GP locum chambers

A modern solution for tomorrow's GP workforce:

P Newman, R Fieldhouse

Full report and start up guide

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A modern solution for tomorrows GP workforce
1.0 Executive Summary

In 2012 Dr Penny Newman undertook a review of the sustainability of GP leadership for commissioning on behalf of NHS Midlands and East SHA. This identified that GPs are under significant pressure due to increasing complexity of patient demand, changes in the GP workforce to more part-time and sessional roles, new commissioning responsibilities, poor access to GP locums and difficulties in recruitment with many GPs nearing retirement. New models of primary care were recommended to ensure sufficient GP capacity and capability as providers and commissioners in future.

This paper outlines how the innovative model of GP locum chambers can help address these challenges, options for development and how to get started. It is a resource for GPs, Clinical Commissioning Groups (CCGs), Commissioning Support Units (CSU) and others and aims:

- To encourage locum GPs to start a chambers themselves or join one already established
- To enable other local organisations to seed and grow interest
- To provide information on options for development, costs and benefits as a basis for local discussion.

This resource is published in two parts: The Executive Summary and a fuller description and start up guide available from penny.newman1@nhs.net. It accompanies work commissioned simultaneously by Penny Newman and Jill Matthews on behalf of the SHA from the Nuffield Trust and Kings Fund on new models of care Securing the Future of General Practice available from http://www.nuffieldtrust.org.uk/publications/securing-future-general-practice

1.2 What is a GP locum chambers?

Locum GP chambers are self-funding professional groups of locum GPs working as a ‘virtual practice’, supported by a team of managers and clinical directors. All business, professional and governance issues relating to the day-to-day engagement of all GPs in the chambers takes place within the chambers’ managed environment.

1.3 Why is chambers a good idea?

- To ensure a high quality of care provided by GP locums, who have ongoing support to meet revalidation requirements
- To meet with greater ease fluctuating and increasing patient demand and fill gaps in practice rotas due to holidays and sickness
- To encourage GP recruitment and retention, particularly in rural areas and inner cities where there are difficulties attracting new doctors
- To support commissioning by enabling GPs to be released from their practices and through providing a pool of experienced and flexible locum GPs as a local resource
- As an attractive alternative to a conventional partnership, salaried or independent locum contract, especially for increasing numbers of female GPs with childcare responsibilities and those with portfolio careers who want to work flexibly.

1.4 Why are chambers needed now?

The increasing complexity of patient needs and organisational and workforce requirements require consideration of new models of primary care beyond the small traditional full-time practice-based model. This includes the creation of a more highly organized, professional GP locum workforce as a buffer to fluctuations in supply and demand.

1.5 What are the benefits over locum agencies or being an independent locum?

- **Benefits for patients**: Patients receive better care from locum GPs who
  - Work within professional teams, as part of a managed organisation rather than outside of one
  - Have been vetted and are known locally
  - Understand the local health system and referral pathways
  - Have access to peer support and review
  - Receive regular up-to-date evidence based clinical information
  - Are organized and incentivized to provide excellent clinical care
  - Have opportunities to develop and flourish
  - Are supported to adopt rigorous revalidation processes.
- **Benefits for sessional GPs for GP locums**: a flexible working pattern combined with personal autonomy, a sense of belonging, reduced administrative burden, ease of booking and invoicing, peer support and reduced isolation, ease of revalidation, educational support and development opportunities. For salaried GPs: potential access to educational and career development, information cascades and peer support if isolated.
- **Benefits for practices** include assurance in filling sessions, simplified booking and invoicing, quality of care, trusted provider, patient satisfaction and complaints addressed.
- **Benefits for CCGs** include access to a pool of high quality locum GPs as back-fill, advisors and providers of newly commissioned GP services, with knowledge of good practice gleaned from working in multiple practices throughout a locality.
1.6 What options are available to create new GP locum chambers?

- Do nothing and continue to use independent GP locums and locum agencies
- Locum GPs create and fund their own local chambers
- "Hosting" a chambers such as linking the chambers to an out of hours provider, a GP provider organisation or CSU
- CCG commission a locum chambers
- Establish a local branch of an established network of UK chambers.

1.7 How much will it cost?

Funded by the GPs themselves, by sharing workload and infrastructure, the costs in joining the chambers are offset by the increase in efficiency and numbers of sessions undertaken. To start up a CCG wide chambers would cost in the region of £50,000, excluding savings to practices compared to the use of locum agencies.

The option appraisal indicates that principally due to an ability to use its infrastructure and IT, joining an already established national chambers would produce an earlier return on investment of 9 versus 63 years and deliver the greatest improvements in quality, access, recruitment and retention, support for commissioning and use of existing expertise. However, local models linking to arrangements already in place may create a greater sense of local ownership from locum GPs and practices, although take longer to establish.

1.8 How can we get started?

Initial steps include gaining a common understanding of this relatively new concept amongst GP locums and their agreement to participate. Managerial support and IT systems are needed for marketing, bookings and clinical governance.

1.9 Conclusion

The key driver in the creation of a successful chambers is leadership from local GP locums, building on their desire for autonomy while creating a sense of belonging to their chambers.

Where locum GPs do not want to take on the job of creating chambers themselves or with the support of other established chambers, the CCG, CSU or other local organizations can provide the necessary support to seed and grow interest and GP locum and practice membership.
2.0 Introduction and Overview

In 2012, NHS Midlands and East undertook a review of sustainable GP leadership for commissioning. This review identified that GPs are significantly over stretched due to increasing complexity of patient demand, changes in the GP workforce to more part-time and sessional roles, new commissioning responsibilities, poor access to GP locums, and difficulties in recruitment with many GPs nearing retirement. It recommended a review of new models of primary care to ensure sufficient GP leadership capacity and capability as providers and commissioners in future.

This document outlines how the innovative model of GP locum chambers can help address these challenges, options for development and how to get started.

This document is written for the NHS Commissioning Board, Commissioning Support Units, CCGs and GPs who want to commission or develop a locum chambers locally.

3.0 Market analysis

The following issues have been identified as placing a strain on GPs and practices in providing and commissioning services:

1. Practices often experience difficulty in accessing locum cover, especially at short notice and over holiday periods, to cover gaps in rotas, surges in patient demand and release GPs for commissioning.1,2
2. The quality of traditional locum cover may be variable, with high profile cases calling for a review of out of hours care.3
3. Some areas are experiencing difficulty in GP recruitment and retention with an ageing workforce and many GPs nearing retirement.
4. All GPs, including locums, are required to revalidate, while some locum agencies fail to comply with necessary governance processes.
5. Locum agencies may be variable in quality and costly to practices.
6. There are increasing numbers of salaried and locum GPs (sessional GPs) who account for approximately 40% of the workforce, and have been described as demotivated and disenfranchised, principally due to isolation (section 4.0).
7. There is a lack of career pathway for sessional GPs, a problem for succession planning and leadership in general practice in future.4
8. CCGs will need to commission more services based in the community and primary care, instead of high cost secondary care, which is likely to require additional GP capacity.

4.0 Sessional GPs

Sessional GPs (non-principals) consist of salaried, locum and retainer GPs. Sessional GPs have the same qualifications as contractor GPs.

- A salaried GP is employed by the practice and receives a salary for a fixed number of hours worked.
- A GP locum is essentially a freelance GP who can either work independently, through one or more locum agencies, or as a member of a chambers.
- A retainer GP has a part-funded educational contract intended for GPs with young families.

Currently between 40% and 50%5 of GPs are locum and salaried with higher numbers in England and London where up to two thirds of all GPs are now sessional6.

- The number of locum GPs is not recorded but estimated to be about 20%).
- Approximately 24% of GPs are salaried. Between 1999 and 2009 there was a nearly tenfold increase in the number of salaried GPs, while the number of contractor GPs remained roughly the same.

The majority of sessional GPs are young women working part-time. In a recent BMA survey, 70% of sessional GPs were women, compared to 43% of contractor GPs. According to the National Association of Sessional GPs (NASGP) database, 61% of locums are female.

Locum and salaried GPs choose these roles for a variety of reasons: to gain experience; identify a practice to work in long term; as a positive career choice; balance work and family life; as part of a portfolio; after retirement; to fit in with existing roles; and as partnerships are unavailable.14,15

The main problem that sessional GPs encounter as providers of care is isolation, often exacerbated by working part-time and out of hours, with poor access to educational meetings and information cascades which can impact on professional effectiveness in a number of areas:

- Lack of information about systems and support structures
- Effects on personal self esteem, motivation, confidence and empowerment
- Missed opportunities for professional peer interaction
- Increased risk of professional difficulties, due to missed opportunities for “benchmarking” and lack of feedback
- Unintended ignorance of protocols (“enforced underperformance”).16

Locum GPs are regarded as Doctor’s Outside Managed Organisations and so will receive a “heavier touch” in revalidation. GP locums may experience:

- Difficulty in recording and learning from significant events, either untoward or beneficial
- Lack of access to a unique username/password when signing into a practice’s computer system, so that any problems may be incorrectly assigned
- Low status and hence susceptibility to less positive feedback from patients and colleagues
- Problems in complying with complaints procedures and being unable to respond and change their practice accordingly
- Greater difficulty undertaking clinical audit.17

Equally, the engagement and participation of sessional GPs in commissioning is relatively limited although they will need to comply with new pathways, prescribing and referral patterns.

Recommended solutions to reduce sessional GPs isolation and improve career development and engagement in commissioning include: the creation of self-directed learning groups; a contact register to improve communication; education; support with project work; formal talent management and a change in mind set amongst GP partner colleagues – all of which can be delivered through the creation of a locum GP chambers for both locum and salaried GPs.
5.0 Definition of locum GP Chambers

GP chambers are self-funding professional groups of locum GPs supported by their own team of managers and clinical directors. All business, professional and governance issues relating to the day-to-day engagement of all GPs in the chambers takes place within the chambers managed environment. A typical chambers would consist of approximately 14 GPs averaging 5 sessions each a week, working across 50 different practices.

6.0 Service description GP locum chambers

Each chambers is equivalent to a 'virtual practice', with a team ethos of mutual co-operation and collaboration. Every member performs all their work for their chambers, and sessions that a requested individual can’t fulfill are allocated instead to another appropriate chambers colleague. GP locums in chambers work within professional teams, as part of a managed organisation rather than outside one.

The chambers manage all the non-clinical aspects of their members’ professional lives, leaving the member to focus on the clinical aspects of his/her work. In particular, chambers managers:

- Agree mutually beneficial terms and conditions in advance with GP locums and practices
- Coordinate and match practices’ urgent, short – and long-term needs with members’ skills and availability
- Find work and organise bookings, billing, invoicing, NHS superannuation and payment
- Have immediate access to all known locum availability from pre-populated calendars
- Can book and confirm all sessions instantly
- Operate a ‘Same Day Standby’ service to cover a practice if a GP falls ill at short notice
- Are able to enforce unique usernames and passwords in every practice to enable retrospective clinical audit and compliance with information governance requirements
- Create patient-friendly laminated A5 card profiles for every member which includes a photograph, list of qualifications and special interests and scannable QR code for patient feedback
- Issue all members with professional name badges, dense-laminated door name plates and parking permits
- Organise bi-monthly internal chambers meetings and regular educational and training events e.g. mandatory basic life support and child protection training

Members ‘crowd-source’ and share local and national clinical information on a shared IT platform. In this way, they are informed about prescribing protocols, educational events, contact numbers, referral guidelines, practice formularies and information about specific practices. Equally they are able to undertake peer review and compare audit data with other locums or across the chambers as a whole.

Within the scheme, established members can take on a leadership portfolio in any area:

- General clinical e.g. referral management, clinical guidelines, commissioning, education, revalidation
- Specific clinical e.g. women’s health, urology, dermatology
- Non-clinical e.g. liaison with RCGP, IT, social media.

A supportive environment, on-tap information, educational programmes and processes in place for feedback, audit and complaints ensure high quality of care as evidenced by the Medical Protection Society who offers a discounted ‘practice scheme’ to members of chambers and the NHS Revalidation Support Team who said of Pallant Medical Chambers “[freelance locum chambers]...not only elevates the standing of your doctors, it also sets example to the practices that engage you about how to achieve high quality”.

Due to the managed environment and flexible workload, GP chambers can also help support the rehabilitation of sick doctors, salaried GPs, GP training in the core skills needed by GP locums, or in future providing freelance nurse practitioners and practice nurses.
7.0 Benefits of chambers for patients, sessional GPs, practices, CCGs and the NHS

Note: Although members of chambers currently include mostly locum GPs, many of the benefits described below could, in principal, be also be made available to salaried GPs if not available from their practices, with or without the opportunity to take on additional locum work.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Without chambers</th>
<th>With chambers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost, access to locums and ease of booking</td>
<td>Locum agencies charge the practice a fee over and above the fee received by the locum.</td>
<td>Chambers are entirely funded by charging each member a percentage of their income, instead of charging the practice.</td>
</tr>
<tr>
<td>Efficiency of bookings and invoicing</td>
<td>Each locum has personal rates, T&amp;Cs and booking conditions. Usually manual.</td>
<td>Standardised Terms and Conditions (T&amp;Cs) and comprehensive data on every GP’s experience. Chambers has access to every member’s calendar, and is able to confirm booking by return when a practice requests sessions. Practice managers receive simple, monthly invoices.</td>
</tr>
</tbody>
</table>

**Quality of care**

**Sessional GP isolation**
Growing numbers of sessional GPs; GP demotivated and disenfranchised, principally due to isolation.

Chambers create a community of motivated sessional GPs with flexible contracts, peer support, opportunities for development and equitable financial reward.

**Dissemination of information**
Sessional GPs may be hard to reach and find difficulty keeping up-to-date with local clinical information.

Integrated chambers-specific IT platform enable members to access and share information from the CCG and local practices e.g. on prescribing and referral protocols.

**Education**
Ad-hoc.

Education and training organised in-house and open to non-members, such as local salaried GPs and partners.

**Quality of care**
Quality of traditional locum cover is variable.

Centralised continuous feedback through well established systems and processes. Effective channels of communication, support, built in audit, education and complaints procedures and a known bank of often long term locums who work exclusively for the chambers, which monitors performance and complaints.

**Revalidation**

<table>
<thead>
<tr>
<th>Patient satisfaction &amp; engagement</th>
<th>Variable.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaints</td>
<td>No active systems for reporting or reflection.</td>
</tr>
<tr>
<td></td>
<td>Reported immediately and involve an in-built mentor scheme, significant event reporting and support from lead partners and clinical directors.</td>
</tr>
<tr>
<td>Appraisal and revalidation support</td>
<td>Ad-hoc feedback structures.</td>
</tr>
<tr>
<td></td>
<td>Inbuilt records of locum activity and education. Chambers can facilitate audit, patient and colleague feedback.</td>
</tr>
<tr>
<td>Responsible Officer</td>
<td>Locum agencies do not all comply with necessary governance for revalidation.</td>
</tr>
<tr>
<td></td>
<td>As chambers members remain freelance and are not employed by the chambers, they fall under the jurisdiction of the RO assigned under their performers list registration. Revalidation services offered by chambers are developed with the approval of their local RO.</td>
</tr>
<tr>
<td>Recruitment, retention and succession</td>
<td>Little or no ability for CCGs to gauge capacity of locum GP workforce.</td>
</tr>
<tr>
<td></td>
<td>Locum chambers provide an attractive option for recruiting locums, for example, in rural areas. Their websites are able to advertise posts for salaried doctors.</td>
</tr>
<tr>
<td>Career pathway and succession</td>
<td>Lack of development and career pathway for sessional GPs. Problems for succession planning and leadership in general practice in future.</td>
</tr>
<tr>
<td></td>
<td>Multiple leadership roles within the chambers to enable clinical or non-clinical portfolio opportunities including with their CCG. Sessional GPs become more visible and high-status in local GP community.</td>
</tr>
<tr>
<td>Support for the CCG and commissioning</td>
<td>Lead CCG GPs have limited flexibility for meetings.</td>
</tr>
<tr>
<td></td>
<td>Locum chambers are able to coordinate CCG meetings around the availability of CCG GP leads and locums to provide the backfill.</td>
</tr>
<tr>
<td>Increase availability of GPs for CCG meetings</td>
<td>CCGs will need to commission services from primary instead of secondary care.</td>
</tr>
<tr>
<td></td>
<td>Provides flexible GP support for CCG commissioned services e.g. in A&amp;E, as well as ability for locum GPs with specialist skills to be utilized appropriately.</td>
</tr>
</tbody>
</table>

**Case study**

NHS Coastal West Sussex Clinical Commissioning Group CCG has had an active chambers since 2004. Members of that chambers have taken on significant commissioning roles in that CCG: an executive director; a programme clinical lead for planned care; a clinical project lead for urgent care; clinical advisor for ambulatory care and 5 other chambers members providing the “GP in A&E” service, as well as providing backfill for the commissioning duties of locality leads. In each case, the locums’ experience of working across multiple practices across the CCG, and their inherent flexibility, has enabled the CCG to focus on practices delivering their QIPP agendas.
8.0 Description of options for developing a chambers

The following description outlines the advantages and disadvantages of maintaining the status quo (do nothing) and of creating different models of locum chambers.

8.1 Do nothing

Locum GPs most commonly work independently as self-employed individuals or through anything up to 10 locum agencies at a time:

8.1.1 Independent locums

Any fully qualified GP can perform a surgery for any practice having registered on a PCT’s performer’s list.

- The advantages of being an independent locum include personal autonomy and self-employed status, a lack of overheads, choice of practice and flexible workload.
- The disadvantages such as variable quality, isolation and lack of career development are described in section 4.0. Locum GPs are not trained to be self-employed, running their own business, marketing, advertising, handling complaints, managing bookings, organising invoices, handling payments, accounts, quality improvement and continuing professional development.

8.1.2 GP locum agencies

- The advantages of working through locum agencies include effective management of tax and insurance, prompt payment on a weekly basis, finding, booking and confirming sessions, and handling all the invoicing and payments. Some agencies organise educational events.
- Disadvantages include the need for locums to be registered with multiple agencies and loss of NHS superannuation entitlement. Agencies are private companies, sometimes without appropriate clinical governance mechanisms.

8.2 Options in creating locum chambers

These are described below and include:

1. Chambers started and funded by local GP locums alone
2. Funded and hosted by a local organization e.g. CSU or provider organization
3. Pump primed or procured by a local organization e.g. CCG
4. Locum GPs create/join a “hub” of an already established chambers

<table>
<thead>
<tr>
<th>Options in creating GP Locum Chambers</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Chambers started and funded by local GP locums alone</td>
<td>Ongoing costs borne by the freelance GPs themselves e.g. for venues for meetings and booking management.</td>
<td>Members would need to use their own salaries and time to establish the chambers.</td>
</tr>
<tr>
<td>Ownership</td>
<td>The locum GPs would have a greater sense of ownership of their chambers.</td>
<td>Members assume a greater responsibility for the chambers successes and failures.</td>
</tr>
<tr>
<td>Leadership</td>
<td>From amongst the GP members themselves.</td>
<td>The chambers may not have the right mix of leadership and skills.</td>
</tr>
<tr>
<td>Lead-in time</td>
<td>Quicker start than if locums do it themselves.</td>
<td>Could take 6 months to train staff, develop and/or implement new IT platform.</td>
</tr>
<tr>
<td>2. Chambers funded and hosted by a local organization</td>
<td>Able to use the infrastructure of the existing organization.</td>
<td>Locum GPs tied to one provider.</td>
</tr>
<tr>
<td>Costs</td>
<td>Locum members would have little or no financial risk tied into ownership of the business.</td>
<td>More equivalent to salaried role. There may be conflicts of interest if funded or managed by organizations owned by purchasers of their service. Contractual obligations e.g. to provide out-of-hours services may be off-putting and reduce membership. Websites added to existing ones may lead to technical difficulties.</td>
</tr>
<tr>
<td>Ownership</td>
<td>From amongst the GP members themselves.</td>
<td>The chambers may not have the right mix of leadership and skills.</td>
</tr>
<tr>
<td>Lead-in time</td>
<td>Quicker start than if locums do it themselves.</td>
<td>Could take 6 months to train staff, develop and/or implement new IT platform.</td>
</tr>
<tr>
<td>3. Chambers pump primed or procured by a local organization e.g. CCG</td>
<td>Resources at the disposal of the CCG who could procure a chambers in a relatively short space of time.</td>
<td>Competition on price may result in a provider who may not have local ownership and engagement.</td>
</tr>
<tr>
<td>Costs</td>
<td>Locums may feel disenfranchised as CCGs are accountable to member practices causing potential conflicts of interest.</td>
<td>Other priorities and procurement may lead to delay.</td>
</tr>
<tr>
<td>Ownership</td>
<td>If investment is significant, could be within 6 months.</td>
<td>Other priorities and procurement may lead to delay.</td>
</tr>
<tr>
<td>Lead-in time</td>
<td>If investment is significant, could be within 6 months.</td>
<td>Other priorities and procurement may lead to delay.</td>
</tr>
<tr>
<td>3. Locum GPs create/join a “hub” of an already established chambers</td>
<td>No setup costs or other ongoing costs.</td>
<td>For example, costs initially 0% for 6/12, then 5% for 6/12, then 10% management fee, including VAT (cost borne by members).</td>
</tr>
<tr>
<td>Costs</td>
<td>Members have full control on rates and say in running the business.</td>
<td>Will be initially managed from remote area e.g. West Sussex, Yorkshire. Requires ideally 5 locums to join.</td>
</tr>
<tr>
<td>Ownership</td>
<td>Potentially optimal for members owning shares in parent company. Local manager employed when reach approx. 8 WTE members.</td>
<td>May feel a lack of local autonomy as payment initially made to, and decisions made by, a private and geographically distant company.</td>
</tr>
<tr>
<td>Leadership</td>
<td>Each chambers has a chambers lead partner. Leadership portfolios are an existing part of established chambers.</td>
<td>May feel a lack of local autonomy as payment initially made to, and decisions made by, a private and geographically distant company.</td>
</tr>
</tbody>
</table>
## 9.0 Resource requirements and costs

Cost of chambers membership is based on a percentage of the member’s income. The chambers generates all its income as a payment from the locum as opposed to a locum agency which generates its income from a practice. Unlike an agency locum, GP locums retain their self-employed status and ability to make NHS superannuation contributions. Although there is a cost to the members averaging 10% + VAT of all their locum income, the benefits and improved booking systems result in a net gain for members through tax benefits, greater efficiency and reduced medical defence costs.

For example, the membership cost model adopted by Pallant Medical Chambers:

- 0% of income deducted for a limited period for the first few ‘pioneer’ members in a new area
- 5% of income deducted for chambers lead partners
- 10% of income deducted for established members
- 15% of income deducted for a limited period for new members in an established chambers.

The model relies upon all members within each separate, distinct chambers agreeing the same rates to charge to allow practices consistency in pricing and immediate continuity should an absent locum need cross-cover in the event of being taken ill. In order to fulfill a judgment made by the Office of Fair Trading, all members of a chambers must therefore only trade as part of that chambers, and not independently.

### 9.1 Start up costs

In establishing a locum chambers using options 1-4 above, there will need to be an initial investment to provide funding to cover the start up costs. The anticipated investment required will be the same for the chambers set up by GP’s or a hosted local organization e.g. Commissioning Support Unit or procured by the CCG itself. The startup costs associated with joining or becoming “a hub” of a national chambers would be lower due to the infrastructure already established. Table 3 sets out the startup costs expected for the various options.

The costs in Table 3 are made on the assumption that a CCG wide locum chambers is required. In this instance, all four options will need time invested in marketing the concept to GP practices and gaining locum GP membership. It is envisaged that targeted road shows as well as mail shots would be required.

### 9.2 Annual Running Costs

For the purposes of calculating the annual running costs (and return) the following assumptions have been made:

- Figures are based on a chambers that has 10 GP members.
- Each session costs £225 although the rate nationally is variable, and would be determined by members in each chambers.
- Each member would be available for at least 5 sessions per week for an average of 46 weeks per year.
- The GP members would pay the chambers 10% of their sessional rate.

The Managers salary includes on-costs and assumes a 20 hours per week at a salary equivalent to an Agenda for Change band 4. The clinical lead has been based on 26 sessions per year at a rate of £225 per session. The Clinical Director would effectively be paid a retainer of £20k per annum.

The role of the Clinical Director is to generate membership, oversee recruitment and quality of GPs, liaise with practices, manage significant events and complaints, take on a strategic role in establishing the chambers specialist services e.g. minor surgery, liaise with the CCG, manage any chambers staff and ensure the efficient running of the IT system. Established chambers may have more than one clinical director to cover particular roles e.g. finance, IT and procurement, HR, training, mentoring and appraisal, clinical governance, quality, complaints and significant events, marketing and development, strategic development.

The chambers would provide training to its members but as detailed in section 6 this could extend outside of just members and a small element of income has been included for training of non-members.

### Table 3: Start up costs

<table>
<thead>
<tr>
<th>Locum GPs set up their own</th>
<th>Hosted by a Local Organisation e.g. CSU</th>
<th>Pump Primed by CCG</th>
<th>Hub of Nationally Established Chambers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Marketing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practices</td>
<td>£150</td>
<td>£150</td>
<td>£150</td>
</tr>
<tr>
<td>Locums</td>
<td>£400</td>
<td>£400</td>
<td>£400</td>
</tr>
<tr>
<td>Marketing general</td>
<td>£500</td>
<td>£500</td>
<td>£500</td>
</tr>
<tr>
<td><strong>Project Management</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Manager</td>
<td>£19,500</td>
<td>£19,500</td>
<td>£19,500</td>
</tr>
<tr>
<td>Clinical Director</td>
<td>£30,000</td>
<td>£30,000</td>
<td>£30,000</td>
</tr>
<tr>
<td>Office Equipment</td>
<td>£2,000</td>
<td>£2,000</td>
<td>£2,000</td>
</tr>
<tr>
<td>Legal Costs</td>
<td>£1,000</td>
<td>£1,000</td>
<td>£0</td>
</tr>
<tr>
<td><strong>Infrastructure Investment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Web Site Design</td>
<td>£300</td>
<td>£300</td>
<td>£0</td>
</tr>
<tr>
<td>IT System</td>
<td>£45,000</td>
<td>£45,000</td>
<td>£0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£98,850</strong></td>
<td><strong>£98,850</strong></td>
<td><strong>£52,550</strong></td>
</tr>
</tbody>
</table>
The start-up costs (Table 3) for the 4 options would be met from different sources. If the GP’s establish their own chambers the pioneers will need to fund the start up costs. The hub of nationally established chambers would absorb the start up costs in order to gain business. A model hosted by a local organisation or pump primed by the CCG will require investment funding provided by the NHS.

The annual running costs shown in Table 4 provide the annual surplus based on the assumptions used. The return on investment shows that with the higher set up costs of the first 3 options it would take 63 years to repay the set up cost investment whilst the final option which takes advantage of an established national infrastructure would repay its investment within 9 years.

9.3 Cost savings

Example: If an independent or locum chambers GP charges £225 for an “average” afternoon surgery, and works on average 5 sessions per week for 46 weeks, the cost to the local health economy would be £51,750 per annum per locum. For a CCG with about 300 GPs partners and 60 salaried GPs, and a population of approximately 480,000, one would expect approximately 60 GP locums working an average of 5 sessions per week i.e. a total cost of £3,105,000 per CCG.

Locum agencies offer sessions to locums for anything up to £840 per day, then charge the practice an additional management fee of between 20% and 30%. This is equivalent to an approximate cost of £525 per session, or £120,750 per locum per year based on 5 sessions, or a total cost of £7,245,000 per CCG.
10.0 Option Appraisal

The 5 options including “do nothing” have been assessed against 5 areas of benefit described in section 7.2. A weight has been assigned to each benefit depending upon its importance. For each option the 5 areas of benefit are scored out of 10 with 10 being the highest level of benefit.

The weighted score is achieved by multiplying the score by the benefit weighting to create a total weighted score for each option.

Table 5 provides the ranking of each option in terms of aggregate benefit. The option that would deliver the highest level of benefit would be for GP locums to create a local hub of a nationally established chambers.

<table>
<thead>
<tr>
<th>Weight</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do Nothing</td>
<td>Hosted by a Local Organisation e.g. CSU</td>
</tr>
<tr>
<td>Maintaining Quality</td>
<td>40</td>
</tr>
<tr>
<td>Access to Locums (ease of booking)</td>
<td>20</td>
</tr>
<tr>
<td>Recruitment &amp; Retention &amp; Succession</td>
<td>25</td>
</tr>
<tr>
<td>Support Commissioning</td>
<td>10</td>
</tr>
<tr>
<td>Existing Expertise Established</td>
<td>5</td>
</tr>
<tr>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

Table 5: Option Appraisal

11.0 Conclusions

There is current difficulty in attracting and retaining high caliber GP locums at the same time as an increase in demand due to rising patient needs and expectations, problems in GP recruitment and new GP commissioning responsibilities. GP locum chambers can help address these challenges.

Patients would be better served by the presence of a high quality and well motivated locum GP workforce. The benefits to the NHS include reduced cost compared to locum agencies, reduced variation in quality of GP locum care, additional and flexible capacity to match fluctuations in demand and greater adherence to new pathways. The benefits to practices are ease of booking and confidence in a known pool of locums, while locum GPs themselves benefit from having a more robust, supportive, secure and efficient – yet still flexible – base from which to work.

The key driver in the creation of a successful chambers is leadership from local GP locums, building on their desire for autonomy and creating a sense of belonging to their chambers. Where there is less enthusiasm for them to take on the job of developing local chambers independently – either by themselves or with the support of an established chambers – there is a crucial role for the local CCG or other local organizations to procure or provide the necessary support and generate interest.

The option appraisal indicates that joining an already established hub of a national locum chambers provides the greatest benefit. Lower IT costs create greater surplus after initial investment, produce an earlier return on investment (9 compared to 63 years) and would deliver the highest level of benefit when ranked according to improvements in quality, access, recruitment and retention, support for commissioning and use of existing expertise. However, local ownership from locum GPs and practices is critical and an important consideration amongst others when deciding which model to adopt.
Appendix

Getting started – A “how to do it” guide for GP locums who want to establish a chambers

1. Start collaboration – between local freelance GPs
   Agree a small amount to set up a local information hub.
   • Start a blog to act as the central information hub.
     - www.wordpress.com
     - www.blogger.com
   • Meet your local primary care organisation/CCG to explain aims and ask to receive all their alerts that go to practice managers.
   • Identify managerial skills to help out and to arrange a venue and time and get everyone together to discuss plans and local educational topics.
     - www.doodle.com

2. Safety – Effectiveness
   • Nominate a lead or one of you to take turns to record everyone’s bookings that can also be accessed online.
     - www.google.com/apps
   • Agree ground rules for making bookings – everyone must have a username/password for every practice IT system.
   • Confirm everyone’s bookings by email.
   • Design a patient-oriented profile for each member – photograph, qualifications, background, training etc. and print these out for receptionists to give to patients.
   • Now that you’re meeting up regularly – organised by your chambers manager – put aside regular time to get feedback from members about each practice so that you can collectively constructively provide feedback to your practices.

3. Professionalism
   • Give your newly created collaborative a name to reflect the way you’re working: “chambers”, “cooperative” or “collaborative”
   • Arrange for everyone to have proper name badges and doorplates, and make sure you have your new chambers name on them too.
     - www.simoney.co.uk
   • Programme in some social time – perhaps a meal out, or a coffee morning?
   • Set up a protected Facebook group, Google+ page or Google user group.
   • Organise some informal educational evenings and invite other local GPs along too, whether or not they belong to your chambers.
4.0 Esteem/Performance

- Develop feedback forms, or adapt some of the free ones on the NASGP website, and publish them on your website so that you can all access them from any surgery or home.
  - www.nasgp.org.uk

- Since you’re now always logged in under your own username/password – all arranged (and enforced!) by your chambers managers – your chambers colleagues and other practice GPs will be able to see your consultations and be in a good position to give feedback about you.

- Because patients now see your GP profiles – you’re no longer ‘just a locum’ – and see your name badges and door plates, asking for their feedback will be a lot more relevant.

- As well as encouraging practices and other members for feedback, make sure you team up to provide feedback for practices.

- Perhaps this is a good time for you to nominate one of you to be your chamber’s lead or clinical director.

- Think of a simple topic to audit and create a brief on-line survey and put the link to it on your website (hidden by a password) for all your chambers colleagues to contribute to.

- See if your chambers members want to meet up one-to-one in a mentoring-type relationship to discuss cases?

5.0 Self-actualisation/Success

- If some of your have particular special interests, develop a special service that your chambers can offer to local GP surgeries or your CCG?

- With your managers, you’re in a very strong position to organise cover across many practices.

- Why not forge a formal link with your local RCGP faculty or LMC?

- Or meet up with your local primary care organisation – such as a CCG – and see if there’s a role there for you.

- As you grow in number, allow members to be ‘partners’ within your chambers – each partner have the autonomy to use their special interest to further the ethos of your chambers. These lead partners could take a lead on education, or referrals, IT or clinical guidelines.

6.0 History of GP Locum Chambers

The concept of freelance GP locum chambers was developed by locum GPs as a solution to their professional isolation. In March 2004 South East Hampshire Primary Care Trust (PCT) identified an urgent need for a well organised, high quality group of GPs and offered to ‘pump-prime’ a 6-person freelance GP chambers – Pallant Medical Chambers – in Chichester, West Sussex.

Since then, that group of 6 freelance GPs in Chichester has become a larger collection of chambers and has grown to over 70 current members working across 10 different smaller chambers, mostly around south-central England but also in Avon, Surrey, South West London and Essex. In addition, in date, 3 other chamber collectives, all operating in a similar fashion, have been set up by local locums, bringing the total number of freelance GPs currently working in the UK to over 110 across 15 different smaller chambers.

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