Sessional GP Support Teams

Report of the
NASGP Way Forward Meeting 2002

Held at the RCGP on Saturday 23rd February 2002

Foreword

At the NASGP's council meeting in October 2001, we decided to mark the 5th Anniversary of the NASGP with a meeting of Sessional GP leaders from around the UK to develop a means by which the NASGP can bring together all the positive things that have happened to Sessional GPs (SGPs) over the last few years into a workable solution for all SGPs.

On the basis of this, 35 GPs forfeited a Saturday to attend a workshop in London to help us achieve this.

We agreed to use the following as the basis of the day's meeting, making some minor changes to the aim as the day progressed

Summary

In order for SGPs to be fully enfranchised into the structures and processes of their Primary Care Organisation (PCO), the PCO should employ a facilitator [Sessional GP Liaison Officer] to organise and co-ordinate the non-clinical functions of SGPs in its area as well as supporting the SGPs' quality maintenance mechanisms for appraisal and revalidation such as coordinating feedback and collecting audit data. This facilitator would be supported by a fully trained GP mentor (clinical director) to oversee the professional and pastoral needs of those SGPs, and together form the PCO's Sessional GP Support Team (SGPST).

Aim of the Meeting:

to design a framework in which Sessional GPs can co-exist and/or thrive and/or lead and/or flourish within a “managed” organisation

After introductions, delegates gave their personal reasons for attending. We then indulged ourselves on trying to define all the Big Issues that were affecting Sessional GPs by going round the group in a ‘brainstorming’ session.

Initial issues raised by those present:

- Are we as SGPs in a position to be in control of or shape our future?
- Organisation, identification and location of SGPs – currently there is a mishmash of sporadic, localised and variably managed schemes. This should be solved by the implementation of Supplementary Lists, although some Health Authorities appear to be slow in getting this in place
- Revalidation:
  - coping with additional workload?
  - will the processes work for SGPs?
  - will SGPs get support from local PCOs?
  - Revalidation not the same thing as appraisal (latter should be flexible)
  - Audit - difficult to do audit when peripatetic
- Supplementary Lists:
  - what benefit to SGPs?
  - nature of questions asked
  - who will hold them?
  - who will have access to them?
- Working in managed system (integration) vs. not being managed
  - SGPs seen as threat to the system "Doctors Outside Managed Organisations"
  - recognition of SGPs as professionals in their own right
  - would flexibility be sacrificed by working in a managed system?
- Poor Performance
  - How do SGPs fit into local and national procedures
  - Will SGPs be more vulnerable to under performing – "enforced underperformance"
  - Can SGPs help improve the under performance of GP principals?
  - Does the lack of managed systems increase the risk of underperformance?
- Recruitment and Retention:
  - choice of jobs/getting balance right (e.g. survey currently being carried out in Wales re what SGPs want now and in the future)
  - maintaining the workforce
  - re-entry schemes to allow GPs who not currently working back in to general practice
- Political representation
  - How can we encourage more SGPs to be involved in representing the best interests of other SGPs at a local and national level?
- Implement what **we** want
  - Difficulty in persuading local PCOs that the needs and rights of SGPs need to be met
  - leverage to extract resources (funding difficulties)
  - negotiation
- Education:
  - management becoming more political
  - access to and provision of education for SGPs is poor
  - difficult if on few sessions per week/low income
  - funding
  - paid protected time
  - needs
  - skills/IT
  - relationships with PCOs
  - part-time GPs
  - will GP tutors exist in the future?

- Isolation
  - Especially Northern Ireland (not even at Supplementary List stage) and therefore “learned helplessness”
  - Link English systems to provide access for all SGPs' (devolution is pretty scary if you’re already feeling isolated)
  - Cohesiveness
  - Resources available to SGPs vary from area to area.
  - Highly dependant on the motivation of local individuals

- Quality Assurance and Workforce Issues
  - PCTs becoming more aware of SGPs
  - equity: there should be no difference in the quality of care that patients receive whether its from Principals or Sessional GPs
  - Morale and quality – we feel good if we are able to treat patients well
  - Guiding PCTs in defining number of GPs in their area

This had turned out in some ways to be quite a ‘negative’ session, with delegates airing all the bad things about working as a Sessional GP. So after coffee and Danish pastries (we do things properly at the NASGP), we chose four central themes which grouped together all these issues and formed four smaller groups with the remit of turning these issues into positive, constructive solutions.

Breakout Sessions #1

"Develop a way for SGPs to be involved within a management structure, define how SGPs can work with other organisations and co-ordinate pay and conditions"

Facilitated by Jenny Fox

"Management" is a nebulous term. The group took this to mean as being a framework within which people work.
Local groups to drive the agenda would be helpful
Consider how to work with PCTs at base level and higher – SGP representatives on PCT boards?
Funding is the problem – need to negotiate somehow and need to be clear on what is being requested
NASGP to recommend that each PCT should fund some form of support for a facilitator at each level? Will advise on how to provide this and outline the possible benefits
Need to motivate and support the workforce
Conditions an important issue at present
Practices should welcome SGPs, make them feel part of the team
Practices should encourage, by their own attitude, patients to accept SGPs as part of the team

"How can SGPs Negotiate for a local deal"

Facilitated by Tina Ambury
SGPs should come up with advice as to how to go forward
SGPs to learn how to vale and "sell" themselves
Different ways of approach
an offer to help solve problems locally is more effective than an aggressive stance.
formulate a local business plan
Supplementary List
Who should will be holding it?
How to make it work for SGPs
Best Practice
draw together examples and publish – on NASGP website?
Problem sharing – local monthly meetings?

"How would our solution tackle workforce planning, Recruitment and Retention and Supplementary Lists"

Facilitated by Jane Harrison

Management
Older doctors as mentors? (Government are starting to discuss)
Undervaluing of GPs
by public, media, Government and also consultant colleagues
therefore "spin doctors" to promote role of GPs?
Should GPs still be in the front line?
Too much time spent managing trivial conditions
Paperwork could be more efficient and less time-consuming
Recruitment and Retention
retainer scheme good way of keeping people on board – abolish 5 year limit?
should it be changed to assistants post?
SGPs should have their own management team and own quality systems

- Revalidation
  - Should be of a low (attainable) standard rather than a high one
  - Should be flexible, i.e. not on just one assessment
  - The idea of appraisal should be positive – Government should be advised by SGPs as to how to appraise
  - GMC confused appraisal with assessment
  - Should have time resources for SGPs to get folders up and running
  - Valuable that SGPs can feed back thoughts re principals

Reconvening after this breakout session, the facilitators from each group presented their groups ideas.

Summary of 1st Breakout session - Solutions

- Needs to be a one-size-fits-all solution
- Must be locally led but coordinated nationally
- Must be able to skillfully negotiate for SGPs at PCO level
- Each PCO needs a "facilitator/administrator/personnel officer" supported by a "SGP Mentor/clinical director/guru"
    - Organisation

Supplementary Lists
Maintain database
Audit/feedback
Continuing Medical Education
Applying for PGEA
Journal clubs
Lectures and talks
    - Co-ordination

Freelance GP availability
Practices' manpower needs
LMC support
Information
With PCO e.g. Annual Report
    - Support

Pastoral
Professional
Quality standards e.g.
NASGP Code of Good Practice
Practice Packs
Freelance GP Contracts
Acts as a continuum for local VTS
Educational
Occupational Health
    - Motivate the local SGP workforce

Liaison with SGPs
Develop sense of ownership
Involve SGPs in local Primary Care Development

- Must be what the PCO needs
    - Solves a common agenda
    - Provides local PCO solutions
    - Disseminating best practice

Sharing of information between practices
Good practice
Problem sharing
Skills
Workforce
Managing manpower
Developing locally defined posts
To suit SGP
To suit PCO/practices
    - TOTAL QUALITY MAINTAINANCE
    - A better term than audit
    - Facilitate feedback between SGPs, practices and PCO

From this, a clear theme had emerged – that what we really need as Sessional GPs is for each PCO to set up a **SGP Support Team** to manage the GPs on their supplementary list by appointing a person (**Sessional GP Liaison Officer**) to facilitate Sessional GPs (such as a personnel manager/administrator) complemented by one or two sessions a week from a GP "mentor" or "Guru".

It also emerged that 2 of the delegates (Roger and Kathy) were already involved in a very similar project in Bromley, which had been started some 2 years ago as a response by their PCT to recruit Sessional GPs into the area.

Again, we took 5 main headings and broke out in to smaller groups to both explore these issues further and to test if this outcome would be appropriate.

Breakout Session #2

"Describe the role of the SGP Liaison Officer (SGPLO) (job description, offices, funding)"

Kathy and Roger outlined their scheme (LocEmdoc) in Bromley, set up to keep SGPs in the area, give them access to paid education and access also to the pick of available sessions. Questionnaires sent out have shown that SGPs are the happiest of the GPs in the area!

- Office runs on 2½ sessions GP time/1 full-time admin. role per week
- Weekly mailshot – information about work available and other items
- Database of SGPs
- Encouraging SGPs to register on Supplementary List
- Checking SGPs' credentials to save practices time and trouble
- Feedback to practices and Freelance GPs
- Support given to Freelance GPs
- Standard setting (LocEmdoc uses a lot of NASGP suggestions)
- Evaluation at the end of each Freelance GP's sessions in a particular practice – good for problem solving amicably and swiftly
- Reporting to PCT in return for funding (£100,000 p.a. – population approx. 300,000, approx. 60 practices). Practices and SGPs who make arrangements between themselves are asked to let the scheme know to keep the money for education flowing in – i.e. evidence of Freelance GP activity
- Education – need for assessment
- Application for PGEA
- Retainers, etc. should also be in the system
- No need to restrict to SGPs – framework could be used for pharmacists, nurses, etc.

"How would this SGPLO support the SGPs and the PCO"

- Need for a "fixed" facilitator
- Make finding work easier – keep the workforce happy
- Improve morale – SGPs know they have someone to turn to
- Efficiency – coordinated SGP workforce rather than chaotic
- Putting SGPs in touch with other supportive bodies (LMC, NASGP, local SGPG, PCT subgroups, clinical workgroups, hospital liaison etc.)
- Access to CME
- Safety (educational needs)
- Helping when complaints are made
- Continuation of VTS
- HPE – years worth of protected facilitated learning time

"How could this idea be disseminated at a national level"

- Educational support has to be responsive to local needs but promulgated nationally
- Supplementary List a great opportunity – puts SGPs on a professional par with principal colleagues
- It may put restrictions on way in which SGPs work.
- A clearing system may be preferable –
    - practices would put sessions they cannot fill through clearing system operated by local or national facilitators.
- Knock-on effect – a well-implemented local scheme would create a "virtuous cycle", whereby neighboring PCTs would also have to set up similar schemes to "compete" for SGPs
    - reciprocal arrangements with local PCTs which have facilitators (beneficial also to SGPs who live on or near PCT boundaries).
- Benefits to PCT: well-known, well-informed local workforce
- Pastoral care – could be continued by LMC

"In what ways could feedback between SGPs, practices and the PCO be facilitated"

- essential – what a great way to learn
- practices gain from other practices – lack of communication at present
- system needs to address all problems – major and minor
- helps filter out individuals' worries
- practice manager could hold card forms
- suggest items for comment (boxes with titles)
- leave space to state if want to discuss the matter further
- remind that feedback should be constructive
- give phone number so doctor in question can contact the issuer and gives warning to prepare
- indicate how to take to "next stage" if necessary
- need for a named appraiser?
- feedback could be used towards appraisal
- NASGP to develop feedback system in conjunction with medical indemnity company and RCGP to ensure quality and viability of system

“In what ways could Audit be facilitated”

- We agreed that we share the experience of not so far being able to find a way to use the audit cycle process to evaluate SGPs’ personal work, therefore we should go for Total Quality Maintenance (TQM).
- Part of quality work would include joining in with audits being done in any practice we are working for.
- Individual SGPs would need to show evidence of the processes that they are applying to their own TQM.
- tool for evaluating quality, producing change, measuring improvements
    - what can a Sessional GP practically do?
    - audit referrals
    - patient satisfaction surveys
    - identify specific learning needs (PUNS & DENS), meet needs and review management
    - prescribing – it will be easier to measure prescribing when ID numbers in place
    - measure significant events
- facilitators should agree locally based audits
- is auditing personal or practice-based? (GMC wants to know how the individual is participating in the audit process to see how he/she is working with others
- practices to be asked to provide feedback to SGPs on hospital admissions

Appendix - SGPST Frequently Asked Questions

"Do the Sessional GPs continue to be self-employed, but with more organised support from the SGPLO and mentor?"

Yes - it's a form of "soft management". As you know, GP principals are technically self-employed. Employing all the SGPs would be fraught with problems - a bridge too far perhaps for some Sessional GPs and/or PCTs.

"In what sense are the Sessional GPs 'fully enfranchised members of the PCT' beyond their existing role of working in the area?"
Because they will formally be involved in clinical governance; be represented at PCT/LMC level; opportunities to actually help develop and lead in primary care development. For example, at the SGPST weekly/monthly management meeting, it transpires that there is a huge variation in the delivery of diabetic care - some good and some bad - across the PCT. So it is suggested by one or two of the SGPST members that they set up a peripatetic diabetic clinic, with the same two trained GPs (Freelance GPs) working regularly in every practice seeing every diabetic in the PCT, feeding back into the clinical governance mechanisms, building up a wealth of data, knowledge, experience and measurable outcomes.

"Are the Sessional GPs funded to participate in education/ clinical governance?"
No less so and no more so than any other GP in the PCT.

"Would you expect all local practices to go via the SGPLO to set up any Sessional GP cover required?
It would make sense! Some Sessional GPs may hate the idea of this, and so they could/should be left to their own devices. But as the system unfolds and those Sessional GPs being booked by the SGPLO start to receive greater benefit, I would expect that those initially dissenting Sessional GPs may finally give it a go. It would be wrong to force any SGP to something they don't want to - the trick is to develop a service, highlight its benefits for all concerned, and then invite people to join in.

"What about Out of Hours work?"
A lot of Sessional GPs can't be bothered - why should they? But, as a member of a SGPST , as they gained greater ownership of their PCT and the PCT/OOH co-op greater ownership of their Sessional GPs, I believe that greater synergy would develop and Sessional GPs would be far more willing to do OOH than they are now.

"Most of our Sessional GPs here work in several PCTs - how do you envisage this working?"
The idea is each SGP would be a member of only one PCT. But two or more PCTs could share meetings, running costs etc. or hold away days together. In terms of booking Sessional GPs, SGPLOs from different PCTs could easily "borrow/share" Sessional GPs.

Many thanks to Clare Mitchison, Clinical Governance Facilitator for Brighton and Hove City PCT, for posing these questions.

Further Details

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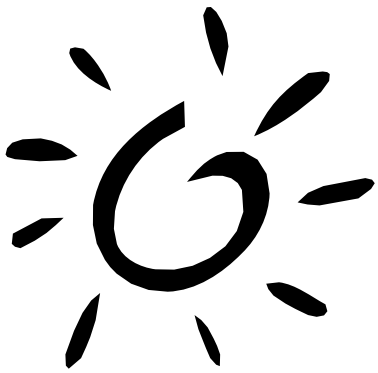

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