WHAT IS JEREMY HUNT’S GAME PLAN?

INSIDE
Nine pages of analysis on the new 2016/17 GP contract
Whatever you might think of Jeremy Hunt, he is a masterful politician. The Teflon minister has overcome stiff odds and in three months will become the longest-serving health secretary ever. But he has also become one of the least popular. Last month saw a nadir in his relations with the medical profession, with the imposition of a contract on junior doctors eroding any remaining goodwill among doctors;

This followed months of missed targets in A&E and a ‘new deal’ for GPs among doctors, turning his attention away from junior doctors and refocusing on GPs, — he actually has a game plan to deliver a 1% pay uplift for partners – the shrewdest operators in the Cabinet — and 5,000 new GPs by 2020. For most,

But, like the arch-politician he is, Mr Hunt has adapted his tactics and is putting some money where his mouth is. The new GP contract — announced last month — gives an indication of the direction of travel. After nearly a decade of pay cuts, a 2% funding uplift represents a significant investment of cash into general practice. For the first time, the contract includes a detailed assessment of rising practice costs for indemnity fees, national insurance, employer superannuation and running expenses. Some of the extra funding will be eaten up by the massive hike in CQC fees, and the whole deal does little to reverse what used to be the traditional ‘awkward squad’ — GPs.

So that just leaves the traditional ‘unsocial hours’ pay premiums that would prove an impossible wishlist. This is designed to ‘maintain the profession as the jewel in the crown of our NHS’ and fulfil Mr Hunt’s promise of 10,000 new GPs and 10,000 other professionals — such as pharmacists and physician associates — working in general practice.

Smoke and mirrors

Pulse has learned the announcement — planned for February but delayed until next month because of the junior doctors’ campaign — that the Government has given 250,000 signatures. This represents a significant investment of cash into general practice, thought to be worth around £2.5bn, but the 3.2% funding uplift from April does not offer more. The GP contract special — announced last month because of the junior doctors’ campaign — that the Government has given 250,000 signatures. This represents a significant investment of cash into general practice, thought to be worth around £2.5bn, but the 3.2% funding uplift from April does not offer more.

The manifesto promised a ‘truly seven-day NHS’, parity for mental health and 5,000 new GPs by 2020. For most, that would prove an impossible wishlist. But Mr Hunt seems impervious to the naysayers.

The elements of this game plan have a common theme — powerful and popular pledges to patients, announced in grandiose style, yet ultimately left to wither and die. Some of the extra funding will be eaten up by the massive hike in CQC fees, and the whole deal does little to reverse what used to be the traditional ‘awkward squad’ — GPs.

Mr Hunt says ‘this deal is just the start of significant new investment’. General practice has been promised year-on-year funding increases of 4.5% until 2020. Negotiations continue on a new ‘package’ of measures to take the pressure off general practice, thought to be worth around £2.5bn, but the 3.2% funding uplift from April does not offer more. But following the installation of a Tory government, yet ultimately left to wither and die. Some of the extra funding will be eaten up by the massive hike in CQC fees, and the whole deal does little to reverse what used to be the traditional ‘awkward squad’ — GPs.

One of the reasons he has been given such licence by his boss is that — as one of the shrewdest operators in the Cabinet — he actually has a game plan to deliver a package of measures to take the pressure off general practice, thought to be worth around £2.5bn, but the 3.2% funding uplift from April does not offer more. But following the installation of a Tory government, yet ultimately left to wither and die. Some of the extra funding will be eaten up by the massive hike in CQC fees, and the whole deal does little to reverse what used to be the traditional ‘awkward squad’ — GPs.

Praities.

Jeremy Hunt versus...

...junior doctors

Mr Hunt last month announced he was imposing a contract on junior doctors in England after talks broke down, with the Government refusing to step back from its decision to remove ‘unsociable hours’ pay premiums from Saturday and weekday evenings. The BMA has now announced it is to launch a judicial review over what it calls the ‘embarrassing’ revelation that the Government failed to carry out an equality impact assessment before imposing the contract.

It also announced it would announce a new package of measures to take the pressure off general practice, thought to be worth around £2.5bn, but the 3.2% funding uplift from April does not offer more.

...GPs

Leaders voted in January for GPs to be barred from submitting undated resignations within six months if negotiations for a rescue package for general practice are not successful. The GPC has already said it does not consider the 3.2% funding uplift from April enough and that ‘broader solutions are needed’. LMC leaders will meet again in May and their Lima could be toughened up if the Government does not offer more.

...consultants

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The protracted contract fight with the juniors has been ill advised and has managed to unite the – famously riven – medical profession in opposition against him.

The juniors’ resistance to being bullied into acceptance was – in part – behind the vote at the recent Special LMC Conference to consider mass resignation in six months by GP leaders, whose ultimatum to the Government is unlikely to be met by an underfunded ‘rescue package’.

Before then, cuts to PMS payments will kick in, and will see many more practices suddenly lose large chunks of their funding from April. Many of these will have to cut services, and some may be forced to close altogether.

Crisis worsens
Meanwhile, the GP recruitment crisis continues to worsen, with Health Education England’s campaign to attract medical graduates to general practice failing spectacularly last year, with round one applications for August 2016 falling by 5% to a record low.

And the NHS pension scheme changes that will come into force from April (see Practice Diary, page 55) are likely to contribute to the brain drain of older GPs retiring or reducing their working hours.

So the famously lucky health secretary’s game plan hangs in the balance. These next three months are going to test his resilience and may well be decisive in determining his legacy.
Huge uncertainty remains over the Prime Minister’s flagship election pledge to extend GP hours, finds Sofia Lind

David Cameron's dream of GP practices opening all hours is fast becoming an expensive nightmare.

The first wave of his ‘Lions’ Challenge Fund’ pilots across England have tested seven-day GP access pilots and, in many cases, delivered questionable results. Released with little fanfare last month, NHS England’s official evaluation of the scheme’s seven-day GP access pilots made little mention of consultants or experienced doctors – which has been held up by the Department of Health as evidence of the scheme’s success.

The evaluation found that each GP appointment costs £3.2m over 3 years at 80,000 additional routine appointments per year.

Even enthusiastic areas, such as Bury, which has been held up by the Department of Health as evidence of the scheme’s success (see box) are unclear about whether they will pursue the scheme. Despite a spokesperson saying the scheme has ‘worked very well’, discussions about its future are ‘ongoing’ (see box, page 8).

In summary, four of the schemes will continue in some form, two have drastically cut funding and one is reviewing its options. Unless additional money is found to allow CCGs to continue to fund the schemes, it is likely that many will fall foul of cuts as commissioners try to balance their books.

NHS Southwark CCG in one area is going ahead full stream with seven-day GP access but it is not cheap. The CCG has committed £3m for a year for the next three years for the six additional routine appointments from 8am to 8pm every day, at two sites in the south London borough.

NHS Slough CCG also told Pulse it is continuing to fund extra evening and weekend GP appointments, and commissioning more in Barking, Havering and Dagenham, in east London, will continue to fund routine seven-day GP access, but it will be restricted to people with five or more long-term conditions.

Bristol and South Gloucestershire will have tested seven-day access the pilot areas were significant, the pilots. The £3.2m estimated savings are minor, self-presenting A&E cases, delivered questionable results.

Additional hours are most likely to be offered was typically in the range of £20 to £50.

Seven-day GP access pilots made a £2m scheme across 22 practices offering 8am-8pm every day, but stopped providing weekend access before the end of the pilot due to a lack of demand.

Current status: Undecided, subject to an ongoing evaluation

Bury

Pilot: Scheme offering 8am-8pm weekend access. Current status: Undecided, subject to an ongoing evaluation

Burridge, Richmondshire, Whitby

Pilot: £3.5m scheme across 22 practices offering 8am-8pm every day, but stopped providing weekend access before the end of the pilot due to a lack of demand. Current status: Undecided, subject to an ongoing evaluation

Cumbria

Pilot: £3.6m scheme covering 13 GP practices offering extended access until 6pm on weekdays and 8am-8pm at weekends. Current status: Undecided, subject to an ongoing evaluation

Darlington

Pilot: Scheme across 10 practices offering 8am-6.30pm weekday opening, but has already dropped Sunday opening during the pilot stage. Current status: Undecided, subject to an ongoing evaluation

Derbyshire and Nottinghamshire

Pilot: £3m scheme over 29 practices offering 8am-8pm access, seven days a week. Current status: Undecided, subject to an ongoing evaluation

Derbyshire and Nottinghamshire

Pilot: £3.6m scheme covering 13 practices offering extended access until 6pm on weekdays and 8am-8pm at weekends. Current status: Undecided, subject to an ongoing evaluation

Devon, Cornwall and Isles of Scilly

Pilot: £2.5m scheme covering 22 practices, 8am-8pm access every day. Current status: Undecided, subject to an ongoing evaluation

Dorset and South Gloucestershire

Pilot: £3.2m scheme offering 8am-8pm access every day, but cut weekend opening hours during the pilot stage. Current status: Undecided, subject to an ongoing evaluation

East Riding of Yorkshire and North Humberside

Pilot: £1m scheme across four practices offering 8am-8pm access every day seven a week. Current status: Undecided, subject to an ongoing evaluation

West Wakefield

Pilot: £4.7m scheme offering 8am-8pm access seven days a week. Current status: Undecided, subject to an ongoing evaluation

Hampshire, Richmondshire and Whitby

Pilot: £1.5m scheme covering 13 GP practices offering extended access until 6pm on weekdays and 8am-8pm at weekends. Current status: Undecided, subject to an ongoing evaluation

Hambleton, Richmondshire, Whitby

Pilot: £3.5m scheme across 22 practices offering 8am-8pm access every day, but stopped providing weekend access before the end of the pilot due to a lack of demand. Current status: Undecided, subject to an ongoing evaluation

Harrow

Pilot: £4.1m scheme across four practices offering extended access until 6pm on weekdays and 8am-8pm at weekends. Current status: Undecided, subject to an ongoing evaluation

Herefordshire

Pilot: £2m scheme offering 8am-8pm access, seven days a week, covering 10 practices. Current status: Discussions ongoing

Herefordshire

Pilot: £2m scheme offering 8am-8pm access, seven days a week, covering 10 practices. Current status: Discussions ongoing

Hertfordshire

Pilot: £2.5m scheme offering 8am-8pm access every day, but cut weekend opening hours during the pilot stage. Current status: Undecided, subject to an ongoing evaluation

Hertfordshire

Pilot: £2m scheme covering 22 practices, 8am-8pm access every day. Current status: Undecided, subject to an ongoing evaluation

Hull

Pilot: £3.2m scheme offering 8am-8pm access, seven days a week. Current status: Undecide

Hull

Pilot: £2m scheme covering 22 practices, 8am-8pm access every day. Current status: Undecided, subject to an ongoing evaluation

Hull

Pilot: £3.2m scheme offering 8am-8pm access, seven days a week. Current status: Undecide

Hull

Pilot: £2m scheme covering 22 practices, 8am-8pm access every day. Current status: Undecided, subject to an ongoing evaluation

North Kent

Pilot: £3.6m scheme covering 13 practices offering extended access until 6pm on weekdays and 8am-8pm at weekends. Current status: Undecided, subject to an ongoing evaluation

North West London

Pilot: £4.7m scheme to offer other 8am-8pm access during the pilot stage and only one area – Brent – has promised funding post April 2016

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Evidence tells us that improved access to primary care can change patient behaviour and reduce walk-in centre, out of hours and A&E attendance. So in Bury, we decided to act.

Based on the successes of a pilot project, which reduced A&E attendances by 25%, GPs in Bury (under the banner of Bury GP Federation) applied for funding from the Prime Minister’s Challenge Fund to increase our extended access. Our Radcliffe centre was already successfully providing GP services from 6.30pm to 8pm weekdays and 8am to 6pm at weekends for patients registered at six local practices. Using the learning from the pilot, we expanded this ‘hub and spoke’ model and added four more ‘hubs’ across the borough.

Key to the success of our extended hours project has been the ability to make all patient records accessible from each of the five hubs, something we know other areas have struggled with. We’ve been fortunate that all Bury practices are on the same clinical system, but this alone would not have been sufficient; positive collaboration made possible by working together in a federated model has been crucial.

We have been able to offer extended access to all 195,000 patients registered at all 33 GP practices in Bury. As well as the additional 1,400 GP appointments we are offering each week, every one of our practices has signed up to offer phone consultations as a routine alternative to face-to-face appointments.

We haven’t experienced the lack of demand that some other pilot sites found. Sunday demand (although lower than for weekday evenings and Saturdays) has been steady and we have simply adjusted resourcing levels to match demand. Sunday appointments can alleviate pressures on practices that arise from Monday morning demand.

Other criticisms centre on the resourcing of extended access, but I believe, that if every GP in our borough volunteered to do one extended access shift a month, we could sustainably resource our extended access service.

Seven-day opening has worked very well for us in Bury. That said, discussions with commissioners are ongoing regarding the future model of extended access.

**If all our GPs did one shift a month, we could resource the service**

Dr Peter Thomas is organisational medical director for Bury GP Federation and a GP in the town

**Reference**

1 RCGP. The Future of GP Out-of-Hours Care. 2014. tinyurl.com/RCGP-future

**Expensive luxury**

GP leaders say the overall picture shows that seven-day GP access – even if managed through hubs, rather than requiring all practices to open every day – is an expensive luxury the NHS cannot afford at the moment.

GPC deputy chair Dr Richard Vautrey said: ‘At £3 a consultation, no reduction in hospital admissions and only minimal changes in A&E minor injury attendances, there must be real questions about the wisdom of continuing these schemes.’

The RCGP has written to the House of Commons Health Committee’s ongoing primary care inquiry saying it ‘rejects’ the seven-day GP access policy because it is ‘unrealistic due to the huge pressure general practice is under, with existing services in urgent need of resources’.

And Pulse has learned the pilots are causing real concern among out-of-hours providers. Chair of the Northern Doctors Urgent Care group John Harrison says the pilots are offering GPs up to double the out-of-hours rate – £100 an hour plus – meaning the group cannot compete.

He says: ‘We lost a quarter of our workforce within a couple of weeks. Not a lot of GPs want to do out of hours, so a scheme like this causes absolute mayhem.’

But the DH is under strict orders from Number 10 to make the scheme work. The first pledge in the Conservatives’ 2015 election manifesto said the party would ‘provide seven-day a week access to your GP and deliver a truly seven-day NHS’.

Although the scheme appears to be floundering, the Government is likely to find the resources to make it happen. In July, Pulse learned the DH had raided £25m from the Primary Care Transformation Fund – previously the infrastructure fund designed to improve GP premises – to help fund the second wave of pilots, which launched this year.

Other areas are using NHS England’s ‘Vanguard’ pilot funding to carry forward seven-day access schemes. For example, the West Wakefield GP federation, a first-wave Challenge Fund pilot, is now trialling the ‘multispecialty community care’ model under NHS England guidance, which the federation said ‘encompasses evening and weekend services’.

The Treasury’s spending review (due to be announced as Pulse went to press) could well assign some of the £8bn in NHS funding to extending seven-day working across the service.

The GPC may have ruled out agreeing to seven-day access requirements in the GP contract for next year, but negotiations are ongoing and it would be a surprise if the health secretary attempted to strongarm extended access in as a contractual requirement.

The wheels may be coming off, but don’t underestimate the PM’s determination to maintain momentum. GPs are in for a rocky ride.
EDITORIAL

Tribal truce vital for GPs’ future

For historical reasons, general practice is split along many lines: sessional versus partner; GMS versus PMS; urban and deprived versus leafy suburbia. Now, though, there is another divide, and one that is currently running much deeper than the others.

The way I see it, there are two tribes are battling over the soul of the profession, and it is a struggle with tremendous consequences for the way GPs will work in the future. The first tribe – let’s call them the ‘reductionists’ – are in the ascendant.

They are the GPs who argue that general practice is full, that its open door is being abused by patients, hospitals and politicians. And this is completely understandable. Efforts to boost access and adjust ‘skill mix’ have been outflanked by the twin foes of chronic underfunding and soaring demand.

Recent Government promises of increased investment of 4-5% a year do little to reverse this. As Pulse reveals on page 26, even in five years’ time, GPs will still receive less than 8% of NHS funding as secondary care continues to suck up resources.

Reductionists look around and see rising rates of burnout among partners, practices struggling to recruit and young GPs seeking greater job satisfaction as locums. Their solution is to stem the tide of demand by saying ‘no’, refusing unfunded work and reducing the GP role to serve the genuinely vulnerable and sick.

This is the tribe behind the recent LMC vote that backed exploring mass undated resignations if a rescue package is not forthcoming by July. You see their influence in campaigns against the continual redefining of what GPs do, the ongoing drive to burden practices with public health interventions and social work – checking patients’ boilers and the like. But in the other corner, is a different tribe.

I shall call them the ‘expansionists’. They see NHS England’s Five Year Forward View as a blueprint for extending the role of general practice and a chance to build a truly primary care-led health service. They don’t see policymakers as ‘the enemy’ and have little truck with the view that general practice should hunker down and ‘do less’.

They are the GPs that support social prescribing, welcome moves to employ physician associates and pharmacists, and view super-practices providing more specialist and community services as the future. Unlike the reductionists, they have a seat at the table with ministers and they are first in line for extra funding from the health service when it comes. And – let’s face it – they are the ones that are more likely still to be around in five years’ time.

Now tensions can be creative – every ying needs a yang – but I would argue that general practice has to find a way to call a truce and bridge the divide between these two tribes. The reductionists struggle to offer any compelling vision for the future of general practice, whereas the expansionists have no answer to how those outside super-practices can survive in the short to medium term.

And the truth is that in most GPs there is a mix of reductionist and expansionist thinking, but the current climate has tipped many into the reductionist camp. GP leaders now need to find a way to end the tribal conflict so the profession can unite in the battle for its future. As Frankie Goes to Hollywood put it: ‘When two tribes go to war, one is all that you can score.’

General practice must find a way to bridge the divide between these two tribes

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**DIABETES SPECIAL**

**FIVE-MINUTE REFRESHER**

**Glycaemic management of type 2 diabetes**

Consultant Dr Tahseen Chowdhury presents an overview of treatment options for diabetes

Dr Tahseen Chowdhury is a consultant in diabetes and metabolism at Barts Health NHS Trust

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**Diet and lifestyle alone**

- **HbA1c >48mmol/mol**
  - Consider if patient needs assistance to give insulin
  - Dr has hypoglycaemia on human insulin
  - Dr needs twice-daily NPH

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**Metformin**

- **HbA1c >58mmol/mol**
- **(modified release if sustained release not tolerated)**
- Aim for <53mmol/mol

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**Repaglinide 0.5-4mg with meals**

- Can be used first line if metformin not tolerated or second line with metformin

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**First intensification**

- **HbA1c >58mmol/mol**
- **If metformin intolerant**
  - First line – DPP-4 inhibitor or pioglitazone or sulfonylurea
  - Or DPP-4 inhibitor + sulfonylurea
  - Or pioglitazone + sulfonylurea
  - Or second intensification with insulin-based treatment

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**Second intensification**

- **HbA1c >58mmol/mol**
- **If BMI >35kg/m² (33 in Asians), choose metformin + NPH insulin**

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**Drug Details**

- **Dermatitis/Glucose tolerance**
  - Consider if patient needs assistance to give insulin
  - Dr has hypoglycaemia on human insulin
  - Or needs twice-daily NPH

- **DPP-4 inhibitor**
  - Sitagliptin 50-200mg per day, linagliptin 5mg per day
  - Weight neutral
  - Linagliptin useful in renal disease
  - Use for six months and stop if ineffective

- **GLP-1 receptor agonist**
  - Exenatide 0.5-10mcg bd, liraglutide 0.6-1.8mg od, lixisenatide 2-10mg od, exenatide LAR 2mg weekly, dulaglutide 0.75-1.5mg weekly
  - Suitable if BMI <35 (33 in Asians) and there are obesity-related comorbidities, or occupational concerns with insulin
  - Nausea, diarrhoea, common
  - Continue for more than six months if 1mmol/mol HbA1c and 3% weight loss
  - GLP-1 plus insulin only to be used with specialist care and advice from a consultant-led MDT

- **Insulin**
  - Sliding scale: 10-20 units/kg per day
  - Can be used in pre-diabetes, gestational diabetes, type 1 diabetes
  - Stop if eGFR <30, reduce if <45
  - Start slow, titrate, after meals

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**First intensive:**

- **Metformin + DPP-4 inhibitor or pioglitazone or sulfonylurea**
- **Or Metformin + sulfonylurea**
- **Or Metformin + GLP-1 agonist**

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**Second intensive:**

- **Metformin + DPP-4 inhibitor or sulfonylurea or pioglitazone or sulfonylurea or GLP-1 agonist**

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**If BMI <35kg/m² (33 in Asians), or BMI <35 for whom insulin would have occupational implications, or if weight loss would benefit obesity-related comorbidities, choose metformin + sulfonylurea + GLP-1 agonist**
Supporting the next generation of GPs

Pulse brought together a panel of recently qualified GPs to discuss the issues affecting them and the future of the profession.

There are many issues facing newly qualified GPs at the moment that many are worried about whether they can sustain a career of full-time medical practice for another 30 to 35 years. Do you think you can?

Often GPs are making their careers sustainable through developing portfolio options, building their careers around core, general clinical practice and then taking in different things that take their interest and help them evolve as people. I think that’s much more in vogue. Many more people see that to be happy and successful in your career you don’t have to follow the traditional model.

I’m very lucky that I’ve got a large number of very supportive partners in my practice who also have different interests. But if I were to lose one of my partners there may well be a requirement for me to scale back on some of that enriching activity. That’s one of our biggest threats. And as a group of salaried GPs, we’re not the ones that are going to be retiring in the next five years.

We’re pretty much in the same boat as many practices are. In the last five to 10 years, we could have quite a few partners leaving. [The problem will be] trying to fill those gaps and still do what we want to do.

I started off as a partner straight after training, literally the day after I finished my training. I enjoyed it and I found it enriching. It was a steep learning curve, but it became unsustainable from a stimulation and motivation point of view. That motivated me to move to my current career pathway. I think I can sustain it until I retire, but I don’t think I could as a full-time salaried GP or partner.

Have there been any changes in your GP’s expectation of their careers or has the job changed?

In a demographics, patient expectations and the culture of litigation that is adding so much pressure. Increasingly we’re having to work in a way that is defensive and that’s taking a higher priority than it should do, which fundamentally makes the job less fulfilling for all of us.

I worked as a salaried GP and then as a partner in a particularly demanding practice. Eventually I had to make a choice to change the way I worked or to leave medicine completely. I’m pleased that I decided to stay, but if I can do things outside of direct patient contact that also pay, it gives me a little bit more flexibility and choice. At the moment, practices are one partner away from disaster. If one leaves, everyone is struggling and it’s all hands on deck.

You don’t have time to sit and listen to patients because you’re always thinking: ‘I’ve got blood results, I’ve got labs, I’ve got this many phone calls to make’. If we had enough doctors, we wouldn’t have this.

I’ve been in my partnership with the same number of doctors for five years, so it’s been relatively stable. But within that time, the nature of the work has changed. The amount of paperwork, the demand for appointments and the tick-box culture is getting worse. That would make increasing my sessions difficult.

Is the number of clinical decisions people have to make in a day?

It’s increasingly like a conveyor belt. You’re having to make an increasing number of speedy decisions, while keeping at the back of your mind the legal aspects. There isn’t time to sit down and come up with a collective plan. You feel like you’re being asked to make a decision in every single case and it’s not always necessary. That expectation has changed dramatically in the time I’ve been qualified.

We’re working as salaried GPs and then a partner in a particularly demanding practice. Eventually I had to make a choice to change the way I worked or to leave medicine completely. I’m pleased that I decided to stay, but if I can do things outside of direct patient contact that also pay, it gives me a little bit more flexibility and choice. At the moment, practices are one partner away from disaster. If one leaves, everyone is struggling and it’s all hands on deck.

You don’t have time to sit and listen to patients because you’re always thinking: ‘I’ve got blood results, I’ve got labs, I’ve got this many phone calls to make’. If we had enough doctors, we wouldn’t have this.

I’ve been in my partnership with the same number of doctors for five years, so it’s been relatively stable. But within that time, the nature of the work has changed. The amount of paperwork, the demand for appointments and the tick-box culture is getting worse. That would make increasing my sessions difficult.

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because we’ll all be phoning in sick. We’ll be taking our annual leave. We’ll be leaving at 5.30pm. Suddenly they’ll realise what we do for our patients. But the patients who’ll suffer from that model are the ones that don’t have a voice, those who are chronically ill or the elderly. They don’t care whether I can Skype them or email, they just want to see me.

ZN
It goes back to needs versus wants, doesn’t it?

HK
Yes, the key to improving the state of general practice isn’t really coming up with different models. The nub of the problem goes to fundamental recalibration of patient expectations and a ban on Government interventions.

SB
Then we have a model we can sell to incoming students. At the moment, they’ve got nothing to aspire to. We’re all knackered. The Government hasn’t got a clue what it’s doing and there’s no viable career prospect left for them. If everyone knows what they’re doing and has a far better work-life balance, people will want to become GPs again.

KM
We need to have a 30-year plan on what we expect as a nation. Then clinicians, patients and politicians will have the same expectations of what we’re trying to achieve.

JB
I’ve thought for a while that the NHS relationship with the Government ought to be like the Bank of England’s; one step removed. So we have people that are actually in the industry making decisions, rather than MPs that were local councillors only two minutes before they got their first junior minister post.

ZN
It’s empowering GPs on the ground to be able to say ‘no’ to inappropriate requests and know that if we then get a complaint, it will be backed by our professional bodies, our medical and legal cover and also the Government. A consistent message that: ‘You may find that the paracetamol you can buy for 12p is no longer available on prescription, because we can’t afford it on the NHS any more.’ As a profession, that would feel amazing.

NP
What do you think about the leadership in the profession itself? As newly qualified GPs, do you feel supported by the BMA and RCGP?

SB
I cancelled my BMA membership when Medical Training Application Service came in. I got caught between the systems and felt there was no one speaking for me. I know there is lots of work going on behind the scenes, but I don’t feel there is a loud enough voice from general practice to say ‘no’. It’s only over the last couple of years, with social media, that you have started to see younger people coming through and having a voice, through Tiko’s Group and things like Resilient GP and GP Survival.

JB
The RCGP is a very academic force. I’m not going to get that excited about the fact that they’ve developed a new e-learning module on chronic kidney disease when two of our partners have phoned in sick. I cancelled my BMA membership about three or four years ago, around the time of the first strike around pensions. However, on joining the LMC, a lot of what Dr Chaand Nagpaul was saying as head of GPC resonated with what I was experiencing in the practice. This encouraged me to take up my subscription again.

ZN
I’m not a member of the RCGP or the BMA. I do feel a bit sorry for the RCGP, because there’s been some frustration with them for not representing GPs. But that’s never what they were intended to do. From the BMA, what I miss is the strength of language. When you look at some other professions they’re really quite strong in the language they use and they’re quite powerful. When health secretary Jeremy Hunt makes announcements about what he’s going to do, we need someone to stand up and say: ‘This is stupid. It’s never going to work.’

SB
If Unison or Unite, or the transport unions, were faced with the continual problems that we were getting, someone would just be standing up saying: ‘Enough is enough.’ That voice isn’t there.

NP
Do you feel the younger generation has been sold down the river by the older generation?

HK
It’s problematic because younger GPs are a bit like the younger electorate when it comes to general elections. It’s a democratic process and any of us can stand for those positions in the BMA and the RCGP and if elected, can express our views.

ZN
Whatever negotiations have gone on in the past, we’ve not been part of them. But I would say that there is movement in the profession now to stand up and say: ‘No. This is not safe, this is not sustainable.’ Older colleagues who are nearer retirement perhaps don’t want
to rock the boat or they just want to get their heads down. But they need to either support us, or get out of the way.

**NP** How much of a shock is it when you start practising as a GP after training?

**KM** It was a big shock for me.

**SB** It depends on your trainer. Mine was very clear that I needed to be up to 10-minute appointments well in advance of the CSA. I went into a salaried role with a BMA model contract at a nice practice with enough GPs. Although I wasn’t particularly well supported, the clinical work was straightforward.

**JB** I had a fairly easy transition to partnership, compared with most of my colleagues, with a six-month run-in. But some have already resigned or gone abroad, just 12 months after starting a salaried post.

**SR** It depends on your VTS cohort. We were all keen to go into partnerships so we wanted to learn about all the aspects of general practice that would make us a GP, not just make us somebody who’s got an MRCP. But recently a lot of the focus seems to be on the exams. And, that’s not right, because it’s just one part of it. If you think about when we went from being medical students to being house officers or foundation doctors, we had a week to learn what it was to be a house officer. If you had that sort of transition from being a GPST to being a GP, it would help.

**NP** How can we support the next generation of GPs? Watch video clips from our panel and give us your views pulsetoday.co.uk/pulsepanel

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**JB** In my practice, we are a group of like-minded individuals who religiously meet at 10.30am for a coffee break. It brings that sense of community back, which is necessary. I’ve never worked as a locum or freelance GP, but I think one of the most difficult things about those roles is not having that consistent support network of peers.

**KM** I worked in a salaried role in a practice that didn’t have an ‘open door’ policy and I was very isolated in that role. Now I work as a locum through chambers and I get better support than I ever did in a salaried role. I can text, I can email, I can go on to our online forum and we have monthly CPD meetings. There is a group of like-minded GPs. In the area I work, the chambers group has the monopoly on locums in the area. So we are able to pick and choose, pretty much, the practices that we work at and the projects we’re involved with.

**NP** Obviously at the moment there is a shortage of GPs and there’s a lot of talk about using other healthcare workers, such as physician associates and pharmacists. Is this just a cheaper way to provide care?

**KM** If my mother or father went in to see a GP and they didn’t see a qualified GP, I would feel shortchanged. There is something absolutely fundamental about what we do in terms of pulling all the strings of clinical medicine, the social context, and extracting that out with a good communication. You can’t impart that on a short training scheme.

**JB** In my academic role, I work with people who train physician associates and I have great respect for them. But they’re not training to be GPs. It’s not just being shortchanged – it’s a real risk to patient safety.

**SR** The lack of transparency is shocking. General practice is incredibly difficult to do well. Five years in, I’m still learning. There are excellent allied professions doing brilliant jobs, but we have to be clear what their role and remit is and that they’re not a substitute for GPs.

**JB** Certainly, in my practice, I think we operate more efficiently and safely for having two excellent advanced nurse practitioners who prescribe and help deal with most of our same-day demands. But what about the patient that presents to three different healthcare professionals in an acute setting with the same cough? Who is thinking this could be the first presentation of cancer? Who’s looking at the presentation of a bit of back pain, stomach pain and low-level depression, and drawing it all together as anxiety, rather than referring them for every investigation under the sun?

**NP** It’s interesting that none of you have mentioned pay. Is that not a motivator?

**JB** I spent the last week handing out food vouchers to people. We spend our days being told about people who are struggling. I cannot moan about the level of remuneration I have when these are the people I’m dealing with day to day.

**ZN** None of us went into medicine to be multi-millionaires and if we did we picked the wrong career. But you want to pay off your student loan, get rid of your credit card and pay your mortgage.

**JB** Most of our issues about pay are that it’s incredibly over-inflated in the press and nowhere near what is reported. I know I’m paid well compared to the average person on the street, and I’m not paid well compared with someone with my qualifications and level of experience. But if I get my work-life balance sorted, I would be more than happy.

**HK** Speaking to my students, pay is never a primary motivational factor. Our main motivation is providing good care and finding fulfilment in what we do. I don’t think a pay increase of 10% or whatever will necessarily increase GP recruitment. It certainly won’t increase the incentive for the students I teach. But we hate being misrepresented. The figure that’s portrayed in the media is so different from what we take home and that figure often drives patient expectations.

**ZN** That hits my personal morale more than anything. I’ve had patients question my earnings in consultations and it really upsets me. Not the fact that they are questioning, but that people don’t seem to think I do anything that is worth what they think I earn. I want to be judged on the difference I make, not what you think I earn. I should harden up, I know.

Are you within five years of training? Want to join our panel of new GPs? Email editor@pulsetoday.co.uk

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**KM** The great thing about the group I run on Facebook, and about Resilient GP and GP Survival, is that it is about creating these support networks online. We learn from each other, and having that supportive structure is important to grow into veteran GPs at an earlier stage. Otherwise it will eat you up and you will go abroad or drop out.

**JB** It’s a big shock for me.