Health and Social Care Select Committee: NHS Long-term Plan: legislative proposals inquiry

1. The Royal College of General Practitioners welcomes the opportunity to respond to this consultation on legislative changes proposed to support the delivery of NHS England’s Long-Term Plan.

2. The Royal College of General Practitioners (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 RCGP is an independent professional body with expertise in patient-centred generalist clinical care.

3. On the whole, the RCGP is supportive of the broad legislative changes described by NHS England to support the delivery of the Long-Term Plan. The Long-Term Plan commits to an additional £20.5bn per year for the NHS, and an additional £4.5bn a year for primary and community care. This is welcome given the resourcing challenges that have faced general practice and the wider NHS in the past 10 years. The Long-Term Plan sets out the direction of travel towards more integrated, collaborative placed-based care, and this is welcomed by the RCGP.

4. However the RCGP believes that there are areas in which the proposals from NHS England could go further to support the aim of integration and the sustainability of the NHS. Most notably, the extended shared duty of all NHS organisations to the
'quadruple aim'; the integration of the GMC Registers; and the centralisation of commissioning responsibility for sexual and reproductive healthcare services with NHS England.

The Health and Social Care Act: Promoting collaboration and getting better value for the NHS.

5. The Health and Social Care Act 2012 ("the Act") sought to set patient choice and marketised competition as the operating logic of the NHS in England. It also set out the duty of NHS Improvement, Clinical Commissioning Groups (CCGs) and other bodies to ensure that care was delivered in an integrated way. These two duties have often been in conflict, impacting negatively on the delivery of patient care.

6. The RCGP has previously argued that there are cases where choice and competition do not help facilitate the delivery of integrated care. While care can be – and often is – integrated across different providers working together, the RCGP believes it is important to acknowledge that there are occasions where delivering integrated care requires a single provider to ensure a holistic approach to individual patient care, the sustainability of a provider's services, and the ability to develop a place-based approach to population health.

7. During its passage through Parliament, the RCGP repeatedly opposed the Health and Social Care Bill, arguing against the Clause 75 provisions of the Bill that enshrined the centrality of competition in the commissioning of services. Further to this, the RCGP called for Monitor’s role to be focused on encouraging collaboration and integration.

8. The RCGP also warned that the Clause 75 provisions did not sufficiently specify the circumstances when services would need to be put out to tender, causing CCGs huge administrative burdens by needlessly putting contracts out to competitive tender.

9. The RCGP therefore welcomes the intention to revoke the Section 75 powers of the Act which we have observed have acted as a barrier to the development of new care models and collaboration between local NHS organisations.

10. The RCGP also welcomes the removal of NHS commissioning from the Public Contracts Regulations, and the implementation of a ‘best value test’.

The Integration of Care

11. The RCGP has long championed integration of care. Integration is essential to ensuring that the health and social care system continues to deliver high quality, person-centred care to the UK’s ageing population and the increasing numbers of people living with multiple long-term conditions.

12. The RCGP is supportive of integration and the positive steps being taken to improve collaboration between different parts of the health and social care system. We are keen to see this develop in positive ways. It is still important to note that whilst we consider that integration will assist in relieving pressure on the system, it is unlikely to provide the uplift in capacity that is necessary to manage increasing demand. The RCGP has previously outlined five tests for integrated care. It is our view that proposed models of integrated care must:
a. Ensure community based services are led by community-based clinicians with a patient-centred perspective.

b. Underpin safe patient care by ensuring that GPs can continue to act as independent advocates for their patients, with the emphasis on the patient not institution.

c. Be patient focused, responding to the needs of the individual and protecting them from over-medicalisation, with GPs working with specialists to contribute to the holistic care of the individual.

Proposed models of integrated care must not:

d. Lead to major top down structural re-organisation.

e. Lead to the diversion of NHS funding away from general practice and primary care given their vital role in delivering person centred care.

13. The RCGP is therefore encouraged that the changes proposed in the consultation document do not set out a ‘complex reassignment of functions that currently sit with CCGs and Trusts’, but instead seek to ‘remove the barriers to collaborating and joint decision making by letting Trusts and CCGs exercise some functions and make some decisions jointly’.

14. The RCGP also welcomes the provisions to enable joint committees of NHS Providers and CCGs to allow formal collaboration between commissioners and providers to make joint decisions to serve the best interests of their local populations. It is essential that these joint committees are required to have sufficient GP representation to ensure the effective delivery of person-centred holistic care in the community.

15. We support the recommendation that Parliament legislate to remove the legal barriers that currently limit the ability of CCGs, local authorities and NHS England to work together jointly. However, the RCGP believes that the legislation must go further in order to address the fragmented commissioning arrangements that exist for sexual and reproductive health (SRH) services.¹ The 2012 Health and Social Care Act introduced an inherently fragmented set of commissioning arrangements, meaning that there is no single body that oversees the care of patients accessing sexual and reproductive healthcare.

16. These commissioning arrangements have created a situation in which care is provided inconsistently, exacerbating health inequalities, generating unnecessary costs for the NHS and ultimately leading to a disrupted, disconnected and disappointing experience for patients. The RCGP believes that the commissioning responsibility for sexual and reproductive healthcare services should be held by NHS England, in order to facilitate the development and delivery of joined-up patient pathways across the whole country.

17. The current system has created a postcode lottery where some local commissioners excel at integrated commissioning and others do not. A centralised service commissioned by a single NHS body would mean that harder to reach communities, who would not naturally visit an SRH service could access care in another health environment (for example their regular GP appointment). This would improve wider health outcomes and tackle health inequalities that exist around access to SRH. It would also ensure that spending for sexual health services was ring-fenced, facilitate

better long-term planning of services, and enable an improved approach to workforce planning and training.

18. Centralising the commissioning of SRH services would make the most economic sense, as Public Health England estimates that for every £1 spent on publicly funded contraceptive services, £9 is saved and these savings mostly benefit the NHS, while the spending mostly sits with local authorities.

19. We also support the proposal that NHS England be given the ability to allow collaboration between groups of CCGs. However, this must be done in a way which remains locally accountable.

20. The King’s Fund found that the benefits of CGGs working collaboratively with neighbouring commissioners include:
   a. economies of scale
   b. getting strategic alignment with neighbouring commissioners
   c. having a greater degree of influence over large providers, and avoiding duplicating similar pieces of work
   d. sharing ideas and learning
   e. bringing about improvements in patient care, for example through more effective integration of services.

21. The RCGP would like to see the proposed ‘triple aim’ for all NHS bodies extended to reflect a ‘quadruple aim’, including cultivating the NHS workforce. Whilst we believe that a shared duty towards the ‘triple aim’ of better health for everyone, better care for all patients, and efficient use of NHS resources is a step in the right direction, the ‘quadruple aim’ also requires all NHS organisations to ensure the NHS workforce find meaning in their work. Engaged, productive and contented staff are an essential part of an effective healthcare system.

22. The RCGP believes that instituting this quadruple aim would recognise the centrality of the workforce to the NHS and would encourage all NHS organisations to seek to recruit and retain the very best staff, while ensuring their wellbeing and protecting them from burnout. This will help to prevent workforce crises, such as the one currently facing general practice and the wider NHS, and ensure the long-term sustainability of the health service.

Integrated Care Trusts, Primary Care Networks and the voice of GPs

23. The RCGP regards contract evaluation and negotiation to principally be a preserve of the British Medical Association, the trade union for doctors and medical students in the UK. However, we are briefly outlining our concerns because the Integrated Care Trust contract has wide ranging implications for the role of the GP and the delivery of patient care. While not specifically covered under this consultation, it is closely related and hence we have outlined our views on this below.

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24. We believe the ambition to develop Primary Care Networks (PCNs) better aligns with a multi-speciality community provider’s contract, rather than with a more directed and controlled one. An Integrated Care Provider contract subject to Foundation Trust/Council direction seems likely to offer reduced autonomy and leadership opportunities for GPs, and correspondingly lower accountability to the local community. GPs serve as vital independent advocates for patients, and are already strongly aligned with local person-centred care.

25. We accordingly welcome the creation of the new vehicle of Integrated Care Trusts, which ought to enable a greater degree of GP and primary care leadership than would be possible under the Foundation Trust model. We also welcome the recent statement by Stephen Hammond that under the ‘fully integrated arrangement’, GP practices would be able to suspend their contract rather than being required to relinquish them. However, we are not clear if and how practices who have taken this step to participate in a fully integrated ICP arrangement would be able to participate in a Primary Care Network. It is also essential that the constitutional arrangements for ICPs provide full opportunities for GP leadership and we would welcome further engagement with NHS England and the Government on the details of what this should look like.

26. One of the key strengths of the GP partnership model has been its vital role in encouraging innovation in general practice and enabling GPs to continue to be independent advocates for patients. There is a significant risk that this will be significantly diminished should GPs move towards larger, complex, centralised Foundation Trust or Council-led systems. The independent review of the partnership model in general practice, commissioned by the Secretary of State for Health and Social Care and NHS England, reported earlier this year. It found that practices working at scale, for example through Primary Care Networks, ‘has the potential to improve and support general practice influence at a system level if the right incentives and expectations are put in place’. It adds outlines there is a ‘clear case for partnerships and general practice to be the building blocks and leaders within their local healthcare system, working across boundaries with other services to provide high quality personalised care’.5

27. The review added that NHSE should introduce a requirement for all STPs or ICSs to have a primary care plan that has been developed with the Local Medical Committees in that area and with general practice at its core. It also recommends including requirements to demonstrate that plans have been constructed with staff working in general practice.6

**Integrating the GMC Registers**

28. The RCGP, alongside the BMA, believes that the formal recognition of GPs as specialists in general practice/family medicine in the UK is long overdue, in the spirit of breaking down perceived barriers between primary and secondary care. At a time of major system change, it is important that GPs and secondary care consultants are perceived as peers and experts in their relevant fields. The necessary changes to

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5 [https://www.gov.uk/government/collections/gp-partnership-review](https://www.gov.uk/government/collections/gp-partnership-review)

6 Ibid
enable this have also been supported by the independent review of the partnership model referenced above.\textsuperscript{7}

29. It is an anomaly that the postgraduate GP Speciality Training (GPST) remains formally unrecognised in this respect, and we continue to call upon the government and General Medical Council to make the changes necessary to add GPs to the List of Specialists, and subsequently for the status of GPs to be formally equal to that of their secondary care colleagues.

30. As we move to a more integrated system it is essential that barriers between primary and hospital care are broken down, that GPs are given a strong voice in the system, and are formally recognised as specialists in general medicine.

**Merger of NHS Arms Length Bodies (‘ALBs’).**

31. Given the focus on integration of services, the RCGP welcomes the merger of NHS England and NHS Improvement, believing that integration at the most senior level sets the correct direction of travel for the NHS.

32. However, the RCGP believes that any merger of the NHS ALBs must guarantee a greater degree of representation of primary care at a senior governance level, recognising and redressing the imbalance towards secondary care that has persisted on the boards of the NHS ALBs.

33. The RCGP also supports the recommendation by the Health and Social Care Select Committee that there must be better collaboration between ALBs in relation to matters of workforce, education and training. In particular, there is a need for improved collaboration and clearer division of responsibilities between NHS England and Health Education England. To facilitate this, and in addition to the new powers of delegation proposed in the consultation, we recommend that there should be a new duty of collaboration on NHS England and Health Education England in these crucial areas.

\textsuperscript{7} https://www.gov.uk/government/collections/gp-partnership-review