General practice in Northern Ireland: The case for change

February 2015
Foreword

The health and social care system in Northern Ireland continues to face many challenges which can only be met through radical change and building a consensus on the choices – sometimes difficult ones – which will have to be made to balance demand, need and limited resources.

The financial environment across the public sector will be very tight for the next few years. That financial reality, coupled with increasing demand and need for health and social care, will require substantial – not incremental – changes to how services are planned, resourced and delivered.

With increasing specialisation of hospital doctors, GPs are now the only generalists in the health service and they have a role in coordinating patient care across specialties as well as their traditional role as gatekeepers to secondary care. Indeed, general practice continues to be the first point of contact for 90% of health and social care related matters.

The drive is to do more in primary care. More could be done in terms of service integration, developing coherent pathways of care and management of demand.

Such improvements will require leadership from politicians, professionals and managers and a robust public debate about what health and social care can and cannot be delivered for the money available.

The last decade has seen a comparative reduction in resources for primary care relative to secondary care. There has also been a sharp growth in demand for GP services. These factors have combined to result in a decline in morale amongst GPs and a lessening of the attractiveness of general practice as a career path.

The sustainability of general practice now needs urgent attention.

Many policies and strategies state that health and social care services should be clinically led and primary care centred. After a decade in which funding and workforce has been focused on secondary care, the health service in Northern Ireland needs to pivot back towards primary care.

This document outlines how general practice – if empowered and adequately resourced – could work in a holistic manner with the rest of our health service to deliver safe, accessible and high quality care to our patients in a more cost effective way.

This will require a paradigm shift of thought, actions and funding allocation if we are to have the workforce in the community to meet patient need.

This document outlines the case for change.

Dr Tom Black
BMA Northern Ireland General Practitioners Committee chair
### Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>2</td>
</tr>
<tr>
<td>Characteristics of general practice</td>
<td>2</td>
</tr>
<tr>
<td>Implications of the current situation for general practice</td>
<td>3</td>
</tr>
<tr>
<td>Context</td>
<td>4</td>
</tr>
<tr>
<td>Workload</td>
<td>5</td>
</tr>
<tr>
<td>Workforce</td>
<td>11</td>
</tr>
<tr>
<td>Funding</td>
<td>14</td>
</tr>
<tr>
<td>Investment in premises</td>
<td>14</td>
</tr>
<tr>
<td>Hubs and spokes</td>
<td>15</td>
</tr>
<tr>
<td>Information technology</td>
<td>16</td>
</tr>
<tr>
<td>Federations</td>
<td>17</td>
</tr>
<tr>
<td>Conclusion</td>
<td>19</td>
</tr>
</tbody>
</table>
**Introduction**

General practice is recognised as one of the most cost-effective, high quality means to deliver care to patients in their communities.¹

Countries whose health systems are orientated towards primary care achieve better health outcomes, higher satisfaction with health services and lower costs overall.²

General practice is the backbone of primary care and it is most effective when integrated across the wider primary care team, including nurses, pharmacists and other allied health professionals.

Effective patient care requires support for a primary care centred service with links to hospitals and emergency care. In addition, changes in diagnostics and treatment allow more people to be managed in the community rather than in hospital. General practitioners (GPs), as expert medical generalists, provide whole person diagnosis and holistic care management to their patients.

However now more than ever, general practice is facing challenges in the form of increased workloads, difficulties in recruiting and retaining doctors and real term reductions in investment in primary care. The reducing budget for health and social care is a reality; put together with increased workloads and recruitment and retention issues and a perfect storm has been created.

**Characteristics of general practice**

- For most people a GP is their first point of contact with the health service
- GP practices are community based and accessible to everyone
- GPs are closely linked to secondary care and other allied health professionals
- GPs are highly trained to treat complex health and social care needs
- GPs act as advocates on behalf of their patients
- GPs and their patients build up long-term relationships

TYC (Transforming Your Care), an overarching road map for change in the provision of health and social care services in Northern Ireland, proposed a change in how services were to be structured and delivered in order to make best use of all resources available, and in so doing, ensure that our services are safe, resilient and sustainable into the future.³

BMA Northern Ireland welcomed the opportunity that TYC proposed. We agreed that a much bolder approach was needed and that many of the visions outlined in TYC dovetailed with BMA Northern Ireland’s vision for the health service.⁴

This included the reconfiguration of services to take account of increasing levels of chronic diseases and an ageing population. The vision also called for planned and managed service reconfiguration in secondary care to include reduction of locations where full acute services are provided, enabling development of specialist teams and facilities in fewer hospital locations. This is driven by the need to provide quality services for patients; in essence a “shift left” to primary and community settings.

BMA Northern Ireland believes a distinction must be made between transforming services and transferring work. It is vital that there is no disconnect between primary and secondary care.

---

¹ Mirror Mirror on the Wall — Survey of primary care physicians in 11 countries. Perspectives on care, costs and experiences. Commonwealth Fund 2014
³ Transforming Your Care – Vision to Action, DHSSPS, 2013
⁴ BMA(NI) vision for the health service in Northern Ireland 2010
Implications of the current situation for general practice

It is clear in Northern Ireland that we have reached the point of no return for general practice.

Multiple drivers that have precipitated the current crisis include an ageing population, particularly those over 85, increases in obesity and long term chronic illnesses, the reality of economic constraints and workforce challenges.

If nothing is done to change the course we are on, the following will become a reality:

– Recruitment and retention of GPs will become even more difficult
– Patients will experience increasing delays in accessing their GP
– The ability of practices to deliver a range of services will be limited
– Some practices will no longer be viable and may have to close

Aside from the implications for general practice, there are significant ramifications for secondary care. These include:

– Referrals to outpatients will increase and consequently patients will have to wait longer to be seen
– There will be less co-ordination and continuity of care for patients
– Patients with complex needs will be more likely to present at an emergency department, further exacerbating pressure within secondary care
– There will be less preventative mechanisms in place such as child care clinics and vaccinations, potentially leading to further hospital admissions
– The capacity to deliver on public health initiatives will be severely compromised such as reducing obesity and smoking cessation clinics, again potentially leading to patients needing to be seen in hospital

Doing nothing is not an option if general practice is to survive.

This document sets the scene for the current state of play within general practice in Northern Ireland and the crisis we currently face.
**Context**

**Key points**

- The population of Northern Ireland is projected to increase by 8% to 2 million by 2025
- The number of people aged 65+ is set to increase by 42% to 370,000
- The number of people aged 85+ is set to increase by 82% to 55,000
- The prevalence of long-term conditions such as diabetes, respiratory problems, stroke and obesity is increasing

The need for, and demands placed on, health and social care in Northern Ireland are growing and will increase chiefly because of an ageing population, higher prevalence of chronic conditions as well as advances in technology and drug therapies.

As outlined previously, other pressures emanate from increasing patient expectations and changes in the way services are delivered. This is happening at a time when money available for health and social care is reducing in real terms.

There are growing pressures on general practice services, whilst spend on services is relatively static.

The government policy response has been to increasingly promote self-help within communities, advocate healthier lifestyles and to shift the balance of care from hospitals to primary and community care settings.

GPases a pivotal role in delivering quality patient services. In essence they act as gatekeepers to the rest of the health and social care system. Even though GPs account for just 3% of the workforce, they deal with around 90% of health related cases. Accessible and well-resourced general practice is essential if the health service is to deliver good patient outcomes.

---

6 Transforming Your Care – Vision to Action, DHSSPS, 2013
7 Transforming Your Care – Vision to Action, DHSSPS, 2013
8 In-depth Review of the General Practitioner Workforce, Centre for Workforce Intelligence (CFWI), Final Report, July 2014
There has been an increase in workload, coupled with a decreasing workforce. Rising patient demands and expectations are occurring against a backdrop of increasing financial constraint.

This is deeply concerning; the impact on health and social care will be significant, putting the future of general practice at risk.

We have calculated that there is currently an under-investment in general practice in Northern Ireland. To bring us up to the UK average, there would need to be a recurrent investment of at least £33 million per annum.\(^9\)

Funding for health and social care will always be outstripped by demand. That is all the more reason to invest in general practice. If general practice is unable to cope, the knock-on effect on the overall system will be great. There is a need now, more than ever, to invest in a GP-centred service in order to achieve overall savings, through improved efficiency and effectiveness in the longer term.

**Workload**

Workload in General Practice has been increasing inexorably for the last decade.

**Key points**
- In 2013, GPs prescribed almost 39 million prescription items per year – approximately 20 prescription items per person per year\(^10\)
- The number of acute prescriptions increased by 28% from 2003/04 – 2013/14
- The number of repeat prescriptions issued increased by 42% in from 2003/04 to 2013/14
- The number of test results dealt with by practices increased by 217% from 2003/04 to 2013/14
- Administrative tasks per patient rose by 115% from 2003/04 to 2013/14
- Total consultations rose from 7.2 million in 2003/04 to 12.7 million in 2013/14\(^11\)
- This works out at 6.6 consultations per patient per year, or an increase in overall consultations per patient of 63% from 2003/04 to 2013/14
- Consultation rates for practice nurses rose by 65% from 2003/04 to 2013/14
- Consultation rates for treatment room nurses rose by 35% 2003/04 to 2013/14

Figure 2 shows the overall acute prescribing rates in Northern Ireland by financial year. The overall acute prescribing rate in Northern Ireland rose from 4.23 acute scripts per person in 2003/04 to 5.43 in 2013/14.\(^12\)

---

\(^9\) Based on 2013/14 figures (UK figure of £142 per head of population, less the corresponding figure of £125 for Northern Ireland) x Northern Ireland registered population (i.e. £142-£125=£17 x 1,921,215=£33m.)

\(^10\) Northern Ireland Audit Office report on Primary Care Prescribing 27 November 2014


\(^12\) Estimating the volume & growth in consultation rates in general practice in Northern Ireland, 2003/4 to 2013/14: Analysis of survey returns from General Practices. DHSSPS February 2015
Figure 2: Change in acute prescribing rate in Northern Ireland by year

Figure 3 shows the overall repeat prescribing rates in Northern Ireland by financial year. The overall repeat prescribing rate in Northern Ireland rose from 8.67 repeat scripts per person in 2003/04 to 12.27 in 2013/14.\textsuperscript{13}

Figure 3: Change in repeat prescribing rate in Northern Ireland by year

---

The increase of 217% in dealing with laboratory test results is summarised in Figure 4.

Figure 4  Change in rate of laboratory test results in Northern Ireland by year

The rise of 115% in administrative workload is demonstrated in Figure 5.

Figure 5  Change in rate of administrative workload in Northern Ireland by year

---


The increase in consultation rates is summarised in Table 1. The consultation rate per person has risen from 4.04 consultations to 6.6 consultations per patient per year, an increase of 63%.16

These workload figures do not reflect the complexity of consultations and the growing comorbidity of an ageing population; nor do they reflect the time needed to deal with the growing administrative tasks required to ensure continuity of care.

Table 1  Consultation rate per patient and total volume of consultations per year in Northern Ireland

<table>
<thead>
<tr>
<th>Year</th>
<th>Consultation Rate</th>
<th>Number of consultations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>4.04</td>
<td>7,224,479</td>
</tr>
<tr>
<td>2005</td>
<td>4.38</td>
<td>8,224,840</td>
</tr>
<tr>
<td>2006</td>
<td>5.07</td>
<td>9,116,258</td>
</tr>
<tr>
<td>2007</td>
<td>5.57</td>
<td>10,135,490</td>
</tr>
<tr>
<td>2008</td>
<td>6.00</td>
<td>10,384,366</td>
</tr>
<tr>
<td>2009</td>
<td>6.07</td>
<td>10,384,366</td>
</tr>
<tr>
<td>2010</td>
<td>6.26</td>
<td>11,365,352</td>
</tr>
<tr>
<td>2011</td>
<td>6.41</td>
<td>11,833,879</td>
</tr>
<tr>
<td>2012</td>
<td>6.44</td>
<td>12,182,628</td>
</tr>
<tr>
<td>2013</td>
<td>6.60</td>
<td>12,682,667</td>
</tr>
<tr>
<td>2014</td>
<td>6.60</td>
<td>12,708,815</td>
</tr>
</tbody>
</table>

General practice has managed to cope with this increase in workload by working harder and longer, as well as through the use of multidisciplinary working, computerisation and the movement away from home visits to surgery-based consultations. This is shown in Figure 6.17

Figure 6  Change in consultation rates for GPs, nurses and home visits in Northern Ireland by year

Hospital workload has not increased at the same rate as general practice.

During 2013/14, there was a total of 611,708 admissions to hospitals in Northern Ireland. This was an increase of 4.8%, i.e. less than 1% per year, from the number admitted in 2009/10. This is summarised in Figure 7.18

**Figure 7**  Total admissions to HSC hospitals in Northern Ireland (2009/10 – 2013-14)

During 2013/14, a total of 1,560,375 patients were seen at consultant-led outpatient services within HSC hospitals in Northern Ireland. This was an increase of 56,846 (3.8%) on the number seen in 2009/10 (1,503,529).19 This is summarised in Figure 8.

**Figure 8**  Total attendances at consultant led outpatient services in Northern Ireland (2009/10 – 2013/14)

---

18 General Practice Medical Workforce Planning Interim Report (DHSSPS), 2014
19 General Practice Medical Workforce Planning Interim Report (DHSSPS), 2014
Population growth and the relatively high health needs of the population in Northern Ireland have also contributed to an increase in GP workload. Not only is the number of consultations rising year-on-year, but the complexity of the care provided by GPs has increased. As Table 2 shows, on the basis that 1 is the average need, we can see that Northern Ireland has the highest relative health needs across the UK.\(^{20}\)

**Table 2  Estimation of relative health need per person**

<table>
<thead>
<tr>
<th></th>
<th>England</th>
<th>Scotland</th>
<th>Wales</th>
<th>N Ireland</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.91</td>
<td>0.98</td>
<td>1.07</td>
<td>1.11</td>
</tr>
</tbody>
</table>

In addition to the rise in daytime GP services, out of hours GP consultations have increased by over 18% between 2008/09 to 2012/13 without a concomitant increase in funding.\(^{21}\) The vast majority of out of hours consultations still take place with working general practitioners, in addition to their daytime workload.

We believe that workload in general practice has reached saturation point. The intolerable demands on GPs and their staff have created a workforce crisis where young doctors choose not to enter general practice and, more worriedly, experienced GPs are choosing to leave. This can no longer be sustained with the staff and resources available to general practice.

---

20 Analysis of Northern Ireland Audit Office data from 2007/08 to 2009/10 (Deloitte), cited in General practice medical workforce planning interim report (DHSSPS/HSCB) 2014

21 General Practitioner Medical Workforce Planning Interim Report (DHSSPS) 2014
Workforce

Key points

- There are 351 General Practices in Northern Ireland
- Of the 1171 GPs, 55% are men and 45% are women
- The average list size of 1641 patients per GP is the highest in the UK
- There are 61 GPs per 100,000 patients in Northern Ireland, which is lower than elsewhere in the UK
- There needs to be 46 more GPs trained per year in order to meet gaps in workforce

Evidence indicates that the growth in the general practice medical workforce has not kept pace with the demand for general practice services. In contrast, full-time equivalent hospital registrars have increased at an annual average rate of 11%, hospital consultants at 4%, SAS (Staff, Associate specialists and Specialty Doctors) Grades at 8% and GPs at less than 1%.

This is summarised in Figure 10.

Figure 10  Index of Northern Ireland medical and nursing workforce 2002 – 2013 (base 100)

The General Practice workforce is not growing as quickly as in other areas of the health service.

Based on a comparison with England, Northern Ireland requires 111 GP training places per year, compared to the current 65.

Of the 65 GPs in training locally, just 33 GPs had fully completed their training in 2014.
This has been a noticeable trend in recent years where the number of fully trained GPs has been significantly lower than the annual intake of trainees due to, for example, the effects of maternity leave and an increase in part-time training.28

Account also needs to be taken of the fact that more GPs are seeking to work part-time, and combine work in general practice with other aspects of medicine.

Training more GPs will not, of itself, resolve the workforce problem. It is vital that general practices are funded adequately to be able to have enough GPs in each practice.

There is also a need to increase investment to enable general practice to take on a range of medical staff if we are to realise the vision of care in the right place at the right time.

The demographics of the workforce are changing considerably, with more women choosing to become GPs, as shown in Figure 11 below.

The GP workforce gender split in 2013 was 55% men and 45% women compared to 80% men and 20% women in 1985.29

This creates further pressure as younger, female GPs have differing commitments outside of work, for example due to maternity leave and caring responsibilities. This, in turn, reduces the numbers of hours they can work per week. We have estimated that the number of GP whole time equivalents is closer to 950, rather than the total head count of 1,171 GPs.30

**Figure 11 Breakdown of GP headcount by gender**

---

28 DHSSPS 2014 General Practitioner Medical Workforce Planning Group: Interim Report
29 Pressures on general practice in Northern Ireland DHSSPS 2014.
30 Calculation based on NIGPC survey
In addition to the gender profile, the age profile of the general practice workforce shows that almost a quarter (24%) of GPs in Northern Ireland are aged 55 and over. This means many GPs will be planning to retire in the near future. The age profile of GPs in Northern Ireland is summarised in Table 3.

This compares unfavourably with England and Scotland, where there are 22% and 20% of GPs in this age category. In Wales, GPs aged 55 and over account for 23% of the medical workforce.\(^\text{31}\)

### Table 3  
**Age profile of GPs in Northern Ireland at 1 October 2014**\(^\text{32}\)

<table>
<thead>
<tr>
<th>AGE BAND</th>
<th>% OF GPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>29-34</td>
<td>11</td>
</tr>
<tr>
<td>35-39</td>
<td>18</td>
</tr>
<tr>
<td>40-44</td>
<td>14</td>
</tr>
<tr>
<td>45-49</td>
<td>16</td>
</tr>
<tr>
<td>50-54</td>
<td>17</td>
</tr>
<tr>
<td>55-59</td>
<td>16</td>
</tr>
<tr>
<td>60-64</td>
<td>6</td>
</tr>
<tr>
<td>65 and over</td>
<td>2</td>
</tr>
</tbody>
</table>

\(^{31}\) Figures collated by Royal College of General Practitioners 2014  
\(^{32}\) Based on figures collected by Business Service Organisation 2014
Funding

Key points
– £241 million was spent on GMS (general medical services) in 2013/14
– GMS spend in Northern Ireland is 6% of the total health spend. The UK average on GMS spend on health is 8%\(^{33}\)
– This results in a lower investment per patient in Northern Ireland despite relative health needs in Northern Ireland being higher than in other parts of Great Britain

Table 4 shows the comparative investment per patient, GP and practice across the UK.\(^{34}\)

<table>
<thead>
<tr>
<th>COMPARATIVE FUNDING POSITION 2013/14</th>
<th>England</th>
<th>Wales</th>
<th>Scotland</th>
<th>Northern Ireland</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>INVESTMENT PER PATIENT Excluding dispensing</td>
<td>£141</td>
<td>£130</td>
<td>£164</td>
<td>£125</td>
<td>£142</td>
</tr>
<tr>
<td>INVESTMENT PER GP Excluding dispensing</td>
<td>£222K</td>
<td>£204K</td>
<td>£214K</td>
<td>£206K</td>
<td>£220K</td>
</tr>
</tbody>
</table>

The total investment per patient on GP services in Northern Ireland is the lowest of all four countries in the UK.

Based on these figures, BMA Northern Ireland estimates that in order to bring the investment in general practice up to the UK level, an additional sum of at least £33 million recurrent funding would be required.\(^{35}\)

Investment in premises
The majority of consultations in the health service take place in GP surgeries. Good quality accessible premises that allow a range of diagnostics and treatment for patients are vital for the delivery of modern healthcare and to enable and strengthen the link between primary and secondary care.

General practice requires modern accessible premises which are well equipped and can deliver appropriate care in their local area. BMA Northern Ireland has frequently called for improvements in premises that general practice services are provided from and to ensure local practices have the resources they need to sustain the current high levels of patient care.

Fundamental to TYC is a “shift left” in services from hospital to local communities. As a result, GPs have seen an increase in the range and volume of services that are now being provided in General Practice.

If this is to continue on the scale expected, then investment in bricks and mortar is needed so that general practice premises are fit for purpose with new and/or upgraded accommodation for GPs and community based services.

The amount spent on premises in Northern Ireland per patient has been consistently lower than anywhere else in the UK. This is summarised in Figure 12.\(^{36}\)

---

33 Based on Public Expenditure Statistical Analysis (PESA) 2014
34 Comparative UK Funding, Project support analysis branch DHSSPS 2014
35 Based on 2013/14 figures (UK figure of £142 per head of population, less the corresponding figure of £125 for Northern Ireland) x Northern Ireland registered population (i.e. £142-£125=£18 x 1,921,215=£33m.)
36 Comparative UK Funding, Project support analysis branch DHSSPS 2014
To ensure best value for the required extra funding, there should be:

- An overall plan of work to ensure all GP premises are able to meet existing and future health service requirements
- Adequate funding to support premises development
- Facilitation of general practices to work together in, for example, federations, to provide more services 'out-of-hospital' where appropriate

Ultimately, the aim will be to support premises development so that:

- Patients will continue to be able to get the majority of their services from their own general practice premises
- Where it makes sense to do so, patients can go to larger primary care facilities (hubs) to get a range of diagnostic services such as tests, some x-rays and other services previously only available in hospital settings

**Hubs and spokes**

The BMA is generally supportive of HSCB (Health and Social Care Board) plans to develop a 'hub and spoke' model of care, the aim of which is to have a number of hubs of various sizes across Northern Ireland, containing primary and community health and social services. Hospital outreach clinics and some diagnostics may also be included, with the services included in each hub depending on the service model agreed for each locality.

The BMA is also supportive of the initiative known as the financial transactions capital scheme, part of which involves a loan scheme to GP practices wishing to improve or develop existing premises or build new premises.

There needs to be a much more concerted effort to support sustainable infrastructure in primary care in general and general practice in particular.
Information technology

Key points

– The NIECR (Northern Ireland Electronic Care Record) has over 14,000 registered healthcare professionals using the system to help provide patient care throughout five HSC Trusts and 351 General Practices.
– Since NIECR launched last year, HSC staff have used it to access patient records more than 2.5m times.
– This has contributed to the care of more than 400,000 individuals (22% of the population).
– On average, over 30 patient records every minute are being viewed by HSC professionals through the NIECR.
– 750,000 clinical documents, lab results, radiology reports are being accessed each week.

BMA Northern Ireland believes that investment in IT systems will, in the long term, reduce the administrative burden faced by healthcare staff.

Good information technology is the key to effective and timely care of patients. It is needed to record patient information and share that information securely as patients move around different parts of health and social care.

The investment to date in IT in primary care is to be welcomed, however there is much to do in order to reduce the need for paper and to enhance the flow of information in a digital format.

The NIECR has been a fantastic advance to support integrated care by enabling the sharing of information between primary care and secondary care across the health service and to provide an information system truly centred on the patient rather than on institutions.

GP can now make referrals electronically using the Clinical Communications Gateway, which provides a secure method of transferring electronic referrals from the practice to hospital.

There is now a need to ensure that hospital processes for referral and triage are also available electronically.

Electronic links enable access to core patient data by the out of hours GP service, emergency departments and the ambulance service. The key information summary will be particularly useful in the care of patients with multiple conditions and cancer.

Further IT enabled solutions would include:
– The introduction of electronic transfer of patient records when moving GP practice, i.e. GP to GP transfer.
– Developing further secure IT links between GP practices and between primary and secondary care to reduce the need for paper.
– Continuing the move away from paper based records.
– Enabling more patients to gain greater access to information and, for example via a secure web portal, to book appointments and request prescriptions to help them in managing their own care.
– Develop IT enabled alternatives to face to face consultations with GPs which will have the confidence of patients and doctors.
– Supporting Project ECHO (Extension for Community Outcomes) to establish IT enabled networking of GPs, hospital doctors, nurses and other professionals to support community based care and continuing professional development.
Federations

Key points

- Workload is beyond the capacity of general practice
- Workforce is in crisis because of excess workload
- An investment of at least £33 million of recurrent funding is needed to bring us to the UK average
- Federations of practices offer new ways of working to increase the capacity and scope of services

GPds in Northern Ireland have for many years been at the forefront of identifying and implementing solutions to counteract the rising challenges. Even though GPs are under significant pressure in an ever financially constrained environment, they have still risen to the challenge of finding mechanisms to deal with this current crisis.

BMA Northern Ireland’s GP Committee has been responsible for the creation, development and implementation of a network of Federations of GP practices.

It is our vision that general practice will carry on providing continuity of care within our communities, providing essential services and chronic disease management. Colleagues in secondary care will continue to provide specialised hospital services.

We believe that Federations of practices have the potential to support primary care to work at a scale needed to take on the area of integrated care required for ‘shift left’ as envisaged in TYC.

In a role of multispecialty community providers, a federated approach could offer, for example, advanced diagnostics, outpatient clinics and complex care pathways.

Federations could potentially:
- Increase the range and type of services in the community
- Improve access to diagnostics
- Provide extended hours
- Support GP out of hours services.

This will help to:
- Reduce demands on emergency and outpatient departments
- Free up GP practice time which in turn will
  - increase the number of GP appointments available
  - provide longer appointments for those patients with complex health and social care needs and long term chronic illness

Federations have been established as not-for-profit Community Interest Companies and will, ultimately, be established across Northern Ireland. Each Federation will comprise around 20 General Practices, delivering services to approximately 100,000 patients.

It is envisaged that local Federations of GP practices will develop over the next three to five years into MCPs (Multi Professional Community Providers), similar to the model outlined in NHS England’s “Five Year Forward View”.38

Federations in each area will grow organically to provide the services required in their local area. However, given the huge prescribing workload currently administered by GPs, a first step for Federations may be to employ practice-based pharmacists to support this work.

38 NHS England (2014) Five Year Forward View
Developing partnerships with advanced nurse practitioners and specialist doctors to cover services such as phlebotomy and diagnostics will also ameliorate GP workload.

As Federations develop, services that are traditionally seen as “step up and step down” will be provided, potentially reducing hospital admissions and keeping patients in a community setting. Such services may include outpatients, day-care, pre-hospital and early discharge arrangements.

It is envisaged that federations of practices will develop into training organisations and providers of education and peer review. In addition, working for a Federation will offer flexibility, which may be attractive to doctors, pharmacists and nurses who require a portfolio career or family friendly job profiles, leading to improved recruitment and retention of staff.

**Timeline for Federation development**

<table>
<thead>
<tr>
<th>Date</th>
<th>Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 2015</td>
<td>The majority of GP practices already incorporated into not-for-profit Federations</td>
</tr>
<tr>
<td>3rd quarter 2015</td>
<td>All GP practices incorporated into not-for-profit Federations</td>
</tr>
<tr>
<td>2015/16</td>
<td>Practice pharmacists in 1/3 of all GP practices</td>
</tr>
<tr>
<td></td>
<td>Federation phlebotomy pilots in place</td>
</tr>
<tr>
<td></td>
<td>Outpatient clinic pilots up and running for rheumatology, ENT and neurology</td>
</tr>
<tr>
<td>2016/17</td>
<td>All practices covered by practice pharmacists and phlebotomy services</td>
</tr>
<tr>
<td></td>
<td>A full spectrum of outpatient services provided by Federations aligned with local need</td>
</tr>
<tr>
<td></td>
<td>Care pathways integrated into Federations functions</td>
</tr>
<tr>
<td></td>
<td>Budgets for community nursing, diagnostics and prescribing devolved to federations</td>
</tr>
</tbody>
</table>

This timeline resonates with the Five Year Forward View from NHS England, which clearly outlines the direction of travel for English general practice.

The developments of Federations of GP practices in Northern Ireland gives us an opportunity to lead the way in healthcare system change, creating greater efficiency and effectiveness, which will result in better services for patients.
Conclusion

It is clear that general practice in Northern Ireland is in crisis and this paper has outlined the key pressures.

It is suffering from an overload of work and a workforce crisis caused by early retirements and a systematic failure to train and recruit young doctors and retain existing GPs. In spite of the growing pressures on General Practice, the level of patient satisfaction remains high:

- 94% of people are satisfied with the care received at their GP surgery
- 75% of people describe the care they get out-of-hours as good
- 83% of people were able to see a GP or healthcare professional fairly quickly

Funding for general practice has suffered real cuts and funding levels for Northern Ireland are now the lowest in the UK. Whilst secondary care has been given funding increases general practice demand has increased dramatically with neither the funding nor the workforce available to meet or sustain this increase.

General practice is the backbone of the health service and its capacity to deliver will have major implications for the rest of the system particularly for emergency departments and admissions, and the ambulance service.

At least £33 million needs to be invested in general practice in order to increase the capacity in primary care.

The health service in Northern Ireland needs to pivot back towards a primary care-led service.

With £33 million investment, general practice could:

1. Employ additional staff
   - Extra practice nurses would be able to run asthma, diabetic and other chronic condition clinics
   - More nurse practitioners would be able to deal with many medical problems
   - An increase in clerical staff to deal with patients and their queries would allow them time to help patients, rather than act as a barrier
   - A range of staff such as counselors and physiotherapists in practice would allow more services to be provided
   - Employing pharmacists within practice would free up time for GPs

2. Employ extra GPs
   - This would lead to increased availability and better access
   - Specialisation could be promoted within practices, with GPs having time to look after chronic conditions
   - It could encourage GPs to carry out more minor surgery
   - More joint/rheumatology injections in practice could potentially be provided
   - Longer consultations would be feasible – 10 minutes is not sufficient to deal with patients with multiple complex conditions
   - There would be more time to care for ill patients in the community rather than in hospital (with the appropriate community support)
   - Safer practice would be promoted, with GPs having time to manage all the tests and hospital letters they receive

39 The GP Patient Survey in Northern Ireland 2010/11
3. Improve/extend premises
   – To accommodate more doctors, nurses and other staff
   – Allow an extended range of services to be delivered
   – To encourage TYC initiatives with community and voluntary sector
   – Allow hospital specialists to carry out clinics in GP premises close to patient’s home
     – especially if there is hospital rationalisation
   – Provide room for IT/project Echo consultations via the internet, subject to agreed governance

Many of these initiatives can be practice based but many will be more appropriately delivered if practices come together in informal groups or more formally in Federations.

General practice is ready to embrace the changes necessary to improve the services for patients.