

The future of General Practice in Northern Ireland

Developing general practice from 2010

February 2010



Royal College of
General Practitioners



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Executive summary

Primary care is the cornerstone of the health service in the UK, with general practitioners (GPs) dealing with 90% of health related cases. GPs in Northern Ireland are arguably amongst the best in the UK, as demonstrated by consistently scoring highly in the Quality and Outcomes Framework (QOF) element of the GP contract.

However, this does not mean that local GPs are content with the status quo. High quality patient care must remain paramount. To ensure this, it is essential that GPs remain at the forefront of healthcare delivery and development in Northern Ireland. Given the changing healthcare environment due to government agendas and patient expectations, the core values of general practice, which focus on patients' needs, must underpin all aspects of primary care.

The Northern Ireland General Practitioners Committee (NIGPC) of the British Medical Association Northern Ireland (BMA(NI)) and the Royal College of General Practitioners Northern Ireland (RCGP(NI)) agreed a project was needed to explore the current and future challenges facing general practice, both internally and externally.

As a result, this strategy was developed to identify how general practice could continue to develop over a ten year period commencing 2010.

This strategy includes:

- The core values of general practice in Northern Ireland
- The context in which GPs are working from the government, patient, business and media perspectives in both the UK and Northern Ireland; and also from the view of the changing profile of the workforce
- Strengths and challenges, opportunities and threats facing general practice over the next five and 10 years

The key element of this strategy is the action plan for delivering on the key challenges identified. Areas in which action must be taken to ensure that general practice continues to lead healthcare for the benefit of patients in Northern Ireland include:

- Developing a framework for effective management of general practice in the future
- Improving leadership and management effectiveness within general practice
- Improving organisation within the infrastructure of general practice
- Improving service and accessibility
- Working with Trusts and commissioners
- Resourcing general practice
- Promoting the unique selling points of general practice
- Identifying and addressing competition issues
- Addressing the educational and training needs of general practice
- Monitoring the impact of medical regulation arrangements

This is an ambitious strategy, which requires input not just from the BMA(NI), the RCGP(NI) and key stakeholders such as the DHSSPSNI, the Regional Health and Social Care Board (RHSCB) and NIMDTA, but from every GP in Northern Ireland. By working together to effectively promote general practice, we can ensure that GPs remain at the centre of healthcare delivery, and that value for money, patient experience and health outcomes remain the focus for future development within Northern Ireland, with patients at the centre of care.

1. Purpose of strategy document

To provide an overview of the strategy to promote general practice effectively over the next ten years and to ensure that general practice and its core values are at the centre of healthcare delivery and development in Northern Ireland.

2 Background to the strategy

The Northern Ireland General Practitioners Committee (NIGPC) of the British Medical Association Northern Ireland (BMA(NI)) and the Royal College of General Practitioners (RCGP) (Northern Ireland) agreed to explore the current and future challenges facing general practice, both internally and externally, and to identify how general practice could develop over a ten year period commencing 2010.

This work built on an earlier BMA(NI) workshop event on 26th November 2006 which considered the future of general practice within potential new arrangements under the Review of Public Administration in Northern Ireland. That workshop assessed the strengths and weaknesses of general practice and the opportunities and threats facing general practice.

3 NIGPC workshop 19th and 20th February 2008

This two day workshop was designed by the Chairman (NIGPC) and Deputy Secretary of the BMA(NI). The workshop was facilitated by the Deputy Secretary and the Policy Officer.

The aims of the event were agreed with the Chairman as:

- To enable leaders in general practice to assess the overall environment affecting general practice over the next five, ten, and, if possible, 20 years
- To assess the opportunities and challenges, both external and internal
- To identify and agree key principles to ensure the effective delivery and development of general practice into the future
- To identify actions needed to address the key issues
- To identify the key elements of a long-term strategy to develop general practice and enhance the key principles

The event was attended by a number of NIGPC members plus the Chairman of the Royal College of General Practitioners (Northern Ireland).

The process adopted for use on the day was: structured, focused, interactive and output driven. Workshop activity included listening to expert speakers.

Four speakers, Dr Brian Dunn (Chairman, NIGPC), Dr Tom Black (Deputy Chairman, NIGPC), Dr David Johnston (Chairman, RCGP (NI)) and Dr Michael McBride (Chief Medical Officer, DHSSPSNI) provided an overview of the future of general practice as they saw it.

This set the scene for identifying, through group work:

- Core values of general practice
- The key issues/challenges facing general practice, over the next five and ten years from the perspective of the:
 - Internal environment
 - External environment
- Key Action Areas which need to be addressed
- Key Actions to be taken

Participants agreed to the development of a strategy to develop general practice that would:

- Make the most of opportunities
- Assess how to meet challenges
- Help shape the agenda for general practice

4 Additional workshops and consultation

A workshop was held on 28 January 2009 to enable GP professionals and other stakeholders to discuss the draft strategy. In addition, views were sought from those who could not attend the workshop. The outcomes from the workshop are incorporated into the strategy.

A workshop was held on 16 April 2009 to seek the views of patients/patient advocates on the proposed 'draft' strategy. Again the outcomes from the workshop, plus the views of those who could not attend, were incorporated into the final strategy.

5 The core values of general practice in Northern Ireland

These were agreed by general practitioners as:

- Providing a "needs-based" service for patients
- Providing "continuity of care" for patients
- Dealing with undifferentiated disease (often at a very early stage)
- Managing risk (only a tiny proportion of consultations result in a referral)
- "Prioritising" services to meet patients' needs
- "Improving patient care and the patient experience"
- Maintaining the "building block" of the Health Service in Northern Ireland as GP based primary care
- Providing the "gateway" to other care (gatekeeper role of general practice)
- Providing and "maintaining" the generalist function
- Providing a "professional" service
- Improving the "organisation and business" of general practice
- Improving "access" and "choice" for patients
- Embracing "partnership" working and continuity of relationships with other service providers in the HSC sector
- "Embracing/shaping" change
- "Protecting" a health service which is "universal and free at the point of delivery"
- Embracing a federated approach for GP practices to work together, to assist and support small practices and ensure that all practices could meet their business and development needs into the future
- Continuously improving quality

- Being responsive to the evolving priorities of the HPSS through involvement in commissioning
- Providing a confidential consultative role
- Fulfilling an advocacy role

6 Environmental context

6.1. External environment

The external environment analysis within which this strategy is developed is detailed below, based on secondary research across a number of sources. It encompasses the government agenda, patients' and business perspectives, and the role of the media in both the UK and Northern Ireland.

6.1.1. Government agenda – UK

As the NHS reached its sixtieth anniversary year, the Prime Minister, Gordon Brown, promised to keep the National Health Service at the top of the Government's agenda, with a focus on reducing infections and improving access to care the priorities in 2008.¹

Over the past five years or so, the government has sought to 'modernise' the NHS, and in exchange for funding, has required the NHS to become more efficient.² Various targets were set in primary care. For example, by 2004, it was a requirement of GP practices to ensure that patients could see a GP within 48 hours.

A new GP contract, introduced in June 2003, sought to reward practices for the achievement of 16 targets, as well as enabling GPs to opt out of providing out-of-hours cover. Many GP practices throughout the UK have continued to meet a significantly high proportion of the targets, resulting in higher costs than originally anticipated by government.

More recently, Lord Darzi, the former Parliamentary Under Secretary at the Department of Health, has been tasked with conducting a 'once in a generation review' of the health service in England, consulting with patients and staff to set priorities for the next 60 years, with a focus on access, quality and safety. The review, called 'Our NHS, Our Future', was published in June 2008.

A further report on a vision for primary and community care was published on 3rd July 2008.³ While the BMA welcomed many of the ambitions contained in this vision, it was thought that previously announced government proposals would undermine the report,⁴ in particular polyclinics, which would serve a wider area and provide some outpatient services in addition to GP services.

The BMA is opposed to the threats posed by polyclinics and the commercialisation of general practice, and believes such changes would be detrimental to patients and the services as a whole.⁵ The BMA is also concerned at the lack of engagement with general practitioners with regard to changes in health policy.

1 www.pm.gov.uk

2 Health Policy Matters Issue 8 October 2003. The University of York

3 NHS Next Stage Review Our vision for primary and community care: What it means for GPs and practice staff. Department of Health 2008

4 Darzi's final vision for primary care is positive though undermined by previous announcements BMA press release Thursday 03 Jul 2008

5 98% of GPs condemn government's negotiation tactics BMA Press release 6th March 2008

A BMA-led 'Support your surgery' campaign took place to encourage patients to show support for NHS general practice⁶. In the three week period ending 6 June 2008, 1,236,085 signatures were collected, calling for the government to invest in existing local GP services and halt its plans for increased commercialisation of primary care in England. This demonstrated a phenomenal level of public support for NHS general practice and strong opposition to Government health policy in England, and Dr Laurence Buckman delivered these to 10 Downing Street. A follow-up UK-wide campaign is currently being developed to capitalise on this momentum.

Funding for general practice in England currently stands at £146.81⁷ per patient, with general practice income generated from meeting required quality and outcome framework targets. However the UK has just come through a recession and there is a massive shortfall in the public purse to fund all public services, including healthcare.

While the Conservatives and Labour have yet to put manifestos to the electorate, the level of public spending looks set to be a major issue in the run-up to the general election, given the current economic climate and the UK deficit forecast for 2009/10 at £175 billion. While the parties bicker over spending plans, Gordon Brown's admission that spending cuts will be needed in his speech to the TUC conference in Liverpool,⁸ after months of insisting spending would continue to rise, confirms that public spending cuts is definitely on the agenda for whatever party becomes the government.

6.1.2. Government agenda – Northern Ireland

In reality, Northern Ireland health care policy changed has little since 1998, with responsibility for health resting with the Northern Ireland Office while the Northern Ireland Assembly was suspended from 2002. Devolution resumed in May 2007 and responsibility for Health returned to a fully functioning Assembly, under the Department of Health Social Services and Public Safety, whose executive powers are provided for by the Northern Ireland Act 1998.

Anything not denoted as a Reserved power or an Excepted power is fully devolved.⁹ For example, medical regulation is neither Reserved nor Excepted and so is devolved to the Northern Ireland Assembly.

The Minister for Health, Social Services and Public Safety is Michael McGimpsey MLA (Ulster Unionist Party). In addition, the Assembly has a Health, Social Services and Public Safety Statutory Committee to scrutinise the Minister and his Department.

While the Assembly has powers to legislate on all aspects of health, there is the option for the Assembly to grant Legislative Consent to the Parliament of the United Kingdom, which will enable it to pass legislation on a devolved issue extending to Northern Ireland. The most recent example of this was the granting of Legislative Consent for the Health and Social Care Bill. While not specific to general practitioners, this Bill covers medical regulation, which clearly will impact on GPs.

6 www.supportyoursurgery.org.uk

7 Investment in General Practice 2003/04 to 2007/08 England, Wales and Northern Ireland April 2009; NHS The Information Centre for health and social care. http://www.ic.nhs.uk/webfiles/publications/investingp0304-0708/Investment_in_%20General_%20Practice_%202003_04_to%202007_08_%20England_Wales_and_%20Northern_Ireland.pdf

8 TUC Conference Tuesday 15 September 2009

9 NI Assembly – Devolved, Reserved and Accepted Powers. BMA(NI) Assembly and Research Unit Briefing Note April 2007

The Review of Public Administration, which was implemented on 1 April 2009, had the aim of delivering wide-ranging and comprehensive modernisation and reform across the public sector. Changes under this will review will impact on GPs, not least through involvement in Local Commissioning Groups.

With regard to the GP contract, while it is essentially a UK-wide contract, there is scope for local policies to be developed and agreed. For example, rather than imposing extended opening hours on GP practices in Northern Ireland as has happened in England, GPs in Northern Ireland voted overwhelmingly in favour of an offer from the DHSSPS to provide funding for new clinical work to be carried out within general practice.¹⁰

There is clearly an opportunity for the profession to work with the Department to provide improved care to the people of Northern Ireland, and extended opening, which has no evidence of improving care, is not a priority locally. Local negotiators from NIGPC work to obtain the best deal possible with regard to clinical direct enhanced services (DESs) in Northern Ireland, although currently, expectations of the DHSSPS are unrealistic and there is frustration that the DESs are still not as good as what is wished.¹¹ In addition, there is concern that funding allocated to particular DESs is being clawed-back, and that unallocated DES funding is being used elsewhere.

Within Northern Ireland, the policy framework for primary care is contained within 'Caring for people beyond tomorrow', a strategic framework for the development of primary health and social care for individuals, families and communities in Northern Ireland.

6.1.3. Patients' perspectives – UK

General practitioners are contracted to deliver a healthcare service to the population. In order to ensure that the customers i.e. patients, are satisfied with the service, surveys are regularly undertaken.

The GP Patient Survey (GPPS) – your doctor, your experience, your say¹² emerged from the 2006/07 contract review negotiations as a means of measuring achievement in the "Improved Access Scheme" and "Choice and Booking" DES. The survey is not related to the GP patient survey in the Quality and Outcomes Framework (QOF)

The GPPS questions patients on:

- their satisfaction with practice opening hours
- the ease of getting through to their practice by phone
- obtaining an appointment within 48 hours
- booking appointments in advance

The results showed that 84% of patients were satisfied with their practice opening hours, and 86% were satisfied with how easy it is to get through to their practice by telephone. 86% of patients were able to get an appointment within 24 hours, and 94% patients recalled discussing choice of specialist when being referred by their GP. Whilst the results were broadly positive, the survey revealed differing levels of satisfaction across different patient groups, particularly by age, ethnicity and location.¹³

10 More chronically sick patients in NI to benefit from treatment within general practice BMA(NI) press release 6 March 2008

11 Letter to the profession from Chairman of NIGPC, 14 August 2008

12 Focus on...the GP Patient Survey. BMA guidance note available online at www.bma.org.uk updated October 2007

13 GP Patient Survey 2007: national results available at www.doh.gov.uk

Despite these positive results, the GPC remains critical of the survey. The survey confirmed what existing patient surveys and studies have already revealed, and as such the GPC considers the cost of executing the survey (£11 million) to be an imprudent use of NHS resources. The survey is now carried out quarterly in England.

The GPC continues to work to ensure that the survey is fair to GPs, and to voice objections to questions which are deemed to be misleading or pejorative. GPC would prefer to revert to more local patient surveys which would be more responsive, and would give practices the opportunity to have a direct dialogue with their patients about the issues.

6.1.4. Patients' perspectives – Northern Ireland

Within Northern Ireland, under the nGMS contract, incentives are offered to encourage practices to use accredited questionnaires to gain patient views and make appropriate improvements. Providing feedback to patients on such questionnaires is also encouraged.

In addition, The Department of Health, Social Services and Public Safety (DHSSPS) commissioned, in 2006, a survey to establish the level of satisfaction with Health and Social Services in Northern Ireland, as well as to identify those areas that the public would like to see changed or improved.¹⁴ This survey followed on from similar surveys conducted in 2003, 2004 and 2005.

The results showed that 95% of respondents were satisfied with GP services; 78% had used the services of a GP in the last 12 months; 92% were satisfied with the general attitude of their GP; 53% of service users were seen within 2 days of making a routine appointment; 74% were satisfied with waiting times for routine appointments; 81% were satisfied with arrangements for emergency appointments; 25% of service users who suggested a change called for shorter waiting times.

Patient satisfaction with GP services between 1996 and 2006 has been independently analysed using data from the Northern Ireland Social Attitudes Survey (1996) and Northern Ireland Life and Times survey (2006). This analysis,¹⁵ by ARK, demonstrated that 80% of people were satisfied with the way GP services were run in 2006 (five percentage point drop since 1996), although the least satisfactory aspect of GP services was the appointments systems (52% satisfaction in 2006; 54% in 1996).

More recent versions of the survey have caused anger amongst GPs as the surveys are now 'perception based' and being used as a means to de-fund practices.

When survey results were published in June 2009, BMA(NI) said that although it was pleased that the majority of patients were satisfied with the care they received at their surgery (94%), it warned that the headline figures hide a gross unfairness, with practices losing funding based on perceptions of patients. For example, one practice in Northern Ireland with a list size of over 9,000 has lost all of its funding for patient access. Despite providing both 48 hour access and offering the option for patients to book ahead, the perception of just 3% of its patients has resulted in a loss of approximately £15,000 in funding for services.

The survey for 2010 is ongoing, with results expected in June.

14 DHSSPSNI – Public Attitudes to Health and Social Services in Northern Ireland (2006)

15 What difference does a decade make? Satisfaction with the NHS in Northern Ireland in 1996 and 2006. By Anne Marie Gray. Research Update No. 52. January 2008. www.ark.ac.uk

6.1.5. Views of the business sector – UK

The Confederation of British Industry (CBI) has been vocal in calling for changes to what it perceives to be an 'outdated and rigid family doctor service [which results in] less effective and unequal healthcare and is placing an unnecessary burden on employees and businesses'.¹⁶

'Just what the patient ordered. Better GP services',¹⁷ a report published by the CBI, stated that the two vital challenges which lead to patient dissatisfaction are poor access to GP services, particularly in deprived areas and inner cities; and the variable quality of services offered. The report recommends making it easier to switch GP; having more flexible, patient-friendly opening times; being able to register at more than one practice; and greater use of walk-in centres and over the-counter advice from pharmacists.

The business lobby group has also said that more should also be done to encourage new surgeries to open, for instance in supermarkets as well as the walk-in centres.

6.1.6. Views of the business sector – Northern Ireland

Within Northern Ireland, the Federation of Small Businesses has suggested that GPs and other health professionals need more effective training on occupational health and access to services via GP surgeries should be developed.¹⁸ Its 2007 Assembly Election Manifesto also states that a better understanding between GPs and business should be fostered, with GPs taking into account the demands of business and offering more straightforward advice on fitness for work in medical certification.

6.1.7. Media views – UK

Despite the relatively high satisfaction with GP services, as demonstrated by the results of patient satisfaction surveys, some sections of the UK national press appear to be biased against GPs. In particular, the recent moves by the Westminster government to impose extended opening hours have been sensationalised; headlines have included 'Government and GPs clash over hours';²⁰ 'Majority of patients want to see GPs outside opening times'.²¹

In addition, some of the media coverage on NHS debt claims that the cost of the new contracts for GPs is one of the major reasons for the current financial crisis, with headlines such as 'GPs earning £250k a year'²² featuring regularly.

Some written media have challenged government policy. For example, in an article entitled 'Making GPs more accessible is just a disguised concession to big business'²³ highlighted that little by little, the privatisation of the NHS is happening, disguised as a crusade for patient power.

16 New prescription needed for GP services says CBI News Release Tuesday 18th March 2008

17 Just what the patient ordered. Better GP services. CBI September 2007

18 CBI – Longer opening hours and more use of pharmacies "not the end of the debate" on GP services News Release Thursday 3rd April 2008

19 Federation of Small Businesses 2007 Assembly Election Manifesto

20 Daily Star. 4th February 2008

21 Daily Mail 29th January 2007

22 The Sun 19th April 2006

23 Making GPs more accessible is just a disguised concession to big business. George Monbiot. The Guardian Tuesday March 11th 2008

6.1.8. Media views – Northern Ireland²⁴

Local press in Northern Ireland, including the Belfast Telegraph, Newsletter and Irish News is monitored on a daily basis by BMA(NI). In general, media coverage of general practice in Northern Ireland has been favourable, with the local papers reflecting BMA press statements and spokesmen comments accurately.

In addition, the local press is being targeted with articles through the hosting of visits by MLAs in GP practices in their constituencies, to build relationships and continue to promote the hard work that GPs undertake.

6.2. Internal environment

The internal environment analysis, in terms of the GP workforce in Northern Ireland, is detailed below, again based on secondary research across a number of sources. With regard to the workforce, education of GPs of the future needs to be prioritised, with core primary care skills developed before trainees begin work in a practice. There is concern that trainers are currently not able to fill gaps in skills and run practices effectively, and that remuneration for training needs to be addressed.

6.2.1. The changing GP workforce in Northern Ireland

Composition

- The total number of GPs has increased by 21%, from 881 in 1985 to 1,110 GPs in 2006
- In 2004, 18% of GPs worked part-time, and 79% of part-time GPs were female

Gender

Between 1985 and 2006:

- The number of male GPs has remained relatively static at just over 700 GPs
- However the proportion of male GPs has decreased from 81% of the workforce to 63%
- The total number of female GPs has risen by 56%, from 169 to 388.
- The proportion of female GPs in the workforce as a whole has increased from 19% to 37%

Age

In 2008

- 24% of GPs were aged 40 years and under
- 55% were aged 40-54
- 20% were aged 55 and above

List size and registrations

- The average GP practice list size was 5,164 in 2008; and
- The average GP list size was 1,610

In 2008

- Northern Ireland had 1,848,746 GP-registered patients, an increase of 3% since 2004
- The Board with the largest share of registered patients was the Eastern Board (39%), followed by the Northern Board (24%), the Southern Board (20%) and the Western Board (17%). These figures reflect the population structure of Northern Ireland
- 67% of the GP practices had fewer than 300 new registrations

24 Central Services Agency

Number of GPs per practice

In 2008:

- Northern Ireland had 362 general practices
- 17% of practices were single-handed GPs
- 48% of practices had either 2 or 3 GPs
- 35% of practices had four or more GPs

Migration flow

There are fluctuations regarding the number of patients who transfer to and from GPs in Northern Ireland and Great Britain.

- 12,401 patients transferred from outside to GPs in Northern Ireland in 2007/08, 609 more than those who transferred out of NI.

Costs

- The net cost of General Medical Services In Northern Ireland in 2007/08 was £174m²⁵

There are a number of problems with current employment trends for doctors entering general practice. Currently it is difficult to become a partner, and the contract change in 2003-4 made it less desirable from a financial viewpoint for a practice to take on a new partner. Anecdotal figures demonstrate that locums make up more than 20% of the work force.²⁶

As partners are notionally self-employed, employment regulations which apply to employees do not hold force. Therefore the current system of private appointments is legal, although not necessarily fair. New partners must comply with suitability for the providers list, and are regulated so as to fulfil stipulations as to suitable training and qualifications.

6.2.2. GP Premises issues

More than nine out of ten consultations in the NHS take place in primary care, usually in a GP surgery. Good quality premises that are adequate for practices to provide patient services are vital to the delivery of modern healthcare.

Traditionally, most practices owned their surgeries buying them with a mortgage and receiving reimbursement from the NHS to represent the use of the buildings. In Northern Ireland, a large building programme in the 1960s moved many GPs from their own premises into Board (now Trust) owned health centres where more than one practice was located with Board employed staff and treatment rooms to provide community nursing for ambulant patients. Little capital has since been expended on these buildings, leaving them poorly maintained and unable to provide satisfactory premises for expanding practices employing more staff and providing a wider range of services. This resulted in many practices choosing to develop their own purpose built premises in the 1980s and 1990s. Since the mid 1990s there has been no large-scale, sustained, integrated government policy of premises development in primary care.

A UK-wide BMA survey, published in May 2006,²⁷ revealed that three quarters of the practices felt their premises were not suitable for their future needs and six in every ten practices worked from premises unsuitable for their current needs.

25 <http://www.northernireland.gov.uk/news/news-dhssps/news-dhssps-june-2009/news-dhssps-26062009-publication-of-the.htm>

26 Personal communication, Dr Janet Watters

27 Survey of GP practice premises BMA May 2006

The survey demonstrated that for many practices, there is a complete inability to absorb any further work simply because of the lack of space and room availability. This is despite the fact that four in ten practices have tried to improve premises in the past five years securing funding from a variety of sources. Without investment, government plans to shift patient care from hospitals to the community, such as those described in the White Paper 'Our Health, Our Care, Our Say' will remain largely unfulfilled.

6.2.3. GP earnings²⁸

The new GP contract was introduced in full in April 2004 following prolonged negotiations and full agreement by all parties. Prior to the introduction of the new contract, there were serious recruitment and morale problems and GPs' pay had fallen behind. This was officially recognised by all parties during negotiations and is reflected in pay increases under the new contract.

The BMA estimates that the overspend caused by GPs' excellent performance in the Quality and Outcomes Framework (QOF) accounted for about £140m – not the £300m reported by Government.

GPs are contracted to be responsible for their patients from 8am-6.30pm every weekday. This constitutes 52.5 hours a week. The average income earned by GPs in the UK is around £95,000 with NI and Scottish GPs earning less than their Welsh and English colleagues. This figure includes some money for out-of-hours sessions which many GPs continue to choose to do in addition to their daytime work. The reported figures on total GP income are based on tax returns and also include GPs' personal earnings such as income from non-NHS work, for example, insurance medicals. Claims by accountants that some GPs are earning £250,000 have been misinterpreted. Such a very high figure will apply to only a very few doctors working in exceptional circumstances. In addition, despite inflation, GPs received no cost-of-living increases whatsoever in 2006/07, an effective pay cut in 2007/08 and in 2008/09 a DDRB recommendation that again will mean a decrease in GP profits.

The QOF was introduced as part of the new GP contract. It currently offers practices up to 1000 points if they deliver high quality on a range of services. These points attract financial resources into the practice.

In 2007/08, the average total QOF points achieved in Northern Ireland was 973.1 (97.3%) of the 1,000 points available.²⁹

No other NHS employee works to a performance-related contract that monitors their activity and provides resources according to evidence-based outcomes.

6.2.4. Quality Awards Programme

The RCGP (NI) offers two award programmes to general practices in Northern Ireland. The Practice Accreditation Award (Pac) is a Northern Ireland Award which has been operational since 2003. It recognises quality in a variety of documented and measurable standards of care being delivered by GP practices. There are 63 essential criteria which must be met and a further 48 "good" and "quality" criteria which can be chosen out of 56.

²⁸ BMA Press information briefing: the consultant and GP contracts December 2006

²⁹ http://www.dhsspsni.gov.uk/qof_statistics_for_ni_08_09.pdf

The Quality Practice Award is a U.K. award and is the highest award offered to a general practice by the RCGP. It indicates excellence in general practice. Practices submit a detailed portfolio of evidence based on an extensive criteria list (147). All criteria must be met for the award to be achieved. This award is, at present, undergoing a major revision which will lead to core criteria for all countries within the United Kingdom and regional specific criteria reflecting the health priorities in the different countries.

Assessment for the awards is through the submission of written evidence, self-assessment and finally an assessment visit from a team of assessors. Three RCGP(NI) trained assessors (four for the QPA) including a GP, Practice Manager/ Practice Nurse and a lay person attends each visit. The assessors ensure that all necessary criteria have been met and also speak with staff members and patients to verify the submitted materials. RCGP has a group of 25 fully trained and experienced assessors who carry out this work and who are provided with regular refresher training to ensure their skills are maintained and current.

Practices that successfully complete the programmes benefit through the demonstrated increase in the quality of their Practice, and also gain confidence in the assurance that all members of the practice team are working to a high level. The awards promote team working, reflective practice, the practice as a learning organisation and patient experience. They support good clinical governance procedures and aid practices in the achievement of QoF indicators. A deliberate by-product of the programme is an improved sense of team morale and satisfaction. The publicity around the presentation of the awards to practices, and the public display of RCGP QPA and Practice Accreditation plaques informs patients that they are receiving a high quality service from their GP practice.

Currently 13 practices in Northern Ireland have achieved QPA and 29 have achieved Pac with others working towards them. The benefits are recognisable by all members of the team.

6.3 Research in general practice

Government also has an agenda to increase the number of NHS patients who participate in research and the contribution of primary care, a key aspect of which is general practice, is very important in this regard. Within the UK, the research agenda is coordinated by the UK Clinical Research Network (UKCRN). The Northern Ireland Clinical Research Network (NICRN) has been established in Northern Ireland to support the clinical research community.

The UKCRN and NICRN both acknowledge the need for patients and the public to be involved if programmes of research are to directly reflect the needs and views of patients and the public. Given that the majority of patient contact occurs in primary care, GPs are in an ideal position to carry out meaningful research which can be translated into the improvement of services and treatments.

Increasing patient participation in research has consequences for GPs and implications for premises and resource provision. Effective research requires support in terms of administration, protected time, adequate premises and expert support through links to recognised networks. Involvement in quality research is an activity which requires recognition and should not rely on unrecognised goodwill.

7. Strengths, challenges and opportunities facing general practice in Northern Ireland in the next five years

Strategy workshop participants identified the following **internal** strengths and challenges and **external** opportunities and challenges facing general practice in Northern Ireland. Whilst these were identified as key issues over the next five years participants also noted that some of these may well extend over a ten year period.

Participants agreed it was important to build on strengths and take advantage of opportunities to promote and develop general practice. Further participants agreed that all challenges need to be addressed so that general practice could develop in a way to ensure that the core principles of general practice would be maintained and developed.

Table 1
Internal strengths and challenges facing general practice in the next five years

Internal	
<p>Strengths</p> <ul style="list-style-type: none"> • Patient – face to face relationship • Developing a model of general practice for the future • Practice(s) commissioning below LCGs (Practice based commissioning?) • Better use of new information technology • Improved multi-disciplinary working • Skills Development e.g. GPs WSI • Education – qualified GPs and registrars • Premises development • Involvement in healthcare commissioning • Improving records management and information management/control • Majority of time committed to patient contact and continuity of care • Ability to conduct clinical research • Comprehensive use of IT in record keeping 	<p>Challenges</p> <ul style="list-style-type: none"> • Sharing care • Clockwatching • Organisational factors • Workforce – addressing the challenges of increasing female/part time GP involvement • Developing medical leadership within general practice • Growth/management of numbers of salaried GPs • Service provision/access • Maintaining and attracting investment/resources • Bringing the profession forward, the challenge of “herding cats” • Controlling contract and workload • Maintaining continuity of patient care • Training issues for general practice • Access challenges • Balancing professionalism and entrepreneurialism • Primary / secondary care interface • Increase number of patients participating in research studies

Table 2
External opportunities and challenges facing general practice in the next five years

External	
<p>Opportunities</p> <ul style="list-style-type: none"> • Public perceptions of general practice • Better use of telemedicine • Co-operation with private/commercial providers • Extend influence through creating other channels /organisations e.g. a GP(NI) Patient Liaison Group • Increasing public influence • Take advantage of opportunities of devolution • Privatisation – independent contracting • Coalition/federation of general practices • Developing relationships with DHSSPSNI/ CMO/professionals, politicians • Examining models & approaches elsewhere • Commissioning • To use media to advantage • Develop partnership working 	<p>Challenges</p> <ul style="list-style-type: none"> • Increasing levels of bureaucracy within Health and Social Care system • Negative media views • Industry view – CBI • Influencing Government/media on health issues • Trusts future roles, “bigger” Trusts present challenges in terms of influence and resource allocation • Development of Trusts as potential competition for provision of general practice services • DHSSPS “funding rules” • Medical regulation, potential for defensive medicine • Integration with secondary care sector • Local/UK health policy • Government health policy after next general election • Premises funding • Development of PCCI & Health Care Centres • Potential duplication of primary care services • Development of non-doctors (e.g. the increasing role of nurses and other healthcare professions in primary care) • Outside threats – polyclinics, wellbeing centres, threats to small practices • Increasing use of A&E by patients, which shifts power to secondary care • Preservation of small practices and fundamental difference between providing ‘care’ and developing the ‘narrative’ of general practice • Regional changes which may cause movement of staff, especially GPs • Deprofessionalisation of the medical profession

8. Strengths, challenges and opportunities facing general practice in Northern Ireland in the next ten years

Strategy workshop participants were asked to envisage the major opportunities and challenges facing general practice over the next 10 years. Many of the issues identified in Tables One and Two above were agreed as relevant to the 10 year timeframe.

Table 3

Internal and external opportunities and challenges facing general practice in the next ten years

Internal	
<p>Strengths</p> <ul style="list-style-type: none"> • Unique selling point of general practice <ul style="list-style-type: none"> - continuity of care - value for money through effective risk management - central role in “End of life” issues - central role in chronic disease management • Leadership skills • Young GP development 	<p>Opportunities</p> <ul style="list-style-type: none"> • High quality NI GP training scheme
External	
<p>Opportunities</p> <ul style="list-style-type: none"> • Niche markets • Federations of GPs • To contribute to the UK Clinical Research Collaboration and government goal of making UK a recognised centre for medical research • Opportunity to improve out of hours care • Opportunity to influence and improve workforce planning 	<p>Challenges</p> <ul style="list-style-type: none"> • Competition • Influencing key stakeholders to influence others • Practices business development – quality/value for money • Increasing use of sessional doctors undermining continuity of care • Increasing patient participation in research

9. Action areas and level of importance

From the information provided in workshop sessions a number of action areas were identified. Participants were asked to rate each, in terms of importance on a scale of 1 – 5, with 5 being the highest level of importance.

The action areas and levels of importance are listed below in Table 4. It is clear that those present viewed all of the action areas as important with all but one scoring 4 or 5. The area scoring 3 was medical regulation, largely because of the unknown impact of the new arrangements and how the civil standard of proof will impact on how doctors practice medicine.

Further analysis was undertaken discussing the challenges under the Action Areas and these have, following further discussion/consultation with GPs/stakeholders, helped to inform the overall Strategy Action Plan in section 12.

Table 4
Action areas and level of importance

Action Area	Level of Importance
Improving organisation within general practice	5
Developing leadership	4
Addressing workforce issues <ul style="list-style-type: none"> - Recruitment - P/T - Salaried - Female GPS 	4
Improving service and accessibility	5
Media strategy <ul style="list-style-type: none"> - Patients - Govt - Press - Industry 	4
Working with new Trusts	5
Public perception	4
Model of general practice for the future inc federation	5
Commissioning	4
Future ways of working <ul style="list-style-type: none"> - Patient views - Telemedicine - Co-operation with other providers 	4
Resourcing general practice	5
Premises PCCI/health and care centres	5
Information management <ul style="list-style-type: none"> - I.T - Records 	4
Education, both undergraduate and postgraduate	5
Unique selling points of general practice/niche markets	5
Competition	5
Medical regulation	3
Promoting research participation	4

10. Resolutions of Annual Conference of Local Medical Committees (Northern Ireland)

The annual conference of Local Medical Committees (LMCs) is generally held in March. This conference is the method by which GPs set policy, including resolutions concerned with the future development of general practice in Northern Ireland.

Further information on resolutions can be obtained from the BMA(NI) office.

11. GAP analysis

Sections seven and eight of this report outline the challenges facing general practice, whilst section nine identified the important areas for action. Essentially the work of the Strategy workshops and the resolutions of the 2009 LMCs conference help to illustrate the gap between the current situation facing general practice in Northern Ireland and what is desired, if general practice is to be effective into the future.

12. Action plan for delivering on key challenges

The Action Plan is reflective of all consultations and discussion during 2008 and 2009, with GPs and stakeholders. It has been produced to provide a roadmap for the future development of general practice in Northern Ireland. Timeframes are outlined, as well as lead responsibilities. It is clear that delivery of the Action Plan is dependent on:

- ongoing commitment of BMA(NI)/RGPC(NI) to deliver actions
- 'buy in' from the profession, on an ongoing basis, to help delivery on the Action Plan
- commitment from key stakeholders and decision makers, particularly the DHPSS, the RHSCB and NIMDTA to enable delivery of key elements of the Action Plan.

The plan outlines the main action areas, timeframes and suggested lead organisations. It is assumed that, regardless of the lead organisation, BMA(NI)-NIGPC and RCGP(NI) will work closely together to achieve the desired outcomes. The resourcing of the delivery of some elements of the plan will require close co-operation with DHSSPS, the Regional Health and Social Care Board, NIMDTA and other stakeholders.

ACTION AREA	ACTIONS	TIMEFRAME	RESPONSIBILITY
Action Area 2 Improving leadership and management effectiveness within general practice			
Improving skills	As per the 'model practice framework' in Action Area 1: Ensure up-skilling of practice management through development and delivery of leadership/management skills programme for lead GP partners	Programme development 2010-2011 Programme delivery annually from 2011 onwards First Review of programme content and effectiveness 2012 and subsequent modification of the programme for 2013	Lead organisation – BMA(NI) – NIGPC This work to be part of the BMA Developing Doctors as Leaders initiative Lead GP partners can assist with development of individual GP practices, through a supporting and mentoring role. Models of good practice will be shared with other practices. Other stakeholders involved in resourcing this action area: NIGPC, RCGP(NI), DHSSPS, HSCB BMA(NI)-NIGPC/RCGP(NI)/External training organisations
Improving skills	Effectively Influence the development of management skills programmes for practice/business managers as delivered by other providers, e.g. AMSPAR, UUJ – communicating research on the needs of practice/business managers within general practice.	2010 onwards	Lead organisations – BMA(NI) – NIGPC/RCGP(NI)

Advantages

Patients will benefit from the development of effective leadership in general practice, as such leadership will seek to improve patient care and deliver effective practice management.

Practices will be better led and developed by GP partners and practice managers with well developed leadership and management skills.

ACTION AREA	ACTIONS	TIMEFRAME	RESPONSIBILITY
Action Area 3 Improving organisation within the infrastructure of general practice			
Federations of practices	<p>Develop Northern Ireland model of federations of practices – within appropriate geographic areas (nb within LCG/Trust areas), taking into account the needs of small, medium and large practices, and the sensitivities relating to becoming federated whilst remaining independent on key aspects of the business of general practice. Account to be taken of current joint working by some GP practices e.g. GPs Together</p> <p>Develop effective communication/management/administration arrangements for federations of practices.</p>	<p>Develop model 2010</p> <p>Consult on model 2011</p> <p>Pilot model in 2012 onwards</p> <p>Monitor effectiveness of federations once implemented, against critical success factors included in the federated model, 2012 onwards</p>	<p>Lead organisation – RCGP(NI) , with support from BMA(NI) and HSCB.</p> <p>To develop model of federations of practices, outlining advantages/commitments, for consultation with GP practices in Northern Ireland.</p> <p>Toolkits will be developed for effective practice management within federations. Such federations may be natural clusters (e.g. geographic, groups of like minded practices) of a manageable size. All GP practices should be a member of a federation. Lessons can be learned from the 'developing' federations in Belfast and Armagh/Fermanagh. The federated model will recognise practices as individual businesses operating within a federated structure. The migration to federations will require: commitment, effective communication; and agreed joint-working arrangements, Federations can also learn from each other and there may be opportunities for cross-federation or multi-federation working.</p> <p>Ensure buy-in of practices to federated model through</p> <ul style="list-style-type: none"> - conference on federated practices - survey of practices - statements of commitment from practices
Practice accreditation	Development and implementation of practice accreditation scheme	Currently being developed by RCGP, but will need to be reflective of the 'model practice' framework agreed in Action Area 1	<p>Lead organisation – RCGP(NI)</p> <p>To develop scheme to ensure good practice standards are identified and communicated. Scheme would be aligned to 'model practice' framework and be a roadmap for practice improvement across all areas of management and methods of service delivery, and that principles of good clinical practice are applied to GPs' involvement in research.</p> <p>Other stakeholders involved in resourcing this action area: NIGPC, DHSSPS, RHSCB, other external expertise for support and assessment purposes</p>

Advantages

Patients will benefit from the sharing of skills and expertise across practices within federated groups, and from service developments initiated by federations. In addition patient confidence in general practice will be improved as federations develop systems and services that are increasingly patient focused and that meet the standards of effectiveness agreed across the practices in the federation. Practice accreditation will be a demonstrable standard for each practice.

Practices will benefit by: sharing leadership; use of effective benchmarking; sharing resources; input to commissioning at a group level; service developments across practices. The accreditation scheme will assist all practices to perform to a minimum standard and to identify areas for further improvement.

ACTION AREA	ACTIONS	TIMEFRAME	RESPONSIBILITY
Action Area 4 Improving service and accessibility			
Patient information	<p>As a result of Action Area 1:</p> <p>Ensure development of a patient information/ education programme in relation to service provision and access to general practice.</p> <p>Core values of general practice 'mainstreamed' into the programme.</p> <p>Programme to communicate how acute and chronic needs are met, and to overview the use of triage, open access, extended and out of hours services.</p> <p>Depending on the issue concerned information provided to patients can be at various levels: Regional level; federated level; practice level.</p>	2010- 2011	<p>Joint Leads – BMA(NI) – NIGPC, RCGP(NI)</p> <p>BMA(NI) -NIGPC/RCGP(NI) to meet DHSSPS/RHSCB to assist in programme and communication arrangements, e.g. media/leafleting-displays/internet information. This will build on the work undertaken by RCGP to develop a patient group in each devolved country, in addition to the UK Patient Participation Group in London. The Northern Ireland RCGP patient group is called "Patients in Practice" (PiP)</p>
Service development and accessibility	<p>Service development and accessibility issues and opportunities to be examined in terms of service needs and resourcing within general practice and taking into account issues regarding individual practices and federations.</p> <p>As part of the programme analyse 'access' issues for general practice to make recommendations for effective management of demand and need (analysis to include: assessment of telephone and on-line booking systems ; and monitoring access issues.</p>	2010-2012	<p>Lead organisation – BMA(NI) – NIGPC</p> <p>Through joint working group of NIGPC/RCGP(NI)/DHSSPS/new HSCB/NIMDTA</p>

Advantages

Patients will benefit from good information being available and will be assured that such information is accurate, up-to-date and comprehensive. In addition accessibility for patients can be improved in line with a balanced approach to managing demand and need.

Practices will effectively communicate the core values of general practice, service availability and access. In addition practices will monitor access management at practice level and within/across federations.

ACTION AREA	ACTIONS	TIMEFRAME	RESPONSIBILITY
Action Area 5 Working with Trusts and Commissioners			
Commissioning	Ensure active engagement in new commissioning processes by GPs.	2010 onwards	Lead organisation – NIGPC Influencing Local Commissioning Groups through participation, engagement, working with lay representatives, and monitoring of performance of LCGs.
	Lobby for extension of commissioning arrangements to practice(s) level.	2010-2011	NIGPC to research benefits of practice based commissioning and/or groups of practices based commissioning, to communicate same to Minister, DHSSPS, media and other stakeholders- and to lobby for a model of practice based commissioning to be introduced below LCG level.
Improving skills	Work to ensure development of effective and properly resourced commissioning arrangements, at HSCB, LCG and practice/ federation level.	2010 onwards	Lead organisation – NIGPC To communicate the need for and ensure effective involvement of GPs at all levels of new Commissioning arrangements, and monitoring of effectiveness of involvement through NIGPC.
	Ensure that GPs take opportunities to provide and develop services that meet the needs identified by commissioners.	2010 onwards	NIGPC – through LCGs , to ensure that general practice plays a lead role in service development to meet commissioning needs RCGP(NI) – through the promotion of RCGP(NI) quality standards which will relate to the standard of services being commissioned.

Advantages

Patients will benefit from GP involvement in local commissioning arrangements. The potential development of practice based commissioning will involve assessment of needs that can best be met at practice level, for patient benefit in terms of local provision and accessibility.

Practices will work with and influence effective commissioning by LCGs, and potentially practices or groups of practices.

ACTION AREA	ACTIONS	TIMEFRAME	RESPONSIBILITY
Action Area 5 Working with Trusts and Commissioners			
Service Delivery	<p>Influence and monitor arrangements for Trusts design/delivery of services and accountability.</p> <p>Ensure, through involvement in the HSCB and LCGs, that HSCB effectively ensures Trusts accountability.</p>	<p>2010-2011 development of influencing strategy</p> <p>2011 Implementation of strategy with monitoring and review arrangements</p>	<p>Lead organisation – BMA(NI) – NIGPC/RCGP(NI)</p> <p>To develop general practice influencing strategy and mechanisms to ensure GPs can effectively work with all stakeholders(including Trusts) to assist/influence the performance of Trusts.</p> <p>Strategy to include:</p> <ul style="list-style-type: none"> - working with HSCB GP advisors, effective lobbying by LMCs and GP practices, creation of general practice forum in each new Trust area. - actions to effectively influence the RQIA, SDU and public. - overview of how and where NIGPC/RCGP(NI) should involve politicians, voluntary and community sector organisations, political parties and elected representatives in local government, Assembly/Executive/Health Committee, Westminster and European Parliament.

Advantages

Patients will benefit from GP practices influencing Trusts regarding the quality of service provision for patients, and through practices monitoring service provision by Trusts- either directly or through the HSCB/LCGs.

Practices will have an increased awareness of services commissioned and provided, and if standards are being met.

ACTION AREA	ACTIONS	TIMEFRAME	RESPONSIBILITY
Action Area 6 Resourcing General Practice			
Workforce planning	Examine current workforce issues within general practice.	2010	Lead organisation – BMA(NI) – NIGPC/RCGP(NI)/DHSSPS/MIMDTA, NISDA Research project to report on workforce issues, and training and development needs. Project to assess current workforce, future workforce needs and associated implications, workforce mix and trends – particularly re GP principals, salaried GPs and sessional GPs.
Resourcing	In line with the results of Action Area 1 Examine current and future resource needs and resourcing of general practice. Influence Minister and other key stakeholders of the need to fund general practice effectively so that continuous improvements can be made.	2010-2011 2011 onwards	Lead organisation – BMA(NI) – NIGPC/RCGP(NI) To develop project to assess funding of general practice, identify funding levels and gaps, influence key stakeholders and funders on funding needs to deliver the model of general practice needed and developed. Produce overall report with recommendations on the funding needs of general practice. Implement influencing strategy to ensure effective funding of general practice.
Premises	Audit of premises utility, against premises needs of general practice, and bring assessment to attention of funders and influencers	2010-2011	Lead organisations – BMA(NI)-NIGPC/RCGP(NI),HSCB Audit premises in terms of fitness for purpose via survey of general practices- on premises and IT issues. Outcomes to include recommendations for developing and resourcing general practice estate from 2010 onwards.
Information Technology	Assessment of future IT needs of general practice and costs of same.	2010-2011 2011-2012	Lead organisation – NIGPC IT Sub-Group/HSCB Survey questionnaire (as above) to each GP practice to assess IT provision and use, as well as future IT needs. Report to DHSSPS on survey and on IT needs of practices, funding of same
Practice staff	Analyse the staffing needs of general practice- staffing levels and grades. Develop the abilities/contribution of practice staff as individuals/practice teams.	2010- 2011 2011	Lead organisation – BMA(NI)/RCGP NI),HSCB, DHSSPSNI Overall analysis of staff needs to support delivery of effective general practice services. Comparison with current staff levels and analysis of any gap. Development programme for practice based staff members and practice teams.

Advantages

Patients will have an effectively resourced service in general practice, to meet their needs. Patients will be seen in 'fit for purpose' premises by a well training patient focused staff team.

Practices will have the infrastructure needed to provide services that are needed by patients.

ACTION AREA	ACTIONS	TIMEFRAME	RESPONSIBILITY
Action Area 7 Developing the unique selling points of general practice			
Communication strategy	<p>Develop a communications project/strategy for promotion of the work and values of general practice to public, media, government and other key stakeholders – “Brand GP”.</p> <p>Unique selling points (USPs) of general practice are listed in Appendix F.</p> <p>Ensure that practices/federations communicate and promote: the work of general practice the work of primary care teams the outputs/outcomes from general practice services, within resource constraints</p>	2010 onwards	<p>Lead organisations – RCGP(NI) – BMA(NI)-NIGPC RCGP(NI) to bring forward the work which is on-going across the UK College in regard to the USPs of GP, with particular reference to the RCGP(NI) work entitled “What sort of Practice”</p> <p>Project/strategy to include campaign to influence media, politicians and public of the values of general practice- past, present and future.</p>
Promotion of values of general practice	Develop two publications under the Brand GP initiative which outline the values and contribution to health of general practice	2010	<p>Lead organisations – BMA(NI) – NIGPC and RCGP(NI)</p> <p>‘The Future of General Practice in Northern Ireland’ summary document and ‘You and Your GP’ publications launched, in January 2010 with press and media coverage, and widely distributed to all GPs and all stakeholders within government, political arena, health service, public service , schools, local councils etc.</p>

Advantages

Patients will have an increased awareness of general practice and the values of general practice, within which services are provided for them.

Practices will communicate the values of general practice that are beneficial to patients and outline the standards within which general practice services are provided.

ACTION AREA	ACTIONS	TIMEFRAME	RESPONSIBILITY
Action Area 8 Identifying and addressing competition issues			
	Undertake research project to examine: – Competition and potential competition for general practice services , and – Opportunities for general practice to provide services , e.g. under new commissioning arrangements.	2010- 2011	Lead organisation – BMA(NI) Project to undertake research and produce recommendations for general practice.

Advantages

Patients will be made aware of competition and the social and economic cost of competition in the provision of primary care services.

Practices can be aware of potential competition and likely impact on patients and service provision.

ACTION AREA	ACTIONS	TIMEFRAME	RESPONSIBILITY
Action Area 9 Addressing the educational, research and training needs of general practice			
Research	Develop the research capacity of general practice to undertake high quality, meaningful, translational research within the primary care setting, which is undertaken with input from patients and other service users.	2010 onwards	<p>Lead organisation – RCGP(NI)</p> <p>To work with other organisations such as the R&D office and NICRN to identify barriers to undertaking primary care research.</p> <p>Work to build research capacity in general practice, leading to better management, resourcing, outcomes and evaluation of research.</p> <p>Investigate the development of local enhanced service for primary care clinical research.</p>
Undergraduate training	Support information to medical school(s) on the benefits of pursuing a career in general practice	2010 onwards	<p>Lead organisation – RCGP(NI)</p> <p>Support current activities of QUB medical school in promoting a career in general practice, and develop closer working relationship with the medical school.</p> <p>Promote collaborative working between RCGP(NI), NIGPC, NIMDTA and QUB to ensure accurate information is distributed.</p> <p>Recognise that the education of undergraduates is a core foundation on which postgraduate training and ongoing professional practice is based.</p> <p>This action point needs to consider resource provision and infrastructure for training within general practice at undergraduate level.</p>
Postgraduate training	Develop closer working relationship with NIMDTA to ensure mutual support, effective funding, input to training development for general practice in Northern Ireland.	2010-2011	<p>Lead organisations – NIGPC and RCGP(NI)</p> <p>Set up joint project group for post-graduate training, which will produce a report with recommendations to DHSSPS.</p> <p>Outcomes from project should include enhancement of the role of GPs as hands-on educators through support programme from NIMDTA to:</p> <ul style="list-style-type: none"> – upskill GPs – ensure an overall development programme for GPs – ensure training for trainers – influence those who allocate resources to allocate level of resourcing needed <p>This action point needs to consider resource provision and infrastructure for training within general practice at postgraduate level.</p> <p>2011 onwards Actively lobby key influencers to ensure recommendations are accepted and implemented.</p>

Advantages

Patients will be better served through effective research and professional development within general practice.

Practices will build on the strengths of training in general practice

ACTION AREA	ACTIONS	TIMEFRAME	RESPONSIBILITY
Action Area 10 Monitoring the impact of medical regulation arrangements			
	Monitor implementation of new arrangements and survey impact of new arrangements one year after civil standard of proof introduced.	2011	Lead organisation – BMA(NI)-NIGPC Survey of GPs on impact and experience of new arrangements. Potential conference on impact of medical regulation in N Ireland (for GPs and other branches of practice). Report from NIGPC to DHSSPS and other key stakeholders. Ongoing monitoring of impact and development of recommendations for improving medical regulation arrangements and communication/lobbying of same to key stakeholders and Government. Ongoing monitoring through feedback from LMCs to NIGPC.
		2011	

Advantages

Patients should benefit from better regulation of the medical profession

Practices will play a key role in monitoring the impact of new medical regulation arrangements on patient care and professional practice.

ACTION AREA	ACTIONS	TIMEFRAME	RESPONSIBILITY
Action Area 11 Partnerships within general practice			
	Promote the benefits of partnership within general practice. Promote partnership approach as the model for effective future management in general practice.	2010 onwards	Lead organisation – BMA(NI)-NIGPC/RCGP(NI) Research and report on the benefits of the 'partnership' model in general practice, identifying any areas for improvement. Promote the values and benefits of the 'partnership' model to practices and other stakeholders, to encourage practices to develop their partnerships/appoint partners. Promote the values and benefits of the 'partnership' model to salaried GPs.

Advantages

Patients will continue to benefit from the delivery of the core values and benefits of the partnership approach in general practice.

Practices will retain the 'partnership' model as the preferred model for business and service development, and develop further the effectiveness of the 'partnership model approach.

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