prostatectomy, with an unrecordable PSA reading, 3 years after external beam radiotherapy with no metabolic relapse, or brachytherapy with no metabolic relapse. Recurrence is monitored by PSA measurements. After being discharged their details, including PSA measurements, are entered into a password-protected database by a specialist nurse, who acts as the patients' keyworker. This database can generate alerts if the PSA is elevated so that patients can be brought back to the clinic by the specialist nurse who can also respond to symptoms or signs of recurrence, adverse effects of treatment or a patient's request. We have over 500 patients on this programme.

When we investigated GPs' views of this programme we detected low confidence levels in managing relapsing/hormone resistant breast and prostate cancer, and in the management of side effects. Half of the GPs were not fully informed about the survivorship programme, which is designed to remove this burden of care from general practice, and many had misconceptions about the programme: 25% thought it was a programme to empower patients who are cured, and 15% thought it simply offered a holistic approach. The purpose of this programme is, of course, to keep patients under surveillance in the community while under the clinical governance umbrella of secondary care.

We aim to promote this programme among the general practice community and to involve patients with active disease being treated in the community.

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A strategic plan

Who is to lead the large strategic changes to general practice that are required to deliver 21st century health services that can respond to the increasing health needs of the population?

In his editorial Chris Drinkwater proposes that we should re-think the provision of primary care in the light of the needs of our 21st century population. Certainly a strategic plan is required. General practice has been allowed to 'evolve' without any clear vision over the last 50 years. It has migrated from being a service that mainly responded to the presenting needs of patients to one driven by QOF. Now a third strand is emerging around co-productive care planning for long-term conditions and older people.

Over the same period other community services have hardly changed, links with primary care teams have been undermined as they have oscillated from one corporate managerial home to another, and organisational and professional interests have undermined the systematic integration of services.

Bearing in mind that GPs have moved from having one job (reactive care for a registered list) to two jobs (reactive and now proactive care with QOF targets) and are likely to be vested with a third (care planning) it is no wonder that GPs feel overwhelmed. Over the same period there have been additional demands as a consequence of clinical workload that has 'moved from secondary to primary care', and additional organisational workload including supporting CCGs.

There is adequate evidence to make the systematic implementation of targeted, multidisciplinary care planning for long-term conditions desirable. Surely this must be led by general practice, with its long-term knowledge and relationship with patients, practice lists and disease registers. However if this new service model is to be established, we will need horizontal integration of general practice with community services, including social care. This will require investment, and the rationalisation of reactive care, including out of hours, at local level using whole systems approaches.

So who is to lead these changes? Drinkwater suggests a 'Chief GP'. I believe that it is unlikely that the substantial changes required can be led from within the bureaucracy of government. Even if they could, the credibility and acceptability of 'managerially' led change is now long past. Surely now is the time for the RCGP and

the BMA to take concerted action to effect change as they did in the 50s and 60s. Now, as then, there is a need for action driven by energetic colleagues from the front line, who are supported by professional bodies with a wide understanding of the issues. However this time we must also engage and enlist the voice of the patients who we serve. They are our strongest allies. The co-production of the new service model jointly with our patients will ensure that we remain focused and not blown off course by political or professional vested interests.

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