BMA

Northern Ireland

Our plan to save general practice

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Our plan to save general practice

General practice in Northern Ireland is in crisis. Over 16 practices have handed their contracts back since January 2023 and those that remain are stretched. GP training is undersubscribed, meaning fewer GPs of the future. We are seeing an unsafe service in every area.

In this plan, we set out what needs to change to stabilise general practice in the short term, how we keep our service, our patients and our GPs safe, and what the future should look like with a modern, accessible, and well-resourced general practice system.

Indemnity

Northern Ireland remains the only UK country where GPs are required to bear very high personal costs for indemnity. England and Wales operate a state-backed scheme, whilst Scotland maintain personal indemnity at a much lower cost. This effectively acts as an additional tax on any GP working in Northern Ireland. It is unfair that in a crisis GPs must take on the majority of risk and all of the cost.

We need rapid action – either from a new Executive or, in their absence, the Permanent Secretary or the Secretary of State for Northern Ireland – **to provide an indemnity solution for all GPs in Northern Ireland through a state-backed scheme. In the short term, this should be provided through direct reimbursement of costs.** The lack of solution for indemnity is having a significant impact on retention of our GPs and on attracting GPs from elsewhere. Progress on this issue represents one of the most significant single actions that can be taken by government.

Multi-disciplinary teams

The rollout of multi-disciplinary teams (MDTs) began in 2018; however, it has largely stalled since then. **We need urgent progress on the rollout of funding for recruitment and premises necessary for this important development.** Establishing MDTs will broaden primary care teams, increase the repertoire of staff available to deal with problems at source and enable GPs to focus on the most urgent care whilst giving patients improved access to services they need without the involvement of a GP. They also help build a strong and sustainable foundation in primary care for the wider transformation agenda that is so critical to the entire health service. With partial rollout, government has created an unacceptable inequity in service that needs to be urgently addressed. **The original plan of 'narrow and deep' has failed; we need to move to a position where every practice is seeing the benefits of additional MDT staff and resource.**

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A new relationship with trusts

General practice has become the repository for work that should be done elsewhere and is the responsibility of others. A lot of this work is unfunded, time and labour intensive, creates significant patient safety and governance issues and is not part of the GMS contract. **To stabilise practices, we need to return this work to trusts who are responsible for it and focus on the work that only GPs can do.**

We can learn from elsewhere and create a plan suitable for Northern Ireland. The *Consensus on Primary and Secondary Care Interface*,[1] produced by NHS Cheshire and Merseyside, **should form the basis of this work** which would result in a local plan endorsed and enforced by the Department of Health and the SPPG, for implementation by LMCs and trusts.

Fixing funding now

We need more funding to shore up the services we are already providing and an increase in funding allocated to primary care as a proportion of the health budget. **The QOF freeze must continue, with a view to moving this funding into core practice funding in future years.** Government must remove any bureaucratic hurdles, box ticking and targets that are not clinically necessary and take GPs away from providing quality care.

Everyone values access to their GP very highly and the funding model must reflect this. **We need to refocus on straightforward and effective core activity, ensuring the continuity of care that remains the bedrock of general practice.**

This will require a unified contract, with the movement of QOF and other incentive funding mechanisms into core general practice funding. This will simplify and clarify the role and expectations of general practice, reduce bureaucracy and allow GPs to focus on patient care. **We also need to see an immediate uplift in the GMS statement of financial entitlements (SFE) which has not been adjusted since 2019.**

Premises

Individual liability for premises disincentivises potential GP partners. **We need trusts or the Department to take ownership of GP premises**. They should procure well-located, designed and resourced premises in the heart of communities and provide them for partnerships to use. This will allow us to focus on our work as clinicians.

We also need an agreed process for the review of service charges that creates a realistic cost model, including a service level agreement that is fit for purpose and clearly represents what is actually being delivered and charged for.

1 https://www.cheshireandmerseyside.nhs.uk/posts/consensus-on-the-primary-and-secondary-care-interface/

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Incentivising partnership

We know that the partnership model provides the best value for patients and the health system overall as well as providing the autonomy and sensitivity to local needs that GPs want. **We need to address the issues that stop GPs taking on partnerships by reducing bureaucracy, making greater use of federations for care and management at scale,** and through an improved GMS contract at the heart of a primary care service planned by the Department of Health to meet the health needs of the population of Northern Ireland. We also need to incentivise GP training, ensure full training uptake, and focus on how we can ensure those who train in Northern Ireland stay here to work as a qualified GP.

Working safely

Safety is paramount but it is being compromised in the current crisis. We are seeing a level of demand that can simply not be met by the current staffing and funding levels. We need to be able to work safely – for our own sakes and our patients. **We need to focus on those with the greatest need rather than try to address the entirety of demand.** Continuity of care, particularly for the most vulnerable and the elderly, is vital and we must discuss safe ways to limit access for others whilst we prioritise this.

This may mean extending the length of appointments and reducing overall contacts to a safe level. **We consider safe working to be no more than 25 per day,** which is widely evidenced in the rest of Europe. Remote consulting, improved triage, multi-disciplinary teams and other parts of the primary care system all have a part to play in enabling this.

It is completely unacceptable to ask GPs and our staff to continue to work in such unsafe circumstances. The Department of Health must take responsibility for this, or bear the responsibility for the consequences. **We will work with the Royal College of GPs to define safe working limits and will expect the Department to recognise and to endorse these.**

A vision for the future

General practice is and will remain the bedrock of the health service. It is the first point of contact for the vast majority of people seeking care and it is this experience which determines people's experiences of the health service as a whole. It is instrumental to patients' journeys through the health service, it absorbs and manages risk within the service. We are embedded in communities and have important roles in health promotion, education and prevention.

General practice will therefore always be best placed to be the first point of contact for anyone that is unwell or perceives themselves to be unwell. It is important for timely early assessment, reassurance where required, access to tests if needed, and onward referral when indicated. This reduces contacts, reduces risks and creates efficiency within the system.

The continuity of care and coordination that general practice offers patients must also remain a fundamental feature but these critical roles are at risk without adequate funding and staffing. **Therefore, the GP training numbers must be maintained, funded and increased.** The future transformation of the wider health service will rely on general practice, so it has to start there too.

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New primary care strategies can reduce waiting lists and significantly improve access, waiting times and accessible care. This will involve greater use of technology as well as moving more care closer to home. There are many examples of enhanced out of hospital care that can reduce A&E attendances, reduce admissions and facilitate early discharge. **These should be rolled out to all areas with trust staffing reconfigured to support primary care.**

Alongside a newly defined core GP offer, **the Department of Health must examine and GP federations must examine what primary care services can be delivered at scale, easing the pressure on practices.**

It is now up to the Department of Health and the SPPG to produce a clear timeline and action plan to address the issues raised here. Only then will we see general practice stabilised and able to move forward towards a safer and simplified model fit for the future.

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