Speech: Primary care is crucial to preventing ill health

Prevention is better than cure – this is such an old saying that we take it as a given. It's become a cliché.

But as a new Health Secretary speaking at the NAPC Conference for the first time, I thought I'd better make sure I know where it comes from.

Google suggested Benjamin Franklin, who said "an ounce of prevention is better than a pound of cure", but it was actually the 16th century Dutch philosopher Erasmus who coined the insight, which has shaped our approach to medicine for nearly 5 centuries.

The irony to this is that Erasmus died suddenly from an attack of dysentery, which we now know is wholly avoidable with the right prevention.

Today, I want to talk about 3 things:

- first, how GPs are at the heart of primary care
- second, how primary care fits within the whole NHS
- and third, how primary care is a crucial part of our wider prevention agenda

Let's start with GPs.

GPs are the bedrock of the NHS. They are the first port of call.

So, first: let's talk GP numbers. Today, there are 41,360 GPs working in England.

Too many GPs are retiring early or opting to work part-time, which makes the challenge of increasing the number of GPs even greater.

We have set a goal of getting 5,000 more doctors into general practice. And we must reach it.

We have record numbers of GPs in training. This year we recruited 3,473 trainees against a target of 3,250. That is a 10% increase on last year.

And we have removed the cap on GP visas so more can come to this country. This is real progress as we try to get the numbers up.

And we need a cultural shift too so that we value GPs more. Being a general practitioner should have the same prestige as being a consultant or a

surgeon. Because GPs are the bedrock of the NHS.

I think you're doing an excellent job, despite all these pressures. The CQC rated 96% of GPs as giving a good or outstanding level of service.

So we must keep supporting and encouraging more people into the profession.

But increasing the numbers of GPs isn't, on its own, enough to meet the growing health challenges we face as a nation.

GPs are part of a team, and through them manage the health of our country. So, GPs working in, and leading, mixed teams of nurses, pharmacists, physios and other healthcare staff is the way forward.

We are on track to increase the number of other clinical staff working in primary care by 5,000 by 2020 to 2021 – and have recruited more than 3,000 since 2015.

We are helping other primary care workers, like dentists and pharmacists, to expand their services so we can make best use of their skills and lighten the load on GPs.

Just to give you one example: community pharmacies.

We have seen our flu vaccination programme reach more than a million (1.3m) people over the past 3 years with people able to get vaccinated quickly and close to home.

Last year, an estimated 12,500 high-risk asthma patients were identified and referred for review by pharmacists. I want to see more of these kinds of partnerships to prevent ill health in pre-primary care.

So yes, there is more we can do. This vision of an expanded and revitalised workforce, less pressured, more supported and rising to these challenges – this is what I foresee.

These are all important considerations for Dr Nigel Watson, as he continues his review of the GP partnership model over the coming months.

The partnership review will be a critical moment as we look towards what is the future of our primary care.

Not just an expanded workforce, but with the support that makes GPs lives easier too.

How much time do you spend doing paperwork? How frustrating is it not to be able to see someone's full medical history – even when they're your patient? Why are the systems so slow and access to scans and other test results so hard?

All these things can be fixed, and I'm determined that we fix them, so we have a fully integrated and interoperable system, easier to use and removing the burden of bureaucracy.

I want to remove as much of the bureaucracy as possible and lift the burden of liability.

I'm committed to delivering a state-backed GP indemnity scheme from April – subject to negotiations on the primary care contract and engagement with stakeholders. I want to reduce indemnity costs as a barrier to doctors entering or staying in general practice. We are writing to GP representatives today with an update on progress and seeking further views.

And we need to go further in freeing up GP time too. The recent QOF (Quality and Outcomes Framework) review suggested how we can get rid of pointless box-ticking indicators exercises so those working in primary care can focus more on what's important to patients. We must improve and simplify QOF.

We must also simplify and standardise the appraisal system. The partnership review is currently exploring how we can support people working in primary care to build their skills and experience, particularly in the early years of their career, and how we can nurture the leaders and the partners of the future.

Primary care is renowned for its ability to innovate. And I support this innovation. This should include practice structure too. Why shouldn't primary care practices be able to set themselves up as John Lewis Partnership style mutuals?

I'm not wedded to any one model, but I am attracted to a model that benefits primary care staff and patients.

I have seen primary care practices that have blossomed under the primary care home model, like Granta in Cambridgeshire, and other new, more integrated care models emerge.

Like Wolverhampton or West Suffolk, where general practice has developed shared data systems with the local acute hospitals.

Like east London, where they have developed shared real-time data systems covering a population of 1.5 million, across 7 healthcare organisations and over 180 GP practices.

Different places. Different models. But the net result is the same – better ways of working and better services for patients.

We need to embrace this diversity of approach because while we may work in different ways, we have to think of primary care as a whole. And we need to think of it as an integrated and integral part of the health system as a whole.

Which is the second thing I want to talk about today and talk about it as we're writing the long-term plan for the NHS.

Too often, we separate into silos: community care, primary care, community mental health, and then in turn separate these off from secondary and acute care.

This model is wrong. It creates barriers. And it must change.

We all know our primary care system is under strain. As the population is getting older. People's expectations are getting greater.

And with these new pressures, there are also new possibilities that are creating more demand. Personalised care. Personalised treatments.

That's why we need to support you, primary and community care teams, to address the challenges you are facing alongside the people you support and care for in as integrated a way as possible.

I've set out my 3 early priorities for the NHS: prevention, technology and supporting the workforce.

Primary care is central to all 3. The future of the NHS rests on getting primary care right, and on shifting our focus so that we keep people out of secondary care.

We must shift our focus to keeping people out of hospital.

As a government, we have made the NHS our number one spending priority. And to guarantee the NHS for the long term, we've proposed £20 billion more per year over the next 5 years.

Currently, of the £114 billion NHS budget, we know that a large proportion goes to acute care. Yet we know that, of the determinants of healthy lifespan, just 20% relates to acute care.

Last year we spent just £16.4 billion on primary care and public health.

For past generations it made sense to focus on things like heart disease and stroke. As a result of these efforts, heart disease is down, strokes are down. We're doing better than ever before.

Yet, the challenges now are around multi-morbidities. So the focus of the system has to move from treating single acute illnesses to care for multiple chronic conditions and promoting the health of the whole individual.

Obesity. Diabetes. Mental illness. Dementia.

These are the pressures of the future. And the only way to address them is by public health and personal health, pre-primary and primary care together.

By preventing people from becoming patients in the first place, supporting our communities to live longer, healthier lives, and to recover sooner when they do need our care and help.

We must adapt and address the health of the population across all ages. These are the challenges of the future and that is what primary care does best.

So as we put £20 billion extra with the NHS, we must change that balance of spending and shift our focus to keeping people well, living in the community,

and out of hospital for longer.

But our support for primary care has got to go beyond budgets. Which brings me to my third point – why primary care has a crucial role to play in the prevention agenda as a whole.

We know that alongside the 20% from acute care, 20% of a healthy lifespan is determined by genetics, 30% is the environment, and 30% is what people can do themselves – the choices they make.

We have to help people make healthier choices and prevent problems developing in the first place.

That's why it is so important we continue to look at the wider environment in which we live and work.

By supporting people into, and staying in, employment. By investing in high-quality housing that is suitable for current and future generations, at every stage of life.

And we must learn from the best, both nationally and around the world.

We need to look at places where people have got this shift of resources right, and managed to rebalance the system between primary and community care on the one hand and secondary care on the other. Like Buurtzorg in the Netherlands.

Under this Dutch model, nurses work in small self-governing teams to provide a range of care and support. They lead the assessment, planning and co-ordination of patient care. And, they're trained to have a flexible skill set, which allows them to deliver a range of treatments including wound care, diabetes monitoring, IV infusion and end-of-life care – and also to navigate the system.

The nurses effectively self-manage. This enables them to gain managerial experience while delivering clinical care. People have talked for years about wrap-around care. With Buurtzorg that is happening.

Compared with other models, the Dutch model delivers higher-quality care at a lower cost. I want to see it grow.

This open-minded approach to new ways of working must also extend to technology.

Now, you may have heard about my thirst for new technology. Some of you may have even downloaded my app – I hope you haven't received too many notifications.

And while I'm a firm believer in the power of technology to help people fulfil their potential. I firmly believe that technology will never replace the need for human care, for the skilled, empathetic people we find in our health and care professions.

And I believe the technology has to work for you: the clinicians, the professionals.

So, our vision for primary care is this:

GPs as the bedrock of the NHS. Part of broader primary care networks. Better integrated and supported within our health system.

All with the goal of treating ill health closer to communities and preventing ill health in the first place, so that the nation we serve can live longer, healthier lives.