation. If it is

identified that some further training is needed the necessary training should be arranged. If appropriate this should be funded by the PCO, though in many areas there is no protected funding set aside for GPs who are deemed to need retraining (this is negotiated locally).

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 appraisal lead or appraisal organiser for the PCO 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 PCO senior clinician/clinical governance lead or the chief executive or responsible officer to convene a panel meeting to consider this further. A PCO Board member should chair this meeting with LMC representation if necessary.

Sources of further information

Most PCOs 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 PCO for details of this procedure.

For additional guidance on preparing and collecting evidence for appraisal, see:

The RCGP website www.rcgp.org.uk/professional_development/appraisal.aspx

The GMC website www.gmc-uk.org/doctors/revalidation/revalidation_gmp_framework.asp

The Northern GP deanery's website for a useful toolkit

www.nelg.org.uk/content/Appraisal%20and%20Revalidation

NHS Education for Scotland has published guidance on appraisal evidence for out of hours doctors www.scottishappraisal.scot.nhs.uk/appraisal-preparation/ooh-gps.aspx

Meeting the costs of appraisal

Locum GPs should receive a contribution towards the cost of their NHS appraisal from their PCO, though this may not cover the full costs. If you experience problems with funding for your appraisal contact the BMA and LMC who should be able to support you.

Revalidation

Revalidation is the process by which doctors will demonstrate to the GMC on a regular basis that they are up to date and fit to practise. It is a positive affirmation that doctors are safe, rather than just an absence of concerns. The satisfactory sign-off of five annual appraisals will form the basis of a recommendation to the GMC that a doctor is fit to practise.

The first step towards the introduction of revalidation began in November 2009 with the introduction of licences to practise. It is now a legal requirement to have a licence and be registered with GMC in order to practise medicine in the UK.

Doctors will undertake a form of strengthened appraisal and collate a portfolio of evidence to demonstrate that they meet the necessary standards. Over the course of the five-year revalidation cycle, doctors will be expected to meet the various criteria that have been set.

Each doctor will relate to a responsible officer (RO) who will assess the portfolio and provide the GMC with a recommendation on the doctor's fitness to practise. It is expected that the overwhelming majority of recommendations to the GMC will be positive and demonstrate that most doctors will have no difficulty in revalidating. In some circumstances, ROs may not be able to provide a recommendation due to lack of evidence or concerns with a doctor's practice or performance. Whilst there will be an appeals mechanism in such cases, revalidation is likely to identify a small number of doctors who will require further training, remediation and/or support.

As previously mentioned, the GMC has published the requirements for supporting information for appraisal and revalidation and refers doctors to their specialty college for specific guidance, which includes specific advice for doctors in special groups or exceptional circumstances, such as peripatetic locums. The GMC has also published separate guidance on colleague and patient questionnaires. As the process evolves and develops, it is likely that further and/or revised guidance will continue to be published by both the GMC and the RCGP.

The GMC has published the requirements for supporting information for appraisal and revalidation and refers doctors to their specialty college for specific guidance, which includes specific advice for doctors in exceptional circumstances, such as peripatetic locums. The GMC states that the supporting information that doctors will need to bring to appraisal will fall under four broad headings:

General information – providing context about what you do in all aspects of your work

Keeping up to date – maintaining and enhancing the quality of your professional work

Review of your practice – evaluating the quality of your professional work

Feedback on your practice – how others perceive the quality of your professional work

Within this, it suggests that doctors will need to provide six types of supporting evidence over the five-year cycle:

1. Continuing professional development
2. Quality improvement activity
3. Significant events
4. Feedback from colleagues
5. Feedback from patients (where applicable)
6. Review of complaints and compliments

The full guidance note can be accessed at www.gmc-uk.org/Supporting_information.pdf_42293176.pdf.

The GMC's guidance is generic and applicable to all doctors. The RCGP's *Guide to the Revalidation of General Practitioners*, meanwhile, outlines proposals for how this guidance will apply to GPs including specific advice for doctors in special groups or exceptional circumstances, such as peripatetic locums. As such, the guide is aligned with the four headings included within the GMC's guidance and details the information that they believe GPs will need to bring to appraisal in these areas.

The RCGP guide is available at www.rcgp.org.uk/pdf/Guide%20to%20Revalidation%20for%20GPs_sixth_edn_210911.pdf.

At the time of writing, revalidation is due to be introduced at the end of 2012. However, this can only happen once the pilots that are currently taking place throughout the UK have concluded and local systems are deemed sufficiently robust to support revalidation. The GMC, in conjunction with the four departments of health, will decide when and where revalidation is rolled out following a 'test of readiness'. While revalidation operates on a five-year cycle, the RCGP guidance is clear that GPs who are revalidated in late 2012 cannot be expected to submit a full five-year

revalidation folder. It states that the minimum requirement can only be for supporting information collected from the time when revalidation is mandated. Full five-year portfolios will only be expected from all doctors when revalidation is entering its second cycle.

The BMA is aware that some PCOs have been attempting to introduce more stringent appraisal frameworks now, using the planned introduction of revalidation to justify this. PCTs have not been mandated to do this, and if you are aware of this happening in your area then please contact the BMA for assistance.

BMA activity

The BMA is working to try to ensure that revalidation is a suitable, fair and proportionate process for all GPs.

Specifically, the BMA has for a long time been concerned that revalidation will be a proportionately difficult process for locum GPs, particularly those who work on a peripatetic basis. The main reason for this is that the requirements are easier to fulfil with a consistent practice base – for example, it is easier to collect patient and colleague feedback when based in one practice.

The BMA has been raising these concerns with relevant stakeholders through consultation responses, letters and meetings, in order to try to ensure that this is a suitable process for locum GPs. The BMA's Sessional GPs subcommittee also has a representative on the steering group for the current pilots that involve locum GPs. The results of the pilots are due shortly, and the BMA will continue to lobby stakeholders to try to ensure that this is a suitable process for locum GPs.

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. Many practices 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
- the particular risks of 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 amount and type of work covered by the locum duty
- prejudices against locums and a lack of established relationships with patients 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 PCO-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 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. 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.

If possible ask locum colleagues which practices are good or bad to work in and steer clear of 'struggling' practices with no permanent clinicians to keep systems in check.

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, 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 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 go wrong. 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.

For locums it is particularly important to document discussions, reasoning, investigations ordered and decisions taken, not just the clinical findings.

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. Some locums now only work in paper-light practices where all consultations are entered on a computer as this means records are never 'missing' and previous consultations are always legible. EMIS 'practice notes' provide the advantage of an audit trail where tasks have been delegated by the locum to other members of staff. 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. 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.

For cases involving child protection, risk of suicide or terminal illness it is a good idea to 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 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 other 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 record 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.

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 the PCO and also available via the Medicines and Healthcare products Regulatory Agency (MHRA) website www.mhra.gov.uk

- 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, it is 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. If you feel it is feasible you might want to state explicitly in your contract for services that you will not 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 Medical Protection Society (MPS) recommends that locums can help safeguard against problems by taking the following steps:

- 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.[§]

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.

§ MPS (2011) *Repeat Prescribing for GPs*

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?
- 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?

Patients will always occasionally present problems for which you need further information. In the absence of a good library, and where you cannot always get hold of a colleague you could

- carry a few reference books in your car boot such as the Oxford handbooks of clinical medicine and of general practice as well as 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 on line resources, databases, eg PUBMED, 'Clinical Evidence' and even some full text journals.

For further information on avoiding isolation see 'Avoiding professional isolation'.

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 the severing of a network of support. For example, a GP could have just finished their training scheme, moved to a new area, returned to the UK after a period abroad or just finished a career break.
- 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 when they move between practices, and might have less access to helpful support mechanisms such as deanery contacts, LMC contacts, and mentorship.
- Locums often do not have the same formal and informal opportunities for discussing their clinical work with colleagues. Some may go weeks without meaningful interaction with other doctors. 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 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 flu pandemic of 2009/10 highlighted real problems with information reaching locums. The BMA's Sessional GPs subcommittee is working to ensure that information is cascaded to locums more effectively.

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 NASGP website www.nasgp.org.uk. 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 GP. 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 list server. 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 a self directed learning group (SDLG). 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 GP educational events.
- Keep an eye out for the GPC Sessional GPs subcommittee newsletter, which you can sign up for electronically. 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 on 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.
- 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. Email your details to gpbulletin@axismediaservices.co.uk
 - the NICE e-newsletter. Register here www.nice.org.uk/newsroom/nicenewslettersandalerts/nicee-newsletter/nice_eneewsletter.jsp
- Out-of-hours work can also provide good opportunities for networking.

Local sessional GP groups

Local sessional GP groups, where they exist, fulfil a number of functions. They:

- allow salaried GPs, locums, retainers and assistants to network. Members gain an opportunity to find out what others are doing, how working conditions vary, where work opportunities exist, etc
- advertise educational events and local news
- provide notification of locum vacancies
- give support to people who need it, for example because they are moving into the area
- are a forum for discussing issues relevant to sessional GPs such as pensions, CPD, appraisal and revalidation.

A list of local sessional GP groups can be found on the NASGP website

www.nasgp.org.uk If your area does not have a sessional GP group you could consider setting one up. For more information on setting up a local sessional GP group see www.bma.org.uk/employmentandcontracts/employmentcontracts/sessional_gps/sessionalgpgroup.jsp

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 so people know where to go
4. Think about combining the group's meetings with educational events so people have an opportunity to keep up to date and network at a single meeting. This may require some liaison with the local GP tutor for sessional GPs
5. Get a website built. 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

Paula Wright, portfolio freelance GP and member of the North East Employed and Locum GP Group

'The only downside (of being a locum) was the isolation and so I asked practice managers for the contact numbers of other locums and contacted as many as I could in the area and invited them all to the first, very informal, meeting of the area locum group in a local pub. This was in a time when there were very few locum groups at all in the UK. We gradually formalised things and soon had sponsorship for the meetings by pharmaceutical companies to pay for educational talks and food, and the locum group has gone on from there.'

'Never criticise the IT. Always work hard at claiming the QOF points unless you are running late.'

Representation of locum GPs

National representation

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 NHS doctors employed 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 General Practitioners Committee

The BMA General Practitioners Committee represents all NHS GPs. It consists of approximately 90 members, with a dedicated negotiating team. The GPC has sole negotiating rights with the Departments of Health for all GPs working under the general medical services (GMS) contract. The GPC is also consulted on issues concerning the whole of the GP profession.

There are national GPCs for Scotland, Wales and Northern Ireland. As a result of devolution the Scottish GPC negotiates directly with the Scottish Government and the NHS Education for Scotland (NES) on some areas. Similarly the Welsh and Northern Ireland GPCs deal with certain issues in discussion with their respective national Assemblies.

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 www.bma.org.uk

Locum GPs may stand for election to the GPC for a regional seat provided that they have worked:

- as an NHS GP for at least 52 sessions over six months during the year immediately prior to the election; or
- as a medically qualified secretary of an LMC; and
- contribute to the LMC voluntary levy. Alternatively locum GPs may be elected to the GPC via the annual conference of LMCs or the BMA's annual representative meeting.

Locum GPs may vote in a GPC election for a regional seat as long as they contribute to the LMC voluntary levy.

Locum GPs can stand for and vote in an election in any constituency where they contribute to the LMC levy (usually the LMC where they do the majority of their work) or, if they work across many Primary Care Organisation (PCO) boundaries, the constituency in which the GP is on the Performers List should be taken as the election constituency.

Sessional GPs subcommittee of the GPC

The GPC Sessional GPs subcommittee is a democratic body responsible for representing all salaried and locum GPs (collectively known as sessional GPs) throughout the UK. The subcommittee has been in existence since 1997 but was previously known as the non-principals subcommittee.

The subcommittee leads on all GPC issues that primarily affect sessional GPs and takes an interest in all things relating to salaried GPs and locums including the model salaried GP contract, the GP retainer scheme, pensions and pandemic flu planning. Recently it has been helping to ensure that appraisal and revalidation are fit for purpose for salaried and locum GPs and that GP commissioning arrangements involve and engage sessional GPs. The subcommittee produces guidance and is instrumental in the running of the BMA's conferences for sessional GPs.

Elections for the 16 regional representative posts on the subcommittee are held every three years. Members are elected on a UK-wide basis. The next elections are due in Summer 2013. A GPC negotiator and a GPC member, both with a special interest in salaried and locum GPs, are also involved in the subcommittee as non-voting members. The current membership of the subcommittee is set out at Appendix 2.

The sessional GPs subcommittee is represented on the main GPC. It currently has four dedicated seats on the GPC. A number of other GPC members are also salaried or locum GPs.

The subcommittee is always very interested in hearing the views of locum GPs. This helps the subcommittee to continue to represent all sessional GPs effectively. Email sessionalgps.gpc@bma.org.uk

Local representation

Local Medical Committees

Local Medical Committees (LMCs) in England, Wales and Northern Ireland are recognised in statute as the local representative body of GPs, including locum GPs. They are therefore recognised to negotiate with their Primary Care Organisation (PCO). 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.

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 Area Medical Committee (AMC) 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

LMCs can help locum GPs in a variety of ways. 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.

Without being a member (ie contributing to the LMC's statutory or voluntary levy), you will not be able to access any of the services that the LMC provides. By becoming involved in your LMC, your voice can be heard locally and nationally, and you can therefore play a real role in shaping policy. Additionally, LMC members who contribute to the voluntary levy are eligible to stand for, and vote in, regional GPC elections**. The levy fees are often minimal, particularly for sessional GPs.

** Sessional GPs who wish to stand in, or vote in, elections to the GPC's Sessional GPs subcommittee do not have to be either LMC members or BMA members.

Representation of locum GPs on LMCs

The GPC is working with LMCs to ensure that proper representation and involvement is available for locums throughout the UK. 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.

You can find your LMC's contact details on the BMA's website:

www.bma.org.uk/representation/local_representation/local_med_committees/index.jsp

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.

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.

Local sessional GP groups

There are a number of local groups of salaried and locum GPs throughout the UK. These tend to be a good forum for networking with colleagues, as well as being supportive and offering opportunities for educational development (see 'Local sessional GP groups'). Some of these have representation on LMC and deanery committees.

Locum GPs and commissioning consortia

Locum GPs have lots to offer new commissioning consortia. The sessional GPs subcommittee has been working to ensure that locums are involved in commissioning and included in the election arrangements. This matter is still under discussion at the time of writing.

BMA support to individual members

Individual expert advice and support on contractual matters is available to BMA members. The BMA also provides representation at grievance hearings and disciplinary hearings, as well as externally before employment tribunals and the civil courts.

GP members who are providers can obtain advice on drawing up contracts for staff and locums, including terms and conditions of service and pension matters from the Employer Advisory Service, which is dedicated to providing advice to GPs as employers and managers of staff. 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 123 123 3 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.

'Do not be a fair weather locum. Sometimes you will have to work hours that may not be convenient for you and practices will appreciate this.'

For locums and providers

The contract for services

A 2010 survey of sessional GPs found that 71 per cent of locums operate without a written 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 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 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 core 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, as defined in the BMA and the NHS Confederation publication *New GMS contract 2003, Investing in general practice*.

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 X-rays 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 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 Performers 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 holidays. Restrictions on the locum's freedom to take leave could affect their employment status with consequences for national insurance contributions etc.)

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 dismissed 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 will be regarded as a dismissal and so 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
- constructive dismissal.

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. However, an instruction to 'resign or be sacked' or other similar pressure is not regarded as termination by mutual agreement. Termination by mutual agreement is not regarded as a dismissal.

Resignation

If a locum genuinely resigns, then this is not a dismissal. The notice period to be given should be outlined in the contract for services. Resignation is not regarded as a dismissal.

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. Premature ending of a fixed term contract **is** regarded as a dismissal.

Dismissal of the locum 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. Where the contract does not refer to pay in lieu of notice, the provider should only provide this after seeking advice since it could have adverse implications. Dismissal with notice **is** regarded as a dismissal.

Termination without notice ('summary dismissal')

A summary dismissal means a dismissal without notice or without pay in lieu of notice. Summary dismissal **is** regarded as a dismissal.

The locum can expect to be dismissed 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 a PCO 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. Indeed, due to the potential difficulties for providers in proving frustration, it would be advisable where possible for providers to follow at least the ACAS Code of Practice on disciplinary and dismissal procedures. Termination due to frustration is not regarded as a dismissal.

Constructive dismissal

This occurs when a provider commits a serious breach of contract, the locum resigns as a direct result of the breach and does not waive the breach (ie the resignation should occur immediately after the breach). Constructive dismissal is regarded as a dismissal. However, constructive dismissal is not a cause of action in itself, and so to bring a claim (eg a claim of wrongful dismissal and/or unfair dismissal) against the provider the elements of that claim must be proved.

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*.

www.bma.org.uk/employmentandcontracts/employmentcontracts/sessional_gps/salariedgpbook.jsp

'Dictate or do your referrals immediately after you have seen the patient. You may not be in the practice again anytime soon so it means they are definitely done!'

'Use Google Bookmarks set up on a Google account so you can readily find commonly needed websites for reference.'

For providers

Reimbursement available to practices for locums

In some circumstances, under the Statement of Financial Entitlements (SFE) a GMS practice is entitled to apply to its PCO for locum reimbursement. For more detail on the conditions for doing this see

www.dh.gov.uk/en/Healthcare/Primarycare/PMC/contractingroutes/DH_4133079

	2012/13 rate	
Prolonged study leave (at least 10 weeks but not more than 12 months) (paragraph 12 of the Statement of Financial Entitlement)	£978.91 per week, although the PCO is able to use discretion to reimburse more.	The educational aspects of the study leave must normally have been approved by the local Director of Postgraduate GP Education (DPGPE) and the PCO must be satisfied that the payments are affordable.
Maternity leave (paragraph 9 of the Statement of Financial Entitlement)	Up to £978.91 per week for the first two weeks and then up to £1500 per week for the next 24 weeks, although the PCO is still able to use its discretion to reimburse more.	Practices are advised to inform their PCO in advance of the pending maternity leave.
Adoptive leave (paragraph 9 of the Statement of Financial Entitlement)	Up to £978.91 per week for the first two weeks and then up to £1500 per week for the next 24 weeks, although the PCO is still able to use its discretion to reimburse more.	Practices are advised to inform their PCO in advance of the pending adoptive leave.
Paternity leave (paragraph 9 of the Statement of Financial Entitlement)	Up to £978.91 per week for two weeks, although the PCO is still able to use its discretion to reimburse more.	Practices are advised to inform their PCO in advance of the pending paternity leave.
Sick leave (paragraph 10 of the Statement of Financial Entitlement)	Up to £978.91 per week, although the PCO is still able to use its discretion to reimburse more.	The PCO can use a variety of factors to determine whether it was/is necessary to engage a locum including practice list size and number of GPs. Practices are advised to inform their PCO as soon as possible of the sick leave.

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 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').

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, registered with the GMC and on a local Performers List. Registration with the GMC can be checked at 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 pension administration and contributions (*see below*). **It is your responsibility as an engager to correctly determine the employment status of your workers.** 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 one session per week, for eight 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 the PCO. In reality (and as with GP providers) the contributions are in fact top sliced from the monthly global sum payments by the PCO.

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 six months at the practice, they are a GP locum in pension terms from day one and the PCT will be responsible for the cost of the employer's superannuation from day one.
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 and the practice will be responsible for the employer's 14 per cent after the six months.

We would expect this principle to apply across the UK.

'Dress conservatively.'

It is important that providers are certain that their 'locum' really is classed as a locum for pension purposes 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 Entitlements). The SFE has penalty clauses including giving the PCO 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 (ie the PCO) 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 48 of the 1995 Pensions Act and section 70 of the 2004 Pensions Act states that the NHS Pensions Division has a legal duty to report any 'breaches of pensions law' to the Pensions Regulator. If an individual is found guilty of a breach they may be subject to a heavy fine of up to £50,000.00 per offence
- 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 020 7383 6166/6138 if you require further guidance in this matter.

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

Practices should therefore administer and process payments for locums in as efficient a manner as possible. Payments made toward the end of the 10 week limit do not allow the GP locum sufficient time to forward the forms and payment to the PCO, particularly if the locum happens to be away. Providers should attempt to apply a 28 days turnaround (at the most) on GP locum payments so that any risk to the pensionable status of their work is avoided.

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 checklist 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:

1. 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
 - where to get a pager if required for on call
 - location of panic button, emergency box, resuscitation trolley, fire exits, toilets, tea/coffee and where other staff can be found.
2. 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) as well as Integrated Clinical Environment (ICE) 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
 - the system for dictation
 - how choose and book is supported
 - where they can obtain information on the computer on local referral pathways, especially fast-track services and their eligibility criteria.
3. Show the locum where they can find:
- stationary: sick 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.
4. 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 is also one of the parameters contributing to assessments of quality made during inspections by the Care Quality Commission (CQC). 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), makes 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 at Appendix 1.

Sources of further information

British Medical Association

www.bma.org.uk

BMA Local Medical Committees

[Local medical committees](#)

General Medical Council

www.gmc-uk.org

HM Revenue & Customs

www.hmrc.gov.uk

Medical Defence Union

www.the-mdu.com

Medical Protection Society

www.medicalprotection.org

Medical and Dental Defence Union of Scotland

www.mddus.com

National Association of Sessional GPs

www.nasgp.org.uk

Royal College of General Practitioners

www.rcgp.org.uk

Appendix 1 – 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		<i>You may want to include surgery, mobile, home numbers</i>	
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 Integrated Clinical Environment (ICE) 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 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 is 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 <i>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.</i>
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? <i>If form insert file path. 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</i>
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? <i>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</i>
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 <xxx> or /and send a practice note to <xxx> 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 2 – Membership of the GPC sessional GPs subcommittee 2010-2013

Dr Vicky Weeks (Chairman)
Dr Stephen Bassett (Deputy Chairman)
Dr Alexandra Ames
Dr Kate Barusya
Dr Katie Bramall-Stainer
Dr Carla Devlin
Dr Nik Howarth
Dr Anne Jeffreys
Dr Malcolm Kendrick
Dr Mary O'Brien
Dr James Parsons
Dr Bashir Qureshi
Dr Mark Selman
Dr Clare Singleton
Dr Vijoy Singh
Dr Lydia West
Dr Paula Wright

Ex-officio members

Dr Laurence Buckman
Dr Beth McCarron-Nash

Appendix 3 – Calculator for fees for locum services

CAR EXPENSES	AMOUNT
Petrol	<input type="text"/>
Tax	<input type="text"/>
Insurance	<input type="text"/>
Breakdown cover	<input type="text"/>
Servicing/repairs	<input type="text"/>
MOT	<input type="text"/>
Other	<input type="text"/>
Financing costs	<input type="text"/>
Capital value depreciation	<input type="text"/>
Parking	<input type="text"/>
% Business Use	<input type="text"/>
ANNUAL CAR EXPENSE (BUSINESS USE)	<input type="text" value="0"/>

Finally fill in the remaining amounts in the calculator

NASGP FREELANCE GP FEE CALCULATOR

TOTAL ANNUAL EXPENSES	AMOUNT
GMC registration	<input type="text"/>
Medical indemnity	<input type="text"/>
BMA subscription	<input type="text"/>
NASGP subscription	<input type="text"/>
RCGP subscription	<input type="text"/>
LMC contribution	<input type="text"/>
Sessional GP Group contribution	<input type="text"/>
Accountancy	<input type="text"/>
Mobile phone	<input type="text"/>
Car	<input type="text"/>
Office	<input type="text"/>
Administrative expenses, stationery	<input type="text"/>
CPD expenses – courses/magazines/reading	<input type="text"/>
Other	<input type="text"/>
Secretarial	<input type="text"/>
Medical instruments	<input type="text"/>
Administrative support	<input type="text"/>
TOTAL ANNUAL EXPENSES	a <input type="text"/>

NUMBER OF SESSIONS PER WEEK	b	<input type="text"/>
TARGET ANNUAL NET INCOME	c	<input type="text"/>
TARGET ANNUAL GROSS INCOME	c+a=d	<input type="text"/>
WEEKLY INCOME	d/45=e	<input type="text" value="0"/>
SESSIONAL RATE	e/b	<input type="text" value="0"/>

Based on original idea from P Wright and devised by the NASGP

OFFICE EXPENSES	AMOUNT
Council tax	<input type="text"/>
Electricity	<input type="text"/>
Gas	<input type="text"/>
Water	<input type="text"/>
Management fees	<input type="text"/>
Home telephone	<input type="text"/>
Computer costs	<input type="text"/>
Other	<input type="text"/>
% Business use	<input type="text"/>
ANNUAL OFFICE EXPENSES	<input type="text" value="0"/>

Appendix 4 – 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 so 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.lfyt.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 www.bma.org.uk/about_bma/benefits_for_members/bmalaw.jsp

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, but not necessarily, 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 that 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
 - involuntarily
- lengthy incapacity
- retirement and death
- defence society
- arbitration
- banking
- accounts
- pensions
- suspension.

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 HM Revenue & Customs (HMRC). 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, preferably one with expertise in advising medical partnerships. Members of partnerships are individually liable for personal taxation.

The BMA offers a partnership drafting service and its Employers Advisory Service will check partnership agreements.

www.bma.org.uk/about_bma/benefits_for_members/bma_business_support/Partnershipagreementdrafting.jsp

Limited liability partnerships (LLPs)

What are Limited Liability Partnerships (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 hold property, employ people, enter into contracts 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 that 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 elsewhere.

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 1985 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.

Membership

Any legal 'person' can be a partner in an LLP, including companies registered under the Companies Act 1985, 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 with an annual turnover of less than £1m and a balance sheet total of less than £1.4m are normally exempt from this requirement.)

- 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. Individual members are self-employed and subject to Class 2 and 4 national insurance contributions.

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 share holding. 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 operating through a company limited by shares, a locum would lose their self-employed status.

'Never gossip about other practices.'
