



National Primary Care Network

First contact care – high impact improvements

Report



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Introduction to the Primary Care Network

The National Primary Care Network (NPCN) is a group of over 500 healthcare professionals from across primary care including GPs, nurses, dentists, physiotherapists, optometrists and pharmacists. It holds a quarterly meeting for around 50 participants from which a report is produced. This is the latest in the series.

The NPCN is delighted to receive the support of Microsoft and CloserStill Media. This report, by reporter Francesca Robinson, is intended as a record of a meeting held on 20 January 2016 at Lettsom House 11 Chandos St, Marylebone, London W1G 9DP.

The meeting was held to set objectives for the network for 2016. Attendees discussed the type of innovative changes that are needed to transform primary care and compiled a list of initiatives that have already been introduced to reduce the pressure on GPs. Ideas for introducing more of this type of transformative change and how the barriers, which prevent new ideas from being rolled out across the NHS, can be broken down, will be the topics for debate at future meetings.

CloserStill Media, the business media company which puts on Health+Care and Commissioning, the largest event for health and social care professionals, supports the NPCN financially but has no input in the NPCN's discussions.

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Forward

At times of great change (which is almost a constant state for the NHS) it is important to create supportive networks and also to reflect on and stimulate debate about successful implementation of change.



The National Primary Care Network will once again in 2016 be doing just this with a nationwide and multidisciplinary group of healthcare professionals and managers, mainly from the primary care sector, bringing thought leadership, critical analysis but specifically evidence based solutions to some of the challenges that the NHS continually faces.

At our first meeting of 2016, on 20 January a small group convened to establish the strategic outlook for the network this year and focus on the outputs planned for 2016. At this first meeting it was decided to use the collective wisdom of the participants to rapidly respond

to the challenge of describing some potentially high impact and measured developments that they knew about and would endorse.

This short document starts to highlight the art of the possible but specifically succinctly describes some ongoing and completed pieces of work that have really tried to transform care locally.

I trust you will enjoy the read.

Dr James Kingsland OBE
President NPCN

Objectives for 2016

A meeting of the National Primary Care Network was held on 20 January to decide what the group wants to achieve during 2016.



Chair Dr James Kingsland explained that the network brings together a wide range of professionals from across primary and community care including GPs, nurses, physiotherapists, allied health professionals, dentists, optometrists and pharmacists, for a quarterly day-long meeting for around 50 participants to debate the key issues that challenge the NHS. The thought leadership is then captured in a report.

The network sits within the administration of the National Association of Primary Care but is independent.

It was agreed that guest presenters – NHS policy experts or decision-makers, politicians, or newspaper editors, will be invited to give a presentation to the meeting to stimulate debate.

Liz Butterfield, Pharmacist Consultant, Brighton and Hove CCG said: "There are so many changes coming around all the time

and the NPCN is an opportunity for leaders in their field who are open to thinking slightly differently, to discuss what primary care is going to look like and to offer some insights and suggestions."

Dr Joe McGilligan, GP, Redhill, said: "This is an opportunity for us to leave our reservations at the door and to start free thinking about how to solve whole problems. If you try to solve issues just within each individual healthcare organisation you miss the point of what the NHS was set up to do. It is important to break down the barriers between all the organisations in order to get away from the functional fixedness that we suffer from in the NHS where everyone looks through the same lens saying we can't change because we've always done it this way. We have to allow thought leadership to find solutions."

Georgina Craig of Georgina Craig

Associates, a social business that works to create a people centred NHS, said: "A real strength of this group is that we can have people like Samantha Jones, Director for the New Care Models National Programme, come along, share her policy slide set of what the Vanguard's are doing and tell us what keeps her awake at night. People like this can work with us to talk about how we can solve problems or do things differently." She said Samantha Jones, who attended a previous meeting had equally found the NPCN meeting invaluable as she had been able to speak to many different leaders, people from different professions and with a wide range of experience and expertise.

Dr Kingsland said the reports of the NPCN debates were very well received and were influential because they represented the multidisciplinary views of senior free thinking people linked to healthcare institutions and organisations.

What changes are needed to transform primary care?

The meeting discussed the challenges currently facing primary care and what is needed to achieve transformational change with a view to deciding which will be the most fruitful topics for debate at the next three meetings planned for 2016.

A key concern was the current pressure on GPs but could more effective use be made of GPs' time by employing other members of the primary care team as the point of first contact for patients?

And if change is to be implemented how do you plan and modernise the workforce and persuade them to accept the cultural and behavioural change that is needed to implement change?

Dr Joe McGilligan said unless the culture of the workforce and an organisation was changed, as soon as the doors closed, people reverted back to form. The debate the NPCN needed to focus on was not about what keeps people awake at night but what gets them up in the morning to do the job. "We often say let's throw more money at problems to make them go away instead of really addressing what the fundamental problem is," he said.

Georgina Craig said the problem in the NHS was that learning was often not shared. She described how she had been working with a Prime Minister's Challenge Fund (PMCF) project but she had no idea about any of the learning that was coming out of any of the other PMCF projects that had been launched across the country. "I thought all the learning was going to be shared but it's not being shared anywhere. So with all of this money that's been invested, what has it actually taught us about the new models of care that we should all be starting to reproduce across the country," she asked.

Ms Craig said an example of an area where transformational change was needed was in the provision of urgent care. The way people were currently accessing urgent care had changed but this was not being taken into account by the people designing services.

She said a survey by the Patients Association and the College of Emergency Medicine made "terrifying" reading. "Almost all of the patients hadn't even bothered to ring their GP first before going to A&E, a third of the patients had rung their GP and had been offered an appointment within three hours but they decided to go to accident and emergency anyway where the average waiting time is less than an hour. If I was a patient and I was told - you can see the GP sometime later today when it suits us, not when

it suits you, and my perception is I will probably have to wait at least an additional half an hour because the GP will probably be running late - or I could go to accident and emergency whenever I liked and I would wait only an hour, I know what I would do.

"There are a whole host of unintended consequences that are manifesting themselves through our lack of understanding of the experience of people overusing services. I worry so much that we are doing things in the NHS when we really don't understand what it's like for the people who are using the system and what their actual experiences are," she said.

Ms Craig said some other work she had been involved in was with frequent attenders in general practice. Interviews showed that people became frequent attenders because of numerous problems in their lives. "If somebody could sit down and spend time helping these people resolve their problems they would stop being frequent attenders. These are not things that can necessarily be addressed by the way that general practice behaves at the moment. But there are obvious solutions when you just stop and listen."

Andrew Nwosu, Regional Lead for Allied Health Professionals, NHS England (London), said: "People in the workforce do need to change their behaviour and the system needs to change so that people can utilise the most appropriate service. But we need to understand that when those changes have occurred, what fundamentally engendered that shift?"

Nicki Price, Managing Partner, Woodsend Medical Centre, Corby, Director, 3Sixty Care Ltd, described a large transformation programme in Corby Northamptonshire with which she is involved that is challenging the traditional way of working around how patients access care.

An audit showed that only 30% of patients needed to see a GP the same day so they have introduced a GP working in a consultant role as leader of a multi-disciplinary team, who meets and greets patients at the door and triages them to the most appropriate healthcare professional. This is releasing time allowing patients with long-term conditions and those needing more complex care patients to have 30 minute appointments with the GP.

In addition they are building a health and well-being centre with access to leisure and exercise facilities that can be prescribed by healthcare professionals to improve patients' wellbeing.

"I've got 60 staff thinking about new ways of working and I've never seen staff so motivated about working in the NHS. It's been quite inspiring to be able to motivate people to work in a different way," said Ms Price.

Dr Raian Sheikh, GP and Clinical Lead, Mansfield and Ashfield CCG, added: "In my practice we have a nurse practitioner who can prescribe who sees about 60 people in a day and soon we are going to have a pharmacist working on site who will be able to see more patients. This means that our GPs have more time to see the people with long-term conditions. What we don't have at the moment is a multidisciplinary workforce. The model of the GP being able to triage is the way forward."

Dr Kingsland said the questions for the NHS were: what delivers behavioural change in daily practice, how do you change the culture of the system, does size of provider organisation matter, how does the workforce need to be modelled, what can be learned from the reforms to date and have we learned anything at all from past reforms and why do we keep reinventing things? Were there some myths to be busted such as – we need seven day services and we need 5,000 more GPs?

"We are going to get 5000 more GPs because somebody said we need more GPs but is there any evidence for this? Personally I think we have got an oversupply of GPs. In my surgery yesterday 80 per cent of the people who needed care didn't need a clinician like me who has been practising for 28 years, they could have been seen by somebody else," said Dr Kingsland.

Attendees described a variety of examples of a high impact change that challenges the idea that more GPs are needed.

But they asked: how have these transformational changes been achieved and how can they be replicated? One of the key questions was how many projects are achieved with the help of front loaded funding? But when the money runs out can the change be maintained and also without frontloaded funding can changes be replicated elsewhere?

These issues will be debated at future meetings and with the aim of producing reports reflecting some innovative new thinking on transforming primary care.

High impact changes that challenge the notion that “5,000 more GPs are needed”.

The following examples of change have been submitted by NPCN members to show how transformational change can be achieved.



Natalie Beswetherick
Chartered Society of Physiotherapy



Nicki Price
Partner, Woodsend Medical Centre, Corby, Director, 3Sixty Care Ltd



Paul Batchelor
Vice Dean, Faculty of General Dental Practice



Liz Butterfield
Pharmacist Consultant, Brighton and Hove CCG



Mukesh Lad
Leicestershire Independent Pharmacy Company (LIPCO) Chair



Dr James Kingsland
President NAPC



Katherine Andrews
Project Manager, Primary Care Innovation Network, NAPC

Andrew Nwosu, Regional Lead for Allied Health Professionals, NHS England (London):
MSK conditions self-referral: making physiotherapists first point of contact for patients

Allowing patients to self-refer to NHS musculoskeletal (MSK) physiotherapy services or occupational health physiotherapists frees up GP time, reduces work absence and prevents acute problems from becoming chronic.

Work related musculoskeletal disorders (MSDs) are the most common type of occupational ill health in the UK. Back pain and other MSDs account for approximately 40% of sickness absence in the NHS and cost about £400 million each to treat. 30 per cent of GPs' workload is MSK conditions, more than 100 million appointments.

This initiative can make a considerable return on investment. Demand for NHS physiotherapy (predominantly MSK care) is expressed per 1000 of the population, and averages 56 per 1000 (ranging from 53 [urban] to 66 [rural] per 1000). In London self-implementation of referral pathways has the potential to save over £2 million. Self-referral for an MSK problem cuts costs for the NHS by an average of £33 per patient.

In Torbay, North Devon, introducing MSK self-referral cut waiting times from 10 weeks to within three days for 90% of patients.

Patients can self-refer in most places in Scotland and two-thirds of Wales, but just three in 10 CCGs in England offer that option in any form and there is one pilot scheme in Northern Ireland.

Georgina Craig, National Direction, Experience Led Commissioning Programme:
Group consultations

Group consultations, also called shared medical appointments, are one-to-one consultations delivered by a clinician in a group setting. In Slough, where they have been introduced as a Prime Minister's Challenge Fund pilot, they are producing following impacts:

- Frequent attenders are attending less often
- Consulting this way is empowering, liberating and rewarding
- GPs and patients have more time to discuss what matters
- It is saving GP and practice time; it's very productive
- Patients love them; "by the third session, they want to take over"
- They work best for complex, poorly controlled patients
- They improve compliance with reviews and monitoring.

Introduction of wellbeing coordinators

NHS Halton CCG commissioned Wellbeing Enterprises CIC to develop and deliver the Community Wellbeing Practice (CWP) initiative. The aim is to connect patients to community-based services and support and enable them to acquire the skills, knowledge and resources they need to make meaningful improvements in their own health and wellbeing.

Every GP practice in Halton has been assigned a community wellbeing officer to whom they can refer patients for personal action planning.

Early results show:

- Over CWP 5,000 interventions so far
- 86% of participants rate their satisfaction of interventions as 8/10 or more
- Demonstrable improvements in wellbeing and depression levels for a majority of patients - Community wellbeing officers attend multi-disciplinary team meetings to support patients with the greatest need.

Natalie Beswetherick, Chartered Society of Physiotherapy: Improved management of MSK problems in primary care

- For five years Allied Health Professionals (AHP) Suffolk has been offering MSK services across 27 sites in the community, accessed through GP referral and patient self-referral. The impact of this service has seen a 40% reduction in the number of referrals to orthopaedics for hip and knee replacements, reducing pressure on secondary care.
- As part of the Arnewood Practice MSK Vanguard project, an advanced physiotherapist has been working in general practice taking appointments two afternoons each week. In the first three months 108 patients saw the physiotherapist instead of GP. This has reduced pressure on GPs who are now able to provide longer appointments for patients who need them. Around 50% of patients who see the physiotherapist require self-management advice and exercises and 30% fewer are referred to community physiotherapy for treatment. All patients said they were happy to be assessed by a physiotherapist rather than the GP, were happy with the outcome and found the service convenient.
- In Windermere, South Lakeland, in 11 months more than 710 patients have been seen by the physiotherapist; 557 were first referrals, 153 follow ups. 79% would normally have seen the GP as first contact – so 560 GP appointments have been saved. There was a 20% reduction in referrals to secondary care. The physiotherapist was also able to offer injection therapy, reducing the referrals to secondary care for injections by 93%. More than 9 in 10 patients rated their care as excellent. The three month pilot has now become permanent.

Liz Stafford, External Relations & Policy Development Manager, Rowlands Pharmacy and Sue Taylor, Chief Officer, Devon Local Pharmaceutical Committee: Pharmacy First scheme – increasing access to primary care

Pharmacy teams in Devon helped more than 8,000 patients during the first five months of a Pharmacy First scheme funded by the Prime Minister's Challenge Fund. The scheme brought together three services to increase

access to primary care and help reduce pressure on out of hours services. The suite of services included a minor ailments service via patient group directions, a winter ailments service and an emergency supply scheme. They saved over 3,790 appointments in general practice, just under 2,000 out of hours appointments and 210 A&E appointments.

Pharmacy First remains a commissioned service, by the end of 2015 it had dealt with more than 21,000 interventions. The next step is to test a direct referral via triage when patients call for a GP appointment.

Nicki Price, Managing Partner, Woodsend Medical Centre, Corby, Director, 3Sixty Care Ltd: A Consultant GP Model

Three GP practices in Corby, Northamptonshire are developing innovative clinical pathways as they progress their plans for a new Health and Wellbeing Centre in Corby Northamptonshire. Recent clinical audits show that only 30% of same day activity requires GP input, the remainder could effectively be dealt with by nurses and allied health professionals.

In the future each same day clinic will be led by a GP consultant who will provide leadership and clinical support to a multidisciplinary team of nurses, allied health professionals, pharmacists and GP registrars. The freed-up GP resource will be refocused on newly designed pathways of care for patients with long term conditions and complex care needs.

Our emerging Primary Care Home model across our Federation will provide the platform for all practices to transform their service offer. It is our aim that 50% of GP time in every practice regardless of size is protected so that an “extensivist” model of care can be implemented for those most in need.

Paul Batchelor, Vice Dean, Faculty of General Dental Practice (UK):

Helping ensure the qualities of life for care home residents

Current policy sees new entrants to residential homes receive a general health assessment, however no oral health measures are included. This is despite both the growing problem of poor oral health in this segment of the population and a lack of knowledge of how problems impact on food choices and social interaction. Untreated oral disease results in pain, difficulty in chewing, swallowing and eating, which in turn leads to food avoidance, dietary modification and even nutritional shortcomings. Such developments are associated with a range of other conditions requiring hospitalisation. A simple oral health assessment provides the opportunity to identify, monitor and act as a filtering process offering improved resource use. Used by a trained carer, the oral health assessment provides the data for discussion about support: is the individual having any problems, are they concerned about their mouth, when did they last make a dental visit? Such assessment can only help lower the need for future medical care.

Currently Wales runs such a programme and Scotland has introduced guidelines.

Dr Shikha Pitalia, GP, SSP Health (provider of primary care services in NW England):
Consultant and advanced nurse practitioner team for elderly medicine in the community

Twelve practices appointed a consultant in elderly medicine and advanced nurse practitioners, who saw 443 patients in five months, completing comprehensive geriatric reviews and anticipatory care plans where appropriate. The average time spent with each patient for a first visit was 40 minutes and 20 minutes for follow-up.

Results:

- 65% were found to be at risk of unplanned admission – all had a care plan agreed
- 100% had medication reviews
- 30% had an anticipatory care plan agreed
- 100% had a second visit to review agreed care plans
- two new diagnoses of dementia were made
- 100% of the over 75s identified in need were seen – GPs would not have had the capacity to do these home visits in such depth.

Dr Shikha Pitalia, GP, SSP Health:
Cardiology e-consultations

Cardiology e-consultations were piloted using telemedicine ECGs in three regions. They supported busy GPs to make evidence-based decisions when faced with patient expectations of admission or referral. The scheme was extremely popular with patients as the rapid access reduced anxiety.

This was a simple pathway with minimal GP time needed to generate referral. It was a shared service between groups of practices. Technicians performed the ECGs in the primary care location and the information was transmitted via a secure N3 connection to a NHS consultant cardiologist. The average time for report was 2 hours with consultant's recommendation whether to refer, admit or manage within primary care.

Results:

- Reduced referrals by 80%
- Reduced avoidable hospital admissions and zero day admissions

The scheme was funded by the NHS England Innovation Fund. This could be funded by commissioners in the future because minimal investment is needed for implementation as the service generates savings. The cost of the service is a fraction of PBR (payment by results) tariffs for A&E attendance, cardiology outpatient attendance and emergency admissions, many of which are zero day admissions.

Dr Shikha Pitalia, GP, SSP Health:
Children's rapid access clinics across 36 practices in St Helens

This service was developed to address high rates of urgent care access when the next GP appointment available after morning surgeries was often the next day. One centralised GP provides emergency weekday clinics from 3.00-

6.30pm across 36 practices covering circa 40,000 children. Bookings are coordinated via a single point of access. The CCG has commissioned the service via the local out-of-hours provider. Practices can direct patients requesting urgent appointments to the service from 11.30am.

Originally piloted during practice based commissioning, the service has evolved over six years with consistent impact on reduced A&E attendance.

Dr Shikha Pitalia,
GP, SSP Health, founder of Acute Visiting Service:
Acute Visiting Service (AVS) – various sites

Established for 10 years in some areas, the AVS exemplifies good collaborative practice in the face of GP shortages. The scheme has been nationally acclaimed to reduce emergency admissions and improve primary care access.

Community based doctors are dedicated solely to providing rapid access home visits for multiple practices, saving valuable GP time per practice. Requests are triaged by the patients' registered practice to ensure safe and suitable referral.

Results:

- Reduced risk of emergency admissions, particularly zero days
- Efficient working with one GP doing home visits for multiple practices
- Improved access at surgeries because GPs can divert home visits to the AVS

The average emergency admission costs £2500 so there is scope for making substantial savings with minimal investment. The simplest solution is to work with local out of hours providers who have the existing borough-wide infrastructure to deliver the service in-hours. Savings from reducing zero day admissions alone are significant. Each home visit directed to the AVS creates three appointments per surgery.

Liz Butterfield, pharmacist consultant,
Brighton and Hove CCG:
Community Pharmacist read/write access to patient records

As part of the Prime Minister's Challenge Fund, Brighton and Hove CCG has developed read/write access to patient records to enable urgent care to be provided with pharmacist consultations in the community pharmacy. GPs manage telephone triage and can refer for pharmacy consultation and make the patient record available to the pharmacist. Numbers so far are small, referral rate back to the GP is very low and feedback from patients is positive. Barriers to expansion may be cultural rather than technical but can provide a safe and accessible mechanism for managing appropriate patients in the community pharmacy whilst also enabling pharmacy consultations to be part of the patient record.

Liz Butterfield, Pharmacist Consultant,
Brighton and Hove CCG:
Polypharmacy reviews in care homes by pharmacists liaising closely with GPs and nurses.

Brighton and Hove CCG has commissioned a comprehensive clinical pharmacist medication reviews service to supplement GP care of elderly residents in care

homes. Prior to reviews starting with each GP surgery, a pre-agreement form is discussed and signed by the lead GP authorising some changes to be implemented by the pharmacists. More complex recommendations are discussed individually with the GPs and then implemented by the pharmacist.

This service is now in its fourth year and has delivered significant on-going sustained financial savings as well as reducing the risk of hospital admission relating to medicines. The figures for annualised prescribing budget savings for 2014/15 were £330,000 with an additional peer reviewed estimated saving from avoided admissions of £380,000 using the RIO scoring method. The annual cost is around £100,000 with 2,000 patient medication reviews undertaken. Sustained changes from previous year will still be producing savings in the current year.

**Mukesh Lad, Leicestershire Independent Pharmacy Company (LIPCO) Chair:
Out of Hours Emergency Prescriptions**

West Leicestershire CCG introduced a scheme in June 2015 called the NHS Emergency Repeat Medicine Service (ERMS). This service allows pharmacist to dispense essential medicines to patients as “Emergency Supply” and is part of the out of hours service to reduce the impact on the local urgent care and acute care organisations. The programme has been linked to the NHS 111 service and is proving to be a success and further analysis is ongoing.

British Medical Journal Open has published an evaluation of an NHS funded community pharmacy emergency repeat medication supply service (PERMSS).

The study examined the cases of 2,485 self-presenting patients to 227 pharmacies across the North East of England who were accredited to provide the PERMSS service.

In the absence of this service, 50% of patients would have missed their medication until they saw their GP. A further 46% of patients would have accessed another out of hours (OOH) service.

The authors found that PERMSS offers a more economical option to the NHS for the management of these patients’ OOH and outside emergency and urgent care service providers (A&E and GP OOH).

The evaluation concludes that the service appears to be an appropriate response to the recent calls for emergency supplies to be provided by community pharmacies in order to reduce the burden on the wider NHS.

**Dr James Kingsland, President NAPC:
The Never Full Practice**

Wirral CCG has made a small investment of £30 per head of registered population in the St Hilary Group Practice in Wallasey. With this, the practice has devised new ways of working, facilitating same day, urgent, and pre-bookable appointments within extended hours to meet the care needs of their registered population. A multispecialty practice based team is delivering a new style of first contact care. Named the “Never Full Practice” it also focuses on delivering a good work-life balance with staff involved in the design and choice of new working

hours. There are appropriate rewards for new innovative services and creating high collective personal esteem. Properly aligned incentives have stimulated improved access and as a result of more practice based finished episodes of care, a saving of £40 per head of population has been realised.

**Katherine Andrews, Project Manager, Primary Care Innovation Network, NAPC:
Primary Care Navigators (PCNs) for Dementia**

Introducing PCN training for non-clinical, patient-facing staff in a Gateshead GP practice built their confidence in listening to dementia patients and their carers effectively, and directing them to the full range of support (both local and national) needed for all aspects of health and wellbeing.

Keys to the success of the PCN role included:

- Wider practice engagement
- A single point-of-contact for nursing homes
- Aligning with coordinated care and multidisciplinary team planning.

PCN performance activities within the first three months included:

- Dementia Screening (+117)
- Assessment for Dementia (+38)
- Care Plans (+396)
- NHS Health Checks (+95)
- Post-discharge (+86) none of whom needed a physician as PCN sorted
- Reduced discharge letters suggesting avoided admissions – from 7-8 per day to 2-3 per week

The National Association of Primary Care provided the training, funded by Health Education England. Funding from the Dementia Direct Enhanced Service, available as part of the general practice contract, was also utilised.

**Dr Ken Aswani, GP, The Allum Medical Centre, Leytonstone:
Specialist clinics in primary care**

The Allum Practice in Leytonstone, Waltham Forest, NE London has over 15,000 registered patients with 800 patients with diabetes. Normally approximately 10% of patients with type 2 diabetes are referred to secondary care as their diabetic control is poor. The options are a change in oral medication, consider other injectables or to start insulin.

Over the last year the practice has benefited from having a Specialist Diabetic Nurse running a monthly clinic in the practice in close liaison with a nurse practitioner.

The result has been that they no longer need to refer to secondary care for type 2 diabetes except in very exceptional circumstances. Based on a typical referral rate of 10%, over 80 referrals have been avoided. This is both cost effective and very much preferred by the patient.

The preferred model for the practice for the management of long term conditions is for the specialist nurse / consultant to run a joint clinic within the practice. The benefits for the patient and clinician development and overall cost effectiveness are significant.

Conclusion and Next Steps

The remodeling of the workforce in new types of first contact care is possibly the most important factor in the provision from a transformed NHS.

By the very nature and construct of the NPCN, there is a recurring inquiry about the evidence base behind the assertion that nationally, the NHS requires 5,000 more general practitioners to meet the increasing demand on list based primary care provision.

The case studies, briefly described in this document, emphasise the need for multi-professional working in the delivery of the care desired by a local population in today's society.

Simply trying harder at what has failed, or is failing, just won't do. Understanding the changing demand on the NHS, shaping that demand and formulating a refreshed type of supply through the right care principles is what is needed.

We may need more GPs to replace the cohort who are retiring, many of whom earlier than expected due to pressures which as a practicing GP I fully recognise, but at this latest time of great change, let's take the opportunity to redesign the primary care sector based on the needs of people in the 21st century.

Topics suggested by this meeting for future debate:

- How can community services integrate with primary care. What needs to happen for sustainable change to benefit the population?
- How can primary care lead transformation by focusing on behaviour change?

- How do we deliver behaviour change?
- Which member of the primary care team is the most appropriate for a given condition?
- Which health or social care professional should be the first point of contact and in which location?
- Challenging professional competence - does self-employment get in the way?
- Are seven-day GP appointments effective and how do we adopt them?
- How do we co-create and sustain the primary care home that delivers three tier key areas of care: acute care, long-term conditions care and out-of-hospital care?
- Why is there such a mismatch between what science knows and what the system does?
- Why don't primary health professionals lead transformational change and aspiration and why do we often default back to what we know?
- Does one size fit all and does size matter?
- Do we need more GPs?

Dr James Kingsland OBE
President NPCN

DATES OF THE NEXT MEETINGS: 13 APRIL • 13 JULY • 24 NOVEMBER

Attendance list

With thanks to all those who attended

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