Recent post from Paula Wright , North East rep for sessional Gps

GP Locums: Villains, Victims or Vanguard

Dear Simon Stevens,

I am writing following your recent visit to a GPC conference where you expressed concern about the 'casualisation' of the GP workforce in response to a question about the role of GP locums. I wanted to highlight some important points about the GP locum workforce.

GP locums provide a much-needed safety net for sporadic gaps arising from sickness, maternity or outside commitments such as commissioning work. They act as vital cross-pollinators of innovation, and as a fresh pair of eyes on difficult clinical scenarios. Locums who refuse to sign repeat prescriptions are often highlighting unsafe systems which have become embedded in stagnant teams, an effect of the siloed culture of general practice.

Locum work allows GPs with caring responsibilities, and other professional portfolios, the flexibility and boundaries around clinical work which they need to remain practicing GPs. Many talented clinicians would not take on vital leadership roles without this option.

Even a small shift into locum work can destabilise localities by setting off domino practice closures – however, general practice has been heading for the rocks for some time due to underfunding and recruitment and retention problems. Perhaps this is a much-needed impetus to radical change and the adoption of new models. Locums are stimulating the shoots of regrowth through new models of working like locum chambers.

GP workload is unsustainable, pushing many to leave or retire. Sessional GP groups and locum chambers help retain GPs in the workforce. Many sessional GPs would actually increase their hours if their working conditions were better. This is an unrealised potential in our workforce which can be tapped without the need for costly retraining or overseas recruitment.

Pejorative generalisations about lack of professionalism in locums who chase the highest bid at the expense of short-notice cancellations are offensive and unfair.

Locum indemnity is costlier due to supposed lack of familiarity with patients, systems and medical records, yet salaried GPs employed in multi-partnership organisations working in the same way are not subject to the same indemnity costs.

The additional funding NHSE has agreed to provide to cover rising indemnity costs will only reach those locums who are in a position to negotiate an indemnity-related rise in their fees. Where their local market does not sustain this they will be excluded from this NHSE initiative.

Locums have to meet the same requirements for CPD, appraisal and revalidation, and yet are often excluded from mainstream education, are not funded for appraisal, and can be barred from retaining nhs.net email addresses. Again recouping the rising costs of CPD and appraisal through fees relies on negotiating fee rises in the face of the downward pressure of published indicative rates.

GMC investigations have a disproportionate impact on GPs who locum, when compared to salaried and partner GPs, as future bookings and therefore income can be adversely affected by this, even before any fault is found. Patient surveys show that a doctor considered not to be the 'usual doctor' is predicted to receive lower ratings. This negative perception, grounded in the absence of an ongoing relationship, disadvantages many locum GPs, making them more susceptible to complaints and claims.

Currently, thousands of pounds of locum superannuation payments remain in a state of invisible limbo, while the processes for ensuring they reach personal pension accounts are subject to the worst scandal management gone wrong that many of us can remember.

The move into locum work can offer greater control over workload and hours and a safety valve for the careers of many GPs who might otherwise leave, but also offers the risk of exploitation by platforms like Uber, Pimlico, DPD and primary care equivalents.

Unlike chambers, online locum platforms and agencies may have restrictive clauses hidden in their terms and conditions that preclude the locum from settling somewhere unless the practice pays a fine of 15% of the GP's income for one year. Performance data held by platforms can be used for commercial gain, at the cost of fairness, with locums potentially discarded as commodities sometimes completely lost to the workforce, despite the investment of public funds in their skills.

In the US it has been argued we need a third category of worker distinct from the independent contractor and the employee, the 'independent worker' with some of the protections of employees like the right to collective bargaining and health benefits. For GP locums specifically we need to add to this better support for education and indemnity, inclusion in communications, better management of superannuation payments, and a robust system of workforce data collection which tracks their contribution.

A fifth of working age adults have tried to find work via 'sharing economy'platforms like Uber, and 11% succeeded. GPs mirror this wider societal trend: 10-25% of GPs are currently thought to work as locums. It is time to look upon this sector of the workforce with the respect they deserve. With support, locums can provide hope for general practice.

I would welcome the opportunity to meet with you to discuss further how together we can ensure locums continue to make a vital contribution to NHS primary care.

Paula Wright, North East representative for Sessional GPs
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