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# Support for Sessional GPs

Report for Royal Medical Benevolent Fund

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## FOREWORD

Are sessional General Practitioners (GPs) the profession's current 'lost tribe'?

With more doctors gaining the qualifications to register as GPs but fewer partnerships available, sessional GPs are certainly a growing tribe, and each year brings more locums and salaried appointments.

Do we know what they consider their needs are and what support is available to them? Do we even know how many sessional GPs there are? Or how many qualified GPs are drifting away from clinical practice because of apparently insuperable obstructions in combining their personal and professional lives?

At the Royal Medical Benevolent Fund we've known for some time that locums can be particularly vulnerable if accident or illness strikes, because they don't have the same employment protection as their colleagues who have salaried contracts. As the leading charity for the medical profession, we've provided financial support and specialist money advice for doctors and their dependants in times of need and are aware at first hand of the problems that can happen to sessional GPs. We aim to help doctors return to work, where feasible, and to retain dignity and self sufficiency, where employment is no longer feasible.

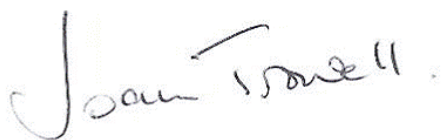
Our Trustees alerted us to the problems recently qualified GPs are facing and we decided to find out more. In order to understand the scope of the issues faced by sessional GPs and the support available to them, we commissioned researchers at Durham University. Their previous work for the Northern Deanery and the research they had undertaken for the RCGP into the revalidation of sessional GPs meant they were particularly well placed to shed light on this group of doctors and we are pleased to be able to present their findings.

To complement this work, we have also undertaken an in house project, looking into the viability of supporting Self-Directed Learning Groups for sessional GPs; the findings of which are available on our website, [www.rmbf.org](http://www.rmbf.org)

We would like to thank the research team at Durham and Dr Paula Wright, for an in-depth report which brings together a mapping exercise to identify how many sessional GPs there now are, a thorough review of the relevant literature, and research among both sessional GPs and those working with them.

The researchers identify that some progress has been achieved in recognizing the needs of sessional GPs over recent years and in meeting these in some areas. The resourcefulness of sessional GPs in creating their own networks of personal support says much for their professionalism – but this project has identified that more remains to be done, particularly with the implementation of Revalidation, in accepting that there is still a need to develop systems to include and not exclude sessional GPs, if their training and skills are not to be lost to the profession and the NHS in the future.

We hope that this research will highlight the issues currently faced by sessional GPs working in the UK and so encourage dialogue amongst key decision-makers in order to implement policies and structures to support sessional GPs in their careers, in the best interests of patients, the profession and sessional GPs themselves.



Joan Trowell  
Chairman  
Royal Medical Benevolent Fund

# EXECUTIVE SUMMARY

## Background

“Sessional GP” is an umbrella term used to help define fully qualified GPs (i.e. not GP registrars) who are not conventional partners in a practice. The term ‘non-principal’ was in common use until 2006, but was felt to be too negative. Sessional GP refers to freelance GP locums, chambers-based locum GPs, salaried GPs contracted to a practice or a PCT, GPs working exclusively for Out of Hours Organisations and GP retainers. Sessional GPs have long been recognised as experiencing professional isolation encompassing lack of contact with peers, exclusion from information cascades, poor access to education and low status. A number of organisations including the NASGP, BMA, deaneries and local sessional GP groups have brought about important improvements in this situation. Reforms in general practice mean that numbers of salaried GPs have grown sharply. The number of locum GPs remains a minority (though exact statistics are not routinely collated and this group remains the most vulnerable in terms of professional isolation).

## Aim

To explore the support needs of sessional GPs and how these are being met using a range of support system models.

## Method

This is a mixed methods study. An open ended survey was distributed by email to members of the virtual Advisory panel to gain an overview of issues regarding support for sessional GPs and to help inform data gathering.

1. A mapping exercise was carried out to provide information on the number, type and location of sessional GPs in the UK.
2. A literature review and information search were conducted to report on any published research in the subject area and to provide information on support networks and organisations across the UK.

A combination of qualitative and quantitative methods was used to identify issues faced by sessional GPs and the contribution of self-directed learning groups (SDLGs) and other forms of support:

3. An electronic survey was distributed to all deaneries across the UK to provide information on educational and wider support offered to sessional GPs and how this was provided i.e. by educators with special responsibility for sessional GPs or by the wider deanery network. The survey was piloted with three experts working in the field of support for sessional GPs.
4. An electronic survey was distributed to sessional GP groups and locum chambers across the UK to provide further information on the format and function of these groups, any strengths or difficulties, and any sessional GP needs that the groups were unable to meet. This survey was also piloted with three experts working in the field of support for sessional GPs.
5. Focus groups were held with sessional GPs, including members of sessional GP groups and SDLGs, to identify issues faced by sessional GPs, current sources of support and any unmet needs, and to explore factors which enable or inhibit success in a support group. Focus groups were supplemented by telephone interviews where necessary.

## Findings

The number of salaried GPs has risen sharply in the UK. There are no robust systems for counting locum doctors, and the possibility of legal dual registration (in Scotland in more than one board) or unintended dual registration in England further exacerbates this difficulty.

### Issues faced by sessional GPs

Isolation was a major theme identified in all sources of data in this study as well as in previous literature.

The Deanery survey revealed that isolation was reported to impact on three main areas: lack of information about systems and support structures; effects on personal self esteem, motivation and empowerment and, thirdly, missed opportunities for professional peer interaction (for example to discuss significant events [SEAs], benchmarking against peers or discussion of challenging cases).

Isolation was also the predominant issue identified by sessional GPs themselves, especially those doing odd sessions or locuming in a single practice. Factors felt to contribute to isolation were lack of contacts with other sessionals or other GPs within the practice, poor access to meetings and poor access to peer support networks. Other effects of this isolation were poor access to information and, for some, insufficient access to educational opportunities and a lack of feedback. The culture of the practice also impacted on some salaried GPs' perceptions of status and fairness within the practice.

Deanery educators reported that sessional GPs missed out on information cascades from PCTs, relating to education and other developments (guidelines and services). However some deaneries are working with PCTs to address this, with data protection issues creating barriers which could be overcome through pro-active management of performers' list information. Appraisal and revalidation were also identified as an issue. Sessional GPs experienced lack of support with data collection and in being equitably funded to participate in appraisal on the same basis as partners.

# SUPPORT FOR SESSIONAL GPs

## • Sessional GP groups

These groups were reported by sessional GPs to be beneficial in helping reduce isolation and providing education, information on educational events and job vacancies. These groups were felt to be of particular value to GPs new to the area and newly qualified GPs.

Groups were largely funded from membership fees and run by volunteers, with the majority receiving no support from external organisations, though many maintained links with deanery tutors. Common difficulties reported by groups included struggling with lack of funding, lack of administrative support, difficulty recruiting volunteers to run the groups and variable attendance at meetings, particularly where the membership was geographically dispersed or very transient. Needs that sessional groups felt they were unable to meet were around support for appraisal and revalidation, advice on contractual issues, mentoring, fora for SEAs and support for newly qualified GPs.

## • Locum Chambers

Locum Chambers provided a shared administrative and booking system for locum work, with fees set by the group, and members pay a percentage of their sessional income towards the shared management costs. Chambers also provided educational, professional and peer support and support for locum doctors with health difficulties. There was a considerable investment of unpaid time in setting up and running Chambers, with no external funding, and it was considered that new Chambers would need a lot of support in getting started, although once established they are self-funding and financially independent. Locum respondents however reported high levels of satisfaction with working in this model, mainly relating to additional opportunities for professional peer interaction to discuss clinical work, and support for the booking/administrative and evidence collection aspects of locum work.

## • Self-Directed Learning Groups (SDLGs)

For the purpose of this study these groups were defined as “groups of GPs who meet for education and peer support without any paid or unpaid external facilitation”.

The autonomous and informal nature of these groups means there is no central or regional register for these and thus no means to establish their prevalence at present except through a GP population survey (which was outside the scope of this project).

Focus groups and interviews revealed that these groups were reported by members to be informal, without ties to any organisations (e.g. Primary Care Trusts (PCTs), or deaneries). The optimal size of groups was between six and eight members, with meetings being held at members’ houses in rotation at intervals of approximately four to six weeks, usually on a set day of the week.

The format of the group meetings usually included: a social “catch up”, educational slot (e.g. presentation or case discussion) and planning of future meetings. Activities included: clinical topics, feedback on educational/training events, case reviews, significant events, journal article discussion and discussion of audits. Some groups had a journal club and summarised journal articles. Meetings were documented or minuted and this was found to be useful for evidence in appraisals.

Groups tended to be informal in nature with a flat structure. Elements for a successful SDLG included the need for a sense of ownership by members, explicit ground-rules, personal commitment, regular review and rapport. Perceived benefits of SDLGs were peer support (both professional and emotional), providing a learning environment and evidence for appraisals.

Groups varied on the degree to which they planned meeting activities, with some planning a few months ahead and others working on a “turn up and share” basis. Groups had formed either as a continuation of Membership of the Royal College of General Practitioners (MRCGP) study groups or as a result of tutor facilitated initiatives to promote networking and understanding of the SDLG model.

The Deanery survey revealed that many educators with a dedicated role regarding sessional GPs had played a role in helping set up SDLGs. Attributes of successful SDLGs reported by deanery educators included: individual attitudes or behaviours such as being motivated, committed, open and trustworthy with a willingness to share experiences; and having good organisation, for example, clear ground rules, set days to meet, and reviewing of feedback and organisation within the group. Size also seemed to be important: groups should be small enough to enable all members to contribute and allow supportive trusting relationships to develop, but large enough to allow for non-attendance (approximately six-eight members). Other important elements were having a shared outlook and similar attributes such as age and stage in life.

It was reported in both these sets of data that at the setting up stage facilitation of networking and guidance were useful, and for established groups opportunities to share experiences between groups would also be of value.

## **Discussion and Conclusion**

A number of developments have contributed to the improvement in working status and conditions of sessional GPs be they employed or locums. Salaried GPs have benefited from the introduction of paid CPD time in contracts of employment for salaried GPs, greater support via deanery led initiatives such as the Flexible Career Start scheme and other supported salaried schemes (e.g. retainer scheme; returner scheme) etc. Locums have benefited from the professionalisation of their image through the NASGP, and better local peer support through local sessional groups. Both groups have benefited from educator conferences where models of good practice have been shared between deaneries, the increased understanding of sessional GPs arising from their scrutiny in appraisal; and the development of web and email means of networking and of online education which is subject to fewer access problems than traditional GP education events.

It was evident from this research that there are different strategies being used to address the issues faced by sessional GPs and these are fulfilling different needs, but there are still barriers to support.

Some of the barriers to accessing education identified in the SCOPME report such as time, money, family commitments and lack of information continue today despite high profile reports recommending a more inclusive approach by PCTs in including sessional GPs in their information cascades. Sessional GPs working in Out of Hours organisations and Prisons particularly suffer from lack of support, professional isolation and problems accessing education.

This report is the first study into the roles of and issues facing local Sessional GP groups and Locum chambers. It also identified in detail the role of and benefits provided by SDLGs as well as the features which makes these successful. Facilitating access to SDLGs and supporting the further development of these groups and enabling them to share and learn from each other could further their contribution. Information sharing between sessional GP groups, deaneries, PCTs and locum chambers would also be of value. Sharing approaches and examples of good practice between deaneries via national conferences focusing on sessional GPs has been crucial and needs to continue.

Current developments in, for example, professional regulation and the introduction of revalidation have further implications for sessional GPs and their support groups, which need to be examined by all those with responsibility for, or interest in, support for sessional GPs.

## **Suggestions for Further Research:**

Out of hours organisations and prisons - focused research looking at ways in which their GPs can be better supported, have more opportunities for discussion with colleagues, give and receive feedback, and have help with obtaining evidence for appraisal and revalidation.

## **Suggestions for Implementation:**

Information sharing between organisations

- Opportunities for Sessional GP groups to share experiences specially to address common dilemmas of sustainability
- Need for more sharing between SDLGs on their methods and models- Need for deaneries to pro-actively support creation of SDLGs
- Need for more sharing of knowledge between deanery educators involved in sessional GPs
- Opportunities for PCTs to learn from Sessional GP groups, chambers and deaneries about sessional GP issues
- PCTs should be surveyed about their approach to supporting sessional GPs (including them in cascades by email; including them in education and appraisal)



## Summary Tables

The following tables summarise key findings regarding isolation; the impact of recent developments regarding support for sessional GPs; a summary of support needs of sessional GPs and organisations meeting these support needs, and a summary of our evolving understanding of self-directed learning groups.

**Table1: Risk Factors for Isolation**

Risk factors for becoming isolated	Aspects of Isolation	
	Social (not meeting peers)	Communication (not on distribution list for cascades)
Being newly qualified	Loss of contact with trainer and scheme colleagues	
Being new to an area		Takes a while for PCTs to add doctors to their distribution lists
Working as a locum	Often only one locum in a surgery, and rely on sessional GP groups to meet other locums, also mobility and no practice base	Missed where cascades are purely distributed via practices
Being salaried	Often only one or two in practice; Practice meetings scheduled around partners so they miss these	
Working in prison	Usually work in isolation	Yes
Working in OOH organisations	Few if any meetings with colleagues and work in isolation	Yes
Working few hours	Often scheduled to work on partners' day off so meetings scheduled for days when all partners are in.	
Working in a rural practice	Difficulty accessing Sessional GP groups and SDLGs, meeting peers	

## Effect of Isolation:

Personal	Professional	Organisational
Demoralisation, anxiety, lack of confidence, feeling undermined and poorly supported, demotivated	<ul style="list-style-type: none"> <li>• No benchmarking against peers</li> <li>• Less access to education</li> <li>• Lack of career progression</li> </ul>	<ul style="list-style-type: none"> <li>• Working outside protocols therefore inappropriate use of services, inefficiencies and complaints</li> <li>• Not feeding into SEA discussions</li> </ul>

**Table 2: Developments and their Positive Impact on Support Needs and Issues for Sessional GPs**

	<b>Isolation</b>	<b>Education</b>	<b>Status</b>	<b>Other</b>
Increasing numbers of salaried GPs (PMS, new GMS contract)	Yes		Yes	
Schemes for salaried GPs (career start, LIZEI, returners, Flexible career scheme, returners)	Yes	Yes	Yes	
Locum gaining access to NHS pension scheme			Yes	
Wider use of email	Yes	Yes		
NASGP role in advocating for sessional GPs and supporting local groups	Yes		Yes	
Increase in sessional GP groups	Yes	Yes		
Creation of deanery tutor roles with a specific role for sessional GPs	Yes	Yes		
Deanery conference for tutors		Yes	Yes	
Deanery conference on professional development for sessional GPs		Yes	Yes	
BMA conferences for salaried GPs	Yes		Yes	
Creation of SDLGs	Yes	Yes		
Creation of performers lists		Potentially		More visible
Model salaried GP contract		Yes	Yes	
More locum matching websites e.g. GP networks, etc				Better able to find work when new
Creation of locum chambers	Yes	Yes	Yes	
Introduction of appraisal 2002		Yes- indirectly as appraisers can signpost		Improved understanding
Revalidation		Indirectly		Indirectly may drive improvements
LMCs trying to involve sessional GPs and changes in sessional representation in GPC	Potentially		Potentially	

**Improvements in Education:**

- CPD in model contract
- PGEA (previously only available for partners) now in global sum to be used for all clinicians
- E-learning
- Email improving sharing of information
- Deanery schemes e.g. Career Start/Retainers/Flexible Career Scheme/Returners
- Mentoring schemes
- Self Directed Learning Groups

**Table 3: Summary of Support needs of Sessional GPs and Organisations Meeting these Support Needs.**

**1. SDLGs, Sessional GP groups, Locum Chambers and Deanery**

	<b>SDLGs</b>	<b>Sessional GP groups</b>	<b>Chambers</b>	<b>Deanery</b>
Education	Yes - this is one of two most common core aims	Many groups provide educational meetings (some in collaboration with deanery).	Yes - regular education	Yes - some deaneries providing programmes specifically geared towards sessional GPs. Some also facilitate creation of SDLGs.
Support with appraisal and revalidation (evidence collection and guidance)	Yes - more so in recent years: discussion of Significant events, and audit and reporting back on courses for CPD credits	Sharing of dilemmas and solutions about appraisal and revalidation but groups too big generally to provide a valid forum for discussion of SEAs and audits.	Yes - at its best chamber models support collection of a variety of forms of evidence for A&R.	Assistance by sharing/cascading information, and fielding queries. Some set up revalidation groups to help sessionals discuss evidence e.g. SEAs.
Peer support, reducing isolation	Yes - this is one of two most common core aims	Yes - this is a key role; delivered by a variety of meetings (committee style; social, educational) and web and email based tools (email groups, discussion fora etc).	Yes - working very much as a team with regular meetings to discuss clinical matters, and SEAs.	Indirectly this occurs through deanery organised education especially in programmes specifically dedicated to sessional GPs as this makes networking between them easier than in a mixed GP group.
Professional support: infrastructure and information about professional issues	Yes - sharing experiences of different practices and employment issues	Yes - provides key means of obtaining necessary information when starting out as a freelance locum (e.g. registering for tax, NI and pensions; and accessing information on locum vacancies).	Yes - key role for chambers, with manager handling bookings, feedback collection, and clinical lead overseeing quality and recruitment and education.	Some deaneries organise professional development days e.g. “Survive and Thrive” looking at a range of needs (negotiation, MBTI; contracts; portfolio working; team roles; leadership; etc).
Information: about education; vacancies; services, local guidelines, etc.	May pool information picked up on an <i>ad hoc</i> basis through working in different practices - jigsaw of information.	Variable - a small minority probably act as a supplementary cascade mechanism to sessional GPs where PCT have not been inclusive but this relies on a good website.	Bulletin to all members containing job/ education/ clinical. Managers place info from local providers on extranet.	Some deaneries try to fill in cascade gaps where PCTs have not been inclusive of Sessional GPs e.g. via newsletters; via newsletters. Some are using web based methods to share information about educational provision (e.g. Wales Prakpak)

## 2. BMA, NASGP and PCTs

	<b>BMA</b>	<b>NASGP</b>	<b>PCTs</b>
Education	<p>Masterclasses focused on employment and negotiation</p> <p>Regional workshops by employment advisers</p>	No	<p>Many PCTs provide protected learning time events for whole practice teams but vary in the extent to which they</p> <p>a) inform sessional GPs b) offer them places.</p> <p>Some will cascade only via practices; or will admit them only if they working in the PCT at that time both of which create barriers.</p>
Support with appraisal and revalidation (evidence collection and guidance)	Guidance issues on funding for locum appraiser	An extensive collection of resources written by sessional GPs (members only part of website)	PCTs vary in how equitably they fund appraisal for partners and sessionals. Communication often still via practices which doesn't reach sessional so reduce access to guidance, and appraisal events in some areas.
Peer support, reducing isolation		In so far as helps sessional GPs find their local sessional GP group because of the "register" of local groups kept on NASGP website	Some PCTs e.g. Durham, Sunderland offer specific initiatives to support peer support amongst sessionals.
Professional support:  infrastructure and information about professional issues	<p>Individualised advice for members</p> <p>handbook for salaried GPs</p>	Variety of useful documents such as "code of conduct"; booking terms; induction packs, competencies of locums, etc	No
Information: about education; vacancies; services, local guidelines, etc.	No	No - but it does support dissemination of British National Formulary (BNF)	<p>Poor in many areas.</p> <p>This depends on whether distribution of information is targeted to be inclusive of whole performers list or based entirely on practice network which is less inclusive.</p>

**Table 4: Self Directed Learning Groups - Summary of our Evolving Understanding.**

	Literature Review	Deanery survey	Focus Groups
Starting group	Reasons for starting group: reduce isolation education  Following from transition from VTS to partnership	Some tutors have facilitated getting funding from PCTs  Some “launch” groups by facilitating initially then leaving or training up facilitators - this is the exception as most groups have flat structure with no clear leader/facilitator but a rotational role	Followed from MRCGP study groups or  facilitated by social networking events organised to help create SDLGs  Benefited from guidance at outset about how to set one up
Activities	Case discussion Topics Audits Professional dilemmas Journal presentations Courses		Case discussion Topics Audits Professional dilemmas Journal presentations Courses and SEAs
Benefits	Less isolation Keeping up to date Informal knowledge of practices Better retention in area Empower as far as employment terms Learning more relevant to GP practice as agenda controlled by members Behaviour change achieved more effectively by group learning than lectures Passing exams (MRCGP)		Preparing for appraisal Benchmarking /checking one’s practice and standards against others  Less threatening than discussing in front of or with “employer” clinicians  Efficiency - “don’t have to go to all the courses yourself”- can just get feedback Keeps you motivated Keeps you up to date Peer support Gathering information about job market and employment
Crises	YPG-drop in attendance; unmet needs or expectations resulting from lack of explicit aims and ground rules  Elwyn et al. - failure to clarify and establish goals, confused organisational structure, hidden agendas, inappropriate behaviour		Small groups: someone moves away or goes on maternity leave  Clash of personalities in a small group

Factors for success individual		Self-aware; motivated Ownership; responsibility Willingness to meet-time Willingness to share and trust Shared outlook (common status)	Trust Commitment
Factors for successful organisation	Non-hierarchical-rotational facilitation	Clear ground rules Set day of month to meet Planning ahead- many plan a few months ahead Reviewing the activity regularly Balance of time on peer support and education Facilitation skills Shared/common aims Access to an educational resource Size- enough for sustainable attendance but ensuring commitment and involvement from all Opportunities for learning from other groups or expert/advisers on group Methods/educator	Size- to sustain momentum, and share workload but ensure everyone involved/participating and committed and develop trust/peer support, and easy to coordinate Mostly 2 hour meetings at people's houses Format- quick catch up followed by planned activity (case/topic/ etc and discussion) plus planning future meetings at end. Many have a "just turn up" approach without pre-planning and rely on various people bringing material. No leader- non hierarchical, rotational chairing minutes taken and sent round Ownership Clear ground rules e.g. Confidentiality Good rapport Diversity of experiences and skills complementing each other Having only one person from a practice Recruiting- by word of mouth Balance between informality and getting something out of the group
Evaluation	Elwyn et al: task/ process; people/ resources; organisation; communication or Guide (NELG): meeting objectives; ability to participate; how decisions are made; time management; methods; ground rules		Variations in how formally this is done e.g. annual review or as spontaneous discussion as part of meeting Can result in changes in format or process Giving feedback important and how it is given- so people don't feel criticised and doesn't undermine trust Would like to share between groups as part of evaluation Evaluation against the aims the group has set and against the ground rules for example

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# 1. BACKGROUND

“Sessional GP” is an umbrella term used to help define fully qualified GPs (i.e. not GP registrars) who are not conventional partners in a practice. The term ‘non-principal’ was in common use until 2006, but was felt to be too negative. Sessional GP encompasses freelance GP locums, chambers-based locum GPs, salaried GPs contracted to a practice or a PCT, and GP retainers. Sessional GPs constitute a growing proportion of the GP workforce<sup>1</sup>, particularly with new models of primary care and the introduction of other providers which rely more heavily on salaried GPs than traditional practices<sup>2</sup>. Across the UK, the proportion of salaried GPs increased from eight percent of the GP medical workforce in 2004 to almost one-fifth in 2008<sup>3</sup>. In England the number of salaried GPs increased from 786 in 1999 to 7,310 in 2009<sup>4</sup>, and in Scotland the number increased from 188 in 2004 to 480 in 2009<sup>5</sup>.

It has been suggested that working as a locum GP has increasingly become a positive career choice (rather than a stop-gap for recently qualified GPs before joining a full-time partnership), particularly with the growing number of newly qualified female GPs, as being a flexible way of working, and also because of its dedication to clinical family medicine rather than managerial contractual obligations<sup>6</sup>. Locuming can provide opportunities for newly qualified GPs to gain exposure to different types of practices in different locations and can contribute to career decisions<sup>7</sup>.

Salaried employment offers reduced hours and freedom from out-of-hours and administrative responsibilities, but still retains all the usual clinical responsibilities. A study based on the 2005 GP census (England) found that salaried GPs tended to be either younger (<35 years) or older ( $\geq 65$  years), female, or overseas qualified (particularly from the European Economic Area), and were more likely to work part-time and hold personal medical services (PMS) contracts. Salaried GPs were more mobile than principals, and have become increasingly so, and also tended to be concentrated in slightly more affluent areas<sup>8</sup>.

However, issues have also been raised regarding support for sessional GPs. This study set out to explore the issues faced by sessional GPs as opposed to GPs more generally and to identify ways in which, and how successfully, their needs are being met.

## 2. METHODOLOGY

### 2.1 Aim of study

To explore the support needs of sessional GPs and how these are being met.

#### Objectives

- To explore the issue of professional isolation and its prevalence and impact on sessional GPs
- To establish current barriers in access to education and professional support
- To identify successful models of professional support for sessional GPs (including self directed learning groups [SDLGs] and sessional GP groups)
- To identify factors which enable or inhibit success in a support group

### 2.2 Method

The study used mixed methods, from literature review to collecting survey data to qualitative methods. An open ended survey was distributed by email to members of the virtual Advisory Panel to gain an overview of issues regarding support for sessional GPs and to help inform data gathering.

A mapping exercise was carried out to provide information on the number, type and location of sessional GPs in the UK.

A literature review and information search were conducted to report on any published research in the subject area and to provide information on support networks and organisations across the UK.

A combination of qualitative and quantitative methods was used to identify issues faced by sessional GPs and the contribution of SDLGs and other forms of support.

An electronic survey (See appendix 1) was distributed to educators in all deaneries across the UK to provide information on educational and wider support offered to sessional GPs and how this was provided i.e. by educators with special responsibility for sessional GPs or by the wider deanery network. The content of the survey was informed by literature, discussions with experts and guided by project objectives. The usability of the survey was tested with four colleagues. It was subsequently piloted with three experts working in the field of support for sessional GPs.

An electronic survey (See appendix 2) was distributed to sessional GP groups and locum chambers across the UK to provide further information on the format and function of these groups, any strengths or difficulties, and any sessional GP needs that the groups were unable to meet. The usability of the survey was tested with four colleagues. It was subsequently piloted with three experts working in the field of support for sessional GPs.

Focus groups were held with sessional GPs, including members of sessional GP groups and SDLGs, to identify issues faced by sessional GPs, current sources of support and any unmet needs, and to explore factors which enable or inhibit success in a support group. Focus groups were supplemented by telephone interviews where necessary. The topic guide for the focus groups and telephone interviews (See appendix 3 and 4) was informed by the advisory panel comments, literature and discussion with experts in the field.

## 2.2.1 Recruitment

### Deanery Survey

An e-mail containing a link to an electronic survey was distributed to all deaneries via Northern Deanery GP educator networks and other contacts identified by the researchers through phone calls to deaneries. The invitation and survey was targeted at GP educators with a dedicated role for sessional GPs with a request for it to be forwarded to the most appropriate person within their deanery if there was not a dedicated educator. The email was followed up by one reminder two weeks after the initial closing date.

### Sessional GP Groups and Locum Chambers Survey

An email invitation containing a link to an online survey was sent to organisers and leaders of all UK sessional GP groups and locum chambers (on the NASGP list of Sessional GP groups). The e-mail was followed up by one reminder two weeks after the initial closing date. Distribution was facilitated by the Chief Executive Officer of the National Association of Sessional GPs (NASGP), using the contact list for groups on the NASGP website. The email was followed up by one reminder two weeks after the initial closing date.

### Qualitative Data Collection

Invitations to participate in the qualitative part of the project were distributed by email via GP appraisal leads and via a regional sessional GP group to all sessional GPs working in the Northern Deanery. The invitation asked them to respond to a generic research e-mail account if they were able to attend a focus group or take part in a telephone interview. Two reminder e-mails were sent out after two and four weeks.

## 2.2.2 Analysis

The electronic surveys to sessional GP groups/Locum Chambers and to Deanery educators were analysed using SPSSv17 for descriptive statistics. Free text sections were coded thematically<sup>9</sup>.

The interviews were tape recorded subject to participants' permission and transcribed verbatim. The transcripts were coded qualitatively using a framework approach<sup>10</sup>. The stages of the analysis involved:

**Familiarisation** - gaining an overall view of the data that had been collected. This involved reading the transcript data and noting the range, depth and diversity in the data collected. Meetings between the researchers who were engaged in the same process enabled discussion of the concepts and themes that emerged from the data.

**Identifying a thematic framework** - identifying the key issues, concepts or themes by which the data could be examined and sorted. The construction of the framework drew upon:

- **a priori issues** - those issues that guided the study aims and were developed into the interview schedule
- **emergent issues** - those issues that were raised by the respondents
- **analytic issues** - those themes that emerged from patterns and re-occurrences in the data
- **Indexing** - applying the framework to the data. This involved re-reading the transcripts and coding sections of text which relate to themes or sub-themes in the thematic framework.
- **Charting** - collecting all the selected sections under a particular theme and viewing the data as a whole for each theme. The researchers read the quotes and looked for similarities and differences in the data as well as sub-themes that sat below a theme.

- **Mapping and interpretation**-bringing the key themes within the dataset together and pulling together the findings of the analysis as a whole to address the aims and objectives of the research.

### **2.2.3 Ethics**

A query outlining the project was submitted to the National Research Ethics Service (NRES) query line querying whether this project was required to go through ethical approval. The response was that it did not require ethical approval from NRES as it was deemed to be a service evaluation. All data was handled, processed, stored and will subsequently be destroyed by the Research Team in compliance with the Data Protection Act 1998. All data collected from participants was anonymised and given a unique identifier. Only the research team had access to the data.

### 3. LITERATURE REVIEW

#### Workforce

In the late 1990s a recruitment crisis was unfolding in general practice. The increase in number of female GPs, the desire for more part-time working, and a trend for earlier retirement were all contributing to this. It was increasingly recognised that newly qualified GPs were not taking up partnerships<sup>11,12</sup>. In one survey less than 20% of those leaving schemes sought partnership straight away<sup>13</sup>. Commonly cited reservations were not feeling prepared for the business aspects of partnership and workload - particularly out of hours work and the need to reconcile work and family life<sup>14</sup>. This RCGP report recognised the need for a change in thinking on this issue:

‘it has to be acknowledged that a large amount of effort has been expended in recent years trying to increase the conversion rate of GP registrars to principals [...] it is now more appropriate to acknowledge that non-principals are here to stay and to concentrate efforts on understanding the impact they make on the service through their participation rates and their career patterns.’

A number of salaried schemes were created to try and address recruitment difficulties in London<sup>15</sup>, Liverpool and Durham<sup>16</sup>. Durham Career Start<sup>17,18</sup> offered a two-year salaried post, with mentorship, peer support, a six-month elective to pursue an interest and a 10% bonus on taking up a partnership. Interestingly whilst the Career Start scheme addressed some of the issues around capability and preparedness for partnership it also highlighted the other priorities influencing this career transition, namely ‘the range of career options, the need to balance home and family life and the size of the commitment which partnership entails (both personal and financial)’.

‘Career Start seems to have gone some way towards settling those questions. They are about whether, given that a choice exists, partnership best fits the doctor’s circumstances. Clearly, some perceive that it does not, and it is this belief that is at the root of their reluctance to commit to partnership’<sup>18</sup> (p47).

Research on the Career Start doctors’ choice of practice identified several factors influencing their decision. The feature which was deemed most discriminatory and most commonly cited was ‘good communication at all levels, with frequent opportunities for doctors to meet for informal talk, to share problems and for second opinions’. Other features were group (rather than single handed) practice, being close to home, a supportive welcoming environment with shared goals, efficient management and with longer appointment length.

#### Salaried posts

The Primary Care Act<sup>19</sup> allowed health authorities scope for the first time to commission primary care from any local provider within the NHS family, better tailored to meet local needs, and introduced the term ‘Personal Medical Services’. Personal Medical Services (PMS) contracts were introduced in 1997<sup>20</sup>, aiming to address some of the constraining and bureaucratic aspects of the national General Medical Services contract. One of the aims of PMS was to offer more flexible employment opportunities in general practice and it was indeed found by the Audit Commission to have contributed to ‘filling previously hard-to-fill clinical posts’<sup>21</sup>. PMS removed many of the financial barriers (in GMS) to taking on employed GPs and thus with each successive wave of PMS the number of salaried GP posts rose. The NHS plan<sup>22</sup> published in 2000 included an expectation that a third of practices would work in PMS by 2002 and the majority by 2004. Despite this rapid expansion, national terms and conditions of employment for salaried GPs were only finally published in 2004<sup>23</sup> as part of the new GMS contract<sup>24</sup>, and even then were only a requirement for GMS practices and PCTs, though the BMA and General Practitioners Committee (GPC) recommended their adoption for all salaried GPs. This contract finally brought to salaried GPs many of the benefits which hospital doctors already enjoyed: better than statutory maternity pay, sick pay and redundancy entitlements based on previous service within the NHS (not just the current employer) and perhaps most controversially the entitlement to four hours of weekly CPD time for full-timers (pro-rata for part-time doctors).

The publication of the new nationally agreed contract of employment for salaried GPs was also accompanied by the publication of a salaried pay range below which practices and PCTs were not allowed to go. This was linked to the rate then payable to Non-consultant Career-Grades, although these hospital doctors, unlike GPs, had not attained their specialist qualification. Unlike hospital posts, the pay range for salaried GPs agreed between the BMA and Department of Health, and revised annually with each Doctors and Dentists Review Body (DDRB) award has no salary increments. Sessional GPs received a pay rise of 3% in the first two years of their new contract, whilst partners pay increased by 58%<sup>25</sup>.

A study of job satisfaction found that salaried GPs were more satisfied with their remuneration, working hours and the recognition they got for their work, and reported lower stress than non-salaried GPs. They were less satisfied with their colleagues and fellow workers and their physical working conditions. However, overall levels of job satisfaction were similar<sup>26</sup>. A 2004 national survey also found no significant difference in job satisfaction for salaried status<sup>27</sup>.

Since the introduction of extended hours in 2008, under threat of potential practice income falling, many salaried GPs have had no choice but to take on these antisocial duties, in some cases with no additional financial reward, with such duties often being allocated to salaried GPs rather than partners<sup>28</sup>.

### **Flexible Career Scheme and returner Scheme 2002-2006**

The Flexible Career scheme was introduced in 2002 with the aim of addressing recruitment and retention problems<sup>29</sup>. This scheme, which emphasised the principles of *Improving Working Lives*<sup>30</sup> provided part-time employment, with the flexibility of annualised hours, mentoring and educational supervision, the option to take on other non GP work to promote portfolio careers, and an expectation of longer term employment by the host practice after the end of the scheme. Doctors joining the scheme were eligible to receive a “Golden Hello” payment of up to £12,000 for committing to a post for more than two years. In her review of the impact of the scheme Viney<sup>31</sup> states that:

*‘There had been a growing lost tribe of locum GPs who were outside mainstream clinical governance and education. They were seeking flexibility and a defined workload, to fit in with portfolio careers, a work-life balance, or family commitments. Most of these GPs are now working in a managed educational environment; the scheme has helped retain doctors who might otherwise have been lost to the workforce, and enabled some GPs to return to work.’*

A survey of retainer and Flexible Career Scheme (FCS) doctors in London (n=92 responses out of 97) found that they had significantly greater overall job satisfaction, and reported less stress, than principal, salaried and locum GPs in a 2001 national survey using the same questionnaire<sup>32</sup>. They were most satisfied with their colleagues and fellow workers, the amount of responsibility they get and their hours of work. They were most dissatisfied with their remuneration, recognition for good work, and physical working conditions. The greatest sources of stress were having insufficient time to do justice to the job, increased demands from patients and inappropriate demands from patients. The sources of least stress were night visits, finding a locum and being on call.

In a final evaluation of the London Deanery experience of this scheme<sup>33</sup>, members are said to have valued highly the sense of belonging to a practice and of being able to balance work and family, thus helping motivation and enjoyment of work. The doctors were also encouraged to develop PDPs, valued having protected time for CPD, and for older doctors the opportunity to approach retirement in a more phased way, by jettisoning the non-clinical responsibilities of practice management. One of the findings was that doctors expressed a desire to network with other scheme doctors both educationally and to form support groups. The funding of this scheme was originally held by the Department of Health nationally and not cash limited, but new funding ceased in 2006, with the last posts reaching their completion in 2008.



The Flexible Career scheme also included funding to create “returner” posts of up to six months full time equivalent for doctors who had been absent from clinical practice for a significant period and needed re-induction to clinical work under supervision. The scheme was found to offer value for money in terms of providing practising GPs, and was highly valued by the GPs themselves, but again members stated that they would have liked more opportunities for meeting and networking with peers<sup>34</sup>.

### **Retainer Scheme 1972 to present, revised 1992 and 1998**

The retainer scheme, initially named the “Women Doctors Retainer Scheme” in 1972, was revised in 1977 to become the “Doctors Retainer Scheme” to allow men to be admitted. It was intended to help doctors keep in touch with clinical practice, by working up to two sessions a week and committing to seven educational sessions per year. Evaluations of the scheme however showed that retainers received little educational support<sup>35</sup>, terms and conditions were poor (with many employed as locums without a contract, pension, paid holiday or study leave), and there was no flexibility for retaining non GP skills. The revised retainer scheme<sup>36</sup> addressed many of these difficulties, allowing up to four sessions on the scheme, requiring employment (rather than casual work as locums) in a training practice, educational supervision and mentoring, and flexibility for non GP work outside the scheme. A number of deaneries confirmed that the new retainer scheme provided a more supported and educationally based environment,<sup>37,38,39</sup> even if difficulties with terms of employment and rates of pay persisted. The reduced term of the scheme to five years was unpopular as it was felt to be too short to help bridge the years which would take the typical retainer to when her youngest child was at school. The revised scheme allowed access to the NHS pension scheme and the BMA published a model contract which was subsequently revised in 2004 in line with the GPC model salaried contract.

### **British Medical Association (BMA), General Practitioners Committee (GPC) and Local Medical Committees (LMCs)**

The Non-principal subcommittee of the General Medical Service Committee (GMSC) was created in 1996 and, following the change in term proposed by the NASGP, adopted the name “Sessional GP subcommittee” (of the General Practitioners Committee). The Committee’s purpose was to improve the lot of all kinds of sessional GPs, and to make representations on their behalf within the General Practitioner’s Committee relating not just to working conditions but on issues such as appraisal. From its inception it fought for access to the pension scheme and the introduction of nationally agreed model terms of employment amongst other issues. Following the introduction of the 2004 contract<sup>24</sup> the committee steered the production of guidance around Job Planning<sup>40</sup>, and “In House Performance Review”<sup>41</sup>, key tools to support salaried GPs in making the most of their salaried position<sup>42</sup>. They also published guidance on how to negotiate pay<sup>43</sup> and how to have an influence through local representation<sup>44</sup>. In 2009 the “Salaried GPs handbook: A Guide for salaried GPs and their employers”<sup>45</sup> was published. The Committee also succeeded in establishing the right of salaried GPs to have individual prescribing numbers, which allowed them to obtain standardised reports of their prescribing, useful for personal development and appraisal<sup>46</sup>. After the Office of Fair Trading’s ruling that the publication of locum fees was against competition law, the BMA withdrew its published locum rates and published with the NASGP guidance for locums on how to go about setting individualised locum fees<sup>47</sup>.

Sessional GPs are represented by direct election to the sessional GP subcommittee of the General Practitioners Committee (GPC) however it has long been known that they are under-represented in GPC. They can also be represented on their local LMC however they remain under-represented in these as well<sup>48</sup> as there is a commonly voiced concern that LMCs cannot fairly represent both employers (contractors) and employees (sessional GPs)<sup>49</sup> and therefore money spent on LMC membership may not be well spent. Failure to take up membership necessarily reduces the voting capacity of sessional GPs and therefore their influence on LMCs overall.

The General Practitioners Committee (GPC) has set up a Sessional GP Representation Working Group to review the arrangements for the representation of sessional (salaried and locum) GPs within the GPC and BMA, and at a local level<sup>50</sup>.

Research carried out for this working party by the BMA's Health Policy and Economic Research Unit (HPERU)<sup>51</sup> includes focus groups, a survey of LMC and a survey of sessional GPs (final response rate of 28.5% 1,786 responses of 6,256 questionnaires sent out). The report confirms that many (over half) sessional GPs became a sessional GP out of personal choice though 27.4% of respondents reported that they were looking for a GP partnership post.

- The most pertinent issues facing sessional GPs (48.2%) were terms and conditions /working conditions.
- 51.3% of respondents indicated that they were very dissatisfied or dissatisfied that issues facing sessional GPs are being addressed by the profession.
- Three quarters (77.2%) of respondents stated they were not engaged with their local LMC.
- The majority of respondents who commented on how sessional GPs are represented within the BMA indicated that they would like to see increased representation within the existing structure.
- The most common theme derived from the content analysis of respondents' responses relating to the representation of sessional GPs within the BMA indicated that sessional GPs perceived that they are being inappropriately treated by contractor GPs. Respondents' statements include being "used", "professionally limited", "treated as inferior" or "disposable" by contractor GPs (19.7% of cases).
- Support from colleagues was the most important factor to consider when deciding whether to accept a post.

### **The professionalisation of locums: The creation of NASGP**

It has long been recognised that, whilst locum work offers flexibility, this comes at a price: 'poor professional status; managing oneself as a self-employed professional with no managerial support; and the lack of access to education, clinical governance and the ever-increasing collection of evidence for appraisal and revalidation'(p.32)<sup>6</sup>. The increasing use of locums can mean more locums being unfamiliar with local systems and processes, which may have implications for risk management<sup>52</sup>.

Risks locums may face can include: unrealistic expectations from/of practices; lack of information on services available in/to the practice; time pressure; professional isolation; poor transfers of information and handovers; lack of knowledge of locum by practice and unfamiliarity of locum with the practice's patients; lack of support from the practice, e.g. for good continuity of care; practices expecting locums to perform risky tasks e.g. signing repeat prescriptions; clash of beliefs between locum and practice; and limited practice feedback <sup>53</sup>.

A 2005 Conference<sup>54</sup> on Understanding Sessional General Practitioners highlighted the mobility of some sessional GPs throughout the system, which can cause problems in ensuring the availability of appropriate, timely and adequate information. However, the conference report also noted that these GPs are in a unique position to have developed an overview of the system in which they operate, but there is neither a cultural expectation nor a mechanism that permits sessional GPs to feedback to practices.



Locums may not always be told about complaints, although there is likely to be a new system in place following the 2009 government reforms to the NHS and social care complaints system which could mean that locums feel more involved in complaint handling<sup>55</sup>. They face an unpredictable income with no sick pay, holiday pay or maternity pay and whilst there are advantages in diversity of work it can also be unsettling. In addition, time management is particularly important as a locum when ‘time equals money’<sup>7</sup>.

Locum GPs receive varying support from agencies. Some agencies offer regular appraisal and opportunities for continuing professional development (CPD) and seeking feedback about the locum’s performance after each placement, whilst others do not see it as their responsibility to give support or training to the locum staff on their books<sup>56</sup>.

In 1997 the National Association of Non-Principals was founded with the broad aims of promoting equality for non-principals and reducing isolation<sup>57</sup>. Its objectives included representation, dissemination of information (newsletter and the British National Formulary), support and welfare of non-principals, to act as a central register of non-principals, to commission and coordinate research, to support local non-principal groups<sup>58</sup>, to organise conferences and to achieve equivalent status for the non-principal to that of the GP principal. It aimed to be an independent national organisation, seeking better remuneration for CPD for non-principals and equal pension rights. It sought financial recognition for non-principals’ experience and seniority, published many useful resources such as a professional code of conduct for these doctors, the Standardised Practice (Induction) Pack, locum booking terms and forms and guidance on how to handle complaints against locums. The NANP had a key role in promoting the creation of locally based non-principal groups by providing a central register in which virtual groups could be created until such time as someone came forward to take on running them. One of the big early achievements resulting from lobbying by the NASGP and BMA was the inclusion of GP locums in the NHS pension scheme from April 2001.

In 2002, following the NANP event “The Way Forward”, the concept of the Virtual Practice or Locum Support Team<sup>59</sup> was created: ‘the new concept for the integration of Freelance GPs into the structures and processes of the NHS’. These teams, which could be based in PCTs, GP practices, commercial agencies or independent groups would provide a single structure to manage not just the manpower aspects (matching supply and demand), but also quality assurance through clinical leadership, clinical governance and ensuring locums were up to date with their CPD<sup>60</sup>. The report from this event referred to each PCT having a manager charged with managing the supplementary list of non-principals, and supported by a GP mentor or “guru”. This structure would improve the support available to locums (also referred to as freelance GPs), improve their access to education, and support feedback and audit processes which were increasingly recognised as important for appraisal.

In more recent times the NASGP has worked closely with the Royal College of General Practitioners (RCGP) and the Department of Health (DH) in raising issues around the potential difficulties locums would encounter in appraisal and revalidation. It has also recently been consulting on a document entitled “GP Locums: The Skills We Need And How To Achieve Them”<sup>61</sup> aimed to address the training gap experienced by newly qualified GPs entering the locum market.

Taking the opportunity which the new 2004 contract brought in the abolition of the term “principal”, the NASGP coined the term ‘sessional GP’ to replace the word ‘non-principal’ GP which had long been perceived as pejorative.

## Sessional GP groups

Sessional GP groups are geographically based, mainly self-funded groups run by volunteers to provide peer support, job vacancy information and education. They help reduce isolation both professionally and socially, offer opportunities for sharing experiences and opportunities, and help improve communication locally<sup>62</sup>.

The NASGP provides a national register for these groups, which includes seventy-nine entries<sup>63</sup>.

**Table 5: Number of Sessional GP groups on the NASGP website (UK 2010)**

Area	No. of Sessional GP Groups
South & West	8
South Thames	11
North Thames	14
Anglia & Oxford	8
West Midlands	8
Trent	5
North West	8
Northern & Yorkshire	5
Wales	3
Scotland	8
Northern Ireland	1
<b>Total</b>	<b>79</b>

### Services typically offered by a sessional GP group are<sup>64</sup>:

- Newsletters
- List of locums in the area
- Website
- Group discussions on: working conditions, appraisal and revalidation, pensions, educational issues, different practices and job vacancies and working in out of hours care providers
- Information about vacancies and education
- Meetings of an educational, social or professional nature

In 2008, the NASGP was increasingly aware that local sessional GP groups struggled with a lack of funding, admin support and infrastructure and proposed a system to anchor these to NASGP for additional support, by means which would also provide much needed increased membership for the NASGP. This was called the “NASGP Allied Groups”<sup>58</sup>. At the time of writing no local groups have entered into this arrangement with the NASGP.

Sessional GP groups have continued to increase in number, aided by guidance and sharing of good practice about models which have worked well, particularly as the use of internet sites and electronic networking has an ever increasing impact on these unresourced communities<sup>65</sup>.

## Locum Chambers

There is little evidence that PCTs have adopted the NASGP's Locum Support Team model in the way in which it is described, with the exception of a London PCT<sup>66</sup>. However, in 2004 a modified form of the Locum Support team was created in the first Locum Chambers - Pallant Medical Chambers<sup>6,67,68</sup>. The chambers model aspired to address a number of the difficulties of working as a locum: administrative support for the bookings side, administrative support for audit, and collection of feedback, networking for peer support, education and discussion of clinical practice. All this was funded from an income related contribution from each member which goes towards employing managers and clinical director time. Locum chambers do not receive any form of funding from the NHS.

Locum Chambers are described as a 'virtual GP practice', with its own team of managers and clinical directors. Pallant has four managers to 45 members and has three clinical directors. Each individual chambers has no more than 15 members and each has its own nominated Chambers Lead. The managers manage the allocation/confirmation of bookings, payments and superannuation. Membership of chambers requires interview by a panel of directors (and any other members), CV scrutiny, the taking up of references and a probationary period. Members pay a small percentage of their income as a management fee. Features of the chambers include: significant event generation and discussion and six other multisource feedback tools to generate evidence for appraisal; a set of door plates, name badges and their own 'GP profiles' for members to use at each surgery; a unique, username and password provided by all practices for their IT system; and regular monthly meetings with a minimum level of compulsory attendance for continuing professional development. In addition, feedback is provided to a selected practice once a month, for example to help the practice improve patient care or provide a better working environment<sup>6,69</sup>. Regular (bi-monthly) internal Chambers meetings, with a minimum level of compulsory attendance, involve the sharing of clinical experiences, discussion of significant events, and mutual support. In addition, there are bi-monthly consultant speaker meetings, open to all sessional GPs in the area<sup>70</sup>.

There are currently eight Pallant Medical Chambers, located in Sussex (Chichester and Worthing), Hampshire (Winchester, Southampton and Portsmouth), Surrey (Kingston-upon-Thames), Avon (Bristol) and South Wales (Cardiff)<sup>70</sup>, and two further Medical Chambers in Yorkshire<sup>63</sup>.

Chambers have provided a way to standardise locum rates for a small group without infringing competition rules; a legal test case against a group of anaesthetists working in Chambers had already successfully defended itself against this accusation<sup>71,72</sup>.

## Deaneries

In the 1990s a number of deaneries carried out surveys into the educational issues affecting non-principals<sup>73,74</sup>. The largest and most well known, covering 598 non-principals, with a response rate of 80%, was published by SCOPME<sup>75</sup>. The surveys revealed a variety of problems: isolation, low status, poor peer support, financial insecurity and a “triple whammy” of disincentives limiting access to education: loss of income, childcare costs and course fees. As well as difficulties accessing education<sup>76</sup> these GPs also had problems accessing professional peer support (mentoring, careers advice, opportunities for career development). There was also confusion among non-principals regarding eligibility for, and availability of, funding for education. SCOPME made a series of recommendations:

1. The mechanism for regional/deanery registers of GP Non-Principals should be examined by all concerned.
2. Induction to a practice needs to take place for all GP Non-Principals. Examples of good practice should be collected and disseminated.
3. On educational grounds, a contract and/or written statement about employment terms should be given to eligible Non-Principals and should specify time available for education within contracted hours.
4. Professional career counselling should be available and all should be encouraged to avail of it. A nominated person, with appropriate skills, on the Director of Post Graduate GP Education's (DPGPE) staff, should be given responsibility for this.
5. GP Non-Principals should be included in mentoring schemes in general practice.
6. The educational needs identified by this study should be brought to the attention of those responsible for planning educational activities for GPs including practice-based education.
7. GP Non-Principals should be included in initiatives to help GPs to draw up personal educational and development plans.
8. Special account should be taken of the needs of locums in managing chronic disorders and those who spend little time in medical work.
9. GP Non-Principals should be routinely notified of local educational activities in the same way as principals and have easy access to post graduate centres and associated libraries.
10. All GP Non-Principals should be provided with written information about their eligibility for educational funding. This information needs to include contact names at the agencies concerned.
11. Mechanisms need to be devised so that GP Non-Principals have appropriate access to financial support to meet their educational needs.
12. GP Non-Principals should be given proper time for education (study leave). This needs to be specified in contracts of employment in the case of assistants and long term locums.
13. GP Non-Principals should be included on the mailing lists for important publications.

The SCOPME survey was repeated in 2000<sup>77</sup> and its findings showed encouraging improvements in a number of areas. More respondents had contracts of employment, isolation had reduced, and this tied in with greater contact with local tutors and post-graduate centres and non-principal groups. Access to education remained a problem, attributable to loss of income as before but many more of them had PDPs (personal development plans). “On call” was now less frequently cited as a reason for not taking up partnership, but respondents were concerned about the added administrative burden this career option entailed.

Important developments in the intervening four years were clearly beginning to have an impact, namely the advent of non-principal groups which were increasing in number thanks to the steer of the NASGP, and the increasing number of deanery led initiatives supporting non-principals.

These included return to practice initiatives, Career Start and other supported salaried schemes, and the creation of dedicated educationalists supporting non-principals<sup>78,79,80,81,82,83</sup>. Problems with access to information continued to be an issue<sup>76</sup>.

Educators were coming together to think about the problems affecting non-principals and their complex social, organisational and professional roots. This complexity is recognised in the introduction to the proceedings of one of these events:

*‘...separating the educational provision for non-principals and medico-political issues was difficult because creating opportunities for non-principals’ professional development and job satisfaction requires significant resources and equality with principals, which requires educationalists, policy makers and budget holders to work together’<sup>84</sup>.*

Subsequent national conferences also served to stimulate change and spread ideas for new initiatives<sup>85,86,87,88,89</sup>.

The introduction of supplementary<sup>90</sup> lists (now known as Performers Lists) also created the opportunity for integration of sessional GPs into the GP workforce, as far as access to education, information and other sources of support, though the SchARR report<sup>91</sup> highlighted that this potential had yet to be realised and much could be done to support sessional GPs if these lists were better used. These recommendations are repeated in recent reports about tackling performance concerns<sup>92, 93</sup>.

Further research in London found that only 38% of the sessional GPs felt up to date with local primary care initiatives and developments and 40% were unsure. Locums were more likely to disagree that they felt up to date than salaried GPs and under half (46%) felt supported with professional development in their PCT<sup>1</sup>.

## **Royal College of General Practitioners (RCGP)**

The Royal College of GPs has been looking into the professional needs of newly qualified GPs, the majority of whom work as sessional GPs. The “First5” is a new initiative which will support new GPs from completion of training to the first point of revalidation at five years<sup>94,95</sup>. This will include the following components to be delivered or supported by the College and its local faculties:

- Connecting with College - promoting a sense of belonging and appropriate representation within the College:
- Facilitating networks – peer support and mentoring
- Supporting revalidation
- Career mentorship – making the most of a career in general practice
- Continuous professional development (CPD) and new skills

## Higher Professional Education (HPE)

The Higher professional development scheme was designed to support the CPD needs of newly qualified GPs, in particular relating to “business, staff management and building confidence” in order to aid recruitment and retention<sup>96</sup>. It reflected prevalent thinking at the time that the reduced progression from training scheme to partnerships was a result of lack of confidence and skills, though subsequent research has shown that changing priorities and aspirations have been an equally significant factor in these career choices<sup>19, 20</sup>. The scheme provided funding for course fees as well as for “locum cover” enabling 20 days per annum away from coalface work. It was initially designed with new principals in mind, locums being unable to claim for income lost for taking timeout from clinical work as their peripatetic nature prevented them from naming a practice through which to claim the “locum cover” costs. The “triple whammy” (loss of income, course fees and childcare costs of education) described in the SCOPME report<sup>75</sup> was therefore only partially addressed for this group of doctors by the HPE scheme. Participants were required to produce a PDP and the scheme was designed to run over one year. By 2003 the rules had been relaxed and made more flexible such that it could run over two years and could be used to address clinical educational priorities which many newly qualified GPs judged as more pressing than non-clinical priorities.

A national evaluation<sup>97</sup> of the scheme drawing on four sources showed that the non-clinical emphasis originally expected by the Department of Health was subsequently replaced by clinical education to tackle the prioritised needs of participants. A national survey (23% response rate) showed uptake to be around 84% though local HPE leads estimated this to be around 50% with the following being named as barriers to its uptake: difficulty taking timeout out from practice, wanting a break from education, travelling distance to meetings and inflexible funding systems. It had no impact on the total amount of education carried out when non-participants were compared with participants. Activities covered by HPE funding could include formal courses and self directed learning and many areas provided specific peer group based HPE scheme facilitated by HPE tutors. Choice of activity differed between participants and non-participants with the former spending comparatively more time on clinical meetings and courses rather than personal learning and self directed groups. The participants reported that the HPE covered only 19% of their education and training time with 54% remaining unfunded. Claims analysed as part of HPE evaluation showed that “specific HPE activities” (i.e. activities organised with HPE participants on mind) related accounted for 51% of claims with other courses accounting for 20% and personal study accounting for 20%. Whilst it did not appear to stimulate independent self directed learning there was evidence that it did address feelings of isolation and uncertainty through its group based activities providing opportunities for newly qualified peers to network <sup>97,98</sup>.



## **The introduction of appraisal**

Appraisal was introduced for Principals in 2002<sup>99</sup> informed by the original report by SchARR on appraisal<sup>100</sup>. A subsequent report published in 2003 explored the implications of extending appraisal to non-principal. The report highlights many of the professional issues which locums face such as isolation and lack of access to information about education. It stresses the importance of locums being appraised by GPs who understand their role and encourages locums to come forward to become appraisers themselves.

The SchARR report<sup>91</sup> also identifies the responsibilities of the host PCT for ensuring that non-principals are offered appraisal and for making adequate financial provision for this.

### **It recommended that practices should:**

- invite locums to take part in the professional life of the practice by inviting them to attend practice meetings and training events or discussions, and contribute to significant event or other audit processes
- facilitate their access to professional materials (journals, training videos etc.) and to patient data, particularly prior and subsequent data about patients they have seen (to assist with their own audit processes)
- support steps locums might wish to take to learn the views of their patients and colleagues
- ensure that practice principals are available for handover discussions or briefings, facilitating routine communication about patients; and generally for professional exchange and advice.

The report states that the deaneries should have a ‘a coherent and explicit ‘inclusion’ strategy for ensuring that non-principal GPs are informed about developmental and educational opportunities and events and have facilitated access to them; and for adjusting their range and character to meet the needs of non-principals’.

The report outlines a variety of types of documentation which a locum can produce to support the appraisal process, some easier than others. So for example PDP, PUNS (patients’ unmet needs) and DENs (doctors’ educational needs), workload, patient complaints or letters of appreciation were all deemed to be easier to produce than clinical audit, significant events, and patient and colleague feedback. Clinical audit was already known to pose challenges for non-principals<sup>101</sup> however the report describes some examples which, whilst not being considered a “cyclical process of continuous improvement”, deliver the core essence of audit: ‘a process of scrutinising your work to make it better’, for example reviewing a series of consultations six months later (which involves revisiting a practice one no longer works in), or a log of a series of referrals with outcomes.

The report recommended the establishment of “GP Tutors or Facilitators to work specifically with non-principals in every Deanery, so that all non-principals (and locums in particular) have a named tutor to whom they can turn for advice and support, including support in preparation for appraisal”. Following the publication of this report, a toolkit for sessional GPs was developed and produced in the Northern Deanery<sup>102</sup>.

Since the introduction of appraisal there is an increasing understanding of the difficulties sessional GPs and locums in particular face with regards to obtaining evidence for appraisal and revalidation. Many of the forms of supporting information which are required for a GP are a core part of the daily work and role of a partner but not of a locum or salaried GP. This is particularly true of activities such as disease based audits, carried out with a view to improve practice systems and care delivered by teams, normally supported by staff skilled in IT or pharmacists.

Sessional GPs, generally unsupported by non-clinical staff, with little influence over practice systems and potentially moving on before changes are made are not well placed to adopt this as a relevant example of evidence for appraisal. Similarly Significant event audits (SEAs), intended to trigger improvements in systems, after sensitive discussion within a multidisciplinary team, become less relevant to locums, who are rarely invited to join in meetings, may be fearful of reporting incidents because of “whistleblowing” connotations, and who have little opportunity to trigger improvements. They therefore find themselves limited to using SEAs as a “solo” reflective tool or within a practitioner group, providing they belong to one. The CPD credits system which magnifies the “credit” value of education<sup>103</sup>, where changes in practice systems can be demonstrated is also designed with partners in mind as sessional GPs have less means to show “impact” of their education in whole practice systems. A recent revalidation pilot focusing on Sessional GPs in the Northern Deanery however has highlighted alternative forms of evidence which could be used for revalidation to demonstrate reflection and improvement in practice. ([http://www.rcgp.org.uk/revalidation/revalidation\\_guide.aspx](http://www.rcgp.org.uk/revalidation/revalidation_guide.aspx))

From a baseline of essentially individualistic GP working practices, various policy developments have contributed towards the emergence of group based activity amongst GPs. These have included the need to achieve changes collaboratively between practices<sup>104</sup>, e.g. through audit and primary care groups, the advent of vocational training (creation of trainers groups and also presence of trainees stimulating more in house meetings), the introduction of PGEA with the 1990 contract<sup>105</sup> (this payment recognised time spent on education, and provided a means of accrediting in house meetings, of both a clinical and non-clinical nature), section 63 funding<sup>106</sup>, and funding from LIZEI<sup>107</sup> to name only a few. MRCGP exams have been the drivers of “Study groups”<sup>108</sup> which helped trainees prepare for membership exams and Balint groups looked at consulting skills and the relationship between doctors and patients. “Young Practitioner Groups” which included GPs in the transition between training and partnership<sup>109,110</sup> had a support and educational remit intended to overcome perceived isolation and the inadequacies of hospital based education.

Multi-practice practitioner groups are common, with surveys on the Mersey region showing that 35% of principals are involved in small groups with the commonest stated aims being educational and social (to reduce isolation and improve peer support)<sup>111</sup> and 48% of these received the support of their local GP tutor.

The term self-directed learning groups (SDLGs) has been adopted to encompass many of the groups described above, (study groups (formed to help prepare for MRCGP exams), young practitioner groups and so on)<sup>112, 113, 114</sup>. The term self-directed refers to the fact that members determine the learning agenda and there is no formal leadership or external steer and normally no external paid or unpaid facilitation. Their aims mirror those of the groups already mentioned (education and mutual peer support). There is no central register for these groups. More recently another explicit aim for joining or forming such groups has been the need to collect evidence for appraisal and revalidation (for example the need to have a forum to discuss significant event audits and evidence of CPD).

The activities of these various kinds of practitioner groups have included preparing update topics, presenting journal papers, audits, random case analysis, role play, Balint style discussion, development of standards, social events, discussing PUNs and DENs, complaints, SEAs; case discussion (e.g. clinical, ethical); journal review (each member tracking a certain number of publications and reporting back with a synopsis of what has been published and its importance); reporting back on courses attended by members and presentations by speakers from secondary care or the local PCT<sup>113,114,115</sup>. The term performance review is frequently used: *“Most of the young principals groups I have attended have been concerned with performance review and so have overcome any problems of irrelevance- they start with their own work”<sup>115</sup>.*



A number of authors have described features considered important for the success of self-directed learning groups<sup>112, 113 114,115</sup>:

- the need for planning of meetings,
- agreed ground-rules (e.g. trust, confidentiality, commitment to the group over time, equity of contribution),
- explicit aims,
- rotation of facilitation skills,
- regular self-evaluation,
- size between eight and fifteen to ensure a critical and sustainable attendance

Leadership was found to be particularly valuable in ensuring that outside (hospital) speakers, when invited by the group, addressed the group's learning agenda and not the speaker's agenda and to protect peer discussion rather than have a didactic lecture imposed. Others have usefully described the evolution of their groups and problems encountered by the absence of some of the above features e.g. (explicit aims; divergent aspirations)<sup>109,110</sup>.

There is already a body of understanding about groups in health and education from the work of Elwyn *et al.* which concurs with our own evolving picture about SDLGs in General practice<sup>116</sup>. Poorly performing groups may have fallen victim to members behaving inappropriately or having hidden agendas; groups having been established inappropriately (e.g. confused organisational structure), not having developed properly (e.g. failure to clarify or state the group's goals and secure agreement on the task, failure to share), or being poorly facilitated. Further, the group may become too comfortable and uncritical, too cohesive and cosy and 'groupthink' may occur.

Regular self evaluation by the group is therefore key to ensuring not only its survival but its efficacy<sup>112, 113, 114, 115</sup> and should focus on attainment of objectives, ability of members to participate, decision making; time management, discussion/agreement on any changes to aims, methods, ground rules; and actions agreed by the group (e.g. new methods of working, new ground rules). Listening skills and feedback skills are considered important in group evaluation.

An alternative framework suggested by Elwyn *et al.*<sup>116</sup> focuses on:

- task/product; process (e.g. decision-making, respect for ground rules, appropriateness of roles, conflict resolution, problem-solving);
- people; resources (e.g. equipment, time);
- organisation (e.g. group structure, communication channels), and
- objectives (appropriateness of goals and role of group in setting, agreeing and adapting goals).

## Out of Hours work and Sessional GPs

Sessional GPs working in OOH services face many of the difficulties affecting sessional GPs working as day time locums namely isolation, lack of access to information and education and difficulty obtaining evidence for appraisal. The death of a patient in February 2008 treated by a locum doctor who practised in Germany is the subject of an independent enquiry into Take Care Now's (TCN's) provision of OOH GP services by the Care Quality Commission (CQC). Its interim report recommends that they should scrutinise out-of-hours services more closely including the proportion of shifts covered by non-local doctors, the induction and training those doctors receive, and the quality of the decisions made by clinical staff<sup>117</sup>.

A recent review of OOH services<sup>118</sup> found that the provision of induction varied widely between providers, with particular difficulties in guaranteeing inductions to locums sourced at short notice. In some circumstances providers would rely on agencies to provide their induction. The report recommends that induction should be provided to staff "unfamiliar with the area or the provider" and cover policies and procedures, command of the English language, clinical system to be used, and prescribing processes. "A more individually tailored induction process will be used when a GP is working a first shift in the UK or is not familiar with the geographical area." It also recommends shadowing, mentoring support when required and initial audit and case review after the first few sessions worked. The review also made recommendations about the commissioning and performance management of GP Out of Hours providers; the selection, training and use of clinicians (including locum GPs), and management and operation of PCT performers lists).

It is recognised that doctors working out of hours should have specific training to deal with the challenges in this kind of work and COGPED produced a position paper on how this might be delivered for GP registrars<sup>119</sup>. However some GPs may come to out-of-hours work some time after completing training having ceased to practice out-of-hours for professional or personal (family commitments for example) reasons. Other doctors coming to the UK for the first time via locum agencies may use out-of-hours work as their first stepping stone into UK general practice. For these doctors, well supported and individually tailored induction is vital.

## Isolation

Nearly all the literature reviewed here relating to sessional GPs refers to isolation as an endemic problem for these GPs. The isolation has a number of root causes which include, being in a minority and therefore not having contact with peers and lack of access to information, education and professional support and career guidance.

The SchARR report<sup>91</sup> highlighted the problems of isolation amongst sessional GPs

*'...some locums may go for weeks at a time without any meaningful interaction with another doctor' (para 7).*

This problem may not be exclusive to sessional GPs, as GPs spend more time working in relative isolation, particularly with the advent of computerised document management systems, email communication and online education, and have relatively few opportunities to meet with colleagues from other practices<sup>120</sup>. However a 'two-tier system' can operate in some practices regarding the balance of money, power, and information; salaried GPs can be excluded from certain meetings, discussion of new developments and financial aspects of the practice<sup>2</sup>. There can be negative stereotypes of non-principals<sup>121</sup>. Principals may regard salaried GPs as less committed to primary care and less flexible<sup>2</sup>.

Issues of isolation from peers and lack of insight into deficiencies have been found in cases of GPs whose performance has raised serious concerns, and may have implications regarding revalidation<sup>122</sup>. GPs 'may be isolated by virtue of being single handed or a locum or by the dysfunctional working of their professional or group practice' (p550). Mentoring and practitioner groups may help reduce isolation, increase a sense of collegiality and facilitate critical discussion with peers<sup>122</sup>.

## 4. FINDINGS

### 4.1 Mapping of Number, Type and Location of Sessional GPs in the UK

The composition of the GP workforce has changed considerably over the past decade. For example there has been a significant increase in the proportion of salaried GPs, from eight percent of the UK GP medical workforce in 2004 to almost one-fifth in 2008<sup>3</sup>.

This section summarises statistics on the number, type and location of sessional GPs across the UK, and relates these figures to those for the total GP workforce. Fuller breakdowns of figures are provided in Appendix 5.

Sources in each of the four UK countries were used to gather information on the most up-to-date figures available. In several cases there were limitations to the figures obtained (e.g. some exclude locum figures). Comparison between countries from these sources was difficult due to different types of data collection and different terminology.

#### England

An NHS Information Centre for Health and Social Care report<sup>4</sup> provides statistics for NHS Staff in England for 1999-2009, however it excludes statistics for locum GPs.

In September 2009, 71.0% of GPs were GP Providers. Of the remainder, 18.2% was made up of 'other GPs' (i.e. practitioners who are paid a salary), 1.2% were retainers, and 9.6% were registrars.

**Table 6: Numbers (headcount) of GP Practitioners by type, 30 September 2009 (England)**

	All GPs	GP Providers	Other GPs (=salaried)	GP Retainers	GP Registrars
Total	40,269	28,607	7,310	471	3,881
Percentage	100%	71%	18.2%	1.2%	9.6%

Source: The NHS Information Centre 2010

The number of GP Providers has remained relatively static between 1999 and 2009, rising by only 3.3%, whilst the number of 'other GPs' (salaried) increased by on average a quarter each year, from 786 in 1999 to 7,310 in 2009.

#### Scotland

Data supplied by individual health board records for the purpose of an NHS Quality Improvement (NHS QIS) Report on GP Appraisal in Scotland published in January 2009<sup>123</sup> are reproduced in the following table.

**Table 7: GPs working in different capacities across Scotland**

GP Providers	Sessional GPs <sup>1</sup>	Salaried GPs <sup>2</sup>	Retainee GPs
3,841 (68%)	1,270 (22%)	376 (7%)	164 (3%)

<sup>1</sup> Self-employed GPs who contract their services to practices on a fee paid basis

<sup>2</sup> GPs who hold a contract with, and are directly employed by, GP practices or boards

Information Services Division statistics published in 2010<sup>5</sup> show that over the last five years there has been a large (155.3%) increase in the headcount of salaried GPs, from 188 in 2004 to 480 in 2009, representing 10.7% of all qualified GPs (i.e. excluding registrars) compared to 4.5% in 2004.

GP statistics for Scotland (September 2009) are shown in Table 8 below, but do not include GPs who work only as locums or GPs who work only in Out of Hours services.

**Table 8: Number (headcount) of GP performers by GP performer type and gender, 30 September 2009 (Scotland)**

	All GPs	Performer <sup>1</sup>	Performer salaried	Performer retaine	Performer registrar/ST
Total	4,941	3,836	480	165	472
Male	2,436	2,126	148	2	166
Female	2,505	1,710	332	163	306

<sup>1</sup> A Performer is most likely to be a partner in a practice

Source: ISD Scotland

## Wales

Workforce statistics for General Practitioners in Wales<sup>124</sup> indicate that at 1 October 2009, there were 1,940 Practitioners in Wales. In these statistics, salaried doctors and Assistants are included in All Practitioners, and GP retainers are shown separately. Data on locums is not available.

**Table 9: GP practitioners by region and board in Wales, 1 October 2009**

	All GP practitioners (incl salaried & assistant; excl locums)	GP Retainers	GP Registrars
Wales	1,940	55	161

Source: Stats Wales

## Northern Ireland

In Northern Ireland statistics 'GP' refers to Unrestricted Principals or Equivalents (UPEs) and salaried GPs. In October 2008 the total number of these GPs was 1,148, of whom 22 were salaried GPs<sup>125</sup>. There were an additional 539 GPs who were also registered to provide General Medical Services within Northern Ireland. A full breakdown of figures is shown in the following table.

**Table 10: Numbers of GPs in Northern Ireland, October 2008**

UPE	Salaried	Locum	Retainer	Returner	Assistant	Associate	Restricted	Registrar	ST2
1,126	22	396	30	4	2	1	7	64	35

Source: HSC Business Services Organisation

## UK-wide

For this report, data was requested by the researchers from Binley's databases<sup>126</sup> for April 2010 and is summarised in Table 11. This data includes retainers and locum GPs (also GPs who are both locums and salaried). In addition it includes figures for Assistant and Associate GPs and Flexible Career Scheme GPs. Some of the GPs within these categories will have additional responsibilities e.g. Practice Manager, GP Trainer, Computer Manager, Chair Lead GP, Medical Officer, Civilian Medical Practitioner, but each GP has only been counted once.

These figures show that, of a total of 44,707 GPs in April 2010 across the UK (including Assistant and Associate GPs and Flexible Career Scheme GPs), 74.05% are GP partners, 17.33% salaried, 4.79% locums (plus 0.33% both salaried and locum GPs), and 1.36% are GP retainers.

**Table 11: Number (headcount) of UK GP performers by GP performer type, Country April 2010 (supplied by Binley's<sup>126</sup>)**

	<b>Locum GP</b>	<b>Salaried GP</b>	<b>Locum &amp; Salaried</b>	<b>GP Retainer</b>	<b>Assistant GP</b>	<b>Associate GP</b>	<b>Flexible Career Scheme GP</b>	<b>GP Partner</b>
England	1756	7114	138	390	512	258	55	26,299
Islands	6	5	1	2	8	5	0	177
Scotland	189	373	6	140	56	29	1	3768
Wales	87	208	1	44	16	4	0	1751
N. Ireland	103	48	2	32	8	3	0	1112
Total	2141	7748	148	608	600	299	56	33,107
Percentage	4.79%	17.3%	0.33%	1.36%	1.34%	0.67%	0.12%	74%

As an adjunct to all the above figures, an additional method of data collection was explored to identify whether any further, or confirmatory, data could be added to this part of the study.

Performers List managers for PCTs or Boards across the UK were contacted by e-mail (in some cases followed up by telephone call) and asked to provide current figures for the number and type of GPs on the Performers List for their area. Collated figures are shown in the tables below. However, there are several limitations with respect to this data capture which mean that the figures must be treated with great caution. The main issues identified were lack of consistency in terminology used for different GP types, both across the four countries and within England, and ways in which data is collected and recorded. The latter issue was more prominent in England with multiple PCTs, some collecting their own data and some using agencies, whereas data was co-ordinated by one person in each of the three other countries. These limitations highlight an important finding in themselves. Finally, whilst there was a very high response rate (86%) to our request in England, particularly given the tight timescale of the project, this does not give full figures for England.

**Table 12: Performers List figures for England (supplied between April and June 2010; response rate 86%)**

SHA	Partner / Provider & Sole Contractor	Locum & OOH Locum	Salaried (incl PCT salaried)	Performer (incl GMS Performer; PCT employed Performer; Practice employed Performer)	Returner	Returner	Flexible Career Scheme	Career Start	Registrar
London	2483	1154	1059	1477	23	7	2	12	443
South East Coast	857	341	194	0	15	3	0	0	227
South Central	1972	748	268	2625	53	9	2	0	317
South West	2800	1091	888	1752	71	6	5	2	335
East Midlands	2236	498	616	3041	19	4	6	0	1124
West Midlands	1979	695	504	1575	21	0	9	0	411
East of England	2916	878	613	1581	44	3	10	0	309
North West	2340	927	555	1336	28	1	3	0	840
Yorkshire & The Humber	2768	788	775	2742	42	2	7	0	618
North East	1334	371	425	-	26	3	8	17	284
Totals	21,685	7491	5897	16,129	342	38	52	31	4908
Percentage of GPs (excl registrars)	41.97%	14.5%	11.41%	31.22%	0.66%	0.07%	0.1%	0.06%	

**Table 13: Performers List figures for Scotland (as at 12.4.10)**

Health Boards	Performer provider GPs	Performer (main contract holder)	Performer Salaried (NHS Board paid)	Performer Salaried NHS (practice paid)	Performer Salaried (other)	Performer Retainee GPs	Performer Returner	Performer Registrar GPs	All contracted GPs	Principal NHS Board Performer List GPs available to work as a locum (without a practice contract)
Ayrshire & Arran	2	269	0	0	12	3	0	37	<b>323</b>	66
Borders	4	90	0	3	5	5	0	14	121	44
Dumfries & Galloway	129	0	1	7	1	3	0	20	<b>161</b>	72
Fife	246	0	1	13	0	2	0	21	<b>283</b>	70
Forth Valley	0	214	2	12	4	12	0	25	<b>269</b>	66
Grampian	14	392	30	28	51	21	1	66	<b>603</b>	169
Greater Glasgow & Clyde	0	860	5	19	31	26	0	157	<b>1098</b>	256
Highland	87	209	24	31	25	6	0	43	<b>425</b>	253
Lanarkshire	1	344	0	16	6	7	0	35	<b>409</b>	75
Lothian	11	572	1	27	72	57	2	109	<b>851</b>	176
Orkney	0	18	3	1	13	1	0	1	<b>37</b>	29
Shetland	0	12	10	4	5	1	0	1	33	8
Tayside	0	298	1	9	6	15	0	56	<b>385</b>	122
Western Isles	2	28	1	3	10	0	0	2	<b>46</b>	18
Total	494	3306	79	173	241	159	3	587	<b>5042</b>	1424
% of GPs (excl registrars)	85.3%		11.07%			3.57%	0.07%			

Source: General Practitioner Contractor Database (GPCD), ISD Scotland, Extracted 15/04/10

Notes: There are 97 Single handed GPs on the Performers List for Scotland. They have been included in the above table. The categories Flexible Career Scheme and Career Start are not applicable in Scotland.

**Table 14: Performers List Figures for Wales (as at 16.6.2010)**

SHA	LHB	Partner / Provider	Sole Contractor	Locum	Salaried	Retainer	Returner	Registrar
Abertawe Bro Morgannwg University	Abertawe Bro Morgannwg University	308	7	96	24	8	2	77
Aneurin Bevan	Aneurin Bevan	302	15	102	64	7	2	36
Betsi Cadwaladr University	Betsi Cadwaladr University	458	20	151	34	11	1	41
Cardiff & Vale University	Cardiff & Vale University	260	9	82	27	12		51
Cwm Taf	Cwm Taf	114	13	41	48	7		29
Hywel Dda	Hywel Dda	212	8	67	35	5		33
Powys Teaching	Powys Teaching	121	0	40	9	0	1	6
Totals		1775	72	579	241	50	6	273
Percentage of GPs (excl registrars)		67.8%		21.26%	8.85%	1.83%	0.22%	

Source: BSC Contractor Services South East Wales

**Table 15: Performers List Figures for Northern Ireland (as at 1.4.10)**

Health & Social Care Board	Unrestricted Principal	Restricted Principal	Locum	Salaried	Retainer	Returner	ST2 & ST3
Belfast Commissioning Group	267			16			
Northern Commissioning Group	267			9			
South Eastern Commissioning Group	184			12			
Southern Commissioning Group	203			9			
Western Commissioning Group	191			3			
Totals	1112	7	414	49	26	6	137
Percentage of GPs (excl ST2 & ST3)	69.3%		25.65%	3%	1.6%	0.37%	

Source: HSC Business Services Organisation

Notes: 'Unrestricted principal' refers to a current partner in a GP practice, who is free to work in any practice in Northern Ireland. 'Restricted principal' refers to a performer registered only to work in a hospice in Northern Ireland. In addition, there are 2 Assistant GPs and 1 Associate GP on the NI Performers List.



## 4.2 Survey of Educators Involved with Sessional GPs

This survey looked at three broad areas:

1. Educational and other forms of support provided by deanery educators
2. Specific experience relating to self directed learning groups
3. Wider issues relating to isolation, and ways in which it is being addressed.

Responses were received from 15 out of the 20 deaneries across the UK to which the survey was distributed. The total number of responses was 34, of which 23 were from educators/advisers who considered themselves to have a dedicated role in supporting the educational, professional or appraisal needs of sessional GPs. Of those 23, six were the only educator/advisor in their deanery with this dedicated role. Other deaneries had up to six with this role.

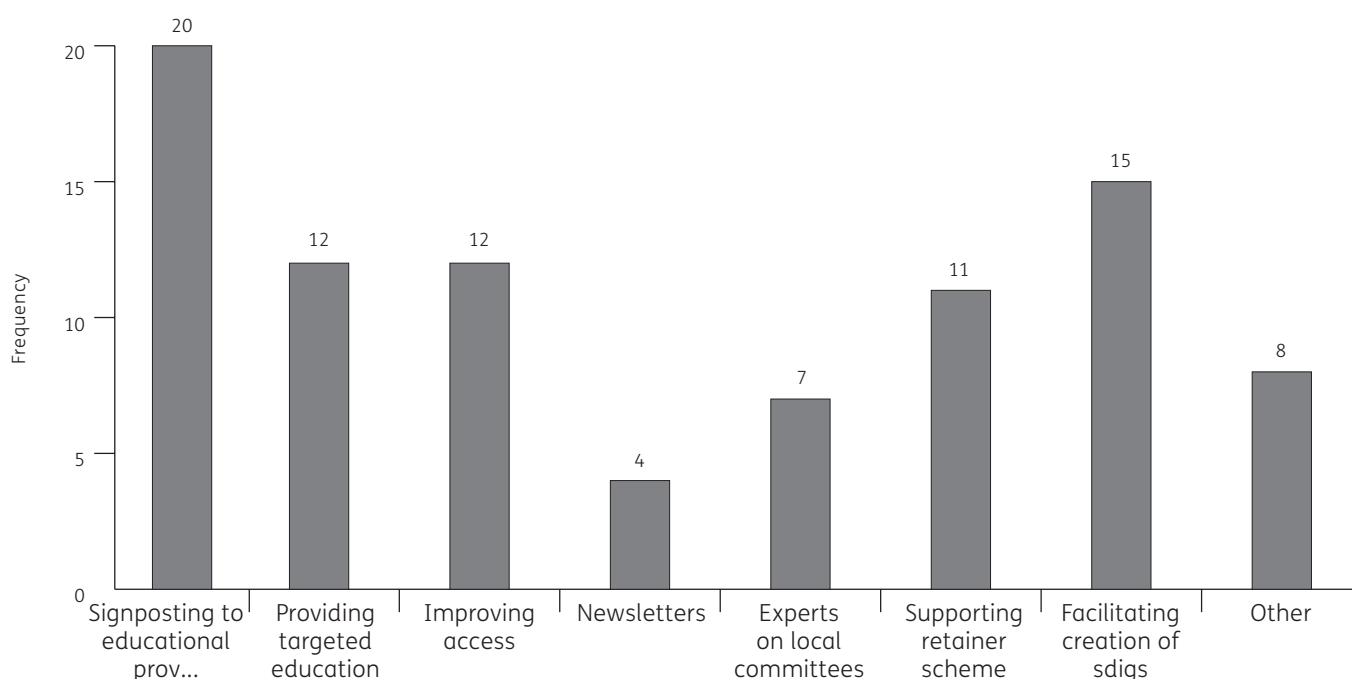
Eleven responses were from educators who did not consider themselves to have this exclusive role. These educators explained that support for sessional GPs was provided in with that offered to the GP population in general, with no distinction being made in the needs of this group of GPs. Sources of support included GP educators/advisers, Associate Directors, and CPD and Appraisal Managers/administrators. There were deaneries which employed an educator or associate adviser with specific responsibility for retainers and refreshers. Some tutors were doing temporary extra sessions to support GPs in career transition, which is mainly but not exclusively aimed at sessional doctors.

### 4.2.1 Support Provided for Sessional GPs

#### Respondents with a dedicated role (n=23)

Respondents were asked to state what roles they took on as part of their dedicated role. The most commonly undertaken role was signposting sessional GPs to educational providers, followed by facilitating the creation of self-directed learning groups. Other roles undertaken by approximately half of the respondents were providing education targeted at sessional GPs, improving access by sessional GPs to 'mainstream education' by working with local organisations, and supporting, running or advising on the retainer scheme. Approximately one-third of respondents stated that they acted as expert on local committees/panels etc. on issues around sessional GPs, and a small number produced newsletters for sessional GPs. Frequencies are provided in Chart 1 below.

**Chart 1: The role of educators/advisers with a dedicated responsibility and the support they offer.**



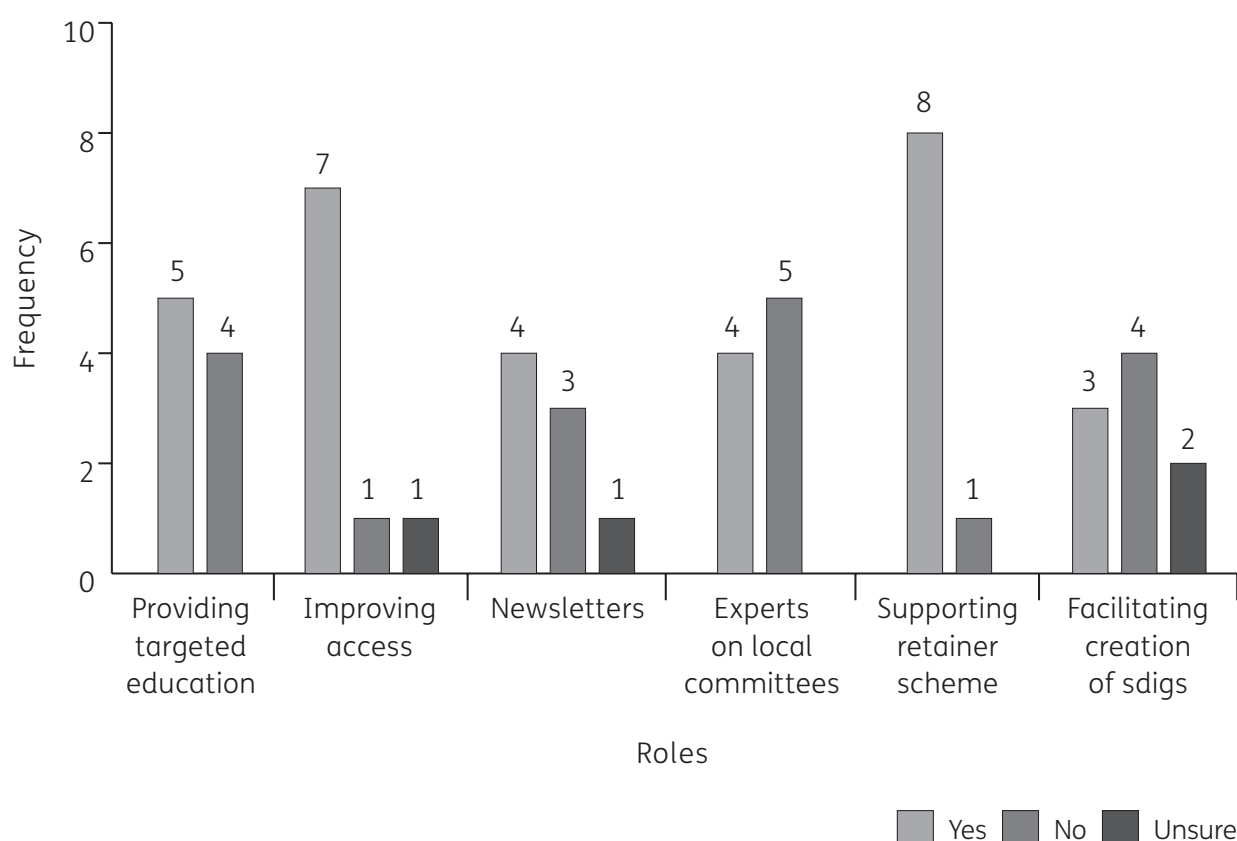
## The 'other' roles undertaken in relation to supporting sessional GPs included:

- Providing advice and support in connection with appraisal and revalidation; one to one feedback on audits and Significant event audits
- Providing website information and mentoring
- Supporting sessional GP groups, fielding queries relating to working conditions as sessional GPs and supporting setting up of locum chambers; facilitating learning sets, e-groups, or self directed learning groups
- Dealing with queries from doctors returning from career breaks; extra help (offers of interviews) for doctors in career transition
- Exit interviews for GP Registrars when they finish their training.
- Courses aimed at newly qualified GPs, who are often sessional

## Respondents with a non-dedicated role in supporting sessional GPs (n=11)

The majority of the respondents with a non-dedicated role stated that Deanery roles and responsibilities for sessional GPs included supporting, running or advising on the retainer scheme and improving access by sessional GPs to 'mainstream education' by working with local organisations. Just under half stated that their deanery provided education targeted at sessional GPs or produced newsletters or guidance for sessional GPs. A minority reported that the deanery acted as experts on local committees/panels on issues regarding sessional GPs or had a role in facilitating the creation of self-directed learning groups.

**Chart 2: Roles undertaken by the Deanery regarding sessional GPs**



### 4.2.2 Educational Support

Some respondents reported that educational opportunities were provided specifically for sessional GPs. Others reported that all relevant Deanery events are open to sessional GPs.

Education specifically targeted at sessional GPs included clinical programmes; CPR and child protection; career development days for sessionals or retainers (e.g. “Survive and Thrive” promoting positive aspects of being sessional doctors, and promoting further portfolio options e.g. mentoring), training days (e.g. appraisal and revalidation for sessional GPs); consultation skills refreshers; consultant/GPwSI shadowing opportunities; away days for retainers and returners; and an annual conference for retainers and sessional GPs.

*A dedicated programme aimed specifically at sessionals has also been found to be important as they feel more at ease asking questions amongst their “peers”.*

*I have produced a Performers Pack which includes information and advice for sessional GPs on resources for educational locally, how to gather evidence for appraisal etc.*

### 4.2.3 Other forms of support

Just over half (n=18) of respondents reported on forms of support in place for sessional GPs other than educational support.

The most commonly mentioned forms of support were mentoring and careers advice (through meetings, website or annual conference). Some forms of support were not specific to sessional GPs, and they were included in programmes for all GPs e.g. leadership programmes, an Organisational Effectiveness Programme and an annual conference for newly qualified GPs covering finance and career opportunities. Several of the tutors with a dedicated role for sessional GPs reported on their availability for queries e.g. regarding working conditions and starting out as a sessional GP. One tutor referred to the existence of LMC support.

*As GP tutor I am trying to contact any GPs new to the performers list (including sessional GPs) to arrange one to one meetings with them. I plan to organise a newsletter update (to all on the list) including revalidation information and offering self directed learning groups.*

*As an educator with a dedicated role for supporting sessional GPs, I am happy for any sessional GP to e-mail or phone me with any queries, e.g. about working conditions, starting out as a sessional GP (especially as a locum), how to obtain counselling etc.*

### 4.2.4 Enquires from Sessional GPs

96% of respondents reported that they received queries from sessional GPs.

Enquiries related to most of the roles already referred to such as signposting to education (particularly CPR and child protection) or getting onto mailing lists or cascades and difficulties gaining places or funding on courses or events. There were also queries related to appraisal and revalidation, where to find appraisers and how to access information and collect evidence.

General professional queries included careers advice, particularly following career breaks and access to the retainer scheme; how to access self directed learning groups, and advice about issues relating to working as a locum or a salaried GP e.g. contracts and locum fees, superannuation and pensions.

## 4.2.5 Involvement of Deanery Educators in Sessional GP Groups and Self-Directed Learning Groups

### Contact With Local Sessional GP Groups

‘Sessional GP group’ normally refers to a group of sessional GPs within a defined geographical area who come together for educational opportunities and job vacancies, and to provide mutual professional peer support, often under a clear leader and funded by membership fees or receiving in a minority of cases some external funding from deaneries, pharmaceutical companies, PCT and so on.

Many tutors were aware of groups running locally, and many have liaised with or supported sessional GP groups or may use them as a route for cascading educational or other information e.g. local guidelines. Some have more formalised links for example providing representation.

*We have a representative from the [sessional GP group] on the educational consortium in the deanery. We work closely with them to support delivery of appropriate educational events/support to sessional doctors.*

*The individuals who convene the groups are invited to meetings of the Steering groups from each of the Education trusts. Deanery co-ordinates this group meeting*

*I work very closely with the group. As the group has grown quickly and has healthy funds it has been possible to invest in its website to provide educational information to members (but open to all sessional GPs)...The educational programme for sessional GPs is on the same evening and same place as the sessional GP group meeting so that sessionals can come out once a month and get both peer support and education.*

One respondent commented on their own participation in a sessional GP group:

*The [anon] sessional GP group is an excellent group. I attend regularly and have done for many years we provide mutual support, share clinical case discussions. It is a forum for discussing SEAs for locums who don't have the option in practices (essential for revalidation), we are planning sessions on audit for locums and salaried drs - for revalidation ... Sometimes a member talks on a specific topic ...We sometimes share job opportunities/vacancies.*

### 4.2.6 Self-Directed Learning Groups

Self-directed learning groups are defined here as groups of GPs who meet regularly for the purpose of mutual support and continuing professional development, without regular external paid or unpaid facilitation. Respondents in some cases did not distinguish clearly between self-directed learning groups (SDLGs) and the more formal larger sessional GP groups.

Numbers of SDLGs vary widely as the true self-directed groups maintain no formal links with any structures advertise by word of mouth and are largely self-sufficient. About three quarters of the respondents knew of SDLGs in their area, most knowing of between one and six groups, two knowing of twelve and one knowing of twenty.

*I know of 12 SDLGs because of personal contacts and because I have helped set them up; but an educated guess deanery-wide would be 50 groups. Most have no formal links to educators so suspect there may be many more out there. GP population in this deanery 2388*

Tutors in many areas help set up groups by facilitating networking of GPs within the same area, disseminating information about SDLGs (e.g. Guide on NELG website) and in some areas facilitating funding via PCTs. In some cases tutors describe an initial involvement in a launch period, by facilitating a group for a period of months then leaving it to let it run itself e.g. retainers group, or providing some skills training for facilitators who will then help run the groups they belong to and are trying to set up.

*At my meetings I ask people who are interested in meeting nearer home and put them in email contact. I offer to attend to help set up group and provide quality assurance if needed.*

*Advise on content and help with networking and pointing new sessional GPs to the existing groups*

*I have organised annual events for people to meet each other and find out about SDLGS. I produce an A5 booklet for them explaining some of the mechanics of the groups (importance of ground rules, being clear about purpose, regular reviews etc) and have been pleasantly surprised how well people take these forward and set up successful groups.*

In Scotland where there is a scheme called practice based small group learning (based around a Canadian model with an annual subscription for use of learning materials), tutors tell new retainers about this scheme on entry to the retainer scheme.

Most tutors report that there is no mechanism for feedback from SDLGs to the deanery as they are independent and private. Informal feedback comes mainly via the appraisal route to tutors who are appraisers. Some groups will only report back when requesting funding.

*Very little formally; mainly incidental and via informal networks; hear about different ways of agenda setting and how badly handled membership issues (i.e. taking on new members) can really upset the trust between members.*

*Currently we are not seeking feedback as they are independent. However I hear and see reflection and feedback at appraisals of sessional GPs and am impressed by the rigour*

## **Attributes of Successful Self-Directed Learning Groups**

Tutors described a range of **personal** attributes which they believed helped make SDLGs successful. These included being self aware, motivated, committed to the group, willing to trust and share experience, each having a sense of ownership and responsibility towards the group, group ethos and being able to make time to meet.

**Organisational** attributes thought to contribute to success included having clear ground rules, a set day of the month to meet (reducing time spent coordinating schedules), planning ahead, reviewing and feeding back to each other on activities and satisfaction with meeting groups aims; clarity of decision making (e.g. which decisions need unanimous vote and which just need majority, geographical proximity of members and autonomy from other organisations). One group used an online spreadsheet (on googledocs) to update the members' "rota" for hosting meetings and presenting topics.

Some respondents commented that **size** was an important element of a successful SDLG and that the group should be of a small size. One person mentioned an ideal size of 6 to 8 people in a group so that most monthly meetings are viable even when some people are unable to attend.

Other **important attributes** thought to contribute to successful groups were having a shared outlook or similar work context (e.g. sessional), common aims or needs, facilitation skills, a non threatening environment, a balance of time spent on education and peer support and access to an educational resource.

#### 4.2.7 What would make Self-Directed Learning Groups more Successful?

Respondents commonly stated that help was often needed in the setting up stages by putting people in contact with each other and providing information about successful models/guidance. It was also thought that individuals new to area or newly qualified needed help to find existing groups which might be open to new recruits without taking away the groups' autonomy to recruit.

*More opportunities to learn from other SDLGs, many grapple with common issues: falling numbers when people leave; getting people to commit to attend to ensure meetings are viable. There is a balance to be had where meetings are not perceived as "pressure" like work but there is sufficient commitment amongst members for people to feel it is a reliable event. Some grapple with feeling groups are too academic with not enough support for informal time and some possibly suffer the other way. The latter are more likely to lose momentum and dissipate; there is a sense of "re-inventing the wheel"*

*Some leadership skills, connecting with other groups and regional meetings*

*Making it easier for the GP tutor to contact specific groups e.g. sessional doctors, new doctors on the list.*

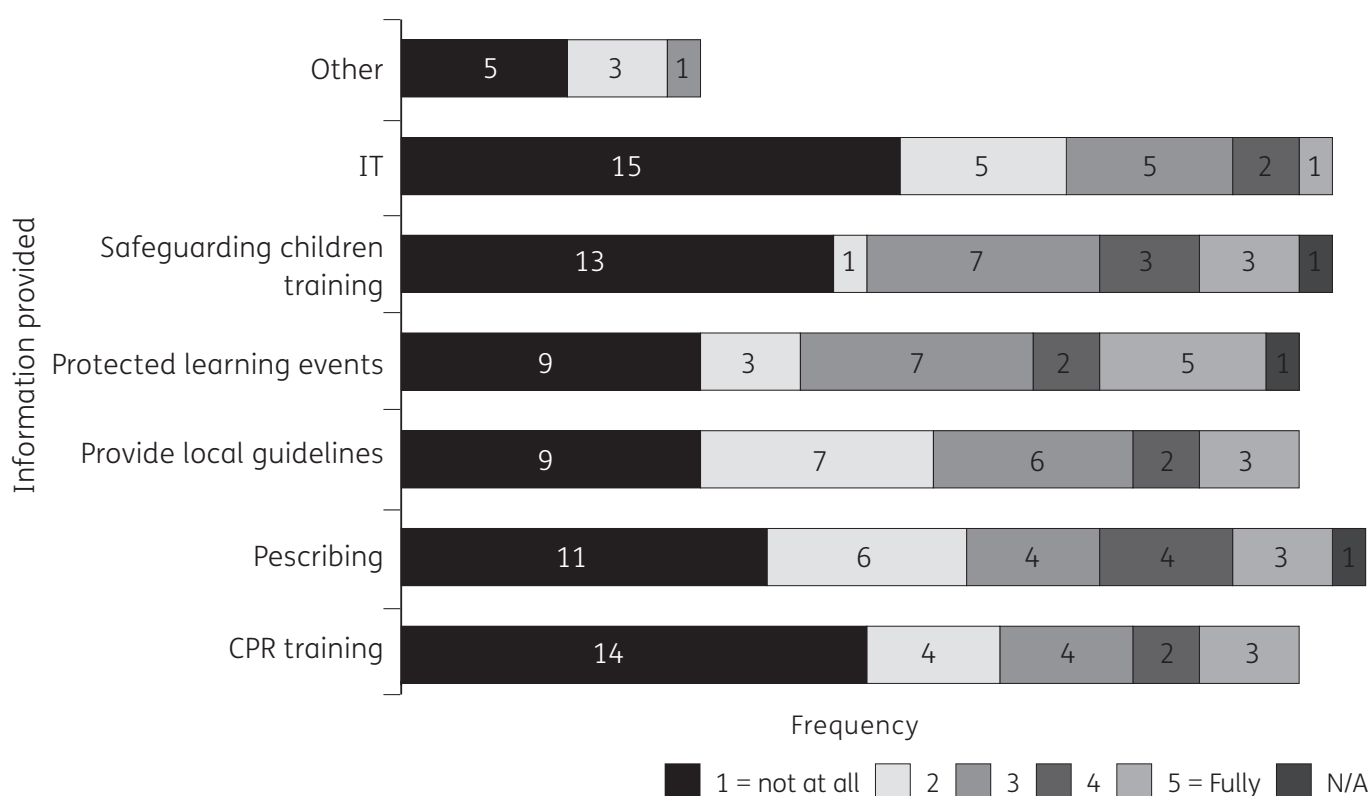
*Some simple do's and don'ts for people wanting to set one up. A place to advertise (if that is wanted) for members. Possible meeting places. Probably, some tutor help*

A number mention that groups seek funding and paid facilitation e.g. tutor input, and this reflects some confusion between self-directed groups and more formalised educational programmes for sessional GPs.

#### 4.2.8 Lack of Information

A number of tutors seemed aware of sessional GPs experiencing difficulty in obtaining information from PCTs about educational opportunities and other developments.

**Chart 3: A Chart showing the extent to which PCOs inform Sessional GPs**



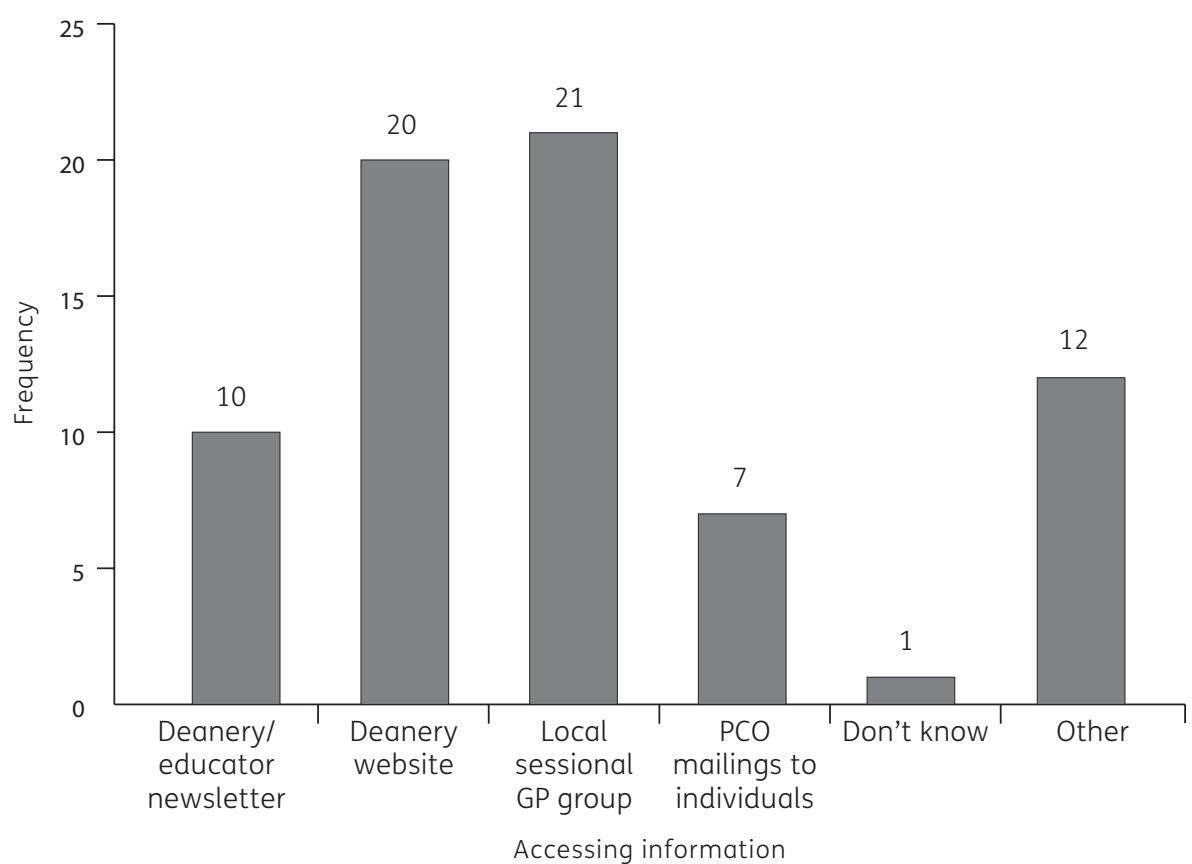
A number of tutors seemed to be working actively with PCTs to try and address this issue using email. Data protection restrictions prevent performers list contact details from being used this way automatically so a second consent and registration process is often required to build up distribution lists.

*I have a PCT administrator with a list of sessional doctors and doctors in the locum bank (not a complete list). We try and email out info to them but are not always remembered in info sharing from the PCT*

*If in a fixed session and on PCT email list OK, if a locum less successful.*

The Deanery website and Local Sessional GP group were commonly mentioned as important sources of information about educational events for sessional GPs. Other sources included PCO mailings directed to individuals (rather than to practices); Deanery/educator newsletter or other emails from tutors, and Websites (PCO, Faculty, Local sessional GP group, Education trusts).

**Chart 4: Accessing information about educational events**



**4.2.9 Isolation**

**4.2.10 Professional Isolation**

Professional isolation has often been identified as an issue affecting sessional GPs. Respondents were asked whether they were aware of problems arising as a result of isolation. Seventy two percent of respondents reported that they were aware of problems, and 21% that they were not. Seven percent were unsure.

Respondents outlined three broad areas which were affected by isolation. The first is best described as lack of information about systems and support structures and the second encompassed wider more intangible and personal effects of isolation on self-esteem, professional functioning and achievement. The third area related to missed professional opportunities for peer interaction.



#### **4.2.11 Lack of Information**

It was considered that isolation can result in ignorance/lack of information about educational opportunities, difficulty finding work and lack of information about (and therefore fear of) appraisal and revalidation requirements. It can also result in lack of information about prescribing updates and lack of knowledge of referral pathways (resulting in complaints).

#### **4.2.12 Personal Effects of Isolation**

These included demoralisation, anxiety, lack of confidence, demotivation and lack of career progression, feeling undermined and poorly supported, and feeling that they cannot contest employment issues if they are the only employed GP in the practice.

*They struggle to keep up and lose confidence. The newly qualified are particularly vulnerable as are those with young children who have recently relocated here to follow partners' jobs.*

#### **Lack of Contact with Peers and Networking**

Effects included not knowing how to gather evidence for appraisal and revalidation (not enough opportunities to share ideas for this); nowhere to discuss SEAs; lack of benchmarking, and not hearing about follow up of patients

*Many! Often these doctors have employment/contract issues and they feel that they cannot contest them as they may then have a bad reputation and not get other jobs/partnerships. I have also been told about sexism on the part of employers when women request maternity leave. They feel that they have no one to discuss these issues with particularly as many of the older GPs they may have approached are partners themselves.*

*Locums in particular feel isolated, and are often unsure how to deal with issues such as working on their own in a small practice, not having a chance to talk to partners in the practice, losing confidence, often finding it difficult to attend educational meetings (they are often covering for principals who are attending these meetings) or worrying about losing income as being at a meeting means loss of work.*

Fifty-nine percent of respondents reported that they were aware of local initiatives which may help with issues of professional isolation, 34% were not and 7% were unsure. Respondents mentioned a wide variety of initiatives which they perceived as helping to relieve isolation. These were groups (sessional GP groups, SDLGs, Retainer groups, email/web based groups), tutors/annual meetings with associate director; mentoring; interviews on entry to the medical performers list; practices inviting sessional GPs to their meetings and to protected learning events, and "kasebook".

#### **4.2.13 Support Needs Not Currently Met By Deaneries**

Sixty-two percent of respondents reported that they were aware of sessional GP needs not currently being met by the Deanery or some other source of support and 28% stated that they were not aware of any unmet needs. Ten per cent were unsure.

The needs perceived by respondents as not being fully met included: career development (including exit interview at end of training) and employment advice; mentoring; information about education and PCT intranet and access to education cascades; support for revalidation and appraisal, and not enough SDLGs.

*Support with revalidation tasks e.g. easy topics for a locum to audit - self-record-keeping, prescribing, referrals etc - I will promote this through my tutor role and sessional GP group. Encourage PCTs to keep sessional doctors informed and seek individual prescribing numbers. Ensure all practices have decent locum packs, induction, IT support, and individual log in (to facilitate audit trails for individual doctors).*

#### 4.2.14 Additional Concerns and Suggestions

Other issues identified by respondents regarding support for sessional GPs related to the following three broad areas:

##### **The Role of PCTs and GP Practices**

Some respondents considered that PCTs and GP practices needed to have a stronger role in supporting their salaried doctors and including locum GPs.

*GP Practices/practice managers need to have a stronger role in supporting their salaried doctors. They should have full access to all the info that the partners get so they are kept in the “loop”*

*Many partners are unsupportive of sessional GPs and exploit them. Any initiative which highlights this and promotes mentoring/development of sessional GPs would be helpful. Obviously many sessional doctors are bright enthusiastic professionals and represent an untapped resource. However, currently many feel disenfranchised.*

*Encourage PCTs to keep sessional doctors informed and seek individual prescribing numbers.*

#### 4.2.15 Funding

##### **Concerns were raised by some about funding.**

*Employers have a duty to support those on contract and PCTs have a duty to those on their Performers List - these duties are not being fulfilled. SHAs do not provide Deaneries with funding for this purpose - it has to be topsliced from MADEL - not possible as we move to ‘tariff’ based funding*

*Since 2007 all funding in our deanery has been diverted to GP training so we have no funding for post CCT GPs including sessional ones. We have no deanery funded GP tutors. We continue with the retainer scheme but I am not sure how I will identify a funding stream for this.*

#### 4.2.16 Revalidation

Several respondents raised the issue of revalidation and the need to support sessional GPs in evidence collection, e.g. recommending specific multi-source feedback and patient feedback tools for sessional doctors, and practices encouraging locums they regularly use to attend their SEA, audit and protected learning meetings.

*Emphasise that locums should be invited to in house education, practice meetings, SEA discussions and be informed of any complaints or PRAISE/positive feedback, invite locums to perform audits of their choice (not just QOF), patient and multisource feedback to facilitate revalidation. Recommend specific MSF and patient feedback tools for sessional doctors*

## Summary

There were 34 responses from 15 out of the 20 deaneries across the UK. Twenty three of the 34 responses were educators/advisers who considered themselves to have a dedicated role in supporting the educational, professional or appraisal needs of sessional GPs. Eleven responses were from educators who did not consider themselves to have this exclusive role. Support was inclusive to all GPs with no distinction being made in the needs of sessional GPs.

Seventy-two percent felt that there was a prevalence of isolation among sessional GPs. Isolation was reported to be in three main areas; lack of information about systems and support structures, personal and intangible effects of isolation such as professional functioning and achievement and the third was around a lack of contact with peers and networking.

Issues faced by sessional GPs were reported to be a lack of information from PCTs about education opportunities and other developments. However some deaneries are working with PCTs to address this. In addition data protection restrictions prevent performer list contact details being used to distribute information.

Designated tutors help set up SDLGs. There is a lack of knowledge about how many SDLGs there are, this is mainly due to their informal nature and not being linked to any organisations.

Attributes of successful SDLGs were reported to be personality within the groups for example, being motivated, committed, open and trustworthy with a willingness to share experiences. SDLGs which have a good organisation for example, clear ground rules, set days to meet, reviewing of feedback and organisation within the group. Size also seemed to be important with the general thinking that groups were better smaller rather than bigger. Other important elements were having a shared outlook and similar attributes such as age and stage in life. To help make SDLGs more successful it was reported that guidance at the setting up stage and examples of successful models would be helpful.

Additional concerns were around the role of PCTs and GP practices in supporting sessional GPs, funding for sessional GPs and revalidation and support they will need in collecting the required evidence.

### 4.3 Survey of Sessional GP Groups and Locum Chambers

‘Sessional GP group’ normally refers to an informal group of sessional GPs within a defined geographical area who come together for educational opportunities and job vacancies, and to provide mutual professional peer support. Chambers are a relatively new form of formal sessional GP group which provides a shared administrative and booking system for locum work as well as clinical leadership and mechanisms for collecting feedback on performance and evidence for appraisal and revalidation.

#### The survey explored three main areas:

1. Membership, organisation and running of the group
2. Services provided by the group
3. Strengths and difficulties, and any needs the groups are unable to meet

Eighty-one questionnaires were distributed to group contacts and eleven email addresses were found to be invalid, meaning that seventy were successfully distributed. Sixty-five questionnaires were completed, giving a response rate of 93%. Fifty-seven responses were from sessional GP groups and eight from Locum Chambers (this is the total number of Locum Chambers posted on the NASGP website at the time of distribution).

The analysis in the next section provides a breakdown of descriptive statistics of sessional GP groups and Locum Chambers, which are presented separately and have not been compared with each other.

#### 4.3.1 Sessional GP Groups

#### 4.3.2 Group Membership

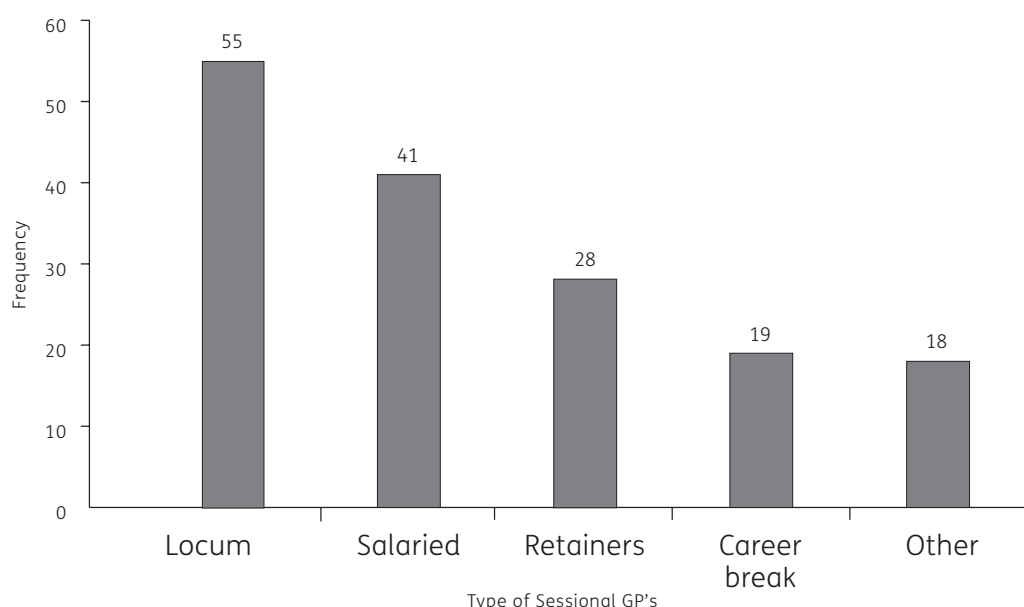
The Sessional GP groups in the sample had on average 49 members and had been running for between one month and 20 years.

**Table 16: Sessional GP group membership and months of running**

	N	Min	Max	Mean	Std. Deviation
No of members	47	1	180	49.32	45.329
How long the group has been running (months)	55	1	240	91.33	65.789

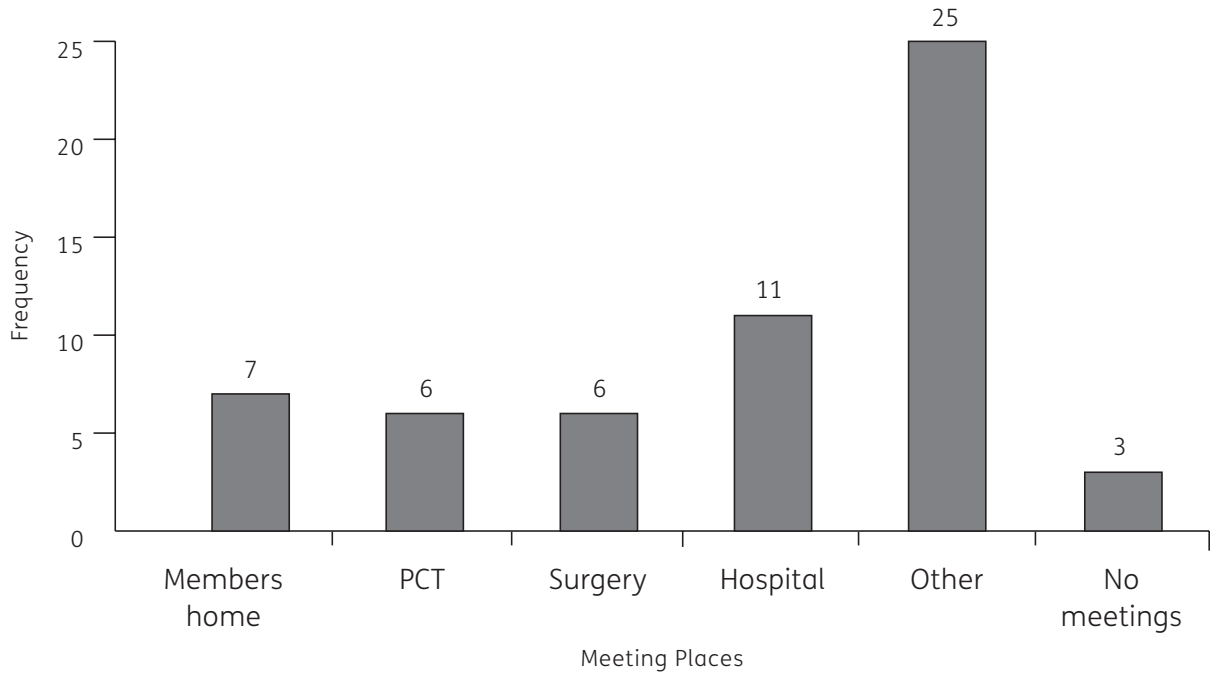
The group membership consists mostly of locum and salaried GPs.

**Chart 5: Membership of Sessional GP Groups**



Group meetings take place at venues such as hospitals, surgeries, PCTs and members’ homes, as shown in the chart below.

**Chart 6: Venues where Sessional GP Groups meetings take place**

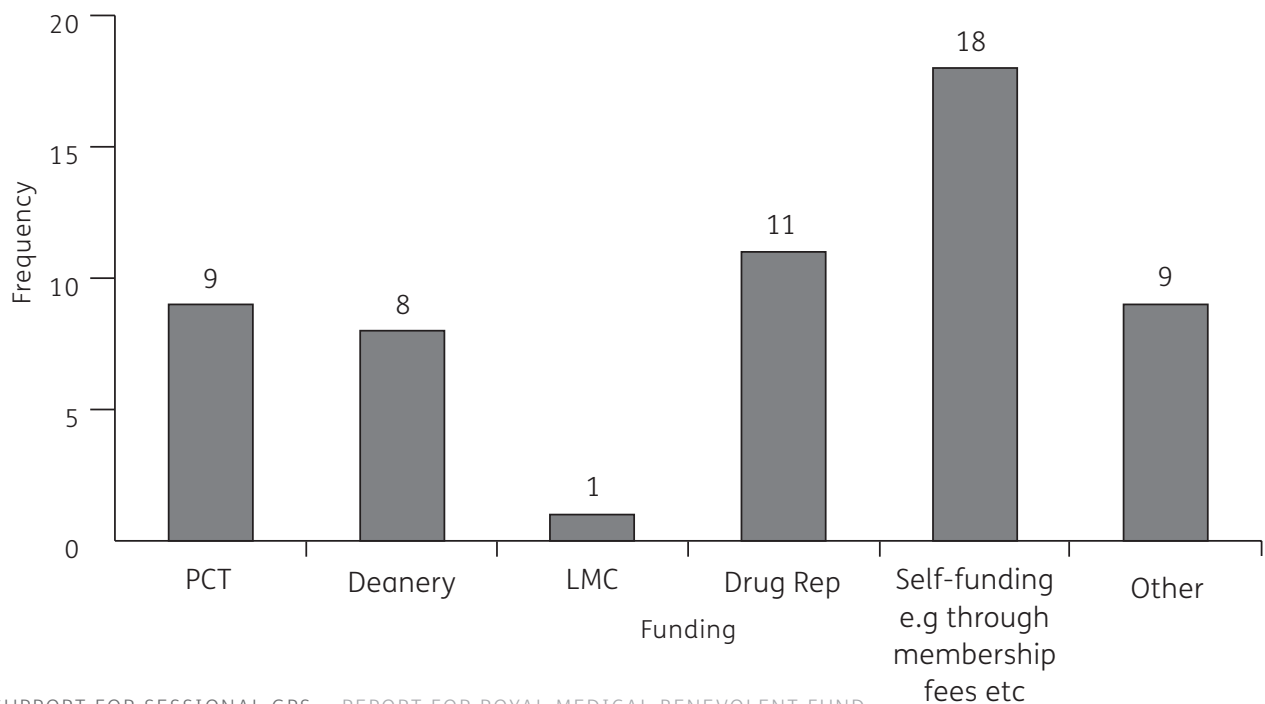


The other places that sessional groups meet include Chaplaincy/Church, hotels and restaurants, health organisations, the RCGP, Universities and a Postgraduate Centre.

**4.3.3 Group funding**

The most common sources of funding are membership fees (26%), pharmaceutical representatives (19%), PCTs or deanery. The majority of groups receive little or no funding and rely on using free venues, or speakers who do not charge a fee, and the volunteered time of their organisers. The following table shows a breakdown of funding of sessional GP groups.

**Chart 7: Sessional GP Group Funding**



#### 4.3.4 Organisation of the group

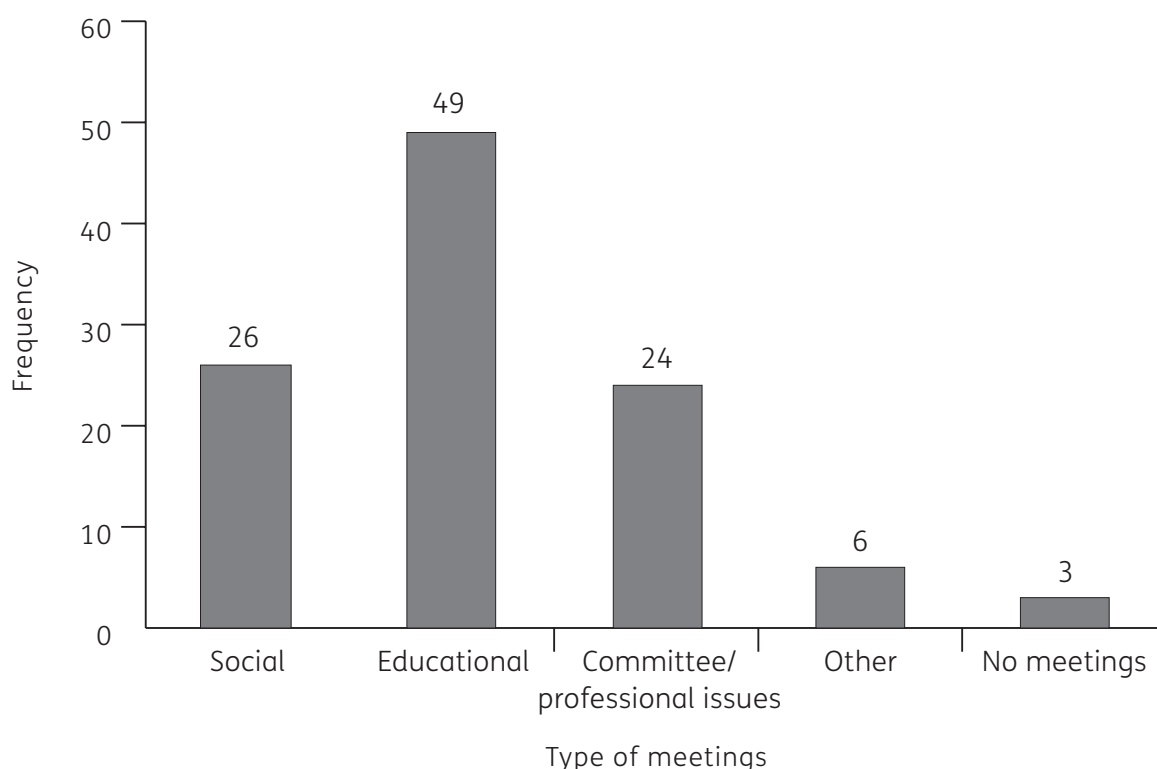
Seventy per cent of groups were run by volunteers (n=40). Eight groups were run by both paid help and volunteers and six groups were run by paid help and/or administrators alone. Eighty-eight percent (n=50) of sessional GP groups held regular meetings and twelve percent (n=7) did not. The majority of meetings were held at monthly intervals (n=20).

Eighty-two per cent (n=47) of respondents reported that there was not a minimum number of meetings that their members had to attend, 10% (n=6) said that there was a set number. These ranged between two and four meetings a year. Three groups commented that they had tried to enforce a minimum number of group meetings to be attended but found it difficult to 'police' this. Eight percent (n=4) responded 'not applicable' to this question.

#### Types of meetings

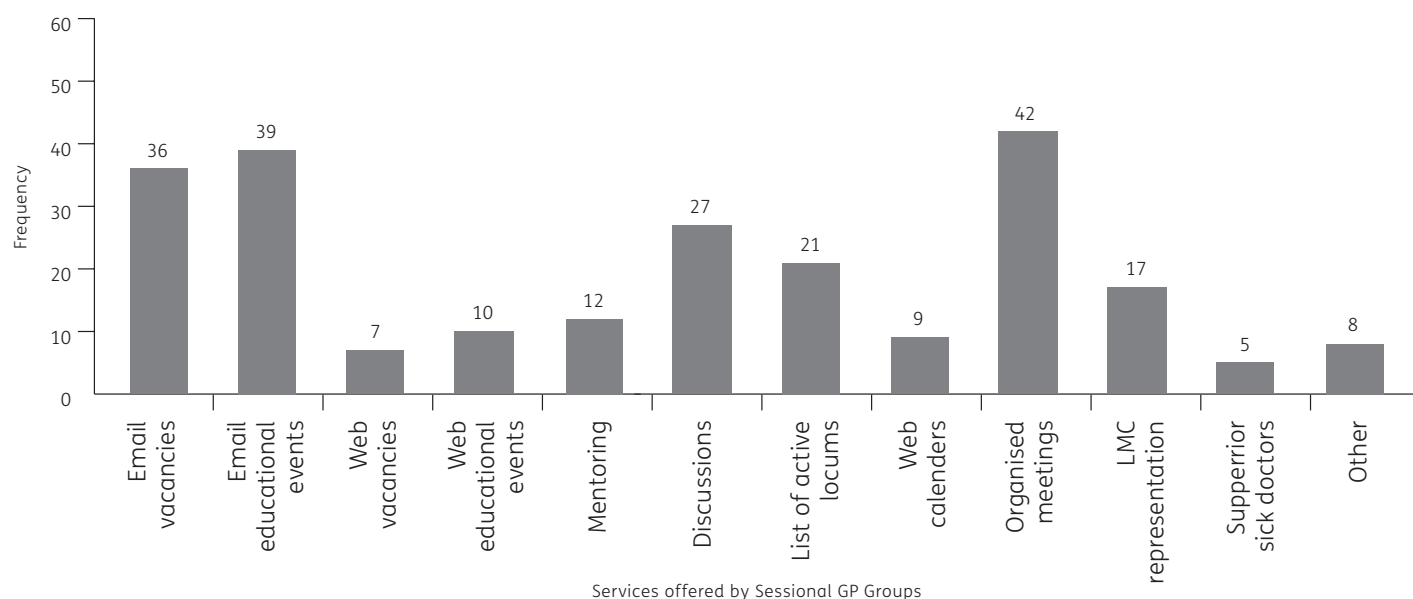
Groups held a variety of types of meetings with educational meetings being the most common, followed by social or "committee/professional issues" type meetings. Other types of meeting included networking and discussion meetings and discussion of revalidation tools e.g. SEAs. Three groups did not hold meetings.

**Chart 8: Types of Meetings held by Sessional GP Groups**



Services offered by the groups were varied in nature with many offering a number of services, the most common being organised meetings, email notification of educational events and email notification of vacancies. The following graph shows the type of services offered by sessional GP groups.

**Chart 9: Services offered by Sessional GP Groups**



#### 4.3.5 Links with other organisations

A small number of groups had representation on and/or communication with the Local Medical Committee (LMC), and individual groups referred to formal recognition of the group and the publishing of minutes. One reported as follows:

*One local LMC has provided co-opted seats for 2 members of our group until a new constitution was brought in which created a sessional GP “constituency” thus improving representation from sessional GPs*

Three respondents reported links with the local BMA office, through their providing a speaker or an interactive session at meetings. A small minority of respondents reported on links with the PCT, for example through funding facilitators or admin support, use of building and occasional contact. A smaller number referred to Deanery support, reporting on financial support such as funding for events and speakers. Two referred to the RCGP funding a room and one to it acting as a contact point for information. Other support identified by respondents included drug reps, speakers (e.g. local consultants) providing services free of charge, and the NASGP which publishes information on groups on the members’ page of their newsletter.

#### 4.3.6 Strengths of groups

Respondents commented frequently on the benefit groups offered in terms of professional support, networking, reducing isolation and educational meetings. The variety of type and length of experience was also seen as valuable for this networking function.

*They value the support aspect of the group and those who come to meetings value the opportunity to share experiences and difficulties of being a sessional GP and also (I think) the opportunity to discuss both clinical and nonclinical issues in a safe and supportive educational environment.*

*Many ways to make contact and share experiences with other members (social meetings, email group, mentoring), meetings which combine networking/social with an educational (deanery organised) meeting- help sustain attendance and interest*



Providing information was also key to reducing isolation, as it enabled GPs to obtain work, access education and be better informed in general:

*Members often mention that they value the mailings - mostly of educational events, but also some Alerts etc which are sent out as this lessens their isolation especially when starting off their career as a sessional GP*

*Keen to help each other and advertise work among the locum group*

*Good communication about good and bad practices to work in.*

The ethos of the group was identified as a strength by several respondents, who commented on groups being informal, friendly and supportive.

*Flexible, still meeting after two years, informal meetings with clinical focus where no question is stupid etc...*

*Supportive, non confrontational, friendly*

A number of groups referred to the value of being independent of other organisations e.g. LMC, PCT

*We are independent of third parties who may have competing interests e.g. LMC, deanery, PCO.*

and of offering flexibility for members to come and go as they need

*Our membership is fluid so that people can come and go while they are in transition though there tends to be a smallish core membership of longer term attenders.*

*The group changes over time but is friendly and welcoming and works well as a “slow open” group; self-funding, self-governing, we are in total control of ourselves*

A common strength was the potential for groups to support revalidation and appraisal processes for example by discussion of significant events, education and sharing information.

#### **4.3.7 Difficulties encountered by groups**

The predominant challenge for these groups was sustaining themselves on volunteers without any source of funding. The costs of funding an affordable venue and the difficulty in identifying a means to hire paid admin support without taking on employment responsibilities were also mentioned. Time commitment for volunteers was also mentioned as an issue.

*Sustainability is the main problem due to: Lack of funding Having to rely on 2 enthusiastic GPs who sacrifice their own time to keep the group going Apathy amongst sessional GPs - not many career locums in area and low number of salaried GPs Options: A consistent funding stream with admin person to keep the group going. Start charging members Approach LMC, deanery, PCO for funding Convert to Locum Chambers Consider Practice based small group learning (PBSGL) as in Scotland.*

*No funding or ability to pay someone to run the admin side. Due to this it is difficult to attract a volunteer to run the group as the time commitment is not inconsiderable. Developments such as website and online booking etc are not possible without funding.*

*We have wanted for a long time to pay an admin person to do some of the membership tasks (bank cheques etc) but do not have the set up to employ someone (and don't want to take on employment risks) so has taken a long time to find a way to sort this out by "buying in" time from a practice receptionist who is paid by us through her practice and so not technically employed by us.*

Some respondents mentioned poor attendance at group meetings, partly due to geographical spread or certain demographics (e.g. few "career locums" i.e. GP doing locums for a few years, GPs with young families).

*wide area covered and difficult to find suitable location/time to suit all members; scattered over a large geographical area, previous poor attendance at meetings meant they were no longer justifiable. The group now exists via email only.*

Groups try to cater for diverse needs (i.e. support relating to working conditions e.g. quasi "union"; education, peer support) so it was considered difficult to argue for funding to come from one source (PCT/deanery).

There were needs which required greater infrastructure such as web based information and access to PCT cascades.

*having a website which automates membership, communication about educational events, vacancies and meeting minutes etc reduces enormously the running costs of a group but a group needs some capital up front (£1500-2000) to get this going and many small groups have nowhere to turn for this. Once a website is created locums will start registering and practices can start advertising jobs and it all gains momentum and can grow.*

One respondent referred to a concern over feeling open to legal action with no means to defend themselves:

*One ongoing concern we have over the years is that of legal action against us and how we would protect those volunteer members who help run the group. We are lucky to have accumulated a reasonable amount of money (£7k) which could be used to hire a lawyer but it worries us. We ask elected "officers" who help run the group to tell their medical defence organisation and ask to be covered as part of their subs and we also have an agreed constitution which states explicitly what elected officers can and can't do (e.g. not give advice, not give interviews etc).*

#### **4.3.8 Needs which groups felt unable to meet**

There were a number of needs which groups referred to as difficult to meet. These included support requiring expertise such as support for appraisal and revalidation or advice on contractual issues.

*Support to meet the requirements of revalidation. Also there is no system for locums to receive NHS mailings as do all other GPs so information about changes to services is not received*

*...around advice for salaried GPs on terms and conditions – further to that provided by BMA etc. NASGP has filled a huge gap but there is always room for more. Some sessional GPs are very isolated still, especially those with other difficulties – health for example.*

Other unmet needs referred to included mentoring, providing fora for SEAs and support for newly qualified GPs.

Some respondents referred to the need for a means of feedback from practices to locums and groups being asked to provide this.

*Lack of feedback is a major barrier to professional and personal development. There is potential for the SGP group to act as an intermediary to provide anonymous feedback from practices to GP locums (and vice versa).*

There were groups which were able to meet these needs and groups varied widely in what they provided and what they perceived as unmet needs. This variation relates to the size and degree of organisational development of the groups.

4.3.9 Locum Chambers

4.3.10 Membership

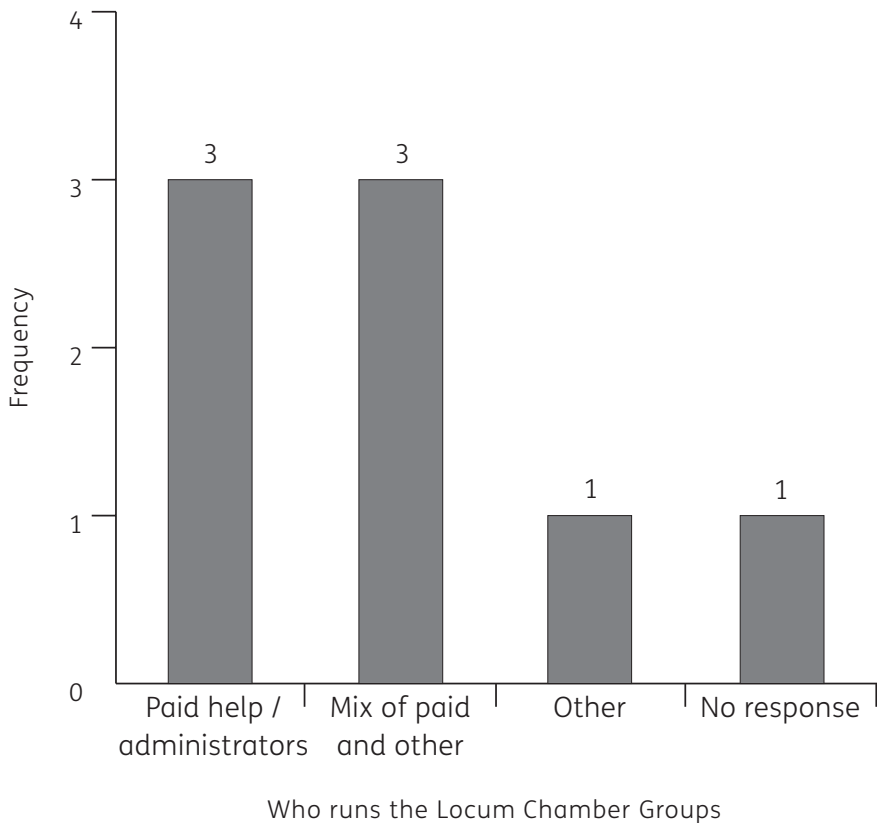
Locum Chambers had an average of ten members and had been running for between three months and six years.

Table 17: Locum Chamber membership and months of running

	N	Min	Max	Mean	Std. Deviation
No of members	7	2	30	10.57	9.071
How long the group has been running (months)	8	3	72	26.12	29.372

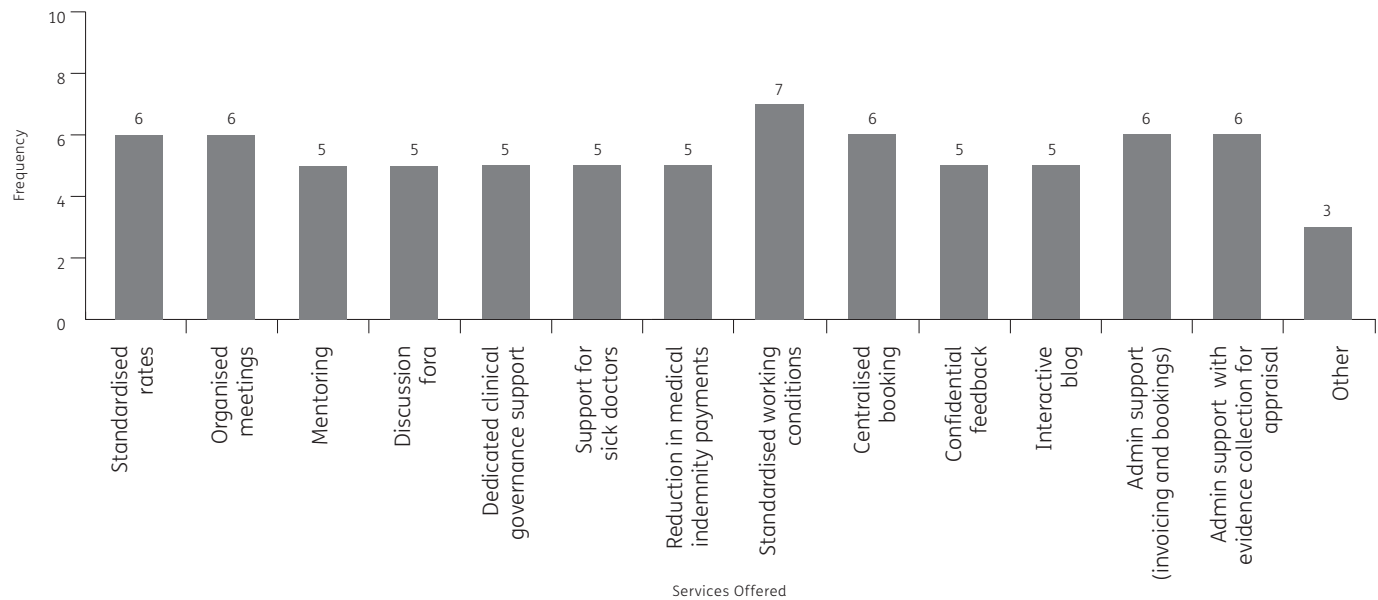
The groups are run mostly by paid help/administrators. Members pay a set percentage of their sessional income as management fee to the organisation to cover administrative costs (e.g. arranging sessional bookings with practices; pension forms).

Chart 10: A chart showing how Locum Chamber Groups are run



The majority of Chambers offered the following services to locums, which they would not receive working as independent locums: standardised rates and working conditions; centralised booking; reduction in medical indemnity payments; organised meetings, discussion fora and interactive blogs; support for sick doctors, mentoring and confidential feedback systems/processes, dedicated clinical governance support and admin support for invoicing and bookings, and with evidence collection for appraisal.

**Chart 11: Services offered from Locum Chambers**



Other services for members noted were peer-led education by sharing GP expertise, and facilitation of revalidation (e.g. group audits). One respondent referred to purchasing NASGP practice packs for every practice.

*Complaints and sig events all managed – pretty much all appraisal evidence facilitated. We’re now all able to do audit and have several audit projects which we’re launching this week – all data collected centrally and can be personalised to individual and group and comparisons made.*

*social contact with other members; raised professional standing (proven by the number of GP partners who apply to join!); more power in dealing with locum issues locally – including rate setting; sharing ideas of how to improve how we all work*

All Locum Chambers held regular meetings usually held between one and two months. Sixty-two percent (n=5) reported that members are expected to attend regular meetings this was reported as a minimum of 50%. Meetings are most commonly held in members’ homes and are social and educational.

There were, in addition, organisational meetings.

*All chambers managers and directors meet once a month for a ‘business meeting’. Chambers leads meet 2-3x/year. Directors meet every other week for strategy meetings - sometimes whole day workshops*

Chambers report valuing the peer support and infrastructure which is provided, along with the contacts and relationships developed with local practices.

*Work in a collaborative rather than competitive mode, peer support, creating a sense of belonging, cumulative learning by sharing learning points*

*As a Chambers, with the support networks that brings, we are able to quickly build a good relationship with local GP practices*

However, they also refer to the problem of the time which needs to be invested to set up the organisation (which can be off putting to locums who see this working choice as a short term stop gap).

*Lots of unpaid time spent setting up from scratch - business plan/ partnership agreement/ contracts/ terms and conditions etc. Information gathering about the requirements for freelance GPs as regards revalidation - lots of disparate sources*

*It's a MASSIVE amount of work to set all this up and run - and it's all been done from scratch. It would be fantastic if other locums could benefit from working in chambers but they'll need a lot of support to get it off the ground. LOTS of support*

The fee which locums pay to be members (% of income) can also be off putting.

*Having to contribute to the running costs out of one's own income (cf. individual locum GP) - we've had no extraneous funding*

*It costs a lot of money!!!! But I think it's really worth it and because it's so organised I actually end up earning more money - so in the end the tax-deductable cost is offset against better financial stability and increased income.*

*It is a large chunk out of our pay, but we suspect it will be worth it*

Other difficulties referred to by chambers are financial support in running patient questionnaires and promoting the benefits of Chambers to practices.

One respondent found the centralised booking arrangement inflexible:

*Shared amount of bookings not leaving free space to arrange individual sessions when amount of sessional bookings are low gives some a sense of dissatisfaction, however as an individual locum the same uncertainty of getting booked sessions applies*

#### **4.3.11 Summary**

Sixty-five questionnaires were completed giving a response rate of 93%. This high response rate could reflect the commitment from the sessional group leads. Fifty seven responses were from sessional GP groups and 8 from locum chambers.

There is clearly a need for sessional GP groups in supporting sessional GPs. Current groups are seen as a valuable source of education and support and may go some way towards fulfilling unmet needs of this cohort of GPs and reduce isolation. Needs that sessional groups felt they were unable to meet were around support for appraisal and revalidation, advice on contractual issues, mentoring, fora for SEAs and support for newly qualified GPs.

Barriers to success and sustainability of sessional groups were reported to be a lack of funding and thus having to rely upon volunteers and free venues. A lack of admin help was also an issue for groups. In addition the wide geographical spread can impact negatively on attendance of groups.

Locum Chambers provide a shared administrative and booking system for locum work, with fees set by the group, and members pay a percentage of their sessional income towards costs. Chambers also provide educational, professional and peer support and support for locum doctors with health difficulties. There is a considerable investment of unpaid time in setting up and running Chambers, with no external funding, and it was considered that new Chambers would need a lot of support in getting started.

## 4.4 Qualitative Data: Perceptions of Sessional GPs on Issues and Support

### 4.4.1 Participants Demographics

Four focus groups (n=17) and 21 telephone interviews were conducted with sessional GPs working in the Northern Deanery. Of the 38 participants, 12 were male and 26 were female. Fourteen participants had been qualified as a GP for less than five years. The age range of the participants is shown in Table 18.

**Table 18: Age range of sessional GPs**

<35	36-45	46-55	56-65	>65	Unknown
14	11	10	1	1	1

Participants held a range of posts as shown in Table 19 below.

**Table 19: Types of sessional GPs**

Locum	Locum + OOH	Locum + salaried by practice	Salaried by practice	Salaried by PCT	Retainer	Retainer + OOH	Portfolio	Partner (within last 4 months)
9	5	4	10	3	3	1	1	2

Other than one retainer not currently in work, participants worked between under one and ten sessions per week.

**Table 20: Approximate number of sessions worked (1 unknown)**

1 or less per week	2-4 per week	5-7 per week	8-10 per week
4	11	10	12

Twenty-four of the GPs were members of an SDLG and 14 of these were also members of a regional sessional GP group. A further six were members of a sessional GP group only. Two were members of the NASGP.

Participants worked in a range of urban and rural practices. The sample thus represented different populations, the North East and North West, including a large rural area in Northumberland, County Durham and Cumbria, as well as large urban centres.

Participants were therefore a heterogeneous group and, as such, they faced related but not identical issues.

### 4.4.2 Issues faced by sessional GPs

#### 4.4.3 Isolation

The predominant issue identified by participants was that of isolation, both professional and personal. This included isolation within the GP practice, for example lack of involvement in meetings and lack of peer support; inadequate access to information and, for some, insufficient access to education opportunities, lack of feedback and some difficulty keeping up-to-date. These issues were particularly apparent for short-term locums who did not build up longer term contact with practices. GPs working in settings such as the prison service also faced challenges in receiving support, such as lack of contact with other GPs and lack of meetings to discuss difficult consultations, policies and practice and contractual issues.

## Support Networks

Several participants noted that they often work in isolation (particularly when doing odd sessions or locuming in a single-handed practice), with little or no contact with other GPs in the practice, either because others were absent or because they were not included in coffee breaks. They therefore felt that they lacked the support networks traditionally developed in practices and had fewer opportunities for networking and fewer support networks, for example to help in dealing with stress and mental health issues. The culture within the practice had a clear impact on support.

*“...you can go through days without speaking to other doctors...sometimes you can go in, do surgery and then you leave. So you do what you are paid to do, and you might not meet any other GPs. And it’s quite difficult to meet other locums too...I think locums are probably more isolated than partners or salaried GPs” (ID 33)*

*“...if they don’t see meeting up every day and talking as important, it’s quite difficult to impress on them the challenges you might have being salaried rather than a partner of the practice” (ID 21)*

*“it depends upon the practice you work in, but you can often not feel quite as supported within the team...and that you haven’t got the influence over your workload particularly and you haven’t got influence over what’s demanded of you in the job and so you’re not kind of guiding the stresses and the pressures that you’re under particularly” (ID 36)*

Some participants reported a lack of support from practices in facilitating their work, for example locum packs were available in some practices, but were not always kept up to date (e.g. referral forms).

*“...support depends on the ethos of the practice you work in...I think it’s fairly standard to get an induction pack but that’ll be very variable in quality and what they do with it, and some will follow it up and, you know, be very sort of welcoming and hospitable to you, but the others might just say ‘here’s your pack and off you go’, so there’s a lot of variation” (focus group 2)*

One participant commented that it could be difficult for less experienced sessional GPs to know who to ask for help, when they no longer had trainers to go to. Some doctors working for an OOH organisation, on the other hand, commented on the peer support they received, one comparing this favourably to their position as a locum.

*“...I would turn round and speak to somebody when they came off the phone ‘what would you have maybe done with this?’ or ‘I had this difficult one’, and they would often ask you and I think that is a good support, it just gives you that little bit of feeling there’s somebody to discuss something with...it’s very informal and I suppose that’s just like in a practice as well...whereas some locum work...I’m very much more noticeably isolated” (ID 32)*

Some respondents reported that other professions who have a counselling role within their own role have some form of mentorship or counselling support. They commented that this would be very beneficial for GPs in their role and felt that this was a missing element within their profession.

*“it’s just basically support isn’t it and other counselling professions recognise the need for a mentoring provision don’t they, but we seem to think we can do it without and I don’t think that’s right and I think you know the salaried GPs are the most isolated so but I think all doctors actually are, I think it’s become out of fashion” (focus group 2)*

*“I mean people that work in mental health get weekly supervision whereas GPs don’t and whether we bounce off each other or we just get on with it you know...I think that is something that doctors often forget and doctors themselves won’t admit to having emotional needs because it’s not within our culture...” (ID 16)*



There were several positive experiences of inclusion and support within the practice, however, and practices were seen to vary.

*“we have quite a good thing in that we have a coffee room and...that’s where the visits are handed out every day, so everyone is encouraged to congregate there after morning surgery and it does help because if you’ve got a dilemma or you just feel like blowing off steam there is usually someone there to do it to, you do actually see your colleagues so that works quite well... our lot are quite committed to keeping that going...sometimes it’s all just nothing to do with patients but you can raise issues and ask for advice” (focus group 2)*

*“the difference between going to a practice as a locum and them saying ‘you’ve never worked here before so your first half hour we have blocked all the patients out so that we can show you how to do things’...‘you’re going to be with us for a while so this morning you are only going to be doing half a surgery and we’d like our IT people to go through the system with you’...and that’s the difference between practices where...if you want to find out more you actually have to go and find someone” (focus group 1)*

### **Access to information**

Sessional GPs did not always feel they were fully part of information sharing, both from outside and within the practice. This related, for example, to educational events and information affecting the care of patients, e.g. new policies and guidelines, local protocols, prescribing information and swine flu updates.

*“...you often miss out on information that comes round often from the care trusts to the practice managers and then they generally email out to their GPs but you often miss out on all that, and generally if you’re just going in odd days it’s difficult to have a hold on stuff” (ID 14)*

*“it’s often a bit disjointed in terms of who hears about them [educational events] and who doesn’t, because I think there’s probably lots of good things that go on that we don’t really hear about” (ID 21)*

### **Access to education and training**

Participants were not always able to attend education sessions, particularly when working in short-term posts.

*“...I mean it’s ok at the moment with me being in a reasonably long-term locum where I can go to their monthly education sessions and things within the practice, but if you’re generally doing just odd days here and there you’re often employed to cover so that the other people can go to their training sessions and that sort of thing and you don’t get to take part” (ID 14)*

This was also an issue for sessional GPs working in remote rural practices, who would have to travel long distances to attend educational events, and for those participants who worked in prisons where sessions were not covered for training. There was also a funding issue for sessional GPs who had to finance courses themselves.

## Ownership and belonging

Sessional GPs sometimes felt ‘on the outside’ or a lack of belonging, which could have implications for support.

*“one of the issues, especially with regard to locum work, is that there’s quite often a lack of a sense of belonging to a practice. And therefore you don’t feel like you really get your teeth stuck into anything properly for any length of time” (ID 35)*

*“...because partners are partners and they’ve agreed to work together for the common aim, they do share things and support each other, but a salaried GP is sort of an add on and it’s like, you know, just an individual sort of on the outside is how I felt, and so there needs to be then an artificial creation of a support mechanism” (focus group 2)*

Whilst a positive career choice for many, e.g. due to having young families, working as a sessional GP did mean for some a lesser involvement in some aspects of practice life, such as practice meetings. These often conflicted with childcare arrangements or were held on days they were not working.

Sessional GPs tended not to be invited to practice business meetings, which some considered appropriate or welcomed. However, it did mean that they felt they lacked influence and were not involved in decision-making, e.g. regarding financial matters, and had less control over their working lives, e.g. the introduction of extended hours, surgery times, and preferred holiday dates. Minutes of meetings were made available in some but not all practices.

*“...I’m salaried but often I am isolated within the practice because the partners will go off and do their partner meetings or whatever and sometimes you’ll not even get the feedback from the meetings so you don’t know what decisions have been made and yet you are supposed to be acting on them” (focus group 1)*

Some locum GPs reported needing to adapt quickly to different environments, not only to procedures and systems, such as different computer systems, different services available locally and different ordering systems, but also to different personalities and relationships among the GPs with whom they were working.

*“I work in three surgeries...and they’re all different. So you have to remember and learn three completely different or basically quite different computer systems. And if you’re on your own...you can spend an awful lot of time asking people how to do things...so it’s a major frustration” (ID 13)*

## Feedback

Working in several practices, or as a single-handed GP, can mean little opportunity for developing relationships with patients and a lack of feedback from (or about) them, as well as little opportunity to compare one’s performance to that of other GPs.

*“...especially with locums, you don’t get the feedback from patients...and it’s similar to single-handed GPs, you don’t really know how you’re doing compared to other GPs. You haven’t got a yardstick to measure yourself against” (ID 33)*

*“...often the practices don’t necessarily forward to you the feedback from the hospitals if you’ve referred somebody, or the blood results. So...you don’t really know long term what’s happened to any of your patients...that’s a big issue with regards to locuming” (ID 35)*

*“...you miss out on the feedback...if you work in as many places, finding out what you do wrong or things that have gone wrong, or gone well...and a lot of this, just having someone else to talk to and saying, you know, in conversations, ‘oh, I did that, was it completely mad or...?’” (ID 37)*

#### 4.4.4 Status

The culture of the practice also had an impact on some salaried GPs' perceptions of status and fairness within the practice.

*"We were put upon. We just had to do all the hardcore work and none of the fun stuff. So, you know, if there were any teaching opportunities we weren't allowed to take those because the partners would take those. If there were any meetings that needed to be attended or any courses, the partners would have first dibs at those" (ID 35)*

*"...if a late visit came in we [salaried] were always made to take it and, you know, any kind of any additional work that came in seemed to be pushed towards the [x no. of] salaried doctors that they had at the practice rather than the partners themselves. So in that way kind of the share-out of the work during the day wasn't necessarily fair" (ID 21)*

Two participants used the term 'second class citizen'.

*"Certainly as a salaried GP and I think in the widest sense practice they can get excluded from education in the non-formal sense that goes on in practices. I think people unwittingly often discriminate against salaried GPs...that...just in the way people talk about salaried GPs. Like you're a second class citizen" (ID 26)*

*"...you are excluded from some meetings and social events and it's just you're made to feel, you know, you're a second class citizen quite a lot of the time. I don't know it's deliberate but it just happens and there's also great confusion over how you're perceived as an employee. There are times when you're perceived as being the equivalent of a partner and you're expected to fulfil the same role and then other times, usually around kind of terms and conditions of employment you're expected to behave as an employee" (ID 19)*

One participant commented on the 'unequal' relationship with other doctors within the practice as the employers of a sessional GP, which could create a barrier in terms of asking for help or advice. Another spoke of there sometimes being a 'them and us' feel with partners – *"you're scared to...speak about things because you're aware very much that you're an employee"* (ID 38)

One GP commented:

*"I went through a phase of not wanting to admit not being a partner" (ID 28)*

#### Appraisal and Revalidation

Some participants reported that they did not feel that practices were considerate of sessional GPs' need to fulfil appraisal and forthcoming revalidation criteria. Several participants commented on a lack of feedback and being able to compare yourself with your peers.

*"You do need some support from those organisations [Out of Hours organisations] to be able to gather that kind of information but also it would be good to get some kind of feedback about what you're doing...you work more or less on your own" (ID 11)*

Others commented on lack of IT access and access to data. Some participants reported that they were not invited to practice meetings which made SEAs especially difficult and made them feel not part of the practice.

*"I don't at the moment have any sort of concept in terms of regular meetings or...and things like Significant Event Analysis it doesn't seem..." (ID 27)*

Some reported that they did not receive protected time within their working time (even if they were a salaried GP) to be able to achieve educational outcomes.

*“I don’t get any protected time, anything educational so I’ve got to do it in my own time and that would include the appraisal stuff” (focus group 2)*

However some participants felt that, whilst they would be able to meet some requirements for the upcoming revalidation process because they were at a fixed practice some sessions a week, they would find it difficult to do, for example, patient satisfaction questionnaires.

*“There are things like patient feedback and...any sort of follow up stuff is actually extremely difficult. Because if you are only there for the odd day here and there it’s just not feasible...I mean you go and do something, and you’re usually pretty busy when you’re at it, because they seem to feed locums with, you know, thousands of patients” (ID 13)*

## **4.5 Support Accessed by Sessional GPs**

### **Sessional GP groups**

Twenty participants were members of a sessional GP group. They tended to hear about the group through word of mouth or through a computer search. One participant reported being contacted through the performers list.

*“...as soon as you get on the performers list they contact you and ask you if you would like to be on their radar and you get emails about every educational event they do and they offer you mentorship if you need it and so on” (focus group 2)*

Sessional GP groups are larger than SDLGs and members of one group reported attendance of approximately twenty at educational meetings. Meetings were held either monthly or two-monthly.

### **Benefits of sessional GP groups**

Sessional GP groups were reported to be helpful in providing education and also information on courses and educational events in the area, for meeting other GPs and reducing isolation, and, for some, in finding work due to the posting of job advertisements. Groups were particularly helpful for GPs new to the area and newly qualified GPs. One participant commented on the benefit of being able to join their group three months before finishing training to help in the search for posts and finding out about practices.

*“I think it’s really good that the site has people advertising their study days or whatever so it’s easy to go onto that and I suppose for me as well, because I live in [anon] but I commute each day and don’t want to go to their local things after work and get home at whatever time, so it’s nice to be able to look on there and find things in the area which I normally wouldn’t know about because I don’t work in that PCT” (focus group 1)*

*“...I moved here and literally you don’t know anybody, then you don’t know any of the hospital doctors or any of their names, you don’t know any fellow GPs. I was just coming out of my registrar year and I did find it quite difficult at first ‘cos you can’t just say to your friend ‘what do you think of that patient?’ and I suppose I joined the [anon] group and that was a really big help because with everything being posted on the website, educational events – if you go to some of them you do get to know people and then I received an email ‘would you be interested in joining a study group?’ and that’s been great as well” (focus group 1)*

Members particularly commented on the range of topics covered in the regular educational sessions held by the groups and their relevance to sessional GPs (e.g. areas in which they may become less confident due to limited exposure such as palliative care and end of life pathways). Some of the compulsory topics were also run at the group, such as CPR. Members also valued the opportunity to make requests for topics. One group also included discussion of significant events.

*“They sometimes ask us when we meet what other subjects do we want to discuss or what other topics” (focus group 2)*

*“It’s very informal when you get to know them personally, and you could just email them if there was something you thought you needed, that you would like education on” (focus group 2)*

Groups sometimes combined having a visiting speaker and the opportunity to discuss issues of personal relevance, e.g. employment issues, and this was valued, as were opportunities for informal networking and discussion.

*“...networking, yes. And in some ways that’s what I would feel is the most important role is just meeting up with other sessional GPs and understanding what conditions they’re working under, because it’s always an uphill struggle trying to stand up for what you see is your position and your rights and things like that, so it’s just useful knowing what other people are experiencing” (ID 19)*

One group was noted for its help in setting up self-directed learning groups. Another was noted for its individual support and access to mentorship for interested GPs. It was helpful knowing that there was someone to contact outside the practice should this be needed if getting into difficulty.

*“it’s an educational thing, then they’ve got the two principal people who kind of run it, you know, you could email or phone them at any time and, you know, if you’re in trouble they’ll either sort you out themselves or they’ll put you in touch with a counsellor, a mentor...there is a host of support services that they can access for you, so I think if you are in trouble then I think you want to be in touch with them” (focus group 2)*

*“there was no set up [in the practice] for people to talk to you, you had to actively hunt somebody out to ask for help and I think about three months after I started [sessional group] actually came to the practice just to tell us about their services...and following on from that I applied to get a mentor through [group] and they gave me a list and I chose who I wanted to be my mentor and I found that really, really useful” (ID 21)*

Features of groups that were considered to contribute to their success included: set days and times for meetings (although some considered this a limitation); the availability of refreshments, particularly for those arriving straight from work; and groups being well-run and organised. Being run by GPs, the topics were of relevance.

## **Barriers to attending sessional GP groups**

The timing of educational events naturally could not always suit members, for example due to other commitments or working extended hours. A particular problem arose for those living or working in rural areas, who were unable to travel long distances to meetings.

*“I think the only difficulty that comes up repeatedly is that the area is very large geographically and some of it’s quite rural, so for some people it’s always very inconvenient to get there” (focus group 2)*

## Improvements to sessional GP groups

One participant raised the issue of remuneration for group leads in cases where there was no PCT funding, as the role was viewed as taking up extensive voluntary time, and suggested the possibility of having a dedicated person to contact or arrange the groups and deal with administration. One participant considered that sessional GP groups should be better promoted to encourage access. Some felt that there could be more opportunity for discussing problems and issues; others felt that the group meetings were too large for this.

## 4.6 Self-Directed Learning Groups

Twenty-four participants were members of a self-directed learning group.

Most of the SDLGs had between six and eight members, two had nine members and one had four members. The majority of participants felt that the optimal number for groups was between six and eight people in a group. Participants reported that if the group was bigger, then not everyone would have a chance to speak and participate in the group discussions. Equally if the group was smaller, then this would mean having to do more preparation for the meeting.

Participants also commented that six-eight members was a good size for keeping the momentum going in group meetings,, as not all members turned up to every meeting but if there were at least four people at the meeting then this meant that it was still a worthwhile meeting.

*[Eight members] “...it’s worked well very well for us because it just means that there’s enough of us that, you know, even if half the group can’t make it it’s still worth meeting” (ID 36)*

Group membership was made up of mainly sessional GPs. However some participants mentioned that their groups had mixed membership with partners being part of the group. These participants felt that this was a good way of getting a different perspective on issues that came up in their day to day practice.

The majority of groups met on a monthly basis with breaks for August holidays. However four participants reported that they met every six to eight weeks.

All groups, bar one, met at members’ houses on a rotational basis. This worked well especially if participants had a young family and meetings could be fitted around this so that childcare did not become an issue. Meetings tended to be arranged at the end of a meeting where members consulted their diaries and arranged a date that was suitable for everyone. Several participants said that meetings tended to be on a set day of the month, for example, every second Tuesday of the month. Participants reported this worked well as they would always know when the meeting was to be held. Meetings tended to be for a period of two hours and were mostly held at night.

Groups had come about through two main ways – growing out of MRCGP study groups and via sessional GP group initiatives.

Several participants reported that their group had been set up at the end of their registrar training, either through making contact with others at a similar stage or, more commonly, through existing training groups.

*“When I finished my registrar post I kind of realised I’m only doing four sessions a week and I really wanted a bit of extra support, you know, so there were some people I knew who had either finished the year before or who were about to finish their training. So I sent an email round everyone in my emails book who would like to join and I got quite a few” (ID 11)*



*“we’d all been in separate study groups for our MRCGP...and I think everybody found that so useful for their exams that, kind of when we finished all our exams and we’d all kind of got our jobs...saying ‘We should keep this on, it would be useful to keep up-to-date’ and I think there was that kind of worry when we finished, ‘Who will help us? How will we help each other? And how will I keep learning?’...and then it just kind of worked from then” (ID 21)*

Sometimes this led to more groups being set up.

*“...there were other people that, geographically, it didn’t work out for them and they’ve since gone on and set up groups in different areas” (ID 11)*

Some of these groups started as essentially more a social or support group, with a more educational element developing later.

*“I think in the early stages...there was an educational element to it, but there was a lot of general support and just getting jobs and not being a partner in a practice and dealing with employment issues” (ID 14)*

A local sessional group leader had facilitated the formation of new SDLGs through two successful methods. One way was through an email distribution, whereby GPs were invited to express an interest and were subsequently put in touch with each other according to geographical location.

*“then we just met up...we did things like setting ground rules and obviously talking about what we wanted to get out of the meetings and how we were going to structure them” (ID 36)*

The second way was through attending a session on setting up SDLGs run by the sessional GP group.

*“I don’t think the support [from the practice] was very forthcoming...why don’t we set something up ourselves and see who is interested...and maybe it was coincidence but at the same time there was this [sessional GP group] education session about setting up SDLGs...so we went there and they were talking about...think about ground rules when you set up a group, how big do you want to have your group? Think about this, think about that, possibilities...so they gave us a little talk on it and they said, ‘Right off you go, get into groups of six [by geographical area], have a chat...” (focus group 3)*

Other ways in which groups were set up were through informal contacts with other sessional GPs or via email contact and, in one case, through meeting other GPs through a sessional GP group.

It was noted that setting up and sustaining a group does require some initiative.

*“at the end of the day, if people can’t show a bit of initiative at the beginning they are never going to be able to sustain a group” (focus group 1)*



## Format of the groups

The majority of the groups followed a very similar format and included all or some of the following:

- Quick catch up
- Presentation of a topic followed by a discussion
- Summary of journal articles
- Summary of educational/training events attended
- Case reviews or discussions around any events or issues that have taken place

For the first 15 minutes of the meeting, group members tended to spend some time catching up with each other. This was seen as an important element of the meeting as an ice-breaker especially for new members of the group.

Most of the groups would have a member of the group presenting on a pre-decided topic or a topic that interested the member delivering the presentation. Members would then discuss the topic as a group. Presentation topics included clinical (e.g. hypertension), professional (e.g. dealing with complaints, CV writing and NICE guidelines) and journal articles. Other topics included presentations on educational/training events attended. This meant that participants were able to keep up to date with what was happening.

*“Once a year we have a meeting to decide who is going to host it...and we just go through a rota really and decide who’s going to lead the meeting or present something at that meeting”  
(focus group 4)*

However some participants did report that they were a lot less formal in pre-deciding on a topic and would just ‘turn up’ and ‘share’ an issue with the rest of the group.

Several groups chose journals to feedback to the rest of the group with key points summarised which helped members who otherwise would not have time to read all of the journals.

Case reviews and issues that emerged within the practice were also discussed. Participants reported that an important feature of the groups was being able to discuss difficult cases and issues that came up within the practice. Participants commented that they valued being able to discuss with peers how they would have dealt with something or being able to talk through an issue.

*“...we tend to talk about problem cases, things we’re not quite sure how to deal with, often things that when you were a trainee you would go and discuss with your trainer and things like that that you get everybody else’s ideas as well about how to manage something...” (ID 14)*

The majority of groups took minutes of their meetings and these were e-mailed round to group members.

## Organisation and decision making within the group

Most respondents reported that there was no designated group leader and that groups were generally informal in their organisation and decision making. Decisions on the format and topics of the meetings were made democratically. Respondents commented that not having a hierarchical structure worked well because of the nature and peer support element of the groups.

*“...I quite like the way there’s not one person in charge...I think in terms of a sort of mentor and friendship sort of thing, that’s kind of...I think it’s quite nice...” (ID 27)*

However some groups did comment that there were ‘covert drivers’ and ‘planners’ within their groups as illustrated in the comment below:

Interviewer: *“Is there a nominated lead?”*

Participant: *“No but one girl is a lot more vocal, so she tends to be quite organising...” (ID 37)*

## Benefits of being in a Self-Directed Learning Group

The majority of participants reported that the main benefit of being part of an SDLG was the peer support element. It provided group members a safe environment in which to share ideas and concerns. Several participants reported that this was particularly important because they may not want to discuss the issues with staff in the same practice.

*“...mostly we talk about difficulties and about how each other might do things or deal with a case and we come from a number of different PCTs so we’ll often use it to look at what other areas do about certain things. Yeah, sort of...sort of benchmarking about what else goes on” (ID 26)*

*“...I think it would be harder if I wasn’t in a group because I think I would be more detached in what was going on there would be nobody saying actually what I am supposed to do about this” (focus group 1)*

*“I think knowing that there’s other people, the benefits, social to a degree, just being able to sort of talk about people’s jobs and the environment they work in...” (ID 16)*

Some participants particularly valued the emotional support offered by the groups as an addition to the professional peer support.

*“...apart from the clinical stuff, it’s nice to have some...a support network. A co-mentoring network, I suppose, where if there’s been an issue at the practice or if there’s been an issue with a patient or a complaint or a worry, then we can share that with our colleagues and peers and just make ourselves feel better” (ID35)*

*“I just find it really helpful and, you know, actually I think it helps your mental health as well because it relieves stress because often like you’ll have a stressful day and you meet everyone and you think, “Oh it’s great just to meet them again and to, you know see that side of it” (ID21)*

*“...And when I go home, every time I go away with a good positive feeling and I think that’s important” (focus group 3)*

Groups provide a good way of keeping up to date with educational events and being able to meet participants’ learning needs and styles.

*“...it keeps you up to date because you’re never going to be able to go to all the meetings but generally as a group one person will bring something up...” (ID 14)*

*“I think it keeps us motivated, it improves our morale because we’re taking charge of our personal educational needs” (focus group 3)*

*“mainly sort of a forum for learning but not on my own; having other people around to discuss things. It’s all very well looking things up but it’s nice to have other people around to discuss things...” (ID 27)*

Many participants reported that presentations, handouts and minutes of meetings were used to provide evidence in appraisals.

*“Yeah quite a lot of things that we do is sort of connected into our appraisals. We plan to do some communication skills...we save them all [minutes of meetings] just to pass them to our appraisals so it shows what we’ve been discussing...” (ID 11)*

*“You just keep a record of what meetings you’ve been to and what, you know, what happened and what your learning actions were and what you’ve done as a result. It always seems to be commented on favourably at appraisal certainly” (ID 36)*

Several participants reported that the groups provided a good way of keeping up to date with journal articles or information from educational/training events.

*“If someone’s found something out then they pass that on. That seems to work really well” (ID 37)*

*“I read more BMJs than I would do normally. As well as getting the summaries of the ones that I haven’t read. I think it’s sort of a bit of confidence almost that you are up to date” (focus group 4)*

Some participants commented that groups were useful for gaining information about the job market and terms and conditions so that members can measure whether they are getting reasonable conditions. In addition several participants reported that groups were good for discussing financial issues such as tax and national insurance.

## What makes a successful SDLG?

Having clear expectations of the group and feeling ownership of the group were seen as important elements of a successful group.

*“I mean our group works well and I think I wouldn’t want it formalised in any way because then I’d feel you were doing it for somebody else. Whereas what drives us is that we’re doing it ourselves” (ID 21)*

*“I think the person who arranged it wanted to meet every week or every two weeks where nobody was turning up because they didn’t meet that frequently and we did have quite a struggle getting people to come” (focus group 1)*

Having clear ground rules was felt to be an important point as was flexibility and reviewing the group.

*“...quite a lot of it might be about management or difficulty with staff or it might be a partner or someone else in your practice where it’s hard to talk to others. So we have a confidentiality rule as well” (ID 26)*

*“...some review time and stuff is really important” (ID 36)*

## Membership

All participants felt that it was very important that they had a good rapport with members within the group. Some participants felt that their group was successful because they were all a similar age and stage in their career.

*“I think it’s important as well to have people who you do like...to be honest, that will otherwise deter you from attending. So I think it probably important to have people that you do like and you can have a chat with and you can speak openly with. And that you can trust...I think that if you have trust and commitment within the group then the rest of the learning just happens by the by really” (ID 35)*

*“And the good thing about study group is that you are actually I suppose we are all of us similar of age and not long qualified...” (focus group 1)*

*“I think cos we are all sort of at a same point and we all get on quite well together you know as people I think that really works well” (ID 11)*

*“...we are all in our [age band] and all in different practices but in kind of similar positions, either long term locums or salaried” (ID 14)*

Some participants considered that having a mixture of ages and stages was beneficial, for example, one person commented that younger members had better IT and researching skills whilst older members brought ‘wisdom and experience’ (ID 28).

Some groups reported that they would not have more than one person from the same practice in the group. This was mainly if something came up within the practice and there was a conflict of interest this may affect the group.

*“That’s our only rule. We don’t have anyone...we only have one person from one practice” (ID 26)*

*“...none of us work at the same place, which I think is very helpful” (ID 21)*

## Recruitment of new members

Recruiting new members to the group was seen as an important element of making an SDLG group successful. Several participants commented that it was really important that the group dynamics were right and that they trusted and got on with the other group members.

*“...to be very protective over it in that don’t just accept other people to join. You’ve got to think quite hard about the dynamics of the group and if it’s working well then, you know, would somebody else coming up to, you know, I think you’ve got to think very selfishly like that as well” (ID 21)*

*“My experience of a self-directed learning group you have to get on with the people within the group. With such a small group you’ve got to feel that, you know, you can trust them and, you know, work in similar ways” (ID 38)*

Some participants commented that it was very important that group members were committed to the group.

*“I mean within our group, for example, there are people who have families...And we still are dedicated enough to it to ensure that we meet up. So I think that it’s important too for people to realise that there is a commitment involved. And there is no point just setting up a group for a short period of time...” (ID 35)*

## Structure of Self-Directed Learning Groups

The majority of groups reported that their groups were informal and not hierarchical in nature and felt that this was a positive aspect of their group in terms of making the group successful. However some participants did comment that getting the balance correct between being informal and getting something worthwhile out of the group was important.

*“I think the balance, it’s getting the balance right between having the support and mentor type thing and actually doing kind of quite perhaps a bit more formal about topics and making sure they’re learning stuff” (ID 27)*

*“I think that’s why it works so well. That you know we are quite flexible. It’s not formal...There’s no kind of key person leading the whole thing. And we all contribute something. And I think that’s important” (ID 35)*

Having a clear idea and structure to the group was also reported as helping the groups to work well.

*“I think that having a clear structure there so it’s not just sort of like an aimless chat works quite well” (ID 11)*

The size of the group was another element which could potentially impact on the success of a group. Some participants felt that if the group size was too big then this would impact negatively on the peer support element of the group and the flexibility and group organisation would be more difficult to co-ordinate.

*“well it’s actually small and personal which is quite nice...too big a group and you don’t get that, maybe the same feeling of being comfortable with the people that are there and getting to know them” (ID 16)*

*“it’s just how it’s worked out with a big group...sometimes it’s quite hard to manufacture the, you know, an environment where people sort of feel able to share stuff I guess” (ID 36)*

*“And my experience of a self directed learning group you have to get on with the people within*

*the group. With such a small group you've got to feel that, you know, you can trust them and, you know, work in similar ways" (ID 38)*

Two participants reported that they did not feel their group was big enough to remain sustainable and felt that if their group was larger **"probably around 8, 9, 10 that kind of number so it's more sustainable"** (ID 11) then there would always be enough members turning up to groups to keep it going.

*"I suppose the number of people. I think if they had a few more just for regular turnouts that would be better" (ID 14)*

Location seems to be an important element to making a group successful. The majority of the groups were held at members' houses on a rotational basis. This seemed to work well for participants and meant that there was a geographical spread.

A guide to setting up groups would be useful e.g. **"you know, a guide for setting up a self-directed [learning group] – a sort of Word document or something with back up if needed for extra advice would probably be useful...possibly an on-line forum..."** (ID 36)

Some participants mentioned that it would be useful to have a central database with other sessional GPs in the area. This would help with being able to recruit members but also with communication such as distribution of information. Participants commented that it was often difficult to recruit new members to the group; they did not know where to look for or advertise for new recruits. Some participants commented that they recruited new members by word of mouth and it was by invitation only.

*"if you had a sort of central database of names and if somebody was interested they would, you know, advertise on there or something" (focus group 3)*

It was important to be clear about what you want out of the group, that everyone wants the same thing and there is a clear structure at the beginning that everyone signs up to.

*"I think just probably being encouraged to think about the structure at the beginning and I mean that was definitely helpful for [our group]...having some guidance about kind of ground rules and objectives is a good idea" (ID 36)*

#### **4.6.1 Needs that Self-Directed Learning Groups are Unable to Meet**

Some participants commented that it depended upon what you wanted out of the group, for example if you worked as a salaried GP you may get peer support from within that practice and may require educational support from the SDLG group. Whereas if you were a locum or in an un-supporting practice then your needs would be very different and you would require both from a group.

*"I think for peer support, is probably more important for me. But then I can sort of see for others, if you're in more of a regular practice you'll have that support from where you're working so you'll want [something different]" (ID 37)*

Formal training such as CPR training was seen as a need that SDLGs are unable to meet because as locums they are often employed to cover practices while staff are at training courses and therefore do not have access to practice training.

Some participants commented that having a mentor to attend the group either on a regular basis or occasionally would be beneficial to help get a different perspective on issues.

*"I suppose another need is sort of like a more experienced GP like a mentoring person would be great. You know somebody who you know cos we are all at the same level so we're looking at it from the same point of view. Maybe somebody who has the that you know 10, 15 years experience they might be able to turn around and say, 'Oh you're not looking at whatever...' point of view because they've got more experience..." (ID 11)*



One participant felt that not all needs could be met by one group and that GPs need to access a number of support groups to be able to meet all needs.

*“I don’t think one group can meet all your needs you know I think it’s either going to be a big group that gets consultants in to speak and does educational side or it’s going to be a smaller group ... I don’t think one size fits all, you may need to belong to two or more different things if you want the whole package but you can probably get the whole package if you sign up to enough things” (focus group 2)*

Several participants, who were not in a group, commented that they would find it difficult to access a group because they were fairly new to the area and would not know where to find a (suitable) group. Another issue mentioned was the geographical location of groups relating to living in a remote area.

*“I’m very aware that I’m moving into a new area. So from my point of view I suppose, I have to learn about who’s around and what’s around...But you know an informal group could be very helpful. One of the problems in this area is geography. I don’t know how many GPs there are, but they’re scattered around a large area” (ID 15)*

#### **4.6.2 Evaluating a Self-Directed Learning Group**

Several participants spoke of undertaking a review of their group, some groups undertaking an annual review. This resulted, for example, in changes to format (e.g. reducing two presentations of a clinical topic per meeting to one to better fit the time available and reduce pressure on members; introduction of journal meetings) and process (e.g. method of choosing topics; changes to teaching style)

*“So if we want to change a learning style...no, not really a learning style, but a teaching style we can do that, if we feedback...we have experimented haven’t we?” (focus group 3)*

Review did not necessarily happen in a structured way:

*“I think it depends a bit on who’s sort of facilitating the session to be honest. So it can be very structured or it might be not so structured. I just think the main thing is that you have a general time to talk about what people feel is working and what isn’t, because we’ve definitely sort of modified things as we’ve gone along as a result of those” (ID 36)*

*“You have a meal and you have a chat and then afterwards it’s sort of a nitty gritty ‘What’s worked well last year? What hasn’t worked well? And how are we going to improve it for next year?’...but it’s not completely rigid that you have to wait until September to make your point, but that’s an opportunity where you can discuss it properly” (focus group 4)*

Some participants considered that it would be useful to evaluate their groups against other groups and see what other groups do:

*“Being able to find out about other people’s groups, about what they do that has been successful. So maybe a bit of networking with other groups, even sort of like a one evening session or something that we could go to, to learn about, you know, how to make the group more successful or how to get more out of them” (ID 11)*

*“I think it would be quite nice to be able to share more between groups about how you resolve different challenges like, you know, obviously maintaining attendance is one...” (focus group 1)*

Evaluation against a ‘norm’ may not be appropriate.

*“I don’t think you can have a blanket, sort of, ‘This is how a group should run and this is what you should do’. I mean it’s sort of up to the individuals how their group runs and what works for all of us isn’t going to work for somebody else” (focus group 4)*

Review of the aims and objectives of groups does, however, seem important. The quote below shows the importance of people discussing their expectations of the group and what their involvement entails to encourage commitment to the group, and of reviewing whether these expectations are being met.

*“...it’s on other people to contribute and if they haven’t then that’s why the group hasn’t had any more meetings...I should think we’ve all got outside interests and maybe we don’t value it enough...it’s hard to say why other people haven’t contributed” (ID 16)*

Several group members referred to their group setting ground rules and evaluation or review could usefully examine whether these rules are being respected, to ensure that members are comfortable with the way the group operates (e.g. in terms of confidentiality, trust).

*“I think initially it gave us some even...in terms of how SDLGs are formed and what sort of things to consider, like ground rules. It helped us to lay the foundations for what we have to do. We obviously made it more suited to our individual needs, but it provided a framework and a starting point. So I think that was quite helpful” (focus group 3)*

*“I think having some guidance about kind of ground rules and objectives is a good idea, and it’s just finding a way in which everybody can contribute and everybody feels it’s a useful session, and it depends on who’s in the group obviously because there may be some people who love learning clinically on their own and do it all and would rather meet and talk about, you know, more sort of interpersonal issues or talk about cases or whatever...so I don’t think you would want it to be too rigid at all, because I think it just totally depends who comes into your group, but the idea of some structure and some review time and stuff is probably the most important thing” (ID 36)*

One participant suggested that:

*“maybe you could have an agenda at the end of a set meeting to talk about the educational needs of the group, just a sort of a run round, maybe half an hour, just to see what people are expecting from it because we haven’t done that. We’ve talked about it informally amongst ourselves but we’ve never actually said what’s wrong” (ID 16)*

One group felt that some external facilitation would be of benefit for the purposes of review.

*“And it would be so nice say for someone to come, even if it was once every six months, and say, ‘How’s the group going?’ and perhaps be...not necessarily a facilitator but, ‘Have you thought of this?’ and maybe even guide you through a little bit and sort of say, ‘Yes, how’s it been going and what about doing this differently?’ And then maybe sit in on an evening and listen to what we do... (focus group 3)*

These findings demonstrate that it is important that everyone gets something out of the group and contributes in some way, particularly as the meetings involve commitment of sessional GPs’ own time. If group members are not committed, or do not feel they are getting what they want from the group, then the group will fail. This is why it is important that ground rules and aims and objectives of the group are set at the beginning of the group and then reviewed during the life of the group.



### 4.6.3 Summary

Four focus groups (n=17 participants) and 21 telephone interviews were conducted with sessional GPs working in the Northern Deanery, making a total of 38 participants (12 male, 26 female). Fourteen of the respondents had been qualified as a GP for less than five years. Twenty-four of the GPs were members of an SDLG and 14 of these were also members of Sessional GP groups. Six respondents were members of sessional GP groups only and two were members of the NASGP.

Participants were a heterogeneous group and faced similar but not identical issues.

The predominant issue reported was isolation faced by sessional GPs, especially those doing odd sessions or locuming in a single practice. This included isolation within the GP practice, for example, lack of support networks, involvement in meetings and lack of peer support. Further issues faced were access to information, and for some, insufficient access to education opportunities and a lack of feedback.

The culture of the practice also impacts on some salaried GPs' perceptions of status and fairness within the practice. Appraisal and revalidation was reported as an issue. Participants felt that practices were not considerate to sessional GPs' needs to fulfil appraisal and forthcoming revalidation criteria.

There were various sessional groups accessed by sessional GPs. These were reported to be beneficial in providing education, and information on courses and educational events in the area. Groups were also reported to help reduce isolation. Groups were helpful for GPs new to the area or newly qualified GPs. Ranges of topics covered in meetings varied and were relevant to sessional GPs. Barriers to attending sessional GP groups were timing of events and geographical location of meetings which were not always suitable.

Another form of support for sessional GPs was self-directed learning groups (SDLGs). These groups were reported to be informal and did not link with organisations or deaneries. The optimal size of groups was between six and eight members, with meetings being held at members' houses in rotation. Groups tended to meet monthly or six-weekly for two hours, usually on a set day of the week.

The format of the groups usually followed a catch up, presentation and discussion (these included: clinical areas and feedback on educational/training events and case reviews or events which have taken place and are discussed. Some groups had a journal club and summarised journal articles. Meetings were minuted and these were found to be useful for evidence in appraisals. Groups tended to be informal in nature with a flat structure. Benefits of SDLGS were peer support (both professional and emotional), providing a learning environment and evidence for appraisals. Groups were also seen as a good way of keeping up-to-date with information and a good way of networking.

Respondents reported that having a good rapport with group members was very important especially for discussing difficult issues. Several participants reported that they undertook evaluation and annual reviews.

## 5. DISCUSSION

This study sheds light on the current position of sessional GPs in the GP workforce: what issues they face, where they obtain support and ways in which support is effectively delivered.

### Issues

Our literature review has captured the demographic, statutory and legislative changes which have had significant influence on the creation of sessional (non-principal) GP working options: PMS, the new GMS contract, the Flexible Career scheme, retainer scheme, career start type schemes and returner (now termed “refresher”) schemes. It also outlines how the Sessional movement has drawn energy from deanery led conferences, the independent National Association of Sessional GPs and the BMA. Whilst sessional GPs today grapple with many issues identified in a systematic way as far back as 1998, namely isolation, lack of access to education and information and low status, there can be no doubt that their status has improved dramatically since that time as understanding of this group of doctors has grown. They are not only less invisible as a group (an effect of being a minority and not on any register in the 1990s), but the amount written about them as a result of formal investigation and reports has increased as well (SchARR appraisal<sup>91</sup>, Northern Deanery RCGP pilot study on revalidation and GPC working party on Representation of Sessional GPs). The visibility and importance of this group is also mirrored in the extensive network of deanery educators established on the back of the SCOPME report<sup>75</sup> and the sharp rise in local sessional GP groups providing informal support to them. We now also have evidence<sup>51</sup> that at least half of sessional GPs work in this way out of a positive choice, and not as often described in the 90s because of lack of skills, confidence or ambition. Some may see this is a transitional phase but many do not. The most significant change which is now expected to influence the way in which sessional doctors work, integrate and are supported is the introduction of revalidation.

Isolation was a major theme identified in all sources of data in this study as well as in previous literature. There are different factors contributing to the isolation which affects sessional GPs. For salaried GPs it arises often out of being the only salaried GP within the practice and so having no peers, having a substantially different role from the partners and often being excluded from meetings if these are of a business nature, leading to them feeling they lack influence and have less control over their working lives. Practice meetings may also be held on days on which salaried GPs are not working at that particular practice. For locum GPs, lack of contact with peers in and out of the work place is a major factor.

Isolation also arises for both groups through not being routinely included in information cascades about education, services, guidelines, vacancies and career opportunities. Currently many clinical, policy and educational cascades from deaneries and Primary care organisations rely solely on the practice network for cascading information to GPs and locums generally but salaried GPs are often not reliably contacted via this route. A recent example relates to swine flu alerts. The advent of email cascades and creation of supplementary and then performers lists has removed many of the financial barriers to being more inclusive of sessional GPs, however many PCTs use remote agencies to manage their performers lists which means this important resource is not properly integrated into the clinical governance systems of the PCT and sessional GPs remain disconnected.

The mobility of locum GPs can also mean that they do not have the opportunity to acquire the knowledge of how a practice and its referral systems, for example, work – knowledge which may often be built over time in a practice through regular contact with peers and access to information systems. This can make them more vulnerable to practising outside of protocols and therefore to complaints.

Isolation may be of particular concern for newly qualified sessional GPs who no longer have the access to trainers and other support networks they had as a registrar and also for GPs moving into a new area and working as locums, where they have no previous support network.

Issues of isolation also seem particularly acute amongst prison doctors and OOH doctors. The former reported negligible contact time during clinical work and lack of opportunities to meet formally as well, resulting in difficulties finding opportunities to discuss difficult consultations, policies and practice and contractual issues. The latter received some peer support from those working alongside them but also commented on the need for OOH organisations to provide feedback on their performance and support in gathering evidence for appraisal.

Deanery educators identified three broad problems arising as a result of isolation. These concerned a lack of information about systems and support structures, lack of contact with peers and networking, and more intangible and personal effects of isolation. The latter included; demoralisation, anxiety, lack of confidence, feeling undermined and poorly supported, demotivation and lack of career progression. Some sessional GPs in our study commented that a lack of support (both professional and emotional) can lead to stress and mental health issues.

Lester et al<sup>2</sup> referred to a two-tier system operating in some GP practices. In our study, many sessional GPs felt they had a lower status as a result of practice culture, distribution of workload, exclusion from meetings and non-formal education, and fewer opportunities for making an individual contribution. The documented pay disparity between partners and salaried doctors since the introduction of the new contract may have compounded this perception. Negative stereotyping of non-principals<sup>122</sup> may persist and contribute to the feeling of being a ‘second class citizen’ expressed by some of our respondents.

Access to education is another major issue for sessional GPs. Previous research<sup>75</sup> identified barriers such as time, costs, family commitments and lack of information. Sessional GPs in the current study also identified these barriers and highlighted lack of access to practice meetings and information cascades. Our qualitative data echoes concerns documented in a succession of reports that sessional GPs are not fully integrated into information cascades and that PCTs have some way to go to addressing this in order to avoid any detrimental impact this may have on their professional functioning and potentially their clinical care.

### **Meeting the needs of sessional GPs**

Key sources of support highlighted by sessional GPs in our study include: Sessional GP groups, locum chambers, SDLGs and deanery tutors. In fewer cases there are PCT initiatives (e.g. GP Choices in Durham) providing a wide range of support including education, peer contact and mentoring.

A number of factors are having a significant influence on the isolation experienced by sessional GPs: the rise in numbers of salaried GPs resulting from introduction of PMS and the new GMS contract and the ease with which they can network free of charge via email. This has provided an important added complement to initiatives led by sessional GP groups (volunteer run) and deanery educators.

The ease of using email and websites for sharing information and the availability of online e-learning modules has also improved access to education for these GPs alongside the introduction in 2004 of contractual entitlement to four hours of weekly CPD for salaried GPs. The latter has also been a driver to more practice based educational meetings including these doctors. Appraisal has increased our general understanding of the issues facing sessional GPs. The postgraduate education allowance (previously only available for partners) was transferred in 2004 into the Global sum for GMS practices with a view to funding the educational needs of all the clinicians (not just partners) so salaried GPs can legitimately request funding towards their educational costs.

Where access to practice meetings is difficult by virtue of working as locums or part-time, participation in educational events outside practices is the main activity which can provide sessional GPs with a sense of affiliation and belonging to a community - this can be via protected learning events, sessional GP groups or SDLGs.

The NASGP's "locum support team" concept which had limited uptake via PCTs has eventually found a model which has received significant interest and is growing rapidly in uptake - Locum chambers. Chambers have the potential to improve the professional image of locums, as being held accountable to peers and part of a managed system with a focus on quality.

Chambers provide a shared administrative and booking system for locum work. Fees are set by the group therefore avoiding the need for individual negotiation without the risk of illegal (anti-competitive) price fixing. They seek to provide a clinical governance and educational infrastructure which overcomes the professional isolation experienced by freelance locums, enabling them to benefit from many of the sources of peer support which a partner in a practice might access but without the added work of running premises, staff, IT and a patient list. Because the Chambers model can have greater longevity than the period for which the average locum works freelance, the GP entering into a chambers benefits from the established reputation of the chambers, which helps in getting work. Practices, once familiar with the concept have a sense of familiarity with the organisation, even if not with each individual doctor. Chambers also offer support for locums with health difficulties and provide a sheltered way for them to rebuild their confidence.

The initial investment of setting up systems, protocols and so on, is mentioned as a potential deterrent to creation of more chambers, particularly by locums who don't see this style of work as a long term option. Our literature, and the recent GPC study<sup>51</sup> and report into sessional GP representation confirms that a significant number of GPs become sessional out of personal choice but around half do not and work this way whilst seeking other forms of work, and thus may be less inclined to invest time and effort into setting up chambers. These will need to rely on a local stable cohort of locums who have felt it worthwhile to pursue a chambers model. Alternatively, in time there may be a market for ready to use resources which locums can adapt when setting up chambers, in much the same way that model legal agreements can be purchased from high street stores.

## **Sessional GP groups**

Participants reported sessional GP groups to be helpful in reducing isolation, providing education and information on educational opportunities in the area, and vacancies. Sessional GP groups are largely self-funding, volunteer-run organisations which aim to provide opportunities for sessional GPs to meet for educational and social/networking purposes. Some groups do receive funding from PCTs or deaneries, or from drug reps, but the majority are self-funding, for example through membership fees. It was widely recognised that sessional GPs needed opportunities to share informal aspects of their professional roles and working conditions, by discussion and comparisons with peers, including a quasi mentoring role which might develop between GPs with different levels of experience.

Some groups are able to provide more practical help such as information on job vacancies and educational events via email or websites and very few offer additional facilities such as mentoring or support for sick doctors. Website and email groups played an increasingly important role in providing infrastructure, networking, email cascades, supporting information, email networking, and administrative support. One group stated that it allowed administrative costs to be reduced substantially by automating membership activation, sending out of minutes and running elections or surveys online.

There is no clear model emerging in terms of affiliation to any local organisation and this is perceived as a valuable form of independence by many groups. It is clear that, un-resourced, groups rely on the goodwill of volunteers and their ingenuity to find cost neutral solutions which allow networking to take place. There is also a prevalent view that some groups may have issues around sustainability because of this model (being un-resourced and unaffiliated). Some groups mentioned that they provide a way to link in to organisations that they may otherwise find it difficult to influence (LMCs, deaneries, PCTs).

Some groups struggle with variable attendance at meetings, partly influenced by geographical spread or difficulties finding affordable venues, administrative support and resourcing. It was recognised that there was potentially a very diverse range of needs which a group might be expected to meet and this posed a challenge for a voluntary group: e.g. information (where it was not cascaded from PCTs), advice about employment terms and working conditions/norms for locums; education, networking and socialising. As groups grow in size the volunteer based model becomes less sustainable and there is evidence that groups are looking to explore models where they can pay (administrators or GPs) for their time running the groups but this brings its own worries about the complexities of becoming employers. Thus the future affiliation and support of these organisations needs careful consideration.

These groups are providing a service to the wider NHS in matching locums to practice vacancies and supporting education at many levels (e.g. information on education, help setting up SDLGs and direct provision of events by some groups). There is little evidence that they are in contact or learning from each other as most grapple with the same issues. There would be great value in bringing together group organisers to share their strategies for overcoming challenges such as sustainability, and help bring about a wider understanding of the impact of these groups for the benefit of sessional GPs and of other organisations, not least the wider NHS.

There is anecdotal evidence of attempts to create new sessional GP groups; however there are significant barriers to reaching a critical mass. One is the “networking effect” i.e. membership and attendance only becomes attractive and worthwhile once there is a reasonable size and chance of each individual meeting peers with whom they will connect. The second relates to the ability of a group which is based on membership fees to attract sufficient funding to set up a website with some functionality, as this requires either significant membership or a significant fee. Finally, where funding is needed to run educational meetings, it may be difficult to attract pharmaceutical representatives, given the current squeeze on the pharmaceutical industry, to sponsor the costs of meetings if attendance is variable and low. All this means that at the early stages significant support is needed in terms of building up membership rapidly (e.g. through signposting or advertising by LMCS, PCT or deaneries) initial funding for website and the establishment of regular meetings, another factor known to help attendance. Another model which can help in this difficult early stage is a more collaborative model where those providing some of the funding (e.g. PCT or LMC) are meeting some of their own needs (for example by building in vacancy advertising into the group website).

### **Self-Directed Learning Groups (SDLGs)**

SDLGs follow the long established tradition of practitioner groups in providing relevant, learner centred and delivered education as well as peer support. Several SDLGs in this study had been set up as an extension of MRCGP study groups but others had arisen as a result of initiatives led by the deanery tutor for sessional GPs or through using the email networking facilities provided by the local sessional GP group website. The deanery events combined the opportunity for interested GPs to meet each other with the dissemination of information about SDLGs through a short guide. Several participants had learned of local groups informally through word of mouth, however this is more difficult for newcomers to an area and the most isolated and they may be particularly dependent on organised events to be able to form or join groups. Once formed, the groups functioned independently with no formal anchor to any organisation. This accounts for the common finding that many groups had no way to tap into the experiences of others groups and to learn from other groups though some expressed a wish for this. Neither groups themselves nor deanery educators knew how many SDLGs were operating locally.

SDLG members valued the educational content which helped meet their needs to keep up to date, the professional and emotional support provided by the groups and their adaptability to members' learning needs and styles. Groups sometimes presented opportunities to learn about the job market and terms and conditions and to discuss financial issues such as tax and national insurance.



Their potential to support appraisal was consistently noted by interviewees in this study through the discussion of significant events and cases - activities from which locums are often excluded in their day to day work. The range of activities undertaken commonly included presentation of clinical and non-clinical topics (often in rotation between members), case discussions, feedback from courses, discussion of journal papers, significant event discussions and, less frequently, audits. Most meetings included elements of socialising and planning for future meetings and most groups met socially once or twice a year.

Attributes of successful groups identified by both members and GP educators were related to personality and group ethos (e.g. trust, motivation, commitment and willingness to share), organisational factors (e.g. clear ground rules, explicit shared aims, regular planning, evaluation through feedback and timing). Group size had an effect on sustainability (with larger groups maintaining momentum even when some members attended less frequently) but also on cohesiveness and trust which was easier to establish and maintain in a smaller group.

It is likely that these groups are providing a benefit to the wider NHS as group education is recognised as being far more effective at bringing about changes in behaviour than other forms of education, and isolation has been recognised as a risk factor for underperformance<sup>85,123</sup>.

As identified in this study and elsewhere, evaluation could usefully consider the task of the group (e.g. its educational/peer support role and function), process issues (e.g. decision-making, respect for ground rules, appropriateness of roles, conflict resolution, time management, interaction and participation); organisation (e.g. group structure, communication channels) and objectives (e.g. appropriateness of goals and role of the group in setting, agreeing and adapting goals)<sup>97,113,114,115,117</sup>. Listening skills and feedback skills are important in group evaluation<sup>117</sup>, as is mutual trust<sup>113</sup>.

There is an important role for tutors to help facilitate the creation of SDLGs through events providing networking opportunities and information. After this, groups need to be able to learn from each other, whilst maintaining their independence and confidentiality. One possible approach would be for educators to provide a central anchor point for SDLGs to register with, submitting a report of their activities for “accreditation” deeming these suitable to be counted as CPD credits for revalidation. In turn this would allow the deaneries to aggregate developing expertise of models which are successful and can be disseminated.

## **Organisational Support**

Whilst appraisal and revalidation has increased the need for PCTs to engage with their sessional Performers and the increased uptake of email has made it easier to communicate with this professionally mobile group there is continuing evidence from our study from both sessional GPs and educators that many sessional GPs are still excluded from information cascades relating to education, clinical services, local guidelines, prescribing, and so on. Some deanery educators were working actively with PCTs to try and address this using email and many sessional GPs relied on their sessional GP groups for information.

Where sessional GPs are appraised electronically PCTs can for the first time have comprehensive and up to date distribution lists for them which could be used for cascades. However, the recommendations of SCOPME<sup>75</sup> and SchARR<sup>91</sup> on cascades have yet to be widely implemented and have recently been reiterated in the DH report ‘Tackling Concerns Locally’<sup>92</sup>.

Issues for salaried staff and locums have been raised in the context of the current reform of professional regulation. The Department of Health (DH) review of the performers list system<sup>92</sup>, undertaken by a subgroup of the Tackling Performance Concerns Locally working group, recommends that ‘PCTs should consider actively supporting salaried and locum practitioners on their list in exchange for a commitment to a reasonable volume of work within the PCT and to keeping the PCT informed of other temporary employment’.

This support should include access to appraisal, CPD and, where necessary remediation; supporting their information needs, and ensuring access to IT systems. It also recommends that locum agencies should provide (or ensure access to) appraisal and CPD for staff. PCTs should regularly check that all the locum and sessional staff on their list have appropriate access to appraisal and CPD. The DOH has agreed with both of the above recommendations<sup>127</sup>.

The report on the review of the performers list system<sup>92</sup> also recommends that the DH should clarify where the responsibility lies for investigating complaints or incidents when a salaried or locum practitioner is temporarily employed in a PCT other than the host PCT, and should discuss with the regulators whether it would be practical to have a single national list of sessional staff, with a unique identifier. The DH is considering this further.

## **Deaneries**

Many deaneries had tutors (or associate directors) with a specific role relating to sessional GPs, possibly as a result of the recommendations of the SCOPME report<sup>75</sup>. Roles commonly undertaken by dedicated tutors included signposting to educational providers, improving access to mainstream education by working with local organisations, provision of education targeted at sessional GPs, managing the retainer scheme and facilitating the creation of self-directed learning groups. Other less commonly adopted roles included producing newsletters, providing advice and support in connection with appraisal and revalidation; supporting sessional GP groups and locum chambers, providing website information and mentoring; dealing with queries from doctors returning from career breaks; and extra help (offers of interviews) for doctors in career transition.

Deanery educational programmes specifically targeted at sessional GPs included clinical programmes; CPR and child protection; career development days for sessionals or retainers (e.g. “Survive and Thrive” promoting positive aspects of being sessional doctors, and promoting further portfolio options e.g. mentoring), training days (e.g. appraisal and revalidation for sessional GPs); consultation skills refreshers; consultant/GPwSI shadowing opportunities; away days for retainers and returners; and an annual conference for retainers and sessional GPs. Wales Deanery has a web based system for providing information about practices, referral pathways and education for sessional GPs (PrakPak) <sup>128</sup>.

Many deaneries did not have a dedicated tutor for sessional GPs but were aware of some provision meeting their needs, others felt that no specific arrangements were necessary and this group could be easily integrated into the mainstream deanery systems. This is an interesting matter of debate as we know historically that prior to the 90s, the ‘mainstream’ deanery structures were not delivering on this aspiration, judging from the findings of SCOPME<sup>75</sup>. Whether deaneries are better at reducing the disadvantages felt by sessional GPs, even in the absence of a dedicated tutor has not been clearly addressed by this study. The SchARR report<sup>91</sup> on extending appraisal to sessional GPs recommended that deaneries adopt an inclusive strategy for addressing the educational needs of all its GPs including sessional but the question is whether the needs are best met by a single one size fits all system or whether specific provision for sessional GPs can be justified.

There is some evidence from our review that sessionals consistently express a desire to learn alongside their “peers” – and they predominantly identify their peers as those who share a similar working status (i.e. Locum, retainer, salaried). Interactive learning involves disclosing knowledge gaps and self-questioning which may be best done amongst those one considers true peers. We also know that the need to compare oneself to other colleagues (“benchmarking”)<sup>129</sup> is a significant motivator for attendance at educational meetings and this activity is perhaps more meaningful again amongst colleagues considered to be true peers. Sessional GPs also seek to access mainstream education so the solution is clearly to have a mixture of opportunities, some based in the wider GP community and some restricted to sessional GPs.



Ultimately the definition of peer group is always to an extent arbitrary, and GP partners themselves may seek different peer groups for different purposes (e.g. locality based education for example practice diabetic leads; deanery wide peer groups for other roles; and mixed groups for SDLGs).

National conferences bringing together tutors who work with sessional GPs have had a major impact on support offered to these GPs and the understanding of their role and there is a strong argument to continue this national sharing process particularly as revalidation approaches. Deanery re-structuring processes have unsurprisingly had an impact on the tutor network and it will be interesting to see how progress towards revalidation is affected by having a robust tutor network with expertise on sessional GPs.

The Royal College of GPs' "First Five" initiative<sup>130</sup> promises to bring additional resources and support for those who have two risk factors for isolation: being locums and being newly qualified. It is important that local faculties of the College work closely with other organisations supporting sessional GPs such as local sessional GP groups, deanery tutors and so on, to reduce fragmentation. Parallel programmes competing for the same GPs can have the unexpected effect of reducing networking because of reduced attendance at competing events or programmes.

## **Practices**

Practices vary in the support provided to salaried and locum GPs and some issues may require cultural change. At a practical level, practices could further support locum GPs by providing induction to the practice<sup>131</sup>, ensuring that an up-to-date locum information pack (e.g. the Standardised Induction Pack developed by MPS and NASGP) is available; providing a box of essential equipment and forms<sup>132</sup>, and ensuring that locums know what clinical software system the practice uses and can access the computer system (e.g. when the system is accessed using a Smart Card), giving all consultants their own username and password so a proper audit trail exists and ensuring that they are familiar with care pathways and clinical referral systems, which can vary widely<sup>132</sup>. Salaried GPs benefit from being included in practice meetings, having the opportunity to develop an individual role, and from informal opportunities for contact and mentoring from colleagues. Practices need to value their salaried GPs as an important resource. The BMA guidance on Job planning helps to set out expectations and aspirations of both employer and prospective employee in a new salaried post. Whilst in house appraisal is discouraged because it is perceived as too collusive, there is a potential role for an annual review of arrangements for these posts using the BMA guidance and tool "in house performance review" to help support professional development and practice development. Salaried GPs are also benefiting from conferences organised by the BMA (e.g. dealing with employment and representation issues) and by deaneries (e.g. dealing with career and professional development issues).

## **BMA and LMCs**

Following the BMA's recent report on representation, significant changes in the way sessional GPs are represented may well occur. Seventy-seven percent of respondents to a national survey of sessional GPs reported they are not engaged with their LMC. These organisations were sometimes perceived as being biased in favour of GP partners<sup>51</sup>. Sessional GPs are more likely to turn to the BMA for technical employment advice as they would be concerned that the LMC would be affected by conflict of interest issues because of representing a majority of employers.

There is an opportunity for closer working between LMCs and sessional GP groups to improve mutual understanding of roles and needs.

## **Out of Hours Organisations and Prisons**

There is evidence of particularly acute problems amongst these doctors in terms of isolation from peers, low morale and poor access to education. There is a need to look at examples of good practice nationally so that useful models can be adopted widely.

## 6. CONCLUSION

There have been improvements over the years for sessional GPs in areas of contracts of employment, introduction of performers lists, greater contact with deaneries and GP tutors, and more GPs having PDPs. Positive changes have included the development of the NASGP and its support for sessional GP groups, initiatives such as the Flexible Career Start scheme and other supported salary schemes. Appraisal has also brought about an increased awareness of issues facing salaried and locum GPs. Email and websites have had a significant impact on networking and access to information, both of which have helped reduce isolation.

It was evident from this research that there are different strategies being used to address the issues faced by sessional GPs and these are fulfilling different needs, but there are still barriers to support. Barriers to accessing education identified in the SCOPME report<sup>75</sup>, such as time, money, family commitments and lack of information remain. Benefits of sessional GP groups, locum chambers and SDLGs have been identified. Existing SDLG members and respondents who were not in an SDLG saw the benefits of being part of an SDLG for revalidation purposes, for example, discussing SEAs. Facilitating access to SDLGs and supporting the further development of these groups and enabling them to share and learn from each other could further their contribution. Information sharing between sessional GP groups, deaneries, PCT and locum chambers would also be of value. Sessional GPs working in Out of Hours organisations and Prisons suffer particularly acutely from lack of support, professional isolation and problems accessing education. Further research into models of support within these organisations is a priority. Information sharing between sessional GP groups, deaneries, PCT and locum chambers would also be of value.

Current developments in, for example, professional regulation and the introduction of revalidation have further implications for support for this group of GPs and the role of support groups, which need to be examined by all those with responsibility for, or interest in, support for sessional GPs.

### **Suggestions for Further Research:**

Out of hours organisations and prisons - focused research looking at ways in which their GPs can be better supported, have more opportunities for discussion with colleagues, give and receive feedback, and receive help with obtaining evidence for appraisal and revalidation.

### **Suggestions for Implementation:**

Information sharing between organisations

- Opportunities for Sessional GP groups to share experiences especially to address common dilemmas of sustainability
- Need for more sharing between SDLGs on their methods and models
  - Need for deaneries to pro-actively support creation of SDLGs
- Need for more sharing of knowledge between deanery educators involved in sessional GPs
- Opportunities for PCTs to learn from Sessional GP groups, chambers and deaneries about sessional GP issues
- PCTs should be surveyed about their approach to supporting sessional GPs (including them in cascades by email; including them in education and appraisal)

## 7. STRENGTHS AND LIMITATIONS OF THE STUDY

A strength of the study was its methodological breadth and its good qualitative sample size giving a broad and triangulated view of the issues faced by sessional GPs and the contribution of different types of support.

There is a potential bias in the sample in that respondents who volunteered to take part in focus groups and telephone interviews may be different from those who declined or did not respond in the study period.

The list of sessional groups used to distribute the electronic survey may not have been comprehensive but is the only known national register. However we are confident that the use of this list did target the vast majority of groups in the UK.

We aimed to target all dedicated educators in each deanery. However there was some difficulty in establishing who held this role in all cases within the timescale of the project.

The surveys to deaneries and the sessional GP groups/Locum chambers were designed to be anonymous in order to allow for frank and detailed level of response. This precluded data being used to highlight gaps by region.

Extensive exploration of data collected by different organisations on the number, type and location of sessional GPs in the UK highlighted that there is a lack of consistency in the types of data collected and the terminology used. This raised difficulty in collating data and giving a full and reliable picture of the number of sessional GPs across the UK. The high demands of time and resources precluded piloting of data collection.

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## **9. APPENDICES TO REPORT SUPPORT FOR SESSIONAL GPS**

## Appendix 1: Survey of Educators involved with Sessional GPs

### Deanery support for sessional GPs

#### 1. Introduction

The Royal Medical Benevolent Fund has commissioned the Northern Deanery Research Team to explore the support needs of sessional GPs (e.g. locums, salaried GPs, retainers, out of hours GPs) and how these are being met.

We are conducting a short survey to find out what support is available for sessional GPs in the UK. We would be grateful if you would take a few minutes to complete this survey about support provided in your Deanery.

During completion of the survey you can change your answers by navigating through the pages using the 'Previous' button.

Responses will be aggregated and individual answers will be confidential to the Research Team. No individuals or deaneries will be identified in reporting of data. We only ask you to name your Deanery to enable us to report on the number of deaneries represented in our data.

If you have any queries about the project please contact Dr Gill Morrow: [g.m.morrow@ncl.ac.uk](mailto:g.m.morrow@ncl.ac.uk) (secretary 0191 2106514)

### Deanery support for sessional GPs

#### 2. Deanery

##### \* 1. Which Deanery are you part of?

- |   |  |   |
|---|--|---|
| <input type="radio"/> East Midlands         | <input type="radio"/> Oxford                       | <input type="radio"/> East Scotland       |
| <input type="radio"/> East of England       | <input type="radio"/> Severn                       | <input type="radio"/> North Scotland      |
| <input type="radio"/> Kent, Surrey & Sussex | <input type="radio"/> South West Peninsula         | <input type="radio"/> North East Scotland |
| <input type="radio"/> London                | <input type="radio"/> Wessex                       | <input type="radio"/> South East Scotland |
| <input type="radio"/> Mersey                | <input type="radio"/> West Midlands                | <input type="radio"/> West Scotland       |
| <input type="radio"/> Northern              | <input type="radio"/> Yorkshire & Humber           | <input type="radio"/> Wales               |
| <input type="radio"/> North Western         | <input type="radio"/> Defence Postgraduate Medical | <input type="radio"/> Northern Ireland    |

### Deanery support for sessional GPs

#### 3. Roles and Responsibilities regarding sessional GPs

##### \* 2. Are you an educator/advisor with a dedicated role in supporting the educational, professional or appraisal needs of sessional GPs?

- ☐ Yes
- ☐ No

## Deanery support for sessional GPs

### 4. Roles and Responsibilities regarding sessional GPs cont...

\* 3. Are you the only educator/advisor in your deanery with this dedicated role for sessional GPs?

☐ Yes

☐ No

If No, how many other educators/advisors have this dedicated role?

\* 4. What does your/their role entail? Please tick all boxes that apply

☐ Signposting sessional GPs to educational providers

☐ Providing education targeted at sessional GPs

☐ Improving access by sessional GPs to 'mainstream education' by working with local organisations

☐ Producing newsletters for sessional GPs

☐ Acting as expert on local committees/panels etc. on issues around sessional GPs

☐ Supporting/running or advising on the retainer scheme

☐ Facilitating the creation of 'self-directed learning groups'

☐ Other (please specify)

## Deanery support for sessional GPs

### 5. Roles and Responsibilities regarding sessional GPs cont...

5. How many people provide support to sessional GPs in your Deanery?

GP educator/advisor for sessional GPs

Other GP advisor/advisor

Associate Director

Other(s) Please specify title & number

6. Does your Deanery undertake any of the following?

	Yes	No	Unsure
Providing education targeted at sessional GPs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Improving access by sessional GPs to 'mainstream education' by working with local organisations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Producing newsletters or guidance for sessional GPs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Acting as expert on local committees/panels etc. on issues around sessional GPs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Supporting/running or advising on the retainer scheme	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Facilitating the creation of 'Self-Directed Learning groups'	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Is there anything else you provide specifically for sessional GPs?

## Deanery support for sessional GPs

### 6. Self-Directed Learning Groups (SDLGs)

We are particularly interested in Self-Directed Learning Groups (SDLGs). These are defined as groups of GPs who meet regularly for the purpose of mutual support and continuing professional development, without regular external paid or unpaid facilitation.

**\* 7. How many Self-Directed Learning Groups are you aware of in the area you cover in your deanery role? (Please indicate roughly the population size or number of GPs covered in that area)**

**8. What role do you play (if any) in setting up or supporting Self-Directed Learning Groups?**

**9. What feedback (if any) do you get from Self-Directed Learning Groups?**

**10. What, in your opinion, makes Self-Directed Learning Groups successful?**

**11. What, in your opinion, would make Self-Directed Learning Groups more successful?**



## Deanery support for sessional GPs

### 7. Educational support for sessional GPs

12. What educational opportunities are provided specifically for sessional GPs by the deanery? (please do not include those provided by the educators/advisors with a dedicated role for sessional GPs, if applicable)

13. To what extent do you think local Primary Care Organisations (PCOs) inform sessional GPs, including locum GPs, directly (not via practice cascades) about the following?(where '1'=Not at all, '5'=Fully)

	1	2	3	4	5	N/A
CPR training	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prescribing information	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Provide local guidelines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Protected learning events	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Safeguarding children training	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
IT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Other (please specify)

14. How would a sessional GP not attached to a practice in your area access information about educational events and opportunities? (please tick all that apply)

☐ Deanery/educator newsletter

☐ Deanery website

☐ Local Sessional GP group

☐ PCO mailings directed to individuals (rather than to practices)

☐ Don't know

☐ Other (please specify)

## Deanery support for sessional GPs

15. What contact do you have with the local Sessional GP group, and what role do you think it plays in supporting education for sessional GPs? (Sessional GP group normally refers to a group of sessional GPs within a defined geographical area who come together for educational opportunities and job vacancies, and to provide mutual professional peer support)

## Deanery support for sessional GPs

### 8. Professional support for sessional GPs

16. What support (if any) do you have in place for sessional GPs other than educational support (e.g. mentoring, careers advice, leadership, career development etc.)?

\* 17. Professional isolation has often been identified as an issue affecting sessional GPs.

Are you aware of any problems arising as a result of isolation?

- ☐ Yes  
☐ No  
☐ Unsure

If yes, please specify

\* 18. Are you aware of any local initiatives which may help with issues of professional isolation?

- ☐ Yes  
☐ No  
☐ Unsure

If yes, please specify

## Deanery support for sessional GPs

### 9. Further support

19. Do you get enquiries from sessional GPs?

- ☐ Yes  
☐ No

If yes, what sort of issues/enquiries do they have?

20. Are you aware of any sessional GP needs that are not currently being met by the Deanery or some other source of support?

- ☐ Yes  
☐ No  
☐ Unsure

If yes, please indicate what these needs are and, if possible, any suggestions for ways in which these could be met

21. Are there any other comments you would like to make in relation to support for sessional GPs?

## Appendix 2: Survey of Sessional GP Groups and Locum Chambers

### Sessional GP groups

#### 1. Introduction

The Royal Medical Benevolent Fund has commissioned the Northern Deanery Research Team to carry out a study to explore the support needs of sessional GPs and how these are being met.

As part of this we are conducting a short survey to gather information on sessional GP groups and Locum Chambers in the UK. Therefore we would greatly appreciate it if you would take a few minutes to complete this survey. During completion of the survey your answers can be changed by navigating through the pages using the 'Previous' button.

Individual answers will be confidential to the Research Team and individual groups will not be identified in reporting of data.

If you have any queries about the project please contact Dr Gill Morrow  
g.m.morrow@ncl.ac.uk

### Sessional GP groups

#### 2. About your group and how it is run

**\* 1. How long has the group been running?**

Years   
Months

**\* 2. Geographical location of group**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> South & West    | <input type="checkbox"/> Trent                | <input type="checkbox"/> North Scotland      |
| <input type="checkbox"/> South Thames    | <input type="checkbox"/> North West           | <input type="checkbox"/> South East Scotland |
| <input type="checkbox"/> North Thames    | <input type="checkbox"/> Northern & Yorkshire | <input type="checkbox"/> East Scotland       |
| <input type="checkbox"/> Anglia & Oxford | <input type="checkbox"/> Wales                | <input type="checkbox"/> West Scotland       |
| <input type="checkbox"/> West Midlands   | <input type="checkbox"/> Northern Ireland     |  |

**\* 3. How many members are there in your group ?**

**\* 4. Who is in the group?**

- |   |   |
|---|---|
| <input type="checkbox"/> Locum GPs              | <input type="checkbox"/> Retainers        |
| <input type="checkbox"/> Salaried GPs           | <input type="checkbox"/> Career Break GPs |
| <input type="checkbox"/> Other (please specify) |   |

**\* 5. Where does the group meet? (please tick all that apply)**

- |   |                                   |
|---|-----------------------------------|
| <input type="checkbox"/> Member's home          | <input type="checkbox"/> Surgery  |
| <input type="checkbox"/> PCT                    | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Other (please specify) |                                   |

## Sessional GP groups

### \* 6. Please state how your group/organisation is funded

☐ PCT

☐ LMC

☐ Deanery

☐ Drug Rep

☐ Other (please specify)

### \* 7. Do members pay a fee to join?

☐ Yes

☐ No

If yes, please explain the fee system

### \* 8. Who is the group run by?

☐ Volunteers

☐ Paid help/administrators

☐ Other (please specify)

## Sessional GP groups

### 3. Group meetings

**\* 1. Does your group hold regular meetings?**

☐ Yes

☐ No

If yes, how often are meetings held?

**\* 2. Is there a minimum number of meetings members need to attend per year?**

☐ Yes

☐ No

☐ Not applicable

If yes, how many per year?

**\* 3. What type of meetings does the group hold? (Please tick all that apply)**

☐ Social

☐ Educational

☐ Committee type/professional issues

☐ Other (Please specify)

**\* 4. Type of GP group**

☐ Sessional GP Group

☐ Locum Chamber

☐ Other (please specify)

## Sessional GP groups

### 4. Services offered by your group

**\* 1. Which of the following services does your group offer to sessional GPs?  
(Please tick all that apply)**

- |  |  |
|--|--|
| <input type="checkbox"/> Email notification of vacancies             | <input type="checkbox"/> List of active locums for local practices |
| <input type="checkbox"/> Email notification of educational events    | <input type="checkbox"/> Web based calendars of locum availability |
| <input type="checkbox"/> Web based information on vacancies          | <input type="checkbox"/> Organised meetings                        |
| <input type="checkbox"/> Web based information on educational events | <input type="checkbox"/> LMC representation                        |
| <input type="checkbox"/> Mentoring                                   | <input type="checkbox"/> Support for sick doctors                  |
| <input type="checkbox"/> Discussion fora                             |  |
| <input type="checkbox"/> Other (please specify)                      |  |

**\* 2. Please indicate whether any of the following organisations provide support to your group and, if so, what type of support (e.g. information, funding, representation in/from your group, contact point for information)**

Local Medical Committee	<input type="text"/>
Local BMA office	<input type="text"/>
Primary Care Trust	<input type="text"/>
Deanery	<input type="text"/>
Royal College of GPs local Faculty	<input type="text"/>
Other (please specify)	<input type="text"/>
If you do not receive any organisational support type 'X' in this box	<input type="text"/>

## Sessional GP groups

### 5. Locum Chambers

**\* 1. What services can members receive through working in Locum Chambers as opposed to working as independent locums? (Please tick all that apply)**

- |  |   |
|--|---|
| <input type="checkbox"/> Standardised rates                      | <input type="checkbox"/> Standardised working conditions                      |
| <input type="checkbox"/> Organised meetings                      | <input type="checkbox"/> Centralised booking                                  |
| <input type="checkbox"/> Mentoring                               | <input type="checkbox"/> Confidential feedback systems/processes              |
| <input type="checkbox"/> Discussion fora                         | <input type="checkbox"/> Interactive blog                                     |
| <input type="checkbox"/> Dedicated clinical governance support   | <input type="checkbox"/> Admin support (Invoicing and bookings)               |
| <input type="checkbox"/> Support for sick doctors                | <input type="checkbox"/> Admin support with evidence collection for appraisal |
| <input type="checkbox"/> Reduction in medical indemnity payments |   |
| <input type="checkbox"/> Other (please specify)                  |   |

**\* 2. Are there any disadvantages to working in Chambers?**

- ☐ Yes
- ☐ No

If yes, please specify what they are

## Sessional GP groups

### 6. Other comments about your group

**1. Please comment on any particular strengths of your group**

**2. Please state any difficulties in the setting up or the running of your group and what, if anything, could help**

**\* 3. In your opinion, do the GPs in your group have other support needs that your group is unable to meet?**

- ☐ Yes
- ☐ No

Please expand on your answer

**4. Are there any other comments you would like to make?**



## **Appendix 3: Focus Group Questions to sessional GPs and self directed learning groups**

### **Introduction:**

The Northern Deanery Research Team/Durham University have been commissioned by the RMBF to carry out a research project on the support needs of sessional GPs, how these are being met, and what further support is needed.

The RMBF works to prevent and relieve financial hardship among doctors and their dependents and medical students. It is currently investigating the possibility of providing support or services to sessional GPs.

As part of this project we are mapping support available across the UK, for example through surveys to Deaneries and support groups. We are holding these focus groups to explore in more depth your experience of support for sessional GPs.

**Give out Information sheet/consent form/participant record – give time to let participants read, ask questions and sign consent form.**

### **Activity**

To get you thinking about support issues for sessional GPs, we would like you to think about why it is important to have support for sessional GPs. *(If asked about this: i.e. Do they have any different or additional needs to principals in relation to support?)*

Please write as many things as you like, but please keep to one thought per post-it.

Group post-its into similar themes and talk through to expand.

Prompts: isolation /education / professional support

### **Questions**

1. What support do you currently access?

Prompts:

\* Groups e.g. sessional GP group, SDLG

\* GP tutor for sessional GPs

\* National organisations e.g. NASGP

\* Websites

\* Follow-on question for each one (except SDLG, coming back to this):

How helpful is this? Is there any other way this group/organisation/role could help?

**SDLG/other group members (and include other focus group participants where possible):**

2. Please explain how the group came about and what help members received from outside with setting up (e.g. introduction via an event, email or with help of local tutors)

3. How many members are in your group?

4. How many meetings a year does the group hold?

5. Decision making and organisation: How are decisions about activities and membership made? At meetings, by email? Is there a nominated lead over all for the group or for given meetings?
6. What sorts of format do the meetings take: Topic prepared by a member, journal club, Cases, Social, etc?
7. What do you think are the benefits to members of being part of the group?
8. What do you think works well about the group and why?
9. What works less well?
10. What would make it work better?
11. What help do you think would be useful for your group now, and to help keep it going in the future?
12. What help do you think would be useful for other sessional GPs trying to form a group?
13. What needs is your group unable to meet for sessional GPs? Why?
14. How else could these needs be met?

For those not in a group:

15. What additional support would be useful for any needs that are currently unmet? How feasible would this be?

**Questions if no group members present:**

If we were to make suggestions to the RMBF about groups for sessional GPs it would be helpful to have your views on what would be useful:

If you were part of a group, how would you see it working?

What would you envisage as its main functions?

What format would you like it to take? How would this be decided?

How often and where would it meet?

What would be the best form of communication between members?

How would you like to see your group supported?

What do you think the benefits would be of being part of a sessional GP group/SDLG?

Can you think of any other issues that may impact on the setting up of a group?

## Appendix 4 : Telephone Interview Questions to sessional GPs and self directed learning groups

**Participant ID:** -----

**Interview date:** -----

**Interviewer:** -----

### Introduction:

The Northern Deanery Research Team have been commissioned by the RMBF to carry out a research project on the support needs of sessional GPs, how these are being met, and what further support is needed.

The RMBF works to prevent and relieve financial hardship among doctors and their dependents and medical students. It is currently investigating the possibility of providing support or services to sessional GPs

As part of this project we are mapping support available across the UK, for example through surveys to Deaneries and support groups. We are holding these focus groups/tel interviews to explore in more depth your experience of support for sessional GPs.

**Interview will take approximately 20 -30 mins**

### Confidentiality statement

Are you happy that the purpose and process of the study has been explained to you?

Are you happy with the interview being recorded and transcribed? This is to aid with analysis. The data will be anonymised and kept securely and confidentially to the research team

Any comments you say will be anonymised when quoted in publications or reports.

I just have some additional information I would like to ask you - this is to help with ensuring we have representation from a range of GPs

### Type of sessional GP (please tick all that apply):

Locum ☐ Urban ☐ Salaried by practice ☐ Rural ☐ Salaried by PCT ☐

Retainer ☐ Qualified <5y ☐ Out of hours ☐ On career break ☐

### Are you a member of any of the following?

NASGP ☐ Local sessional GP group (e.g. NELG) ☐ Self directed learning group ☐ Other ☐

**Age:** < 35 ☐ 36-45 ☐ 46-55 ☐ 56-65 ☐ > 65 ☐

**Sex:** Male ☐ Female ☐

## Questions

1. Can I ask you first of all do you think sessional GPs face different/or additional issues to GPs more generally?

Prompts: isolation / education / professional support

2. What support do you currently access?

Prompts:

\* Groups e.g. sessional GP group, SDLG

\* GP tutor for sessional GPs

\* National organisations e.g. NASGP

\* Websites

\* Follow-on question for each one (except SDLG, coming back to this):

How helpful is this? Is there any other way this group/organisation/role could help?

## SDLG/other group members

How did the group come about and what help members received from outside with setting up (e.g. introduction via an event, email or with help of local tutors)

3. How many members are in your group?

4. How many meetings a year does the group hold?

5. Decision making and organisation: How are decisions about activities and membership made? At meetings, by email? Is there a nominated lead over all for the group or for given meetings?

6. What sorts of format do the meetings take: Topic prepared by a member, journal club, Cases, Social, etc?

7. What do you think are the benefits to members of being part of the group?

8. What do you think works well about the group and why?

9. What works less well?

10. What would make it work better?

11. What help do you think would be useful for your group now, and to help keep it going in the future?

12. What help do you think would be useful for other sessional GPs trying to form a group?

13. What needs is your group unable to meet for sessional GPs? Why?

14. How else could these needs be met?

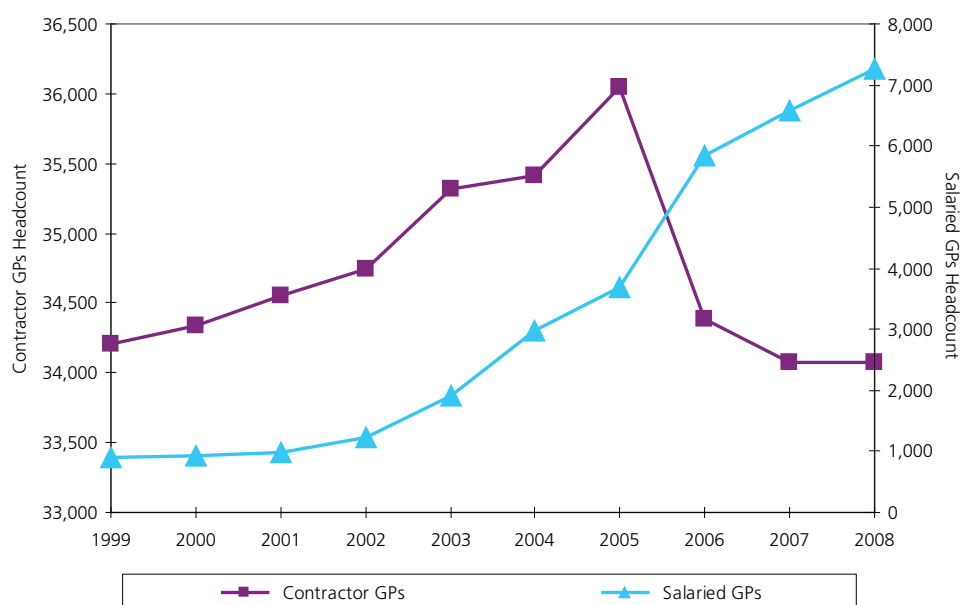
**For those not in a group:**

1. What additional support would be useful for any needs that are currently unmet?  
How feasible would this be?
2. If we were to make suggestions to the RMBF about groups for sessional GPs it would be helpful to have your views on what would be useful:
3. If you were part of a group, how would you see it working?
4. What would you envisage as its main functions?
5. What format would you like it to take? How would this be decided?
6. How often and where would it meet?
7. What would be the best form of communication between members?
8. How would you like to see your group supported?
9. What do you think the benefits would be of being part of a sessional GP group/SDLG?
10. Can you think of any other issues that may impact on the setting up of a group?

## Appendix 5: Mapping of Number, Type and Location of Sessional GPs in the UK: further breakdown of figures

### 1. Growth in number of salaried GPs

Chart 1: 10 year growth in contractor GPs versus salaried GPs (1999-2008)



Source: BMA Briefing Note June 2009<sup>3</sup>

### 2. Breakdown of Figures by Country

#### England

Table 1: Numbers (headcount) of GP Practitioners by SHA and type, 30 September 2009 (England)

	All GPs	GP Providers	Other GPs (=salaried)	GP Retainers	GP Registrars
North East	2,125	1,399	492	23	211
North West	5,144	3,975	854	45	270
Yorkshire & the Humber	4,100	3,292	348	53	407
East Midlands	3,335	2,325	543	14	453
West Midlands	4,096	2,894	709	33	460
East of England	4,095	2,939	724	49	383
London	6,010	3,793	1,558	37	622
South East Coast	3,268	2,234	614	75	345
South Central	3,636	2,657	523	70	386
South West	4,460	3,099	945	72	344
Total	40,269	28,607	7,310	471	3,881

Source: The NHS Information Centre 2010<sup>4</sup>

## Scotland

Table 2: Number of GPs by GP performer type and NHS board, 30 September 2009 (Scotland)

	All GPs	Performer <sup>i</sup>	Performer salaried	Performer retainee	Performer registrar/ST
Scotland Total	4,941	3,836	480	165	472
Ayrshire & Arran	317	273	14	3	28
Borders	122	98	8	6	10
Dumfries & Galloway	160	131	7	3	19
Fife	286	253	16	2	15
Forth Valley	261	213	19	12	17
Grampian	586	410	107	22	51
Greater Glasgow & Clyde	1,074	861	57	29	129
Highland	422	315	63	7	37
Lanarkshire	401	340	27	6	28
Lothian	827	585	97	58	88
Orkney	35	21	14	-	-
Shetland	35	12	21	1	1
Tayside	373	298	13	16	46
Western Isles	47	27	17	-	3

<sup>i</sup> A Performer is most likely to be a partner in a practice

Source: ISD Scotland<sup>5</sup>

## Wales

Table 3: GP practitioners by region and board in Wales, 1 October 2009

	All GP practitioners (incl salaried & assistant; excl registrars, retainers & locums)	GP Retainers	GP Registrars
<b>Wales</b>	<b>1,940</b>	<b>55</b>	<b>161</b>
<b>North Wales Region</b> Betsi Cadwaladr University LHB <sup>1</sup>	<b>438</b> 438	<b>10</b> 10	<b>36</b> 36
<b>Mid and West Wales Region</b> Powys Teaching LHB Hywel Dda LHB ABMU LHB	<b>680</b> 97 251 332	<b>18</b> 0 5 13	<b>50</b> 5 12 33
<b>South East Wales Region</b> Cardiff and Vale University LHB Cwm Taf LHB Aneurin Bevan LHB	<b>822</b> 294 160 368	<b>27</b> 13 8 6	<b>75</b> 25 24 26

<sup>1</sup> Local Health Board

Source: Statswales<sup>124</sup>



## Northern Ireland

Table 4: Number of GPs (UPEs and salaried) by NI Board/Trust, October 2008

Board/Trust	No. of GPs (Unrestricted Principals or Equivalents (UPEs) and salaried GPs
<b>Northern Ireland</b>	<b>1,148</b>
Eastern	473 (Belfast 284, South Eastern 189)
Northern	266
Southern	218
Western	191

Source: HSC Business Services Organisation<sup>125</sup>

### 3. UK figures by SHA/Board April 2010 (provided by Binley's<sup>126</sup>)

**Table 5: Counts of GPs by type and Health Authority UK-wide (April 2010)**

Country	HA	Locum GP	Salaried GP	Locum / Salaried	GP Retainer	Assistant GP	Associate GP	Flexible Career Scheme GP	GP Partners
<b>England</b>	NHS East Midlands	117	542	10	12	20	18	4	2148
	NHS East of England	199	671	7	38	45	14	3	2873
	NHS London	366	1446	47	40	138	50	6	3514
	NHS North East	54	435	3	20	13	6	2	1337
	NHS North West	250	934	22	32	56	26	1	3580
	NHS South Central	136	450	9	48	37	18	6	2177
	NHS South East Coast	147	538	6	60	48	42	11	2161
	NHS South West	152	683	3	70	78	60	17	3031
	NHS West Midlands	166	664	18	28	50	20	2	2752
	NHS Yorkshire and the Humber	169	751	13	42	27	4	3	2726
<b>Islands</b>	Islands	6	5	1	2	8	5		177
<b>Northern Ireland</b>	Belfast Commissioning Group	26	16	2	13	3			277
	Northern Commissioning Group	29	12		6	2			265
	South Eastern Commissioning Group	16	7		6	2	2		176
	Southern Commissioning Group	16	9		6	1			207
	Western Commissioning Group	16	4		1		1		187

Country	HA	Locum GP	Salaried GP	Locum / Salaried	GP Retainer	Assistant GP	Associate GP	Flexible Career Scheme GP	GP Partners
Scotland	NHS Ayrshire & Arran	4	19		1		1		267
	NHS Borders	4	4	1	5	1			95
	NHS Dumfries & Galloway	8	6		4				130
	NHS Fife	15	17		1	2			249
	NHS Forth Valley	12	17	1	11	1			211
	NHS Grampian	24	60	2	20	21	9	1	378
	NHS Greater Glasgow & Clyde	43	48	2	20	3	3		845
	NHS Highland	12	60		5	2	6		305
	NHS Lanarkshire	11	26		2				354
	NHS Lothian	33	70		52	21	2		580
	NHS Orkney	2	5			1	2		18
	NHS Shetland	1	10		1		3		12
	NHS Tayside	20	16		18	3	2		298
	NHS Western Isles		15			1	1		26
Wales	Abertawe Bro Morgannwg University Local Hlth Board	20	31	1	10	1			310
	Aneurin Bevan Local Health Board	19	57		4	4	1		315
	Betsi Cadwaladr University Local Health Board	17	23		7	7	1		417
	Cardiff and Vale University Local Health Board	8	25		11	1	2		269
	Cwm Taf Local Health Board	10	33		8	1			130
	Hywel Dda Local Health Board	9	31		4	1			219
	Powys Teaching Local Health Board	4	8			1			91
<b>TOTAL</b>		<b>2141</b>	<b>7748</b>	<b>148</b>	<b>608</b>	<b>600</b>	<b>299</b>	<b>56</b>	<b>33,107</b>