Dear Colleague

Last week there was yet another distorted media portrayal of GPs, which we challenged. This time the Telegraph, which failed to publish our letter in response to their story, claimed that the increase in elderly patients attending A&E was due to inadequacies in primary care, and more specifically claimed this was a result of the 2004 GP contract, enabling the out of hours opt-out.

It is infuriating and frustrating to hear this story repeated every few weeks when there is not a shred of evidence that the introduction of the GP contract in 2004 bears any relationship to hospital emergency pressures. Indeed, it would be absurd and folly to believe that a return to the pre-2004 contract would magically solve current pressures on hospitals. The obvious fact is that with a significant rise in an ageing population, with greater complex and chronic diseases, it is inevitable that there will be an increase in healthcare demand both in secondary care but also in general practice. Indeed, general practice has cushioned and reduced what would have been even greater pressures in hospitals, with GP surgeries overstretched with an exponential increase in workload, with 340 million patient consultations every year, up 40 million since 2010.

GPs on a daily basis see and visit large numbers of patient who are frail, elderly, housebound, and those with multiple long-term conditions. We know that the factors that could make a difference to keeping such patients in the community and preventing a hospital attendance include better social care support such as home help, walking aids to prevent falls, improved support for carers, increased community and specialist nurses, more responsive community physiotherapy and greater community rehabilitation services.

Therefore, the only sensible way to address urgent care pressures is to optimise care for older and vulnerable patients through a whole system approach underpinned by an urgent care pathway. This would start with improving self care, a radical revision of NHS 111 into a clinically-led call handling service offering high quality advice and management, and integrated with GP out of hours services, community walk-in centres, urgent care units, urgent social care support, and with A&E itself.

We have outlined this integrated approach in **our own vision paper**. Indeed, such an approach is supported by the government's own commissioned report on urgent care by NHS England Medical Director Professor Sir Bruce Keogh. Furthermore, the potential for self-care and improved community services to rescue pressure on A&E is highlighted in the recent NHS England campaign.

GP pay
Another story last week was the continued deliberate misportrayal of GP earnings. Since the introduction of the GP contract in 2004, a number of myths have steadily emerged that not only present a misleading picture of GP pay, but also obscure the real improvements that have been delivered to patients.

Some of these falsehoods appeared in a national newspaper article last week which I strongly challenged in a written piece which was published alongside it.

The article claimed GPs had seen pay rises over 40 per cent in a decade yet we pointed out that NHS England has been selective in the evidence they have chosen to quote in the Telegraph article. In fact, analysis by the NHS Health and Social Care Information Centre shows there has been an 11 per cent decrease in GP income since 2008.

The initial increases in GP earnings in the years immediately following 2004 were deliberately designed to address decades of poor pay that left the GP workforce facing a recruitment crisis, partially as GPs were paid less than other doctors in the NHS. However in recent years, GPs have iniquitously suffered real terms pay cuts as the gap between income and expenses has increased consistently since 2008.

Yet GPs are working harder than ever before seeing one million patients a day, managing an increased range of complex patients, and with a significant movement of care into the community. These workload pressures have resulted in record levels of stress in the profession, and a sharp rise in GPs intending to retire as reported in a recent government commissioned report.

We have submitted robust evidence to the pay review body, the DDRB, highlighting the gap between **GP income and expenses** and the need to fairly recognise the workload and pay for GPs.

Other engagements
We held a special GPC policy day on January 16th, to which we invited guest speakers who were delivering innovative services, from improved access, enhanced use of IT between practices and patients, and the creation of large 'super partnerships'. Although these innovations do not necessarily come from GPC or LMC policy, they helped to stimulate wider discussion and help us to plan our strategy with regard to emerging initiatives.

The GPC negotiators have been busy in commencing their regular set of national roadshows, speaking at venues across England in the coming weeks. **Find your nearest roadshow**

I spoke at a well attended meeting at Coventry LMC last week, and also at Londonwide LMCs this week, and with more to follow next week. These roadshows offer an important opportunity for the negotiators to share GPC policy with colleagues, and I always in particular value hearing from constituents on the ground of their experiences, and issues and concerns that matter to them most.

And finally, last weekend I was surprised and honoured to appear in The Sunday Times list of the 500 most influential people in Britain. I would also like to congratulate fellow GPs, Clare Gerada and David Haslam, for also being on the list. I believe this accolade is recognition of the immense work of GPC in representing a GP workforce that is truly the bedrock of the NHS, and I hope that will indeed be an influence in our negotiations and deliberations with government in the coming year.

As always, please **email us** with any feedback.

Best wishes,

Chaand Nagpaul

3 February 2014