# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>2</td>
</tr>
<tr>
<td>Members of the Sessional GPs in Commissioning Project Stakeholder Group</td>
<td>3</td>
</tr>
<tr>
<td>1.0 Executive Summary</td>
<td>4</td>
</tr>
<tr>
<td>2.0 Recommendations</td>
<td>8</td>
</tr>
<tr>
<td>3.0 Introduction</td>
<td>9</td>
</tr>
<tr>
<td>3.1 Sessional GPs</td>
<td>9</td>
</tr>
<tr>
<td>3.2 Workforce</td>
<td>10</td>
</tr>
<tr>
<td>3.3 Commissioning</td>
<td>12</td>
</tr>
<tr>
<td>4.0 Methodology</td>
<td>13</td>
</tr>
<tr>
<td>4.1 Aims of the Project</td>
<td>13</td>
</tr>
<tr>
<td>4.2 Objectives</td>
<td>13</td>
</tr>
<tr>
<td>4.3 Method</td>
<td>13</td>
</tr>
<tr>
<td>5.0 Results</td>
<td>14</td>
</tr>
<tr>
<td>5.1 Characteristics of respondents</td>
<td>14</td>
</tr>
<tr>
<td>5.2 Current contribution to commissioning</td>
<td>16</td>
</tr>
<tr>
<td>5.3 Potential contribution to commissioning</td>
<td>18</td>
</tr>
<tr>
<td>5.4 Communication with sessional GPs</td>
<td>20</td>
</tr>
<tr>
<td>5.5 Enablers and barriers to engagement</td>
<td>21</td>
</tr>
<tr>
<td>5.6 Culture of primary care</td>
<td>22</td>
</tr>
<tr>
<td>6.0 Discussion</td>
<td>23</td>
</tr>
<tr>
<td>7.0 Conclusion</td>
<td>25</td>
</tr>
<tr>
<td>Appendix A: CCG and sessional GP survey questionnaires</td>
<td>26</td>
</tr>
<tr>
<td>Appendix B: Questionnaire Likert scale question responses</td>
<td>34</td>
</tr>
<tr>
<td>Appendix C: Examples of good practice</td>
<td>39</td>
</tr>
<tr>
<td>References</td>
<td>41</td>
</tr>
</tbody>
</table>
Health services need to adapt to reflect the changing demographics of the population and the needs of their patients. They also need to adapt to the changes reflected in their workforce. The rise of the sessional GP as a substantial and important constituent of the primary care workforce has been ongoing for more than a decade. The increasing number of GPs working outside the traditional partnership model brings a new set of challenges to maximise their potential contribution to all aspects of general practice.

GPs undertake a variety of activities during their career in addition to clinical practice. These include teaching, research, practice management, and leadership roles in service developments and commissioning. We should be making sure that all GPs are supported and empowered to take on such responsibilities, if they wish to, as well as being able to successfully fulfil their clinical commitments and responsibilities at home.

When this project started, we expected that sessional GPs would have little input to commissioning work, and that most Clinical Commissioning Groups (CCGs) would not be making time to involve them. However, we found that this was far from the case: many CCGs are trying to include sessional GPs within their work plans, and there are many sessional GPs who are active within commissioning. Nevertheless, there is still much more than can be done to maximise sessional GP input to commissioning work and workforce, and to reduce levels of variation in their inclusion.

One of the biggest structural challenges facing commissioning, as with primary care as a whole, is effective communication. As people begin to network to understand and share good commissioning practice in England there are a lot of opportunities to bring everybody in a geographical area onto one common mailing list, sharing educational activities and promoting opportunities with commissioning. Lack of reliable communication channels was an issue of great concern for both the sessional GPs and the CCGs. The commissioning groups were often trying to communicate with the sessional GPs, but the sessional GPs were not always getting those communications. The study itself was made difficult by the lack of co-ordinated communications, and this needs urgent resolution.

Looking to the future, it is vitally important that general practice is an attractive career choice for prospective doctors. This can be achieved in part by demonstrating the variety and breadth of work that a doctor is able to do throughout their career as a general practitioner. However, this could be undermined if a substantial part of the workforce is marginalised from key developments and career opportunities, and there is a need to address this together. We need every good GP contributing all their talents; the job of a GP is more complicated than it was, and we need to make sure that all GPs, whether they are partners or sessional GPs, are really able to contribute and to develop their careers.

I would like to thank the members of our Stakeholder Group for their contributions and advice on this project and to all of those CCGs and sessional GPs who participated in this work.

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The project report has an accompanying video, which provides an overview of the project and its importance (www.rcgp.org.uk/SGPC).
1. Executive Summary

1.1 Introduction

This report has been written for CCGs, GPs and NHS organisations to help primary care meet its future challenges by harnessing the potential that exists within the GP workforce.

Clinical leadership and engagement is central to the success of Clinical Commissioning Groups (CCGs) and the profession as a whole.

The nature of work a GP encounters in primary care is currently shifting. Along with continuing to improve the quality of patient care, GPs need to manage changing patient expectations, adapt to demographic pressures associated with an ageing population, and consider public and community health.

Commissioning in a resource-constrained health service also requires strong GP leadership and engagement to ensure system wide, high quality patient care, and this expectation is built into requirements for CCG authorisation. At an individual level, all GPs will be required to consider their referral and management behaviour, and will need to adhere to commissioning decisions if CCGs are to maintain patient care and keep within budget.

Therefore, responsibility for leadership in practice cannot rest with the GP Chair and CCG governing body alone. “Distributed leadership” amongst clinicians involves devolving power and decision making to others in constituent practices who then share the vision and take responsibility for delivery. This will only occur if those with the necessary skills are fully utilised.

Sessional (salaried and locum) GPs now make up between 25% and 50% of all GPs; a significant and rapidly growing proportion of the GP workforce. There is therefore potential for the sessional GPs to play a significant role in both making and complying with CCG commissioning decisions at all these different levels.

GPs are currently experiencing considerable pressure from workload and other demands as both commissioners and providers. As sessional GPs now make up such a large proportion of the GP workforce, excluding them from commissioning means this pressure is felt increasingly by partners who also have practice management responsibilities. The RCGP has been campaigning for more GP training places to help manage demands on GP capacity, and many of these new and additional GPs are likely to work as sessional GPs.

Despite their growing number, recent research on sessional GPs as providers has highlighted their isolation. A report on the issue by the National Association of Primary Care (NAPC) led to the Royal College of General Practitioners being asked by the Commissioning Development Transition Team of the NHS Commissioning Board Authority to undertake this research project.

We summarise here the findings of the research and suggests a number of approaches to increase the engagement of sessional GPs in commissioning.

1.2 Aims and methods

The aims of the project were:

- To identify the degree of sessional GP engagement in commissioning, provide examples of good practice, and develop guidance to enable CCGs to better engage with the sessional GP workforce
- Promote the value of supporting sessional GPs in their development at all stages of their careers in providing and commissioning.

Between January and March 2012 two surveys were created on SurveyMonkey and sent to both CCGs and sessional GPs in England. The response rate was approximately 50% and 7% – the latter being related to difficulties of identifying and communicating with sessional GPs, a significant finding in itself. Survey results were then explored at a workshop with GPs active in commissioning. Key findings are presented here.
1.3 Results summary

- Currently 65% of CCGs allow sessional GPs to vote and but only one third (33%) feel their governing body is representative of the whole GP work force. Two thirds of CCGs report they provide opportunities for sessional GPs to engage in all aspects of their work.

- The majority (92%) of sessional GPs understand what is meant by commissioning, 43% feel able to contribute and 44% would like to get more involved. 9% of sessional GPs reported that they currently have a role in a CCG. More (27%) were interested, but were not invited to participate or able to apply for roles.

- Over half the responding sessional GPs said they would contribute with more support (60%). Approximately one third perceive that they lack the skills and confidence or do not yet feel ready for commissioning roles. A quarter were not currently interested in commissioning roles.

- Of the CCGs that responded, 48% regularly communicate with sessional GPs and 36% felt they keep their sessional GPs fully informed of commissioning decisions. Sessional reported lower levels of CCG communication and only 11% said they received regular direct communications.

- Eleven per cent of sessional GPs agree the CCG keeps GP partners and sessional GPs equally informed, and 7% agree the CCG holds them in the same regard.

- Factors identified by CCGs that could encourage greater engagement by sessional GPs included open and transparent selection processes; the presence of a sessional GP as CCG Chair; having an accurate contact list; specific inclusion of sessional GPs in the CCG strategy and vision; establishing self-directed learning groups (SDLGs); advertising via networks, LMC forums and websites; funded attendance at CCG meetings; involving sessional GPs in project work; and mentorship.

Key facts

Sessional GPs (mainly salaried and locum) make up 25-50% of the GP workforce. The number of salaried GPs has increased by 894% in the last decade (locum GPs are not recorded).

Recent research has highlighted sessional GPs’ isolation as providers. This study aimed to identify their engagement in commissioning through both CCG and sessional GP surveys.

Results indicate that a significant proportion of sessional GPs want, and are able to, contribute more to commissioning than currently.

Learning from good practice, ways to increase sessional GP engagement includes:

- Their ability to vote and be represented on the CCG governing body
- A register and improved direct communication
- Encouragement, education and project support
- Sessional GP groups, networks and chambers
- Allotted time and remuneration
- Formal talent management and succession planning
- Mindset change.

Sessional GP engagement and contribution will aid CCG success, while optimising the potential of the breadth of the GP workforce is important to the profession as a whole, with many GPs expected to retire in future.

There is still time prior to CCG authorisation to ensure these good practice examples are written into their vision and constitution and adopted more widely.
Factors sessional GPs identified that would facilitate their involvement are representation on the governing body, the creation of local sessional GP groups, being encouraged to participate by CCGs and partners, having time released to be able to attend meetings and undertake CCG work, and being remunerated for this; also training, mentoring and coaching.

Barriers to sessional GPs becoming engaged reported by CCGs were their lack of interest in commissioning, poor communication channels, non-availability for meetings, part-time roles, relative inexperience and impermanent positions. Sessional GPs report barriers as being unaware of opportunities, low levels of skill and confidence, not being invited to participate and financial constraints.

1.4 Discussion and conclusion

This study illustrates CCGs have an untapped resource in their sessional GPs. Benefits of greater involvement include utilising the skills of the whole GP community, greater leadership capacity as work load pressures increase and the creation of GP leaders for the future. Sessional GPs may have flexible capacity and fewer potential conflicts of interest. All GPs will need to change their referral and prescribing behaviour to keep within budget and reduce variation to improve quality of care. Finally increased access to senior roles will enhance motivation, job satisfaction and aid recruitment into the profession.

Many CCGs recognise and value the contribution of sessional GPs; however, this is not uniform. Key factors identified in the report that aid greater engagement and participation are considered in detail below:

1.4.1 Representation on CCG governing body. Good appointments to the CCG governing body support the commissioning of good clinical services and should be fair and robust. Adherence to commissioning decisions may be improved if sessional GPs are represented and included in decision making.

1.4.2 Communication. CCGs are likely to overestimate how well they are communicating with their sessional GPs. An up to date register of contact details and direct lines of communication will engage sessional GPs more effectively.

1.4.3 Education and support. Many CCGs report that they have approached sessional GPs but that they have not been able to engage with them. Findings suggest that this may often be due to lack of confidence, which can be increased by encouragement, education, project work and mentoring. Newly qualified GP support networks, such as the RCGP’s First5®, may have a role in encouraging GPs to take on roles in commissioning more quickly after training.

1.4.4 Sessional GP groups. Recent research recommended the creation of self directed learning groups, and a number of areas have established sessional GP networks, groups or locum chambers. These groups can reduce isolation, provide access to education, improve communication and if supplemented by administrative support or websites, can facilitate job placement and flexible back-fill.

1.4.5 Time and remuneration. Sessional GPs need adequate time released from clinical commitments and remuneration to contribute to commissioning, as do all GPs. Many sessional GPs work part-time so may be able to contribute without impacting on patient appointment availability.

1.4.6 Talent management and succession planning. Given the growing pressures on GPs and with a potential short fall in future numbers with many GPs nearing retirement, GP leadership capacity and capability is unlikely to be sufficient to meet current and future challenges unless the skills of the whole GP community are identified and used. This requires proactive ‘talent management’ and succession planning. Increased access to senior roles will increase sessional GP motivation, job satisfaction and aid recruitment into primary care.
1.4.6 **Mindset change.** Good practice examples can be shared but cultures and mindsets are hard to change. A perception of “lower status” in other studies is repeated here, with only 7% of sessional GP respondents feeling they are held in the same regard as GP partners. A very large proportion of sessional GPs are female, and barriers to career progression have been associated with gender, part-time work and individual aspiration and organisational bias as well as contractual status.

1.5 **Conclusion**

This study, similar to others, illustrates the untapped and often overlooked resource in the large and growing numbers of sessional GPs. The benefits for CCGs of tapping into a large, willing and able sessional GP workforce are an ability to share workload, better adherence to commissioning decisions and the creation of new leaders as many GPs retire in future.

Changing mindsets together with greater representation on CCG governing bodies, improved communication, education, sessional GP groups, allotted time and remuneration, formal talent management and succession planning have been identified by this study as key elements to increasing sessional GP engagement and participation in commissioning, for the majority who want to contribute.

As CCG configuration will not be finalised until after authorisation, there is still time to ensure these good practice examples are written into their vision and constitution and adopted more widely.

The success of CCGs will be dependent upon the ability to embrace, utilise and develop potential across the full breadth of the GP workforce. Without engaging sessional GPs, CCGs – and the profession itself – may struggle to meet the significant challenges ahead.
2. Recommendations

1. The results of this study should be disseminated widely to optimise the potential in the GP workforce and raise awareness of the need for, and benefits of, greater engagement of sessional GPs in commissioning prior to authorisation.

2. All CCGs should be aware of the number of sessional GPs in their area, establish and maintain an up to date register and work with them to ensure they share information directly with them by means suitable to the sessional GP community. Individual sessional GPs should ensure their personal record is kept up to date. This is vital to successful workforce planning.

3. CCGs and other stakeholders should run educational events for sessional GPs on ways to increase engagement and commissioning skills. They should also start to plan the educational and revalidation support for their sessional GPs, if they have not already begun doing so.

4. Resources should be identified to support the creation of local sessional GP support networks – this could be via mentors or support groups. The aim would be to increase engagement, quality of care, motivation and recruitment. Co-ordination of sessional GP working could also increase GP capacity and the availability of back-fill.

5. CCGs should ensure that selection to the governing board is fair and representative and that sessional GPs are valued as key members of the GP and the wider primary care community. CCGs should consider the need to increasingly involve sessional GPs as they develop towards and beyond authorisation.

6. Sessional GPs should put their names forward to their CCG if they want to participate in commissioning and ensure that they are included in information cascades in their practice.

7. CCGs should identify and capitalise on the potential of all GPs and other professionals, including nurses and practice managers, to assist the CCG in delivering its functions and distributed leadership.

8. CCGs should make leadership and career development opportunities available to all GPs. Project work and mentoring should be made available to sessional GPs, to provide the necessary professional development and entry into commissioning work.

9. More work needs to done to establish ways to identify and develop talent and ensure succession planning in general practice.

10. Sessional GPs should be reimbursed for their time spent on commissioning activities.
Following a paper by NAPC to the Department of Health in September 2011, the Royal College of General Practitioners was invited to lead a short project to analyse the inclusion of sessional GPs (GPs who are not partners in a practice), in the developing commissioning arrangements in England. Funded by the Department of Health Commissioning Development Transition Team, the project group sought to survey both the emerging Clinical Commissioning Groups (CCGs) and sessional GPs in England, in order to identify enablers and barriers to involvement in the light of the changing roles of GPs resulting from the Health and Social Care Act 2012.

The Act charges GPs with the responsibility of commissioning healthcare services through Clinical Commissioning Groups (CCGs), which will be moving towards authorisation from the NHS Commissioning Board in 2012/13. The advent of clinically-led commissioning will affect how all GPs in England operate, both in terms of service delivery and development. CCGs will have to have robust communication channels to their workforce, make use of the best available clinical talent, and operate through distributed workload and leadership for the best chance of success.

Sessional GPs make up an increasing proportion of the GP workforce and are in an important position to help CCGs succeed, both through clinical workforce support and as prospective GP leaders of the future. Equally CCGs are in an important position to address some of the issues faced by sessional GPs by harnessing their talent and promoting a more motivated workforce. Allowing access to roles within commissioning to any doctor who is suitable will also help keep general practice an attractive choice to medical students, by demonstrating their worth, value and the diversity of work that they can experience.

CCGs are membership organisations whose members are GP practices, and it is the GP practices that have the responsibility for the medical care for the patients on the practice list, not the individual GPs. As a consequence, formal sessional GP involvement in CCGs is unclear, and may vary depending on the constitutions of individual CCGs. Anecdotally, sessional GP involvement in the early phases of CCGs was very variable, ranging from full integration to total exclusion. Yet the demands on GPs to deliver effective commissioning and provision under the new reforms are huge, and there is a clear need to engage all clinical talent and leadership within the primary care workforce in commissioning arrangements.

It is therefore important that current best practice on inclusion and methods to overcome barriers are disseminated before precedents have been set by ‘facts-on-the-ground’, when the CCGs have achieved authorisation.

### 3.1 Sessional GPs

From the literature on sessional GPs it can be seen that many GPs choose not to become partners as a positive career move; this may be best for a portfolio career, a means to a preferred work-life balance, or a desire to do predominantly clinical work. However, feelings of isolation and disengagement from the primary care community are often cited by this group of GPs, with these feelings being especially acute amongst locum, ‘out of hours’ and GPs working in secure environments.

Some of the key themes identified in previous studies include:

- **Lack of structures to enable the identification of, and communication with, sessional GPs.**

  Contacting GP partners is straightforward; however there is no single list of all sessional GPs working in any given area. These parts of the workforce are therefore often not kept abreast of opportunities within the NHS, and this may now include opportunities within CCGs.

- **Evidence of a culture of viewing sessional GPs as ‘inferior’ to partners.**

  Previous work suggests that GP partners are seen as more senior, more experienced, and more knowledgeable than their sessional counterparts. This can result in sessional GPs feeling undervalued, undermined and de-motivated.
Discrimination against sessional GPs.

Both within practices and within CCGs there have been anecdotal reports of sessional GPs being excluded from having a say or taking on key roles despite having the skills to do so.

Lack of support and formal CPD structures for some sessional GPs.

There is great variation in the support and encouragement of sessional GPs depending on their working environment and the nature of their contract.

Gender inequality.

Despite a clear majority of females within the GP workforce as a whole and particularly in the sessional GP group, female GPs are less well represented on core structures such as LMCs than their male counterparts. This mirrors other sectors, where a changing demographic shows slower change in leadership roles than in the workforce as a whole.

It is important to see if these issues have been carried over into sessional GP engagement in commissioning, how these may have been overcome, and what more needs to be done to address these concerns.

It should be noted that for the purposes of this report, freelance locums and chamber-based locums are treated as the same as the other sessional statuses e.g. practice contract or returner schemes.

The exact number of sessional GPs is currently unknown, partly due to there not being a single index keeping track of them and partly down to locum GPs not being counted by any of the statistical or workforce bodies. The NHS Information Centre state that there are 8,585 sessional GPs in England, as of 30 September 2011, but others such as the National Association of Sessional GPs (NASGP) claim many more exist. It is estimated that sessional GPs make up between 25%–50% (even up to 60% in some cases) of the GP population, depending on area. From the British Medical Association (BMA) sessional GPs Demographic Briefing 2010, 50% of all sessional GPs choose to be sessional, with 70.2% of sessional GPs being female and 29.8% being male. Most female sessional GPs tend to be between 36–40 years of age whilst most male sessional GPs are 61 years of age.

Many newly qualified GPs start out as sessional GPs, and this group of GPs is starting to get more support in their transition into their work with career advice and support groups, such as the RCGP First5® and the Continuing Professional Development programme.

Sessional GPs now form a very important part of the GP workforce and based on recent trends this importance will increase.

3.2 Workforce

There is an ongoing shift in the workforce, with fewer GPs working as partners and more as sessional GPs. It is therefore becoming increasingly important that the profile of these sessional doctors is raised and ensure that they are encouraged and supported in participating fully in commissioning as well as clinical provision.

Over the last 15 years, the demography of the General Practice workforce has undergone significant change. Two of the most striking features are the increasing number of women choosing to become GPs and the rise of the sessional GP.

First formally identified as a significant and increasing group of GPs by the Standing Committee on Post-graduate Medical and Dental Education (SCOPME) report in 1998, sessional GPs have become an increasingly important part of the GP workforce. Over the following decade the number of sessional GPs in England (see figure 1) increased an estimated 893.6% from 864 in 2001 to 8,585 in 2011 (an annual increase of 22.5% and 27.8% for male and female GPs respectively). If this trend continues, sessional GPs are likely to become the majority of all GPs in the next decade.

Over this same period, the number of women entering the profession has also drastically increased (see figure 2) with an average annual increase of 5.2% compared to 0.1% annual increase for men over the same period.
Women are projected to become the majority of all doctors sometime between 2017 and 2022\textsuperscript{19}, with the majority of GPs being female likely to be sooner due to the higher rate of women choosing to become GP registrars\textsuperscript{20}. However, despite the increased number of women GPs, the number of women GPs in senior positions has not risen proportionally\textsuperscript{6}.

The rise in the number of sessional GPs can be partially explained by the changes made to the GP contract\textsuperscript{21}, making it easier to become a sessional GP and for practices to employ them, and also due to the increase in the number of women in the GP workforce, the majority of whom are sessional. For these reasons along with the changing nature of the work a GP might be expected to undertake\textsuperscript{22}, has contributed to a change in the attitude to sessional work held by many general practitioners. Where once being employed as a sessional GP was primarily as a prelude to becoming a partner in a practice, it is now (and increasingly so) also a positive career choice for the professional and personal reasons of the GP.

In order to meet the ongoing needs of quality patient care\textsuperscript{23}, manage the changing expectations of the patient\textsuperscript{24} and to face the future challenges in primary care\textsuperscript{25,26} will require the full utilisation of the entire GP workforce and making the right use of the best people for the work to be done. This can only be done through efficient workforce planning\textsuperscript{27,28,29} and by current leaders fostering and encouraging leaders at all levels and in all parts of the GP workforce\textsuperscript{30}, identifying and supporting those with talent, regardless of contractual status, into positions of responsibility to ensure a smooth succession GP leaders.

With the Tooke report on modernising medical careers\textsuperscript{31} and with proposals for extended GP training\textsuperscript{32}, it is important that general practice remains an attractive option to medical students and this relies on making sure that there are career opportunities available to all GPs.
3.3 Commissioning

The RCGP Centre for Commissioning defines clinically-led commissioning as ‘Clinically-led commissioning is a continual process of analysing the needs of a community, designing pathways of care, then specifying and procuring services that will deliver and improve agreed health and social outcomes, within the resources available. Good commissioning places patients at the heart of the process. It is about improving people’s lives and providing high quality services, which are designed around the individual.

Clinical commissioning groups, local authorities and others need to work together to plan and deliver better integration of local services to ensure that communities enjoy the highest quality responsive, affordable and personalised services that are also shaped directly by the people who use them.

The advent of commissioning will affect how primary care works in England for all GPs, regardless of their desire to engage directly with the CCGs or not. There are many reasons why some GPs do not want to get directly involved in the work of commissioning including the effective division of labour.

There are many resources available for individuals and CCGs, such as those provided by the BMA and RCGP Centre for Commissioning, to get more acquainted with what is involved in the commissioning process.

As CCGs approach Authorisation and beyond, they are likely to face many challenges along the way. To be best placed to confront these challenges and succeed in delivering the necessary care to patients within their remit, CCGs will require the use of the best clinical leadership available and robust succession planning for CCG members, in which sessional GPs can make a significant and important contribution to, and can only be done by engaging the entire primary care workforce in the work of the CCG and considering all willing primary care professionals for the roles within the CCG. This is especially true if the CCG wants to not only deliver, but improve the patient experience, through more efficient integrated care.

All GPs have responsibility for delivering safe effective care to their patients; CCGs are best placed to help deliver this by ensuring that they have an engaged and enthusiastic workforce by involving all those that wish to be involved with the CCG.

*For the purpose of this report, commissioning will implicitly refer to clinically-led commissioning, unless explicitly stated otherwise.
4. Methodology

4.1 Aims of the Project

The aims of the project were to:

- Gather intelligence from the sessional GP workforce and from Clinical Commissioning Groups to identify enablers and barriers to sessional GP engagement.
- Identify sessional GPs currently involved in CCGs and learn from any successes and good practice.
- Develop guidance to enable CCGs and sessional GPs to better engage with each other.

4.2 Objectives

- To promote the inclusion of sessional GPs in commissioning roles
- To promote the development sessional GPs at all stages of their careers in providing and commissioning
- To identify and highlight the educational needs of sessional GPs in areas such as management and leadership, to enable their engagement in commissioning
- To provide examples of good practice and best practice models of inclusion, engagement and leadership, along with the conditions necessary for their success
- To feedback the outputs of the project through local NHS bodies such as Deaneries and CCGs.

4.3 Method

The project has gathered intelligence through the use of two targeted surveys; one for CCGs and one for sessional GPs. The data collected from the two surveys was then analysed using both quantitative and qualitative methods, and the results used as part of a facilitated workshop, consisting of both RCGP commissioning leads and sessional GPs, to further explore the conclusions and themes arising from the survey data. The conclusions and recommendations of this survey are the result of this combined process.

The two surveys, created through Survey Monkey\(^1\), were developed to include including numeric, open and closed, scaling, multiple-choice and free text questions. Both surveys were piloted within the Project Stakeholder Group for comment and then distributed widely to respondents. Copies of the survey can be found in Appendix A.

The CCG and sessional GP surveys were distributed via several routes in order to reach as wide an audience as possible. The number who received the survey is unknown. Routes included: A front page article in RCGP news; RCGP news release and webpage; Twitter; RCGP Chair’s Blog; RCGP Practice Managers Network; RCGP First5 network; informal cascades; through SHA Medical Directors following a letter to Professor Sir Bruce Keogh, KBE; NASGP blog; NHS Commissioning network (www.networks.nhs.uk); RCGP Clinical Commissioning Champions; Flyers at London Deanery Sessional GP Revalidation event; Committee of General Practitioner Education Directors; Family Doctor Association, NHS Alliance and National Association of Primary Care Newsletters; project Advisory Group networks.

The CCG survey sought to find:
- Issues faced by CCGs in contacting sessional GPs
- Issues engaging sessional GPs in CCG work
- What CCGs are doing to proactively engage sessional GPs
- What works/does not work
- What structural help do CCGs need to engage sessional GPs

The sessional GP survey sought to find:
- Issues faced by sessional GPs in receiving information
- Issues sessionals GPs face in trying to engage with CCGs
- What sessionals GPs are doing to engage with CCGs
- Examples of what works/does not work
- What personal help do sessional GPs need to engage with Commissioning

The results were presented to an RCGP Centre for Commissioning workshop which included RCGP Clinical Commissioning Champions, members of the Project Stakeholder Group and Sessional GPs.
5. Results

Following distribution, 140 responses were received from the CCG survey and 628 from the sessional GP survey (approximately 50% and 7% response rate respectively).

Both quantitative and qualitative data are given below with quotes where they reflect a general trend. The term “agree” in the following descriptive text includes data from both “agree” and “strongly agree” responses. Additional graphs that further illustrate key points can be found in Appendix B.

5.1 Characteristics of respondents

Figure 3 illustrates the distribution of responding CCGs by SHA cluster, based on the configurations on the 14 February 2012 and compared against data from the survey where a region was specified. Sessional GPs were employed in all the SHA clusters and the majority were employed in NHS Midlands and East (Figure 4). Over two thirds of the sessional GPs who responded were female and mostly locum or salaried (Figure 5). More female than male respondents were recently qualified GPs (Table 1). The majority (60%) worked more than half time or 5–9 sessions in practice.
Figure 5: Primary role of the sessional GP questionnaire respondents

Table 1: Breakdown of sessional GP questionnaire responders by number of year's post-CCT and sex

<table>
<thead>
<tr>
<th>Number of years post-CCT</th>
<th>Female</th>
<th>%</th>
<th>Male</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–4</td>
<td>113</td>
<td>19.65</td>
<td>74</td>
<td>12.87</td>
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<td>25–29</td>
<td>29</td>
<td>5.04</td>
<td>11</td>
<td>1.91</td>
</tr>
<tr>
<td>30+</td>
<td>22</td>
<td>3.83</td>
<td>43</td>
<td>7.48</td>
</tr>
</tbody>
</table>
5.2 Current contribution to commissioning

Many CCGs did not know, or could not easily provide, the number GPs and sessional GPs (head count) in their area (Figure 6).

A third of CCGs agreed that their governing body was representative of whole GP workforce (Figure 7). Election was the most popular method for selection of members and 40% of those CCGs who used election had sessional GP representation. The majority (60%) of CCGs used a competency framework. Two thirds of CCGs agreed sessional GPs were invited to vote, apply for roles and engage in all aspects of commissioning (Figure 8).

Nine per cent of sessional GPs currently have a role in their local CCG (Figure 9) and 19% were informed of roles and vacancies. Sessional GPs were involved in commissioning in a number of ways such as member on the governing body or as SHA lead; as practice and clinical lead; implementing decisions; attending meetings; and reading communications.
Figure 7: Workforce representation on CCG governing body

Our emerging governing body is representative of our whole GP workforce

Figure 8: Ability of sessional GPs to participate in the work of the CCG

Our sessional GP workforce can engage in all aspects of the work of the CCG e.g. developing or implementing new pathways and services

Figure 9: Sessional GPs currently involved in Commissioning

I already have a role in clinical commissioning with my local CCG
5.3 Potential contribution to commissioning

A large majority of sessional GPs (82%) understand what is meant by clinical commissioning (Figure 10). Forty three percent perceive they have the necessary skills, with more male and older GPs responding positively to this statement. Forty four per cent, and especially male and older GPs, would like to be more involved.

The majority (61%) of sessional GPs would engage if given support and training (Figure 11). Nearly half would attend commissioning courses if they were available. GPs 0–4 years post-CCT were the most positive about engaging (73%) and attending courses (62%). Just under a third do not feel ready yet to develop commissioning skills but would like to in future.

Of those sessional GPs who were not involved, the reasons cited included: unaware of opportunities (41%); don’t feel confident to take on the role (32%); feel lack the necessary skills (32%); interested but not invited to participate (27%); no interest (25%); can’t afford to take on the responsibility (16%); interested but not allowed to apply for roles (7%); and other – time; soon to retire; disagree in principle; appears to be huge commitment, poorly supported or recompensed; no payment offered; “it’s a closed shop for partners”.

![Figure 10: Sessional GP understanding of Commissioning](image1)

I understand what is meant by clinical commissioning

![Figure 11: Educational intervention for sessional GPs to engage further with Commissioning](image2)

Given support and training, I would engage further with clinical commissioning in my local CCG
Views of CCGs and sessional GPs about commissioning

“I think sessional GPs often have a broader understanding of the needs of an area and see good and less good practice across many practices.”

“We are often sessional because we have other skills which can be helpful to commissioners – also we are not bogged down by day to day practice responsibilities and can be flexible – many GP principals are too time pressed with on-going responsibilities to their practice and limited flexibility.”

“Sessional GPs provide 35–40% of all clinical GP work and this percentage is rising. This workforce is not reflected sufficiently in local or national CCG activity.”

“It is discriminatory not to have sessional GPs at board level.”

“Freelance GPs are in the rare position of being able to see what’s good for the patient at the NHS without thinking about an individual practice’s bottom line – i.e. seeing the bigger picture and less conflict of interest.”

“From my canvassing there is generally little interest or engagement with issues of clinical commissioning. This is largely through lack of awareness of the opportunities available to sessional GPs to get involved in this process as providers or commissioners.”

“Most of us are not partners because we are not interested in money, business, paperwork, meetings, just want to do what we trained for... diagnosing and treating!”

“I really just want GPs to be allowed to treat patients not take on commissioning, which I believe is a complex task for which I am not trained.”

“Most GPs who work as sessional GPs do so because they have family commitments or other interests that make them choose a lower level of work pressure than a partner’s workload. I am dubious if many sessional GPs would want to take on the extra workload of CCG work.”
5.4 Communication with sessional GPs

Just under a third of CCGs agree they know and communicate with all their local sessional GPs. Nearly half communicate regularly, and feel they keep their sessional GPs fully informed (Figure 12). The following communication channels were used in order of reducing frequency: email (76%); via practice managers (51%); local meetings (48%); clinical education meetings (38%); LMCs, social media and newsletters; and directly (11%).

Twenty seven per cent of sessional GPs receive regular communication from their CCG and feel well informed. Over a third feel they are kept informed of commissioning decisions e.g. new pathways (Figure 13). More salaried GPs than locum and out of hour GPs (OOH) are kept informed.

The most common form of communication was email. A third were informed by their practice managers while others methods of communication were attendance at local and surgery meetings (24%), directly from CCGs (11%), via website and letters (9%) and via LMC and word of mouth.

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Figure 12: Communication with sessional GPs

We regularly communicate updates to our sessional GPs on new pathways/services/guidelines

Figure 13: Communication received by sessional GPs

I receive regular communications from my CCG and I am well informed
5.5 Enablers and barriers to engagement

Factors identified by CCGs that encourage greater engagement include having an accurate register, including sessional GPs in the CCG strategy and vision, locums attending weekly CCG meetings, involving sessional GPs in project work, establishing self directed learning groups (SDLGs), networks and/or LMC forums, annual practice visits and reviews, mentorship, websites, funding for meetings, the presence of a sessional CCG Chair and open and transparent selection processes.

Examples of good practice are given below. A full summary of responses can be found in Appendix C.

- One CCG welcomes all GPs including sessional GPs as well as nurse practitioners.
- Sessional GPs were appointed as vice chair and clinical leads on CCG governing bodies.
- Self directed learning groups (SDLG), sessional GP groups and networks are common.
- Deanery led learning sets.
- Locum GP chambers.
- The LMC takes an active role.
- Sessional GPs, including locums, affiliate with a single practice to enable communication and voting.

Barriers to sessional GPs engagement reported by CCGs include little interested in commissioning, poor communication channels, unavailability, part-time roles, relative inexperience and impermanent positions.

Sessional GPs reported the following support would encourage greater engagement: being paid (75%); having time available (52%); encouragement from CCG (50%); courses (50%); mentoring and coaching (42%); sessional GP on governing body (42%); sessional GP group (38%); encouragement from partners (36%); and different appointment processes (12%).

Views from CCGs and sessional GPs on barriers preventing sessional GP involvement

“There is no protected time for sessional GPs to get involved.”

“Being released by partners is the single biggest barrier.”

“Many sessional GPs feel de-skilled or under skilled in the area of commissioning know how and experience and this limits their desire to get involved.”

“There is definitely a feeling locally among some influential doctors that CCG should not involve locums/sessional doctors as they are not responsible – practices are.”

“The fact commissioning pay is not super-annnuable will make it hard for people to include it in a portfolio career.”
### 5.6 Culture of primary care

Other reports have identified perceptions of lower status of sessional GPs. Seven per cent of sessional GPs agreed their CCG holds sessional GPs in same regard as partners (Figure 14) and 11% agreed they were kept equally informed.

#### Views regarding sessional GPs

“Most partners are not interested in what sessional GPs have to offer and still regard themselves as clinically and generally superior.”

“I think there is much talent and skills among sessional GPs, yet there continues to be a culture amongst Principal GPs that sessional GPs are an inferior breed of GP.”

“We are considered a second rate group of GPs without any clear voice.”

“No-one seems to want to tap into our knowledge.”

“Sessional GPs are pretty much excluded from participation in commissioning. Our voice is not being heard – or regarded as important.”
This project aimed to identify current engagement of sessional GPs in commissioning, learn from good practice and use this information to develop guidance to enable CCGs to optimise potential in their GP workforce. It has some limits as a study:

1. **Reaching the target audience.** There is no single list of all sessional GPs and locums in particular can be hard to identify and communicate with. In order to attempt to overcome this, a number of different sources of information were used such as Performers’ Lists and membership lists of organisations such as RCGP and NASGP. There was also a marketing and communications strategy to address this issue.

2. **Bias of survey respondents.** As with all research and studies, those that choose to complete surveys are not necessarily representative of the entire population. Motivating factors such as enthusiasm or discontent must be considered in drawing conclusions from the survey responses.

3. **Survey/information request fatigue.** GPs are asked to fill in many different surveys, which is likely to result in fewer respondents. As CCGs head towards authorisation, they are under a lot of pressure to deal with requests for information from a variety of sources, which may have resulted in a low prioritisation of this survey.

4. **CCG Configuration.** At the time of the survey, final CCG configuration was still undecided. This may have impacted on responses concerning the membership of CCG governing bodies and numbers of constituent GPs.

5. **Response Rates.** Given the relatively low response rates, respondents may not be representative of the entire CCG and sessional GP population.

However, although the sample of sessional GP respondents is small, their composition matches other demographic studies which imply that the sample is likely to be representative, and the views given echo those of other studies.

This project confirms that CCGs have an untapped resource in their sessional GPs. Sessional GPs report they understand commissioning, and a significant proportion have the necessary skills and want to be more involved.

Benefits of greater involvement include utilising the skills of the whole GP community, greater leadership capacity as work load pressures increase and the creation of GP leaders for the future. Sessional GPs have flexible capacity without impacting on patient appointments and fewer potential conflicts of interest. All GPs will need to change their referral and prescribing behaviour to keep within budget and reduce variation to improve quality of care. Finally increased access to senior roles will increase motivation, job satisfaction and aid recruitment into the profession.

However, commissioning is not for everyone and 25% of sessional GPs have no interest. This is higher than a recent survey which found that 8.8% of all GPs had no interest in commissioning. Equally this report identified significant barriers to engagement.

Factors that encourage greater engagement include representation on the governing body, a register and good communication channels, encouragement from CCGs and practices, education and mentoring, sessional GP groups, chambers and networks, allotted time and remuneration. These are described in more detail below:

6.1 **Sessional GP representation.** Currently 65% of CCGs allow sessional GPs to vote and a third have governing bodies whose composition is representative of the GP workforce. Good appointments to the CCG governing body support the commissioning of good clinical services, and appointment processes should be fair, transparent and robust. In some areas, sessional GPs are Chairs, Vice Chairs and Clinical Leads on the governing body and they are welcomed to vote, apply for roles and attend meetings equally with partners. This inclusive approach needs to be more universal and also applied to other professionals including nurses and practice managers.
6.2 **Communication.** Just over a third of CCGs keep their sessional GPs fully informed of commissioning decisions, and nearly half regularly communicate with sessional GPs. However, sessional reported lower levels of CCG communication. This discrepancy can be partly reconciled through the currently unknown number of sessional GPs in any one particular geographical area. A recent letter from Dame Barbara Hakin recommends that PCTs communicate directly with sessional GPs and that their details are taken from the performers list. This register could now be aligned with records kept by the Responsible Officer.

6.3 **Education and support.** A quarter of sessional GP respondents said that they do not yet feel ready for commissioning roles or they lack the skills and confidence. Being supported to attend meetings and courses, access to mentoring or coaching and encouragement from CCGs and practices to undertake project work would help. Newly qualified GP groups, such as the RCGP’s First5 may help GPs take on bigger role in commissioning more quickly after training. Newly qualified GP groups, such as the RCGP’s First5 may help GPs take on bigger role in commissioning more quickly after training. This up-skilling of new and sessional GPs could form an important part of the CCGs educational framework and revalidation support for all the GPs, alongside the development of clinical pathways.

6.4 **Sessional GP groups.** Recent research recommended the creation of self directed learning groups to reduce isolation, and a number of areas have established sessional GP networks, groups or locum chambers. Created by sessional GPs themselves, CCGs or Deaneries these groups may reduce isolation, provide access to education, improve communication and if supplemented by administrative support or websites, can provide facilitate job placement and flexible back-fill.

6.5 **Time and remuneration.** Being paid and having time available for commissioning were the two factors sessional GPs identified would help most in facilitating their involvement. Many sessional GPs work part-time so are able to contribute without impacting on patient appointments.

6.6 **Formal talent management.** Sufficient GP leadership capacity and capability, as both providers and commissioners, are needed to meet future challenges in primary care. However, general practice is facing a potential short fall in future capacity, unless more doctors can be attracted into the profession. Formal talent management and succession planning will ensure the skills of the whole GP community are identified and used to ease this pressure. Increased access to senior roles will increase sessional GP motivation, job satisfaction and aid recruitment and is needed to ensure the creation of sufficient GP leaders in the future.

6.7 **Mindset change.** Sessional GPs represent an important and growing part of this workforce. However, just 7% of our sessional GP respondents feel they are held in the same regard as GP partners: the perception of “lower status” found in other studies is repeated here. A very large proportion of sessional GPs are female, and barriers to career progression have been associated with gender, part-time work, individual aspiration and organisational bias as well as contractual status. It is important to remember sessional GPs have the same training and qualifications as GP partners.
This study, similar to others, illustrates the untapped and often overlooked resource in the large and growing numbers of sessional GPs. The benefits for CCGs of tapping into a large, willing and able sessional GP workforce are an ability to share workload, better adherence to commissioning decisions and the creation of new leaders for the future.

Changing mindsets together with greater representation on CCG governing bodies, communication, education, sessional GP groups, improved allotted time and remuneration and formal talent management and succession planning have been identified by this study as key elements to increasing sessional GP engagement and participation in commissioning, for the majority who want to contribute.

As the final CCG configuration will not be finalised until after authorisation, there is still time to ensure these good practice examples are written into the vision and constitution of the CCGs and become adopted more widely.

The success of the CCGs will be dependent upon the ability to embrace, utilise and develop potential across the full breadth of the GP workforce. Without engaging sessional GPs, CCGs – and the profession itself – may struggle to meet the significant challenges ahead.
Appendix A: CCG and sessional GP survey questionnaires

Engagement of your emerging CCG Board with the GP workforce

As CCGs form and develop, the structure and composition of the emerging governing bodies (boards) will vary according to local need. We would like to understand the structure of your emerging governing body and the extent to which sessional GPs contribute to commissioning in your area.

A sessional GP is one who is a fully qualified GP but not a partner in a practice. “Sessional GP” refers to those GPs who are locums, salaried or on a retainer contract. These include GPs who work part-time, have portfolio careers, work in prisons and for out of hours services.

In order to gain the support and engagement necessary for successful clinical commissioning, it is important to have effective routes of communication with the whole local GP workforce. This is important not only to encourage clinicians to contribute to work within CCGs as commissioners, but also to provide care to patients in line with your commissioning intentions. For example, supporting appropriate referral behaviour, adherence to pathways and guidelines, and prescribing within formularies.

Whilst communicating with GP partners is relatively straightforward via their practice, staying in touch with sessional GPs, especially locums, is much more challenging. There are examples nationally of successful innovative ways in which emerging CCGs have overcome this but most CCGs may struggle.

We are keen to understand your current methods of communication and any barriers you are experiencing.

Please indicate to what extent you agree with the following statements:

1. **Our emerging governing body is representative of our whole GP workforce**
   - □ Strongly Agree
   - □ Agree
   - □ Neutral
   - □ Disagree
   - □ Strongly Disagree

2. **Our sessional GP workforce can engage in all aspects of the work of the CCG e.g. developing or implementing new pathways and services**
   - □ Strongly Agree
   - □ Agree
   - □ Neutral
   - □ Disagree
   - □ Strongly Disagree

3. **We invite the sessional GPs in our workforce to apply for available roles and vacancies within the CCG**
   - □ Strongly Agree
   - □ Agree
   - □ Neutral
   - □ Disagree
   - □ Strongly Disagree

4. **Sessional GPs would be more likely to be granted core roles if they demonstrated clear commitment to practice(s) within the CCG**
   - □ Strongly Agree
   - □ Agree
   - □ Neutral
   - □ Disagree
   - □ Strongly Disagree

5. **We keep our sessional GPs fully informed of commissioning decisions taking place locally**
   - □ Strongly Agree
   - □ Agree
   - □ Neutral
   - □ Disagree
   - □ Strongly Disagree

6. **We regularly communicate updates to our sessional GPs on new pathways/services/guidelines**
   - □ Strongly Agree
   - □ Agree
   - □ Neutral
   - □ Disagree
   - □ Strongly Disagree

7. **We know and communicate directly with our sessional GPs Engagement of your emerging CCG Board with the GP workforce**
   - □ Strongly Agree
   - □ Agree
   - □ Neutral
   - □ Disagree
   - □ Strongly Disagree
8. In what format do you communicate with your sessional GPs? Please tick all that apply:
- [ ] emails
- [ ] websites
- [ ] letters
- [ ] local meetings
- [ ] surgery meetings
- [ ] Via practice managers
- [ ] Clinical educational meetings
- [ ] Local sessional GP group
- [ ] Other (please specify)

Structure of your emerging CCG board

9. Which County is your CCG situated in?

10. What is the current number or headcount of all GPs in your member practices?

11. What number of those GPs are Sessional (all nonpartners including salaried, retainers, locums, OOH, prison doctors)? Please write NK if not known.

12. Of the members that you have on your emerging governing body, could you please specify how many are:
   - [ ] GP (in total)
   - [ ] Sessional GPs
   - [ ] Female GPs
   - [ ] Non-GP members

13. What processes do you use to identify members of your emerging governing body? Please tick all that apply:
   - [ ] Elected
   - [ ] Selected by interview
   - [ ] Secondment
   - [ ] Co-option
   - [ ] Other (please specify)
14. If elected, who was allowed to vote?
   Please tick all that apply:
   ☐ GP partners
   ☐ Sessional GPs
   ☐ Other (please specify)

15. To become appointed to your CCG, do you use a specific competency framework in order to judge eligibility for the position?
   ☐ Yes ☐ No

   If yes, can the competencies be acquired by any GP at any stage of their career?

Moving forward

16. Please describe any other good practice in relation to sessional GPs as commissioners or providers in your area that can be shared?

17. What barriers are there in reaching sessional GPs and achieving the above?

18. What tools, support or guidance would be helpful to you to improve this?

19. As a CCG would you be prepared to share good practice at RCGP national events planned for sessional GPs in future? For example pathway redesign, how you are engaging GPs, new service models
   ☐ Yes ☐ No

   If yes, please specify in what capacity you would be willing to share

20. Any other comments?
21. If you would be happy to discuss these issues further or if you would like us to feedback the results of this survey, please complete the contact details below.

Name: 
Company: 
Address 1: 
Address 2: 
City/Town: 
County 
Postal Code: 
Country: 
Email Address: 
Phone Number: 

22. Personal information contained on this survey shall be used solely for the ‘Sessional GPs in Commissioning’ project, administration of the RCGP including the Faculties and regional offices, and its membership system. The RCGP may also use this information for the purposes of sending you information about products and services which the RCGP believe will be of interest to you and in promoting the College. If you do not wish to receive this information please tick the box. The RCGP confirms that the information on this form is held subject to regulation of the Data Protection Act 1998.

☐ I do not wish to receive additional information from the RCGP outside the remit of the project.
Engagement

A sessional GP is one who is a fully qualified GP but not a partner in a practice. “Sessional GP” refers to those GPs who are locums, salaried or on a retainer contract. These include GPs who work parttime, have portfolio careers, work in prisons and for out of hours services. The number of sessional GPs in the primary care workforce has increased dramatically since the late 1990s. Today, sessional GPs make up between 25%50% of the local GP workforce, depending on the area.

In order for clinical commissioning to succeed, emerging CCGs (hereafter referred to as CCGs) require the support and engagement of the entire GP workforce to commission and provide better services for patients. We are aware that there is great variation in the level of engagement of CCGs with sessional GPs. In some areas, sessional GPs are sitting on the emerging governing body and/or leading commissioning projects. In others, they are entirely excluded and are unable to vote in elections.

We would like to understand what is happening in your area and hear any examples which we can learn from.

1. We would like to know a little bit about you, in the text boxes please indicate what best describes you:
   - The number of years since completing your GP training
   - Gender
   - The number of sessions a week that you work
   - What is your role in the GP workforce? (i.e. locum, salaried, retainee etc.)
   - Do you have any other roles and a portfolio career?

2. What County are you registered in?

Please indicate to what extent you agree with the following statements:

3. I understand what is meant by clinical commissioning
   - [ ] Strongly Agree
   - [ ] Agree
   - [ ] Neutral
   - [ ] Disagree
   - [ ] Strongly Disagree

4. I feel I have the skills to work in clinical commissioning
   - [ ] Strongly Agree
   - [ ] Agree
   - [ ] Neutral
   - [ ] Disagree
   - [ ] Strongly Disagree

5. I already have a role in clinical commissioning with my local CCG
   - [ ] Strongly Agree
   - [ ] Agree
   - [ ] Neutral
   - [ ] Disagree
   - [ ] Strongly Disagree

6. Please describe in what ways you are involved

7. I would like to be more involved in commissioning
   - [ ] Strongly Agree
   - [ ] Agree
   - [ ] Neutral
   - [ ] Disagree
   - [ ] Strongly Disagree

8. I am not ready yet to develop my skills in clinical commissioning but would like to in future
   - [ ] Strongly Agree
   - [ ] Agree
   - [ ] Neutral
   - [ ] Disagree
   - [ ] Strongly Disagree
9. If you are not involved in clinical commissioning with your local CCG please describe what prevents you (please tick all that apply):
- No interest in commissioning
- I was interested but not invited to participate
- I was interested but not allowed to apply for roles
- I applied but did not get a role
- I don’t feel confident to take on the role
- I feel I lack the necessary skills
- I am not aware of opportunities
- I have been away from practice (e.g. maternity leave etc.)
- I cannot afford to take on the responsibility
- Other (please specify)

10. Given support and training, I would engage further with clinical commissioning in my local CCG
- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

11. If courses were available to me on clinical commissioning I would attend now
- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

12. If you are interested in developing skills in clinical commissioning what would help you? (please tick all that apply)
- Understanding clinical commissioning
- Courses on clinical commissioning
- Mentoring and coaching
- Encouragement from the partners
- Encouragement from the CCG
- Different appointments processes
- Having a sessional GP on the CCG governing body (Board)
- Having a sessional GP Group where we could discuss clinical Commissioning
- Having time made available from practice commitments
- Being paid for clinical commissioning
Communication from CCGs

It is vital that CCGs communicate effectively with the entire GP workforce in order to build engagement and support. This is important not only to encourage clinicians to join work within CCGs as commissioners, but also to provide care to patients in line with their commissioning intentions. For example, supporting appropriate referral behaviour, adherence to pathways and guidelines, and prescribing within formularies.

It is relatively simple for CCGs to communicate with GP partners via their practice but it can be rather more difficult to communicate with Sessional GPs, especially locums. Some CCGs have developed innovative ways of overcoming this but others continue to struggle.

In order to help CCGs improve their communication we are keen to hear about what is happening in your area and any suggestions you may have to improve things.

13. I am kept informed of commissioning decisions taking place locally e.g. new pathways, guidance, services:
   - [ ] Strongly Agree  [ ] Agree  [ ] Neutral  [ ] Disagree  [ ] Strongly Disagree

14. I receive regular communications from my CCG and I am well informed
   - [ ] Strongly Agree  [ ] Agree  [ ] Neutral  [ ] Disagree  [ ] Strongly Disagree

15. Please describe in what format you receive communications (Please tick all that apply):
   - [ ] email
   - [ ] website
   - [ ] letters
   - [ ] local meetings
   - [ ] surgery meetings
   - [ ] information directly from the CCG
   - [ ] information from the practice manager
   - [ ] Other (please specify)

16. I am kept informed of available roles and vacancies within the CCG
   - [ ] Strongly Agree  [ ] Agree  [ ] Neutral  [ ] Disagree  [ ] Strongly Disagree

17. My local CCGs hold sessional GPs in the same regard as GP partners
   - [ ] Strongly Agree  [ ] Agree  [ ] Neutral  [ ] Disagree  [ ] Strongly Disagree

18. Sessional GPs are kept as informed as GP partners in my local CCG
   - [ ] Strongly Agree  [ ] Agree  [ ] Neutral  [ ] Disagree  [ ] Strongly Disagree
Looking to the future

19. We are planning events to share the results of this questionnaire. What would be useful to you?
   - Hear the results of the questionnaire
   - Meet other sessional Gps to share experience
   - Hear about CCG good practice
   - Learn about different ways sessional Gps are being involved in providing
   - Learn about different ways sessional Gps are being involved in commissioning
   - Terms and conditions clinic
   - Learn from inspiring leaders and commissioners
   - Start to develop our own sessional GP group
   - Other (please specify)

20. Are you aware of any examples of good practice in your area for sessional GPs as providers or commissioners e.g. self directed learning groups?

21. Would you like to make any other comment regarding sessional GPs in commissioning?

22. If you would like to be further involved in this project or would like to be informed of the results of this survey, please fill in your contact details below.
   Name
   email address

23. Personal information contained on this survey shall be used solely for the ‘Sessional GPs in Commissioning’ project, administration of the RCGP including the Faculties and regional offices, and its membership system. The RCGP may also use this information for the purposes of sending you information about products and services which the RCGP believe will be of interest to you and in promoting the College. If you do not wish to receive this information please tick the box. The RCGP confirms that the information on this form is held subject to regulation of the Data Protection Act 1998.
   - I do not wish to receive additional information from the RCGP outside the remit of the project.
Appendix B: Questionnaire Likert-scale question responses

Additional graphs from the Likert questions in the two questionnaires are provided here to illustrate key points made in the text.

**CCG Questionnaire:**

Q1. Our emerging governing body is representative of our whole GP workforce

Q2. Our sessional GP workforce can engage in all aspects of the work of the CCG e.g. developing or implementing new Pathways and Services

Q3. We invite the sessional GPs in our workforce to apply for available roles and vacancies within the CCG

Q4. Sessional GPs would be more likely to be granted core roles if they demonstrated clear commitment to practice(s) within the CCG
Q5. We keep our sessional GPs fully informed of commissioning decisions taking place locally

Q6. We regularly communicate updates to our sessional GPs on new pathways/services/guidelines

Q7. We know and communicate directly with our sessional GPs
Sessional GP Questionnaire:

Q3. I understand what is meant by clinical commissioning

Q4. I feel I have the skills to work in clinical commissioning

Q5. I already have a role in clinical commissioning with my local CCG

Q7. I would like to be more involved in commissioning
Q8. I am not ready yet to develop my skills in clinical commissioning but would like to in future

Q10. Given support and training, I would engage further with clinical commissioning in my local CCG

Q11. If courses were available to me on clinical commissioning I would attend now

Q13. I am kept informed of commissioning decisions taking place locally e.g. new pathways, guidance, services
Q14. I receive regular communications from my CCG and I am well informed

Q16. I am kept informed of available roles and vacancies within the CCG

Q17. My local CCGs hold sessional GPs in the same regard as GP partners

Q18. Sessional GPs are kept as informed as GP partners in my local CCG
Appendix C: Examples of good practice

A summary of the good practice received from the two questionnaires is provided in this appendix. The good practice examples are set out under the heading listed in the conclusion of the executive summary.

1. **Representation on CCG governing body**

Many sessional GPs and CCGs gave examples of other sessional GPs being included on CCG governing bodies and in pathway development work. Some CCGs also provided examples of good practice for more representative governing bodies. These include:

- Allocated seats on local GP Forums and on the CCG governing body
- Commitment to having at least one sessional GP and one partner on the board
- Open to sessionals to vote and to be put forward for nomination
- Some CCGs ask sessional GPs to buddy up with one practice for voting and peer review

2. **Communication**

With no robust list of sessional GPs available, many CCGs and sessional GPs provided examples of how they have overcome this.

- Many CCGs work with LMC to contact as many sessional GPs as they can
- Use of social media to communicate with all primary care professionals
- Practices are asked to keep lists of sessionals who they work with and these lists are included in the communication cascades
- Regular e-mail communication of short, relevant information
- Putting together their own register of sessional GPs
- A Self-Directed Learning Group (SDLG) contacted the Chair of CCG directly and now all members of the SDLG are now included in the communication cascade

3. **Education and support**

There were many examples from the two surveys regarding the provision of educational support:

- Locality meetings – Many CCGs replied that they have set up semi-regular education and training events, master classes and conferences
- Some respondents declared that there was willingness to set up specific commissioning sub-groups, especially amongst the deaneries, if there was enough interest
- Several CCGs have set up mentoring schemes for sessional GPs and have included sessional GPs within the practices’ protected learning times

4. **Sessional GP groups**

Many sessional GPs are involved with peer support groups, and many CCGs also highlighted that they are actively trying to help with the setup of such groups. These groups were given as examples for not just CPD, appraisal and revalidation support, but as a ways of keeping in contact with the local GP community. The most popular peer support groups were as follows (in no particular order):

- Self-Directed Learning Groups (SDLGs)
- Local Medical Committee forums
- Deanery-led learning groups
- Virtual groups
- Sessional GP Groups
- National Association of Sessional GPs (NASGP) support groups
5. **Time and remuneration**

There were also some examples of what has been done to address time and remuneration issues faced by sessional GPs. These include:

- Development of a formal strategy to allocate resources and doctors time for commissioning work; portfolio GPs were specifically targeted in this strategy to allow them to commit regular time to commissioning work
- Funding to allow all GPs to attend meetings
- Job sharing for those on commissioning boards
- Sessional GPs being included on the CCG payroll

6. **Formal talent management and succession planning**

A few examples where given from sessional GPs and CCGs regarding talent management. These include:

- Sessional GPs have been nominated for GPwSI status as part of their portfolio development
- Inclusion of sessionals in the peer review process of the CCG work
- One sessional was nominated to join an leadership training scheme run by the SHA

7. **Mindset change**

Some inroads have been made to help embrace all GPs equally.

One CCG visits every member practice annually. As part of this visit they discuss the role of sessional GPs in their practices and how they keep them updated clinically and about commissioning. Other CCGs specifically target sessional GPs for vacant CCG positions and for participation in peer review, pathway development and ‘task and finish’ groups.
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