

Jeremy Hunt sets out the first steps in a new deal for GPs.

When the NHS was set up nearly 70 years ago Bevan recognised that General Practice was special. Despite much opposition he put your independent contractor status at the heart of the NHS, as leaders of the NHS.

And with good reason. Internationally, our primary care system has long been respected and envied. Much of the primary care delivered all over the world today is made in Britain: blood pressure measurement, lung function measurements for asthma, the identification of hay fever or the role of vitamins in nutrition. Today we rank in the top third of countries for primary care doctors per patient.

Even more importantly we get top scores for quality as well. The Commonwealth Fund ranks all major countries on their health systems and it's well known that the UK came top overall last year. Less well-known is that when you dig deeper the areas where the UK amassed many of its marks were on the quality of general practice.

We rank:

- best in the world for having a regular doctor who co-ordinates care
- best in the world for patients knowing who to contact with questions about their condition or treatment
- best in the world for the management of chronic care

In other words a respected, independent US thinktank has made it official: general practice is the jewel in the crown of our NHS.

A jewel we are proud of.

But more importantly a jewel we need to shine brightly because, as I will argue today, the strategic importance of general practice to the NHS cannot be overstated.

Within 5 years we will be looking after a million more over 70s. The number of people with 3 or more long term conditions is set to increase by 50% to nearly 3 million by 2018. By 2020 nearly 100,000 more people will need to be cared for at home.

Put simply, if we do not find better, smarter ways to help our growing elderly population remain healthy and independent our hospitals will be overwhelmed - which is why we need effective, strong and expanding general practice more than ever before in the history of the NHS.

The jewel in the crown?

But the jewel in the crown of the NHS is feeling decidedly unresplendent right now.

The uncomfortable truth is that even though 90% of all NHS contact takes place via GP consultations, successive governments have undervalued, underinvested and undermined the vital role it has to play. Reforms, always well-intentioned at the time, have often had perverse and unintended consequences.

The 1990 contract imposition introduced more accountability but also started a process that felt to many like de-professionalisation. The 2004 GP contract was meant to increase the focus on prevention, but undermined the personal relationship with patients by scrapping named GPs. The Quality Outcomes Framework (QOF) was meant to provide a better focus on outcomes, but has too often ended up as a tick-box process. All of which suggests Ronald Reagan had a point when he said, "Governments tend not to solve problems, only to re-arrange them."

The result has been a profession where many GPs feel overwhelmed by demand and undervalued by the system, unable to give the comprehensive care they want to, and trapped on a daily hamster wheel of 10 minute appointments that lead inexorably to

burnout, early retirement and unfilled vacancies.

That is why a month after the general election I am keeping my pledge to announce the first steps in a new deal for general practice.

Now deals have 2 parties, so I want to be upfront: this is not about change I can deliver on my own. If we are to have a new deal I will need your co-operation and support - both in improving the quality and continuity of care for vulnerable patients and delivering better access, 7 days a week, for everyone.

A new deal on workforce

How we achieve this is complex, and I do not pretend to have all the answers today. But I want to waste no time in making a start with some important elements.

Firstly and most urgently we need to deal with concerns about the primary care workforce.

Since 2010 the GP workforce has increased by 5% with an additional 1,700 GPs working or in training. But at the same time, because of an ageing population and changing consumer expectations, we have seen a massive increase in demand for GP appointments. As a result, we are delivering an estimated 45 million more appointments every year compared to 5 years ago, but even this has not kept pace with demand. The number of people unable to get an appointment has been rising and public satisfaction with access to GPs is falling. People are simply finding it too hard to see their GP and GPs are finding it harder to give the kind of personal care that is the hallmark of their profession.

So at the election we committed to the challenging objective of increasing the primary and community care workforce by at least 10,000, including an estimated 5,000 more doctors working in general practice, as well as more practice nurses, district nurses, physicians' associates and pharmacists. This will be informed by the important work Professor Martin Roland is doing on workforce mix for Health Education England.

The national picture is not uniform, with wide variations from surgery to surgery in the number of GPs available per thousand of population. Even in my own parliamentary constituency, the availability varies between 0.32 and 1.32 GPs per thousand patients of population even with surgeries only a few miles apart.

We therefore need to focus our recruitment on the most under-doctored areas where the problems are most acute.

So today NHS England is publishing data about clinical staffing levels for every practice in the country. This is not a table of staffing needs, which will vary according to demographic and socio-economic profile. But it does indicate that even in areas with similar profiles the variation is unacceptably large.

Tackling this problem will be challenging, but I intend to leave no stone unturned. Quite simply, at every stage of a doctor's career we must do more to promote the attractiveness of general practice.

First we need to transform the experience which medical students have of general practice. We are changing the focus of medical training so that time spent in primary care is not only compulsory but also a better experience. As part of this, a new pre-GP scheme has been launched by Health Education England which, in its first year, had a success rate of 82%.

Secondly, we need to increase and fill our GP training places. They are going up from 2,600 to 3,250 annually and we are working with the Royal College of General Practitioners (RCGP) on a national marketing campaign to encourage medical students to choose general practice. This points out that general practice is likely to be the biggest growth area of the NHS in coming years with some of the most exciting transformations in care. This campaign started this year with an encouraging 300 more applicants

attracted into recruitment as a result.

Next, by working with the profession we will improve routes back to general practice for experienced doctors. An induction and 'returner' scheme for those returning to the profession from overseas or from a career break has been refreshed and now includes support with the cost of returning to general practice. Over 50 GPs have already taken up this offer.

We will also explore with the BMA and RCGP new flexibilities to retain those precious GPs who are nearing retirement but may want to work part-time as they too have a critical role to play.

Innovation in the workforce skill mix will be vital too in order to make sure GPs are supported in their work by other practitioners. I have already announced pilots for new physicians' associates, but today I can announce those pilots are planned to ensure 1,000 physicians' associates will be available to work in general practice by September 2020. Finally, as well as getting more new GPs, we need to make sure they go to parts of the country where they are most needed. Building on the success of a Health Education England pilot in the West Midlands, we will incentivise a number of newly qualified GPs with an extra year of training and support to develop specific skills needed in areas such as paediatrics, mental health and emergency medicine.

A new deal on infrastructure

Getting the workforce right is critical. But so too is dealing with the challenge of the buildings they work in.

Many of our primary care facilities are simply not fit for purpose. If we are to respond to ever changing and ever increasing demand, we need significant improvements in the quality of our physical infrastructure.

So last year we announced the £1 billion Primary Care Infrastructure Fund, spread over 4 years. Over 1,000 GP practices have now had bids provisionally approved for £190 million of investment in premises this year, backing exciting plans to expand services, house integrated services with community and pharmacy providers, and invest in digital innovation.

These include plans - for example - to allow 2 practices in Waltham Forest to co-locate into a new purpose-built surgery, offering a more comprehensive range of services to patients, including an elderly care facility and a falls clinic. Six practices in Solihull are building additional consulting rooms to increased access to primary care services for patients. While in Crawley, the Pavilions building is being redeveloped so the practice can provide a wider range of services and increased capacity for GP training.

Over the next 3 years we will allocate the rest of this fund to invest in further schemes so that over the course of the parliament cities and towns across the country will see visible signs of improvement in primary care facilities.

This investment will also support digital innovation, where GPs have led the way. Online patient access to summary medical records through primary care rose from 3% to a remarkable 98% over the last year. But we need digital, real time, interoperable electronic health records for the whole NHS, so we will help practices link their patient records to NHS secondary and community care providers and the social care sector.

A new deal on access with a 7 day NHS

While we need to improve workforce supply and infrastructure, we will not solve the problems we face by simply doing more of the same.

In particular, we need to address the issue of 7 day care.

The role and purpose of 7 day primary care is about much more than convenience - it is

about making sure precious hospital capacity is kept clear for those who really need it. We have clear evidence from Imperial College London that a lack of access to GPs at weekends results in increases in urgent hospital admissions. As Professor Sir Bruce Keogh develops his new model for urgent and emergency care, we need to make sure general practice plays its part in improving access to routine appointments.

But new models of care should never be one size fits all, and while we must always respect the integrity and accountability through registered lists, different approaches will be appropriate in different parts of the country. Sam Everington says that 20 years ago his stethoscope was his most important device, now it's his iPad. With local flexibility, local knowledge and local clinical ownership comes the prospect of change that is as exciting for the profession as it is for patients - and we want GP partners to continue to be the leaders and innovators in this process.

We can learn from other countries that have made progress in this area, such as the 7 day networks that operate in New Zealand or Alberta, Canada. But important progress is being made here too through the Prime Minister's Challenge Fund. Through it, 18 million people will benefit from improved access, including at evenings and weekends, by March 2016.

This is about a flexible and balanced approach - not that every single surgery will be open in the evenings or at weekends. But at the Watford Care Alliance network of practices patients are offered evening or weekend appointments at their own or a nearby surgery, and for those who can't make it into a surgery an appointment by phone or online, where they see a GP who has full access to their medical record. Dr Mark Semler says, "The Challenge Fund initiatives have demonstrated that - properly implemented - technology has the power and potential to transform the way we do things in primary care. Telemedicine consultations are a powerful tool to assess patients at distance and save GPs large amounts of time."

Other practices are helping to deliver 7 day care by better use of pharmacies. In Brighton 16 GP practices are working with local pharmacies to create 4 'primary care clusters', offering evening and weekend appointments with a GP or pharmacist and giving the pharmacist equal access to GP records. Dr Jonathan Serjeant from Brighton said the pilot has been a "fantastic opportunity for practices to learn to work together...reaching out into their community to work with pharmacists to design, and provide care for people" and "help us understand how to offer more for people in more locations with a different skill mix."

So as we roll out the Prime Minister's Challenge Fund to the whole country, I can today announce that £7.5 million of the primary care infrastructure fund for this year will be used to support community pharmacists with training and appropriate tools.

These new ways of working offer great potential. But what won't work is a return to top-down direction from the Department of Health. Innovation cannot be imposed, it can only be embraced. So please play your part by getting into the driving seat as we move towards more multi-disciplinary working, imaginative use of technology, better coordination with other parts of the NHS and re-imagining roles through federations or responsibility for new integrated community services.

A new deal on assessing the quality of care provided

Additional workforce, £1 billion for infrastructure, support for new models of care - but there is another area where we need a new deal, and that's how we assess quality of care for patients provided in general practice.

Each of us here today, as professionals and as patients, want to see continuous improvement in the quality of care across the NHS. A cornerstone of that improvement

must be having the right information to assess quality, conduct meaningful peer-review and support a true learning culture.

One of the founders of quality improvement techniques in health care, W Edwards Deming, said, "In God we trust, but all others must bring data." There has already been a lot of good work by different groups on developing better data and metrics to assess quality in general practice.

But I have asked the Health Foundation to work with NHS England to do a stocktake of all current metrics, involving a range of stakeholders including NHS England, the CQC, the RCGP, BMA and representatives of patients and the public. This stocktake will review where we are now, and how we can collect and publish better outcomes-driven assessments of the quality of care for different patient groups. This will support the important progress made by Professor Steve Field in establishing the new CQC inspection regime but also address the concerns expressed by many about the shortcomings of some of the data being published.

The Health Foundation will provide an initial assessment for me in the autumn with the first new datasets based around key patient groups published next spring.

Intelligent transparency, though, must have intelligent consequences. One of those is a change in culture - from name and shame to learning and peer review, as championed by Professor Don Berwick in his work on improving safety in the NHS.

Another consequence needs to be much better support for practices identified as in difficulty. So I have today also asked NHS England to work with NHS Clinical Commissioners to develop a £10 million programme of support for struggling practices. This will include advice and turnaround support for the practice itself and help for the practice to work with others to change its business model.

Bureaucracy and burnout

The final area where we need a new deal is not about money or premises or workforce or assessments... but about you. I cannot change the growing numbers of older people who need your help. Nor can I change consumer expectations of healthcare provision that are much higher than 50 years ago. But I can do something about the bureaucracy, paperwork and inappropriate workload that takes up too much of your time and takes you away from patients.

I have already cut the Quality and Outcomes Framework by more than a third and have reduced the reporting requirements linked to enhanced services. But there is more to be done.

So I have asked NHS England to examine how we can reduce bureaucratic burdens on general practice to release more clinical time for patients. NHS England has already surveyed over 200 practice managers and GPs and will be running workshops to determine how to reduce the reporting burden, and will develop practical tools to help GPs better manage the mountain of bureaucracy and paperwork that leads to so much frustration and burnout. I have asked to see the results of that work this autumn.

Your side of the bargain

So plenty of commitments from me. But now perhaps the more tricky part: your side of the bargain.

I am prepared to commit money to this plan - more GPs, more community nurses, more money for infrastructure, help to reduce burnout. The vision for out of hospital care set out in the 'Five Year Forward View' requires more investment in primary care so this is the biggest opportunity for new investment in General Practice in a generation.

But in return I will need your help to deliver a profound change the quality of care we

offer patients.

Around a fifth of GPs' time is spent dealing with patients' social problems including debt, social isolation, housing, work, relationships and unemployment - yet 50% of GPs have no contact whatsoever with local social care providers.

So we need to empower general practice by breaking down the barriers with other sectors, whether social care, community care or mental health providers, so that social prescribing becomes as normal a part of your job as medical prescribing is today.

We need to empower general practice to deliver an even bigger role in public health. The NHS England 'Five Year Forward View' talks about prevention not cure - and if we are going to change lifestyle choices to improve health outcomes family doctors have a critical role to play.

And we need to empower general practice to take real clinical responsibility for your patients. The guidance being produced by the Academy of Medical Royal Colleges this year will help us understand what this really entails - but for patients it is really very simple: knowing where the buck stops for their NHS care.

Everybody needs to know where the buck stops for their care - and most people would like that to be their family doctor. I want to empower you so that aspiration - treasured by doctors as much as by patients - finally becomes a reality.