Implications of the Primary Care Workforce Commission report

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The Primary Care Workforce Commission was set up to identify innovative models of primary care in England that will meet the needs of NHS patients in the future. This article outlines the main recommendations of the Commission’s report and their implications, in particular the enhanced role of community pharmacy within primary care.

Primary care is, in many ways, “the jewel in the NHS crown” and emulated around the world, says chair Professor Martin Roland, in his online introduction to the Primary Care Workforce Commission’s report. However, he adds, it is under mounting pressure, from an increasing workload and growing difficulties in providing appropriate care to patients with increasingly complex medical conditions.

How and why was the Commission set up?
The Primary Care Workforce Commission (also known as the Roland Commission) was established by Health Education England (HEE) in 2014, after Health Secretary Jeremy Hunt called for an independent commission to investigate issues concerning the current and future primary care workforce and make recommendations for change.

Martin Roland, professor of health services research at the University of Cambridge, who is a qualified GP with 35 years’ experience in general practice, chaired the Commission. The other five Commission members have backgrounds in general practice, pharmacy and nursing and together they organised site visits and the collection of written and oral evidence from a wide range of professional and patient organisations.

The Commission's report, The Future of Primary Care – Creating Teams for Tomorrow, was published in July 2015. Its terms of reference, spelling out the context for changes, include a projected 7 per cent increase in the UK’s population to about 68 million between 2012 and 2022. Future healthcare will need to change to meet the challenges presented by an ageing population and growing numbers of patients with medical conditions of increasing complexity, diagnosed and managed in the community, the report says.

Recommendations
The report’s recommendations for meeting the challenges in primary care include those associated with: managing a multi-disciplinary workforce; better use of technology; federations and networks of practices; integrating care; quality and safety; population groups with particular needs (including people with mental
health problems, those in nursing and residential homes and end-of-life care); education and training; and providing better data to make innovation evidence-based.

Some recommendations will require significant extra investment, particularly in terms of staff, but some will result in cost savings through more effective use of NHS resources, says the report. Two “fundamental things” for the successful achievement of the report’s vision of primary care are: having enough appropriately trained staff; and having individual staff members who are armed with the necessary skills to evaluate their work and be empowered to improve the systems.

Primary care will need to adapt to provide “personalised, proactive care to keep people healthy, independent and out of hospital”. Health professionals will also have to adapt to the change in their relationships with patients and their carers as improvements in information technology help to involve patients more in making decisions about their care.

Primary care will still be based around the GP practice holding responsibility for its registered patients’ care but will have an expanded workforce of healthcare professionals including community nurses, pharmacists and physician associates with more administrative support.

The report does not recommend a one-size-fits-all solution for delivering high-quality primary care. High on the list, however, is for short- and long-term strategies to increase recruitment and retention of GPs and a regular review of national targets and similar strategies to tackle recruitment and retention of nursing staff.

Professor Maureen Baker, chair of the RCGP, echoing comments made in other interviews, says: “Morale is very poor in general practice at the moment as a result of underfunding – significant and sustained underfunding – and a shortage of staff, particularly GPs and nurses, and it’s imperative that initiatives are taken for implementing the recommendations of the Roland Commission.”

Changing professional boundaries
High on the list of priorities is also a call for greater involvement of clinical pharmacists, including prescribing pharmacists, in managing people on long-term medication and in care homes (see Table 1). This role, the report says, would be most effective in the GP practice, where the pharmacist would have full access to patients’ records and would be able to maximise interaction with other clinical staff.

Professor Baker comments that the particular skills of the pharmacist and the organisation of their inclusion within the GP’s practice, would determine their contribution to patient care. “If, for example, the pharmacists are independent prescribers they will work in particular ways,” she says. “Others might be more involved in dealing with medication reviews, reviewing medication if patients are in kidney or renal failure, working with practice protocols and guidelines. So there’s a whole range of activities that practice pharmacists can be involved in.”

The report also recommends the wider use of community pharmacists and pharmacy support staff in managing minor illness and advising patients on optimising their medication, with agreed protocols for treatment and referral between pharmacists’ local organisations and GPs’ practices. The development of large practice groupings, for example federations, networks and super-practices, will enable primary care to provide a wider range of services to patients, better development and training opportunities to staff and will enable them to work more effectively with commissioners, specialists, hospitals and social services, says the report.

Professor Baker was co-author and joint architect of the RCGP’s 2007 paper, The Future Direction of General Practice, which introduced the initial concept of federations. She says: “We do feel it’s a good way to help general practice in using a resource more effectively across an area, and it seems one way for practices to support each other.”

The report suggests the new working arrangements could also require a shift in attitudes to traditional professional boundaries and relationships to ensure that staff can take on different roles and work together in a variety of settings. Professor Baker, however, does not foresee concerns about professionals treading on each others’ toes. “I think if it’s set up properly in each practice it shouldn’t be a problem. GPs and pharmacists are both registered professionals, as are nurses. You work within the sphere of your own competencies and work it out between yourselves. GPs and nurses have worked very well together for 30 years so I don’t see that’s likely to be an issue.”

The report concludes that the problems in primary care result from a fall in investment that has left it well behind that in hospitals, despite increased expectations of the work to be done in primary care. In addition, while hospital consultants’ numbers went up by 48 per cent between 2003 and 2013, GP numbers rose by only 14 per cent. Since 2009, with major recruitment and retention problems, the number of GPs per head of population has declined. RCGP estimates, quoted in its submission to the Commission, suggest a shortage of approximately 7700 GPs in England by 2020.

Nursing has been hit by similar recruitment and retention problems,
with a 38 per cent fall in the number of community nurses and a growing dependency on agency staff between 2001 and 2011. Only pharmacy appears to have a potentially adequate supply of newly trained graduates. The final report, however, suggests there should be evolution into new forms of care rather than revolution, says Professor Roland.

What progress has been made?
Nothing is finally settled yet, but how far are new primary care workforce plans along their evolutionary path? What is the news about GP and pharmacist numbers and the fall in investment in primary care? Professor Roland says: “I am pleased with the response of Health Education England (HEE) to our report, with all local offices of HEE preparing workforce plans for primary care including the development of Community Education Provider Networks. HEE is also making progress in developing courses for physician associates to work in general practice.

“The 10-point plan [see Table 2] for recruiting more GPs is a key part of the government’s strategy, though it’s uncertain that the 5000 extra GPs they are committed to by 2020 will be sufficient to meet the needs of patients. The ‘golden hello’ of £20,000 for trainees to work in the most undererved areas is therefore welcome, as is NHS England’s £31 million funding for 700 places for pharmacists to work in general practices.

“NHS England has committed significant additional resources to general practice in the next few years – between 4 and 5 per cent increase each year – though this will only slowly close the shortfall between present funding levels and the proportion of the NHS budget that was spent on general practice 10 years ago.”

As GPs and general practice nurses see growing numbers of patients with complex medical and personal problems, face-to-face consultations become longer and typically exceed the average booking allowance. The Commission recommends that general practices should be organised to allow a significant number of longer face-to-face consultations so patients can be fully assessed and advised about their care options and the best ways to manage their condition.

Table 2. Ten-point plan to build the general practice workforce

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<tr>
<th>Number</th>
<th>Plan Description</th>
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<tr>
<td>1.</td>
<td>Promoting general practice to newly qualified doctors</td>
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<td>2.</td>
<td>Improving the breadth of training for general practice</td>
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<td>3.</td>
<td>Developing training hubs to enhance interprofessional training for the whole primary care team</td>
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<td>4.</td>
<td>Targeted support for GPs moving to underserved areas</td>
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<td>5.</td>
<td>Investment in retainer schemes</td>
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<td>6.</td>
<td>Improving the training capacity in general practice</td>
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<td>7.</td>
<td>Providing incentives for older doctors to remain in practice</td>
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<td>8.</td>
<td>Developing new ways of working, including a broader workforce to support GPs in their clinical work</td>
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<td>9.</td>
<td>Providing schemes to promote easy return to practice</td>
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<td>10.</td>
<td>Targeted investment for those returning to general practice</td>
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It also recommends that people at the end of life and their families should be able to identify and contact named individuals leading on their care, whether a GP, community nurse or specialist nurse. There are already promising developments on this front.

Says Professor Roland: “Progress is being made in a number of areas, for example, NICE guidance in December requiring an identified named lead health-care professional for each patient at the end of life, 24-hour availability of medications and 24-hour access to advice from a specialist in end-of-life care.”

Another, wider recommendation, awaiting further comment, is that patients’ ability to see a doctor or nurse of their choice should be monitored as “a key metric of the quality of general practice care”. Meanwhile, data on the quality of general practice care – to include measures of access, communication, clinical quality and integration – should be publicly available. It should be a priority to develop integration measures, as these do not yet exist in a form that can be routinely applied in the NHS.

What is in the pipeline?
Professor Roland says: “In the next few months, NHS England plans to produce a ‘roadmap’ for general practice, which will include further measures to strengthen and support general practice. The House of Commons Health Committee will also be producing its report on primary care shortly, and we expect this to endorse many of the recommendations in our report.”

Professor Baker gives her predictions for the longer term: “In five years’ time I think we’ll certainly have a wider range of skills. We’ll have more people – more highly skilled professionals – probably have more administrative and support staff to help professionals do what only they can do, and much more of the admin work will be done by appropriate staff.”

What are pharmacists’ plans?
In December 2015, an open letter from the Department of Health and NHS England to the Pharmaceutical Services Negotiating Committee (PSNC) picked up the Roland Commission’s theme of expanding the role of pharmacists into the GPs’ practice and started turning the wheels of change in community pharmacy.7 The letter, revealed at a meeting hosted by pharmacy minister Alistair Burt on 17 December 2015, is signed by Keith Ridge, Chief Pharmaceutical Officer supporting the Department of Health, NHS England and Health Education England and Will Cavendish, Director General, Innovation, Growth and Technology, Department of Health.

It set out the case for integrating community pharmacy more solidly into primary care, citing the Five Year Forward View’s calls to build on the strengths of the NHS and rise to the challenges of the future. The authors went on to invite the PSNC, along with other patient and public groups, to discussions on changes to the community pharmacy contractual framework for 2016/17 and beyond, linked to the spending review. They said: “Community pharmacy is a core part of NHS primary care and has an important contribution to make as the NHS rises to all of these challenges.”

Severe cuts
Dr Ridge and Dr Cavendish then went on to announce a cut of £170 million in NHS
funding for community pharmacies in England, from £2.8 billion for 2015/16 (see Figure 1 for how funding is distributed) to no higher than £2.63 billion in 2016/17; more than 6 per cent in cash terms, with effect from October 2016. They added that the government believes the 6 per cent cuts can be made without compromising the quality of services or public access to them because there are more pharmacies than necessary in some places (99 per cent of the population in England can get to a pharmacy within 20 minutes by car and 96 per cent by walking or public transport, says the accompanying consultation paper).

The Department of Health has suggested that between 1000 and 3000 pharmacies will close. The development of large-scale automated dispensing such as ‘hub and spoke’ arrangements will “provide opportunities for efficiencies” in others. The Department of Health promised to ensure that those community pharmacies upon which people depend would “continue to thrive” and promised to consult on the introduction of a Pharmacy Access Scheme that provided extra NHS funds to some pharmacies.

The consultation paper launched with the letter to the PSNC is called Community Pharmacy in 2016/17 and Beyond. In addition to the PSNC, it was sent to pharmacy stakeholders, including the Royal Pharmaceutical Society and the Association of Pharmacy Technicians UK and other bodies such as Healthwatch England and the Local Government Association.

In his foreword to the document, Dr Ridge said he believed that the profession could go much further in integrating pharmacy into the NHS, but changes to the infrastructure were necessary and the right skills must be in the right place to achieve this goal. He announced a new Pharmacy Integration Fund (PhIF), with £20m funding each year, starting in 2016/17. The PhIF will help to enable integration of clinical pharmacy practice in a range of community care settings, including GP practices and multispeciality community providers and improve links to care homes and urgent and emergency care. An IT infrastructure must be developed to enable interoperability between pharmacy and the rest of primary care, he added.

The consultation paper says that, although community pharmacy already plays a vital role in dispensing and advising on medicines, by integrating it more closely within the NHS, it could play an even greater role. By optimising medicines usage, supporting people with long-term conditions, treating minor illness and injuries and delivering better services to patients and the public, it could help to relieve pressures on GPs and accident and emergency departments, while contributing to seven-day health and care services.

Sandra Gidley, English Pharmacy Board chair at the Royal Pharmaceutical Society, says that pharmacists, who have a five-year training, are an underused resource. She adds: “Hopefully there are signs that this is changing. With people on increasingly complex polypharmacy it makes sense that pharmacists are used to improve the effective use of medication.”

“They could also do more domiciliary visits and see how medicines are actually used. That frees GPs to do the things they’re best at, like diagnosing what’s wrong with patients, and has been shown to be more cost effective and better for the patient. Successful integration would mean that the patient saw the most appropriate health professional at the right time, where all the records were lined up, so a pharmacist who does a review of someone on 20 medicines could see the history.”

The number of pharmacies in England increased from 9748 in 2003 to 11,674 by 31 March 2015, says the consultation paper’s section on NHS funding for community pharmacy. The median average pharmacy receives £220,000 annually in NHS fees and allowances, including margin. In the context of the NHS’s need to deliver £22 billion efficiency savings by 2020/21, as set out in the Five Year Forward View, community pharmacy must play its part in delivering those efficiencies, adds the paper. That means the changes need to ensure the system is efficient and delivers value for money for the taxpayer, while maintaining good public access to pharmacies and pharmacists.

**How will community pharmacy deliver?**

So how will community pharmacy deliver the reforms in the face of 6 per cent cuts and possible closure of up to 3000 pharmacies? Says Sandra Gidley: “That’s the question we’re asking and why we raised concerns in our response to the report. It’s all right having a grand design, but how do you get from A to B and what will be the impact of this? For example, if you just cut money year on year, pharmacy owners will cut staff and maybe cut hours and that will limit public access at a time when we’ve been saying ‘go to your pharmacy first’.”

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**Figure 1.** NHS funding for community pharmacy (2015/16). Total funding £2.8 billion: £2 billion fees and allowances; a further £800 million margin on drug reimbursement fees and allowances; a further £800 million margin on drug reimbursement.

- **Dispensing fees (£869m)**
- **Practice payments (£633m)**
- **Establishment payments (£270m)**
- **Special fees and other allowances (£97m)**
- **Directed Medicines Use Reviews and other advanced services (£86m)**
- **Electronic prescription allowance (£28m)**
- **Repeat dispensing annual payments (£17m)**
Community Pharmacy in 2016/17 and Beyond calls for responses to its proposals to ensure that patients are offered the choice of home delivery or collection when ordering their prescription as well as its plans to introduce new terms of service for distance-selling pharmacies. Online ordering, Click and Collect and home delivery are all growing significantly in other sectors, but less than 10 per cent of adults ordered their medicines online in 2014, according to the Office for National Statistics. Sandra Gidley remarks: “I have a huge concern with the government’s drive to a ‘Click and Collect’ model of pharmacy; that it’s missing out the step where the pharmacist can intervene when necessary. As a community pharmacy locum I see the value of that face-to-face contact where the patient can ask for information. I worry we shall be heading for an American-type system, which is basically a pharmacy call-centre. That sounds as though it saves time, but for me and from the patient’s perspective, it’s second best.”

The consultation paper also seeks the views of the PSNC and pharmacy organisations on proposals to: simplify the NHS remuneration payment system; help pharmacies to improve efficiency and innovation by modernising their dispensing methods; and encourage longer prescription durations, where clinically appropriate, beyond the present 28-day repeat prescription.

Royal Pharmaceutical Society arguments
What does the Royal Pharmaceutical Society hope for from the Department of Health response to the consultation? Says Sandra Gidley: “A good response would be to say, ‘Actually let’s hold off now while we talk to the organisations and plan it,’ which is what they should have done in the first place. I’m not hopeful that will happen.

“We at the Royal Pharmaceutical Society will be putting arguments forward highlighting the value, both to patient care and to NHS finances, of pharmacists doing things differently. We hope that we can make arguments for more clinical services from community pharmacy and perhaps prevent cuts in future years.”

And what hopes for the future?
Ms Gidley says: “We’ve just launched ‘The Right Medicine: Improving Care in Care Homes’ so we would like to see named pharmacists for every care home because there’s a huge potential to improve what happens there.” The Royal Pharmaceutical Society says that elderly people are particularly at risk from errors with medicines as they frequently have multiple health problems and are often prescribed several medicines. The Royal Pharmaceutical Society therefore believes pharmacists should have an embedded role in care homes – with a named pharmacist in every care home – with overall responsibility and accountability for medicines and their use. When that is in place, she wants to examine how pharmacists can improve the lot of frail elderly people, via domiciliary visits.

Conclusion
As primary care faces the escalating difficulties of providing care for an aging population with increasingly complex medical conditions, it will have to work hard to maintain its emblematic status within the NHS.

Staff must adapt to widespread changes, including a diverse, multidisciplinary workforce, federations and networks of practices plus an increasing use of technology and changing relationships with patients and carers. Meanwhile, community pharmacies face up to 3000 closures and GPs are dealing with chronic recruitment shortages.

There are signs, however, that the proposed changes could bring some relief to the system with aid to over-worked GPs in the form of greater opportunities for pharmacists. The Royal College of General Practitioners and the Royal Pharmaceutical Society, who recognised the value of using pharmacists’ expert knowledge in general practice in a joint statement in 2011, have reaffirmed their commitment to increasing collaboration between the two professions and breaking down the perceived barriers to joint working. By combining their skills, hopefully they will find personal and professional fulfilment, improve patient care and restore the lustre to the “jewel in the NHS crown”.

References

Declaration of interests
None to declare.

Joy Ogden is a freelance journalist