



Locum GPs: the skills we need and how to achieve them



Royal College of
General Practitioners

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This document addresses the problems of training, support and governance of non-practice-based GPs. It focuses on locums but is also relevant to GPs in Out Of Hours organisations (OOH).

Locum doctors keep the show on the road. They provide a crucial flexibility in the workforce. At any one time around 25% of GPs are working as locums. These 15,000 doctors consult with around 36 million patients every year. Many GPs spend time working as a locum, especially at the beginning of their careers, and for some it is a long-term career choice. Yet GP training does little to prepare doctors for locum work. Trainers are practice-based and any experience they have of as locums is unlikely to be recent. Vocational training schemes give it little attention. The RCGP curriculum does not mention locums. The profession's governance systems are geared to practice-based GPs.

One locum's experience illustrates the challenges. In three months he worked in 40 rooms and in 20 practices varying from the well-equipped to the chaotic and even dangerous, in seven primary care organizations (PCO) areas. Six clinical software systems were used differently in every practice. He struggled with 20 different models of printer. He referred patients to six different district general hospitals as well as dozens of other secondary care facilities, using six different referral pathway systems, and saw around 2,600 patients, almost all for the first and only time. In three months most partners will not have stepped out of their own consulting room.

Good locums need to be flexible and adaptable, able to get rapidly to grips with each working environment, quick to evaluate and decide how to manage their patients, able to interpret poor patient notes and write good ones, and assiduous about hand-over at the end of each session. Since they work without the cushion of a practice structure they must be resourceful, organised and independent, but able to slot quickly into any team. They need good negotiating and business skills. Since they can only work as well as their working environment permits, they must be able to bear the risks contingent on enforced underperformance. They are particularly vulnerable to complaints, especially as many are newly qualified. Yet they are not being trained for the job or assessed by criteria which test these skills.

NASGP recognises the problems that locum and OOH work presents to those who do it, those who employ them, and those who educate and revalidate them. We offer an analysis of the needs and obligations of all parties, with the aim of benefiting the GPs, practices, the profession and most of all the patients. Locums are a substantial, vital and highly skilled, yet poorly served sector of the GP workforce. NASGP asks the profession's leaders to acknowledge the crucial contribution of the locum in patient care by providing training and support that recognises their special role.

Opportunities for practices and their patients offered by employment of good GP locums

Locums can be much more than a pair of hands filling a gap, both for patients and for practices. Practices which recognise this gain extra benefits from their locums, and working for them is more rewarding. The opportunities include the following:

- A fresh pair of eyes on the patients: locums not infrequently pick up problems that a regular doctor's familiarity with the patient has rendered invisible.
- A fresh approach free of baggage to embedded problems.
- An opportunity to consult with someone new for patients who have lost confidence in their usual doctor or have other reasons for not seeing their usual GP.
- An opportunity to (re)summarise notes and problems.
- A fresh pair of eyes on the practice: locums can spot risks in practices which familiarity has rendered invisible to regular staff. Examples include dangerous building and furniture; faulty equipment; out-of-date, poor or non-existent practice procedures for handling results and reports; confidentiality risks, risky repeat prescribing protocols.
- A source of ideas and experience: a doctor who visits many practices can share information about good and bad practice, and can provide informal performance monitoring.
- An opportunity to identify experience and skills which may be lacking in the practice and of which the practice can make use in the future, e.g. joint injection, psychiatric training, medical student education, GP training, mentoring.
- An opportunity to assess a doctor's suitability for a salaried post or partnership.
- A regular locum can provide workforce flexibility which may be cost-effective.
- A regular locum who knows the practice team can provide not just practical but also emotional support at times of crisis in the practice.
- A locum allows staff members registered at the practice an opportunity to consult with someone other than their employer.

Advantages of being a locum

Many GPs spend time working as locums or OOH doctors. For some it is a career choice, influenced by factors such as the following:

- Being your own boss: some choice about place and time of work to fit in with other careers, family life etc.
- The opportunity to experience practice in a range of social and professional environments.
- Financial advantages of self-employment.
- Professional satisfaction, including appreciation of grateful practices.
- Not directly burdened by PCO bureaucracy and diktats and free of responsibilities of running a practice, so able to concentrate on patient care.
- As a fresh pair of eyes, a real opportunity to make a difference to patients' care.
- Fulfilling a vital flexible role in primary care by supporting practice staff otherwise unable to fulfil their roles.
- An opportunity to assess the suitability of practices for a salaried post or partnership.
- Ability to take extended leave.
- At the end of a career, opportunities to reduce working week gradually.

Particular areas of risk for locums

Locums are doctors who are unknown to patients so they have no established relationship with them. They may be seen by patients as second best, especially if the receptionists convey that impression. They practise under conditions that are at best new to them and at worst dangerous, so it is easy for them to appear inefficient and lacking in knowledge or experience even if they have more of both than the partner they are standing in for. The following are areas of risk:

- Handover to a locum: every patient is new to a locum, and clinical records rarely respect the next GP's unfamiliarity with the patient.
- Hand over by a locum: need to wrap up and hand over all outstanding matters including concerns about patients, dictated referral letters and outstanding investigations.
- Unfamiliarity with practice systems including IT.
- Signing repeat prescriptions, especially in practices with poor repeat prescription traditions.
- Being signed on to practice computer systems as 'a locum' rather than with a unique identifiable username and password.
- Frequently, practices allow inadequate time both for consultations and for administration. Adequate time is especially necessary in practices where risks are increased by poor clinical records, poor organisation, lack of information and absence of support.
- Enforced underperformance, i.e. inability to practise to the best of one's ability due to practice factors outside of one's control (see below).
- Pressure to collude with substandard practice or to undertake activities out of one's competency.
- Being put in a position of risk due to poor briefing by practice, e.g. about safety procedures in the practice and risky visits outside it.
- Taking time off for illness, because it may adversely affect future employment prospects.
- Not taking time off for illness and putting not only personal health but also patients' health at risk. Not taking advice from own GP when necessary.
- Lack of job and financial security, and resulting risk of taking on too much work.
- Isolation, scapegoating and lack of support from practice when things go wrong, e.g. a complaint.
- Difficult to get follow up on investigations organised and referrals made, thus missing out on valuable learning tools.

Training and support required to prepare GPs for locum work

Whether non-practice-based doctors have chosen an independent way of life or had it thrust upon them, the profession has a duty to enable them to meet the associated challenges and responsibilities. Locums have to take personal responsibility for many aspects of their professional life which are provided by practices for partners. Appropriate recognition, training and support are required at all levels. Organisations such as 'locum chambers' offer locums the flexibility of the job but provide day-to-day governance and practical management of locum life. Aspects which need to be addressed include the following:

- Vocational training should include preparation for locum work, since most GPs will undertake this at some point in their careers. This should cover the realities of non-practice-based working and how consulting as a locum and a partner differs, and could include opportunities to shadow a locum or to exchange with other registrars to experience working in an unfamiliar practice. It could also include consideration of the qualities that suggest that a GP is or is not suited to locum work.
- Negotiation courses should be available to raise confidence and avoid learned helplessness and exploitation.
- Opportunities to acquire basic familiarity with clinical software systems, including locally-used but otherwise uncommon systems, should be available.
- A secure NHSnet email address and an Athens account should be provided for every locum to enable them to receive information from PCOs and the NHS cascades and to access Map of Medicine, NHS Clinical Knowledge summaries etc.
- Business and financial preparation: locums need to know about registering as self-employed, paying appropriate National Insurance contributions, contributing to NHS and/or other pensions, taking out suitable health insurance, setting up appropriate business and financial systems, considering services of an accountant and IFA; ensuring financial prudence and probity.
- Personal health: locum and OOH work is particularly demanding and a locum who works when unwell is unlikely to have the support that a partner may receive, and be at greater risk of making a mistake. Locums need adequate financial security and support to enable them to resist the temptation to put themselves and patients at risk by taking on too much work or working when not fit. They should register with, and make use of, a sympathetic GP, recognising it can be difficult for locums who work in all practices in their locality to find a GP with whom they do not have a relationship as an employee. Locums need to invest in their physical and mental health, and to ensure that they have proof of up-to-date Hepatitis B immunisation etc.
- Mentorship is a particularly valuable resource for isolated locums, who lack the support enjoyed by doctors embedded in a single practice team.

- Family health: locums should keep the needs and health of their family in mind.
- Locums need advice and support in establishing a professional approach to arrangement of work, e.g. clear agreed booking arrangements along the lines of the NASGP booking form; providing practices with CV and photo to be given both to staff and to patients; charging appropriately for additional work.
- Conscientious objections e.g. TOP, post-coital contraception, should be made clear to potential employers. Similarly practices should be informed of any procedures a locum is not competent to undertake e.g. IUCD insertion.
- Locums who can offer particular skills e.g. joint injections, IUCD insertion, should work with practices in advance so these can be taken advantage of.
- Locums should be charging practices enough so that they cover professional expenses and can take leave for study, revalidation and holidays. It is important that a locum can take time off without it affecting future employment.
- Enforced underperformance is a risk and reduces job satisfaction. Practices' obligations are described below. Locums can help to protect themselves by carrying their own equipment where practical, carrying useful documents, protocols and information on a security-protected memory stick; using on-line sources of information; or a secure portable device.
- GPs need specific training to develop the special clinical skills required to work as a locum: creating instant rapport, rapid history-taking, quick management planning and bearing risk and uncertainty; ensuring safe hand-over.
- Continual Professional Development (CPD) can be a challenge for locums. They are not always included in circulation lists for information about events, and unlike partners they do not have time and money allotted by contract for study leave. They need to ensure that they charge enough to take time out from clinical work for CPD, and they need to be particularly disciplined in attending and recording learning events e.g. courses and study days, practice meetings; and in keeping records of 'PUNs and DENs' or equivalent, and Significant Event Audits (SEAs).
- Support is needed to facilitate the inclusion of locums in professional communities. Locums need to protect themselves from professional isolation. Organisations which reduce professional isolation need to be supported, e.g. self-directed learning groups (SDLGs) for education, advice, support and local knowledge; locum chambers which provide clinical governance and learning and support. Primary Care Organisation (PCO) need to include all sessional GPs on their performers' lists in information/networking cascades and events. PCOs could give practices financial encouragement to include locums in practice-based educational events. Local Medical Committee (LMC) need to take active steps to involve locums and address their problems. Mentoring is particularly valuable for non-practice-based GPs.
- Preparing for appraisal and revalidation. The profession needs to work to ensure that appraisal and revalidation tests the skills needed by locum GPs and that evidence such as multi-source feedback (MSF) is judged against the standard of locums. It should not prejudice them by judging them on unnecessary skills or by comparing them inappropriately with practice-based GPs. Locums can take advice for local SDLG and NASGP on obtaining 'difficult' evidence such as MSF. Systems and processes,

comparable to those of practice-based GPs, need to be in place to facilitate the collection and analysis of professional data so that this evidence can be produced as effectively and as efficiently as possible.

- Appraisal. Appraisers who are partners need training so they appraise non-practice-based doctors appropriately. Locums can make use of appraisal to explain their difficulties, and to educate their appraisers, and to develop appropriate plans for the following year.
- Locums must not ignore bad or risky practice: The GMC guidelines outline their obligations when they come across an unsafe working environment (physical, organisational) or bad clinical care. They must feed back to the practice, raise it in a SDLG, and bring serious concerns to PCO clinical governance leads/LMC/GMC/defence organisation.

The role of the representative and educational bodies of GPs and practice managers in ensuring that practices meet their obligations as employers of locums

A locum is often engaged at short notice at a time of emergency, but that is no excuse for employment practices which are frequently poor and sometimes exploitative. Practices often fail to get the most out of locums, putting patients at risk as well as themselves and the locums they employ, and contributing to patient dissatisfaction, complaints, and a gulf of bad feeling between GPs who employ and GPs who are employed. Education in employment law, in good employment practice, in their role in enabling locums to practise safely are required. Representative and educational bodies have an obligation to the profession and to patients to demonstrate a culture of good practice, to provide appropriate training and support for practices, and to negotiate contractually-required standards where appropriate. The following illustrates aspects of good practice:

- A clear and secure booking process, with expectations on workload, time and remuneration clear on both sides, e.g. hours, length of appointments, extras, overruns, prescription signing, home visits, chaperones, billing and payment. Requests for extra work to be made politely, payment assured, and reasonable refusal accepted.
- Pay: paying fairly, properly and on time.
- Providing secure storage for locums' valuables (lockable drawers etc)
- A locum is not a partner in disguise: staff need to be educated to understand what a locum can do, what a locum cannot do (e.g. passports, most death certificates and cremation forms), and what a locum will require extra time to do safely (e.g. signing prescription, checking results).
- Giving locums information about the reason for the absence of the GP for whom they are substituting e.g. (long-term sick, suspended) as this may have a bearing on the way patients have been managed.
- Providing each locum with a unique username and password for the practice computer system. This contractual requirement is still not being universally observed.
- Allowing locums adequate time for the work expected of them: all patients are new to them, the systems are unfamiliar, tasks such as administration and handover are an essential part of the job.
- Providing a break during a long surgery, and access to coffee/tea.

- Recognising that signing repeat prescriptions is a particularly high risk area for locums: allowing adequate time (locums need to check all the notes) and accepting reasonable refusal (e.g. unreviewed risky medication, large quantities of benzodiazepines).
- Recognising that interpreting test results and imaging reports takes longer because the locum needs to check all the notes.
- Addressing locums' performance: appreciating good care and discussing different approaches constructively and following GMC guidelines if their performance has given rise to concern. This includes informing the locum clearly but supportively, allowing the locum to involve an MDO where appropriate; contacting appropriate bodies if locums' performance is seriously substandard.
- Education and feedback: inviting regular locums to practice meetings, educational sessions etc and being prepared to pay them to do so; involving them in SEAs; involving them in complaints; facilitating locums' requests for help with obtaining evidence for appraisal such as MSF.
- Taking advantage of locums experience: asking for feedback on the practice and taking their comments seriously.

The role of practices, PCOs and the profession's and practice managers' representative and educational bodies in reducing enforced underperformance

Locums have no control over the environment in which they work. All practices have their own culture and locums must become adept at understanding how practices do things. Practices have an obligation to ensure that their premises and organisational structure provide an environment in which locums (and all their staff) can work to the best of their ability. GPs' and practice managers' representative and educational bodies, and those with a responsibility for governance have an obligation to address through education and contractual requirements a problem which puts locums, and so patients, at risk. The following illustrate how enforced underperformance can be reduced:

- Giving locums adequate time to do their job i.e. realising that locums cannot work safely at same speed (let alone faster) than partners.
- Providing a 'locum pack', which should be in a standard form so that information can easily be found. The pack should contain adequate and up to date information on where to find equipment, forms and information, how to get things done, practice and PCO policies, printouts of websites of local hospitals etc. A locum needs time to look through the pack, and to add new information to it.
- Satisfying themselves that locums are competent to undertake tasks which they wish them to perform.
- Ensuring that equipment provided for locums' use is working, that instructions are available. This includes printers and dictation equipment as well as clinical items.
- If a doctor's bag is provided for home visits, ensuring that equipment is working and drugs are in date.
- Monitoring the standard of clinical records kept by regular doctors and nurses so that locums can be confident that the records are trustworthy and written on the principle that the next doctor seen by the patient may know nothing about them.
- Introducing locum doctors to staff and patients in a positive manner: 'just the locum' undermines the locum's status from the start and will thus have an adverse affect on patient care.
- Providing a briefing on how the IT system is used, including how urgent information is transmitted to doctors and how handover is managed.

- Providing an approachable named contact in the practice, or phone number if there is no-one in the building, whom the locum can ask for advice on IT problems, local clinical pathways and on difficult cases.
- Providing a tidy, comfortable and suitably equipped consulting room, so minimising need for an archaeological dig to find essential tools.
- Establishing a safe repeat prescription system with evidence that it is audited, giving a locum increased confidence to sign repeat prescriptions.
- Establishing safe arrangements for hand-over, e.g. print out appointment list and annotate it to indicate causes for concern, referrals, results awaited, patients to be chased up, patients who behaved unreasonably etc.
- PCOs can help to maintain good practice in their area by recognising their obligation and debt to locums who work in their area, whether or not they are on their performers' list, by understanding the realities of locum work; by actively involving locums, ensuring that they receive information cascades, making available training in all the medical software systems in use in their area, and ensuring that locums have access to occupational health services; and by monitoring practice standards of employment including availability of adequate locum information packs. PCOs can provide safe space for locums who need to blow the whistle on a practice.

Obligations of the profession

General practitioners do not have a good record as employers of their peers. Their expectations are too often unreasonable, their employment practices exploitative and their regard for their colleagues demeaning. OOH doctors are similarly often made to feel second class citizens. The profession, through its leading organisations i.e. the GPC and the RCGP, should set standards, should seek to improve its record and to restore unity to an increasingly divided body or members. The requirements include:

- Recognising 15,000 locums as a necessary, valued and uniquely skilled part of the workforce.
- Ensuring education and training appropriate for non-practice-based work. The current RCGP curriculum does not mention the word locum. The special skills (clinical and otherwise) required are outlined above.
- Ensuring support and governance structures, including appraisal and revalidation criteria, appropriate for non-practice-based GPs, and establishing the principle that data such as multi-source and patient feedback are judged against data from other non-practice-based GPs.
- Ensuring that GPs who are not practice-based have access to contractually required updates and training e.g. resuscitation, health and safety, child protection, smear-taking.
- Ensuring that locums are empowered to charge a rate which allows them to take the same time off clinical work during the working week as partners for courses, updates, in-practice and self-directed learning.
- Setting and monitoring practice standards that permit locums (and practice-based doctors) to practise to the best of their ability and without avoidable risk.
- Ensuring that the profession's local and national bodies (RCGP, local faculties, deaneries, LMCs and GPC) represent and support non-practice-based GPs as they do traditional GP partners.

Special issues for Out Of Hours GPs

Out of hours doctors are providing an increasing percentage of patient care. Much of the above applies also to OOH GPs e.g. poor staffing levels, faulty equipment, no breaks, personal safety, but there are additional points:

- OOH work tends to be relentless: reasonable length of sessions and adequate breaks are essential if doctors are to provide safe care.
- It needs to be recognised that OOH doctors are regularly assessing unknown and acutely unwell patients without access to their medical records.
- GP training needs to include the skills that OOH doctors need to exercise much more frequently than GPs working in practices, e.g. management of life-threatening emergencies.
- Proper training is required for telephone triage sessions, bearing in mind that GP trainers themselves may have little experience of it.
- OOH doctors regularly give patients medication; this needs to be properly stored and in date.
- Cars need to be properly equipped.
- Where tests and investigations are instigated by OOH GPs, the organisation needs safe systems for tracking, interpreting and acting on tests ordered by one doctor and reviewed by another and for ensuring that results are forwarded to the GP with ongoing responsibility for the patients care.
- Systems are necessary for dealing with patients who come to OOH services to request repeat prescriptions.
- OOH work offers limited opportunities to learn from outcomes, so audit of care is not easy. Organisations need to ensure that opportunities for audit are taken advantage of and that doctors are involved in SEAs.
- OOH doctors need to ensure safety netting and safe handover.
- Personal safety is a high risk with OOH work and employers need to ensure that their staff are not exposed to avoidable risk.

Freelance GPs working in other roles

GPs work in a wide variety of roles and require different competencies. Decisions need to be taken about how these skills are assessed. It should also be remembered that some GPs work for prolonged periods in restricted environments e.g. forces doctors seeing only young people and families, university health centre doctors, but they may return to traditional general practice and so need to maintain or refresh their skills and have them assessed. The roles include:

- Contraception and Sexual Health
- HIV
- Services for the homeless, asylum-seekers and other groups outside the general population
- Hospital GP support units – skills in between A&E and MAU
- Emergency care and walk-in centres
- Occupational health
- GPwSI
- Assistants in hospital disciplines
- Armed forces
- Student health centres
- Prisons and other secure environments
- Cruise ships
- Sports events and festivals
- Charitable work, including overseas, NGOs

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