



# *affiliate* Freelance General Practitioner Scheme: aFGP

A new concept from NASGP Council December 2006

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## ***Introduction***

The NASGP first came up with the concept of the Sessional GP Support Team (SGPST) in 2002 as a means of enabling isolated Freelance GPs (FGPs) to team up with local colleagues to share resources and be more involved in local NHS structures and processes.

In its simplest form, our idea was for there to be in place a 'facilitator' to support those GPs in their day-to-day management of work (bookings, audit, payments, billing, superannuation, appraisal, information cascades, meetings, prescribing etc) together with some form of clinical 'leadership'.

This concept is all very well if a SGPST is already in existence in the GP's local area, or if one can afford to invest in setting up a SGPST privately with other like-minded colleagues. But for those FGPs not able to access such a group or who are not keen to work in a team-based environment, there are few other options left to them to easily access various means of support enjoyed by practice/team-based GPs.

The aFGP Scheme is the *concept* of a formal relationship between an individual Freelance GP and a GP practice that allows both parties to benefit from each other.

To this end, we are exploring ways in which an individual FGP can become affiliated to a practice and are proposing the new concept of an **Affiliate FGP** (aFGP).

## ***Advantages of being an aFGP***

1. Access to Continuing Medical Education
  - a. FGPs often have very poor access to clinical meetings. As well as holding internal clinical meetings, a host practice is more likely to learn of other clinical meetings taking place locally.
  - b. FGPs can easily become de-skilled at managing chronic conditions, and so could benefit from participating in educational multidisciplinary meetings with other staff such as practice nurses.
  - c. Access to local clinical guidelines that are otherwise not available to conventional FGPs
2. Revalidation
  - a. The aFGP scheme could provide the aFGP with a 'GMC approved environment'.
3. Mentoring
  - a. The availability of practice based GPs could offer the aFGP access to formal and informal mentoring.
4. Access to audit data
  - a. Although not necessarily contributing directly to the gathering of data by the practice, the aFGP will have access to clinical data for the purposes of simple audit through to complex research.
5. Support
  - a. Working as an FGP can be very isolating, so access to a supportive and willing team of GPs and other health professionals could provide support and improve job satisfaction.
6. Partnership skills
  - a. An FGP can become de-skilled from the inter-personal and management skills needed as a partner. The aFGP may be working Freelance for a relatively short period of time – eg newly qualified, raising a family, looking for a permanent position, following a spouse etc – with the ultimate aim of becoming a partner, so staying within a management environment could help prevent this de-skilling.
7. Quality
  - a. It is likely that the aFGP will, through time, maintain a clearer understanding of the week-to-week management of a practice outwith the experience s/he would gather from providing the usual Freelance GP services. For example, understanding the reasons why a practice provides services in a different way could enable him/her to better deliver those services in other practices.
8. Services
  - a. An aFGP may find it easier to contract their Freelance GP services to other practices if those practices engaging him/her realise their potential.

## 9.MRCGP

- a. Affiliation to a Host Practice could provide the aFGP with access to facilities to enable him/her to study for the MRCGP exam.

### **Case Study #1 David**

David is a GP registrar at Babsham Surgery and plans ultimately to become a partner in a practice. But his wife, a surgical registrar, is pregnant with their second child and neither of them are sure where they will settle. David is very keen to sample as many different practices – and types of practices – as possible so that he can ascertain which type of practice he would like to apply for. He has met other Freelance GPs during his GP registrar year who complained of being professionally isolated.

He has approached his current training practice to become their Associate Freelance GP as he already gets on very well with them. As well as already being a trusted member of the team, he also would like to take on a mentor role with the incoming GP registrars and continue working on several more audit projects.

## ***Advantages of hosting an aFGP***

### 1. Experience and Primary Care Development

1. Although not necessarily performing regular sessions in that practice, the aFGP may have skills, knowledge and experience above and beyond that of the current practice members. Working as a Freelance GP in many different practices, the FGP may be able to call upon his/her experience from working in a broad range of practices to help practices plan their services.
2. Providing an additional professional opinion; it may well be that the aFGP was himself/herself a partner and so the host practice may benefit from the aFGP's wisdom.

How would the practice and aFGP tackle the issue of confidentiality on commercially sensitive issues between other practices?

### 2. Clinical Medical Education

1. An additional GP may improve the quality and balance of clinical meetings

### 3. Mentoring & support

1. An aFGP could make an excellent Mentor
  1. A 'senior aFGP', e.g. retired senior partner, may have a lot to offer a newly qualified partner in terms of experience and advice
  2. A partner in a practice may find it awkward to share certain information with other partners (age, race, gender, financial interests etc) so would have an independent colleague to share problems and ideas with.
  3. Single-handed practices may particularly benefit from an aFGP for these reasons.

### 4. 'Preferred' Freelance GP who knows and understands the practice.

1. Could provide that practice with a better opportunity to engage an FGP who knows more about that practice.
2. The aFGP Scheme could act as a way of 'grooming' a potential new salaried GP or partner.

### 5. Teaching

Medical students and registrars could benefit from the aFGP's experience

1. GP registrars may have little or no contact with Freelance GPs until they become one themselves.
2. An aFGP may be able to provide insight into working in a multitude of different PCTs, practices and locales (inner city vs rural, for example)

## 6. Recruitment

1. An aFGP post may be a way of introducing a new recruit to a practice that otherwise does not often use temporary GPs nor has the need for a salaried GP.

## 7. Portfolios

1. An aFGP may be assigned to a 'portfolio within the practice where they have particular qualities of experience e.g.
  - QOF quality area
  - Women's Health
  - Diabetic Care
  - Information Technology

## ***Financing the scheme***

We are open to suggestions as to how this scheme could be funded:

### 1. Voluntary

- Is the relationship between both parties of equal and mutual benefit?
  - Will the aFGP be able to charge more by virtue of the fact that the quality of his/her services will be greater to practices?
  - Will the potential for improved welfare and morale of the aFGP mitigate the extra involvement that the aFGP provides for the host practice?

### 2. Fee-based

- aFGP pays
- Host Practice pays
- Local funding
  - From PCO
    - To improve recruitment and retention of Freelance GPs
    - As a supervisory scheme for underperforming GPs

### ***Suggested bodies for consultation***

- Royal College of General Practitioners
- Sessional GPs Sub-Committee of the GPC
- General Medical Council
- The National Association of Primary Care Educators
- Small Practices Association
- National Association of Primary Care
- National Clinical Assessment Service

## ***Appendix 1 – So you want to be an aFGP?***

- Make a list of five or so practices that you're already familiar with and that you're prepared to travel to on a regular basis.
  - Your old training practice
  - Your 'ex' practice – perhaps you were a partner or assistant there
  - One where you freelance regularly
  - One where you get on well with the other doctors and staff
  - See if one of your GP friends would be interested in having you as an aFGP
- Write a letter defining what you feel you can contribute to the practice
  - Practical e.g.
    - experience in setting up hypertension/diabetic clinics
    - setting up and maintaining practice website
    - Postgraduate teaching
    - GP training
    - Practice management
  - Clinical e.g.
    - Expertise in family planning
    - Clinical assistant in dermatology
  - Mentoring e.g.
    - Mentoring skills and experience
    - Balancing the practice's mix of gender/race/age
- What would you like from the practice?
  - Occasional advice?
  - An 'in-tray' to receive relevant clinical information?
  - Being part of a team?
  - Involvement in audit projects?
  - Mentoring?
  - Attending CME events?
- Define how much involvement you think would be practical.
  - Attendance and weekly/monthly practice-based learning
  - Attendance at practice meetings
- Suggest an initial meeting with several GPs in the practice to discuss the idea

Once you are comfortable in an aFGP position, please register with the NASGP so that we can contact you at a later date to help us develop and improve the aFGP idea.

## ***Appendix 2 – So you want to host an aFGP?***

- Who do you have in mind?
  - One of your preferred locums?
  - An ex or retired partner
  - A friend?
- Have no-one in mind?
  - Draft a 'job description'
    - Outline the informal nature of the relationship
    - The relationship may attract a locum 'wanting to get more out of being a GP'.
    - What sort of commitment would the practice want?
  - Contact your local Sessional GP Group to see if anyone is interested
  - Ask other practices to see if they could recommend or suggest a suitable GP for the post
    - maybe one of their partners is about to retire?
    - Or they may have a registrar about to qualify
  - Speak to your local GP tutor or PCT
    - s/he may know of a new GP in the area
    - or of a locum that may greatly benefit from this relationship
      - overseas qualified or 'asylum seeker'
      - a professionally isolated GP
      - an underperforming GP in need of assistance or even supervision
  - Advertise the post in any local GP publications etc

Once you have developed such a relationship with a locum GP, please let the NASGP know so that we can help improve the aFGP concept.

## ***Appendix 3 – RCGP Response***

Received 22<sup>nd</sup> August 2006

1. The College welcomes the opportunity to comment on the *National Association of Sessional GPs (NASGP)* consultation document – *Affiliate Freelance GP scheme*.
2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. It aims to encourage and maintain the highest standards of general medical practice and to act as the 'voice' of GPs on issues concerned with education, training, research, and clinical standards. Founded in 1952, the RCGP has over 24,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline.
3. The College believes that this scheme of affiliation would prove beneficial to both parties, allowing FGPs to attend practice meetings, remain involved in practice management and provide support with auditing and locum services. FGPs working in the CPD and management areas of General Practice would benefit from the support, team working and educational input required to minimise any isolation. The aFGP and practice should take responsibility for negotiating the particulars of the working relationship to develop an appropriate and tailored scheme.
4. However, many practices may not wish to fund this scheme. Costs could be born by the FGP (assuming that current locum payments have an element of CPD costs incorporated). Some clarification could be provided regarding how the scheme will be funded, for example, what funding is required if the GP is employed within the practice?
5. Although there are advantages for both parties, more are apparent for FGPs. This imbalance could be redressed for the scheme to work more effectively.
6. It would be beneficial for FGPs to have the opportunity to access other environments, other than practices in a supported way, e.g. prison healthcare services and Tier 2 and 3 substance misuse treatment services.
7. An improved structure may help raise the profile and awareness of FGPs, as well as aiding in quality assurance, appraisal and revalidation. Core objectives and minimum standards should be set in order to keep the scheme flexible, whilst formalising the experience. These objectives could include: mentorship with a GP in the practice, access to clinical meetings and improved communication about health circulars/educational events.

8. I acknowledge the contributions of Dr Linda Harris, Dr Helen Herbert, Dr Brian McKinstry, Dr Christopher Nixon, Dr Kate Shardlow and Dr Jeremy Thompson towards the above comments. Whilst contributing to the response, it can not be assumed that all named necessarily agree with all of the above comments.

## ***Appendix 4 – NAPCE Response***

**5<sup>th</sup> July 2006**

Overall the NAPCE (National Association of Primary Care Educators) welcomes the initiative from the NASGP (National Association of Sessional GPs) in proposing an AFGP (Affiliate Freelance GP) Scheme. It gives a route to educational and organisational support from a practice for a freelance GP (FGP) who becomes “affiliated” to that practice. This would facilitate particularly those freelance GPs who recognise that they may have difficulties, in producing the appropriate and increasingly robust evidence for revalidation that is likely to be required in future.

While the detailed rules for revalidation are still awaited it is clear from other changes in the NHS that the independent route is likely to be more arduous. GPs in a managed environment are likely to find the process less irksome.

It has to be accepted that a significant number of FGPs value their independence and would see this proposal as undermining their chosen professional working style. This document needs to be viewed as a possible alternative way of working and should not be deemed prescriptive. We feel this should be emphasised.

There are some issues to be resolved:

Developing a symbiotic relationship without a broker can be difficult. In the current financial climate it would be difficult to see where funding for a broker would emerge from. The Deanery or LMC would be ideally placed, however these bodies are already stretched and looking for avenues to reduce expenditure.

It might be difficult to decide what arrangements would be mutually beneficial without the balance being in favour of either party. Unfortunately, there are too many examples still of less than best practice in the way a few practices treat FGPs and in the way a handful of FGPs behave.

With the above provisos, NAPCE would support a trial of this system. It could well help a cohort of FGPs to facilitate the collection and organisation of evidence for appraisal and revalidation.

## ***Appendix 5 – Responses from individuals***

- well thought through and much needed.
- freelance GPs are highly variable in experience and character...the aFGP would suit some well, but not others.
- you risk promoting the idea that there is a problem (in GMC terms) that requires a solution.
- The running sub-themes are difficulty in accessing CME (not so), difficulty keeping up with the skills of chronic disease care (not so), difficulty participating in audit and with patient satisfaction surveys (not so).
- The reality is that freelance GPs must charge sufficient to buy the personal time they need for CPD etc.
- Meanwhile up here in Nottinghamshire I've been active with the LMC in holding evening CPD meetings explicitly for sessional and salaried GPs, and at the most recent we did some small group work on some clinical governance proposals from a local 'lead' PCT designed to deal with poorly performing SGPs.
- ...'affiliation'...with [a] LMC rather than with a Practice [is] potentially a better model.
- Your proposed scheme sounds like a truly excellent idea and one that I would like to be part of.
- Sounds like a positive idea
- [As an] aFGP [practices] might include freelance GPs in their practice e-mail list server and thereby keep one easily and effortlessly informed of things going on that - being 'unattached' - one misses out on.
- Training practices are likely to be the most useful. Trouble with them is that they will 'aGFP' their registrars and the rest of us are still out in the cold.
- Another trouble is the very secretive nature of some practices as if they are exposing their underwear if they tell you the real life cost of anything.
- I like the idea because it offers the possibility of tapping in to the information cascade on local service changes, training etc.
- It helps maintain your 'presence' in the workforce and fosters professional links.
- It allows skills and experience that a FGP may have to be used more widely.
- A formalised link to a practice, without having to work sessions, would be very helpful and mutually beneficial - I could provide informal advice, training and support in my areas of expertise in exchange for being copied in to relevant information and invited to educational meetings. Perhaps money would not need to enter in to it...
- Thanks for the creative thinking
- The concept of encouraging a freelance GP to link to a practice to their mutual benefit - particularly with regard to that GP accessing CPD in

the broadest sense - has been taken on by some of the London PCTs. The reality is that it does not really work for those who do not want to link in, and often I suspect that this is behind their desire to work freelance. In particular this applies to those working for the OOH organisation.

- I like the concept and can see it working well.
- In effect I had three practices in my locum years which acted as affiliated practices for me. One allowed me (and baby!) to attend the weekly practice meetings which often had an educational content; another did not allow me to attend the business meetings, but I was very much supported by the GP's in the practice and got to know of, and was invited along to, the local GP and consultant society events via contacts at this practice; and at a third I attended the occasional educational event.
- I think your proposal will formalise something which is happening anyway for some Sessional GP's and give others the chance for this to happen.
- I can only really envisage someone being an aFGP in a practice where they locum regularly. Anywhere else would seem a bit odd for both FGP and practice; most meetings would be boring and irrelevant, and going there would just be an extra effort. For regular locums it would help to have access to clinical meetings, and one would feel more part of the team and serve the practice better if involved in management etc. But not all practices are training practices.
- I've asked a few practices I've been working with about their clinical meetings, all were pleased I came to their meetings.
  
- Many thanks to these members for their comments and useful feedback
  - Lola Tomas-Tello
  - Roxana Whelan
  - Joanna Turner
  - Steve Reay
  - Sarah Feather
  - Julia Whiteman
  - Jeanette McGorrigan
  - Alastair Wilson
  - Michael Loudon
  - Cath Jenson