Next Steps for Primary Care

Innovate Stage

Tuesday 11th September 2017

10.00 – 11.00

Speakers:

- Robert Varnam - Director of General Practice Development, NHS England
- Vish Ratnasuriya - Chair of Our Health Birmingham
- Jeremy Taylor, Chief Executive, National Voices
- Arvind Madan, Director of Primary Care, NHS England
- Jonty Heaversedge. – GP, South East London.

Jenny

Our first session is next steps for primary care, important to the public, 17 million people are now able to access GP appointments during evenings and weekends. This session is about what we are doing to fulfil the General Practice Forward View. We will be using GLISSER on this one, again, if you want to ask a question, go to GLISSER day one innovate and select this session. I will introduce the Panel. We have:

Arvind Madan, Director of Primary Care, NHS England.

Robert Varnam, Director of General Practice Development.

Vish Ratnasuiya, the Chair of Our Health Birmingham.

Jeremy Taylor, the Chief Executive of National Voices and

Jonty Heaversedge, GP and contributor to BBCs Street Doctor

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Robert:

My name is Robert I am a GP about 2-miles that way. I am Director of GP Development at NHS England, involved in their work to help general practice with OD and with leadership development, we will hear a bit more about the stuff we are doing, I am here to mostly set the scene really for those of us who may not know all that much about what is happening in primary care in England at the moment.

As Jenny was saying primary care is at the heart of the NHS, the most used bit of the NHS, at least 90% of people's contacts with the NHS occur, not in hospital but out in the community and in primary care, about a million people will have contact with the GP practice today. Internationally it is one of the bits of the NHS that is most unique and most generates the most interest from people seeking to learn from the NHS.

But you can't have missed the fact that general practice like many parts of the NHS is under huge pressure, some of the pressure is unique and is quite significant and doesn't necessarily reach the same kind of level of media attention as say A&E departments but the pressures are very real.

So for example, in the last 5 years in general practice, we have seen the number of consultations rise by 20% but the number of GP's rise by 4%. We've seen the demands and the expectations and the things that could be done in primary care go up, year on year, the things we would like to see primary doing go up year on year, but neither the funding nor the growth in the work force until recently have in any way kept pace with the growth and expectations and the growth in the possibility. So there is a perfect storm of pressure on primary care right now.

But there is another story as well which is there is an amazing world of innovation happening in primary care right now, that has been building in certain pockets

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around England for a number of years, we will hear some amazing examples of it in this session.

So, we come at an amazing time for primary care where whether you are talking about the glass half empty view and talking of the pressures on general practice in particular or talking about some of the innovations, some of the possibilities of the future change is everywhere. We are going to be hearing a lot about a change, what is happening in change and what is happening to accelerate and spread innovation during this session.

I would like to tell you about something we are going to do in using this GLISSER opportunity, so if you have got a mobile phone, pick it out. We will ask you 2 questions, this is partly to make sure the system is working for you but our speakers would really like to know the answer to these 2 questions we will ask.

The first one is: How involved with you in general practice?

So, people on the stage know an awful lot about what is happening right now and are involved in it. We would like to know how much detail to give for you. I work in general practice, I commission or support it, I work alongside it or none of the above.

Only 4 options quite easy, to remind you to go to glsr.it ... it will ask you the questions, during the course of presentations from colleagues you will have the chance to ask questions and pose comments and that is a much easier way in this particular format than running around with microphones asking questions and things. We would like to hear from you, so log into this system now it will be really beneficial for all of us. If that is possible.

I will ask if we can see please the result of that first question.

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Here we are. So, 11% of people here work in, fifth commission or support. A quarter work alongside and just under half of us none of the above. So that is helpful.

Then the next question now, which will update on the screen.

Which is this: How much do you know about the General Practice forward view?

This was a huge programme of policy and funding and OD and innovation support that was launched by the NHS back in April last year. Some of us in the room we expect to know quite a lot about it. It would be helpful to get the detail from you about yourself, how much you know about it.

So again, if you can answer just 4 options, do you know it very well? Fairly well, not well, not at all. That will be really helpful. Give a few more moments and then I will ask if we can see the results of this question please.

So, a pretty broad spread most of us at least know something about what is happening right now which is really useful for us. Thank you so much for answering that question.

So, we are going to move on, we are going to hear in brief from 4 people involved at the forefront of helping primary care to survive and to transform for the future. Each is going to present slides talk for 4 or 5 minutes I will be helping us keep to time because then what we really interested is kind of hearing your questions on the polling as we go through, having a kind of a chat amongst ourselves about what we think about the challenges that that you raise to us. So, we want you to have your say all the way through this. So, I will begin, by asking Jeremy Taylor to start us off

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from the patient's perspective.

Jeremy

My job in this is to ground the conversation as to what actually matters to patients and people who use the services. National Voices is a charity and an umbrella of charities which advocates for person centred care and for people in communities and the voluntary sector as part of that. So that will give you a clue where we are coming from.

So my first thought is that when we talk about primary care we're actually talking about primary clinical care and the real primary care is the care that people provide for themselves and each other as patients, as carers, as family members and as members of communities and as long as we lose sight of the fact that most of the care takes place in the community I think general practice will continue to struggle with ever rising demand so for us a really important part of redesigning general practice and primary care is that it is a service that supports people to care for themselves. I think it is inching its way towards that but there is still a long way to go.

So when I was briefed for this session I was asked to say something about what are the asks from patients to primary care and what are the asks from primary care of patients, from a system to patients. I've just got a few thoughts, the asks of patients and none of this is rocket science. Can I get an appointment, will I have enough time when I get to see a doctor, will I get the help I need, will you listen to me, will you explain things, will you involve me, will I get a joined up service, will you help me manage, and would you let me do more online and digitally. Because there is a long way to go there.

I'm also going to give you a perspective from patient champions, people working in the system alongside general practice and primary care in Healthwatch and the voluntary sector, patient activists and patient leaders. They would ask all those

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questions of the services, but they would ask a few more I think. They would ask are you going to focus as you design and improve your services on what really matters to people and what they really value. Because what matters to people in health and what they really value is not always the same as what the NHS is providing and its not always what the NHS measures as its successes. Will you make sure it works for everyone, so are you doing what you need to do to get your arms around the diversity in your communities and health inequalities and work to narrow those inequalities or are your services improvements and reforms unwittingly reinforcing a good service with those who already have a good service and leaving other people at the margin. Will you help people take more control so they can do more for themselves and each other and be less dependent on expensive and often disenabling interventions? And will you work with us because we have lots of capacity to bring to the party lots of help and advice and support and volunteering and social action and insight that we can bring to the social improvement endeavour.

And finally the asks of patients from the system. That's often couched in a negative way, we could run this system better if we didn't have these patients in the way. So I'm going to ask some different questions. Will you let us have better conversations with you, are you up for that? Conversations in which we're partners not us on a pedestal telling you what to do as clinicians. Will you let us do more to help yourselves? We would like to help you help yourselves. Not self-care in a sense where we are going to dump on you and get you to do more for yourselves because we can't afford to look after you anymore but a partnership to enable you to do more for yourselves. Will you allow us to bring a team around you of different clinicians, workers and professionals including you as a member of that team to deliver really good joined up care that works for you. Will you let us share your data with the right caveats and protections applied? And will you all help us to get this right because we as clinicians can't do this on our own.

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So I hope I have given you a little bit of a framing around what matters to patients and how we can be involved in the process of getting primary care right which is primarily what happens outside the surgery but also to help primary care as a clinical endeavour be improved through our involvement and to get general practice right which is part of that. We haven't got enough time to debate the distinctions between general practice and primary medical services and how they join up with community services that's a really important part of it too. So that's enough from me, thank you very much.

Robert

You can also vote on the other questions coming in from other people. We'll see where the interest is because I think some really helpful issues raised there. I'm going to hand over to Dr Arvind Madan and let him introduce himself and talk about what's happening from his perspective.

Arvind:

I have been a GP 20 year. I'm a partner in a group practice in London but four days a week I'm Director of Primary Care for NHS England, as of the last 18 months.

We're now 18 months through the general practice forward view, launched in April of last year.

The General Practice Forward View is a five-year strategy to try to stabilise general practice and transform it for the future. Actually, it has 82 different initiatives in and what started with a relatively small group of people working across a number of organisations, including the RCGP and the BMA and others including patient groups, it has now turned into a bit of a movement across the country involving hundreds of

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people in its delivery. What I thought I would do in the short time I have is try and give you a sense of the progress that has been made and a reminder of what life was like beforehand.

Some of the criticisms that we have faced and, you know, in some respects continue to face in some corners. So, one of them is around the General Practice Forward View is not funding general practice sufficiently. Well, the General Practice Forward View includes a plan to increase funding by 2.4 billion extra per annum by 2021.

It is worth teasing that apart a little bit. That's a 14% real terms increase over the next five years and that's in comparison to an 8% increase for the rest of the NHS. There are specific elements of that in terms of the contribution from CCGs, the £3 a head over which we are trying to gain complete reassurance across all CCGs at the moment. The global sum increase in the General Practice contract. The move away from micro incentives and putting more money into frailty as opposed to unplanned admissions in hard services.

And actually, help with some of the wicked problems of general practice, at least in the shorter term, until we come up with longer term solutions to issues such as the rising cost of medical indemnity.

NHS England isn't doing anything about the workforce crisis. Well, we know we have ambitious targets, around 5,000 additional GPs by 2021, and there are a number of things happening to try to get us to a self-sustaining position over our general practice workforce ultimately, such as the increase in the number of places in medical schools, 500 next year and an additional thousand the year after taking us from 6 to 7,500 a year.

Increases in the number of GP training places, 3,250 places per annum. We haven't

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quite filled them, but we are north of 3,000, meaning we have the highest numbers of GPs in training than ever before. The early indication is that we're up 5% on last year. There are enticements not only to bring more doctors into the system but how we distribute them.

For example, the salary supplement schemes for doctors working in under doctored areas, the improvements to the induction and refresher programme, with financial payments so that doctors can sustain their own household incomes while they are going through this phase, but also hand holding support on an individual basis to help them jump the obstacle course that is the return to work process of old.

Probably what you heard most about is the international recruitment programme where we are looking to bring in 2 to 3,000 doctors from abroad. Not just bring them in, but help them settle, so akin to those programmes in Lincolnshire and Essex where we give them a three month induction on what working in the NHS is going to feel like. Pair them up with practices where they have employment. Help for their spouses to find employment and help for children to get into local schools and connect them to local communities from the same origin.

We are doing things to try to dissuade doctors from retiring early. The two factors affecting the GP workforce numbers are doctors retiring early, the attrition rate, and also the number of part timeliness in the profession, because, frankly, which I'll go on to, workload is our major challenge.

There are also things around the GP health programme where we have had 500 doctors gain support for mental health and addiction issues from around the country from that service, which is January of this year.

We are also making progress and we are halfway through the 5,000 target we set

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ourselves in relation to other professionals working in Primary Care.

Improving how we support the nursing workforce, the practice managers development, the clinical pharmacists, 500 in place another 500 approved, and a target of another 1,500 by the end of the General Practice Forward View. Physician Associates being trained at the moment. Mental health therapists, of which we hope there will be 3,000 in Primary Care by the end of the programme. As well as upskilling existing staff within practices.

In terms of the workload, which is possibly one of our biggest challenges, lots of things happening here around self-care. I would like to go back to Jeremy's points but we'll see how the discussion unfolds. Self-care, community pharmacy, social prescribing and things like direct access physiotherapy are also taking place. So, you can go straight to a physiotherapist in some cases with musculoskeletal issues.

Changes to the 111 service. Changes to the rollout of how we are going to do access hubs. So, the whole country is covered, not just the 17 million, covered by March 2019. The practice resilience programme which has put £27 million into practices to stabilise the situation. The Time for Care Programme, which Robert would like to talk about. It is the largest organisational development programme in primary care anywhere in the world ever.

The work that's happening around socialising the changes in the standard contract. So, we take a chunk out of the 16 million low value appointments that relate to hospital episodes where things could have been dealt with in a hospital interaction that end up back in general practice.

How we streamline data collection across the arm's length bodies, how we improve the payments system and how we have moved towards a lower frequency of CQC

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inspections in practices. A whole trend away from the micro incentive culture of the existing contractual mechanisms.

I'm running out of time so I won't say too much on the infrastructure element. But an 18% increase in IT support for GPs and Primary Care and a whole pipeline of activities in relation to the estates and technology transformation fund.

What is this all going to look like in the future? If we bring the bits of the jigsaw together, what is it going to feel like, well the five key enablers I think are around self-care, skill mix, working at scale, around how we use technology and how we align incentives across practices and secondary care. So how I would characterise where we are at the moment is the General Practice Forward View is a good start to address a decade of underfunding in the NHS, which is historically, due to the way we collect data, had an acute sector bias, and we are going to have to work together to get the best version of the General Practice Forward View possible. Some have said it is hardest to know, in the midst of large change in a system, whether it is working or not. Sometimes it is only when you are sitting on the porch in your rocking chair some years later you recognise that was an inflexion point in the history of English general practice.

In my role, I get a constant stream through one ear of: The end is nigh, general practice has gone past its breaking point, it can't be saved from here and in the other ear I get a constant stream of, actually we're starting to get significant changes, we're on the road to recovery and a wider picture of how it can sustain itself in the NHS.

I was asked to assess 59 applications for the General Practice Forward View awards and I was taken aback and I looked beyond my cynicism of course they are trying to portray it well they are trying to win an award here. These were examples of large

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groups of practices taking on some of the changes offered in the General Practice Forward View with evidence to back up the fact that it was starting to make a difference to patient experience, to health outcomes, to how the morale of the workforce was materially different, to value for money in the system.

So, I think for some the jury is still out on whether the General Practice Forward View is working. 18 months into the programme I'd say we're in our teenage years and this is where we find out what the character of the programme is going to ultimately be. But what I would say is we're starting to see evidence that those who are early adopters of some of the menus of support that's available are starting to show progress and are on the road. Thank you.

Robert:

Thank you for the question that are coming in, if you go on GLISSER, you can see the questions as well as the features we may have. We will shift to a local experience of a clinical commissioning group and their work in helping to drive change in primary care. Jonty to talk about his experience from Southwark.

Jonty:

Thank you Robert. Is that I apologise, we have -- there we go, that is fine. Thank you very much indeed. Thank you for inviting me, nice of Jenny to introduce me as a presenter of Street Doctor, a previous career, somewhat, but I am also the Chair of Southwark CCG just been appointed as a regional medical director in London, for Primary Care Transformation and Digital which we may talk about later.

Really the opportunity this morning to talk specifically about some of the work that we have been doing in Southwark, and really, I wanted to begin by reiterating the value of primary care to the system. But importantly that key enabler which Arvind just talked about, working together at scale in general practice, we recognise this as

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being important in Southwark about 5 years ago for a number of reasons. A lot are obviously related to the kind of quality of care we can deliver for our patients and our local population. But we also recognise the value to the system of primary care, why it is important to work collaboratively and to deliver better value within the system.

But also, the opportunities that it creates to work together for staff. The work force opportunities, the new opportunities for different sorts of career and a lot of leadership opportunities that we have seen to come to fruition across Southwark. There were legitimate concerns about the loss of more intimate and personal service.

The continuity of care that patients receive. The connection with the local community and that important sense of identity that people feel with general practice. The secret to all of this, how we will be big and small at the same time. Importantly, how being big can enable us to be better at being small. That is challenge I am really interested in the conversation today, because how we do that is going to be crucial.

Importantly from my point of view, general practice working collaboratively at scale, it isn't just about better general practice, it’s essential to new models of care and delivering community based care. Our model of community based care is called local care networks and at the heart of that is general practice, but as we have started to develop our model of federated model of general practice we’ve been able to wrap around that, the community services, mental health services, district nursing services to think about integrated new model of care for the future as I say, which has general practice as a building block for that.

This is the picture in Southwark currently, I guess on this slide I wanted to flag a couple of important things.

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We recognised early on, we weren't going to specify a model of working collaboratively at scale in general practice, but realised being inclusive and population focused was essential so we have had two federations that have emerged including all 38 practices in Southwark, one in the North of the Borough and one in the south. That is important because it reflects a lot of the other parts of our health economy. We have got an acute Trust in the north and the south, we've got community services aligned in that way, social care is aligned across the Borough in exactly that way.

The practices began by doing things together. This is a message I want to get across strongly, we started of course with some seed funding through what was at the time the Prime Minister's challenge fund, to deliver extended primary care services eight to eight to the services across Southwark. That gave practices a chance to start working together, building on that, over the last couple of years not just deliver services collaboratively but improving the quality of the services together, with the ten high impact actions that I'm Robert will be able to talk further about.

Most recently we have moved to think about how we integrate with the acute trusts and with those in the community. We have started to think about how we can support people with 3 or more long term conditions, recognising that it is usually by trying to do something together, that partnerships are developed and relationships are created. That is at the heart of the care coordination pathways that our GP federations are leading as part of these new models of care.

Finally, I did talk to the federations about the key opportunities they feel they have managed to identify through the process, talked about work force and the opportunities for new careers, new opportunities for leaders, in the south federationthey have created a staff bank which has been helpful in ensuring that we identify people to resource the additional capacity that we have created in general

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practice.

There are efficiencies, relating to the back office but you will see on there, integrated care manager. This is a health care professional who is employed between the practices in a federation to deliver holistic health assessments as part of that coordinated care pathway, we recognise these individual practices, particularly the smaller practices didn't have the resources to offer up the same opportunities to patients. Been able to connect up and communicate with each other with each other using information and technology, so our patient records system is now shared and that is allowed for different ways of working together.

We have been able to look at creating better resilience, that of course has been about deliver better quality, we have a cohort of improvement leaders that have been able to roll out the ten high impact actions as part of the GP forward view, I think we have seen resilience born out of partnership. Recognition, that general practice is leading the way with some pretty strong acute Trusts, Guys and St. Thomas in delivering new models of care is vital.

The challenges there for everyone, they have already been eluded to, Robert mentioned them at the beginning. Fundamentally, trying to sustain the change is challenging and sustaining the change when the pressures of today are great and we have got to have the maintained focus on tomorrow.

I hope that is a helpful brief introduction, happy to join in the conversation afterwards.

Robert:

Thank you, I will ask Dr Vish Ratnasuiya to talk about their work -- excuse us while we very quickly rearrange the slides.

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Vish , over to you.

Vish:

Thanks Robert, I am Vish Ratnasuriya and I'm a GP, and I've been asked to tell you about what the future looks like, had a subliminal view so hopefully that looked familiar, so our partnership is a single merged partnership or super-partnership of 340,000 patients, served by 186 partners and 920 staff across 45 sites, a single partnership but crucially not a single way of operating at practice level, so we can be locally responsive to our population and our patients' needs.

When we thought about large scale change, to give us GP's providers a voice and ... gain efficiencies bust most of all to improve quality for our patients and our practices, we realised that we needed a different model. A model that valued localism, but allowed us to act corporately, under strong leadership and governance to achieve the aims. How? We needed to create a bespoke deed, practices were profit centres, contracts to help locally. This enshrines coal face autonomy, it means responsibility and therefore quality.

We are a ground up organisation. We had no seed funding, I believe we are sustainable. We are growing both within the Birmingham and Solihull footprint as well as Shropshire. We are active in the urban, suburban and rural environments. Whilst the business plan is describes our many streams of transformation, I will focus on these few areas.

Efficiencies, these are the basics of working at scale. We have a single bank account system, where individual practices retain their income and expenditure, a single payroll and a single finance system that allows us to interegate a wealth of information. Live in-house accounting, the previous GP experience between buying them in, done in retrospect, varying quality and methodology, procurement, reducing

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costs to each line by 10 to 15%, this includes indemnity and partnership. Across the board, improving quality and reducing cost.

Work force. We have created in house GP bank, in response to the £1.3 million locum spend premerger, now patients get an improved quality of care and practices get better help with their adhoc needs. We are developing a staff bank and we have various different recruitment and retention schemes, critically designed in response to listening to colleagues at the beginning, middle and end of their career, this results in new ways of working.

We have created a virtual support team, expert GP's, nurses and managers who can help us in times of need, help us with quality issues, providing a menu of solutions, all while reducing risk and improving quality at an industrial scale with MPS.

So, we spent a couple of years building OHP as a platform, we are much greater than the sum of our parts, we have done this in a considered way so that any patient facing change is sustainable.

If when we are critiquing general practice in scale you might say what about the gaps? What about the practices in between? We try to address this, alongside -- oh, I skipped a bit there, alongside 300,000 patient’s worth of OHP practices, we are now working alongside neighbours and colleagues, set the landscape to work in 6 localities, so our redesign based on the coal face. I will skip past one slide, I will go back to that.

Quality, this is really important. Got a single GP CQC registration, The board is inspected, practices provide assurance feeds to the Board. Its managed by a governance team and practices are no longer inspected as an individual site, crucially retaining local accountability, and that is what patients look for and want.

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So back to our localities.

Our redesign is going to be led from the coal face, alongside patients and colleagues from across secondary care and across the system. All working towards the single seamless NHS and care as close to home as possible. We are looking to replicate it in Shropshire.

Access and urgent care, this needs to be part of any future system. From the outset, OHPs wanted to provide 24/7 general practice, we started with whole scale opting in out of hours and we are just starting to work in co-design urgent care with our local acute systems, provider to provider. Importantly starting with the data and what patients need and what their behaviours show us, so watch this space. So that is us, our health partnership, a ground up organisation, it shows the best of general practice, whilst being able to act more corporately, we have enshrined coalface autonomy and leadership, in the face of the local surgery that patients value while GP's sit at the STP alongside Trusts, doing the right thing for patients' practices and the system.

Robert:

Thanks for that colleagues, thank you for the questions you have been posing to us during the session, Just a reminder that GLISSER will be operating throughout the conference as a way of interacting, we like to pick up some of the questions you have been asking us in conversation now with the Panel, I suppose there are 3 big questions I think come up all the way through which I think partly been addressed, I will see what you guys would like to say more about them specifically. The first question has been from people saying what does the future look like of primary care, interesting to ask you in a moment, like each of you to describe what you think it is going to be like for a patient say in 5 years' time when they are accessing primary care, what is different.

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The second question thing is, along the lines, seriously? Is it real? Is it happening? I think to some extent what we have already heard has said yes, and it is in pockets it is in varying work streams I think the rest of the conference is going to give a lot more intricate detail about how that looks and then I think the third question is, a lot of people saying how do we sustain this? How do we spread it? Again, I will kind of close maybe with sort of a question to each of you, what we think we should do more to make that reality.

The first question, so from the patient's perspective, what is going to be different in a few years' time for the patient accessing primary care?

I wonder Arvind, if you can give us a vignette of what you think of the key differences will be.

Arvind:

I think we need to be conscious that most of the time people are well. They stop their lives to receive healthcare. We want to make that disruption as minimal as possible to some degree. We are a diversion off their main road. In that diversion, I think there's the opportunity to actually, in alongside the technology they might use as part of their day to day existence like their fit bits and other wearables and apps, etcetera, that go beyond true healthcare and into, sort of, nutrition, diet, exercise and life style, how might we start to think about, when they do feel unwell, wrap around the kind of opportunities that, you know, 50 million hits to NHS Choices every month.

How do we start to take that kind of appetite for understanding the use of technology in that pathway? How do we start to build on the care navigation training that's happening around the country now, and in which we are investing £45 million over the next three years so our reception teams are better placed to guide people and

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signpost them to other services, around social prescribing, around community pharmacy, around minor ailment schemes, around how the third sector can support us, how we rewire that element of the pathway? How we wrap around the wide range of disciplines that we have within what I think will be a growing primary healthcare team and how we currently think of the practice nurse as part of the team and are starting to think of the clinical pharmacist as part of the team, who else, what else can we be offering?

How can we filter the demands of patients and the needs of patients in a way that actually not only have a great experience of care for them in the most convenient way possible, but helps practices become more efficient, whether that is telephone or online triaging? Where we want to get to is have the right patient in front of the right clinician at the right time and ideally with more time than they are currently getting with the 10 minute traditional consultation.

How do we connect those practices with other practices so we can wrap care around the whole week?

How do we wire in specialist remote support so patients aren't necessarily put on an outpatient pathway, where we can source advice rapidly for them from within the practice with specialists from the local trusts and the wider community services?

Robert:

There is transformational change here. A lot of people are asking questions about how engaged people are, how do you persuade people. There's a lot of stuff about leadership at this conference. Vish, you're at the heart of a group of GP practices who are doing this. How do you persuade them to go on this journey with you so far?

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Vish:

I think we started by listening to colleagues and valuing their opinion. Seeing how using that we could find a way forward. We were very considered and iterative in the way we did things. We consulted practices. We lead through arguments, persuasion, not diktat. We inverted the pyramid in some ways. We provide as much autonomy as we can at the coal face.

Robert:

A lot of questions are coming up whether this is redundant now we are talking about accountable care organisations, accountable care systems, population focus and STPs. Does General Practices not fit or, it seems like Southwark being at the heart of this?

Jonty:

From my perspective, general practice is a key building block to any, we know that general practice is fundamental to us delivering better value. Better value by which I mean better outcomes for patients at lower or the same cost.

So, if general practice is the part of the system that's going to help us deliver that, it doesn't matter whether we are talking about new models of care, MCPs, networks, hubs, fundamentally general practice has to be central to what the new vision is of accountable care.

Accountable care is about people taking shared responsibility for resource around a particular population. General practitioners know how to do that. If they do that hand in hand with the local population, then I'm convinced we're going to start to see better value.

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Robert:

We are going to allow ourselves 20 seconds. Final word to Jeremy from National Voices. Could you say what the offer is, could be, from patients in the public themselves to be part of this journey? How could it look like for us to be doing that in partnership together?

Jeremy:

There's an American patient activist who has written a book called "Let Patients Help." People have huge resources to help themselves, to help others and to help the system. I think the NHS is at the foothills of a climb up towards the peaks of real coproduction, and has barely started the journey.

The offer is there at all levels in the system, from national organisations like ours to tiny voluntary groups, to patient participation groups. The resource is there. I think there will never be enough doctors and nurses and healthcare professionals to sort out all the healthcare problems if we see it primarily as an enterprise that's done to people.

We know that is true morally, we know there's increasing evidence space that supports that contention. So, if it is about mobilising all the resources, then take the offers of help that are already there, but also get out and try to get more help. So, I think there's no limit to that, actually.

Robert: What a great place to finish. Thank you very much indeed.

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