REVIEW OF GP-LED PRIMARY CARE SERVICES IN NORTHERN IRELAND

RECOMMENDATIONS OF WORKING GROUP

MARCH 2016

INTRODUCTION

The role of GPs in delivering a world class health and social care system

GP-led care is a vital element of a fully integrated health and social care service. GPs are the first point of contact for the majority of health and social care related matters. But more than that, GPs play an important role in promoting health and wellbeing, educating people to make the right choices, supporting them to manage their own long-term conditions, and coordinating patient care across specialties and sectors. Increasingly, GPs are able to perform treatments or manage conditions that in the past would have required a referral to hospital. As we continue to transform the way health and social care services are delivered, GPs and other professionals working in primary care are essential partners in promoting population health and social wellbeing, developing new care pathways aimed at actively managing patients in primary care, treating people as close to home as possible and avoiding admissions to hospital.

It is clear that GP-led services are essential to the delivery of the strategic vision for health and social care in Northern Ireland. However, these services are facing increasing pressures. Two recent reports by the British Medical Association (BMA) Northern Ireland GP Committee and by the Royal College of GPs (RCGP) in NI have highlighted specific challenges, including the changing workforce profile, difficulties in recruiting and retaining GPs, the need for a greater skills mix in GP practices, and the need for more investment in new technology and premises.[1] Respondents to a recent national survey of GPs conducted by the BMA pointed to the need to increase core general practice funding and consultation times, and reduce bureaucracy in order to ensure the quality of patient care.[2]

Underpinning all of these issues is the rising demand for GP services, including out of hours services. The population of Northern Ireland has been increasing steadily over the last three decades. The number of people aged 65 and over increased by 2.4% between 2013 and 2014, with 16% of the population falling into this category.[3]

[1] *General practice in Northern Ireland: The case for change* (British Medical Association, February 2015); *Delivering change for general practice: A strategy for improving patient care in Northern Ireland* (Royal College of General Practitioners NI, September 2015).
[2] *National survey of GPs: The Future of General Practice 2015* (British Medical Association, April 2015)
[3] *Population and Migration Estimates Northern Ireland 2014* (NISRA 2015).

Prevalence of long-term conditions is increasing and as the population ages patients are living with an increasing number of co-morbidities, the management and treatment of which can be particularly complex.[4]

The number of consultations per person per year in NI (including GPs, practice nurses and treatment room nurses) rose from 4.04 in 2003/04 to 6.6 in 2013/14, an overall increase of 63%. The estimated total number of consultations increased from 7.22million to 12.71million over the same period, an increase of 76%. In addition to direct patient contact, other elements of the general practice workload also increased between 2003/04 and 2013/14—for example, the overall acute prescribing rate (based on acute scripts per person per year) rose by 28%; repeat prescribing rates rose by 42% (based on repeat scripts per person per year); and the number of lab tests carried out by GP practices is estimated to have increased from 2.06million to 7.02million. In summary, the overall rate of patient contacts (including direct patient consultations and indirect contacts such as ordering repeat prescriptions) increased by 66%.[5] Since 2008 total contacts with GP out of hours services have increased by 18%. By comparison, the number of new and review attendances at emergency care departments increased by 1.7% between 2008/09 and 2014/15; GP referrals to outpatient services increased by 15%; and the number of hospital admissions increased by 4.2%. The increase in GP workload is having an impact on the existing workforce—more than 50 percent of respondents to a recent GP survey reported that their workload was unmanageable or unsustainable.[6]

It is likely that demand for primary care services will continue to increase as the population, and particularly the older population, continues to grow. Importantly, because the number of appointments in general practice is so large (for the majority of people GPs are their first point of contact with the health and social care system) and because GPs only refer a small percentage of cases on, small changes in access to and responsiveness of GP services can have a huge impact on other

[4] Further information on disease prevalence and co-morbidities is detailed in population profiles based on primary care data for the five NI Local Commissioning Group areas, produced by the Health and Social Care Board in February 2016.
[5] "Estimating the Volume and Growth in Consultation Rates in General Practice in Northern Ireland, 2003/04 to 2013/14: Analysis of Survey Returns from General Practices" (Project Support Analysis Branch, DHSSPS, January 2015).
[6] *GP Survey Omnibus Report* (BMA 2015).

services.[7] Therefore, while the recommendations set out in this report are primarily intended to deliver sustainable GP-led services, implementation of the recommendations will also have an impact on other parts of the health and social care system.

Recent investment in GP-led services

In response to the pressures facing general practice, and in recognition of the important contribution of GP-led care to the delivery of a world class health and social care service in Northern Ireland, the Department of Health, Social Services and Public Safety (DHSSPS) has made significant investment in the General Medical Services (GMS) contract over recent years—£241m in 2013/14 and £246m in 2014/15. This equates to approximately 6% of the overall spend on health and social care and approximately £127 per registered patient, compared with a UK average per capita investment of £141.[8] In 2015/16 the Department has invested up to an additional £3.1m in out of hours GP services, up to £1.2m to help meet demand for blood tests and other diagnostic work and boost skills mix, and up to £300,000 to recruit and retain GPs. In addition, up to £10m of funding has been released for GP practices to borrow to upgrade and expand their premises and £350,000 has been made available to meet any revenue costs associated with these expansions and upgrades. In order to avoid increasing the financial pressure on GP practices, the Minimum Practice Income Guarantee did not decrease as a result of the 2015/16 GMS contract . In an effort to reduce the administrative burden on GP practices, while at the same time incentivising the best possible health outcomes, over recent years the number of Quality Outcome Framework (QOF) indicators has been reduced—from 148 in 2012/13 to 64 in 2015/16—and the number of multi-year indicators has increased. The number of QOF points available has also reduced from 1,000 in 2012/13 to 547 in 2015/16, with a resultant transfer of approximately £22m into core funding for GPs.

2015/16 has also seen significant in-year investment aimed at addressing many of the pressures facing GP-led services. An additional £1.1m has been made available

[7] For example, the 12.71m GP consultations in Northern Ireland in 2013/14 resulted in 485,939 new outpatient attendances (a referral rate of approximately 4%). Further information on hospital outpatient activity available on the DHSSPS website at https://www.dhsspsni.gov.uk/articles/outpatient-activity

[8] "GMS Funding—UK comparison work and workloads." (Information Analysis Directorate, DHSSPS, 2015)

to help GP out of hours services meet increased demand for services over the winter months and the 2016 Easter period. Recognising the potential leadership role of GPs, an additional £50,000 has been made available to provide system leadership and management training. £190,000 has been made available to support GP Federations prepare for the delivery of more services in the primary care setting. Investment has also enabled the region-wide rollout of systems to enable more patients to book appointments or order repeat prescriptions online at a time that is convenient for them. In December 2015, the Health Minister announced a 5-year investment initiative that will put close to 300 pharmacists in GP practices by 2021— up to £2.6m will be invested in 2016/17, rising to up to £14m per year by 2020/21, to ease the pressure on GPs and ensure that patients continue to receive a high quality service. And in January 2016 the Minister announced the largest investment in GP training for more than ten years, investing £1.2m per year to fund an additional 20 GP training places, starting in 2016/17. These actions will go a long way to meeting the challenges facing GP-led services, and the additional recommendations and actions identified by this report are intended to build on the significant progress that has already been made in this regard.

Vision for GP-led services in the future

The continued development of sustainable and accessible primary care services centred on the needs of patients must be a top priority. Patients should have access to GP-led services within a reasonable timeframe and continuity of care should be provided where this is important to patient wellbeing. GP-led services must be integrated with the wider health and social care system, with GPs working in partnership with other parts of that system to develop and implement care pathways aimed at treating people in the most appropriate setting. In the future, we envisage that technology will play a much greater part in the delivery of primary care services, from systems that allow patients to book appointments or order prescriptions online, to videoconferencing facilities that allow GPs to have face to face discussions with specialists about a patient's case, online triage and/ or diagnosis systems that help patients and their GPs assess the best course of action, through to cutting edge diagnostic technology located in GP practices.

Delivering this vision requires urgent action to ensure that the Northern Ireland population continues to have access to high quality GP-led services, provided in modern premises by a workforce of highly skilled professionals who have the time to focus on patient care. For doctors and other professionals, action is needed to ensure that general practice is seen as an attractive career option.

As a first step to address the specific challenges and pressures facing GP-led primary care services, in October 2015 the Minister announced the establishment of a working group to look at the issues facing GP-led primary care services and to bring forward recommendations to help address demand for these services. The terms of reference for the Group and details of its membership are appended to this report. In addition to the GP-led care working group, separate reviews of GP out of hours services and nursing services in district and primary care settings have also been completed. Those pieces of work have fed into this review.

This report is the end result of the GP-led care group's work and is structured around the following strategic themes—building a stable GP workforce; building sustainable out of hours services; driving innovation in general practice; improving general practice infrastructure; and delivering high quality, integrated and sustainable primary care services. A number of recommendations have been identified, as well as the key actions required to deliver these. In the working group's view, these recommendations and actions are necessary for the delivery of safe, effective, accessible and sustainable primary care services in Northern Ireland into the future.

STRATEGIC GOAL: BUILDING A STABLE GP WORKFORCE

Both the BMA and RCGP reports draw attention to shortages in the GP workforce and the changing nature of the current workforce. Based on 2013/14 data, Northern Ireland had 61 GPs per 100,000 patients, lower than the other UK countries, while the average practice list size per GP was higher than anywhere else in the UK. While the number of GPs has increased each year for the last number of years, this increase has not been at the same rate as other medical professionals—for example, between 2002 and 2013 the number of full-time equivalent hospital consultants increased at an annual average rate of 4%, SAS Grades at 8% and GPs at less than 1%.[9] In addition, the age, gender profile and working pattern of the GP workforce has also been changing over recent years. Of the 1,171 GPs in Northern Ireland in 2013/14, almost one quarter were aged 55 or over—the oldest GP workforce in the UK. Over the last three decades the numbers of female GPs have been increasing, and half of the GP workforce is now female. The way general practice is organised and delivered must respond to this changing demographic, to ensure that it remains an attractive career option which can provide opportunities for flexible working and support for doctors and other professionals to balance work with other responsibilities.

A recent study by the NI Medical and Dental Training Agency found that of the 295 GPs who qualified in NI between August 2010 and August 2015, 282 are registered to provide general medical services here. Of these, 20% are working as a full-time partner, 5% as a part-time partner, 44% are working as sessional GPs, 7% as salaried GPs and 1% are working in out of hours services only (those GPs who qualified in August 2015 had not yet self-declared at the time the study was completed). The results of this study point to scope for a more mixed service model in the future, with support and opportunities provided for both salaried GPs and independent contractors, and for sessional GPs and partners. What is also clear is that, contrary to the myth that GPs train here and then travel abroad to practise, the vast majority of GPs trained in Northern Ireland over the last five years have remained in Northern Ireland post-qualification.

[9] "Pressures on General Practice in Northern Ireland" (DHSSPS 2014).

Building a stable GP workforce that can deliver sustainable primary care services for the future will require action to increase the number of GPs working in Northern Ireland; support and training to ensure GPs are equipped with the skills needed for a career in general practice and to encourage them to remain in or return to practice (with a particular focus on areas where it has traditionally been difficult to recruit GPs); and developing structures and teams to support GPs and increase the range and quality of services that can be provided to patients in general practice.

Recommendation 1: Increase the number of GPs working in Northern Ireland

A recent report on GP workforce requirements undertaken by the Health and Social Care Board (HSCB) and Public Health Agency (PHA) on behalf of DHSSPS pointed to a significant workforce deficit already affecting the delivery and sustainability of primary care services in Northern Ireland, and recommended increasing the number of GP training places commissioned each year from 65 to 111, beginning in 2016/17 and phased over four years. Acting on this, in January 2016 the Minister announced additional investment of £1.2m per annum to provide an additional 20 GP training places, bringing the total number of GP training places available to 85 for recruitment in 2016. The working group recommends building on this investment to further increase the number of GPs working in Northern Ireland, in order to address the pressures facing GPs and ensure that general practice is seen as an attractive career option for trainee and newly qualified doctors. Increasing GP numbers will mean not only increasing the number of newly qualified GPs—it will also mean ensuring that the existing GP workforce remains in (or returns to) practice in Northern Ireland.

Key actions	
1.1	By July 2016, develop a plan (to include consideration of any additional training and assessment requirements) to supplement the existing GP workforce through overseas recruitment, with initial recruitment of at least 10 additional GPs from the EU during 2016/17.
1.2	By December 2016, develop and seek agreement of a costed plan for the remaining additional trainees to achieve an annual intake of 111 GP training places by 2019/20, as recommended by the HSCB/ PHA/

	DHSSPS GP workforce planning review.
1.3	During 2016/17, ensure effective formalised measures are in place to support newly qualified GPs and help retain the existing GP workforce, with a particular focus on supporting rural and single-handed practices. This should include an evaluation of the uptake and impact of recently revised induction, retainer and returner schemes (to be completed by June 2017).
1.4	By December 2016, build a database of GPs from NI who are working elsewhere, carry out a survey to seek to understand their reasons for leaving, and develop a plan to encourage those considering a career in general practice to remain in Northern Ireland to train and, following training, remain here to practice.
1.5	By September 2017, complete research into overall GP workforce requirements for the next decade, taking into account the changing demographic of the GP workforce, predicted levels of need, and the planned increase in GP training places in NI and elsewhere in the UK.

Recommendation 2: Ensure GPs have access to training that provides the skills needed for a career in general practice

In order to build a stable GP workforce, it will be important to ensure that newly qualified doctors are equipped with the skills needed to build a career in general practice. This will require increased exposure to general practice for students in undergraduate medical programmes, as well as to out of hours services for doctors within their postgraduate GP training. In order to implement plans to increase community-based undergraduate general practice teaching, there is a need to review the current curriculum and allocation of the supplement for undergraduate medical and dental education (SUMDE) funding, so that account is taken of the corresponding reduction in students' hospital-based teaching. Academic leadership will also be required to ensure that teaching is undertaken by GPs with a clear vision of their role within an integrated health and social care service. Action is needed to recruit experienced clinical academic GPs who will be equipped with the necessary skills to steer this important change at undergraduate level and to inform plans for enhanced postgraduate training.

The changing nature of the GP workforce will require greater flexibility in the way GP-led services are delivered—while there remains much support among the GP workforce for the independent contractor model and the opportunities it can provide, there is also a growing demand for salaried positions. The working group is therefore in favour of a mixed economy of service provision, with support and opportunities provided for both salaried GPs and independent contractors. Opportunities that could be explored further to support such a model include the introduction of post-certificate of completion of training (post-CCT) fellowships for GPs in Northern Ireland. These have already been introduced elsewhere in the UK and provide newly qualified GPs with a package of postgraduate training, research and employment. As well as providing newly qualified GPs with greater skills, experience and resilience, post-CCT fellowships could potentially target areas where it is currently difficult to secure sufficient GP cover, for example in rural practices or in out of hours services.

Key actions	
2.1	By September 2016, develop a GP clinical academic contract of appointment.
2.2	By October 2016, approve the strategy and associated action plan (including funding model) to revise the undergraduate medical curriculum delivered in Northern Ireland so as to optimise the learning opportunities within primary care / general practice.
2.3	During 2016/17, GP representatives should work with members to increase the number of GP trainers to support trainee and postgraduate GPs and to act as ambassadors for a career in general practice.
2.4	During 2016/17, GP representatives should encourage members to participate in training aimed at enhancing the skills of GPs and the wider practice team, including in areas such as leadership, management and communications.
2.5	By March 2017, engage with other UK regions to consider whether more could be done to provide GP trainees with a structured programme aimed

	specifically at equipping trainees with the skills and confidence needed to work in out of hours.
2.6	By December 2017, develop and consider a business case for the introduction of post-CCT fellowships for GPs.
2.7	By December 2017, work with other UK regions to consider the case for enhanced GP training programmes of four years, with at least 24 months spent in general practice placements.

Recommendation 3: Develop the structures and teams to support GPs

The increasing demand for GP services is well established. It is recognised that in order to continue to meet this demand, changes are needed to the traditional model of service delivery. A 2013 report by The King's Fund and Nuffield Trust concluded that "the development of larger-scale organisations or networks [of general practices] with new services, different skill-mix, and fresh professional and leadership opportunities, is a pressing priority for primary care."[10] GP practices working together and at scale have a number of potential benefits, both in terms of the quality of care provided to patients and the sustainability of services—benefits could include the delivery of a consistent model of high quality care to patients across the region, increasing the range of services that can be delivered in a primary care setting, and reducing variance in the provision of GP-led services.

In Northern Ireland, 17 GP Federations have been established as not-for-profit community interest companies. These have already had a significant impact in areas such as the delivery of the acute care at home model and in managing demand for elective services in the primary care setting. The Department and the HSCB have provided support to GP Federations in 2015/16. In December 2015, the Health Minister announced a 5-year investment initiative that will see close to 300 pharmacists working alongside GPs via Federations by 2021 and an additional £190,000 has been made available on 2015/16 to help Federations prepare for this work. A number of projects are already underway that seek to make best use of GP Federations and initial reports suggest that these have been effective in delivering seamless, coordinated care across the primary, community and acute sectors.

[10] *Securing the future of general practice: New models of primary care—Summary* (The King's Fund, Nuffield Trust, July 2013: 18).

Embedding the GP Federation model will be important to delivering many of the recommendations and actions set out in this report. GP Federations can help to address capacity and workload issues by providing additional resilience to GP practices, for example through the pooling of resources and skills to support single-handed and/ or rural practices. GP Federations can also support the delivery of new services and enable greater specialisation within primary care, as well as disseminating good practice and quality improvement tools across GP practices.

In addition to GP practices working together to deliver a consistent standard of care, it will also be important for GPs and other professionals to continue to work together as part of highly skilled, multi-disciplinary general practice teams. Recent investment in practice-based pharmacists was an important first step in this regard. Continuing to build practice teams consisting of, for example, practice nurses, advanced nurse practitioners and allied health professionals (AHPs) will help to ensure that patients can be seen by appropriate professionals in a timely fashion and are supported to manage and improve their own health, that GPs have access to advice when they need it, and that GPs' time is reserved for patients who most need to see them. Other practice staff, including receptionists and practice managers, will also be key to increasing the resilience and efficiency of general practice. In addition to practice-based teams, district nurses, AHPs, social care teams and other community-based healthcare professionals play a key role in ensuring coordinated and seamless care for patients across organisational boundaries, and it is important that strong links between general practices and community teams are reinstated and maintained.

Key actions	
3.1	During 2016/17, embed the GP Federation model in Northern Ireland so that Federations become self-supporting by April 2018. This process should include the development of a policy statement on the role of GP Federations in Northern Ireland.
3.2	During 2016/17, consider findings of PHA/ HSCB review of general practice nursing, including its recommendations on the future framework for nursing in primary care.

3.3	During 2016/17, continue implementation of Delivering Care to ensure appropriate district nurse staffing levels.
3.4	During 2016/17, continue rollout of practice-based pharmacists in line with agreed business case with up to 300 pharmacists in place by 2020/21. In addition, continue to develop plans to build the teams working alongside GPs in practices, including for example advanced nurse practitioners, AHPs and administrative staff.
3.5	During 2016/17, work with universities, nursing and GP representatives to increase exposure to primary care in nurse training programmes, by facilitating practice placements for pre-registration nursing students with appropriate mentorship in place. Report and any further actions required should be identified by September 2016.
3.6	By December 2016, building on the wider recommendations of the HSCB/ PHA review of nursing services in district and primary care settings, consider opportunities to provide structured induction, mentoring and professional development programmes to support general practice nurses to develop enhanced skills and competencies.
3.7	By March 2017, ensure district nursing teams are aligned to GP practices, that general practices have access to named district nurses, and that regular case management meetings are in place between GPs and district nursing teams.

STRATEGIC GOAL: BUILDING SUSTAINABLE OUT OF HOURS SERVICES

GPs play a vital role in providing advice and treatment to patients at all times of day, including outside of normal working hours in urgent cases. Sustainable GP out of hours services are essential in ensuring that people in need of urgent medical assistance have access to advice and treatment from an appropriate source. However, across the UK, GP out of hours services are coming under increasing pressure, with rising demand and difficulty securing sufficient numbers of GPs to deliver safe and sustainable services. In Northern Ireland, in recognition of the challenges facing GP out of hours services, a number of actions have already been taken to increase capacity and attract more doctors and other staff to work in the service. In 2015/16, funding of £3.1m was made available to support out of hours, including a contribution towards indemnity payments for doctors working out of hours shifts. An additional £1.1m has been provided in-year to help the service cope with increased demand over the winter months and during public holidays. Action has also been taken to build the skills mix in out of hours as well as in hours, including the introduction of nurse triage. And in recognition of the important links between in hours and out of hours services, efforts have been made to increase accessibility of in-hours GP services through, for example, the rollout of facilities to allow people to book appointments or order repeat prescriptions online, as well as running extended GP surgeries in the evenings and at weekends. However, despite these actions out of hours services remain under significant pressure with some out of hours providers having to consolidate available resources and temporarily close some bases to ensure services remain safe for patients and staff.

Out of hours review

In addition to the review of GP-led primary care services, a separate review has also been taken forward by the Department, with input from the HSCB and service providers, focusing specifically on the provision of GP out of hours services. The purpose of this review was to examine the current delivery of GP out of hours services across Northern Ireland to identify good practice and opportunities to improve service provision within existing resources. The review considered the short, medium and long term opportunities to improve the service, drawing on emerging findings and other relevant reviews. The short term opportunities identified by the out of hours review are already being pursued by the GP out of hours

Operational Task Group. Given the service provision implications between in hours and out of hours GP services, the recommendations stemming from the out of hours review have been incorporated into this report.

Addressing the challenges facing GP out of hours services will require action to ensure that services are delivered as effectively and efficiently as possible, including better use of technology; regional rollout of best practice; providing appropriate training and support to administrative and clinical staff to give them confidence to effectively undertake out of hours work; building the skills mix in out of hours as well as in hours services; and continuing to educate patients on the range of options available to them for the management of minor complaints and on the appropriate use of GP out of hours services.

Recommendation 4: Provide an effective GP out of hours service

Key actions	
4.1	During 2016/17, service providers should explore opportunities to build the skills mix in out of hours services, including through the use of nurse triage services and pharmacist prescribers. Providers should also consider the scope for partnership working with other services, such as community pharmacies, to ensure that patients are directed to the most appropriate health professional.
4.2	During 2016/17, to reduce demand on GP out of hours, run an emergency supply pilot to allow pharmacists to provide an emergency supply of medication to patients free of charge, without the need for a repeat prescription.
4.3	From June 2016, all service providers must use the Adastra patient management system to routinely analyse management information and ensure that resources are deployed as effectively as possible to meet predicted service demand.
4.4	By November 2016, run a targeted media campaign to clearly articulate the role of the out of hours service.
4.5	By November 2016, review the current out of hours key performance

	indicators to assess whether they remain appropriate for the effective and efficient provision of out of hours services.
4.6	By December 2016, introduce a remote triage service across the out of hours service to meet periods of high demand.
4.7	By February 2017, develop a regional training programme for out of hours staff, initially concentrating on call handlers to enable better call categorisation, through improved communication and negotiation skills.
4.8	By February 2017, review the home visit arrangements across the region to identify opportunities for improving the service and making more effective and efficient use of the GP out of hours vehicles.
4.9	By March 2017, consider trialling the Ask My GP in out of hours following the outcome of the in-hours pilot (see recommendation 5.1).
4.10	By June 2017, develop and commence a trial of an interface service delivery model (times to be considered but potentially between the hours of 4pm to 9pm), with a view to rolling it out across the region.
4.11	By June 2017, review the number of out of hours bases.

STRATEGIC GOAL: DRIVING INNOVATION IN GENERAL PRACTICE

There has already been significant progress to develop innovative approaches to the delivery of GP-led care in Northern Ireland. For example, GPs across Northern Ireland are working with the NI Clinical Research Network to support patients' involvement in high quality clinical trials, with the aim of improving the management of illness, promotion of wellbeing and the provision of preventive care. The implementation of the Electronic Care Record (ECR) means that all GP practices can now send referrals electronically via the Clinical Communications Gateway (CCG) which are received into secondary care via the ECR platform. An eDischarge system is being piloted in 17 GP practices. Online booking and repeat prescription services are already in place or under development across NI. The CCG is also being trialled to enable referral for advice requests from secondary care colleagues. And Project ECHO is underway with the aim of establishing knowledge networks between secondary and primary care physicians, and other healthcare professionals using videoconferencing tools.

Recommendation 5: Embed research and innovation within general practice to deliver high quality, accessible, sustainable and coordinated GP-led primary care services.

GP involvement in research and development activity ensures that research has real relevance and impact and will ultimately improve the quality of care provided to patients. The shift of clinical care from a hospital setting into the community has increased reliance on GPs' support in recruiting patients and monitoring their progress in studies. There is a need to ensure that GPs with the appropriate knowledge, skills and resources continue to support the delivery of research and the evaluation of innovations in practice, to ensure that sound evidence informs conclusions about the effective and efficient use of scarce resources.

Innovative technology has the potential to make a significant impact both on the way in which services are delivered to patients and on GP workload. Online triage systems such as Ask My GP can help to ensure that people are directed to the most appropriate professional thereby reducing the demands on GPs' time; diagnostic technology located in GP practices means that GPs are able to arrange tests and analyse results without having to refer patients to hospital; the electronic care record

facilitates the sharing of patient information securely across providers; and online booking and triage systems can improve patient access and ease GP workload. Technology can facilitate more effective communication between general practice and hospital teams, for example by connecting GPs and other primary care practitioners with hospital physicians remotely to enable timely access to specialist advice; and by putting in place mechanisms to access and act on results of diagnostic tests and ensure that any relevant information is shared with the patient and their health professionals.

Key actions	
5.1	During 2016/17, pilot online triage system, Ask My GP, at 10 practices across NI. Subject to evaluation of this pilot, consider the case for full rollout of the system across NI.
5.2	By June 2016, evaluate the pilot of Project Echo and consider rollout as appropriate across NI.
5.3	By March 2017, all GP practices should offer their patients the opportunity to book appointments and order repeat prescriptions online.
5.4	By March 2017, agree and implement governance arrangements for the management and sharing of diagnostic test results by secondary and primary care clinicians via the Electronic Care Record.
5.5	By August 2017, building on eDischarge pilot, consider rollout of agreed solution to allow electronic transfer of hospital discharge letters.
5.6	By December 2017, introduce a system to allow the electronic transmission of prescriptions in primary care, in the context of the development of an e-pharmacy strategy in Northern Ireland.

STRATEGIC GOAL: IMPROVING GENERAL PRACTICE INFRASTRUCTURE

Modern premises with access to state of the art diagnostic technologies are key to attracting more doctors to work in general practice. *Transforming Your Care: Vision to Action* recognised the need to invest in the development of primary and community infrastructure, and proposed the development of a "hub and spoke" model of delivery with a range of services provided under one roof. Significant progress has already been made to implement this model—the health and care centres in Ballymena and Banbridge opened in early 2016; construction of a new centre in Omagh is due to be completed in late 2016, with occupation in early 2017; and plans for new health and care centres in Lisburn and Newry are at an advanced stage of procurement. £10m financial transaction capital funding has already been made available via a GP infrastructure loan scheme to improve premises. However, investment in GP premises per patient has historically been lower in NI than elsewhere in UK.[11]

Recommendation 6: Ensure that GP premises are fit for purpose and that GPs and their teams have access to the technology, equipment and physical space they need to provide high quality care and treatment.

With many more services being delivered in a primary care setting it is essential that GP premises are fully accessible and fit for purpose; that GPs and their teams have access to the technology and equipment they need to provide high quality care and treatment for their patients; that premises provide the physical space necessary to support training of GPs and other staff; and that general practice has the physical capacity to continue to contribute to research and innovation.

Key actions	
6.1	By December 2016, develop a business case for ringfenced recurrent resources to support improvement and upgrade of GP premises.
6.2	By September 2017, carry out a stocktake of existing GP practices and develop a plan of work to ensure that by 2025 all premises are fit for

[11] "Comparative UK funding" (DHSSPS 2014).

	purpose and have access to facilities that enable them to deliver high quality services (including GP, medical student and nurse training and research) in a primary care setting.

STRATEGIC GOAL: DELIVERING HIGH QUALITY, INTEGRATED AND SUSTAINABLE GP-LED PRIMARY CARE SERVICES

Any changes to GP-led primary care services must safeguard and improve the quality of care and treatment provided to patients accessing those services. Quality in health and social care is generally defined as encompassing three elements—high quality care is care that is clinically effective, safe, and provides a positive experience for people using services. Both the BMA and RCGP reports warn that with increasing demand for services and with more time being given over to administrative and other duties, GPs have less time to focus on patient care.

Work is already underway to try to support GP practices to improve the quality of the services they provide. A demand management local enhanced service (LES) was introduced in 2012/13 aimed at helping GPs to manage workload and demand, and improve the responsiveness of GP-led primary care services. Practices participating in this LES have improved access to services by reviewing and making changes in a number of areas, for example the use of telephone triage systems and telephone consultations, patient education programmes and self-care policies, and the development of alternatives to standard GP appointments.

Better integration of primary, secondary and community services will also have an impact on the quality of services provided to patients and has the potential to maximise health outcomes for the population of Northern Ireland. Work is already underway to improve the interface between these sectors. For example, a pathway has been developed in the Belfast Trust area to provide direct admission to the ward for frail elderly patients in need of geriatric care, thereby avoiding attendance at the emergency department. The development of a dermatology primary care pathway in the Northern Trust area has seen GPs lead on the care and referral of patients with dermatological needs, supported by an accessible network of expertise in both primary and secondary care dermatology as well as by a peer-led education programme. GPs, working with secondary care clinicians, have also had a key role in the delivery of the acute care at home model in the Belfast Trust area.

Building on progress to date, the working group has identified a number of further actions which seek to utilise GPs' unique understanding of their populations' health and wellbeing needs to improve the quality of services provided to patients as well as improving patients' experiences of those services.

Recommendation 7: Introduce measures to reduce unnecessary demands on GP time and ensure that GP services are equipped to effectively respond to appropriate demand.

While patients report high levels of satisfaction with the care they receive at their GP surgery, and the majority of people are satisfied with access to their GP services, a recent study by the Patient and Client Council reported that more than one third of respondents waited more than five working days for a non-urgent appointment. The results of a patient exit survey, based on 265 GP practices and a sample size of over 20,000 patients, show that 20% of patients waited more than five working days for their appointment. The vast majority of respondents were very or fairly satisfied with the care they received from their practice (95%) and would recommend the practice (96%), although only 36% of patients reported that they could easily get through to the practice on the telephone and only 35% of respondents had been able to access a same day appointments. Importantly though, only 37% of total respondents considered that their appointment was urgent. So while timely access to services can contribute to a positive patient experience, action is also needed to balance patients' expectations of the service with their clinical need, to ensure that urgent patients can be seen as a priority and that appropriate alternatives are in place for less urgent patients.

In addition, GPs report that a proportion of their time is spent on administrative work which could better be spent on direct patient care, for example re-referring patients to hospital who failed to attend an outpatient appointment. And while it is clear that demand for GP services has increased over the last decade, and activity in general practice has increased in response, consideration should be given to how best to optimise general practice's ability to continue to meet (appropriate) demand for services. Practices working together as Federations and pooling resources to deliver consistent standards of care and reduce variation will be an important step in this regard.

Many of the recommendations and actions in this report are intended to improve the accessibility of GP services and ensure that supply matches demand—for example, actions to train, recruit and retain more GPs and build the skills mix in general practice will mean that patients can be seen within a clinically appropriate timescale by the most appropriate health professional. However, there are a number of specific steps that could be taken to ensure that demand for GP services (both in-hours and out of hours) is appropriate and that services are organised and delivered to respond effectively to that demand.

Key actions	
7.1	From April 2016, GP practices should consider reviewing levels of demand and putting in place appropriate measures to manage and respond to that demand as effectively as possible. Measures might include the use of text reminder services and communications with patients regarding their responsibilities to use GP services appropriately.
7.2	During 2016/17, consider and, if appropriate, implement changes to the current arrangements for managing patients who fail to attend a hospital appointment, in line with recent developments in England, with the aim of reducing the administrative burden on GPs.
7.3	By September 2017, consider proposals to restrict prescribing of medications by developing a 'less than suitable for prescribing list' and a 'prohibited list' of medications, to ensure the best and most appropriate use of GP time and resources.

Recommendation 8: Ensure that GPs and the wider primary care team have a key role in improving population health and wellbeing, in line with the strategic vision outlined in *Making Life Better*, and in planning services to meet population need

The role of GPs has changed significantly over recent years. The traditional view of GPs as the gatekeepers of health and social care services is no longer accurate. The focus of the health and social care service in Northern Ireland is shifting increasingly towards prevention and wellness. As the main contact the majority of

people have with healthcare services, GPs have a key role in improving and protecting population health and in educating people to make healthy choices. GPs also have a unique understanding of the health and wellbeing needs of their local populations and as such have an important part to play in planning services to meet those needs. The reforms to the health and social care system in Northern Ireland announced by the Minister in November 2015 are intended to reduce the layers of bureaucracy and provide for more seamless services across primary, community and secondary care. GPs—working together in federations and alongside partners in the community, acute and community and voluntary sectors—will be essential in securing the successful implementation of this vision.

Key actions	
8.1	From April 2016, complete an impact assessment on GP-led services prior to implementation of any significant service developments.
8.2	During 2016/17, consider the existing mechanisms for integrating health and social care services across primary, community and secondary care; and ensure that GPs and other members of the primary care team continue to have a key role in the assessment of the health and care needs of the population and in the planning of services to meet these needs.
8.3	By September 2016, develop a forum to ensure that GP representatives are involved in the planning of public health campaigns and that for each campaign an assessment is made of the potential for increased demand on GP-led services.
8.4	By March 2017, develop a service directory of health promotion and improvement resources, for use by GP-led teams; and explore the possibility of linking the e-referrals system to this directory.
8.5	By June 2017, develop a business case for Data Quality in Practice, which would enable the extraction on an ongoing basis of a minimum data set from GP practices' clinical systems. This action will facilitate appropriate secondary uses of data such as planning of services and risk stratification.

Recommendation 9: Put in place recognised measures aimed at improving patients' experience of GP-led services, in line with the strategic vision set out in Quality 2020

Involving patients in the delivery of GP-led primary care services is critical. Not only can it provide patients with a say in the way practices are run or care is delivered, it can also empower patients to act as ambassadors for the practice, sharing information (including tips on healthy lifestyle choices or how to manage long-term conditions) with other members of the community. GP practices should regularly and routinely involve their patients in the planning and delivery of services. It is recognised that many practices already run patient participation activities. This approach should be rolled out across all GP practices to ensure that patients have an opportunity to identify the issues that matter to them and to contribute to the development of solutions aimed at improving the quality of services provided.

Actions are also required to improve the interface between primary, secondary and community services. For example, ensuring GPs have timely access to specialist advice can avoid unnecessary admissions to hospital and can mean that GPs are equipped with the information necessary to support and treat patients in primary care. Improved pre- and post-admission pathways can also contribute to a more positive patient experience and safer, more coordinated treatment and care. And effective partnership working between GPs and other professionals such as social workers and AHPs is critical in developing community-based solutions to meet the health and care needs of the local population

Key actions	
9.1	By December 2016, GP practices should consider the introduction of recognised quality improvement methodology as appropriate.
9.2	By March 2017, GP practices should actively consider the most suitable methods to ensure that patients are involved in the planning and delivery of services, including through the establishment of patient participation groups where this is appropriate.
9.3	By March 2017, begin a review of pre- and post-hospital admission pathways, to ensure information is communicated effectively to patients

	and clinical teams, and that there is clarity of responsibility for the management of patients.
9.4	By June 2017, develop a directory of secondary care services and contact details of relevant specialists, to ensure that GPs can follow up on patients who have been referred to a service.

SUMMARY AND RECOMMENDATIONS

Much good work is already underway to ensure that GP-led primary care services continue to provide high quality advice, care and treatment to the population of Northern Ireland. No-one can be in any doubt that GPs and the teams who work alongside them in general practice provide an essential service in supporting people to make the right choices for their own health and wellbeing, in helping people to manage often complex conditions in the primary care setting, and in providing treatment and carrying out procedures that until relatively recently would have required a hospital admission. As the Northern Ireland population continues to age, and as more and more people live with chronic conditions, it is clear that the role of GPs and the general practice team will only increase in importance over the coming years.

However, it is also clear that GP-led services cannot continue to meet rising demand and expectations without urgent action to address the pressures currently facing the service. Steps have already been taken to increase the GP workforce and support the existing workforce, and it will be important to build on these. But GPs cannot work in isolation, and building sustainable GP-led services will also mean ensuring teams of highly skilled professionals are available to work alongside GPs to provide patients with access to the most appropriate advice, support and treatment. Again, building on developments that are already underway, GP-led services of the future should be delivered from modern premises with access to diagnostic and other technology that reflect the central role of GPs in managing and treating more complex conditions in the primary care setting, that will ensure GPs have access to specialist advice and that patients have timely access to high quality services coordinated across primary, secondary and community care. Delivering this vision will ensure that general practice is viewed by doctors and other health professionals as an attractive choice that provides real opportunities for a challenging yet rewarding career.

Appendix

Future of GP-led Services Working Group

Terms of Reference

There are increasing demands on GPs, practice nurses and other primary care providers in Northern Ireland. While the Department's Primary Care Strategic Framework – *Caring for People Beyond Tomorrow* – sets out the approach to primary care provision from 2005 to 2025, the challenges we now face necessitate consideration of the strategic approach and opportunities for reform, particularly in GP-led services.

The working group will be driven by the need to improve the health of the population, improve people's experience of care and ensure value/cost effectiveness. An ageing population and an increase in long term conditions require new and innovative ways of working if we are to continue to provide world class Primary Care Medical Services in Northern Ireland.

Remit

The working group will consider the delivery of primary care medical services delivered in GP surgeries by GPs or other professionals, including the implications of changes to the GP contract being considered in other parts of the UK. The working group will not directly consider the provision of social care services or community services, aside from considering their interfaces with GP-led primary care.

Scope

The working group shall consider:

- Immediate steps to help address demands on GP-led services
- What the future demand for primary care services may look like and the impact on workload
- The mix of skills necessary to meet and manage this demand
- The involvement of patients in the planning and delivery of GP services
- Trends in the make-up of the existing primary care workforce and the implications of this for the future provision of primary care
- The organisational structures and contractual arrangements that will help manage that demand, having regard to the recent reviews of administration and commissioning
- How to ensure the effective integration of primary care services with other parts of the health and social care system to maximise good health outcomes for the population

- Different methods of working which would see demand dealt with in different ways, including through patient self management
- How the shift of care from hospitals to home and community settings is impacting on the nature and form of care required in communities
- The impact of these changes on primary care infrastructure requirements
- Current models for delivering primary care infrastructure and existing trends in provision
- The delivery of clinically and cost effective prescribing
- The opportunities (and risks) presented by and approach to information technology; telemonitoring and telephony services; and the internet
- The opportunities presented by and approach to data analytics and risk stratification
- Relevant developments in the rest of Great Britain which could have an impact in Northern Ireland or from which we can learn
- Good practice from within NI and elsewhere in the world in relation to primary care provision
- Continuing to develop a learning system for Primary Care Medical Services that will ensure continued innovation and development.

The group shall consider and draw on the emerging findings from other relevant reviews that have taken place recently or that are underway.

Timing

The group shall make clear recommendations on actions to help address future demand for primary care medical services. The group shall provide a report by February 2016 to the Minister for Health, Social Services and Public Safety, drawing on relevant evidence and information.

Membership

The group shall be chaired by the DHSSPS Deputy Secretary Healthcare Policy Group.

Representatives on the group shall include:

Deputy Chief Medical Officer, DHSSPS

Chief Nursing Officer, DHSSPS

Chief Pharmaceutical Officer, DHSSPS

Head of GMS, HSCB

Representative/s from BMA NI GP Council

Representative/s from RCGP

Representative from the Royal College of Nursing NI

Representative from AHP Federation NI

Health and Social Care Trust Director of Primary and Community Care

Patient/carer representative