




A GP federation
for 21st century patient care in
N. Ireland

7th March 2009
Dr Gerry Burns



Why - Local drivers

- Change apathy  overload
- PBL cover by BELDOC
- Bureaucratic and Administrative overkill
- E.g. 3 in 1 DES (COPD, asthma and obesity)
- Dysfunctional secondary care
- demographics
- Practice managers are re creating wheel

Changing landscapes -- Change from without

- Agenda for change
- RPA
- A 20 year Vision -- a healthier future
- Priorities for Action

- Skill mix
- Intermediate care ICATS
- Primary care Commissioning changes
- APMS private providers recent DES

5.2.1. The changing GP workforce in Northern Ireland²²

Composition

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

Gender

Between 1985 and 2006:

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

Age

In 2006

- 24% of GPs were aged 40 years and under
- 57% were aged 40-54
- 19% were aged 55 and above

List size and registrations

- The average GP list size has decreased by 14%, from 1,865 in 1985 to 1,631 in 2006

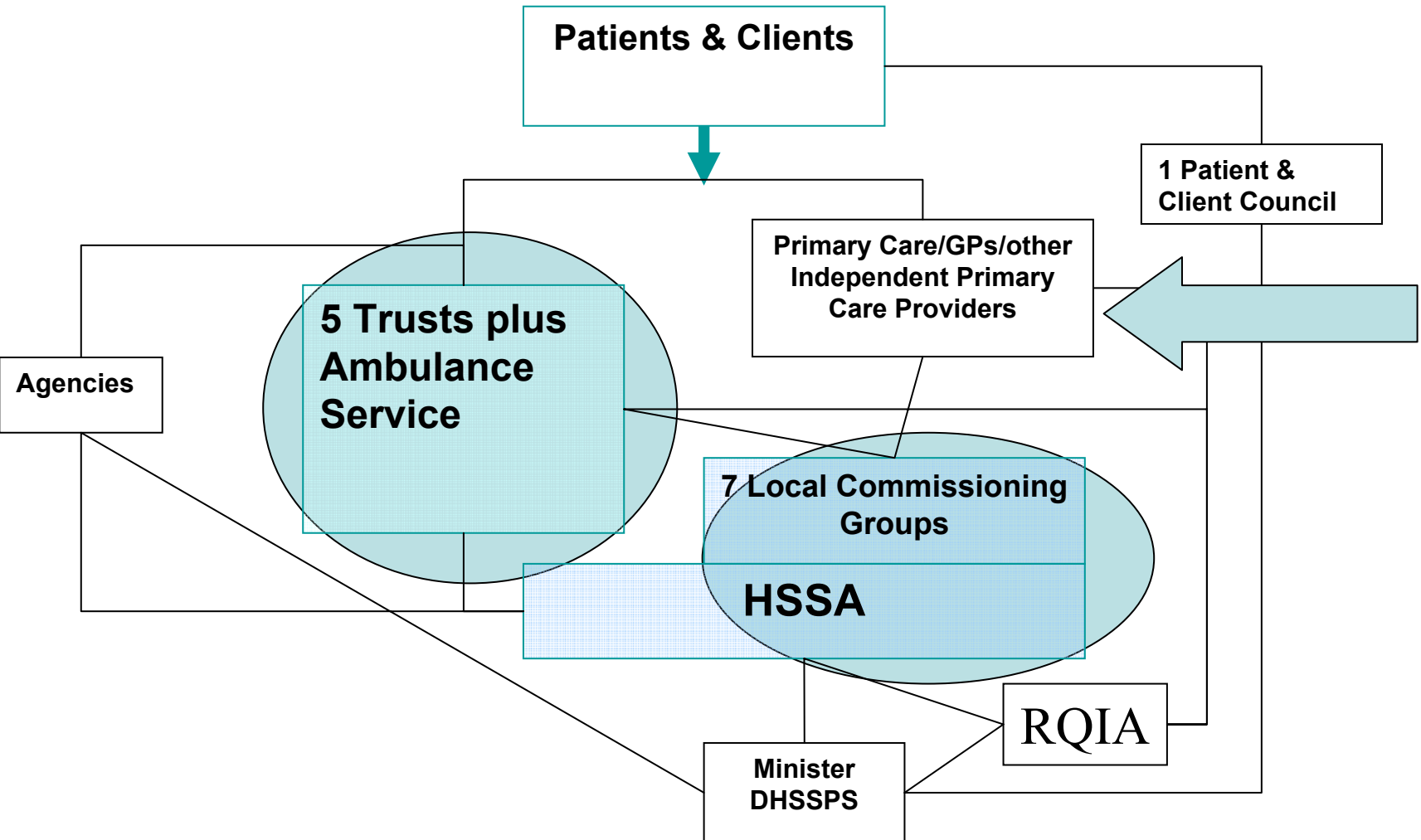
In October 2006

- Northern Ireland had 1,810,032 GP-registered patients, an increase of 1% since 2004
- The Board with the largest share of registered patients was the Eastern Board (39%), followed by the Northern Board (24%), the Southern Board (20%) and the Western Board (17%). These figures reflect the population structure of Northern Ireland
- 72% of the GP practices had fewer than 300 new registrations

Our route so far

- meetings in our locality
- Starting in Nov 2006
- Uniformity of agreement
- Model probably best works for smaller practices but not exclusively
- Process was subsumed by commissioning agenda with RPA LCG and CCA
- But this is
 - the provision of care &
 - organisation of practices

The New Structures





Department of
**Health, Social Services
and Public Safety**

An Roinn

**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

www.dhsspsni.gov.uk



a healthier
future



a healthier future

A Twenty Year Vision
for Health and Wellbeing
in Northern Ireland

2005 - 2025

Twenty year Vision

Big themes

- chronic disease prevalence is increasing
- Chronic disease care to be delivered in community
- Team based approach
- Doctors don't have to do everything so other HCP will provide more services to patients



Royal College of
General Practitioners

RCGP
SEP 2007

The Future Direction of General Practice

A roadmap

Royal College of General Practitioners
London | 2007



Executive summary

8 To achieve optimal care, the strategic and organisational development of general practice must be increased. This will include the development of collaborative groupings or federations of practices. GPs need to become more united as a professional group. In this way, it should be possible to improve access and provide an extended range of services. The practice and the primary healthcare team must remain the basic unit of care. This federated model of general practice, championed and led by GPs, is essential to counter the challenges of a 'market' approach in the NHS, a particular concern in England. A 'one size fits all' model is not recommended or possible. We recommend that local GPs and health economies should determine their own evolution. An organic approach to change is recommended, involving citizens in the dialogue.



9 We caution against the development of 'polyclinics' that focus purely on diseases and technical care but commend the value of co-location of services to reduce fragmentation of patient experience. Whatever models are adopted, the cardinal values of general practice such as interpersonal care and continuity based on care for defined populations and registered lists must prevail.

10 The implementation of better models of care will require strong clinical and professional leadership from GPs. We urge GPs to organise themselves locally into a force to be reckoned with. A progressive and dynamic approach is needed. Education and training will be fundamental to delivering change. Investment of resources will be necessary to support the new model of care including the development of premises and the underpinning workforce and training requirements.



11 The new MRCGP exam means that all new GPs will be eligible to become members of their standard-setting body on a voluntary basis. Having a single professional body for GPs provides opportunities for more strategic governance of the profession, more 'joined-up thinking' and improved long-term professional development.

12 We believe general practice should become a major contributor to preparing the future NHS workforce. Current constraints to this (such as inadequate premises) must be identified and rectified.

13 The future is exciting for general practice. GPs must adapt and grow to meet new challenges. There are many opportunities to work with patients to improve patient care and for GPs to develop enticing

Primary Care Federations

Putting patients first

A plan for primary care in the 21st century from the Royal College of General Practitioners



June 2008

Executive summary

In the NHS of the early 21st century it is increasingly clear that GPs, their staff and other primary care professionals all need to work together in ever closer alliances and networks.

A Primary Care Federation is an association of general practices and community primary care teams that come together to share responsibility for developing high quality, patient focussed services for their local community.



There could and should be a range of Federation structures from a relatively loose alliance to a highly managed model. Federations would be based on a collective legal entity such as a social enterprise, limited company or charity.

Federations would help ensure the continued viability of primary care – and the important personal link between the patient and the GP – in a period when small or single handed practices, operating in isolation, are finding it increasingly difficult to maintain the necessary levels of safety and clinical governance.

Primary Care Federations would also offer economies of scale that could lead to valuable efficiency gains that could be ploughed back into more services.

Federations would have high calibre management and could develop the collective delivery of certain “back office” functions such as finance and human resources.

With more GPs involved Federations would have the critical mass to ensure that different GPs could concentrate on different priorities. They would be able to develop more effective services for promoting health and preventing ill-health.

Federations would improve the range of primary care services by moving services from hospital settings and developing as many services as possible within the community including enhanced diagnostic services.

Primary Care Federations would offer advantages to GPs and their staff not least of which is the freedom to deliver a more professional and comprehensive service. But the greatest advantages are those that improve services for patients. These would include:

- Better access to GP services with opening hours that reflect the needs of the local community
- Different ways of accessing services with booked appointments and unscheduled, “walk in” clinics
- Services in reassuring GP settings rather than in hospitals or hi-tech health centres
- Strong patient involvement with patient representation on Federation boards
- Tailored services specifically designed to address very local needs
- A greater emphasis upon health promotion
- Continuity of care with patients able to choose between their own GP or another in the Federation

In coming together as Federations, GP practices would be expected to explain clearly how they proposed to work together and what values they shared. Typically a new Federation would need:

- A formal legal structure
- A management board (including patient representatives)
- An executive management team
- A written public constitution
- A public communication strategy
- A public engagement strategy

Primary Care Federations would be likely to publish an annual report and prospectus of services and would be likely to need a comprehensive website.



British Medical Association/Royal College of General Practitioners
bma.org.uk/northernireland

The future of General Practice in
Northern Ireland
Promoting general practice 2008 – 2018






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ACTION AREA	ACTIONS	TIMEFRAME	RESPONSIBILITY
Action Area 2 Improving organisation within the infrastructure of general practice			
Federations of practices  	<p>Develop Northern Ireland model of federations of practices - within appropriate geographic areas (nb within LCG/Trust areas), taking into account the needs of small, medium and large practices, and the sensitivities relating to becoming federated whilst remaining independent on key aspects of the business of General Practice.</p> <p>Develop effective communication/ management/ administration arrangements for federations of practices.</p>	<p>Develop model 2008- 2009</p> <p>Consult on model 2009</p> <p>Pilot model in 2010 onwards</p> <p>Monitor effectiveness of federations once implemented, against critical success factors included in the federated model, 2011 onwards</p>	<p>Lead organisation – RCGP (NI) , with support from BMA(NI)</p> <p>To develop model of federations of practices, outlining advantages/commitments, for consultation with GP practices in Northern Ireland.</p> <p>Ensure buy-in of practices to federated model through</p> <ul style="list-style-type: none"> - conference on federated practices - survey of practices - statements of commitment from practices 



Mission Statement

GPST

- **1. To develop a GP federation that is willing and capable to provide modern 21st century holistic health care to our patients**
- **2. To ensure high quality patient care by providing the correct working environment for GPs and their associated primary health care team staff.**
- **3. To protect the social capital of quality family practice, embedded within local communities**

Who



- From Holywood to Hillhead
- From Abbots Cross to Ardmore
- From Duncairn Gdns to Cherryvalley

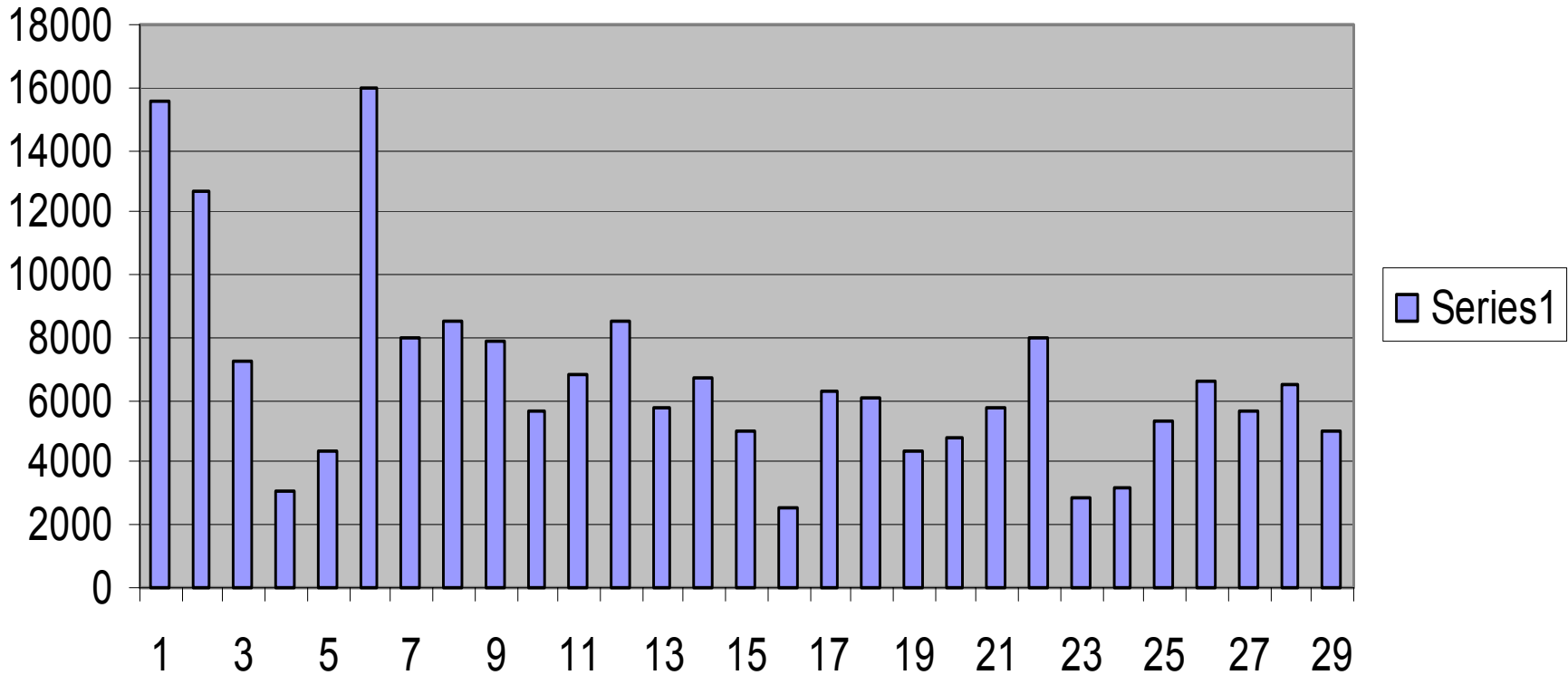
- Over 120 GPs
- over 200000 patients

- Average practice had 2.7 GPs and 4685 patients

Staff

- 41 practice managers
- 72 nurses
- 175 reception staff

average costs heirarchy



Smaller practices

Enhanced services

- All but one do minor surgery
- 2 practices do violent patients
- 4/5 done CBT
- 60% do English speaking
- A couple don't do pharmacy
- CVA few do this
- 4/5 do extended surgeries



- Newsletter
 - Web site
 - Phone
 - Building insurance
 - Office costs
-
- BMA NI
 - EHSSB DES learning disability

Collaborative services

- **Tier 1 Redirect what already do**
- Back office work/economies of scale
- Staff cross cover
- Enhanced services using Specialist nurse/GP/AHPs

- **Tier 2 at a later date**
- Need to move services from hospitals
- Need primary care commissioning
- diagnostics including X rays CT scanners DEXA USS
ECHO doppler lung function
- CDM e.g. mental health diabetes skins
- Physiotherapy AHPs
- Telemedicine CDM

Primary Care Federations - governance and structure

Practices, specialists and community teams that join together to form a Primary Care Federation will need a formal or legal structure in which to work. A number of options are available and Federations should be free to select the model that best matches their local needs. Form should follow function.

Structural options include:

- Formal commissioning consortia
- Social enterprise companies
- Charities
- Companies limited by guarantee ←
- Companies limited by shares
- Specialist personal medical services (SPMS) companies



Non profit making organisation
No dividends or shares

Collaborative working

- Clinical governance,
- prescribing issues,
- staffing issues,
- Health and safety,
- secondary care issues,
- practice organisational,
- teaching and training.

Collaborative services

- Enhanced services
- CDM
- Minor surgery
- CPD
- CPR

long term collaboration

- Practice nurses and staff cross cover
- Medical care assistants
- Intermediate care/diagnostics
- Extended surgery openings hours
- Travel medicine
- CDM care pathways
- Diabetic CDM care in community
- Pandemic flu collaboration

An interesting thought

Insanity is continuing to do the same things and expecting different results.

Albert Einstein