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March 2016 | www.pulsetoday.co.uk

IN THIS ISSUE
3.5 CPD HOURS

WHAT IS JEREMY HUNT'S GAME PLAN?

INSIDE
Nine pages of analysis on the new 2016/17 GP contract

GP contract special

> This deal is just the start of significant new investment
> *Jeremy Hunt*

What is Jeremy Hunt's game plan?

The health secretary has dealt with the juniors, now it is GPs' turn, finds Nigel Praities

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 that blew up in his face. Meanwhile, the whole health service is facing financial meltdown, with trusts running up multimillion-pound deficits and scores of GP practices closing.

A YouGov poll revealed that his public approval rating sunk in the wake of the contract imposition, with just 17% of voters saying he is doing a good job, compared with 65% who think he is doing a poor job. A recent petition calling for his resignation garnered 250,000 signatures.

The very reason Mr Hunt was parachuted in from the culture department in 2012 was to take the health service off the front pages before the general election – and, as such, he was not expected to stay for long.

But following the installation of a Tory majority government, he has been let off the leash and looks more secure in his post than ever.

Not only is he still in post, he is already turning his attention away from junior doctors and refocusing on GPs, promising a new 'package' that is set to reform general practice far more than the recently concluded GMS contract negotiations.

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 promises made in the Conservative party's 2015 election manifesto.

Impervious

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 populist pledges to patients, announced in grandiose style, yet ultimately left to commissioners and medics to deliver.

The release last month of a new Mental Health Taskforce report[1] was an attempt to establish parity with physical health – yet the buck has been passed to commissioners to find the £1bn of 'new funding' to implement the report's recommendations (see analysis, page 24).

Meanwhile, the health secretary may have toughed it out with the contract imposition – but it is trusts and junior doctors who are left to draw up weekend rotas in secondary care with strained relationships and no extra funding.

So that just leaves the traditional 'awkward squad' – GPs.

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 £220m 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 increases 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 nearly a decade of cuts, but the 3.2% uplift is expected by accountants to deliver a 1% pay uplift for partners – the first income increase for seven years.

And 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 £110m.

This is designed to 'maintain the profession as the jewel in the crown of our NHS' and fulfil Mr Hunt's promise of more 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 – is expected to contain details of a much-delayed refresh of the GP retainer scheme designed to defuse the looming retirement timebomb. It will also trumpet the release of more than 100 'golden hellos' to tempt GP trainees to work in areas with low levels of training recruitment, such as Lincolnshire, Blackpool, the Lake District and Isle of Wight, as revealed by Pulse last month.

Also, there is also likely to be an extension of the Prime Minister's Challenge Fund, which pump-primes seven-day GP access schemes. Some 57 pilots covering 18 million patients have already been launched – although Pulse has revealed that almost half of those in first wave have already reduced their opening hours due to lack of demand.

All of this will feed into the new voluntary GP contract that is being worked on behind the scenes for 2017. This will be restricted to groups of ▶

ALAMY / CHARLES MILLIGAN X2

1% is peanuts...
...but it's all part of Mr Hunt's grand plan, says Pulse editor Nigel Praities.
pulsetoday.co.uk/editor

Jeremy Hunt versus...

...junior doctors

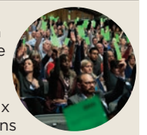
Mr Hunt last month announced he was imposing a contract on junior doctors in England after talks broke down, with the Government refusing to step back from its decision to remove 'unsociable hours' pay premiums from Saturdays and weekday evenings.

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 three more 48-hour strikes this month and next, during which junior doctors will only provide emergency care.

It comes as health education chiefs wrote to hospitals threatening to withdraw training funding from those not implementing the new contract.

...GPs



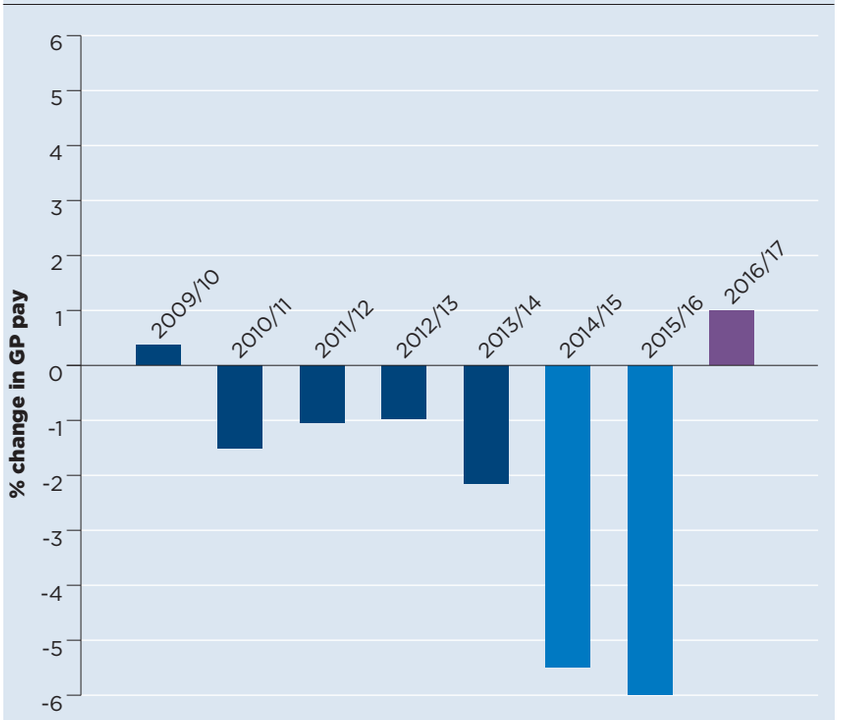
LMC leaders voted in January for GPs to be canvassed on submitting undated resignations within six months if 'negotiations for a rescue package for general practice' are not successful. The GPC has already said it does not consider the 3.2% funding uplift from April enough and that 'broader solutions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

...consultants

The Government last year demanded negotiations and had threatened an imposition if the BMA did not agree to talks. But they have been put on hold while ministers focused on the juniors. Mr Hunt wants to remove a clause giving consultants the right to refuse non- emergency work in unsociable hours.

GP CONTRACT 2016/17

The ups and downs of GP pay



Sources: Health and Social Care Information Centre using HMRC data, September 2015 (dark blue), Pulse pay surveys (light blue) and projected pay increase (purple)

practices covering at least 30,000 patients and will provide routine seven-day GP access and more specialist services in the community, as envisioned by NHS England's *Five Year Forward View*.

But, of course, as might be expected from the master tactician, Mr Hunt's game plan contains a lot of smoke and mirrors.

The insistence from him and NHS England that they were pumping more money into primary care has been undermined by the fact that the actual proportion of NHS funding devoted to primary care has decreased this year from 7.31% to 7.23%.

The majority of extra funding (£1.8bn) has been used to bail out cash-strapped hospitals. As a result, there is unlikely to be enough money for primary care to carry out what the health secretary is expected to announce in his package. Pulse understands from insiders that the GPC has said £500m will be needed – almost five times the amount actually on offer.

And, in the long run, it might be that this very game plan – and the further distrust that it is likely to bring – turns out to be Mr Hunt's undoing.

> The majority of the extra funding has been used to bail out cash-strapped trusts

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 85) 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.

Reference

1 Mental Health Taskforce for England, 2016. *The Five Year Forward View for Mental Health*. tinyurl.com/gvc4or3

What GPs are saying about the new contract

'The changes provide stability but they don't make the radical changes we need to manage workload pressures, expand our workforce and make general practice sustainable in the long term. The recent Special LMC Conference called for an urgent rescue package and it's why we are pushing the Government and NHS England to deliver this.'

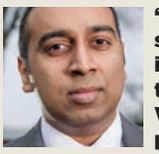
Dr Richard Vautrey, GPC deputy chair

'Exhausted GPs can't do or take any more. It's not safe and it's not fair. We must get that simple message out and harness their power. One message, one profession, all patients.'

Dr Michelle Drage, Londonwide LMCs chief executive

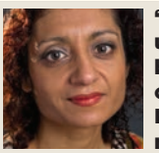
'We hope that this [£220m investment] is an indication that a wider suite of measures... will offer hard-pressed GP practices around the country short-term relief, and help to build a robust general practice service that will keep the NHS sustainable and our patients safe, for the future.'

Dr Maureen Baker, RCGP chair



'The Government should not be fooled into thinking it lets them off the hook. We still need a bigger plan on workforce, funding and managing patient demand if we are to not just to hold back the tide facing general practice, but crucially begin to turn the corner back towards the kind of innovative GP services we all want to see.'

Dr Krishna Kasaraneni, GPC education, training and workforce subcommittee chair



'I will not be thankful until the GP budget is back up to a minimum of 12% of the overall NHS budget and neither should anyone at the GPC.'

Dr Shaba Nabi, Pulse columnist and GP in Bristol

COVER STORY

Wheels come off seven-day GP access drive

Huge uncertainty remains over the Prime Minister's flagship election pledge to extend GP hours, finds Sofia Lind

MORTEN MORLAND

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

The first wave of his £400m 'Challenge Fund' pilots across England have tested seven-day access to GP practices and, in many cases, delivered questionable results.

Released with little fanfare last month, NHS England's official evaluation of the first wave of seven-day GP access pilots made less than convincing reading.

It found a 15% reduction in minor, self-presenting A&E attendances after more than a year of the pilots. The £3.2m estimated savings in the pilot areas were significant, but were dwarfed by the schemes' £50m initial funding.

The evaluation found that each appointment offered cost up to £50. It recommended that, given reported low utilisation on Sundays 'in most locations, additional hours are most likely to be taken up if provided during the week or on Saturdays (particularly Saturday mornings)'.

The Department of Health was quick to brand the first wave a 'success', but, as Pulse has reported before, the reality is that almost half of the pilots have already reduced their opening hours.

As central government funding runs out for the first wave, Pulse can now reveal that only two of the 19 areas providing seven-day access have fully committed to fund them beyond next March, while one has restricted access to patients with long-term conditions and another has had to apply for renewed government funding.

Two areas have told Pulse they intend to scale back their schemes. Devon, Cornwall and the Isles of Scilly has said it will not be funding the extended hours schemes beyond next April, other than a single site in Exeter that will provide a winter-only Saturday GP surgery service for 18 weeks from 7 November, 2016. NHS Hambleton, Richmondshire and Whitby CCG also said it had no current plans to reinstate weekend opening having dropped it earlier this year.

Uncertain future

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 13 are reviewing their options.

Unless additional money is found to allow CCGs to continue to fund the schemes, the likelihood is many will fall foul of cuts as commissioners try to balance their books.

NHS Southwark CCG is one area going ahead full-steam with seven-day GP access – but it is not cheap. The CCG has committed £2m a year for the next three years for 80,000 additional routine appointments from 8am to 8pm, seven days a week, 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 commissioners 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 ▶

What is the evidence?

- The Challenge Fund pilots found practices worked more 'collectively' and 90% of patients said extended GP opening hours was either very or fairly convenient[1]
- There was a 15% reduction in minor self-presenting A&E attendances in pilot areas, compared with a 7% reduction nationally. There was no discernible change in emergency admissions or use of out-of-hours services
- The average cost per appointment offered was typically in the range of £30 to £50
- Very low weekend utilisation figures (particularly on Sundays) contrasted with the 'success' of the weekday non-core slots
- The Department of Health said: 'By 2020 this approach will be rolled out across the country as part of our plan for a seven-day NHS'
- But the GPC said the official evaluation raised 'real questions' about the wisdom of persisting with the schemes
- Another recent study found only 0.4% of people would benefit from Sunday GP appointments, with the majority preferring Saturday access[2]

References
1 NHS England. *Prime Minister's Challenge Fund: Improving Access to General Practice First Evaluation Report*: October 2015.tinyurl.com/Pilot-evaluation
2 Simpson J et al. Access to general practice in England: time for a policy rethink. *Br J Gen Pract* 2015; 65;640;606 -607

What next for the seven-day GP access pilots?

1 Cumbria
Pilot GP clinics at a local hospital. Undergoing a patient consultation on extended GP access
Current status Under review

2 Darlington
Pilot Scheme across 10 practices offered 8am-6.30pm weekend opening, but has already dropped Sunday opening during the pilot stage
Current status CCG has not committed yet to long-term funding

3 Hambleton, Richmondshire, Whitby
Pilot £2.5m 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 No current plans to reinstate weekend opening

4 Morecambe
Pilot £1m scheme across four practices offering 8am-8pm opening seven days a week
Current status Refused to state

5 West Wakefield
Pilot £1.4m scheme offering 8am-8pm access, seven days a week across six practices
Current status Undecided, subject to an ongoing evaluation

6 Bury
Pilot Says scheme offering 8am-8pm on weekdays and 8am-6pm at weekends across 30 practices 'has worked well'
Current status Discussions 'ongoing'

7 Derbyshire and Nottinghamshire
Pilot Testing extended hours and use of Skype consultations for a million patients, but cut weekend opening hours during pilot
Current status Under review. One area (NHS Rushcliffe CCG) has said it will wait until details of the new voluntary GP contract emerge before committing to funding

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

9 Birmingham
Pilot £1m in two practices offering 8am-8pm GP access seven days a week
Current status Pending evaluation

10 Herefordshire
Pilot 24 practices were opening until 8pm every day, but two sites have already dropped Sunday opening
Current status CCG to review longer-term sustainability

11 West Hertfordshire
Pilot 15 practices providing daily access until 8pm, but Sunday pm opening dropped
Current status CCG to review and make decision in January 2016

12 North-west London
Pilot £5m scheme to offer 8am-8pm access during the week and six hours at weekends
Current status Changed opening hours during pilot stage and only one area – Brent – has promised funding post April 2016

13 Barking, Havering, Dagenham and Redbridge
Pilot £5.6m scheme covering 137 practices offered access to practices until 10pm on weekdays and 8am-8pm at weekends
Current status Has launched scheme for weekend routine GP appointments, restricted to people with five or more long-term conditions, and urgent appointments for other patients

14 Southwark
Pilot: 45 practices offering 8am-8pm access, seven days a week
Current status: The CCG has committed £2m per year for three years (around 80,000 additional appointments per year)

15 Slough
Pilot £3m scheme with 16 practices offering 8am-8pm access every day, but cut weekend opening hours during the pilot stage
Current status Existing scheme will continue to be fully funded by the CCG

16 Bristol and South Gloucestershire
Pilot £2.9m scheme in 24 practices, 8am-8pm access on Saturday and 11am-5pm on Sunday
Current status It has also received funding from the second wave of the Challenge Fund, so pilot will continue

17 South Kent Coast
Pilot 8am-8pm opening, seven days a week, covering 13 practices
Current status CCG in discussions about further funding

18 Brighton and Hove
Pilot £2m scheme over 18 practices, with 8am-8pm access every day
Current status Discussions ongoing

19 Devon, Cornwall and Isles of Scilly
Pilot £3.6m scheme covering 230 practices, but cut weekend opening hours during pilot
Current status Just one site out of a total of 40 will continue weekend opening

Key
Continuing
Under review
Drastically reduced /cancelled

Source: Pulse enquiries to all first-wave pilot schemes funded under the Prime Minister's Challenge Fund from April 2014

This job is making me ill – a poem
pulsetoday.co.uk/anon-poem

COVER STORY

'Seven-day opening can work, but our discussions are ongoing'

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.[1] 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

continue its scheme after receiving new funding from the second wave of the Challenge Fund.

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 £43 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 increase 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 no 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.

NEIL O'CONNOR

VIEWS

EDITOR OF THE YEAR
BSME AWARDS 2015

Nigel Praities is editor of Pulse. Follow him on Twitter @nigelpraities or email him at editor@pulsetoday.co.uk

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 sees 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.

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

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.'

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Printed by Headley Brothers, The Invicta Press, Ashford, Kent

ISSN 0048-6000

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

Download a PDF in a larger format. Go to pulsetoday.co.uk/refreshers

DRUG DETAILS

Detemir/Glargine
- Consider if patient needs assistance to give insulin
- Or has hypoglycaemia on human insulin
- Or needs twice-daily NPH

DPP-4 inhibitor – sitagliptin 25-100mg per day, linagliptin 5mg per day
- Weight neutral
- Linagliptin useful in renal disease
- Use for six months and stop if ineffective

GLP-1 – exenatide 5-10μg bd, liraglutide 0.6-1.2mg od, lixisenatide 10-20μg 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 11mmol/mol reduction in HbA1c and 3% weight loss
- GLP-1 plus insulin only to be used with specialist care and advice from a consultant-led MDT

Insulin
- On starting offer structured programme
- Start with NPH insulin once or twice daily
- Biphasic or NPH + short acting if HbA1c >75mmol/mol
- Biphasic with short-acting insulin analogue if patient prefers injecting immediately before meal, or if hypos problematic or blood glucose rises after meals

Metformin 500-2,500mg 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
- Modified release if sustained release not tolerated

Pioglitazone 15-45mg per day
- Avoid with heart failure, bladder cancer
- Bone fracture reported
- Weight gain
- Oedema

SGLT2 inhibitor – canagliflozin 100-300mg, dapagliflozin 5-10mg per day, empagliflozin 10mg per day
- Consider dual or triple therapy or with insulin
- Can aid weight loss
- UTI and thrush common
- Contraindicated in eGFR <45
- Avoid with diuretics
- Use for six months and stop if ineffective
- Consider DKA if patient becomes acutely unwell

Sulfonylurea – gliclazide 40-320mg daily
- Effective, but care in elderly, especially with hypoglycaemia
- Can cause weight gain

***Consider relaxing the target HbA1c on a case-by-case basis in:**
- People who are older or frail
- People with significant comorbidities such as cardiovascular disease or renal impairment

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PULSE PANEL

The panel

Nigel Praities NP
Pulse editor (chair)

Dr Zoe Norris ZN
Locum GP in Hull, columnist for Pulse and Huffington Post

Dr Hamed Khan HK
Salaried and A&E GP and clinical lecturer at St George's, University of London

Dr James Betteridge JB
GP partner in Derbyshire, CQC clinical adviser and member of Derbyshire LMC

Dr Kartik Modha KM
Locum GP in London, founder of Tiko's GP group and myhealthspecialist.com

Dr Susie Bayley SB
GP partner in Derby and vice-chair of GP Survival Committee

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

NP There are many issues facing newly qualified GPs and the impression I get is 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?

KM Often GPs are making their careers sustainable through developing portfolio options, building their career around core, general clinical practice and then adding 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.

JB 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 younger GPs, we're not the ones that are going to be retiring in the next five years.

ZN We're pretty much in the same boat in that, within the next 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.

HK 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.

NP Has there been a change in younger GPs' expectation of their careers, or has the job changed?

HK It's 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.

ZN I worked as a salaried GP 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.

SB 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.

NP Is it the number of clinical decisions you have to make in a day?

SB 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 are being asked to make a decision on every single case and it's not always necessary. That expectation has changed dramatically in the time I've been qualified.

JB Increasingly we're being asked to respond to patient want, not patient need. At some point in time there's got to be some realistic conversations with patients about what we expect primary care to deliver, and more importantly, what it isn't going to do. Because I think if we try to keep primary care as a catch-all answer to everything we're going to be on the pathway to disaster.

KM In the MRCGP exam, there's a lot of focus on communications skills, the hidden agenda, the underlying issues that might have caused a patient's health problem in the first place. So, we're given all these brilliant tools through our training. But when you get into clinical practice, all you get is 10 minutes. What we're asking from GPs is a heck of a lot. At some point we need to recognise we are humans and ask whether we are being fair to our GPs.

ZN Often we can be 20 or 30 minutes behind, but then your next patient wants you to sign a letter for the council to get a parking permit, or something else that is totally inappropriate. This is not the patient's fault, but that's not the best use of our very limited resources and energy.

> "I'm not sure I'll have a job in five years' time"
> *Dr Zoe Norris*

Before I became a locum GP, I was getting burned out and I didn't even want to ask: 'Have you got any questions?' at the end of a consultation. I just didn't have the time and energy if they said: 'Yes'. It made me want to cry. And it's horrible to be in that position as we became doctors to try to look after the whole person and to make a difference.

JB That's part of the recruitment difficulties at present. If you were to go to any hospital in 10 years' time, I would argue that an orthopaedic surgeon will be doing broadly the same job that they do today. I can't accurately tell medical students what primary care and the doctor's role within it will look like in 10 years' time. Will there be two breeds? Someone who does purely acute and out-of-hours surgery, and somebody doing more chronic care? It's very difficult to recruit someone to a specialty if you can't describe to them what their job is going to look like at the end of it.

ZN I'm not sure I'll have a job in five years' time. One of the reasons I work the way I do now is because I want to have an option. If primary care suddenly shifts and I don't do clinical work anymore, I still need to make an income for my family.

NP In Scotland, they are looking at contractual limits on GP workload as they go as far towards a salaried role as possible. Do you think this is a good idea?

HK As independent contractors, we are seen as a bottomless pit by the Government. [But] I'm not necessarily convinced that problem could be solved by moving to a salaried role and there's a huge risk that we would give away even the limited control that we have at the moment. The last people I trust with carrying out another reorganisation of primary care is the Government. If it could be more GP led, I would support it. But I doubt very much that it would.

SB It would just be the same, but run in a slightly different way. At the moment we benefit from some aspects of the partnership model and if we try to make it a one-size-fits-all, we will lose more than we gain.

JB If general practice went to a salaried model, the first thing that would happen is loads of GPs would phone in sick. One of the reasons I went into general practice is that I feel I have a sense of ownership for my cohort of patients that can't be handed over at 6.30pm, in the same way that you would if you were on the shop floor of A&E. This feels more right to me in my relationship with those patients.

SB I think I'm torn with the salaried model, because part of me thinks 'let's do it'. Go for it and make us all salaried ▶

JON ENOCH

PULSE PANEL

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 re-calibration 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,

> If Unison were faced with our problems someone would say 'enough'
> *Dr Susie Bayley*

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 ▶

JON ENOCH

PULSE PANEL

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.

SB 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 MRCGP. 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.

> Having a support network is important. Otherwise it will eat you up
> *Dr Kartik Modha*

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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 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.

ZN 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.

HK 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.

SB 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 renumeration 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.

SB 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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