

# The future of primary care

## Creating teams for tomorrow

Report by the Primary Care Workforce Commission



“With its highly skilled workforce, effective multi-disciplinary teams and well-developed IT systems, the NHS is in an unparalleled position to develop a modern primary care system that is truly world class.”

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# Foreword

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Primary care faces increasing and unprecedented pressures. The commission aimed to identify solutions that would meet the present and future needs of the NHS and, if our recommendations are carried out, we believe that many of the current problems in primary care could be addressed. The commission members brought a wealth of experience and knowledge that provided depth and balance to the work and I would like to thank them for their contributions, challenge and support in writing this report. Focusing on care provided in general practice, community pharmacy and community nursing, our aim was to identify ways in which primary care could develop so that patients could continue to be confident that they would receive high quality primary care. We also wanted to identify ways forward that would result in primary care increasingly becoming the career of choice for young doctors, nurses and pharmacists.

When I left medical school in 1975, I had no doubt that I wanted to be a GP. It had always seemed to me the most rewarding branch of medicine – combining a wide range of clinical challenges with one to one relationships with patients that rarely occur in other branches of medicine. I remain proud to live in a country with a healthcare system that has long been respected and admired around the world. With the constant problems that seem to surround the NHS, it's easy to forget that primary care in the UK is often held up as an example that other countries seek to emulate.

Through the submission of evidence, site visits and dialogue with local and national organisations, what we found was that exceptional people and teams had taken opportunities to create new and innovative ways of working. We also looked at the international literature to see what could be learnt. As a result this report will be of interest to a wide spectrum of readers, including those receiving, delivering or planning primary care. The commission believe the solutions are many and can be applied at a national level and local level. This will include better and smarter ways of working such as hospital doctors working more closely in community settings and the expansion of the broader multi-disciplinary team including nurses, pharmacists and new roles such as physician associates.

On behalf of the commission, I would like to thank the many individuals and organisations across the country who responded to our request to share their work and experiences. These formed the evidence and the basis for recommendations for this report. A special mention is due to the twelve sites we visited across England who went the extra mile to meet us and whose work we found inspiring. The commission's work would not have happened without the untiring support from staff in the programme team at Health Education England who worked against very tight deadlines.

**Professor Martin Roland CBE**

Chair, Primary Care Workforce Commission

## Thank you from Health Education England

On behalf of Health Education England, I would like to extend our thanks to Martin and everyone who contributed to this review. This includes the commission members, local and national organisations, primary care practices and the healthcare professionals who shared their varied and innovative ways of working on which this report is based.

Health Education England exists for one reason only - to help improve the quality of care by making sure our

NHS workforce has the right numbers, skills, values and behaviours to meet the needs of patients. The primary care workforce is a key part of the future of the NHS and will continue to evolve.

We will now look closely at the recommendations that have been put forward in this report.

**Professor Ian Cumming OBE**

Chief Executive, Health Education England

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# Executive summary and summary of recommendations

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## The context

The UK has been at the forefront of modern primary care development, and many countries continue to look to the NHS as a model to emulate. However, primary and community care services now face major challenges; with an increasing workload, an ageing population, and increasingly complex medical problems being diagnosed and managed in the community. The relationship between the public and health professionals is also changing – with an increasing focus on giving people information and involving them in decisions about their care.

## The problem

Investment in primary care has fallen well behind investment in hospitals, despite increasing expectations of the work that should be done in primary care. Between 2003 and 2013, the number of hospital consultants increased by 48 per cent while GP numbers increased by only 14 per cent. Indeed, the number of GPs per head of population has declined since 2009, with major problems of recruitment and retention. Nursing is another area of serious concern, with an ageing workforce in general practice nursing and similar problems of recruitment and retention. Between 2001 and 2011, the number of community nurses fell by 38 per cent and there is a growing dependency on agency staff. Only in pharmacy does there appear to be a potentially adequate supply of newly trained graduates. Furthermore, many primary care premises now appear outdated in relation to the extended range of services that should be provided in the community.

## The vision

The Commission's vision for the future of the primary care workforce is drawn from the people we have met, the evidence we have read, our professional experience and, perhaps most of all, from the innovative examples of primary care we saw across the country. We were universally impressed and inspired by these visits. There is very little in this report that is not already happening somewhere in the NHS. What is needed is for these examples of outstanding practice to be rolled out more widely.

Much of what we recommend can be achieved rapidly, though other changes will take time, especially those that require cultural change and the development of relationships across organisational boundaries. However, with a highly skilled workforce, effective multi-disciplinary teams and well-developed IT systems, we believe that the NHS is in an unparalleled position to develop a modern primary healthcare system that is truly world class. Focusing on care provided by healthcare professionals working in general practices, community nursing and in pharmacies, we offer a vision of primary care that will provide challenging and fulfilling careers for health professionals while delivering a standard of care to patients of which the NHS can be truly proud.

To achieve this vision, primary care needs to change. It will still be based around the GP practice holding responsibility for the care of its registered patients, but practices will have a stronger population focus and an expanded workforce. Many existing healthcare professionals will develop new roles, and patients will be seen more often by new types of healthcare professional such as physician associates. Clinical staff will have better administrative support and, when needed, healthcare professionals will be able to spend more time with their patients to discuss and plan their care. They will also be able to communicate with patients and with other health professionals by phone, email, electronic messaging and video-conference.

Individual general practices and community pharmacies will work more closely together through networks and federations in order to provide a wider range of services, and IT systems will become joined up across providers of primary care. Primary and community care staff will also work closely with secondary care and social services through some of the models outlined in the NHS *Five Year Forward View*. Premises will be upgraded, making better use of existing community facilities in order to support closer working with hospitals and with social services, and to provide a wider range of diagnostic facilities.

Building new models of care needs to be done equitably. Some of the most deprived areas of the country have the greatest recruitment problems, the biggest resource challenges and the greatest health need. First-class primary healthcare must be available in all parts of the NHS.

It will be important to support these changes through education and training, especially in general practice nursing and community nursing, where career structures and training opportunities lag well behind training for doctors. Primary care staff, including managers, will need training and ongoing support to provide leadership and management of new and emerging primary care organisations.

In order to achieve our vision, we make the following recommendations.

## A multi-disciplinary workforce for primary care

Two fundamental things are required in order to deliver the vision of primary care that we have outlined in this report: there need to be sufficient staff with appropriate training to do the work that is needed in primary care, and individual staff members need to have the skills to evaluate what they are doing and be empowered to improve the systems in which they are working.

In preparing this report, we saw a range of models for delivering high-quality primary care. In addition to excellent traditional practices where there were more doctors than nurses, we also saw practices where there were more nurses than doctors, and practices where significant amounts of the workload were undertaken by other health professionals such as pharmacists or physician associates. For this reason, we do not recommend one particular staffing model or ratio (for example, GPs or general practice nurses per head of population). All general practice teams need both medical and nursing input (Sections 2.2.1 and 2.2.2), but we see major opportunities to expand the primary care workforce through the use of other healthcare professionals (Sections 2.2.3 to 2.2.5).

There are also opportunities to reduce the administrative burden on healthcare professionals. This is a major cause of workload stress and a significant issue cited by GPs leaving the profession early. GPs currently spend 11 per cent of their time on administration. If administrative staff (such as medical assistants) took on half of this work, this would be equivalent to 1,400 more full-time GPs in England. New approaches to the best use of administrative support roles need active piloting and evaluation (Section 2.2.4).

We make the following recommendations in relation to the primary care workforce:

1. Both short-term and long-term strategies are needed to increase recruitment and retention of GPs. The measures to increase GP numbers outlined in the Ten Point Plan agreed by Health Education England (HEE), NHS England, the Royal College of General Practitioners (RCGP) and BMA in 2015, should be implemented rapidly along with the Government's commitment to recruiting 5000 additional GPs. National targets for GP numbers should be regularly reviewed. There should also be scope to adjust plans at local level providing that those plans can be demonstrated to meet local need. (Sections 2.2.1 and 6, recommendation to HEE, NHS England, professional bodies and general practices)
2. Measures equivalent to the Ten Point Plan agreed for GPs are needed to improve recruitment and retention in primary care nursing. The number of general practice nurses and community nurses needs to increase in order to address both current shortfalls and the number of nurses due to retire in the next 5-10 years. (Section 2.2.2, recommendation to NHS England, HEE and general practices)
3. There should be greater involvement of clinical pharmacists, including prescribing pharmacists, in the management of people on long-term medication and people in care homes. This role is best carried out in the GP practice in order to allow full access to the patient record and to maximise interaction between the pharmacist and other clinical staff in the practice. (Section 2.2.3, recommendation to NHS England, HEE, general practices and community pharmacies)



4. Wider use should be made of community pharmacists and pharmacy support staff in managing minor illness and advising people about optimising their medicines. There should be agreed protocols for treatment and referral between local organisations of pharmacists and GP practices. *(Section 2.2.3, recommendation to NHS England, HEE, federations of community pharmacies and GP practices)*
5. There are substantial potential benefits from a range of new approaches to staffing in general practices including the wider use of physician associates and healthcare assistants. The potential for paramedics to substitute for GPs in the assessment of urgent requests for home visits merits further evaluation. *(Sections 2.2.4 and 2.2.5, recommendation to NHS England, HEE, the National Institute for Health Research and general practices)*
6. New support staff roles have the potential to reduce the administrative burden on GPs and nurses to enable them to focus on clinical care. These roles should be developed and evaluated. *(Section 2.2.4, recommendation to HEE, NHS England and practices, the National Institute for Health Research)*
7. More evaluation is needed of new approaches to using allied health professionals in primary care, especially to determine whether direct access for some conditions makes cost-effective use of NHS resources. *(Section 2.2.5, recommendation to the National Institute for Health Research)*
8. 24-hour community nursing services should be available in all areas in order to achieve a significant and sustainable shift of care from hospital to the community. *(Section 2.2.2, recommendation for NHS England and CCGs)*
9. The costs and benefits of using a relatively unskilled workforce to triage requests for out-of-hours care are not sufficiently well established and may be a cause of hospital overuse. Research is needed to compare skilled versus less-skilled staff providing telephone triage in out-of-hours care. *(Section 2.6, recommendation to the National Institute for Health Research and CCGs)*
10. Practices should analyse their clinical case-mix when deciding what skills they need to deliver high-quality care. They then need to agree clear criteria for what each healthcare professional will do and ensure that staff are fully competent in the roles they undertake. *(Section 2.2.7, recommendation to general practices, CCGs and healthcare regulators)*
11. Practices need to create protected time and space to support effective team working. In line with the consultant contract, contractual and employment arrangements for staff in primary care should include time to support professional activities focused on quality improvement and clinical governance. *(Section 5, recommendation to NHS England, HEE, GP and pharmacy practices)*

## Making better use of technology

Building on the strength of electronic general practice records, primary care staff, including community nurses and health visitors, should be able to access a common primary care record. In addition, we regard it as outdated that healthcare professionals working in primary care are unable to communicate freely with hospital specialists, for example, by using email and electronic messaging.

We also believe it will soon appear outdated that, unlike countries such as Denmark, patients and clinicians cannot routinely communicate by email: if 5 per cent of GP consultations could be dealt with by email, this would save 17 million face-to-face consultations a year. However, we do not know to what extent emails from patients would generate additional demand. We make the following recommendations in relation to making better use of technology:

12. Email correspondence and electronic messaging should become routine between primary care healthcare professionals and hospital specialists, enabling both to seek advice and give guidance on patient care. While this may need protected time in the working day, there are significant potential cost savings in terms of reduced referrals to hospital. *(Section 2.3.1, recommendation to NHS England and CCGs)*
13. Email correspondence between primary care clinicians and their patients should be piloted prior to becoming a routine part of NHS care. The impact of introducing emails from patients on the primary care workload should be evaluated, bearing in mind its potential to reduce face-to-face consultations. *(Section 2.3.2, recommendation to NHS England, general practices and the National Institute for Health Research)*
14. Primary care staff, including community nurses and health visitors, should use a common medical record based on the general practice electronic record. *(Section 2.2.2, recommendation to NHS England, CCGs and to local authorities)*

- 15.** There should be a single point of access to out-of-hours services to avoid patients needing to make more than one call to get advice. Software solutions that go beyond the Summary Care Record need to be accelerated so that GP out-of-hours services have full access to electronic medical records including care plans. *(Section 2.6, recommendation to NHS England, CCGs and general practices)*

## Federations and networks of practices

Despite the strong worldwide reputation of UK primary care, it is increasingly recognised that the traditional small, independent 'corner shop' model of general practice and community pharmacy can no longer fully meet the needs of patients. Practices will need to be linked in networks, federations or large practices ('super-practices') or as part of multi-specialty community providers. This will enable them to provide a wider range of services, to offer better opportunities for staff development and training, and to work more effectively with commissioners, specialists, hospitals and social services.

Support and training is needed for those taking on leadership and management roles in these new organisations. Primary care staff have historically been relatively unengaged in NHS opportunities for leadership training and this must be redressed.

Federations or networks of practices offer opportunities to develop links with patient groups and local community organisations in a way that is very difficult for individual practices. This will provide better support for people with long-term conditions and others with particular health needs. Federations and networks also offer the opportunity to engage patients much more actively in planning primary care services than has been possible before.

- 16.** Large groupings of general practices (for example, federations, networks and super-practices) and federations of community pharmacies have much to offer in extending the scope of care provided in the community and improving coordination of care. Their development should be supported. *(Section 4, recommendation to NHS England and professional bodies)*
- 17.** Within federations and networks, staff should be identified with responsibility for developing links with patient groups and with local community

and voluntary organisations. *(Section 3.3, recommendation to GP federations and networks and federations of pharmacies)*

## Integrating care

Fragmentation of care is one of the major faults in health and social care, and the current array of community-based services is confusing for the public and professionals. We make the following recommendations in order to improve integration of care.

- 18.** In line with some models in the NHS *Five Year Forward View*, specialists should be involved in a wider range of activities that bring them into direct contact with primary care staff. These might include routine email and telephone advice, supporting continuous quality improvement by attending multi-disciplinary team meetings, supporting primary care staff working in extended roles and providing referral clinics in primary care settings. *(Section 3.1, recommendation to NHS England, CCGs and general practices)*
- 19.** Contracts for community nursing services and GP out-of-hours care should require bidders to demonstrate that they have the ability to integrate well with other primary care providers. This will encourage contracts to be held by organisations representing primary care providers, for example, federations of GP practices, multi-specialty community providers or primary and acute care systems, rather than by stand-alone providers or community trusts *(Sections 2.6 and 3.2, recommendation to NHS England and CCGs)*
- 20.** There should be a single point of access to community services and social services for urgent assessments. To facilitate effective multi-disciplinary assessment (for example, acutely ill older people, discharge planning), staff from the necessary range of healthcare disciplines and from social services should be co-located and develop a team-based approach. *(Section 3.3, recommendation to NHS England, CCGs and local authorities)*

## Quality and safety in primary care

GPs and general practice nurses are seeing patients with increasingly complex problems some of whom require longer face-to-face consultations. Already, the average time spent by GPs in each consultation exceeds the average booking interval. This is particularly important for



patients with complex medical and personal needs, where doctors need to be able to give longer appointments for comprehensive assessment and management, and where better patient education may result in improved use of medication and more effective self-care.

If face-to-face consultations become longer, some of this increased time may be offset by people having their problems more satisfactorily addressed at an initial consultation and not needing to return. Time may also be freed up for longer consultations by employing other team members to see less complex cases and by extending use of other forms of communication (such as phone, video-conferencing and email).

As people develop more complex long-term conditions, it will become more important for patients to see a clinician whom they know so that their preferences can be taken into account avoiding, for example, unwarranted polypharmacy. For healthcare professionals, it is increasingly important that they should see patients that they know in order to provide safe care for patients with complex problems within time-constrained consultations. The increasing difficulty that patients experience in

booking with a particular doctor or nurse is becoming a major issue for patient choice in the NHS.

- 21.** General practices should be organised so that a significant proportion of face-to-face consultations can be longer in order to enable patients to have time to fully explore their health problems, their options for care and how they can best manage their conditions. *(Section 2.4.3, recommendation to NHS England, CCGs and general practices)*
- 22.** The ability for people to book to see a doctor or nurse of their choice should be monitored as a key metric of the quality of general practice care. *(Sections 2.4.2, recommendation to NHS England, CCGs and general practices)*
- 23.** Data should be publicly available on the quality of primary care. This should include measures of access, communication, clinical quality and integration. It is a priority to develop measures of integration since these do not currently exist in a form that can be routinely applied in the NHS. *(Section 2.4, recommendation to NHS England and National Institute for Health Research and the CQC)*

## Population groups with particular needs

### Socio-economic deprivation

**24.** Measures are needed to address inequalities in the distribution of healthcare professionals in order to improve the major deficits seen in areas of socio-economic deprivation and poor health. New workforce initiatives should be prioritised in these areas. (*Section 2.5.1, recommendation to HEE and NHS England*)

### Care for children

**25.** GP practices should have access to a named paediatrician and a named children's nurse. They should have named health visitors who use a common NHS electronic record to share information with other primary care staff. (*Section 2.5.2, recommendation to HEE and NHS England*)

### Care for people with mental health problems

**26.** Practices or groups of practices should have access to a named consultant psychiatrist and a named mental health worker such as a primary care mental health worker or community psychiatric nurse. (*Section 2.5.3, recommendation to NHS England*)

### Care for people with challenging health and social care needs

**27.** Clinical commissioners should address the needs of people with challenging health and social care needs (such as homeless people and substance abusers) that need 'one-stop' healthcare hubs where people can receive multiple services in one place. This may be addressed by practices established to provide care specifically for vulnerable groups or through conventional practices with on-site access to a multi-disciplinary team that includes social workers and drug and alcohol teams. (*Section 2.5.4, recommendation to NHS England and CCGs*)

### Care for people in nursing and residential homes

**28.** Care for people in nursing and residential homes should be organised so that all patients in a home are cared for by one GP practice, except where a resident asks to be registered with a different practice. Likewise, one community pharmacy, ideally linked to the practice, should provide advice on safe prescribing and medicines use in each home. (*Section 2.5.5, recommendation to CCGs, general practices, community pharmacies and care home owners*)

**29.** Within general practices, one or two doctors should take responsibility for their patients in each home, prioritising proactive care over responding to acute illness, for example, with regular 'ward rounds'. GPs should have access to the full electronic medical record with the ability to prescribe electronically while they visit nursing or residential homes. (*Section 2.5.5, recommendation to general practice and care home owners*)

### Care at the end of life

**30.** People at the end of life and their families should be able to identify and contact named individuals who lead on their care, for example a GP, community nurse, or specialist nurse. (*Section 2.5.6, recommendation to general practices*)

**31.** Healthcare professionals providing care to patients at the end of life should have access to an up-to-date care plan 24 hours a day, access to community nursing services 24 hours a day, and to night sitting services. They should have ready access to drugs commonly used at the end of life, and advice from palliative care specialists should be available 24 hours a day. (*Section 2.5.6, recommendation to NHS England, CCGs and community pharmacies*)

## Education and training: creating learning organisations

With some exceptions (for example, medical student teaching and GP training), little priority has been given in the NHS to training and professional development for staff working in primary care. This needs to change and we make several specific recommendations relating to training. In addition to these, an infrastructure needs to be provided to support training across the primary care workforce including training and support for quality improvement activities.

**32.** Structured training opportunities should be available to all primary care staff wishing to develop extended clinical, academic or leadership roles during their careers. There is a particular need for leadership training and ongoing support for primary care staff with leadership roles in federations and networks and for staff to develop skills in quality improvement. We also identified a need for staff to be trained in new forms of consultation using phone, video-conference and email. Specific provision is needed for foundation programmes with minimum training standards for registered nurses who transition from secondary to primary care, (*Sections 2.2.1 and 2.2.2,*

*recommendation to CCGs, HEE, general practices and regulators)*

- 33.** Pre- and post-registration placements in primary care should be commissioned as part of routine training for nurses and pharmacists as they are for medical students and GPs. *(Sections 2.2.2 and 2.2.3, recommendation to HEE)*
- 34.** The number of pre-registration pharmacy placements needs to increase in order to meet the enhanced role for pharmacists identified in this report. These placements should include experience in community pharmacies and in general practices as well as in hospitals. *(Section 2.2.3, recommendation to HEE and community pharmacies)*
- 35.** There should be opportunities for joint training of health and social care staff to enable more efficient assessments to be made and to increase understanding between the professions. Community staff making urgent assessments of acutely ill patients should receive basic training in the skills of other members of their team in order to increase the efficiency of their assessments. *(Section 3.2, recommendation to HEE, NHS England, CCGs, local authorities, healthcare regulators and professional bodies)*
- 36.** Community Education Provider Networks provide a model that promotes inter-professional learning based around the needs of local populations. This model forms part of the concept of a training hub in the Ten Point Plan and should be developed further in order to meet the educational needs of multi-disciplinary primary care teams. *(Section 5, recommendation to NHS England and HEE)*

## Providing better data about primary care; making innovation evidence based

We received a consistent message planning in primary care is difficult because of the lack of reliable systematic data about the numbers of different disciplines in primary care, who currently does what, and whether they have the appropriate skills to deliver the wide range of functions that are needed. Workload and activity surveys are carried out infrequently, by a range of interested parties and without any consistent methodology. This needs to change to enable better planning and evaluation of primary care in future. In addition, many innovations in primary care are poorly evaluated with a piecemeal approach to evaluation that makes it hard for policy makers or NHS leaders to defend the use of the resources.

- 37.** Data should be available to enable details of the workforce, the work carried out by them, and the quality of that work to be available on a routine basis. *(Section 8, recommendation to NHS England)*
- 38.** All new resources invested in new models of care should include a component for suitably trained staff to evaluate and share evidence of their effectiveness in order to justify new ways of working. *(Section 8, recommendation to NHS England and the National Institute for Health Research)*

## Making change happen

Some of our recommendations will require significant additional investment, particularly the need for additional staff. However, not all of the recommendations are expensive and some will result in cost savings from better use of NHS resources. If primary care can offer a consistent and coordinated service, this will reduce the constant demands for growth in the acute sector and many of our recommendations are designed to reduce the demand on specialist services.

Compared to recruitment of new staff, many of our recommendations will be less expensive. These include education and training, IT development, and changing contracting requirements for some NHS services. Some of these will result in cost savings from better use of NHS resources.

Some of our recommendations require a minimal investment, for example the ability for GPs and general practice nurses to communicate easily by email with their specialist colleagues in hospital. Some recommendations require only the will to change, for example, one GP practice having responsibility for all patients in a care home except where residents specifically request an alternative GP, patients at the end of life being able to identify who is responsible for coordinating their care, and introducing the ability for patients to see a doctor or nurse of their choice as a key performance metric for the NHS.

Some recommendations require technical solutions that are long overdue. These include general practices, community staff and health visitors using a common patient record. Software solutions need to be accelerated so that staff visiting care homes and those providing out-of-hours care have full access to the patient's medical record.

Some of our recommendations require further research or evaluation. All new NHS initiatives should collect data to show whether they have added value and improved quality and patient/staff experience. There is an urgent need for good measures to show the extent to which care is well integrated: these measures need to be developed. We think there is a strong case for allowing patients to email their GP or nurse as in some other countries, but the impact on primary care workload needs to be assessed. Some new roles in primary care also need further evaluation before they can be widely recommended. These include new administrative roles such as medical assistants, physiotherapists providing first-contact care without referral, and paramedics responding to urgent requests for care.

The 'triple aim' of healthcare – of improving population health, improving patient experience and containing cost – needs to become a 'quadruple aim' that includes improving the working life of health professionals. This recognises that care of the patient requires care of the provider. If our recommendations are implemented, we envisage primary care moving rapidly out of its present situation with constant talk of crisis to one where a high-quality service is provided by well-motivated professionals. Our vision for the future is summarised in the following box:

### Our vision of primary care for the future

Primary care will have at its heart active collaboration between healthcare professionals and the people they care for. This patient-focused approach will require collaboration between professionals and strong team working, both within and across organisational boundaries.

Primary care practices will include a wider range of disciplines. As well as GPs, nurses and administrative support, primary care teams may include healthcare assistants, physician associates, paramedics, allied health professionals, social workers and others. Pharmacists will increasingly become a core part of the general practice team.

It will be normal for general practices to work together, for example, as parts of federations or networks of GP practices, giving smaller practices access to an extended primary care team. Community pharmacies will also form networks that may sometimes join with general practice networks.

Given the complexity of people's needs and the need for time to fully engage people in managing their care, many face-to-face consultations will be longer. Primary and community care staff will make greater use of technology to increase access and support for patients. They may communicate by phone, by video-conference

and by email, and practices will provide web-based support to help patients manage their own conditions. Staff will be able to guide patients to a wider range of resources from lay and voluntary organisations.

Community nurses and health visitors will work much more closely with general practices and will share electronic records with them. In many cases, contracts for community nursing services will be held by federations of GP practices to improve integration of care.

Hospital doctors and nurses will increasingly work with others in community settings, for example, in care of the elderly. While hospital-based specialists may run clinics and see patients in the community, a major role will be to support clinicians in primary care.

Support staff will deal with much of the administrative work currently done by doctors and nurses (such as dealing with most email and electronic tasks), freeing them up for clinical work.

High-quality education will be available to all staff working in primary care to give them access to continuing professional development, to enable them to develop advanced skills, and to provide them with the leadership and management skills to run new primary care organisations such as federations of GP practices.

# 1. Introduction

## 1.1 The challenges to be addressed

Good primary care is widely acknowledged as key to delivering effective and efficient healthcare. The UK has led the world in the development of primary care over the last 50 years, and many countries continue to look to primary care in the NHS as a model to be emulated. Nevertheless, the NHS faces major challenges. The Commission on the Future Primary Care Workforce has been set up in response to these challenges:

- An increasing population
- A rapidly ageing population
- Rising demand for care with increasing numbers of primary care visits each year
- Increasing numbers of complex patients with multiple long-term conditions
- A need for increased time with patients to support self-management and to share decision making

- Progressive move of care from hospitals to primary care
- A need to provide better access to primary care
- Poor coordination between general practice, community health services and hospitals, and between the NHS and social services.

Demand for primary care is increasing, particularly for people with multiple complex problems. Workload projections suggest that older people with multiple long-term conditions, including people with frailty, will be the major source of increasing work for primary care in coming years. The long-term increase in the complexity of people seen in primary care is illustrated by changes in patterns of investigation, where the number of test results dealt with by practices tripled between 2003 and 2013. Likewise, in prescribing, the number of people with complex and potentially hazardous prescription regimes more than doubled between 1995 and 2010 (Figure 1).<sup>1</sup>

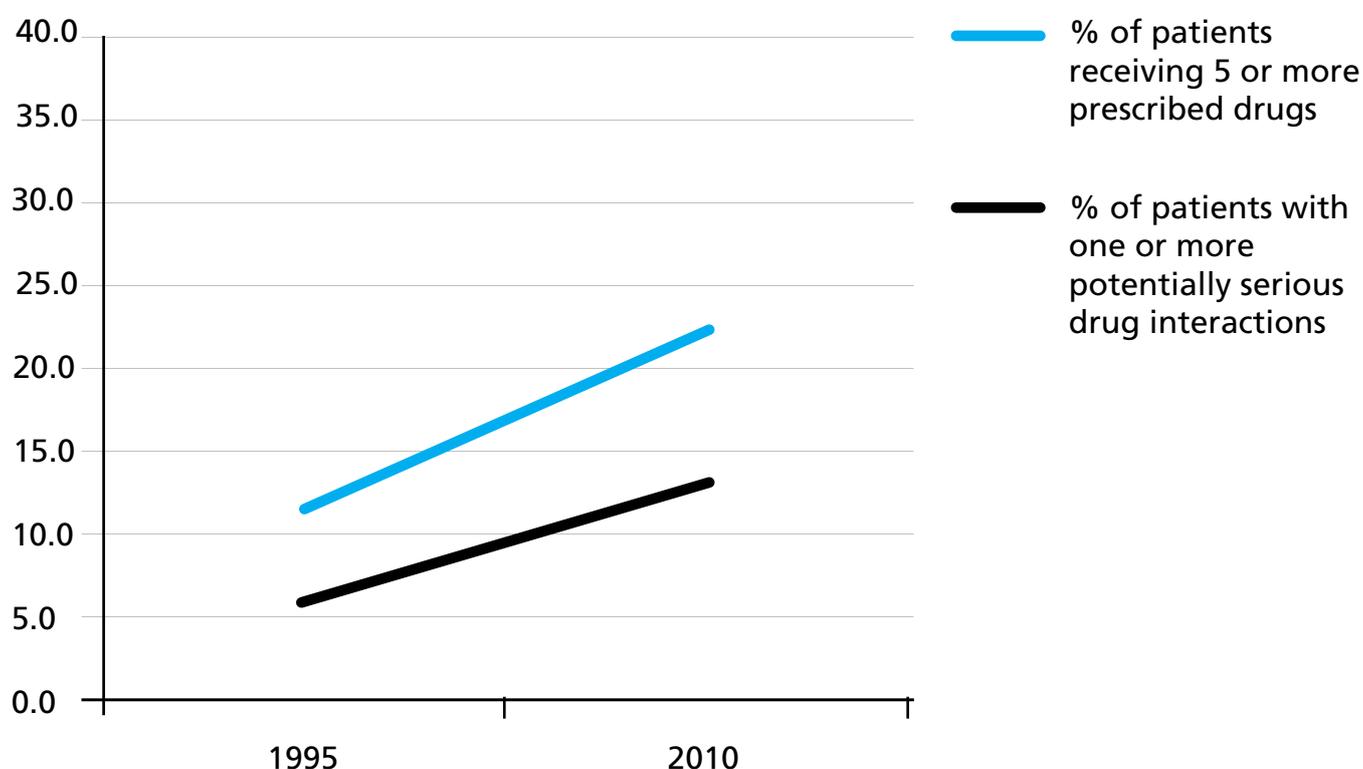


Figure 1: Increase in complexity – percentage of people on multiple medications and at risk of serious drug interaction (data from Guthrie et al, BMC Medicine 2015; 13: 74)

<sup>1</sup> Data on investigations are from Northern Ireland and on prescribing from Scotland. Up-to-date data on these are not available for England.

These challenges are not being addressed by the current distribution of resources. Investment in primary care has fallen well behind investment in hospitals, despite increasing expectations of the work that should be done in primary care. Between 2003 and 2013, the number of hospital consultants increased by 48 per cent while GP numbers increased by only 14 per cent.<sup>2</sup> Indeed, the number of GPs per head of population has actually declined since 2009. To add to this, there are now substantial difficulties in recruitment and retention: in 2013/14, 8 per cent of GP places and 12 per cent of GP training places remained unfilled, and fewer than 20 per cent of foundation doctors say that general practice is their first choice of career.

Nursing is a second area of major concern: from 2010 to 2014, a time when more care was being delivered in the community, the nursing workforce in acute trusts expanded by 4 per cent while the community nursing service contracted. Nursing also has an ageing workforce with problems of recruitment and retention: 64 per cent of general practice nurses are over 50, with only 3 per cent under 40. Between 2001 and 2011, the number of community nurses fell by 38 per cent,<sup>3</sup> and there is a growing dependency on agency staff.

Young healthcare professionals looking to work in primary care should find stable and fulfilling career structures, but instead they often find inconsistent

employment arrangements and uncertain opportunities for career development. The changes we describe in this report will meet these challenges, but not with the current workforce and not without changes in the ways that healthcare professionals work in primary care. Investment is needed, both to attract young healthcare professionals to work in primary care and to facilitate the development of new models of care.

The aim of the Commission is to propose models of primary care that meet the needs of the population, both now and in the future. In doing this, we have been mindful of people's need for both urgent and routine care that is readily accessible, and for new models of care that will continue a longstanding shift of care from hospitals into the community, as outlined in the NHS *Five Year Forward View*. To do this, there needs to be a reversal of longstanding investment in secondary care at the expense of primary care. For example, Figure 2 illustrates a 20-year decline in the percentage of NHS doctors who are GPs.

In addition to investment in primary care, there is a need for much closer integration between primary and secondary care and between health and social care, along with a need for a focus on prevention and reducing health inequalities. The work that is required from primary care is crucially dependent on activity in other sectors; increasingly, pressures on secondary care and on social services have important knock-on impacts on primary care.

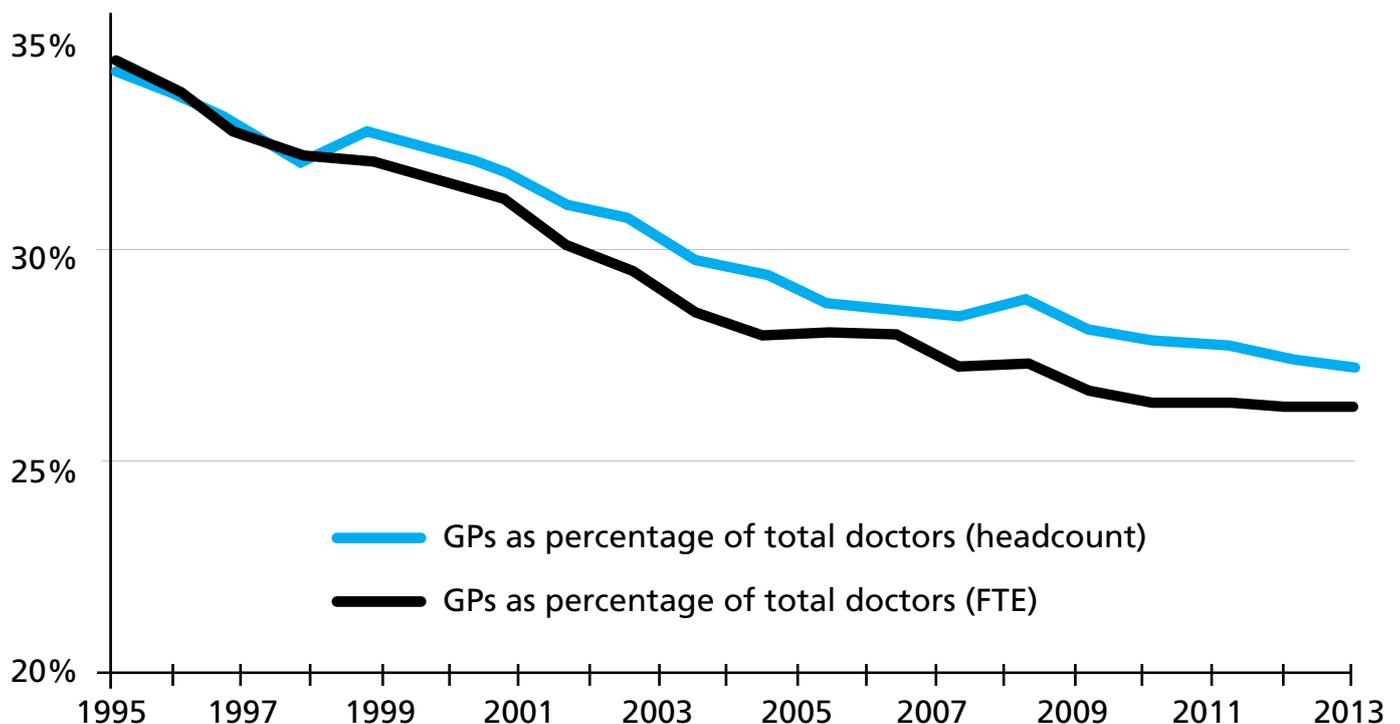


Figure 2: GPs as a percentage of the medical workforce, 1995-2014 (from CfWI, EE30)

<sup>2</sup> [www.hscic.gov.uk/catalogue/PUB13849/nhs-staf-2003-2013-gene-prac-rep.pdf](http://www.hscic.gov.uk/catalogue/PUB13849/nhs-staf-2003-2013-gene-prac-rep.pdf)

<sup>3</sup> [www.rcn.org.uk/\\_data/assets/pdf\\_file/0008/521198/004366\\_District\\_nursing\\_harnessing\\_the\\_potential.pdf](http://www.rcn.org.uk/_data/assets/pdf_file/0008/521198/004366_District_nursing_harnessing_the_potential.pdf)

In planning services for the future, primary care needs to provide:

- the first point of contact with healthcare professionals who are able to deal with the great majority of physical and mental health needs
- high-quality care that is accessible, affordable and acceptable to all groups in the population
- continuous lifetime care that is person-centred, rather than disease-focused
- comprehensive care that provides for all needs that are common in the population
- co-ordinated care, especially for people with complex health needs
- care that has a focus on the population and not just on the needs of individuals.

There is a growing need for strong multi-disciplinary teams working in primary care, and for primary care staff to work more closely with other sectors. However, at the core of each team will be generalists able to deal with a wide range of problems, supported by team members with more specialist roles all working to their full potential. The models of care we describe involve training staff to take on new roles to substitute for work previously done by others (for example, replacing work done by GPs with physician associates or healthcare assistants), and also training staff to do new work not previously done by anyone (such as training specialist nurses to case-manage elderly people with frailty).

In line with the NHS *Five Year Forward View*, we believe that general practice plays a central role in both providing primary care and coordinating care more widely. However, general practice needs to become more outward facing, more population focused, to work more closely with the range of other disciplines involved in delivering care in the community, to take more responsibility for training and development of its own staff, and to work more pro-actively with secondary care and social services.

The 'triple aim' of healthcare – of improving population health, improving patient experience and containing cost – needs to become a 'quadruple aim' that includes improving the working life of health professionals. This recognises that 'care of the patient requires care of the provider'.<sup>4</sup> We provide a vision of primary care that will provide challenging and fulfilling careers for young health professionals while delivering a standard of care to patients of which the NHS can be truly proud.

*Main sources of evidence: RCGP (EE25, FF33, FF117), RCN (FF127), NHS Confederation and National Association of Primary Care (EE33), BMA (EE58, FF137), Centre for Workforce Intelligence (EE30, FF134), Nuffield Trust (EE43, FF108), RAND Europe (FF105), NHS Five Year Forward View (FF106), RCGP/General Practice Foundation (FF108), Kings Fund (FF118), Health and Social Care Information Centre (FF119), General Medical Council (FF122).*

## 1.2 Health Education England's mandate, the Commission's aims and working methods

This report was commissioned by Health Education England (HEE) at the request of the Secretary of State for Health. HEE has a broad mandate,<sup>5</sup> which includes ensuring that the NHS has a workforce with the right skills, values and competencies.

The aim of the Commission is to identify models of primary care that will meet the needs of the future NHS. The Commission's report will therefore inform HEE's future plans in terms of the types of staff that need to be recruited to the NHS, and their training needs throughout their working lives. Key recommendations of the report require action from others, including NHS England. We considered care provided by GPs, general practice nurses, community nurses and healthcare assistants, allied health professionals, physician associates and pharmacists, including the roles that each might play in the primary care workforce. The report does not extend to opticians, dentists and some other primary care nurses, such as school nurses or nurses working in care homes. The Commission collected evidence from the following sources:

- Calls for evidence from a wide range of national, regional and local organisations – over 200 documents were received in response to this call. These are available at Annex Bi
- Visits by the Commission to sites selected to provide examples of innovative practice. Following a call for suggestions, visits were made to twelve organisations across England, listed at Annex D
- Oral evidence sessions, in which we took further evidence from representatives of leading national organisations
- An overview of the national and international literature conducted by RAND Europe available at Annex Aii

<sup>4</sup>Bodenheimer T, Sinkov C. *Ann Fam Med* 2014; 12: 573-6, <http://www.annfammed.org/content/12/6/573.full>

<sup>5</sup>[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/411200/HEE\\_Mandate.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/411200/HEE_Mandate.pdf)

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## 2. Delivering primary care to meet the needs of the population

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### 2.1 Up-scaling: increasing capacity to provide community-based services

Despite the strong worldwide reputation of UK primary care, it is increasingly recognised that the traditional small, independent 'corner shop' model of general practice no longer meets the needs of patients. Much of the evidence presented to us identified a need for general practice to be scaled up, and that this was needed in two ways:

- Practices need to be large enough to provide the range of services that patients should expect to receive in any practice. This will also ensure that healthcare professionals have sufficient support from others in the team so that they can make effective and efficient use of their clinical skills.
- Practices need to be linked (for example, in networks or federations) in order to provide a wider range of services, to offer opportunities for staff development, to interact effectively with commissioners, specialists and hospitals, and to collaborate with social services.

However, this scaling up must also preserve people's ability to access care at convenient locations near their homes, and preserve the particular benefits of small practices so that people can get continuity of care and develop trusting relationships with individual healthcare professionals. We suggest ways in which both of these can be achieved. The basic design features of primary care should be based around:

- a registered list of patients
- pro-active, population-based care delivered by a multi-disciplinary team
- an experienced clinician to make decisions about care early in the consultation process
- ready access to diagnostic tests
- continuity of relationship where important, set against timely access where needed
- care for patients with multimorbidity that is tailored to the needs of the patient

- high-quality end-of-life care
- clinical leadership and professional management
- information systems that can be accessed from different parts of the service
- high-quality premises that are fit for the increased range of services being provided in the community.

*Main sources of evidence: NAPC (EE33), COGPED (EE41), Nuffield Trust (EE43, FF108), RCGP (FF33), COGPED (EE41), Vitality Partnership (EE01), Health Education North West (EE38), Leeds CCGs (EE22), NHS Devon and Cornwall (EE26).*

### 2.2 Up-skilling: increasing the ability of primary care teams to deliver care

Primary care teams need to increase both in size and in the scope of what they do, because:

- more care will be provided in primary care in the future
- many parts of the country have difficulty in recruiting sufficient GPs and nurses, and there will be a lag as more are trained
- some primary care professionals, such as physician assistants and pharmacists, can manage significant parts of the primary care workload
- some team members can bring specialist skills to the general practice workforce, for example, pharmacists in medicines optimisation and physiotherapists for musculoskeletal problems.

#### 2.2.1 GPs

There is a current shortage of GPs, which is likely to get worse. The NHS *Five Year Forward View* recommends that the number of GPs in training should be expanded 'as fast as possible', and NHS England, HEE, the Royal College of General Practitioners (RCGP) and BMA have agreed a 'ten-point plan' to address this shortage.<sup>6</sup>

Projections of long-term shortfall are difficult to predict and depend on training places being filled, GPs staying in the UK, GPs staying in the workforce, and age at

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<sup>6</sup>RCGP, BMA, NHS England, HEE (2015). Building the Workforce – the New Deal for General Practice. [www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/01/building-the-workforce-new-deal-gp.pdf](http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/01/building-the-workforce-new-deal-gp.pdf)



retirement. A number of submissions highlighted the poor state of current data on the primary care workforce, including workload figures. We note the government's commitment to an additional 5,000 GPs by 2020, and also workforce planning provided by the RCGP arguing that 8,000 more GPs are needed to provide more comprehensive out-of-hospital care and clinical leadership for an expanded service.

The increase in work reported by GPs over recent years relates especially to the ageing population, to the increasing number of people with multiple long-term conditions, and to work traditionally undertaken in hospitals. The work done by GPs will change and is likely to focus increasingly on complex cases, with more routine care being provided by other healthcare professionals whom we describe in subsequent sections. In Section 2.2.6, we discuss further the roles of different members of the general practice team ('What role should each profession take?').

In Section 6, we reproduce the key points from the ten-point plan agreed in 2015 between NHS England, HEE, RCGP and BMA. Urgent implementation of this plan will have a substantial impact on GP recruitment and

retention. While local implementation will be needed and will be led by local demands, national bodies need to ensure that resources are made available and give clear direction on effective approaches for improving recruitment and retention. Central direction will also be needed to ensure that the workforce shifts into the most underserved areas, as the market currently works against this; the areas with the lowest professional incomes, poorest premises and least locum/workforce availability are often those with the most deprived populations and worst health.

The lack of clearly structured career development is one of the things that medical students and doctors early in their careers find unattractive about general practice. This relates partly to what is possible in a lifetime in the speciality. In addition to having a rewarding career as a GP, many doctors do undertake additional roles in primary care – either developing a special clinical interest, a role in education, undertaking research, or other leadership roles within primary care. These opportunities are not as visible as they should be.

Although our prime remit did not include a review of the GP contract, we were not presented with convincing



evidence for either retaining or moving away from the independent contractor status of GPs. We heard that it has served the NHS well in some respects (such as harnessing the entrepreneurial abilities of GPs) and less well in others (for example, the lack of career structures and training opportunities for employed staff). However, we note that in other countries a range of employed, semi-private (like the NHS) and private arrangements can all be used to provide good-quality care.

### Recommendations

- Both short-term and long-term strategies are needed to increase recruitment and retention of GPs. The measures to increase GP numbers, as outlined in the Ten Point Plan agreed by HEE, NHS England, RCGP and BMA in 2015, should be implemented rapidly along with the government's commitment to recruiting 5000 additional GPs.<sup>7</sup> National targets for GP numbers should be regularly reviewed. There should also be scope to adjust plans at local level providing that those plans can be demonstrated to meet local need.
- Structured training opportunities should be available to GPs who wish to develop extended clinical, academic or leadership roles.

*Main sources of evidence: RCGP (FF33), BMA (FF137), Centre for Workforce Intelligence (EE30), National Association of Primary Care (EE33), COGPED (EE41), NHS England (FF106).*

### 2.2.2 General practice and community nurses

The UK has been ahead of many other countries in recognising the benefits that nurses bring to the primary care team. Indeed, the rising burden of chronic disease has resulted in an international drive to expand the nursing role in primary care. In this section we focus on general practice nurses and community nurses, while also recognising that healthcare assistants have important roles in the workforce. We have chosen not to focus on individual nursing job titles or roles in our recommendations (such as specialist nurse, advanced nurse practitioner) as the actual tasks carried out by nurses often depend as much on experience and the supportive environment in which they are working as on formal qualifications. While we recognise this as the reality today, we also note the general lack of opportunity for nurses to develop their skills, and the poorly defined career paths in primary care nursing. This includes a general lack of governance, especially in general practice, to ensure that all those in the workforce (from healthcare assistants to nurse practitioners) both have and maintain the skills that are required for their roles.

General practice nurses, supported by healthcare assistants, now take on a wide range of responsibilities which, depending on their training and experience, include management of the main long-term conditions such as diabetes and asthma, seeing vulnerable groups such as children, people with mental health problems

<sup>7</sup>[www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2015-03-10/227112/](http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2015-03-10/227112/)

and those with learning disability, as well as taking on generalist roles including the management of acute minor illness. We believe that nurses could take on substantially more care for both acute and chronic conditions, but there are major pressures on the general practice nursing workforce that are similar to those for GPs – difficulty recruiting, an ageing workforce and (more marked for nursing) a lack of well-defined educational opportunities and paths for career progression.

The potential that nurses have to innovate and lead a high-quality service was emphasised to the Commission by a visit to a nurse-led practice in West London, where most of the clinicians are nurses (some with advanced qualifications) with a relatively small amount of support from doctors whom they employ. The business development skills of the Nurse Directors were paramount to the success of this practice. While we do not specifically advocate this as a model for the future, the visit emphasised to us the varied mix of staff within a practice that can deliver high-quality care (such as 'nurse-led, GP-lite', 'GP-led, nurse-lite' and so on), and the opportunity for nurses to take on leadership roles in primary care. We do not believe that these professions should operate on their own – one of the strengths of UK primary care is the way that, over the past 30 years, professionals in general practice have learned to work closely together as part of a multi-disciplinary team. However, teamworking is also hindered by poor records. In line with the government's policy on personalised health and care,<sup>8</sup> general practice staff, community services and health visitors should share a common electronic record.

Some nurses describe their GP employers being unwilling to make time available for continuing professional development, and a lack of equity with colleagues who have NHS Agenda for Change contracts. This can make general practice nursing an unattractive career option and few development opportunities exist for general practice nurses to develop advanced practice or leadership skills, further restricting their career opportunities, for example, in commissioning or leading primary care practices or organisations. Nurses would more readily see primary care nursing as a career if, like medicine, experience in primary care were included at all stages of training through pre- and post-registration placements, and if a career pathway was more visible during training. This is in line with the recommendations in the *Shape of Caring* review.<sup>9</sup> An Education and Career Framework for district and general practice nurses has been developed by HEE and should form the basis for the future educational strategy for this group of nurses.

Health Education Yorkshire and the Humber created a model to encourage entry of nurses into general practice, providing student nurses with accredited high-quality placements attached to practice nurse teams. As a result, the percentage of student nurses considering general practice nursing as a first career choice has increased from 30 per cent to 88 per cent, with an increasing number of practices employing students directly on qualification.

### **Health Education Yorkshire and the Humber: Winners of the workforce category, 2014 HSJ awards**

Due to the ageing nursing workforce in general practice and the lack of succession planning, there is an urgent need to attract pre-registration nursing students and newly qualified nurses into the profession. We believe that the number of general practice nurses needs to increase as they provide an important part of the workforce in health promotion, in managing the demand for acute care, and in the management of long-term conditions.

We also believe that the number of community nurses needs to increase. Currently this number is declining and, although this has been compensated to a degree by the appointment of more specialist nurses and healthcare assistants, the increasingly complex general nursing care that is needed by people in the community requires an increase in both numbers and skills of community nurses. More community nurses will also be needed to ensure that 24-hour community nursing services are available throughout the country, in order to prevent hospital admission of some older people who become acutely ill. This has already been achieved in several places across England and should be rolled out elsewhere.

There are significant opportunities to develop new ways for staff to enter the nursing workforce. For example, accelerated routes for healthcare assistants working as band 4 assistant practitioners can facilitate the entry of existing staff into pre-registration nursing roles in primary care.

The current organisation of community nursing services does not encourage well-integrated care; for example, they have experienced progressive dissociation from GP practices and poorly developed IT systems. Where GP practices are of sufficient size, community teams should be co-located with GP practices in order to

<sup>8</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/384650/NIB\\_Report.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/384650/NIB_Report.pdf)

<sup>9</sup> <https://hee.nhs.uk/work-programmes/shape-of-caring-review/>

maximise opportunities for communication between practice and community staff. In some situations, for example, where there is a community hospital, it may be possible to provide a wider range of services including blood transfusion, chemotherapy and other day-case procedures.

We also find the divide between nurses working in general practices and those working in the community unhelpful and divisive. Consideration should be given to arrangements for common employment terms, common commissioning arrangements and better educational opportunities to encourage integration between the two branches of the nursing profession. We make suggestions in Section 4 on the role that federations or networks of GP practices could play in making this change.

### Recommendations

- Measures equivalent to the 'Ten Point Plan' agreed for GPs are needed to improve recruitment and retention in primary care nursing. The number of general practice nurses and community nurses needs to increase in order to address both current shortfalls and the number of nurses due to retire in the next 5-10 years.
- Nurses should have opportunities for professional development, including the acquisition of advanced clinical skills and leadership skills. Particular provision should be made for foundation programmes with minimum training standards for registered nurses who transition from secondary to primary care.
- Placements for pre- and post-registration nurses in primary care should be commissioned as part of routine nurse training.
- Community nurses and health visitors should use common medical records based on the general practice electronic record.
- 24-hour community nursing services should be available in all areas in order to achieve a significant and sustainable shift of care from hospital to the community.

*Main sources of evidence: RCGP (FF128), RCN (EE53, FF99, FF100, FF125, FF148, FF149), Nuffield Trust (EE43), North Lincolnshire CCG (EE15), Health Education Yorkshire and the Humber (EE27), Health Education North West London (EE44, FF74, FF100), HEE (FF146).*

### 2.2.3 Pharmacists

In this section we consider models where pharmacists work in GP practices as well as the traditional role of the pharmacist operating from premises in the community.

Pharmacists in GP practices may be working as part of a CCG-funded scheme, employed by the practice or a partner in the practice. Pharmacists carry out a range of medicines optimisation tasks in general practices mostly linked to patients on long-term medication, including monitoring and rationalisation of repeat prescriptions, carrying out reviews for people on multiple medications, supporting adherence to medication, and advising on prescribing to care home residents, who are at particular risk of medication-related adverse events. Prescribing pharmacists can take increased responsibility in these roles.

Most pharmacies now have a private consulting space and offer advice in the management of minor illness and reviews for people on new and regular medications. Pharmacists may also hold contracts to offer specific services such as weight management and smoking cessation. The workforce providing these services includes registered pharmacists but also registered pharmacy technicians and other pharmacy support staff. Greater use of these pharmacy services could relieve some of the demand for care from general practices (though might also generate additional demand). We recommend that there should be agreed protocols for local treatment or referral by pharmacists. These would be developed by existing professional bodies, though in future they would be developed by federations of GP practices in association with federations of community pharmacists (or joint federations).

In the Old School Surgery in Bristol, the prescribing pharmacist is a partner in the practice. She reviews people with long-term conditions, does medication reviews, checks medication when people are discharged from hospital, visits housebound people, and leads audit and training in the practice for prescribing and the Quality and Outcomes Framework. The practice also houses a community pharmacist, who sees people with minor conditions and phones 600 vulnerable people each month to check their medication. The practice prescribing costs are £5.46 per patient per year, against a national average of £8.



In our view, pharmacists' involvement in some complex aspects of care such as medication reviews and advising on medication use in care homes is best carried out in collaboration with the general practice team, to allow pharmacists full access to medical records and maximise opportunities for discussion and shared learning with staff in the practice.

### Recommendations

- There should be greater involvement of clinical pharmacists, including prescribing pharmacists, in the management of people on long-term medication and people in care homes. This role is best carried out in the GP practice in order to allow full access to the patient record and to maximise interaction between the pharmacist and other clinical staff in the practice.
- Wider use should be made of community pharmacists and pharmacy support staff in managing minor illness and advising people about optimising their medicines. There should be agreed protocols for treatment and referral between local organisations of pharmacists and GP practices.
- The number of pre-registration pharmacy placements needs to increase in order to meet the enhanced role for pharmacists identified in this report. These placements should include experience in community pharmacies and in general practices, as well as in hospitals.

*Main sources of evidence: Royal Pharmaceutical Society (EE32, FF47, FF48, FF49, FF50, FF51, FF52), BMA (EE58), Old School Pharmacy (EE03), Centre for Workforce Intelligence (EE30), Devon Local Pharmaceutical Committee (EE09), Northumbria Healthcare (EE11), Dorset CCG/Westbourne Medical Centre (EE24), RAND Europe (FF105), Innovation in Health and Wellbeing (EE12), Care UK (FF11), Pharmacy Voice (FF120).*

### 2.2.4 New clinical and support staff roles in general practice

Physician associates (previously called physician assistants) provide generalist clinical care in general practice, typically seeing people with acute minor illness. They have two years training, most after a basic science degree. This training follows the model of a medical qualification (for example, taking histories, performing examinations, making diagnoses, interpreting tests). Unlike the US, physician associates in the UK need authorisation from a doctor when they judge that a patient needs a prescription. Working under the supervision of a GP, they can make a significant contribution to practice workload.

Increasing use is being made of healthcare assistants in carrying out health assessments, performing routine tests, helping people monitor their conditions and carrying out administrative tasks. When the Commission visited Nottingham City Care, we observed healthcare assistants being used to assess urgent requests for community

The Fisher Medical Centre in Skipton could not find GPs to replace retiring partners and decided to employ physician assistants (PAs). They have two PAs who each see around 20 people a day, mostly same-day appointments. PAs are not able to prescribe, so they work closely with GPs, consulting when they have a patient who needs a prescription. The PAs also do telephone consultations and assist the GPs in reviewing investigations and correspondence.

support and receiving training that would enable them to both assess and meet some of the needs traditionally associated with community nursing, physiotherapy and social work.

In our view, these new types of worker, working within general practice teams, have significant potential to address workload issues in primary care. Physician associates (and paramedics – see Section 2.2.5) offer a relatively rapid way of attracting more healthcare professionals into the workforce to address current levels of need and demand, and it is much cheaper to train physician associates than additional GPs. However, more studies are needed to assess how effective and cost-effective these roles are in the long term.

While we recognise considerable potential in developing these new roles, the governance of these new staff members will be of critical importance in ensuring the quality and safety of their work. This is a particular issue where the GP practice is the employer, when GPs need clarification of the training and governance of these new staff members. Federations of GP practices have a particular role in supporting general practices in this area.

There is also a case for training support staff, including healthcare assistants and existing administrative staff, to assist healthcare professionals in the administrative aspects of their work. Excessive administration is a major problem: in a recent survey of GPs leaving general practice before the age of 50, more than half cited excessive non-clinical workload as a reason for leaving general practice, with other common reasons being a dislike of the target-driven approach to patient care and excessive overall workload. Some US family physicians use 'medical assistants' to deal all their emails and electronic tasks (see box). This includes reviewing test results and arranging follow-up appointments where needed, only passing on to the doctor those things that need their direct attention. Staff trained in these roles could substantially reduce the time that healthcare professionals spend on administrative tasks, allowing them to concentrate on clinical work. These roles merit piloting and evaluation.



“The task list is unbearable. I spend 1.5 hours clearing out my task list every evening before leaving and another 1.5 hours at home after the kids go to bed.” (US family physician)

“The medical assistants and nurses are masters of desktop management, authorized to take tasks off the provider’s worklist, calling people back, reviewing messages. The goal is for the physician to see only physician-level work: the rest is delegated to other members of the team.”

Sinsky et al (2013) <sup>10</sup>

### Recommendations

- There are substantial potential benefits from a range of new approaches to staffing in general practices including the wider use of physician associates and healthcare assistants.
- New support staff roles have the potential to reduce the administrative burden on GPs and nurses to enable them to focus on clinical care. These roles should be developed and evaluated.

*Main source of evidence: BMA/RCN (FF99), Health Education Thames Valley (EE16, FF17-19), Health Education Yorkshire and the Humber (EE27, FF39), South East Commissioning Support Unit (FF82-FF86) RCN/ BMA (FF99), Nottingham City Care (EE07), RAND Europe (FF105), Roundhouse (FF136), Early leavers 1 (FF143), Early leavers 2 (FF144)*

### 2.2.5 Allied health professions, including paramedics

We received evidence on the roles that physiotherapists could take as part of primary care teams, which included face-to-face or phone triage of musculoskeletal problems, self-referral to physiotherapy, and physiotherapy as part of a falls service. In some areas, people may book directly with a physiotherapist without referral from a GP, though access may be restricted to those who meet pre-agreed criteria. Published evidence suggests that the costs of self-referred physiotherapy consultations may be less than for patients referred by GPs, but studies do not generally look at the overall impact on general practice workload. The economic benefit of physiotherapy interventions is likely to be greater if reduced time off work is taken into account – that is, increases in work productivity may offset possible increases in NHS costs associated with wider use of physiotherapists. Input from physiotherapy and other allied health professionals may also be beneficial in maintaining independence on some long-term (for example, neurological) conditions.

The cost-effectiveness of individual physiotherapy interventions is therefore likely to depend on whether they substitute for, or are additional to, standard GP care and whether the economic benefits of returning to work are taken into account. Physiotherapists’ ability to work independently in primary care would be enhanced if they were more widely able to prescribe (since 2014, some have become prescribing physiotherapists), as this would reduce the need for parallel GP appointments.

Some practices have started to use paramedics, especially for initial assessment of urgent visits that would otherwise require a GP to leave the surgery. We were told that they can be safe and effective in this role, but we do not know how often a visit by a GP is still required, or the cost-effectiveness of employing paramedics in this role compared to using other practice staff. This is a role that would benefit from further piloting and evaluation.

<sup>10</sup> Sinsky C et al. (2015). In Search Of Joy In Practice. American Board of Internal Medicine Foundation.

[www.abimfoundation.org/~media/Foundation/Initiatives/Primary%20Care/070913\\_Finding%20Joy%20in%20Practice%20FULL%20WHITE%20PAPER.ashx?la=en](http://www.abimfoundation.org/~media/Foundation/Initiatives/Primary%20Care/070913_Finding%20Joy%20in%20Practice%20FULL%20WHITE%20PAPER.ashx?la=en)



## Recommendations

- More evaluation is needed of alternative approaches to using allied health professionals in primary care, especially to determine whether direct access for some conditions makes cost-effective use of NHS resources.
- The potential for paramedics to substitute for GPs in the assessment of urgent requests for home visits merits further evaluation.
- practices with substantial input from an employed pharmacist or a community pharmacy on site with access to medical records
- practices employing physician associates
- practices where there is a contract with the ambulance service to deploy paramedics to urgent home visits

*Main sources of evidence: Chartered Society of Physiotherapy (EE23, FF32, EE54), Health Innovation Network South London (EE52), College of Occupational Therapy (EE55), Royal College of Speech and Language Therapists (EE29), RAND Europe (FF105)*

### 2.2.6 What role should each profession take?

During the course of site visits, we have become aware of a number of different staffing models operating in practices. These include:

- practices where nurses outnumber doctors
- practices where doctors outnumber nurses

- practices where people can book directly with a physiotherapist.

In all cases, there was a recognition that all the staff working within primary care needed to function as one cohesive team, deploying their respective skills to achieve the best outcomes for their patients and the wider population. Since there are a number of models that appear to be able to provide high-quality care, we do not recommend one particular staffing model, such as GPs or general practice nurses per head of population, although all general practice teams need both medical and nursing input. We also see major opportunities to expand the primary care workforce through the use of other healthcare professionals.

The overall staffing of individual practices should relate to the tasks that need to be done. These include preventive care, diagnosis and management of acute physical and mental illness, management of chronic physical and mental conditions, and care at the end of life. The majority of these tasks require staff with a broad range of skills able to carry out the role of a generalist.

We would not, therefore, support suggestions that the patient population should be segmented into groups to be seen by particular healthcare professionals (for example, paediatrics, acute care, mental illness, cancer, or long-term conditions). The actual staffing of an individual practice is likely to depend on local circumstances, including local availability of staff. In our view, the need for the 'expert generalist' will increase rather than decrease. The reason for this is that segmentation of the population into those with acute minor illness and people with long-term conditions will become increasingly untenable as the population ages: people with acute illness will increasingly be those who also have long-term conditions, often on multiple medications.

We also recognise a role for healthcare professionals with advanced clinical skills exercising these within federations and networks of general practices, and working with specialists to provide a wider range of services. Later in this report, we draw attention to the needs of particular population groups (Sections 2.6.1 to 2.6.6), and to geriatrics, paediatrics and psychiatry, where close links with specialists will be particularly beneficial (see Section 3.1).

Healthcare professionals in primary care will need an increasing range of skills, including telephone, video and email consulting, skills in health coaching, and increased skills in care planning and coordination. Formal training in these roles will increase the attractiveness of primary care as a career to young healthcare professionals.

Cuckoo Lane Surgery in Hanwell is a nurse-run practice with two nurse directors and 26 staff, including six nurse practitioners, four practice nurses, one healthcare assistant and four hours of sessional GP time a day. The practice offers the full range of primary care services for its 4,600 patients, including some services that it provides for the locality (such as paediatric phlebotomy). This practice which was recently rated 'outstanding' by CQC, demonstrates an alternative staffing model that can be used deliver high-quality care.

In summary, a wide range of staffing models, which include GPs, nurses and other health professionals, can deliver high-quality primary care. For this reason, we do not recommend one particular staffing model, although all general practice teams need both medical and nursing input (Section 2.2.1 and 2.2.2). We see major opportunities to expand the primary care workforce through the use of other healthcare professionals (Section 2.2.3 to 2.2.5).

### 2.2.7 How should practices change their skill mix?

There are many opportunities to change practice skill mix and staff roles. These changes can help address workload issues, improve the patient experience and sometimes deliver savings. However, achieving these benefits requires careful planning and support. As one practice said to us: "Always gather your data and evidence to justify a new member of the clinical team." Practices should analyse their clinical caseload in order to decide on the skills that will meet the needs of their population. They also need to agree clear pathways and referral criteria for what each clinician will see and do, and ensure people fully understand their new roles and evaluate these together over time.

There are particular opportunities for different staff to manage minor illness, to work with patients in the management of their long-term physical and mental conditions, to undertake medicines optimisation, and to care for children and young families. The new staff employed by practices or groups of practices may include pharmacists, specialist nurses, physicians' associates, physiotherapists, healthcare assistants and hospital specialists. One practice we visited employed a wide range of professionals on a sessional basis and calculated that they made savings of 50 per cent, compared to employing GPs for the equivalent number of sessions. An alternative to employing new staff can be to extend the skills of current staff. This can lead to more responsive care as well as a deeper appreciation of each team member's skills.

#### Recommendation

- Practices should analyse their workload and clinical case-mix when deciding what skills they need to employ. They then need to agree clear criteria for what each healthcare professional will do and ensure that staff are fully competent in the roles they undertake.

### 2.2.8 Team working

Effective team working is a critical underpinning to high-quality care, particularly when practices are using a wider range of staff to manage patients with complex problems. Strong team working not only ensures effective use of a different skill mix but also has a big impact on the quality of the working lives of staff. One practice told us that they try to create an ethos that staff should never feel they are on their own.

Team working does not happen automatically and requires setting time aside to reflect as a team on the needs of their patients. Recruitment based on values as well as competences can strengthen a team's alignment. We were impressed with the mutual support evident in some practices we visited, which had brief 'huddles' once or twice a day for staff to share experiences, anxieties, stresses or successes. This reduced the isolation that very easily arises, even in a large group, when staff are too busy to look beyond the next thing they have to get done.

#### Recommendation

- Practices need to create protected time and space to support effective team working.

## 2.3. Making better use of technology

Primary care has for some time made widespread use of technologies that are still only patchily being introduced into hospitals – for example, electronic records, automated alerts for drug interactions/allergies, and automated guideline prompts. In the future, home-based technologies will either facilitate remote monitoring of people's health or enable them to test themselves (for example, anticoagulant monitoring). We anticipate that these may significantly affect the way in which healthcare is delivered, to the extent that each technology proves to be a cost-effective alternative to conventional care.

The area on which we focus in this report, because it particularly affects the primary care workforce, is the use of electronic communication such as email or video-conferencing between primary care staff and both patients and hospital specialists.

### 2.3.1 Communication with other specialists

We regard it as outdated that GPs and specialists are unable to communicate freely by email or by electronic messaging. Although some areas have commissioned services that enable GPs to email specialists for advice, these remain the exception rather than the rule. Often people need to be referred to hospital just for a simple query to be answered. At a time when there is so much focus on integration of care, it seems bizarre to us that provision is not made within the job plans and contracts of both GPs and specialists to encourage this basic level of communication.

### 2.3.2. Communication with patients

We also anticipate that video-conferencing consultations will become a common extension of the telephone consultations that are already widespread in general practice. For example, the West Midlands Vitality partnership has already introduced smartphone apps and video-conferenced consultations to supplement traditional methods of access. These approaches allow practices to move away from a 'one size fits all' response to their patients.

We think it will soon look outdated that, in an age where so much communication occurs by email, few people can email their GP or practice nurse. In contrast, 86 per cent of GPs in Denmark (see box) and 46 per cent in the Netherlands use email regularly to communicate with patients.

'Web-GP' at the Hurley Group – an NHS organisation that runs a number of practices and GP walk-in centres across London – offers:

- a symptom checker
- self-help guides and videos about common conditions
- signposting to alternate sources of care such as local pharmacies
- 24/7 phone advice within one hour via 111
- e-consultations in which people can submit questions to their GP for response within one working day

In Denmark, people have been able to email their GPs for over 10 years. They log into the practice website to send their email, with the word limit set by the GP (typically 150 words). Patients are reminded that emails must be for non-urgent problems. GPs often send emails to communicate test results and have standard templates for this. Nursing home staff can also email the GP, for example, with medication queries. Many GPs have a nurse or admin assistant checking their e-mails, answering the simple ones and only passing on the more complex ones to the GP. The largest group of email users is older people with chronic conditions. The practice is paid 4.20 euros per email. The use of email has increased rapidly, from 400,000 in 2006 to 4 million in 2013 (Denmark's population is 5.6 million).

The use of these new technologies does have limitations, including information security and challenges in establishing and maintaining IT infrastructure. Furthermore, we do not know whether email would reduce the need for patients to come into the surgery or would generate additional demand. The experience of Kaiser Permanente, a US healthcare organisation, is that allowing patients to email their doctor does not lead to any reduction in face-to-face consultations. In Section 2.2.4 we describe the use of medical assistants to deal with emails and electronic tasks, to reduce the administrative burden on clinicians. Allowing patients to email practices does not mean that doctors or nurses have to provide all the responses.

As the nature of consultations changes, with greater use of phone, video or email, training methods will need to reflect the different skillsets required for alternative forms of consultation.

### Recommendations

- Email correspondence and electronic messaging should become routine between primary care healthcare professionals and hospital specialists, enabling both to seek advice and give guidance on patient care. While this may need protected time in the working day, there are significant potential cost savings in terms of reduced referrals to hospital.
- Email correspondence between primary care clinicians and patients should be piloted prior to becoming a routine part of NHS care. The impact of introducing emails from patients on the primary care workload should be evaluated, bearing in mind its potential to reduce face-to-face consultations. Healthcare

professionals should receive training in consultations via phone, video-conference and email.

*Main sources of evidence: RAND Europe (FF105), Westbourne Medical Centre/Dorset CCG (EE24).*

## 2.4 Maintaining quality and safety of care

There are several elements that determine whether a healthcare system delivers high-quality care. These include:

- Can people access healthcare when they need it?
- Is the care people receive safe and effective, including both good clinical quality and good interpersonal communication?
- Is care well coordinated?

In this section, we discuss access to primary care and two important elements of clinical effectiveness, which we believe will become increasingly important as the population ages and more complex problems are seen in primary care. These are the importance of continuity of care and of healthcare professionals having sufficient time with patients. We discuss coordination and integration of care further in Section 3. This is a particular issue in relation to patient safety, because many threats to patient safety occur due to fragmented or poorly coordinated care.

In our view, data should be publicly available on the quality of primary care. This should include measures of access, inter-personal communication and whether people can see the clinician of their choice (for example, through patient surveys), clinical quality (for example, through QOF) and measures of integration. It should be a priority to develop measures of integration since they do not currently exist in a form that can be routinely applied in the NHS.

### 2.4.1. Access

Good access includes the availability of appointments, timeliness of care and the ability to access a GP or nurse of the patient's choice. All these are important components of access that go beyond simple opening hours. Pharmacies already have long opening hours and extending GP opening hours has been a strong policy focus recently.

People generally have good access to general practice. In 2014/15, 85 per cent of people reported that they were able to get an appointment last time they tried and the

appointment was 'very convenient' or 'fairly convenient' for 92 per cent of them (about half in each category). However, the percentage of people who report they are unable to secure an appointment has been rising (from 9 per cent in 2012 to 11 per cent in 2015), and the percentage of people whose appointment was at a convenient time has been falling.

In the face of rising demand, practices have introduced a range of alternatives to the traditional GP appointment. These include seeing other healthcare professionals (for example, see Sections 2.2.2 to 2.2.5) and the use of telephone consultations. New approaches to making it easier for people to book appointments include online booking. One practice that has developed a smartphone app for people to make appointments (see box), and in Section 2.3.2 we discuss how the Hurley Clinic is providing online support to patients through 'Web-GP'.

The Robin Lane Medical Centre in Pudsey developed a smartphone app for people to request appointments, send secure messages to healthcare professionals and set appointment reminders. In addition to the convenience that the app offers to people, it's helped to reach patient groups who may not ordinarily interact with their GP – for example, young people seeking confidential advice about sexual health.

Practices can therefore provide a range of ways in which care can be accessed. In our view, discussion around access has focused too strongly on practice opening hours. While these are important, the discussion needs to be balanced by considering the ease with which people can make appointments (for example, they may only be able to phone at 8am for a limited number of 'available' slots), the range of clinical staff available, and other important aspects of quality.

## 2.4.2 Continuity of care

There is a tension between providing rapid access to general practice and offering continuity of care. Recent changes to NHS policy (for example, patients having a named GP) have emphasised the importance of the personal care that patients should receive and the importance of continuity of care. As the Nuffield Trust suggests in one of their design principles for primary care, people should be offered "continuity of relationship where this is important, and access at the right time when it is required".

There are a number of concepts grouped under the term 'continuity of care'. These include informational continuity (for example, several people having access to the same electronic record), management continuity (for example, following an agreed protocol for management of a long-term condition) and relational continuity (that results from seeing the same doctor or nurse on a regular basis over time).

Relational continuity has been declining in recent years and results from the GP Patient Survey suggest that, year on year, 3 per cent fewer people are able to see the doctor of their choice (see Figure 3). This is despite the fact that most people have a particular doctor they prefer to see – 52 per cent for 18-24 year olds, increasing to 81 per cent for ages 75-84. The increasing difficulty that patients experience in booking with a particular doctor or nurse is becoming a major issue for patient choice in the NHS.

Loss of continuity is potentially as great a problem for GPs as for patients. As the population ages, patients and their medical records become more complicated, and it becomes more difficult for the GP or nurse to deal safely with a patient with complex problems that he or she doesn't know within the space of a time-limited consultation. The RCGP has provided a toolkit suggesting ways in which continuity of care can be improved within the context of modern general practice.<sup>12</sup>

<sup>12</sup> [www.rcgp.org.uk/policy/rcgp-policy-areas/continuity-of-care.aspx](http://www.rcgp.org.uk/policy/rcgp-policy-areas/continuity-of-care.aspx)

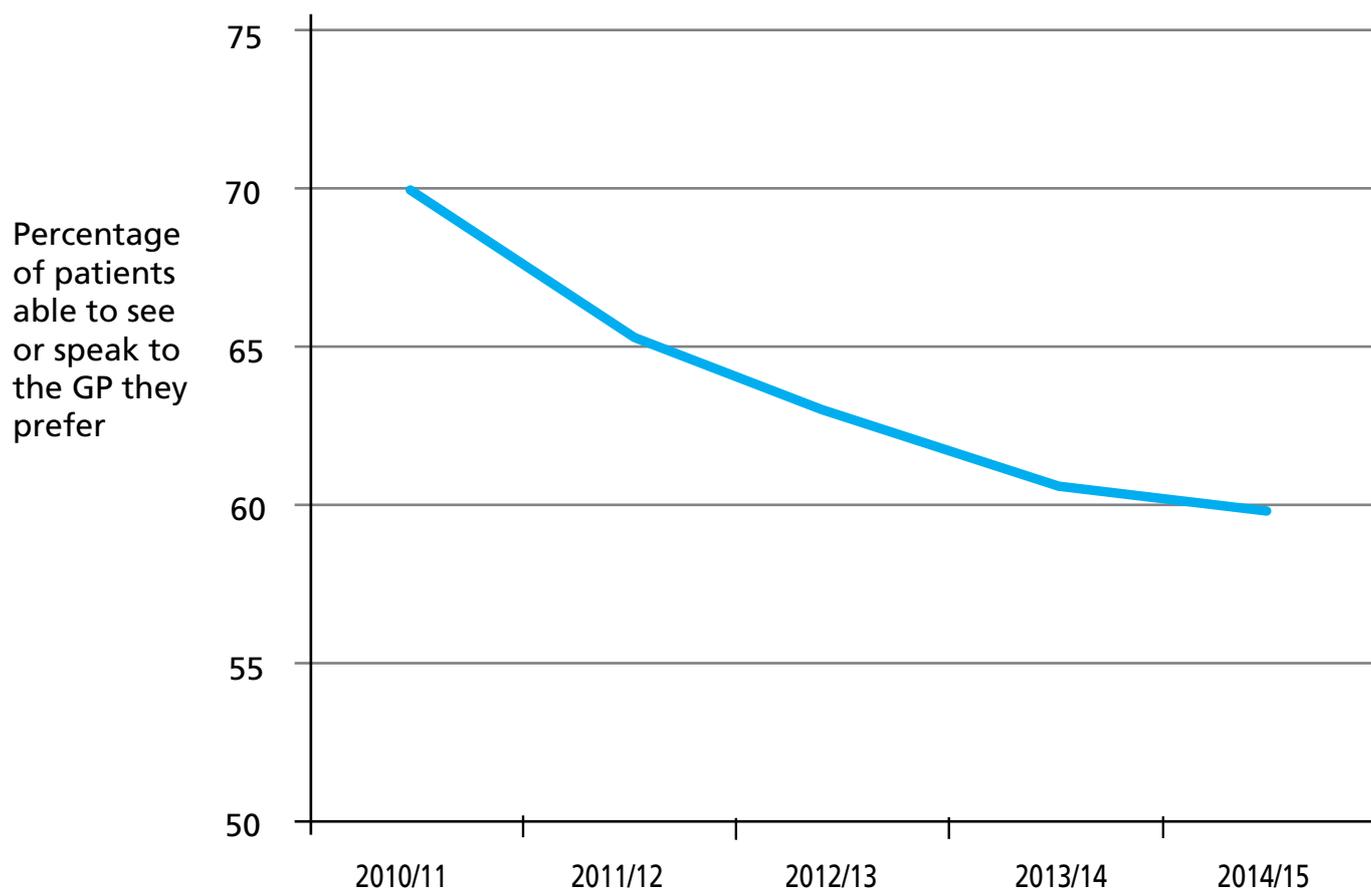


Figure 3: Percentage of people able to see or speak to the GP they prefer 'a lot of the time', 'almost always' or 'always' (of people who say they have a particular GP they prefer to see – data from GP Patient Survey)

### 2.4.3 Giving people enough time in general practice consultations

Fully addressing the needs of people with complex conditions requires a different approach to consultations. Care needs to be less episodic and reactive, and focus more on supporting patients to look after their own conditions. This takes time and a ten-minute consultation is inadequate for many of the people attending a general practice. In 2006, the average time spent by GPs in consultations (11.9 minutes) already exceeded the booked 10-minute appointment slot that most practices offer. When consultations are rushed, important clinical needs can be missed, as can be the core issues that individuals want addressed.

We noted that, in many European countries, consultation times are longer than in the UK. In the country with the longest booked consultation time (Sweden, 25 minutes), people also have consultation rates around a quarter of those in the UK. The 'Year of Care Partnerships' envisaged

by the NHS provide more time in planning care so that care becomes less reactive and episodic.<sup>13</sup> This type of care requires a move away from the standard short consultation.

The number of problems that need to be dealt with during a consultation is likely to increase further as the population ages. Furthermore, even 'minor' acute problems will be increasingly present in people who have complicated long-term conditions. Therefore, the pressure on healthcare professionals to deal with several problems during a consultation will increase. We are aware that some doctors and many nurses already book routine consultations at 15-minute intervals, and practices that operate this type of booking arrangement have described to us how this helps them deal with people's problems more effectively. Alternative approaches that reduce the need for face-to-face consultations should be evaluated, including phone and email consultations with patients.

<sup>13</sup> [www.yearofcare.co.uk/](http://www.yearofcare.co.uk/)



## Recommendations

- General practices should be organised so that a significant proportion of face-to-face consultations can be longer in order to enable patients to have time to fully explore their health problems, their options for care and how they can best manage their conditions.
- The ability for people to book to see a doctor or nurse of their choice should be monitored as a key metric of the quality of general practice care.
- Data should be publicly available on the quality of primary care. This should include measures of access, communication, clinical quality and integration. It should be a priority to develop measures of integration since these do not currently exist in a form that can be routinely applied in the NHS.

*Main sources of evidence: RCGP (FF33, FF34, FF135), BMA (EE58), Nuffield Trust (EE43, FF108), RAND Europe (FF105).*

## Tackling a crisis – the experience of Group Health Cooperative, Seattle

In the 2000s, Group Health Cooperative in Seattle introduced reforms to make primary care more efficient. They brought in advanced access, laid off nurses, reduced consultation times and introduced productivity incentives for doctors. Productivity improved, but A&E visits went up, doctors became burnt out, reduced their hours and retired early. There was a looming crisis.

They decided they couldn't go on as they were. They redesigned their care on the principles of the patient-centred medical home, with more attention on personal relationships with individual healthcare professionals, better team working and better coordination. They reduced the number of patients per doctor and increased appointment times. They recruited medical assistants and clinical pharmacists. Nursing roles were extended to include outreach work. They shifted much of their work to email and phone contacts. A&E visits fell, and both patients and staff were happier. They also became more profitable.

## 2.5 Population groups with particular needs

### 2.5.1 Care in areas of severe socio-economic deprivation

People in areas of major socio-economic deprivation often suffer the dual disadvantage of poor health and poor health services. 'GPs at the Deep End' is a group of GPs working with general practices serving Scotland's 100 most socio-economically deprived populations, and comparable support groups are also being set up in English areas of socio-economic deprivation.

Deep End projects have identified a range of measures to improve the care of, and outreach to, the most vulnerable and marginalised groups within local communities. These include targeted appointments for people with the most complex needs, combined with additional consultation time, practice-attached community link workers to help people navigate the health and social care systems, connecting practices and individuals to community resources for health, and attached alcohol and mental health workers.

There are marked regional variations in the numbers of healthcare professionals across England; for example, the number of GPs per 100,000 ranges from 63.4 in the North West to 81.5 in the Thames Valley. Furthermore, the poorest regions, where health is also worst, have fewest GPs and the greatest difficulty recruiting, with many posts remaining unfilled. In addition to addressing deficiencies in staffing, reducing inequalities in distribution of staff may be as important as the absolute increase in numbers. We note international experience that providing training places in underserved areas increases the likelihood that doctors will stay in those areas, and that non-financial incentives (such as ongoing training and support) are just as important as financial incentives in encouraging health professionals to work in these areas.

The NHS *Five Year Forward View* suggests new ways of working, with GP practice staff working more closely and empowering communities. This may be of particular importance to encourage in areas of socio-economic deprivation, where poor lifestyles make a major contribution to ill health.

### Recommendation

- Measures are needed to address inequalities in the distribution of healthcare professionals in order to improve the major deficits seen in areas of socio-economic deprivation and poor health. New workforce initiatives should be prioritised in these areas.

*Main sources of evidence: RCGP (FF33, EE19, EE18).*

### 2.5.2 Care for children

The UK's outcomes for children are among the worst in western Europe, with, for example, childhood asthma mortality nearly five times as great as most other EU countries. A recent report by the Royal College of Paediatrics and Child Health (RCPCH), RCGP and RCN suggests standards for the care of children, several of which focus on training and support for clinicians in primary care. The recommendations include a link consultant paediatrician and a link community children's nurse for each GP practice or group of practices, better access to advice on sick children, and the development of local care pathways for common conditions.

We endorse these recommendations but note that hospital paediatricians are increasingly specialised. Primary care paediatrics may need to be included as part of their training if they are to be most effective in supporting staff in primary care. We also note that GPs in some parts of the country may be unfamiliar with the role of the community children's nurse and their potential role, for example, in avoiding admissions of sick children. In our view, health visitors should have a more prominent role in the management of a wide range of child health problems, and there should be at least one named health visitor for all GP practices, who uses a single electronic record alongside other members of the primary care team.

### Recommendations

- GP practices should have access to a named paediatrician and a named children's nurse.
- GP practices should have named health visitors who use a common electronic NHS record along with other primary care staff.

*Main sources of evidence: RCPCH (FF116, FF117).*



### 2.5.3 Care for people with mental health problems and learning disabilities

Many people either present to primary care with mental health problems or have mental health problems associated with their physical conditions. Mental healthcare and care for people with learning disability are always at risk when budgets are under pressure. From 2010 to 2014, there was a loss of nearly 4,000 nursing posts in mental health services and over 1,500 learning disability nurses (nearly 30 per cent of this workforce). The result is that, increasingly, specialist staff can only deal with the most severe illness.

Resources for primary care practitioners have increased through the development of IAPT (Improving Access to Psychological Therapies) services, and in some areas, the attachment of primary care mental health workers to practices. General practices need links to mental health advice for the wide range of psychological problems seen in both adults and children in primary care, and to consultant advice for those with more serious mental health problems. These links might include availability for telephone advice, face-to-face case reviews and on-site clinics.

#### Recommendation

- Practices or groups of practices should have access to a named consultant psychiatrist and to a named mental health worker such as a primary care mental health worker or community psychiatric nurse.

*Main source of evidence: RCN (FF127).*

### 2.5.4 Care for people with challenging health and social care needs

Some groups of people, for example, homeless people, substance abusers and asylum seekers, may have particular needs that span a range of health and social care needs. Homeless people may need particular access to services for drug and alcohol abuse, and they may also need more flexible appointment systems and more proactive approaches for follow-up than other groups in the population. We have seen examples of practices set up specifically to provide care for these vulnerable groups, where care from a range of agencies is available. While this type of service may also be available in conventional general practices, it is unlikely to be easily provided in small practices that do not have on-site access to a wide multi-disciplinary team.

The York Street Practice in Leeds supports homeless people and asylum seekers, those with transient lifestyles and people who are vulnerably housed. Funded through an APMS contract, they:

- have a rolling list of 1,200 people, with 30-50 new/removed registrations per week
- have a team that includes GPs, nurses, care navigators, drug and alcohol therapists, mental health nurses with additional support from lawyers, benefit workers and housing support
- actively involve their users in developing their services.

## Recommendation

- Clinical commissioners should address the needs of homeless people and asylum seekers who need 'one-stop' healthcare hubs, where people can receive multiple services in one place at one time. This may be addressed by practices established to provide care for these vulnerable groups or through conventional practices that have on-site access to a multi-disciplinary team that includes social workers and drug and alcohol teams.

*Main source of evidence: RCGP (FF34)2.5.5 Care for people in nursing and residential homes*

### 2.5.5 Care for people in nursing and residential homes

People in nursing and residential homes are being admitted to hospital with increasingly severe and complex conditions. This report does not extend to the important issues of staffing within homes themselves, but there are important knock-on changes for primary and community services in the NHS. People living in homes are particularly vulnerable to adverse reactions from medications and many avoidable admissions are believed to occur in people from homes. Providing good care in homes is more difficult when care is reactive rather than proactive, when the doctor does not know his or her patients, and when there are poor links with local pharmacies. Difficulties are compounded when a home is served by several GPs.

We saw examples where care was reported to be greatly improved when one doctor took responsibility for all of a practice's patients in a care home, and where only one or two practices provided care for people in any one home. This allows care to be better planned, (for example, by undertaking regular 'ward rounds' of patients, most of whom will be known to the GP), increases coordination between the practice and the home, and allows more opportunity for training of staff. However, this should not override the wishes of residents who specifically wish to be registered with a different practice. Pharmacists have an important role in advising on safe prescribing and medicines use in care homes. As with GPs, there should be one pharmacy responsible for providing this care. This may or may not be the same pharmacy that dispenses prescriptions.

Medicines are a major source of error and potential harm to residents of care homes. Medication errors can also be reduced by GPs always having access to the full medical record when in a home (for example, by carrying a practice laptop), prescribing while in the home (for example,

Practices in Newton Abbott got together with care home managers and agreed that, provided the residents agreed, one practice would look after each care home. They used the Prime Minister's Challenge Fund to provide homes with access to a local GP from 8am to 8pm, seven days a week. A GP with a special interest, supported by an interface geriatrician, leads a multi-disciplinary frailty service that operates seven days a week from the community hospital. GPs, care home managers, patients and relatives all think care has got better and job satisfaction has increased.

through a dedicated wireless printer) and by using a practice-attached pharmacist to review medication regimes (this may or may not be the same pharmacy that dispenses prescriptions). We also note (in Section 3.1) the potential benefits of linking consultant geriatricians to GP practices, and this is likely to be particularly important because of the increasing number of elderly people with frailty.

Joint provision of education involving local authorities, health services and care home staff could help to improve the quality and coordination of care. Such training could include placements of nurses in training in care homes and could also include training to meet the needs of residents with dementia, especially those with challenging behaviour.

## Recommendations

- Care for people in nursing and residential homes should be organised so that all patients in a home are cared for by one GP practice, except where a resident asks to be registered with a different practice. Likewise, one community pharmacy, ideally linked to the general practice, should provide advice on safe prescribing and medicines use for each home.
- Within general practices, one or two GPs should take responsibility for their patients in each home, prioritising proactive care over responding to acute illness, for example, with regular 'ward rounds'.
- GPs should have access to the full electronic medical record, with the ability to prescribe electronically while they visit nursing or residential homes.

*Main sources of evidence: Royal Pharmaceutical Society (EE32, FF131), Northumbria Healthcare NHS FT (EE11), RAND Europe (FF105), Royal College of Nursing (FF125).*

### 2.5.6 Care at the end of life

People at the end of life have special needs that are often poorly met, especially out of normal surgery hours (two-thirds of the week). Care needs to be arranged around the needs of the patient rather than, as is all too often the case, the needs of the service. Care plans are important and need to be shared proactively with patients and their carers. Patients and their families should be able to identify and contact named individuals who lead on their care, such as their GP, community nurse or specialist nurse.

In surgery hours, it is important to provide continuity of care wherever possible. Each patient at the end of life should be able to identify one GP who takes the lead for coordinating their care and one other clinician who they know will be familiar with their care.

Out of hours, healthcare professionals need access to the patient's medical record. This is already happening in some areas, with partial solutions in others. The issue will only be satisfactorily addressed by software solutions that give out-of-hours clinical staff (such as GPs, community nurses) full access to medical records. While this would benefit people seeking out-of-hours care more generally access to accurate and up-to-date information is particularly important for people at the end of life.

There should be a single point of access to 24-hour domiciliary care services and community nurses which are rapidly and reliably available (for example, within two hours). Often this will be from community nurses, although we have seen examples where other professionals (such as physios and social workers) have training from each other's disciplines to be able to carry out urgent assessments. This function can also often be provided by healthcare assistants. There should also be rapid access to a service to stay with people overnight (commonly provided by 'Hospice at Home' schemes or charities such as Marie Curie). Such services should also be available to other people who might otherwise need to be admitted to hospital (for example, an older person with frailty who develops an acute illness).

Poor availability of drugs is a common problem at the end of life. Wider use should be made of 'just in case' boxes, which include a range of drugs that may be needed at the end of life. Nominated pharmacists should be available to provide 'just in case' boxes inside and outside working hours for use by doctors or nurses in the patient's home, and prescribing pharmacists should be able to alter prescriptions to match the patient's needs.

Practice teams may need advice from palliative care specialists, and advice should be available, at least by phone, 24 hours a day.



## Recommendations

- People at the end of life and their families should be able to identify and contact named individuals who lead on their care for example a GP, community nurse or specialist nurse.
- Healthcare professionals providing care to patients at the end of life should have access to an up-to-date care plan 24 hours a day, access to community nursing services 24 hours a day, and to night sitting services. They should have ready access to drugs commonly used at the end of life.
- Advice from palliative care specialists should be available 24 hours a day.

*Main sources of evidence: RCGP (FF33), Health Education East of England (FF53), Royal Pharmaceutical Society (FF48), RCPCH, RCGP and RCN (FF106, FF107).*

## 2.6 Urgent care

Urgent care out of normal office hours has become a source of confusion for people who are not always clear how to access care, and sometimes require two phone calls to get through to someone for advice. People are also often unclear who is giving them advice. Sometimes the practice phone line is directed through automatically to NHS 111, in other practices a message instructs them to call NHS 111. Having been triaged by NHS 111, people may then be referred back to a GP out-of-hours centre.

There needs to be a single point of access for all people to avoid them having to make more than one phone call. The person they speak to needs to be able to give advice and, where appropriate, direct the patient to somewhere they can be seen. GP out-of-hours services should have access to the electronic records of practices they are covering. This is easier when most practices in a district are using the same electronic record (for example, EMIS-Web or SystemOne). Software solutions that go beyond the Summary Care Record and allow access to more than one electronic medical record system need to be accelerated.

Integration of out-of-hours care with other primary care services is likely to be enhanced where the contract for providing out-of-hours care is held by an organisation

providing other primary care services – for example, a federation of GP practices, multi-speciality community provider or a primary and acute care system. This model is likely to be preferable to contracts with a third-party provider. Contracts for out-of-hours care should in future, therefore, be required to demonstrate integration with existing primary and community care services.

We note that at the same time as hospitals are using more experienced staff to triage people (for example, consultant physicians in A&E 12-18 hours a day), triage in primary care is carried out by increasingly unskilled staff (NHS 111). Experienced doctors and nurses may provide more effective triage, reducing unnecessary hospital attendances. Their effectiveness is further enhanced if they can prescribe after telephone consultations through electronic links to pharmacies. One submission suggested locating pharmacists in NHS111, which enables them to give advice to call minders and on-call GPs and, where appropriate, to prescribe.

## Recommendations

- There should be a single point of access to out-of-hours services in order to avoid people needing to make more than one call to get advice. Software solutions that go beyond the Summary Care Record need to be accelerated so that GP out-of-hours services have full access to electronic medical records including care plans.
- Contracts for out-of-hours care should require bidders to demonstrate that they have the ability to integrate with other primary care providers
- The costs and benefits of using a relatively unskilled workforce to triage requests for out-of-hours care are not sufficiently well established and may be a cause of hospital overuse. Research is needed to compare skilled versus less-skilled staff providing telephone triage in out-of-hours care.

*Main sources of evidence: College of Emergency Medicine (EE17, FF20-22), RCGP (FF33, FF36, FF37), visit to Corby Urgent Care Centre, Health Education Thames Valley (EE16), Care UK (F11), Urgent Care Commission (FF76), RCGP (FF101/103).*

## 3. Integrating care

### 3.1 Working with other specialists

Fundamental to the NHS Five Year Forward View are new ways of working between GPs and specialists. Two key models proposed are the Multispecialty Community Provider (MCP) and the Primary and Acute Care System (PACS). While not mutually exclusive, MCPs envisage a much wider range of specialist services being delivered in the community, often from expanded community facilities that are closely linked to general practices, and PACS offer an alternative model of much closer links between primary and secondary care.

In implementing these models, it will not be sufficient simply to locate doctors from other disciplines in community-based facilities. This often happened in the 1990s, when GP fundholders provided funds for others to do outreach clinics in GP surgeries. Although popular with patients, specialists lost economies of scale from working in hospitals and little learning took place between GPs and other specialists, both of whom were too busy to spend time with each other.

MCPs envisage something different that involves a much closer relationship between GPs and other specialists. This may include:

- consultant-run email and telephone helplines providing advice for GPs, nurses and other health professionals
- consultant participation in multi-disciplinary team meetings, for example, reviewing people in nursing homes
- consultants with sessional time to support primary care staff to work in extended roles, for example, by running joint clinics or attending primary care-led clinics where their main function is to give advice and support healthcare professionals in primary care
- outreach clinics in primary care settings.



Whitstable Medical Practice, an NHS Vanguard site, offers:

- on-site physiotherapy, audiology, ultrasound and sigmoidoscopy
- consultant-led cardiology, orthopaedic, gynaecology and urology clinics
- Epilepsy, dermatology clinics and minor surgery clinics led by GPs with a special interest

While there is potential for a range of specialists to work more closely with health professionals working in the community, this will be particularly beneficial for children, older people and those with long-term mental health problems. These are the areas where close liaison with primary care staff will be most valuable and is needed to provide better-integrated care. In other specialties (such as ENT or dermatology), the benefits of developing a closer interface with specialists in primary care settings include supporting GPs and specialist nurses to take on extended roles. This may include support for GPs or nurses with a special interest who are managing referrals from other local practices.

A number of contractual/employment models are suggested in the NHS *Five Year Forward View*. These include practices or federations employing specialists (doctors or nurses) or taking them as partners. The PACS model envisages a single organisation providing primary and specialist care. As yet there is no preferred model – the key is that new models encourage new ways of working rather than simple translocation of services.



### Recommendation

- In line with some models in the NHS *Five Year Forward View*, specialists should be involved in a wider range of activities that bring them into direct contact with primary care staff. These might include routine email and telephone advice, supporting continuous quality improvement by attending multi-disciplinary team meetings, supporting primary care staff working in extended roles, and providing referral clinics in primary care settings.

*Main sources of evidence: NHS Five Year Forward View (FF106), Health Education East of England (EE35, FF56, FF58), British Society of Rheumatology (EE54), RAND Europe (FF105), Health Education North West (EE40), Health Education North Central and East London (EE42).*

## 3.2 Working with community health services

The need for better-integrated community services is most obvious in relation to older people with frailty at risk of hospital admission or needing to be discharged from hospital. In addition to conventional community nursing roles, important roles include the introduction of intermediate care teams, community matrons, virtual wards, in-reach and outreach teams, and other types of specialist nurse. For urgent assessments (and ideally all assessments), there needs to be a single point of access

for primary care professionals to refer people so that one phone call can trigger a needs assessment from a range of health professionals. These could include nurses, therapists, end-of-life care, reablement and care home support. Social workers should be part of these teams, preferably co-located with healthcare staff.

We visited one site where staff making urgent assessments were trained in basic skills by other members of the team. This meant that one team member could make an immediate assessment of nursing, physiotherapy and social work needs, increasing the speed and efficiency of initial assessment. We also received evidence on the benefits resulting from joint training of health and social care staff.

Because of the poor coordination of general practice and community nursing care, there are arguments for the contracts for community nursing services being held by primary care providers of sufficient size, for example, federations of GP practices, multi-specialty community providers or primary and acute care systems, rather than by standalone community trusts. This would offer better opportunities for integrating care, compared to the standalone community trust, and facilitate benefits such as shared electronic medical records. We therefore recommend that future contracts for community nursing services should require demonstrable integration between primary and community care services as well as the ability to provide high standards of employment practice. It

should be noted that we are not recommending that community nurses be employed by individual practices, except possibly by 'super-practices' that represent very large populations.

Community paediatrics (including community paediatricians, school nurses, specialist physiotherapists, psychologists and occupational therapists) presents particular problems for providing well-coordinated care. Paediatricians need close links to hospital colleagues and facilities, yet they are often denied access to the full range of hospital investigations. On the other hand, community paediatric staff also need to liaise closely with the education department of local authorities for children with developmental delay, with special schools, and with child and adolescent psychiatry services for children with behavioural disorders.

### Recommendations

- Contracts for community nursing services should require bidders to demonstrate that they have the ability to integrate with other primary care providers.
- There should be a single point of access to community services and social services for urgent assessments.
- Community staff making urgent assessments of acutely ill people should receive basic training in the skills of other members of their team in order to increase the efficiency of urgent assessments.

*Main sources of evidence: NAPC (EE33), Nottingham City Care (EE07), Harrogate FT & CCG (EE13), Central Manchester CCG (EE14, FF14, FF15), RCGP and the College of Social Work (EE14), Royal College of Nursing (EE53, FF99, FF125), RCGP (FF103), Nuffield Trust (EE43).*

## 3.3 Working with social services and local communities

Many respondents pointed to the need for better integration between health and social care, but there is no clear blueprint for how this should be achieved.

Social workers have particular skills in working with patients with complex problems and handling risk, and there are substantial opportunities for closer working with primary care. This may either be with social workers from local authorities or with the increasing number of social workers who work either independently or with charities. Commissioning of social workers to join primary care teams could come from either health or social care budgets.

We were impressed with examples where requests for urgent assessment or hospital discharge planning were referred to joint teams, including co-located health and social care staff, to facilitate share decision-making and learning.

Although co-location of health and social care staff has clear benefits, there are considerable cultural differences between staff that come from each of these backgrounds, and also practical differences, especially for small practices or community organisations. There should be opportunities for joint training of health and social care staff to enable more efficient assessments to be made and to increase understanding between the professions.

More systematic approaches are also needed to integrate local community and public health interventions with primary and community care. This would enable practices to advertise and promote these opportunities to patients. Time and skills within the public health and primary care workforce need to be allocated for this type of work to enable the skills and facilities within communities to support people, especially people with long-term conditions and population groups with particular needs, whom we discuss in Sections 2.5.1 to 2.5.6

### Recommendations

- To facilitate effective multi-disciplinary assessment (for example, acutely ill older people or discharge planning), staff from the necessary range of healthcare disciplines and from social care should be co-located and develop a team-based approach.
- There should be opportunities for joint training of health and social care staff to enable more efficient assessments to be made and to increase understanding between the professions.
- Staff should be identified in federations or groupings of GP practices with responsibility for developing links with local community organisations, in order to provide better support for people with long-term conditions and others with particular health needs.

*Main sources of evidence: Skills for Care (EE19), RCGP and the College of Social Work (EE14, FF107), Halton CCG (EE18), The College of Social Work (EE49), British Association of Social Workers (FF97, FF98).*

## 4. Working together: federations and networks of practices

Federations and other collaborative networks are an important way of enabling primary care organisations such as GP practices to provide a wider range of services, while at the same time offering the benefits of a smaller organisation, such as convenient location and continuity of care. At the same time, community pharmacists are starting to develop their own federated structures, occasionally with GPs. Primary care providers working together can also help monitor and better understand variation in clinical performance by sharing comparative data. Working collaboratively and sharing ideas across federations and networks can also help new models of care and new staff roles to emerge.

Three main types of organisation are described, with the most common developing models as follows:

- Super-partnerships – large-scale single partnerships created through formal partnership mergers.
- Multi-practices – small-scale GP partnerships managing multiple practices and services.
- Federations or networks – collaborations between multiple practices through informal linkages (networks) or formal legal contracts (federations).

These larger organisations have the ability to provide the governance and capability to hold contracts for services such as out-of-hours care and community nursing. In addition, they reduce the isolation of smaller practices and enable them to:

- share resources
- deliver a wider range of services in the community, including diagnostic services
- provide links to community resources, including the voluntary sector and services provided by local authorities
- provide extended opening hours
- share investment in training and in the development of staff career structures (for example, general practice nurses), including support for small practices in releasing staff for training
- provide an element of governance, for example, in relation to terms of service and employment, and access to training for staff employed by GP practices.

The extent of ambition varies considerably between these new organisations. Some federations exist principally to share back-office functions, Continuing Professional Development (CPD) programmes and to enhance educational capacity. Others have used a federated or super-practice structure to invest in new buildings to provide a wide range of extended community-based services. These organisations may also be large enough to take on collective responsibility to bid for contracts to run other community services, for example, GP out-of-hours care, community nursing and allied health professionals, and this type of contract has the potential to reduce some of the fragmentation that currently exists in community services. Larger primary care organisations may also be able to employ specialists directly or contract for sessional time from specialists, mirroring some innovative models elsewhere in the world, such as the Pegasus Alliance in Christchurch, New Zealand.

The Suffolk GP Federation is owned by 65 practices, has 630,000 registered patients, 60 staff and a turnover of £4 million. The federation is a community interest company with an elected board of GPs, practice managers and a chief executive. The federation has expanded the role of primary care, provides a range of services to support local practices and facilitates work with other organisations.

Invicta is a GP Federation in East Kent and is also a community interest company. It has a narrower focus but also provides local services across its patch, including a minor injuries service and training for paramedics. The federation took over a practice that would otherwise have closed following the retirement of its GPs.



Federations and large practices have a particular opportunity to extend the reach of primary care to involve community groups, voluntary organisations and local authority services. Small practices do not have the staff or time even to be aware of the wide range of resources that may be available for people in the community. Federations offer the opportunity to make these links and reverse the longstanding detachment of general practice from their communities that has developed over recent decades. However, some federations have developed without a specific focus on local geographies. This may need to change if they are to take on roles such as holding contracts for community nursing services.

Federations and large practices also offer better opportunities to involve patients in planning services than Practice Participation Groups linked to individual practices. Federations of practice should engage actively with patient groups in planning services.

There is currently no optimal size for a general practice federation, and they typically range from 50,000 to 150,000 patients. Significant investment is required in some cases to ensure that the infrastructure is able to support multi-disciplinary services, including the challenge of ensuring that patient records can be shared between different members of an extended team. To reflect the growing multi-disciplinary nature of the primary care workforce, there need to be opportunities for general practice nurses and practice managers, among others, to take leadership positions in these organisations. In particular, federations should appoint a lead nurse responsible for professional development and for ensuring equitable access to education and training for nurses employed in the federation.

Significant investment will be required in leadership and organisational development for primary care staff taking on responsibilities in these new organisations. In particular, investment is needed to develop the right culture and the next generation of primary care leaders and managers to ensure that change is sustainable. Primary care staff have historically been relatively unengaged in NHS opportunities for leadership training and this must be redressed.

### Recommendations

- Large groupings of general practices (for example, federations, networks and super-practices) and federations of community pharmacies have much to offer in extending the scope of care provided in the community and improving coordination of care. Their development should be supported.
- Within federations and networks, staff should be identified with responsibility for developing links with patient groups and with local community and voluntary organisations.
- Management and leadership training and ongoing support for primary care staff, including doctors, nurses and pharmacists, should be provided in order to encourage those wishing to develop leadership roles in these new organisations.

*Sources of evidence: RCGP (FF33, FF139), BMA (EE58), Vitality Partnership (EE01), RCN (FF123), NAPC (EE33), Nuffield Trust (EE43, FF108), RAND Europe (FF105), Family Doctor Association (FF07-FF10), NHS Confederation and National Association of Primary Care (EE33), Leeds North South and East CCGs (FF28).*

## 5. Creating learning organisations

During the course of its visits, Commission members visited organisations that demonstrated some striking examples of innovative practice. While some of these stood out for the work that they were doing, we were also struck by the way in which they combined innovative work with the characteristics of learning organisations. In particular, they made time during the working day to share experiences and clinical problems. They were organisations where mutual support between staff shone out.

We asked about key factors that were needed to achieve this combination of productivity, clinical achievement, positive motivation, and team cohesiveness. The unanimous answer was that space had to be made to reflect and to share problems and successes with colleagues in their team, in spite of the working day being filled with clinical work. We also noted that practices we visited understood the principles of quality improvement. They observed what they did, they shared difficult issues, and they were data-rich and able to use data to reflect on how to improve their performance. An open and supportive approach enabled them to take on new roles in a safe way that developed trust across the whole team.

The need for protected time for education was repeatedly emphasised to us, alongside the value of skills in evaluation to enable people to reflect critically and improve on the work that they were doing. Time and support were also needed for innovations to spread: too often, innovative practice is confined to the innovator's immediate circle.

Training and CPD can be difficult to organise for an individual practice or pharmacy and there is wide variation in the access and time given to staff training. Federations of general practices and Community Education Provider Networks (CEPNs) have the necessary scale to develop and deliver training. In particular, CEPNs aim to promote inter-professional learning based around the needs of populations. They provide an opportunity to meet the educational needs of the multi-disciplinary primary care team, but also bring in community organisations and local authorities to provide education that is much broader than that traditionally provided to single professional groups. These models should be developed further.

### CEPNs have the potential to:

- connect training and non-training practices, community services, other services and education providers
- be developed, owned and delivered in the community
- co-ordinate training and workforce development across professional groups
- expand community training placements
- develop new roles where needed, such as care navigators and physician associates
- build sustainability and stability through local collaborations.

We note that the standard NHS consultant contract includes programmed time for 'supporting professional activities', which include audit, continuing professional development and clinical governance activities. Contractual and employment arrangements in primary care need to make equivalent time available for reflective learning among primary care staff and to meet the needs of their professional organisations, such as the Nursing and Midwifery Council.

### Recommendations

- Community Education Provider Networks provide a framework that promotes inter-professional learning based around the needs of local populations. This model should be developed further across England in order to meet the educational needs of multi-disciplinary primary care teams.
- In line with the consultant contract, contractual and employment arrangements for staff in primary care should include protected time to support professional activities focused on quality improvement and clinical governance. These activities need to be backed by an infrastructure to teach and monitor quality improvement activities.

*Main sources of evidence: RCGP (FF33), BMA (EE58), Health Foundation (FF109, FF110), Westbourne Medical Centre/Dorset CCG (EE24).*

## 6. Creating sustainable careers

Fewer than half of GPs working in England who responded to a recent BMA survey say they would recommend general practice to a medical student or doctor in training, and anecdotal evidence suggests that similar views about general practice nursing are prevalent. The changes we have recommended are designed to deliver high-quality primary care at the same time as creating productive and satisfying careers.

The changes we recommend will require additional staff to be recruited to primary care but equally important are the additional skills that will be needed from the current and future primary care workforce. These include extended clinical skills for the roles that healthcare professionals in primary care will be delivering in future, and the management and leadership skills that will be needed to run new and evolving primary care organisations. Structured opportunities to release staff for in-service training during their careers will be needed and will make primary care a more attractive career if they become more systematically available.

We endorse the 'Ten Point Plan' for building the general practice workforce recently published by RCGP, BMA, NHS England and HEE.<sup>14</sup> The plan includes the need to promote general practice in medical schools, to enhance recruitment to specialist training schemes for general practice, to improve the breadth of training, to invest in schemes to retain doctors in the workforce and enable them to return after career breaks, and to provide incentives for doctors to remain in practice at the end of their careers. We also note the suggestion of portfolio options to extend doctors' options towards the end of their careers, in order to retain experienced doctors near to retirement within the workforce. This revives a proposal that was included in the 2003 GP contract but never enacted. HEE and NHS England will need to lead on specific strategies to recruit, retain, retrain and return GPs to service. There will need to be both short and longer-term strategies for sustaining any uplift in the GP workforce.

### Ten-point plan to build the general practice workforce (RCGP, BMA, NHS England, HEE, 2015)

1. Promoting general practice to newly qualified doctors
2. Improving the breadth of training for general practice
3. Developing training hubs to enhance inter-professional training for the whole primary care team
4. Targeted support for GPs moving to under-served areas
5. Investment in retainer schemes
6. Improving the training capacity in general practice
7. Providing incentives for older doctors to remain in practice
8. Developing new ways of working, including a broader workforce to support GPs in their clinical work
9. Providing schemes to promote easy return to practice
10. Targeted investment for those returning to general practice

This plan focuses on the need for education of GPs, however, in the work of the Commission we noted substantial gaps in the training needs of other primary care professionals. These same principles should be applied in particular to the training of general practice and community nurses. The percentage of the nursing workforce working outside the acute sector has remained virtually unchanged over the last decade, despite increasing amounts of work moving into primary care. GPs, general practice nurses and community nurses all suffer from workforce shortages and an ageing workforce. There needs to be a much stronger focus on primary care nursing as a career during general nurse training, and the specific skills required for primary care nursing should be included as part of the pre-registration nursing curriculum. Better support is needed around continuing professional development and mentorship for existing nurses working in primary care, including opportunities to extend their clinical, leadership and

<sup>14</sup> RCGP, BMA, NHS England, HEE (2015). Building The Workforce – The New Deal For General Practice. [www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/01/building-the-workforce-new-deal-gp.pdf](http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/01/building-the-workforce-new-deal-gp.pdf)



management skills. Nurses also need formal training opportunities so that they can move easily from hospital nursing into general practice and community nursing, for example, after a career break. In addition to this, we received evidence that the quality of ongoing training and support for general practice nurses is very variable across the country, including whether nurses are released for training by their employers.

We had a number of submissions from specialist societies, such as The Royal College of Psychiatrists, the British Society for Rheumatology and the British Orthopaedic Association, pointing to the need for better training for primary care clinicians in their specialties. In relation to developing new models of care, there will be a particular need for clinicians in primary care to receive training for extended roles, but also for the nature of training to change and be based increasingly on interactions between specialists and generalists working in primary care settings rather than lectures delivered outside the workplace. Physiotherapists have a particular role to play in bridging primary and secondary care for musculoskeletal conditions.

Increasing the primary care workforce by recruiting more doctors, nurses and allied health professionals may not be the most effective or cost-effective way to provide some types of care in primary care settings. We identified particular opportunities for providing training and ongoing support for physician associates, healthcare assistants and possibly paramedics. We noted a potential new role for medical assistants that is used in some other countries to relieve healthcare professionals of administrative work (such as dealing with most email and electronic tasks), and evaluation of this new role is recommended in the ten-point plan.

We noted a number of ways of bringing more healthcare assistants working in extended roles into the primary care workforce, including the use of apprenticeships schemes to recruit local people, and schemes for healthcare assistants working in general practice who want to train as general practice nurses. These may both be ways of adding to the primary care workforce.

In contrast to shortages of GPs and general practice nurses, there is likely to be an excess of trained pharmacists in England over the next few years, although there are currently insufficient pre-registration training places to enable all graduating pharmacists to become registered. There are opportunities for pharmacists to increase their contribution to primary care, especially if training is offered to enable them to provide extended roles as part of the general practice team (see Section 2.2.3). Increasing the supply of pre-registration placements for pharmacists may be one of the most rapid ways of increasing the primary care workforce in the short term. Such placements would ideally include experience in both hospitals and in primary care.

*Main sources of evidence: RCGP, BMA, NHS England, HEE (FF111), Centre for Workforce Intelligence (EE30), RCGP (FF33), BMA (EE58), COGPEd (EE41), RCN/BMA (FF99), RCN (EE53), NAPC (EE33), South Sefton CCG (EE21), Dorset CCG/Westbourne Medical Centre (EE24), HEE Yorkshire and the Humber (EE27, FF39-FF45), Royal College of Psychiatrists (EE20), British Society for Rheumatology (EE54), BOA (EE57), Health Education East of England (EE34-EE37, FF53-FF58), Health Education North Central and East London (EE42, FF63, FF64), Health Education South London (EE28, FF66-FF69), Health Education North West London (EE44, FF74, FF100), SE Commissioning Support Unit (EE46), RAND Europe (FF105).*

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## 7. Making change happen: planning the future workforce

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Three things are required in order to deliver the vision of primary care that we have outlined in this report. First, there needs to be sufficient staff with appropriate training to do the work that is needed in primary care. Second, those staff need to have the skills to evaluate what they are doing and be empowered to change and improve the systems in which they are working. Third, the context in which staff are working needs to change. The NHS *Five Year Forward View* has created the right political and policy context for change, but some of the fundamental funding mechanisms in the NHS also need to change in order to incentivise care that is truly integrated across sectors. Key to this also is that the NHS can measure the key outcomes that are now required from the health service.

In the course of this enquiry, we sought out innovative examples of primary care for us to visit (see Annex D). We were universally impressed and inspired by these visits. We were equally impressed by the individuals who had led changes in their local service as by the changes themselves, but the NHS cannot rely on exceptional people in a few places to deliver the scale of change that is needed. A much wider section of the workforce needs to be involved in both leading and managing change, with support for organisational development across primary care.

Training should be made available to primary care staff to enable them to take on leadership roles, including training in and ongoing support for strategic planning and business development. A culture needs to be encouraged within primary care to innovate and embrace change. Some of the changes we suggest in this report will, in the medium term, reduce the constant feeling of fire-fighting that many primary care workers feel and provide space to develop the service in the ways that are needed.

Some of the changes we have asked for will be difficult. They call for cultural shifts, for example, working with unfamiliar staff, where we know that change is slow and crucially dependent on developing personal relationships. Most of the changes we suggest are incremental, but some require organisational change where change itself is disruptive. Indeed, some of the many changes that have occurred in the NHS in recent years have reduced the capacity of those working in primary care for innovation. While urgent changes are needed to address workforce

issues in primary care, it is important not to expect quick results from new models of care that require new relationships to be formed and trust to develop.

Governance is also important. The changes envisaged in the NHS *Five Year Forward View* point to NHS staff taking on a wide range of new and unfamiliar roles. It is essential that adequate clinical and corporate governance arrangements are in place, not only to ensure that care is of sufficiently high quality but also to ensure that those responsible for providing those services are aware of their responsibilities.

A core issue for this Commission has been the misalignment between trends in the professional workforce and population need. As we described earlier, the rising burden of chronic disease and frailty requires significantly more care to be delivered by primary and community services, yet recent workforce trends have not supported this shift from secondary to primary care. Many attribute this misalignment to a failure in workforce planning at both a national and local level, however, workforce planning is becoming increasingly complex and difficult. The factors that should inform a workforce plan – population health need, the nature of care and workforce roles – are all changing and interdependent. These changes are further accelerated by medical and technological advances.

Given these complexities, workforce planning is necessarily a balancing act that requires the ability to respond flexibly and adjust to changes in supply and demand factors over time. A submission from Health Education Yorkshire and Humber showed the value of a scenario-based approach. They recognise that there is no single workforce solution. Some practices in areas with lower retirement and healthy recruitment to training pathways may continue to configure their workforce to historical norms. However, they believe that most practices will find themselves under increasing workload pressure and will need to see their workforce evolve to embrace a wider skill mix out of necessity. A few practices will be in a more extreme situation that demands more radical workforce transformation, with a complete redesign of clinical pathways, significantly fewer GPs and much higher use of non-medical staff. Individual solutions will depend on both the needs of the population and the local availability of staff.

## 8. Providing better data about primary care; making innovation evidence based

A consistent message we received was that planning in primary care is difficult because of the lack of systematic data about who currently does what in primary care, or data on whether the primary care workforce has the appropriate training and skills to deliver the wide range of functions that are needed. Workload and activity surveys are carried out infrequently, by a range of interested parties, and without any consistent methodology. This needs to change to enable better planning and evaluation of primary care in future. In addition, many innovations in primary care are poorly evaluated. There is often a piecemeal approach to evaluation, which makes it hard for policy makers or NHS leaders to defend the use of their resources and be held to account for their implementation in practice.

- Data should be available to enable details of the workforce, the work carried out by them, and the quality of that work to be available on a routine basis.
- All new resources invested in new models of care should include a component for suitably trained staff to evaluate and share evidence of their effectiveness in order to justify new ways of working.

*Main sources of evidence: RCGP (FF33), NHS Confederation and NAPC (EE33), Nuffield Trust (EE43, FF112) Health Education East of England (EE34), Health Foundation (FF109, FF110), Health Education Yorkshire and Humber (FF39).*



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## 9. Conclusions

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Crises sometimes turn out to be opportunities. General practice was certainly in crisis in 1965, when there were acrimonious disputes over the GP contract and 18,000 GPs signed undated letters of resignation from the NHS. Despite deep divisions within the profession, these negotiations resulted in the 1966 GP contract that turned out to be the salvation of general practice at the time, with the introduction of support for practice staff and premises laying the foundations of modern general practice.

Another crisis occurred in 1991 when incentives were introduced for meeting immunisation and cervical cytology targets. Most GPs had only paper records and had to go down to their local computer store to start developing a recall register – yet that was the start of what is now the most comprehensive primary care electronic medical record of any country in the world.

There are certainly those who believe there is a crisis in primary care at the present time, but there are also opportunities. The government continues to see a strong system of primary care as the foundation of the NHS, with primary care practitioners responsible for both commissioning and providing an increasing range of services. Our recommendations look to provide a workforce that is fit and able to deliver care to a changing population with changing needs, but who will always require high-quality compassionate care whenever they meet the NHS.

Our vision for the future of primary care is drawn from the people we have met, the evidence we have read, our professional experience and, perhaps most of all, from the innovative examples of primary care we saw across the country. We were universally impressed and inspired by these visits. There is very little in this report that is not already happening somewhere in the NHS. What is needed is for these examples of outstanding practice to be rolled out more widely. Two fundamental things are required in order to deliver the vision of primary care that we have outlined in this report: there need to be sufficient staff with appropriate training to do the work that is needed in primary care, and individual staff members need to have the skills to evaluate what they are doing and be empowered to improve the systems in which they are working.

Much of what we recommend can be achieved rapidly, though other changes will take time, especially those that require cultural change and the development of relationships across organisational boundaries. However, with a highly skilled workforce, effective multi-disciplinary teams and well-developed IT systems, we believe that the NHS is in an unparalleled position to develop a modern primary healthcare system that is truly world class. Focusing on care provided by healthcare professionals working in general practices, community nursing and in pharmacies, we offer a vision of primary care that will provide challenging and fulfilling careers for young health professionals while delivering a standard of care to patients of which the NHS can be truly proud.



To achieve this vision, primary care needs to change. It will still be based around the GP practice holding responsibility for the care of its registered patients, but practices will have a stronger population focus and an expanded workforce. Many existing healthcare professionals will develop new roles, and patients will be seen more often by new types of healthcare professional such as physician associates. Clinical staff will have better administrative support and, when needed, healthcare professionals will be able to spend more time with their patients to discuss and plan their care. They will also be able to communicate with patients and with other health professionals by phone, email and video-conference.

Individual general practices and community pharmacies will work more closely together through networks and federations in order to provide a wider range of services, and IT systems will become joined up across providers of primary care. Primary and community care staff will also work closely with secondary care and social services through some of the models outlined in the *NHS Five Year Forward View*. Premises will be upgraded, making better use of existing community facilities in order to support closer working with hospitals and with social services, and to provide a wider range of diagnostic facilities.

Building new models of care needs to be done equitably. Some of the most deprived areas of the country have the greatest recruitment problems, the biggest resource challenges and the greatest health need. First-class primary healthcare must be available in all parts of the NHS.

It will be important to support these changes through education and training, especially in general practice nursing and community nursing, where career structures and training opportunities lag well behind training for doctors. Primary care staff, including managers, will need training and ongoing support to provide leadership and management of new and emerging primary care organisations.

In preparing this report, we saw a range of models for delivering high-quality primary care. In addition to excellent traditional practices where there were more doctors than nurses, we also saw practices where there were more nurses than doctors, and practices where significant amounts of the workload were undertaken by other health professionals such as pharmacists or physician associates. For this reason, we do not recommend one particular staffing model or ratio (for example, GPs or general practice nurses per head of population). All general practice teams need both medical and nursing input (Sections 2.2.1 and 2.2.2), but we see

major opportunities to expand the primary care workforce through the use of other healthcare professionals (Sections 2.2.3 to 2.2.5).

There are also opportunities to reduce the administrative burden on healthcare professionals. This is a major cause of workload stress and a significant issue cited by GPs leaving the profession early. GPs currently spend 11 per cent of their time on administration. If administrative staff (such as medical assistants) took on half of this work, this would be equivalent to 1,400 more full-time GPs in England. New approaches to the best use of administrative support roles need active piloting and evaluation (Section 2.2.4).

In order to achieve our vision for primary care, we make the following recommendations:

## A multi-disciplinary primary care workforce

1. Both short-term and long-term strategies are needed to increase recruitment and retention of GPs. The measures to increase GP numbers outlined in the Ten Point Plan agreed by Health Education England (HEE), NHS England, the Royal College of General Practitioners (RCGP) and BMA in 2015, should be implemented rapidly along with the government's commitment to recruiting 5000 additional GPs. National targets for GP numbers should be regularly reviewed. There should also be scope to adjust plans at local level providing that those plans can be demonstrated to meet local need. (*Sections 2.2.1 and 6, recommendation to HEE, NHS England, professional bodies and general practices*)
2. Measures equivalent to the Ten Point Plan agreed for GPs are needed to improve recruitment and retention in primary care nursing. The number of general practice nurses and community nurses needs to increase in order to address both current shortfalls and the number of nurses due to retire in the next 5-10 years. (*Section 2.2.2, recommendation to NHS England, HEE and general practices*)
3. There should be greater involvement of clinical pharmacists, including prescribing pharmacists, in the management of people on long-term medication and people in care homes. This role is best carried out in the GP practice in order to allow full access to the patient record and to maximise interaction between the pharmacist and other clinical staff in the practice. (*Section 2.2.3, recommendation to NHS England, HEE, general practices and community pharmacies*)

4. Wider use should be made of community pharmacists and pharmacy support staff in managing minor illness and advising people about optimising their medicines. There should be agreed protocols for treatment and referral between local organisations of pharmacists and GP practices. *(Section 2.2.3, recommendation to NHS England, HEE, federations of community pharmacies and GP practices)*
  5. There are substantial potential benefits from a range of new approaches to staffing in general practices including the wider use of physician associates and healthcare assistants. The potential for paramedics to substitute for GPs in the assessment of urgent requests for home visits merits further evaluation. *(Sections 2.2.4 and 2.2.5, recommendation to NHS England, HEE, the National Institute for Health Research and general practices)*
  6. New support staff roles have the potential to reduce the administrative burden on GPs and nurses to enable them to focus on clinical care. These roles should be developed and evaluated. *(Section 2.2.4, recommendation to HEE, NHS England and practices, the National Institute for Health Research)*
  7. More evaluation is needed of new approaches to using allied health professionals in primary care, especially to determine whether direct access for some conditions makes cost-effective use of NHS resources. *(Section 2.2.5, recommendation to the National Institute for Health Research)*
  8. 24-hour community nursing services should be available in all areas in order to achieve a significant and sustainable shift of care from hospital to the community. *(Section 2.2.2, recommendation for NHS England and CCGs)*
  9. The costs and benefits of using a relatively unskilled workforce to triage requests for out-of-hours care are not sufficiently well established and may be a cause of hospital overuse. Research is needed to compare skilled versus less-skilled staff providing telephone triage in out-of-hours care. *(Section 2.6, recommendation to the National Institute for Health Research and CCGs)*
  10. Practices should analyse their clinical case-mix when deciding what skills they need to deliver high-quality care. They then need to agree clear criteria for what each healthcare professional will do and ensure that staff are fully competent in the roles they undertake. *(Section 2.2.7, recommendation to general practices, CCGs and healthcare regulators)*
  11. Practices need to create protected time and space to support effective team working. In line with the consultant contract, contractual and employment arrangements for staff in primary care should include time to support professional activities focused on quality improvement and clinical governance. *(Section 5, recommendation to NHS England, HEE, GP and pharmacy practices)*
- ## Making better use of technology
- Building on the strength of electronic general practice records, primary care staff, including community nurses and health visitors, should be able to access a common primary care record. In addition, we regard it as outdated that healthcare professionals working in primary care are unable to communicate freely with hospital specialists, for example, by using email and electronic messaging.
- We also believe it will soon appear outdated that, unlike countries such as Denmark, patients and clinicians cannot routinely communicate by email: if 5 per cent of GP consultations could be dealt with by email, this would save 17 million face-to-face consultations a year. However, we do not know to what extent emails from patients would generate additional demand. We make the following recommendations in relation to making better use of technology:
12. Email correspondence and electronic messaging should become routine between primary care healthcare professionals and hospital specialists, enabling both to seek advice and give guidance on patient care. While this may need protected time in the working day, there are significant potential cost savings in terms of reduced referrals to hospital. *(Section 2.3.1, recommendation to NHS England and CCGs)*
  13. Email correspondence between primary care clinicians and their patients should be piloted prior to becoming a routine part of NHS care. The impact of introducing emails from patients on the primary care workload should be evaluated, bearing in mind its potential to reduce face-to-face consultations. *(Section 2.3.2, recommendation to NHS England, general practices and the National Institute for Health Research)*
  14. Primary care staff, including community nurses and health visitors, should use a common medical record based on the general practice electronic record. *(Section 2.2.2, recommendation to NHS England, CCGs and to local authorities)*



- 15.** There should be a single point of access to out-of-hours services to avoid patients needing to make more than one call to get advice. Software solutions that go beyond the Summary Care Record need to be accelerated so that GP out-of-hours services have full access to electronic medical records including care plans. *(Section 2.6, recommendation to NHS England, CCGs and general practices)*

## Federations and networks of practices

Despite the strong worldwide reputation of UK primary care, it is increasingly recognised that the traditional small, independent 'corner shop' model of general practice and community pharmacy can no longer fully meet the needs of patients. Practices will need to be linked in networks, federations or large practices ('super-practices') or as part of multi-speciality community providers. This will enable them to provide a wider range of services, to offer better opportunities for staff development and training, and to work more effectively with commissioners, specialists, hospitals and social services.

Support and training is needed for those taking on leadership and management roles in these new organisations. Primary care staff have historically been relatively unengaged in NHS opportunities for leadership training and this must be redressed.

Federations or networks of practices offer opportunities to develop links with patient groups and local community organisations in a way that is very difficult for individual practices. This will provide better support for people with long-term conditions and others with particular health needs. Federations and networks also offer the opportunity to engage patients much more actively in planning primary care services than has been possible before.

- 16.** Large groupings of general practices (for example, federations, networks and super-practices) and federations of community pharmacies have much to offer in extending the scope of care provided in the community and improving coordination of care. Their development should be supported. *(Section 4, recommendation to NHS England and professional bodies)*



**17.** Within federations and networks, staff should be identified with responsibility for developing links with patient groups and with local community and voluntary organisations. (*Section 3.3, recommendation to GP federations and networks and federations of pharmacies*)

## Integrating care

Fragmentation of care is one of the major faults in health and social care, and the current array of community-based services is confusing for the public and professionals. We make the following recommendations in order to improve integration of care.

**18.** In line with some models in the NHS *Five Year Forward View*, specialists should be involved in a wider range of activities that bring them into direct contact with primary care staff. These might include routine email and telephone advice, supporting continuous quality improvement by attending multi-disciplinary team meetings, supporting primary care staff working in extended roles and providing referral clinics in primary care settings. (*Section 3.1, recommendation to NHS England, CCGs and general practices*)

**19.** Contracts for community nursing services and GP out-of-hours care should require bidders to demonstrate that they have the ability to integrate well with other primary care providers. This will encourage contracts to be held by organisations representing primary care providers, for example, federations of GP practices, multi-specialty community providers or primary and acute care systems, rather than by stand-alone providers or community trusts (*Sections 2.6 and 3.2, recommendation to NHS England and CCGs*)

**20.** There should be a single point of access to community services and social services for urgent assessments. To facilitate effective multi-disciplinary assessment (for example, acutely ill older people, discharge planning), staff from the necessary range of healthcare disciplines and from social services should be co-located and develop a team-based approach. (*Section 3.3, recommendation to NHS England, CCGs and local authorities*)

## Quality and safety in primary care

GPs and general practice nurses are seeing patients with increasingly complex problems some of whom require longer face-to-face consultations. Already, the average time spent by GPs in each consultation exceeds the average booking interval. This is particularly important for patients with complex medical and personal needs, where doctors need to be able to give longer appointments for comprehensive assessment and management, and where better patient education may result in improved use of medication and more effective self-care.

If face-to-face consultations become longer, some of this increased time may be offset by people having their problems more satisfactorily addressed at an initial consultation and not needing to return. Time may also be freed up for longer consultations by employing other team members to see less complex cases and by extending use of other forms of communication (such as phone, video-conferencing and email).

As people develop more complex long-term conditions, it will become more important for patients to see a clinician whom they know so that their preferences can be taken into account avoiding, for example, unwarranted polypharmacy. For healthcare professionals, it is increasingly important that they should see patients that they know in order to provide safe care for patients with complex problems within time-constrained consultations. The increasing difficulty that patients experience in booking with a particular doctor or nurse is becoming a major issue for patient choice in the NHS.

- 21.** General practices should be organised so that a significant proportion of face-to-face consultations can be longer in order to enable patients to have time to fully explore their health problems, their options for care and how they can best manage their conditions. *(Section 2.4.3, recommendation to NHS England, CCGs and general practices)*
- 22.** The ability for people to book to see a doctor or nurse of their choice should be monitored as a key metric of the quality of general practice care. *(Sections 2.4.2, recommendation to NHS England, CCGs and general practices)*

- 23.** Data should be publicly available on the quality of primary care. This should include measures of access, communication, clinical quality and integration. It is a priority to develop measures of integration since these do not currently exist in a form that can be routinely applied in the NHS. *(Section 2.4, recommendation to NHS England and National Institute for Health Research and the CQC)*

## Population groups with particular needs

### Socio-economic deprivation

- 24.** Measures are needed to address inequalities in the distribution of healthcare professionals in order to improve the major deficits seen in areas of socio-economic deprivation and poor health. New workforce initiatives should be prioritised in these areas. *(Section 2.5.1, recommendation to HEE and NHS England)*

### Care for children

- 25.** GP practices should have access to a named paediatrician and a named children's nurse. They should have named health visitors who use a common NHS electronic record to share information with other primary care staff. *(Section 2.5.2, recommendation to HEE and NHS England)*

### Care for people with mental health problems

- 26.** Practices or groups of practices should have access to a named consultant psychiatrist and a named mental health worker such as a primary care mental health worker or community psychiatric nurse. *(Section 2.5.3, recommendation to NHS England)*

### Care for people with challenging health and social care needs

- 27.** Clinical commissioners should address the needs of people with challenging health and social care needs (such as homeless people and substance abusers) that need 'one-stop' healthcare hubs where people can receive multiple services in one place. This may be addressed by practices established to provide care specifically for vulnerable groups or through conventional practices with on-site access to a multi-disciplinary team that includes social workers and drug and alcohol teams. *(Section 2.5.4, recommendation to NHS England and CCGs)*

## Care for people in nursing and residential homes

- 28.** Care for people in nursing and residential homes should be organised so that all patients in a home are cared for by one GP practice, except where a resident asks to be registered with a different practice. Likewise, one community pharmacy, ideally linked to the general practice, should provide advice on safe prescribing and medicines use in each home. *(Section 2.5.5, recommendation to CCGs, general practices, community pharmacies and care home owners)*
- 29.** Within general practices, one or two doctors should take responsibility for their patients in each home, prioritising proactive care over responding to acute illness, for example, with regular 'ward rounds'. GPs should have access to the full electronic medical record with the ability to prescribe electronically while they visit nursing or residential homes. *(Section 2.5.5, recommendation to general practice and care home owners)*

## Care at the end of life

- 30.** People at the end of life and their families should be able to identify and contact named individuals who lead on their care, for example a GP, community nurse, or specialist nurse. *(Section 2.5.6, recommendation to general practices)*
- 31.** Healthcare professionals providing care to patients at the end of life should have access to an up-to-date care plan 24 hours a day, access to community nursing services 24 hours a day, and to night sitting services. They should have ready access to drugs commonly used at the end of life, and advice from palliative care specialists should be available 24 hours a day. *(Section 2.5.6, recommendation to NHS England, CCGs and community pharmacies)*

## Education and training: creating learning organisations

With some exceptions (for example, medical student teaching and GP training), little priority has been given in the NHS to training and professional development for staff working in primary care. This needs to change and we make several specific recommendations relating to training. In addition to these, an infrastructure needs to be provided to support training across the primary care workforce including training and support for quality improvement activities.

- 32.** Structured training opportunities should be available to all primary care staff wishing to develop extended clinical, academic or leadership roles during their careers. There is a particular need for leadership training and ongoing support for primary care staff with leadership roles in federations and networks and for staff to develop skills in quality improvement. We also identified a need for staff to be trained in new forms of consultation using phone, video-conference and email. Specific provision is needed for foundation programmes with minimum training standards for registered nurses who transition from secondary to primary care, *(Sections 2.2.1 and 2.2.2, recommendation to CCGs, HEE, general practices and regulators)*
- 33.** Pre- and post-registration placements in primary care should be commissioned as part of routine training for nurses and pharmacists as they are for medical students and GPs. *(Sections 2.2.2 and 2.2.3, recommendation to HEE)*
- 34.** The number of pre-registration pharmacy placements needs to increase in order to meet the enhanced role for pharmacists identified in this report. These placements should include experience in community pharmacies and in general practices as well as in hospitals. *(Section 2.2.3, recommendation to HEE and community pharmacies)*
- 35.** There should be opportunities for joint training of health and social care staff to enable more efficient assessments to be made and to increase understanding between the professions. Community staff making urgent assessments of acutely ill patients should receive basic training in the skills of other members of their team in order to increase the efficiency of their assessments. *(Section 3.2, recommendation to HEE, NHS England, CCGs, local authorities, healthcare regulators and professional bodies)*
- 36.** Community Education Provider Networks provide a model that promotes inter-professional learning based around the needs of local populations. This model forms part of the concept of a training hub in the Ten Point Plan and should be developed further in order to meet the educational needs of multi-disciplinary primary care teams. *(Section 5, recommendation to NHS England and HEE)*



## Providing better data about primary care; making innovation evidence based

We received a consistent message planning in primary care is difficult because of the lack of reliable systematic data about the numbers of different disciplines in primary care, who currently does what, and whether they have the appropriate skills to deliver the wide range of functions that are needed. Workload and activity surveys are carried out infrequently, by a range of interested parties and without any consistent methodology. This needs to change to enable better planning and evaluation of primary care in future. In addition, many innovations in primary care are poorly evaluated with a piecemeal approach to evaluation that makes it hard for policy makers or NHS leaders to defend the use of the resources.

37. Data should be available to enable details of the workforce, the work carried out by them, and the quality of that work to be available on a routine basis. (Section 8, recommendation to NHS England)
38. All new resources invested in new models of care should include a component for suitably trained staff to evaluate and share evidence of their effectiveness in order to justify new ways of working. (Section 8, recommendation to NHS England and the National Institute for Health Research)

## Making change happen

Some of our recommendations will require significant additional investment, particularly the need for additional staff. However, not all of the recommendations are expensive and some will result in cost savings from better use of NHS resources. If primary care can offer a consistent and coordinated service, this will reduce the constant demands for growth in the acute sector and many of our recommendations are designed to reduce the demand on specialist services.

Compared to recruitment of new staff, many of our recommendations will be less expensive. These include education and training, IT development, and changing contracting requirements for some NHS services. Some of these will result in cost savings from better use of NHS resources.

Some of our recommendations require a minimal investment, for example the ability for GPs and general practice nurses to communicate easily by email with their specialist colleagues in hospital. Some recommendations require only the will to change, for example, one GP practice having responsibility for all patients in a care home except where residents specifically request an alternative GP, patients at the end of life being able to identify who is responsible for coordinating their care, and introducing the ability for patients to see a doctor or nurse of their choice as a key performance metric for the NHS.

Some recommendations require technical solutions that are long overdue. These include general practices, community staff and health visitors using a common patient record. Software solutions need to be accelerated so that staff visiting care homes and those providing out-of-hours care have full access to the patient's medical record.

Some of our recommendations require further research or evaluation. All new NHS initiatives should collect data to show whether they have added value and improved quality and patient/staff experience. There is an urgent need for good measures to show the extent to which care is well integrated: these measures need to be developed. We think there is a strong case for allowing patients to email their GP or nurse as in some other countries, but the impact on primary care workload needs to be assessed. Some new roles in primary care also need further

evaluation before they can be widely recommended. These include new administrative roles such as medical assistants, physiotherapists providing first-contact care without referral, and paramedics responding to urgent requests for care.

The 'triple aim' of healthcare – of improving population health, improving patient experience and containing cost – needs to become a 'quadruple aim' that includes improving the working life of health professionals. This recognises that care of the patient requires care of the provider. If our recommendations are implemented, we envisage primary care moving rapidly out of its present situation with constant talk of crisis to one where a high-quality service is provided by well-motivated professionals. Our vision for the future is summarised in the following box:

### Our vision of primary care for the future

Primary care will have at its heart active collaboration between healthcare professionals and the people they care for. This patient-focused approach will require collaboration between professionals and strong team working, both within and across organisational boundaries.

Primary care practices will include a wider range of disciplines. As well as GPs, nurses and administrative support, primary care teams may include healthcare assistants, physician associates, paramedics, allied health professionals, social workers and others. Pharmacists will increasingly become a core part of the general practice team.

It will be normal for general practices to work together, for example, as parts of federations or networks of GP practices, giving smaller practices access to an extended primary care team. Community pharmacies will also form networks that may sometimes join with general practice networks.

Given the complexity of people's needs and the need for time to fully engage people in managing their care, many face-to-face consultations will be longer. Primary and community care staff will make greater use of technology to increase access and support for patients. They may communicate by phone, by video-conference and by email, and practices will provide web-based support to help patients manage their

own conditions. Staff will be able to guide patients to a wider range of resources from lay and voluntary organisations.

Community nurses and health visitors will work much more closely with general practices and will share electronic records with them. In many cases, contracts for community nursing services will be held by federations of GP practices to improve integration of care.

Hospital doctors and nurses will increasingly work with others in community settings, for example, in care of the elderly. While hospital-based specialists may run clinics and see patients in the community, a major role will be to support clinicians in primary care.

Support staff will deal with much of the administrative work currently done by doctors and nurses (such as dealing with most email and electronic tasks), freeing them up for clinical work.

High-quality education will be available to all staff working in primary care to give them access to continuing professional development, to enable them to develop advanced skills, and to provide them with the leadership and management skills to run new primary care organisations such as federations of GP practices.

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## Biographies of Commission members

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**Martin Roland CBE (Chair)**  
Professor of Health Services  
Research, University of Cambridge

Martin has been at the University of Cambridge since 2009. He trained at the University of Oxford, where he obtained his doctorate. Following vocational training for general practice in Cambridge, he worked as a GP in London and in Cambridge before moving to the Chair in General Practice in the University of Manchester in 1992 where he worked as a GP in central Manchester. In 1994, he established and subsequently became Director of the National Primary Care Research and Development Centre where his main areas of research interest were developing methods of measuring quality of care, and evaluating interventions to improve care in the NHS. He now co-directs the Cambridge Centre for Health Services Research, collaboration between the University of Cambridge and RAND Europe. Professor Roland was a practising GP from 1979 to 2013.



**Professor Nick Barber**  
Director of Research,  
The Health Foundation

Nick lectured as a pharmacologist before entering hospital pharmacy, where he was a chief pharmacist at the National Heart Hospital and at Oldchurch General Hospital. He became a Professor at UCL School of Pharmacy in 1992 and founded their Department of Practice and Policy. In 2012 he became Director of Research at The Health Foundation. He has published over 160 peer reviewed papers, particularly in the areas of medication safety, technology assessment, patient adherence and pharmacy practice. This work led to the creation of the national New Medicine Service (NMS) in community pharmacies. He has been a visiting Professor in patient safety at Harvard Medical School, has presented the BBC2 series 'The Victorian Pharmacy' and is a former Vice-President of the Royal Pharmaceutical Society of Great Britain. In September 2013, he received the Royal Pharmaceutical Society's lifetime achievement award.



**Amanda Howe**  
Professor of Primary Care,  
University of East Anglia

Amanda has been a GP since 1983. She is a practicing academic at the University of East Anglia where she joined the foundation team in 2001 to set up the new Norwich Medical School. She is Vice Chair (professional development) for the Royal College of General Practitioners, previously holding posts as Chair of Research and Honorary Secretary where she led initiatives on generalism, GP careers, and workforce. Amanda has also been active in the World Organisation of Family Doctors (WONCA), working in particular on equity initiatives and is now their President elect. Her involvement in academic practice was originally driven by a desire to give medical students the chance to meet patients in their own communities and to see the full breadth of health and illness in the context of people's lives. The theme of personal and professional enablement underpins a diverse research portfolio on mental health, resilience, professionalism, and the impacts of community based learning. Her work with students, residents, and colleagues is based on similar values – championing the best of general practice through an ambition to lead change, assist learning and deliver relevant evidence that will help professional development and patient care.



**Candace Imison**  
Director of Healthcare  
Systems, The Nuffield Trust

Candace joined the Nuffield Trust as Director of Healthcare Systems in December 2014. She was previously Deputy Director of Policy at The King's Fund where she researched and published on a wide range of topics including future healthcare trends, service reconfiguration, workforce planning, polyclinics, community health services and referral management. She has extensive senior management experience in the NHS, including board level for providers and commissioners. She was director of strategy for a large acute trust and director of commissioning for a large health authority. She worked on strategy and policy at the Department of Health between 2000 and 2006, including work for the Modernisation Agency leading a workforce modernisation initiative. Candace is currently a non-executive director and vice chair of an acute trust in south west London. She is also on the advisory panel of the Centre for Workforce Intelligence. She holds a master's degree in health economics and health policy from the University of Birmingham and a degree in natural sciences from the University of Cambridge.



**Gregory Rubin**  
Professor of General Practice and  
Primary Care, Durham University

Greg is a Professor of General Practice and Primary Care in the School of Medicine, Pharmacy and Health at Durham University. He is Director of the Evaluation, Research and Development Unit. His research interests lie in the diagnosis and management of significant disease in primary care, at the interface with secondary care and the configuration of health services to enable this. He has a substantial programme of research and service development in the field of early cancer diagnosis and is part of the Policy Research Unit for cancer awareness, screening and early diagnosis. Until 2014, he was the Royal College of General Practitioners UK Clinical Lead for cancer research UK.



**Karen Storey**  
Primary Care Lead Nurse  
Workforce, Health Education  
West Midlands

Karen leads on the development of the primary care non-medical workforce, with a particular focus on the nursing workforce in general practice. She has spent 5 years working with Coventry and Rugby Clinical Commissioning Group as Primary Care Lead Nurse, responsible for education and development. Prior to this she was the Primary Care Access Nurse at Bath & North Somerset PCT developing roles within primary and community care. She was also the Clinical Lead Nurse for Bath NHS walk-in centre. She has a background as a General Practice Nurse, an Advanced Nurse Practitioner and is a qualified Independent Nurse Prescriber. Karen has an MSc in health studies and her dissertation researched into leadership in general practice nursing. Karen is a member of the RCN Practice Nursing Association Steering Committee. She has recently been appointed as the Chair of the Health Education England general practice nursing sub group which is part of the Transforming Nursing for Community and Primary Care Workforce steering group.

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## Annex A: Evidence considered by the commission

### i) submitted

### ii) literature

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All documents can be accessed from the [Health Education England website](#)

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## Annex B: Terms of Reference for the Commission

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The UK population is projected to grow by approximately 7% to 68 million between 2012 and 2022. The future health and care system will require greater emphasis on community, primary and integrated services, being able to care for and support patients in appropriate settings for example, their own home and care homes.

Primary care services will need to change to meet the challenges of an ageing population and to better serve those with complex health and care needs; providing personalised, proactive care to keep people healthy, independent and out of hospital. Additionally, improvements in information technology will support people to take control of their own care, with greater support and information for carers.

New models of care and ways of working will mean moving away from traditional professional boundaries and ensuring staff are able to take on different roles across a variety of care settings where it benefits patients. More working in multi-disciplinary teams and work to break down barriers between primary and secondary care is required.

This multi-professional workforce needs to be given the right education and training to ensure they have adaptable and transferable skills that are continually refreshed and reviewed so that they are responsive to evidence and innovation to enable 'whole person' care driven by patient rather than professional need.

Our long-term workforce planning and development strategy needs to focus on the anticipated future population needs.

This Commission will be cognisant of the needs of and be aligned with other strategies being developed both within

Health Education England (HEE) and partners across the systems for example; Transforming Primary Care and The Urgent and Emergency Care Review.

### Purpose of the Commission

The Commission will identify models of primary care that will meet the needs of the future NHS. This will inform priorities for HEE investment in education and training to deliver a primary care workforce that is fit for purpose, flexible and able to respond to new models of primary care. The commission will highlight good examples of integrated, patient focussed out of hospital care which will influence service commissioners and regulators.

In identifying future models of primary care, the Commission will need to be cogniscent of:

1. Patient and population need.
2. Emerging models of primary care care which respond to population need including:
  - A shift from secondary to primary and community care settings with increased care taking place closer to home
  - Better integration of primary and secondary care
  - Better integration of health and social care
  - New ways of working in urgent and emergency care
  - 7 day services
  - Adjusting the shape of medical training to support a more generalist and a specialist workforce
  - Supporting self-care and management of long term conditions.

3. Maximising the contribution of the skills needed to deliver models of care, including detailed reviews of skill mix and working across boundaries. Including determination of successful models and champions for these.
4. Education and training:
  - Transferable skills between healthcare settings
  - The use of competency based frameworks for developing workforce need
  - Novel training models
  - Development of advanced practice
  - Return to Practice of professionals including primary and community care nurses and GPs.
  - Technology Enhanced Learning
  - Consistent training content and standards between agencies
  - Developing hub and spoke practice training models
  - Increasing practice placement capacity across primary and community care
5. Workforce modelling within specific settings and care models considering best practice examples.
6. Making careers in primary and community care more attractive to a broad range of health professionals which might include consideration of incentives, support for return to practice and consideration of retraining and supporting the current workforce.

### How we will work

The commission will engage with key partners across the health and social care system including patients and public through HEE's Patient Advisory Forum.

### Current workforce initiatives

HEE is already leading on a number of initiatives relevant to the development of the out of hospital workforce. It will be important to align emerging outputs from these initiatives to the commission.

### Research

The commission will undertake research to feed into the work of the Commission. The research will look to identify:

- International comparisons
- Different workforce models in primary care both nationally and internationally
- Identifying good practice both nationally and internationally, including case studies
- Identifying champions for models of care or workforce interventions
- Consideration of workforce outcome measures.

### Measures or indicators of success

The commission will need to consider and identify clear and robust indicators and measures of success which might include economic analysis and impact assessments and outcome measures. This element of the work will be procured externally.

### Cost implications

This is an important commission but is limited in its scope due to the timescale of 6-months. It will be less broad than reviews for example, Shape of Training and Shape of Caring.

A realistic costed budget will need to be determined and supported by system partners.

### Timescales

- Establish the Commission including Terms of Reference during Autumn 2014
- Undertake the work of the commission during January – May 2015
- Make recommendations during July 2015

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<sup>15</sup> Professor David Greenaway, Securing the future of excellent patient care (Greenaway Review, 2013)

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## Annex C: Individuals and organisations which submitted evidence; site visits

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Acorn Surgery, The Oak Tree Centre  
Beacon Medical Group  
Bolton Community Practice CIC  
Brid Inc  
British Acupuncture Council  
British Association of Social Workers  
British Medical Association (BMA)  
British Orthopaedic Association  
British Society for Rheumatology  
Care UK  
Centre for Workforce Intelligence  
College of Occupational Therapy  
College of Social Work  
Committee of General Practice Education Directors (COGPED)  
Cuckoo Lane Health Care  
Devon Local Pharmaceutical Committee  
East Lancashire Hospitals NHS Trust (ELHT)  
Fakenham Medical Practice  
Family Doctor Association  
Fisher Medical Centre  
Gaywood House Surgery  
General Medical Council (GMC)  
Guy's and St Thomas' Community Service  
NHS Foundation Trust  
Health Education East Midlands  
Health Education East of England  
Health Education England Central  
Health Education Kent, Surrey and Sussex  
Health Education North Central and East London  
Health Education North East  
Health Education North West  
Health Education North West London  
Health Education South London  
Health Education South West  
Health Education Thames Valley  
Health Education West Midlands  
Health Education Wessex  
Health Education Yorkshire and Humber  
Health Innovation Network South London  
Hurley Group  
Imperial College London  
Invicta Health CIC  
Jhoots Pharmacy  
Kingskerswell and Ipplepen GP Practice  
Lakeside Surgery  
National Association of Patient Participation  
National Voices  
NHS Barnsley CCG  
NHS Blackpool CCG  
NHS Central Manchester CCG  
NHS Chorley and South Ribble CCG and NHS Greater Preston  
CCG in partnership with Health Education North West, Lancashire  
Teaching Hospitals Foundation Trust and Lancashire Care  
Foundation Trust  
NHS Cumbria CCG  
NHS East and North Hertfordshire CCG  
NHS England Devon, Cornwall and Isle of Scilly  
NHS Halton CCG  
NHS Hambleton, Richmondshire and Whitby CCG  
NHS Harrogate and Rural District CCG  
NHS Leeds North CCG, Leeds West CCG, Leeds South and East CCG  
NHS North Lincolnshire CCG  
NHS Richmond CCG  
NHS Somerset CCG  
NHS South Sefton CCG and Southport and Formby CCG  
NHS Waltham Forest CCG  
NHS West Norfolk CCG  
NHS Westbourne Medical Centre/ Dorset CCG  
North East Essex CCG  
NHS Confederation  
NHS England  
Northumbria Healthcare NHS Foundation Trust  
Nottingham CityCare CIC  
Nuffield Trust  
Oxford Health NHS Foundation Trust  
Oxford University Hospital Trust in partnership with Oxford GP  
Deanery, Emergency Multidisciplinary Units (EMU) and Witney  
Community Hospital  
Pharmacy Voice  
Primary Care Education Group, Parklands Practice  
Queen's Nursing Institute  
Royal College of General Practitioners (RCGP)  
Royal College of Nursing (RCN)  
Royal College of Psychiatrists (PCPsych)  
Royal College of Speech and Language Therapists (RCSLT)  
Royal Medical Benevolent Fund (RMBF)  
Royal Pharmaceutical Society (RPS)  
Salford Royal Foundation Trust  
Sentinel Healthcare SouthWest Community Interest Company  
Sherdley Medical Centre and Eldercare at St Helens Hospital  
Skills for Care  
South East Community Support Unit  
St Austell Health Group  
Stowhealth  
Suffolk GP Federation  
The Chartered Society of Physiotherapy (CSP)  
The Old School Surgery/Old School Pharmacy  
The Royal College of Emergency Medicine (RCEM)  
The Vitality Partnership  
UK Association of Physician Associates (UKAPA)  
Urgent Care Commission  
York Street Medical Centre, Leeds Community Healthcare  
NHS Trust

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## Glossary

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This glossary is to help readers understand terms they may not be familiar with, particularly if new to the field, and given the complexity of the Primary Care workforce. These definitions are not intended to mandate usages.

### Advanced Nurse Practitioner

A registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A Master's Degree is recommended for entry level to an Advanced Nurse Practitioner role.

### Allied Health Professionals

Allied health professions are health care professions distinct from nursing, medicine and pharmacy. They include arts therapists (art therapists, drama therapists and music therapists), chiropodists/podiatrists, dietitians, occupational therapists, orthoptists, orthotists, paramedics, physiotherapists, prosthetists, radiographers, and speech and language therapists.

### APMS contract

Alternative Provider Medical Services (APMS) is a contracting route available to enable Primary Care Organisations (PCOs) to commission or provide Primary Medical Services (PMS). APMS provides the opportunity for locally negotiated contracts allowing PCOs to contract with non-NHS bodies, such as voluntary or commercial sector providers, (or with GMS/PMS practices) to supply enhanced and additional primary medical services. PCOs can enter into APMS contracts with any individual or organisation to meet local needs, as long as core NHS values are fully protected and secured.

### Clinical Commissioning Group

A Clinical Commissioning Group (CCG) is an organisation responsible for implementing the commissioning roles as set out in the Health and Social Care Act 2012. They do this by planning and designing local health services in England then 'commissioning' or buying health and care services including Planned Hospital Care and Urgent and Emergency Care.

### Community Interest Company

A Community Interest Company (CIC) is a type of company introduced by the United Kingdom government in 2005 under the Companies (Audit, Investigations and Community Enterprise) Act 2004, designed for social enterprises that want to use their profits and assets for the public good.

### Multi-specialty Community Providers

A new model of working first described in the NHS *Five Year Forward View*, the MCPs envisage a much wider range of specialist services being delivered out of hospital and in the community, often from expanded community facilities which are closely linked to general practices through formal or informal federations or networks.

### NHS Agenda for Change

Agenda for Change (AfC) is the current National Health Service (NHS) grading and pay system for all NHS staff, with the exception of doctors, dentists and some senior managers.

### NHS Vanguard Site

These are individual organisations and health and social care partnerships which were chosen by NHS England in 2015 to develop models to support improvement and integration of services with the aim of transforming how care is delivered locally.

### Physician Associate

The Physician Associate is an innovative new health professional, who works with the clinical team to provide quality health care across the NHS. They carry out defined duties under supervision to support but not replace doctors.

### Primary and Acute Care Systems

The NHS *five year forward view* introduced a collaborative approach to improving patient care by forming Primary and Acute Care Systems (PACS). These create new partnerships under a variety of frameworks to join up GP, hospital, community and mental health services and provide new models of care delivery.

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## **Prime Ministers Challenge Fund**

A development fund helping to improve access to general practice and stimulate innovative ways of providing primary care services. The Government asked NHS England to lead the process of inviting practices to submit innovative bids and overseeing the pilot schemes. Wave one was launched in April 2014 and saw twenty pilot schemes selected that is benefitting over 7 million patients across more than 1,100 practices. In March 2015 a second wave was launched with 37 pilot schemes covering 417 practices, serving over 10.6m patients. They were chosen to lead the way in testing innovative ways of increasing access and delivering wider transformational change in general practice.

## **Super-practices**

Large scale GP practices created by merging patient lists and combining services to achieve economy of scale and increased capacity for care and patient services. Super-practices may be over multiple sites or combined in one facility with additional services.

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