The Royal College of General Practitioners (RCGP) welcomes the opportunity to submit evidence to the Department of Health and Social Care consultation on Advancing our health: prevention in the 2020s.

RCGP is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 53,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. The College is an independent professional body with expertise in patient-centred generalist clinical care.

Executive Summary

3. The RCGP is supportive of the ambitions in the prevention green paper, which covers a number of different areas where progress can be made, given the right conditions. However, we have identified three areas that the prevention green paper fails to adequately address and will need to be considered more closely if implementation is to be successful. The strategy must include more detail relating to investment, accountability and integration, and workforce, training and research before the more specific enquiries in the green paper can be answered. These will be vital to success of the prevention agenda and the reduction of health inequalities across the country.

4. The prevention agenda by its very nature requires stable, long term commitment. Resources must be allocated over multiple financial years and protected to provide structure and certainty to prevention planning. This includes commissioning services, but also investing in the workforce and in good independent research. Central and local government must be held accountable for their progress on delivering on this agenda, to address the social determinants of health and providing a core programme of public health initiatives to contribute to the prevention agenda.
Investment in prevention

5. The RCGP is deeply concerned by the significant cuts to public health that have taken place since it was transferred to local authorities as a part of the 2012 Health and Social Care Act. The effect of this cut is that the grant is now £850 million lower in real terms than it was in 2015. This is the equivalent of a 25% cut to the public health spend per head since 2015. Estimates from the Health Foundation show that it would take investment of £1 billion to bring spending back to 2015 levels on a per-head basis.¹

6. Furthermore, the RCGP notes that while patients continue to live longer, they do not necessarily do so in good health, and that in many cases, inequalities in health outcomes are rising. This has created additional workload in general practice, notably in areas that already experience deprivation and are often more likely to experience workforce and provision gaps, and face practice closures.

7. The RCGP welcomes the Secretary of State’s focus on prevention as a central aspect of health policy, and we believe that making the NHS sustainable for the future will involve enabling and supporting patients to make healthier choices, reducing levels of demand on the service and levels of chronic ill-health. We recognise that general practice has a significant role to play in this, given the right resources.

8. We believe that the Government should be bold in continuing well evidenced measures such as the Soft Drinks Industry Levy, which have proven effective in supporting health improvement and tackling childhood obesity. Money raised from these interventions should be specifically reinvested in the public health budget to further improve the health of the nation over the long term. This could include investing the fitness facilities to make them available to citizens for free, or at least subsidised.

9. Government must consider ways to protect the public health budget, both now and in the future, to ensure that long-term aims are not sacrificed for short term gains. Overall budget cuts, particularly in local authorities, have meant that funding for public health is used to support other services – such as social services, citizens’ advice bureau, or trading standards. Reversing this hollowing out of public health budgets would go a long way to laying the ground work to making the prevention agenda a success.

Accountability and Integration

10. The RCGP welcomes the notion of health in all policies. However, for the prevention agenda to move forward in the manner envisioned in this green paper, there must be increased accountability for public health outcomes at a both a national and local level. National accountability of all government departments would highlight the importance of the prevention agenda and encourage policy makers to value it more, helping to maintain a stronger focus on improving the health of the nation in the long term.

11. There must also be increased accountability for public health at a local level. As mentioned earlier, budget cuts to local authorities have meant that public health money has been used to support other areas. This has resulted in a reduction of some services, such as in sexual and reproductive health, which has increased demand in primary care. The RCGP has previously called for responsibility for public health and the public health budget to be brought under the remit of NHS England, however recent announcements from DHSC have indicated that responsibility for public health will remain with local authorities. It is vital that this is teamed with stronger accountability, with a single agency responsible for the development, delivery and evaluation of public health services across England.

12. Primary care is commissioned by a different organisation with a different budget. This means that local authorities do not shoulder the direct costs of cutting public health services in their area. Since local authorities do not benefit financially to taking a preventative approach to healthcare, it creates a perverse incentive to cut preventative services. Stronger national requirements to commission services relating to public health and prevention, along with better enforcement powers, would guarantee that local authorities were more accountable in this vital aspect of the prevention agenda.

13. The RCGP recognises there is a significant role for GPs in supporting the delivery of some aspects of the prevention agenda by virtue of the high levels of public trust they enjoy. The traditional strength of general practice lies in the strong trusting relationship between GPs and their communities. Primary Care Networks, as they mature, will offer more opportunities to focus on health of their population as a whole. However, it is important that PCNs are not seen as a panacea for all aspects of population health management in order to make up for disjointed action elsewhere in the system.

14. Local authorities must be required to ensure that preventative services are properly integrated with local healthcare systems. The college would like to see public health, local authorities, and health and social care being supported to co-commissioning services underpinned by long-term joint funding streams. This will build shared goals, avoid duplication, and help to meaningfully address issues that affect citizens’ health and wellbeing.

15. Strategies and services should be co-produced with local populations, primary care networks and other local service providers to give implementation the best chance of success. Local providers should be encouraged to develop joint online collaborative portals for health, social care, public health and local authority as a “one stop shop” for services in one place.

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2 RCGP. Sexual and Reproductive Health: Time to Act, 2018 Report (accessed 14 October 2019)
3 RCGP. Sexual and Reproductive Health: Time to Act, 2018 Report (accessed 14 October 2019)
Workforce, Training and Research

16. General practice is rooted in the community it serves and can act as an anchor for the populations that they serve. Patients interactions with any part of the health service offer opportunities for the delivery of tailored healthy lifestyle advice. There is evidence that particular opportunities, such as perioperative care, can be used to give patients the tools to make healthier lifestyle choices after the post-operative period. However, this approach is difficult to implement consistently without a workforce that is adequately trained and resourced to handle these sensitive conversations using established best practice.

17. General practice is currently under huge strain. The volume of patient contacts is greater than 10 years ago – between 2007 and 2014, clinical workload rose by at least 16%. However, between 1996 and 2016 the number of FTE GPs per 1,000 people declined by 5%, while the equivalent figure of hospital doctors per 1,000 people rose by 72%. This, along with the demands of an ageing population and the corresponding rise in multiple long-term and complex conditions, means that workload in general practice is at an all-time high. Implementation of the prevention agenda would be an important tool in supporting sustainable healthcare delivery beyond the 2020s.

18. Successive strategies for the NHS to rise to the challenges of delivering the best healthcare in the 21st century have placed an emphasis on moving care away from hospitals and into the community. The Long Term Plan outlines how primary care will support this through primary care networks and redesigns of hospital outpatient services. This change will significantly increase the workload of GPs as these changes are embedded in local health systems, at a time when the number of FTE GPs is declining.

19. The RCGP calls for the DHSC to provide sufficient funding and training for the workforce that will be expected to deliver on this prevention agenda. GPs and the wider practice team cannot be expected to provide public health or preventative services without proper investment in the development of the workforce to support delivery. Investment in workforce development will encourage service providers to deliver services and contribute to the wider strategy as their skills and knowledge progress. This will be a key factor in delivering on the ambitions of the prevention agenda set out in this green paper.

20. The RCGP would also like to see the government ensure that public health experts and expertise are at the forefront of developing and implementing public health strategy that feeds into the preventions agenda. Prevention policies must be protected as much as possible from the detrimental effects of political interference, instead relying on an evidence based approach to creating prevention policies that will promote better health in population.

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7 P Johnson, E Kelly, T Lee, et al Securing the future: funding health and social care to the 2030s, Institute for Fiscal Studies and The Health Foundation, 2018
Addressing Health Inequalities

21. Health inequalities are not only entrenched but widening in some cases. Across the UK, the gap in healthy life expectancy at birth between the best and worst performing areas in 2015–17 was 21.5 years for females and 15.8 for males. All of the determinants of health that are mentioned in this consultation can also be found in work looking at the sources of health inequalities. Primary care and the health service as a whole have an undeniably important role in working to address health inequalities, but they cannot be expected to compensate for the inadequacy of support in other areas. ‘Prevention in wider policies’ is welcomed and is a fundamentally important aspect of addressing the social determinants of health; including eliminating in-work poverty, eliminating child poverty, ensuring the welfare benefits system is fit for purpose and reducing the wealth inequity gap. This needs to be driven and owned by centralised government, with local communities’ engagement as policies are implemented.

22. The college calls on government to consider how to direct support and resources to more socio-economically deprived areas. This must be done in conjunction with the communities whose health needs are being addressed. Ownership of health and healthy behaviours at an individual level is important, but wider determinants must be addressed at a system level, with communities capable of helping themselves with the right resources. This should include directing resources to invest in all the facets of a community, from the road and pavement infrastructure including surfaces and lighting to increase ease of walking; investing in communal green spaces and cycle routes; investing in work opportunities; providing support services to navigate benefit claims through social prescribers; investing more in health visitor, midwife and Sure Start schemes to improve early intervention help for disadvantaged families; building on the work of the loneliness strategy to reach out to isolated citizens, and any other services that a community identifies as a priority for its population.

23. These more socio-economically deprived communities must be given the chance to develop the organisations that add the most value for them and help them to create health for their population, thereby working to reduce the health inequalities that are all too prevalent. It is essential to listen to the community itself, as disempowered communities lead to dependency while empowerment will build the community, build relationships and neighbourhoods. Research has shown that health benefits that are realised when people are encouraged to take up creative practice in the arts and humanities, from reducing social isolation and building compassionate communities, to improving mental wellbeing and helping people to recover from illness. The government must invest in these types of services to contribute to the creation of health across a community.

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8 Office of National Statistics Healthy Life Expectancies, UK:2015–17, 2018
9 https://www.nhsalliance.org/health-creation/ (accessed 14 October 2019)
11 http://cpmr.mentalhealth.org.uk/ (accessed 14 October 2019)