



Review of Governance Arrangements Relating to General Practitioner (GP) Services in Northern Ireland

June 2016

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The Review was undertaken by:



The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland. RQIA's reviews aim to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest. Our reviews are carried out by teams of independent assessors, who are either experienced practitioners or experts by experience. Our reports are submitted to the Minister for Health, Social Services and Public Safety, and are available on our website at www.rqia.org.uk.

RQIA is committed to conducting inspections and reviews and reporting on four key stakeholder outcomes:

- Is care safe?
- Is care effective?
- Is care compassionate?
- Are services well-led?

These stakeholder outcomes are aligned with Quality 2020¹, and define how RQIA intends to demonstrate its effectiveness and impact as a regulator.

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¹ Quality 2020 - A 10-Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland - <http://www.dhsspsni.gov.uk/quality2020.pdf>

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Executive Summary

For the majority of patients in Northern Ireland, general medical practice is the most common access point to healthcare. The GP provides ongoing care for a defined list of patients and acts as a gatekeeper providing onward referral to other areas of HSC, when necessary.

A new General Medical Services (GMS) contract came into force on 1 April 2004, which was designed to provide a range of improvements in patient care. The 2004 contract also introduced the Quality and Outcomes Framework (QOF), which was designed to deliver a structured, evidence based approach to chronic disease management. It remunerates practices dependent on their achievements, measured against a range of evidence-based clinical and organisational indicators, with points and payments awarded based on achievement level. Although voluntary, all practices in Northern Ireland participate.

On 1 April 2009, following the Review of Public Administration, the HSC Board was established and its Directorate of Integrated Care (DoIC) assumed responsibility for monitoring the GP contract and for assurance of the safety and quality of GP services.

On 4 November 2015, the Minister for Health Social Services and Public Safety made a statement regarding the role of commissioning in Northern Ireland which included an intention to close the HSC Board.

The review team considered that the processes established by the HSC Board, in relation to their assurance of safe and effective care were robust. Revalidation had been taken forward appropriately, appraisal systems continued to be effective and links with the Northern Ireland Medical and Dental Training Agency (NIMDTA) in terms of information sharing in relation to revalidation and safe and effective care had been strengthened.

Effective service user engagement was also discussed as part of the review. A Patient and Client Council (PCC) report on access to GP services was generally supportive of the availability of services but made a number of recommendations designed to improve access. The HSC Board has developed and is working through an action plan designed to comply with these recommendations.

The focus of Transforming Your Care (TYC), the blueprint for future HSC services in Northern Ireland, is to move the emphasis of treatment from the acute sector to services provided either in or at least close to people's homes. GPs are now arguing this has contributed to an increasing workload, without a concomitant increase in either manpower or resources. All GPs in focus groups noted the increase in workload. The review team considered that increasing workload, if not addressed, was potentially a safety issue for patients accessing primary care medical services.

Coupled with the increasing workload, the age profile of GPs in Northern Ireland shows that almost a quarter of GPs are aged 55 and over. Many of these practitioners may be planning to retire in the near future. The review team considered that GP manpower issues would potentially affect workload in terms of lack of availability of locums but this may also affect effectiveness of services due to lack of time to engage in quality improvement activity.

The review team however welcomed the announcement by the minister for health, regarding investment in GP training with £1.2million per year providing 20 additional GP training places. Equally welcome is the further investment to place up to 300 pharmacists in GP practices by 2021, to improve medicines optimisation for patients.

The review team considered that the systems and processes that the HSC Board has developed, in assuring the safety of primary care medical services were robust and as long as that continued there was no necessity to introduce a further layer of regulation. The team considered that there may be a role for RQIA in facilitation of quality improvement, perhaps in conjunction with the newly formed Improvement Network for Northern Ireland (INNI). This may lead to a more structured approach to quality improvement in primary care, similar to the Scottish Patient Safety Programme.

The review team considered that in terms of primary care medical services it was important that whatever structures were put in place, robust governance and assurance structures for this area must be maintained. If they are not maintained some further form of assurance should be developed. This further assurance, if necessary, should be a collective development involving input from RQIA, as the systems regulator in Northern Ireland.

The report makes 9 recommendations to support continued assurance in primary care medical services.

Chapter 1: Introduction and Context

1.1 Introduction

For the majority of patients in Northern Ireland, general medical practice is the most common access point to healthcare. The GP provides ongoing care for a defined list of patients and acts as a gatekeeper, providing onward referral to other areas of health and social care, when necessary.

A GP should among other things:

- Care for their patients in a holistic way and in the context of their work, family and community circumstances.
- Care for all ages and sexes across all disease categories.
- Care for patients over a period of their lifetime.
- Provide advice and education on healthcare.
- Perform legal processes such as certification of documents and where necessary provide reports.

There are 349 general medical practices in Northern Ireland, containing 1,171 GP partners in practice; 55% are men and 45% are women. The average Northern Ireland list size is 1,641 patients per GP, which is the highest in the United Kingdom².

In 2013-14, the budget for GMS was approximately £241 million³. GMS spend in Northern Ireland is 6% of the total health spend. The United Kingdom average spend on GMS is 8%⁴.

A new GMS contract came into force on 1 April 2004⁵, which was designed to provide a range of improvements in patient care including:

- improved access
- higher standards of record keeping
- better management of chronic disease
- provision of a range of nationally agreed enhanced services with the ability to develop locally enhanced services in response to need

The 2004 contract also introduced the QOF, which was designed to deliver a structured, evidence based approach to chronic disease management. It remunerates practices dependent on their achievements, measured against a range of evidence-based clinical and organisational indicators, with points and payments awarded based on achievement level. Although voluntary, all practices in Northern Ireland participate.

² bma.org.uk/.../nigpc_gms_strategy_caseforchange.pdf

³ bma.org.uk/.../nigpc_gms_strategy_caseforchange.pdf

⁴ Based on Public Expenditure Statistical Analysis (PESA) 2014

⁵ http://www.dhsspsni.gov.uk/index/hss/gp_contracts.htm

In 2004, when the contract was introduced, although GPs are classed as independent contractors, the then HSC Boards provided a contract management function, with regard to service commissioning and assurance of safety and quality of services.

On 1 April 2009, following the Review of Public Administration, the HSC Board was established and its DoIC assumed responsibility for monitoring the GP contract and for providing assurance of the safety and quality of GP services.

On 1 April 2004, alongside the adoption of a new contract, a Primary Medical Services Performers List (PMPL) was introduced into Northern Ireland by legislation⁶. The legislation states that a doctor is required to be listed as a primary medical services performer, in order to perform any primary medical service which a board is under duty to provide or secure provision of. The HSC Board is responsible for the admission of doctors to the PMPL and for their removal from the list, subject to strictly defined criteria, set out in the regulations.

1.2 Context for the Review

Revalidation

On 16 November 2009, the General Medical Council (GMC) introduced arrangements through which every doctor wishing to remain in active practice, in the United Kingdom, is required to hold a licence to practise, by undergoing a process of revalidation.

Revalidation is based on existing clinical governance systems and involves each doctor collecting a portfolio of evidence over a five year cycle, to comply with standards set out by the GMC. In June 2010, legislation enacted by the Northern Ireland Assembly required each body designated by the legislation to appoint a Responsible Officer (RO)⁷. The RO would be responsible for ensuring that effective clinical governance arrangements were in place and for making revalidation recommendations to the GMC, concerning doctors linked to their organisation.

One of the main components of revalidation for GPs is a system of appraisal, with which all doctors on the PMPL have to engage. The HSC Board has contracted with the NIMDTA, for the delivery of medical appraisal for all GPs on the PMPL. In 2008, RQIA carried out a review of appraisal arrangements provided by NIMDTA for primary care and concluded that processes were well established, with effective leadership.

⁶ The Health and Personal Social Services (Primary Medical Services Performers Lists) Regulations (Northern Ireland) 2004.

⁷http://www.legislation.gov.uk/nidsr/2010/9780337981302/pdfs/nidsr_9780337981302_en.pdf

In December 2011, RQIA carried out a Review of Readiness for Revalidation in Primary Care in Northern Ireland and concluded that primary care in Northern Ireland was in a good position to begin revalidation⁸.

This further Review of Primary Care Arrangements would provide assurance that the HSC Board processes in place to support revalidation and also to assure the safety and effectiveness of primary care medical services, continue to be robust.

The review also needs to be set in the context of a number of other factors.

Increasing Workload

Population projections⁹ indicate that there will be a large increase in the number of older people in Northern Ireland. Numbers of those aged 65 and over are projected to increase by a quarter in the 10 year period 2012-22. The group aged 85 and over is projected to rise by almost 50%. An increase in the proportion of elderly people will mean that there is likely to be a rise in the prevalence of long term conditions, such as diabetes, respiratory problems and stroke. This will impact on all areas of HSC including primary care. In terms of workforce in place to deal with the increasing workload, the British Medical Association (BMA) strategy document *General Practice in Northern Ireland: the case for change* includes figures that indicate that the number of GP Partners per 100,000 of the population (61) is lower than anywhere else in the United Kingdom (UK)¹⁰.

Transforming Your Care¹¹

In June 2011, the then Minister For Health, Mr Edwin Poots MLA, announced that a review of the provision of HSC services in Northern Ireland would be undertaken. The report was published in December 2011 and was designed to provide the blueprint for the future provision of health and social care in Northern Ireland.

A future model for integrated care was described in which:

- Most services would be provided locally and local services would be better joined up with hospital services.
- Services would regard the home as the hub and be enabled to ensure people can be cared for at home, including at the end of life.
- Where specialist hospital care is required, patients should be discharged into the care of local services as soon as their health care needs permit.

⁸http://www.rqia.org.uk/cms_resources/RQIA%20Review%20of%20Revalidation%20in%20Primary%20Care%20in%20NI%2015%20Dec%2011.pdf

⁹ www.nisra.gov.uk/demography/default.asp20htm

¹⁰ bma.org.uk/.../nigpc_gms_strategy_caseforchange.pdf

¹¹ <http://www.dhsspsni.gov.uk/transforming-your-care-review-of-hsc-ni-final-report.pdf>

- A changing role for general practice with practices working together as federations of practices with integrated care partnerships set up to deliver a full range of health and social care.
- Shifting resources from hospitals to enable investment in community health and social care services.

One of the main elements arising from the review was the focus on maintaining care as close as possible to people's homes, with an increasing role for GPs. This has the potential to provide further pressure on a workforce that already sees itself as having an increasing workload.

Role of the Regulator in other parts of the United Kingdom

Scotland – Healthcare Improvement Scotland (HIS)

Historically, HIS has focused its activities in secondary care. However in its new 6-year strategy "Driving Improvement in Healthcare"¹² it sets out an intention to improve the quality of care provided in primary care, including general medical practice.

A joint project between HIS and the Royal College of General Practitioners (RCGP) in Scotland was established, to develop a quality framework for general practice. A short life working group was established which:

- Mapped existing quality and safety activities in general practice.
- Considered what quality would be in the National Health Service (NHS) in Scotland in the near future.
- Identified gaps or omissions.
- Determined opportunities for further development.

The result was a Quality Framework for General Practice in Scotland¹³ which is designed to:

- Empower general practice teams to improve quality and safety in response to the needs of their patients and practice.
- Identify roles and responsibilities of organisations and individuals in developing tools and activities.
- Reflect current developments in general practice in the NHS in Scotland.

However, the development of a quality framework is recognised by both HIS and RCGP as being only the first step. Further work is required, which will include development of standards and a self-evaluation tool for practices, as well as providing support for practices to help to improve quality of care.

¹² <http://www.bing.com/search?q=driving+improvement+in+healthcare+HIS&src=IE-TopResult&FORM=IE10TR&adlt=strict>

¹³ http://www.healthcareimprovementscotland.org/our_work/primary_care/programme_resources/gp_quality_framework.aspx

England – Care Quality Commission (CQC)

CQC has developed a system of monitoring and inspecting of GP practices in England. A system of “intelligent monitoring¹⁴” has been developed in order to plan inspection activity and to help inspection teams to ask informed questions, about the quality of care provided by practices. The system draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including:

- Quality and Outcomes Framework
- GP Patient Survey
- NHS Business Services Authority
- Hospital episode statistics
- Information Centre Indicator Portal
- NHS Comparators

CQC reports that their intelligent monitoring system is one of the lines of inquiry, which then helps to determine a rolling programme of inspections of GP practices. CQC inspection teams include CQC inspection staff, GPs, practice managers, practice nurses and experts by experience. The inspection methodology includes examination of policies and procedures and interviews with staff and patients. All inspection reports are published on the CQC website.

Wales – Health Inspectorate Wales (HIW)

In October 2012, the Welsh Government published “Learning for the Future- Taking forward and building on recommendations from the Robert Powell investigation¹⁵”. One of the nine actions contained in the document was that HIW should undertake a rolling programme of reviews, to test the effectiveness of governance arrangements within local health boards, for assuring the quality of primary care.

The initial programme of reviews has been completed and has informed the development of an inspection programme of GP practices in Wales. During 2014-15 a pilot inspection programme was carried out which has allowed HIW to:

- Test how standards for health services in Wales are being met.
- Identify a number of areas where significant improvements have been made.
- Identify areas for GP practices to make improvements.

In the future, HIW plans to continue its inspection activity in general practice.

¹⁴ <http://www.cqc.org.uk/content/intelligent-monitoring-gp-practices-data-update>

¹⁵ <http://gov.wales/docs/dhss/publications/121009rpactionplanen.pdf>

Access to GP Services

In May 2014, the PCC published a report entitled Access to GP Services¹⁶. The aim of the study was to gather the experiences of people in relation to accessing GP services, with a specific focus on their journey through the practice setting, from initially contacting the GP practice, making an appointment, through to seeing their GP or another appropriate healthcare professional.

The study also sought to measure overall satisfaction with access to GP services and identify areas for improvement.

The majority of respondents, (73.5%) said that overall they were satisfied with access to their GP service. However, respondents aged 65 and over and those who were retired were most satisfied, in comparison with 25-64 year olds and those in full time employment.

In relation to contacting their practice, respondents reported difficulties which included phone lines being engaged, waiting on hold for long periods of time, the practice setting a very limited time slot each morning to take calls and the use of premium rate numbers.

Most respondents were aware of the opening hours of their GP and the majority of people (73.7%) were happy with the hours that their GP practice operates. However, those in employment and full time education were less happy with opening hours.

PCC in its conclusions noted that access to GP services is multi-dimensional and the priorities that people place on varying aspects of access, are different, but that access to GP services should be effective and flexible and based on the needs of all patients.

Complaints

The PCC Annual Complaints Report (2014-15)¹⁷ highlighted that a total of 2,308 people contacted their complaints support service in 2014-15. 1,196 wanted advice, information and/or signposting, while 1,112 wanted specific help or advocacy in relation to a complaints case.

The areas of care raised by people supported by PCC through their complaints support service were:

- hospital inpatient (26.6%)
- trust community service (16.4%)
- GP services (16.1%)
- hospital outpatient (15%)

¹⁶ http://www.patientclientcouncil.hscni.net/publications/index/reports#pub_access-to-gp-services-full-report.-may-2014

¹⁷ http://www.patientclientcouncil.hscni.net/uploads/research/PCC_Annual_Complaints_Report_2014-2015_-_July_2015.pdf

- hospital emergency department (7.9%)
- other (17.9%)

The most common themes in relation to GP services were:

- Treatment and care including inappropriate treatment, misdiagnosis, medication errors and quality of care.
- Communication, including poor information provided for patients and lack of engagement with both patients and families.
- Staff attitude including being dismissive, uncaring and lacking in compassion.
- Waiting times including delays in getting through to GP services.

It was decided that, as PCC had already carried out a review of access to GP services this, along with complaints data and assessment of HSC Board processes for assuring service user involvement, would be used as the service user component of the review.

GP Federations

The term GP Federation refers to a model, whereby groups of individual practices work in partnership with each other, to share expertise and resources, with the aim of providing better patient care.

The argument put forward is that within the changing picture of complex care options and increasing need, the traditional model of care will not be adequate and practices will have to merge and evolve into larger collaborative structures, in order to survive and be effective.

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

The BMA highlighted in a recent publication 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 manage and administer (subject to additional funding):

- increasing the range and type of services in the community
- improving access to diagnostics
- providing extended hours
- supporting GP out of hours services

This should 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.

The BMA also shared their views that local Federations of GP practices will develop over the next three to five years into Multi Professional Community Providers (MCPs), similar to the model outlined in NHS England's "Five Year Forward View"¹⁸. Each Federation will comprise around 20 general practices, delivering services to approximately 100,000 patients.

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.

Consultation

Potential reviews for inclusion in the RQIA three year review programme are sourced through a period of consultation with stakeholders, including members of the general public. During consultation for the 2015-18 programme¹⁹, there were a number of suggestions from members of the public that GP practice was an area that should be included. RQIA is therefore carrying out a review examining the current governance processes in place in the HSC Board, to provide assurance that care provided in general practices in Northern Ireland is safe, effective and compassionate.

Ministerial Statement

On 4 November 2015, the Minister for Health Social Services and Public Safety made the following statement regarding the role of commissioning and specifically the role of the HSC Board in Northern Ireland.

"From conversations I have had with clinicians it is clear that many feel that our commissioning system doesn't work, they don't understand it and, worst of all, it actually inhibits innovation. Our commissioning system isn't as effective as we need it to be. Whether this is because of shortcomings in the model or in its implementation is immaterial."

"We have too many layers in our system. I want to see the Department take firmer, strategic control of our Health and Social Care system, with our trusts responsible for the planning of care in their areas and the operational independence to deliver it."

¹⁸ NHS England (2014) *Five Year Forward View*

¹⁹http://www.rqia.org.uk/publications/corporate_strategy_and_three_year_review_programme_consultation_2015___18.cfm

“What I am signalling is an end to the current way we commission healthcare in Northern Ireland. It has not worked and arguably is never going to work well in a small region like ours. I propose that we close down the Health and Social Care Board. This is about structures, not people. The Board has many talented people working within it, doing many important things to a very high standard. But the administrative structures created during the last Assembly term do not serve us well especially as they blur the lines of accountability and weaken authority.”

“I will retain a Public Health Agency that renews its focus on early intervention and prevention. I will ensure a much greater focus within the Department on the financial and performance management of the trusts, through the creation of a specific directorate within the Department.”²⁰

The structural changes outlined by the minister would be subject to a period of public consultation; however if they proceed as outlined it would have major implications for the HSC Board structures that formed the focus for this review.

1.3 Terms of Reference

The Terms of Reference of the Review:

1. To assess the current governance arrangements and processes in place, to assure that services delivered by GPs in Northern Ireland are safe, effective and compassionate.
2. To examine the emerging issues in general practice that may impact on the safety and effectiveness of services.
3. To consider the role of the regulator in other areas of the United Kingdom and to assess any future role for RQIA in quality improvement within GP services.
4. To report on the findings, identify areas of good practice and, where appropriate, make recommendations for improvement.

1.4 Methodology

The review methodology was designed to gather information about current governance processes and quality improvement arrangements in place, to assure that services delivered by GPs in Northern Ireland are safe, effective and compassionate. The review did not directly include the views and experiences from service users or carers; however the PCC report Access to GP Services and information provided by the PCC annual complaints report, were taken into consideration when planning and carrying out the review.

²⁰ www.dhsspsni.gov.uk/statement041115

The methodology was as follows:

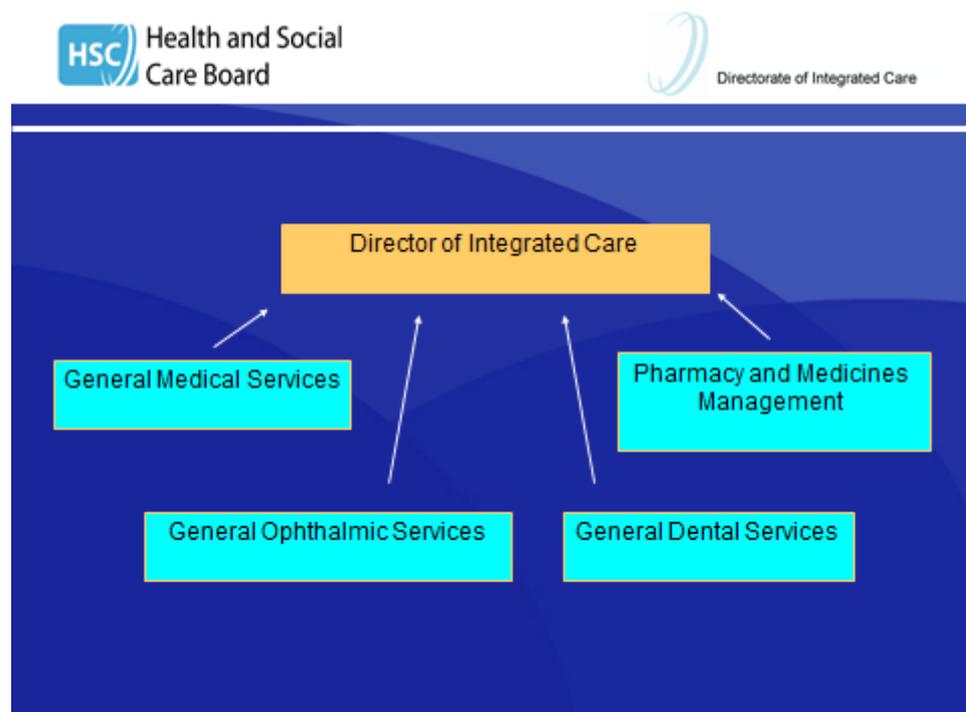
1. Literature search/review to determine relevant areas in relation to the provision of GP services within Northern Ireland.
2. Discussions with the RCGP.
3. Discussions with the HSC Board.
4. Self-assessment Questionnaire completed and returned by the HSC Board.
5. Focus groups with GPs through engagement with the 17 ICPs.
6. Interview with HSC Board staff.
7. Publication of an overview report of the findings of the review.

Chapter 2: Findings

Findings from the review are presented in four sections:

- 2.1 - HSC Board Family Practitioner Services (FPS) Management Structure
- 2.2 - Safety
- 2.3 - Effectiveness
- 2.4 - Service User Experience

2.1 HSC Board Family Practitioner Services Management Structure



Family Practitioner Services (FPS) are part of the directorate of integrated care. An assistant director with responsibility for commissioning of general medical services, reports to a Director of Integrated Care. The assistant director is supported by a number of medical advisors and business support teams, which are located in five local offices – Belfast, South Eastern, Northern, Southern and Western. Each local office is led by a business support manager with input from assistant business support officers and administrative support staff.

The HSC Board general medical services team, monitors compliance with the terms of the general medical services contract, which is entered into between the HSC Board and each of the 349 medical practices in Northern Ireland. The contract defines essential (core) services as:

- The diagnosis treatment and prevention of medical conditions.
- The provision of a first point of contact for patients who are ill or believe themselves to be ill with an acute, chronic or terminal illness.

The HSC Board is also responsible for the management of the PMPL. The Assistant Director performs the role of the RO and ensures the provision of appraisal and the management of conduct and performance of doctors, for whom the HSC Board is the designated body, in relation to revalidation. Only doctors on the Northern Ireland PMPL may practice as a GP, which ensures that a range of other checks such as GMC registration and Access NI checks take place.

Local Commissioning Groups (LCGs) are committees of the HSC Board. They are responsible for assessing health and social care needs of local populations and then commissioning services at a local level to meet these needs. General Medical Services Business Support Teams assist LCGs to develop and deliver enhanced service specifications, through GP practices, for their local areas.

ICPs assess and reform care pathways, making proposals for change or new services, which the LCG considers and then commissions from the appropriate provider/s. ICP support teams work closely with HSC Board general medical services staff in taking forward proposals which impact on GP practice.

The Directorate of Integrated Care has responsibility for the management of ICPs. A project director and five clinical and business support teams provide support to 17 ICP committees.

2.2 Safety

Contractual and Statutory Requirements

There are contractual and statutory requirements for general practice and the review team was informed that all practices must provide annual assurance to the HSC Board of their compliance. The majority of these requirements relate to safety and can be grouped under the following headings:

- communication
- complaints
- governance
- child protection
- consent
- infection control

- professional regulation and insurance
- appraisal
- data protection
- medicines issues specifically vaccination

A more detailed summary of contractual and statutory requirements for general practice can be found at appendix 1.

Clinical Governance

The GMS contract requires medical practices to have an effective system of clinical governance and to nominate a governance lead for the practice. Each practice has to submit an annual return to the HSC Board which includes the following documentation:

- A practice governance record describing clinical governance work undertaken in the previous QOF year.
- A practice governance declaration signed by the clinical governance lead.

The following areas must be covered:

- evidence based practice
- audit
- patient involvement
- education and training
- practice systems
- risk

HSC Board medical advisors carry out a rolling programme of visits to medical practices, with each practice receiving at least one visit in a three year cycle. As part of each visit, a selection of governance activities is discussed and assessed, examples of which are:

- clinical records
- prescribing data
- life support training
- appointment times and availability
- appropriate antenatal care
- child development checks
- cervical screening offered according to current agreed local guidelines

All GP focus groups were supportive of the role of HSC Board medical advisors. They welcomed governance visits as they encouraged clinical governance and audit to be meaningful processes, instead of declining into an exercise designed to tick boxes. In their experience, they found that discussion of QOF data, prescribing data and patient experience data were essential elements in assurance of safe and effective care.

Dealing with underperformance

The HSC Board has developed a procedure for dealing with underperformance, in all areas of family practitioner services, including medical GPs. It covers all GPs including sessional and locum doctors. Two groups manage concerns regarding practitioners, a Regional Professional Panel and a Reference Committee.

Membership of the Regional Professional Panel includes:

- representatives of the RCGP
- representatives of the Northern Ireland General Practice Committee of the BMA
- Director of Medical Education of NIMDTA
- PCC
- user representatives from LCGs

It functions as an advisory committee, to assess the seriousness of concerns about practitioners, provide advice on investigation process, follow up on onward referrals to professional bodies or the Police Service of Northern Ireland (PSNI) and report on its conclusions and make recommendations.

The Reference Committee is an executive decision making body, making formal decisions on disciplinary matters. When considering a serious concern raised against a GP, the options of the reference committee are:

- take no action
- referral to the GMC
- referral to an HSC Tribunal
- referral to the police
- request HSC Board officers to take and complete further investigation/action

Depending on the seriousness of concerns, consideration may be given to the need for the HSC Board chief executive to immediately suspend a practitioner from the PMPL. An annual report is produced on the activity of the Regional Professional Panel. The 2014-15 report included five new medical cases and at 31 March 2015 there were 12 active medical cases. The nature of concerns included:

- clinical difficulties
- governance/safety issues
- misconduct
- health problems
- work environment issues
- personal circumstances other than ill health

The review team discussed with HSC Board staff as to how the training needs of GPs undergoing a remediation process would be met and who would be responsible for supporting them through the process. The HSC Board team indicated that it was not their responsibility and it was not clear if it fell within the remit of NIMDTA.

The review team considered that a robust process was in place to deal with underperforming GPs, but that the area around training needs of GPs undergoing a remediation process needed further discussion and policy guidance.

Recommendation 1	
DHSSPS should provide clarity around responsibilities for meeting the training needs of GPs undergoing a remediation process.	

Adverse Incident Reporting

The HSC Board team reported that all adverse incidents occurring in general practice should be reported to their local HSC Board office. Determination of the need for further classification as a serious adverse incident (SAI) is undertaken by a senior HSC Board officer and/or medical advisor, as part of the regional SAI process. Since 2012, all incidents have been recorded on a regional multi user Access Database which the HSC Board reported as facilitating access to information and also allowing identification of trends across all practices in Northern Ireland.

In January 2013, the recording and management of Community Pharmacy incidents was transferred to the HSC wide Datix system. It is anticipated that all general practice incident reporting will transfer to Datix. If linked to a web based portal, incidents could be logged directly onto the system that would also potentially encourage more robust incident reporting.

The HSC Board team was aware of the importance to patient safety of wide dissemination of learning from SAIs, in order to reduce the risk of recurrence. The review team was informed of a number of different mechanisms to share learning in a timely manner:

- learning letters
- newsletters
- development of audits, guidelines and resources
- practice based learning days and other training events organised by the HSC Board
- learning from adverse incidents may be discussed in individual practices by medical advisors during practice visits

The HSC Board team considered that in light of a GP's position as an independent contractor and also because of the differences related to the smaller size of practices, a specific process could, in future, be developed to consider SAIs in GP practices. They reported that they have found the SAI process to be incredibly bureaucratic. The review team considered that a more focused system for primary care would be a positive step. The need for a robust process for dealing with incidents is well established, however, one process does not necessarily cover all aspects of care. One of the most important aspects of any system that deals with incidents is identification and dissemination of learning. A more streamlined process would refocus on sharing learning from SAIs and allow for learning to be passed on to practices in a timelier manner.

The practice governance declaration also gives an assurance that alert letters have been received and properly dealt with.

In 2013-14, 167 incidents were recorded on the directorate adverse incident database between 1 April 2013 and 31 March 2014, of which 151 related to general medical services.

GMS incidents were categorised as follows:

- medication incidents (e.g. prescribing errors, drug specific issues) - 47%
- patient issues (e.g. records/identification issues) -19%
- interface incidents between primary and secondary care -13%
- premises/equipment issues -13%

The review team considered that the HSC Board should continue to encourage and support adverse incident reporting as sharing of learning from incidents is an important process and forms part of a robust patient safety culture.

Recommendation 2	
Any further review of the Northern Ireland SAI system should consider a more streamlined process for SAIs involving primary care. In the interim, the HSC Board should work to measurably improve the reporting of adverse incidents in primary care in support of learning and safer practice.	

Complaints

The review team was informed that the HSC Board considers complaints handling to be an important aspect of governance, which may improve quality of care and service user experience. Complaints relating to general practices are managed and reported in line with the overall HSC Board complaints procedures.

The Directorate of Integrated Care receives a quarterly complaints report for FPS from the HSC Board Corporate Service Directorate. Any complaints relating to clinical care in general medical practices require a Medical Advisor opinion and are followed up as appropriate. The complaints process has been the subject of a recent internal audit, resulting in a minor priority three recommendation. Local offices analyse complaints about their local practices and ensure that complaints are built into performance management processes, including discussion at practice visits.

Practices are no longer formally required, as part of QOF, to submit an annual complaints review to the HSC Board; however, as it is considered to be an important governance tool, complaints reviews should be available at practice visits. Analysis of complaints and learning arising from complaints is built into HSC Board training events. Operation by individual practices of a meaningful complaints system is also checked by HSC Board medical advisors.

In 2013-14, 247 complaints were made against general practices. The issues causing the highest number of complaints in general medical services were:

- treatment and care – 138 (56%)
- communication – oral and written – 43 (17%)
- staff attitude and behaviour – 23 (9%)

The Directorate of Integrated Care is represented on the HSC Board Regional Complaints Group, which gives them an opportunity to contribute to the wider complaints process and to ensure inclusion of specifically primary care issues.

The HSC Board has an agreed process with the GMC, to pass on complaints they receive about doctors, which, where appropriate, are then dealt with through the Regional Professional Panel.

Medicines Optimisation

The quality, safety and cost of prescribing in primary care medical practices have been managed primarily by an HSC Board team of pharmacy advisors. COMPASS is a prescribing information system designed to provide GPs with data relating to their prescribing patterns. This data, along with other data such as adherence to the Northern Ireland Formulary, are used by medicines management advisors to influence both the effectiveness and cost effectiveness of primary care prescribing. Pharmacy advisors work closely with HSC Board Medical Advisors to assure the quality and safety of prescribing in GP practices.

On 29 July 2015, RQIA carried out a review of Medicines Optimisation in Primary Care²¹. The report made 16 recommendations to improve medicines optimisation processes in primary care.

²¹http://www.rqia.org.uk/cms_resources/RQIA%20Medicines%20Optimisation%20in%20Primary%20Care%20Review%20July%202015.pdf

HSC Board staff reported that an action plan had been developed in order to comply with recommendations contained in the report.

In addition, further investment has been announced which will place up to 300 pharmacists in GP practices by 2021, to improve medicines optimisation for patients²².

Other Patient Safety Factors

The review team discussed with HSC Board staff other factors that may influence the safety of care provided in general practice.

Workforce Issues

The review team was told that each year 65 whole time equivalents (WTE) training places are provided in Northern Ireland through the NIMDTA. The HSC Board considers that according to workforce planning data, that provision falls significantly below the number of GP training places that would be equivalent to existing GP provision in England. Due to a planned increase in England, this gap would increase further.

In January 2016, the Minister for health announced the biggest investment in GP training for over 10 years, with £1.2million per year providing 20 additional GP training places²³. This will bring the training places provided in Northern Ireland through NIMDTA to 85.

The recently published GP-Led Care Working Group report notes that Northern Ireland is broadly in-line with most other United Kingdom countries in terms of GPs per head of population²⁴. However, data indicates that the GP workforce in Northern Ireland is older in profile than anywhere else in the United Kingdom. High retirement rates are likely to have a significant impact in Northern Ireland.

HSC Board staff considered that the apparent shortage of GPs has had a considerable impact on delivery of general medical services, notably on filling of shifts and achievement of key performance indicators by out of hours providers (not a focus for this review), but also on daytime medical practice, due to the low level of availability of sessional doctors to provide locum sessions in practices. They further considered that in the absence of a long term plan to increase GP numbers working in practice, there is a considerable risk to ongoing continuity of general medical services provision to patients, especially in smaller practices in more isolated locations.

²² <https://www.dhsspsni.gov.uk/news/minister-announces-investment-put-pharmacists-gp-practices>

²³ <https://www.dhsspsni.gov.uk/news/hamilton-announces-biggest-investment-general-practice-training-over-10-years>

²⁴ <https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/review-gp-led-primary-care-services.pdf>

The shortage of GP partners in Northern Ireland has been highlighted as a risk on the HSC Board corporate risk register, under the category of Safe, Quality Services and Service Delivery.

The review team was informed that a working group to review GP led services, the remit of which included workforce issues has recently produced its final report²⁵. The review team particularly welcomed this report as the informed opinion of HSC Board staff and a robust service user input were included in its methodology.

Workforce issues were also highlighted in every GP focus group. Lack of locum cover was a recurring theme, coupled with the fact that new GPs do not want to become partners in a practice; they prefer posts that provide more flexibility and less responsibility.

Recommendations from any review of workforce take time to bring about any meaningful change. In the interim, the review team considered that it was important that skill mix within medical practices is used to its full potential to ensure the best outcome for patients.

Recommendation 3	
While awaiting actions arising from the workforce review, the HSC Board should encourage and develop wider skill mix options in primary care to offer continuity to care and to ensure the best outcomes for patients.	

Increasing Workload in GP Practices

Northern Ireland has a population of approximately 1.8m people. The number of people over 75 years is predicted to increase by 40% by 2020. The population over 85 in Northern Ireland will increase by 58% by 2020 over the 2009 figure.²⁶

The fact that Northern Ireland has the fastest growing population in the United Kingdom, with an increasing proportion of older people, means that the number of people with comorbidities is likely to increase. This has led to an increasing need for more complicated medication regimes and a subsequent increasing demand on GP services.

During focus groups with GPs, increasing workload was one of the main topics that arose in every focus group. Practitioners noted the following issues:

²⁵ <https://www.dhsspsni.gov.uk/publications/review-gp-led-primary-care-services-northern-ireland-recommendations-working-group>

²⁶ <http://www.dhsspsni.gov.uk/transforming-your-care-review-of-hsc-ni-final-report.pdf>

- an increase in direct patient contacts
- increasing requests for laboratory tests from secondary care
- increase in the numbers of new patients in each practice
- increase in administration duties
- increased and more complicated prescribing

Some GPs felt that TYC had led to primary care becoming a “dumping ground” and that some of the investigations now being requested and then interpreted, were not suitable for primary care practitioners.

The issue of ten minute appointments was also raised and GPs considered this to be a completely inadequate time in which to carry out a detailed patient investigation, especially in those cases which required analysis of a number of complex comorbidities and complicated special investigations.

Recommendation 4	
The delivery plan for Transforming Your Care should ensure that the shift of emphasis from secondary care to primary care is properly resourced and does not result in excessive workloads for general medical service staff.	

2.3 Effectiveness

Appraisals and Revalidation

The Assistant Director with responsibility for GMS is the RO for all GPs in Northern Ireland. They have responsibility for making recommendations to the GMC as to the revalidation of GPs in Northern Ireland. The GMC has developed a framework and guidance on which revalidation recommendations may be made, which also includes circumstances in which revalidation may not be recommended. This guidance has been implemented locally by the RO.

GP appraisal is one of the main processes supporting revalidation in primary care medical services and the HSC Board has contracted with NIMDTA to develop and manage the GP appraisal process in Northern Ireland. In December 2011, RQIA published its report – Review of Readiness for Revalidation in Primary Care. The report concluded that primary care in Northern Ireland is in a good position to begin revalidation. The HSC Board and NIMDTA have strong leadership in place, with staff committed to ensuring that revalidation is successfully introduced. The team noted that there were effective working relationships between NIMDTA and the HSC Board, which are underpinned by a well-constructed communications protocol.

The report made 10 recommendations for improvement.

As part of the present review, the HSC Board provided evidence to the review team as to how they had complied with all recommendations relevant to their organisation. In discussions with HSC Board staff, the review team gained further assurance that the systems in place for monitoring of the contract with NIMDTA, and for monitoring the quality of appraisals, remained robust.

The HSC Board team reported that:

- There was ongoing refinement of the service level agreement and communications protocol with NIMDTA and ongoing work with GP appraisers relating to the appraisal system and policy development.
- A patient and colleague feedback process, compliant with GMC requirements, is now being delivered by the Leadership Centre.
- There is ongoing assurance by a medical advisor of the appraisal process against GMC requirements for revalidation.

The review team considered that the appraisal process within primary care remained effective and the monitoring process in place was also robust. However, in discussions with HSC Board staff, the review team considered that some further development of the administration processes involved with the appraisal system would be beneficial. The Scottish Online Appraisal Resource (SOAR) is an administrative tool used to aid the appraisal process for doctors in Scotland. It is used to collect appraisal interview details such as date/location/name of appraiser etc. and is maintained by appraisers and local health board administration teams. Appraisees also have access to SOAR, where they can review their past appraisal details, as well as upload documents to share with their appraisers and more importantly sign off their online form 4 (summary of appraisal). The review team considered that development of a system similar to the Scottish system would enhance the Northern Ireland appraisal process.

Recommendation 5	
Consideration should be given to development of an online system for capturing appraisal information, including information that supports appraisal.	

The HSC Board reports that the outcome of revalidation recommendations to date is as follows:

Recommendations to GMC	Total Numbers of GPs as at 31 October 2015
Positive recommendations	12,528
Revalidation deferred	55
Non – engagement statement	5

HSC Board staff described to the review team a robust process of follow-up by medical advisors of any non-engagement with the appraisal process. They also described follow up of any issues that preclude a positive revalidation recommendation such as:

- involvement in SAIs
- information received from the GMC
- information from probity/counter fraud unit
- non-engagement with the appraisal process
- breaches of GMS contract
- health concerns

Quality and Outcomes Framework

The Quality and Outcomes Framework (QOF) is based on nationally agreed evidence standards in both clinical and organisational areas. The clinical domain is designed to provide a more organised, evidence based, approach to chronic disease management and provides an incentive for practices to engage in disease prevention activity. Organisational indicators reward good organisational practice and are self-reported by practices. If a practice engages in a meaningful fashion with the QOF, the health of its patient population should improve. Although participation in QOF is voluntary, Northern Ireland currently has a 100% uptake.

Each year, each medical practice receives a practice specific report, outlining their achievements against each QOF indicator, what the average outcome is for Northern Ireland and where they are ranked. A trends analysis measures and compares their performance with previous years.

Discussion of QOF achievements forms part of the agenda for the three yearly cycle of practice visits. HSC Board medical advisors pay particular attention to practices that are at the lower end of the achievement curve and those practices may be selected for specific focus visits, at which low achievement is discussed. An action plan is developed with the practice, with an agreed timeframe and further visits may take place where required.

In terms of effective care, the HSC Board may also introduce enhanced services which are voluntary and based on the best available evidence at the time. They provide a service that is above that outlined in the standard GMS contract. HSC Board staff provided an example of an enhanced service to provide a planned comprehensive medical review of all patients on long term conditions and to agree an individual care plan, to allow for a more proactive management of their condition than would be available under standard contract conditions.

NICE and Other Guidance

NICE guidance is issued to the HSC Board by the DHSSPS. The HSC Board circulates NICE and other guidance to GPs through e-mail. All appropriate guidance is uploaded onto the Primary Care Intranet, with the aim of keeping

GPs informed of new and or revised guidance. Compliance with guidance is discussed as part of Medical Advisors' practice visits and forms part of a practice's annual governance return.

Training and Continuous Personal Development

The primary mechanism for ensuring that GPs undertake appropriate CPD is annual appraisal, as GMC revalidation requirements specifically reference CPD. Monitoring by HSC Board staff, of the quality of appraisal provided by NIMDTA, ensures that the requirement for appropriate CPD is being met.

HSC Board staff informed the review team that there is no contractual obligation to provide a CPD programme for GPs; however the review team was informed that support for the education team is seen as a key part of the relationship with practices. The HSC Board supports a protected learning programme for practice teams, which feeds into CPD and which covers identified strategic priorities such as protection of vulnerable adults.

In 2013-14, at least six practice based learning days were funded in each locality area. Examples of topics included:

- management of controlled drugs for GPs
- diabetic foot care training
- antimicrobial stewardship in primary care – prescribing guidance
- child protection
- eating disorders

The review team commended the HSC Board for facilitation of training for general practices which is outside its contractual obligations. However, in discussions with HSC Board staff, the review team considered that even though a certain amount of training did take place for the entire team, the emphasis was still too heavily focused on medical staff.

Recommendation 6	
Greater emphasis should be placed on provision of multidisciplinary training in HSC Board training days.	

Practice based audits

The HSC Board submission stated that development of a rolling programme of audits is required by all practices, as part of their programme of governance and the system for learning. Audits should address clinical and non-clinical areas and implementation of new practice should be followed up by audit and re-audit, to provide evidence of the impact of change. Audit may also be used to disseminate learning from serious adverse incidents.

During practice visits, Medical Advisors will discuss practice based audits and changes that may be made as a result of these audits. Learning from audits in other practices will also be passed on by medical advisors as part of their visit.

Examples of audit are:

- Red flag referrals – to assess whether patients referred as red flag meet the Northern Ireland Cancer Network (NICaN) criteria and to assess whether patients newly diagnosed with cancer were referred appropriately.
- Gluten Free Product audit – review of prescribing and compliance with HSC policy and recommendations by the Coeliac Society.
- Keeping Patient Information Secure – in line with Good Practice guidelines, an audit tool to enable practices to examine their policies in relation to protecting information.

HSC Board Initiatives to Reduce Admission and Re-Admission

Prevention of admission to hospital and avoidance of unnecessary readmission, are two elements that will assist with easing pressure on unscheduled care and facilitate the flow of patients through acute services.

HSC Board staff reported that there are a number of enhanced services that are designed to improve care planning and potentially reduce admission, and provided the following examples:

- GP led IV Fluids Service – designed to cover the enhanced aspects of clinical care, to a group of patients who would benefit from intravenous/subcutaneous therapies such as fluid replacement or the administration of therapeutic agents. This service enables GPs to commence such treatments for their patients, in their own homes, where appropriate.
- A multi-disciplinary Belfast Acute Care at Home Team for frail elderly people was officially launched on 14 October 2015. It aims to avoid admissions by enhancing nursing, social, GP, and specialist geriatric care. Patients will be able to have nursing, physiotherapy, occupational therapy and medication in their own home.
- South Eastern Area – Enhanced Care at Home- a locally enhanced service is being piloted in the South East Area designed to reduce admissions. An enhanced care at home GP will be clinically responsible and will provide and/or organise ongoing diagnostic and therapeutic measures, in patients own homes, where possible.
- General Medical Practices have been encouraged to identify patients who have had emergency admissions, to review their care and develop care plans, to reduce the likelihood of further admissions. This has been supported through a system of enhanced service for risk stratification and proactive care management. GPs have been provided with a risk stratified workbook of their practice population to provide seamless care for service users on discharge from hospital.

Quality Improvement in Primary Care Medical Services

The HSC Board was asked what arrangements, if any, were in place to provide advice, support, training and development in quality improvement in general practices. They were also asked if there was an overall strategy in place for quality improvement in Primary Care.

During discussions with HSC Board staff, it was clear to the review team that the HSC Board was carrying out a significant amount of work at a local practice level. Practice based learning days were being provided for the whole practice team and audit was an established part of practice governance. Medical Advisors disseminated good practice and results from practice based audits provided the focus for learning days.

HSC Board staff informed the review team that QOF, by supporting the delivery of structured disease management, using evidence based clinical indicators has improved the quality of care in all practices in Northern Ireland. They also indicated that enhanced services, as they are delivered outside the normal scope of primary care medical services and designed to meet the needs of a local population, also drive quality improvement. Examples of enhanced services were provided:

- Direct Enhanced Service for Patients with a Learning Disability – this service is designed to improve the quality of care provided to patients with a learning disability. It is an example of partnership working between primary and secondary care, by providing a detailed health assessment for individual patients and by promoting a team based approach to care, with improved liaison between service users and carers and health care professionals.
- Provision of Enhanced Services for Patients with Multiple Sclerosis/Parkinson's Disease – the aim of this service is to:
 - develop a register of patients with multiple sclerosis
 - develop a register of patients with Parkinson's disease
 - proactively manage the health care needs of patients with multiple sclerosis through annual review
 - proactively manage the health care needs of patients with Parkinson's disease through annual review

HSC Board staff discussed with the review team the quality of data available in primary care medical services. The HSC Board team considered that the GP record is arguably the richest source of information available across HSC services. It is a longitudinal cradle to grave account of a person's health history. In 2014-15 the HSC Board through an enhanced service with GP practices extracted information from 320 GP practice systems. Analysis of this information allowed risk stratification of this cohort of patients, thus allowing those identified as having the most complex care needs, to be proactively managed. HSC Board staff considered that the data available in primary care medical services should allow for quality improvement initiatives to be taken forward across the entire system.

HSC Board Medical Advisors were able to develop quality improvement at the level of individual practices; however, what was missing was a structure for oversight of quality improvement in primary care, at a strategic level.

The review team acknowledged the amount of work that had been carried out by individual general practitioners and also by HSC Board medical advisors. However, examples of good practice, arising from areas such as clinical audit, though being disseminated at a local level were not being adopted by a larger number of practices. There was no overarching body with the remit to subject improvement initiatives to a quality assurance process and then be responsible for dissemination of those found to be appropriate and sustainable. The review team considered that in line with arrangements in Scotland, RQIA could help to facilitate the development of quality improvement in primary care medical services.

Recommendation 7	
With involvement from RQIA, an overarching structure or network should be established, or an existing network should be tasked with co-ordinating and taking forward quality improvement in primary care and measuring associated outcomes.	

2.4 Service User Experience

As part of QOF, every medical practice must undertake an annual patient experience survey and reflect on results from at least 50 respondents. The main question asked is:

- Would you recommend your GP practice to someone who has moved into the local area?
- A follow up question such as – please indicate the reason for the score you have given.

Results from these patient engagement surveys are discussed by HSC Board Medical Advisors during practice visits.

A system of patient and colleague feedback for GPs, for use in general practice in Northern Ireland and which meets the GMC requirements for revalidation has been developed by the HSC Leadership Centre. HSC Board staff told the review team that the feedback system examines the whole practice of the doctor. Individual doctor feedback reports are discussed at appraisal. The review team was informed that in any year, one fifth of GPs will be preparing for revalidation, which will involve this more detailed survey of patients.

The HSC Board team also informed the review team of a 2014-15 GP exit survey, conducted as part of Northern Ireland Local Enhanced Service - Demand Management. The survey offered patients the opportunity to provide comments about their practice and their experience of care provided by the practice. Over 28,500 patient responses were received. The results of the survey were used by medical advisors during practice visits to develop an action plan for practices. The information is also used in a number of ways designed to improve patient access which include:

- use of telephone triage
- use of alternatives to standard GP appointments
- review of existing GP and nurse surgeries
- review of treatment room services
- use of appointment reminders
- improvement of telephone call handling and customer care

The review team was informed that a number of practices have developed patient participation groups which are designed to:

- develop a partnership with patients
- identify what patients think about their services
- provide a platform to discuss new initiatives

The Patient and Client Council report on Access to GP Services made the following recommendations at both commissioning and practice level.

1. Barriers to accessing GP services which currently exist for the majority of people in employment and for younger people must be addressed. In particular, extended opening hours in the evening and at weekends must be commissioned and implemented to allow people who work or study during traditional, regular hours to access GP services.
2. Steps should be taken to ensure that patient dignity and respect is maintained at all times.
3. General practices should develop better opportunities for patients to provide their views on accessing services and practices should respond to this information.
4. General practices should regularly identify their capacity to deliver services against the needs of patients availing of these services.
5. New and varied technologies should be used to help patients book and manage appointments.
6. GP practices should provide dedicated times to call and make an appointment outside of traditional working hours, (to include evenings and weekends) to improve access to services.

7. Premium rate phone lines for contacting GP practices should be removed.
8. Disability Equality Training should be regularly provided to both GPs and all front line staff working in practices. Technology to help people with specific accessibility needs should be used to ensure that patients do not experience difficulties when visiting their general practice.
9. There should be regular monitoring and publishing of activity relating to access to GP services to learn from practices that offer the best access. Monitoring information should capture profiling data for those who are using services to help anticipate the specific needs of local communities.

The review team was presented with an ongoing HSC Board action plan, designed to address all recommendations contained in the PCC report.

Chapter 3: Conclusions

In December 2011, RQIA carried out a review of readiness for revalidation in primary care in Northern Ireland. The review concluded that the Northern Ireland appraisal process and other governance processes that the HSC Board had in place, to support safe and effective care in GP practices, were sufficiently robust to conclude that primary care in Northern Ireland was in a favorable position to begin revalidation. The review report contained ten recommendations for improvement. As part of this review, the HSC Board was asked to report on progress made in complying with these recommendations. The present review team noted the continuing strong relationship between the HSC Board and NIMDTA and considered that the recommendations from the 2011 report had been complied with.

This review takes place in the context of a volatile, changing landscape. Northern Ireland has an aging population with an associated increase in the prevalence of long term conditions such as diabetes, respiratory conditions and stroke. The focus of TYC, the blueprint for future HSC services in Northern Ireland, is to move the emphasis of treatment from the acute sector to services provided either in or at least close to people's homes. GPs are now arguing this has contributed to an increasing workload, without a concomitant increase in either capacity or resources. All GPs in focus groups noted the increase in workload. The review team considered that increasing workload, if not addressed, was potentially a safety issue for patients accessing primary care medical services.

Coupled with the increasing workload, the age profile of GPs in Northern Ireland shows that almost a quarter of GPs are aged 55 and over. Many of these practitioners may be planning to retire in the near future. The review team was informed that Northern Ireland also has the lowest number of GPs per head of population in the United Kingdom. The recently published GP-Led Care Working Group report notes however that Northern Ireland is broadly in-line with most other United Kingdom countries in terms of GPs per head of population.

The review team agrees with the view of the HSC Board that there is a risk to ongoing continuity of GP services provided for patients, especially in smaller practices, in more isolated locations. The review team considered that GP manpower issues would potentially affect workload in terms of lack of availability of locums but this may also affect effectiveness of services due to lack of time to engage in quality improvement activity. Issues in terms of workforce and workload were highlighted during all GP focus groups.

The review team welcomed the announcement by the Minister for health, regarding investment in GP training with £1.2million per year providing 20 additional GP training places. Equally welcome is the further investment to place up to 300 pharmacists in GP practices by 2021, to improve medicines optimisation for patients.

The review team also welcomes the report of the GP-led Care Working Group, which was set up to look at the issues facing GP-led primary care services. It is acknowledged that in light of their experience, and because of their knowledge of primary care issues, HSC Board input into this working group had been essential.

The review team considered that the processes established by the HSC Board, in relation to their assurance of safe and effective care were robust. Revalidation had been taken forward appropriately, appraisal systems continued to be effective and links with NIMDTA in terms of information sharing in relation to revalidation and safe and effective care had been strengthened.

An effective system for dealing with underperforming practitioners had been developed and processes for dealing with incidents and complaints seemed also to be robust. Learning from incidents and complaints was passed on during practice visits and practice based learning days.

HSC Board medical advisors carry out a rolling programme of visits to all GP practices in Northern Ireland. Visits include discussion of the practice clinical governance system, prescribing data, audit, education and training and performance against QOF indicators. All GP focus groups were very supportive of practice visits and considered that any further layers of regulation were not necessary.

Effective service user engagement is also discussed as part of practice visits. The PCC report on access to GP services was generally supportive of the availability of services but made a number of recommendations designed to improve access. The HSC Board has developed and is working through an action plan designed to comply with these recommendations.

Quality improvement in GP practices was discussed with HSC Board staff and also formed a theme for discussion during focus groups. HSC Board staff carry out quality improvement at a practice level in terms of passing along learning from incidents and complaints and also passing on good practice from audits, carried out in other practices. The review team considered that this practice should continue but that primary care medical services needed some overarching body to have oversight of quality improvement. They were interested to note that the main policy for quality improvement in Northern Ireland (Quality 20/20) did not contain any reference to primary care. GPs in focus groups understood the importance of quality improvement, but were concerned that it would be difficult to progress, due to the workforce and workload issues that have already been outlined.

Finally, the review team considered the role (if any) RQIA might have in primary care medical services. Two of the other United Kingdom regulators – CQC and HIW now have a role in inspection of GP practices; however, HIS has a different role and in partnership with RCGP Scotland has developed an initial quality improvement framework. HIS sees their role as one of facilitation of quality rather than one of inspection.

Further to this Scotland has also developed the Scottish Patient Safety Programme (SPSP) whose primary care element was launched in March 2013. Its overall aim is to reduce the number of events which cause avoidable harm to people as a result of healthcare delivered in any primary care setting. The programme comprises three work streams, delivering a menu of options from which Scottish health boards and practice teams select elements to implement in order to improve reliability and safety of care:

- Safety Culture and Leadership – improving patient safety through the use of trigger tools (structured case note review) and safety climate surveys.
- Safer medicines – including the prescribing and monitoring of high risk medications, such as warfarin and disease modifying anti-rheumatic drugs and developing reliable systems for medicines reconciliation in the community following hospital discharge.
- Safety across the interface – focusing on development of reliable systems for handling test results and written and electronic communication by implementing measures to ensure reliable care for patients.

The review team considered that the systems and processes that the HSC Board has developed, in assuring the safety of primary care medical services were robust and as long as this continued, there was no necessity to introduce a further layer of regulation. The team considered that there may be a role for RQIA in facilitation of quality improvement, perhaps in conjunction with the newly formed Improvement Network for Northern Ireland INNI. This may lead to a more structured approach to quality improvement in primary care, similar to the SPSP.

The ministerial statement of 4 November outlined changes to commissioning structures in Northern Ireland which included the closure of the HSC Board. HSC Board staff have built a robust governance and assurance system and have developed good links with GPs and their representatives. They have also developed, in conjunction with NIMDTA, an effective appraisal process which underpins revalidation in primary care medical services in Northern Ireland. The review team considered that in terms of primary care medical services it was important that whatever structures were put in place, robust governance and assurance structures for this area must be maintained. If they are not maintained some further form of assurance should be developed. This further assurance, if necessary, should be a collective development involving input from RQIA, as the systems regulator in Northern Ireland.

Recommendation 8	
Any reorganisation involving the functions of the HSC Board should maintain the corporate memory and links with GPs and other organisations such as NIMDTA, that have been established by the present HSC Board general medical services structures.	

Recommendation 9	
Where further quality assurance systems are required to be developed in primary care medical services, a collective approach should be employed including RQIA as the systems regulator.	

Chapter 4: Summary of Recommendations

Recommendation 1	
DHSSPS should provide clarity around responsibilities for meeting the training needs of GPs undergoing a remediation process.	
Recommendation 2	
Any further review of the Northern Ireland SAI system should consider a more streamlined process for SAIs involving primary care. In the interim, the HSC Board should work to measurably improve the reporting of adverse incidents in primary care in support of learning and safer practice.	
Recommendation 3	
While awaiting actions arising from the workforce review, the HSC Board should encourage and develop wider skill mix options in primary care to offer continuity to care and to ensure the best outcomes for patients.	
Recommendation 4	
The delivery plan for Transforming Your Care should ensure that the shift of emphasis from secondary care to primary care is properly resourced and does not result in excessive workloads for general medical service staff.	
Recommendation 5	
Consideration should be given to development of an online system for capturing appraisal information including information that supports appraisal.	
Recommendation 6	
Greater emphasis should be placed on provision of multidisciplinary training in HSC Board training days.	
Recommendation 7	
With involvement from RQIA, an overarching structure or network should be established, or an existing network should be tasked with co-ordinating and taking forward quality improvement in primary care and measuring associated outcomes.	

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Recommendation 9	
Where further quality assurance systems are required to be developed in primary care medical services, a collective approach should be employed including RQIA as the systems regulator.	

Appendix 1: Contractual and Statutory Requirements for General Practice

1. The practice provides patients with a practice leaflet which meets the requirements of HPSS (GMS) Regulations (NI) 2004 Schedule 8.²⁷
2. The practice has an agreed procedure for handling patients' complaints which complies with the NHS complaints procedure and is advertised to the patients.
3. Where patients are requesting to join the practice list, the practice does not discriminate on the grounds of race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition.
4. The Practice has in place a system of clinical governance which enables quality assurance of its services and promotes quality and safety. The nominated clinical governance lead, who must be a GP, provides assurance that the structures which underpin clinical governance are embedded within the practice.
5. Individual healthcare professionals can demonstrate that they comply with the national child protection guidance and have been trained in local safeguarding procedures.
6. The practice has a policy for consent to the treatment of children that conforms to the current Children's Act or equivalent legislation.
7. For minor surgery, patients consent to any surgical procedures is recorded.
8. The premises, equipment and arrangements for infection control and decontamination meet the minimum national standards.
9. The practice ensures that all healthcare professionals who are employed by the practice are currently registered with the relevant professional body on the appropriate part(s) of its Register(s) and that any employed General Practitioner is a member of a recognised medical defence organisation and registered on a Primary Care Performers List (or equivalent).
10. All professionals working in the practice are covered by appropriate indemnity insurance.
11. All doctors have an annual appraisal.
12. The practice complies with current legislation on employment rights and discrimination.
13. All practice staff have written terms and conditions of employment conforming to or exceeding the statutory minimum.
14. The practice meets the statutory requirements of the Health & Safety at Work Act and complies with the current Approved Code of Practice in Management of Health and Safety at Work Regulations.
15. The practice has a system to allow patients access to their records on request in accordance with current legislation.
16. There is a designated individual (data controller) responsible for confidentiality.

²⁷ <http://www.dhsspsni.gov.uk/gmgr-annexe-c24>

17. For computerised and other records there are mechanisms to ensure that the data are transferred when patients leave the practice.
18. Computers used by the practice are registered under and conform to the provisions of the Data Protection Act.
19. The practice has a written procedure for the electronic transmission of patient data, which is in line with national policy.
20. The practice adheres to the requirements of the Medicines Act for the storage, prescribing, dispensing, recording and disposal of drugs including controlled drugs.
21. Batch numbers are recorded for all vaccines administered.
22. Vaccines are stored in accordance with manufacturers' instructions.
23. For vaccination and immunisation, consent to immunisation, or contraindications if they exist, are recorded.
24. For vaccination and immunisation, current cold chain guidance is adhered to.
25. For vaccination and immunisation, staff involved in administering vaccines are trained in the recognition of anaphylaxis and able to administer appropriate first-line treatment when it occurs.

Appendix 2: Abbreviations

BMA	British Medical Association
CQC	Care Quality Commission
DHSSPS	Department of Health, Social Services & Public Services
DoIC	Directorate of Integrated Care
FPS	Family Practitioner Services
GMC	General Medical Services
GP	General Practitioner
HIS	Healthcare Improvement Scotland
HIW	Health Inspectorate Wales
HSC	Health and Social Care
HSC Board	Health and Social Care Board
ICP	Integrated Care Partnership
INNI	Improvement Network for Northern Ireland
LCG	Local Commissioning Groups
MPC	Multi Professional Community Providers
NHS	National Health Service
NICaN	Northern Ireland Cancer Network
NIMDTA	Northern Ireland Medical and Dental Training Agency
PCC	Patient and Client Council
PMPL	Primary Medical Services Performers List
QOF	Quality and Outcomes Framework
RCGP	Royal College of General Practitioners
RO	Responsible Officer
RQIA	The Regulation and Quality Improvement Authority
SAI	Serious Adverse Incident
SPSP	Scottish Patient Safety Programme
TYC	Transforming Your Care
WTE	Whole Time Equivalents

Appendix 3: RQIA Published Reports

Review	Published
Review of the Lessons Arising from the Death of Mrs Janine Murtagh	October 2005
RQIA Governance Review of the Northern Ireland Breast Screening Programme	March 2006
Cherry Lodge Children's Home: Independent Review into Safe and Effective Respite Care for Children and Young People with Disabilities	September 2007
Review of Clinical and Social Care Governance Arrangements in Health and Personal Social Services Organisations in Northern Ireland	February 2008
Review of Assessment and Management of Risk in Adult Mental Health Services in Health and Social Care Trusts in Northern Ireland	March 2008
Reducing the Risk of Hyponatraemia When Administering Intravenous Infusions to Children	April 2008
Clostridium Difficile – RQIA Independent Review, Protecting Patients – Reducing Risks	June 2008
Review of the Outbreak of Clostridium Difficile in the Northern Health and Social Care Trust	August 2008
Review of General Practitioner Appraisal Arrangements in Northern Ireland	September 2008
Review of Consultant Medical Appraisal Across Health and Social Care Trusts	September 2008
Review of Actions Taken on Recommendations From a Critical Incident Review Within Maternity Services, Altnagelvin Hospital, Western Health and Social Care Trust	October 2008
Review of Intravenous Sedation in General Dental Practice	May 2009
Blood Safety Review	February 2010
Review of Intrapartum Care	May 2010
Follow-Up Review: Reducing the Risk of Hyponatraemia When Administering Intravenous Infusions to Children	July 2010
Review of General Practitioner Out-of-Hours Services	September 2010
RQIA Independent Review of the McDermott Brothers' Case	November 2010
Review of Health and Social Care Trust Readiness for Medical Revalidation	December 2010
Follow-Up Review of Intravenous Sedation in General Dental Practice	December 2010
Review of General Practitioner Out-of-Hours Services	September 2010
RQIA Independent Review of the McDermott Brothers' Case	November 2010
Review of Health and Social Care Trust Readiness for Medical Revalidation	December 2010
Clinical and Social Care Governance Review of the Northern Ireland Ambulance Service Trust	February 2011

Review	Published
RQIA Independent Review of Child and Adolescent Mental Health Services (CAMHS) in Northern Ireland	February 2011
RQIA's Overview Inspection Report on Young People Placed in Leaving Care Projects and Health and Social Care Trusts' 16 Plus Transition Teams	August 2011
Review of Sensory Support Services	September 2011
Care Management in respect of Implementation of the Northern Ireland Single Assessment Tool (NISAT)	October 2011
Revalidation in Primary Care Services	December 2011
Review of the Implementation of the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults	February 2012
RQIA Independent Review of Pseudomonas - Interim Report	March 2012
RQIA Independent Review of Pseudomonas - Final Report	May 2012
Mixed Gender Accommodation in Hospitals	August 2012
Independent Review of the Western Health and Social Care Trust Safeguarding Arrangements for Ralphy's Residential Care Home	October 2012
Review of the Implementation of Promoting Quality Care (PQC) Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services	October 2012
Review of the Northern Ireland Single Assessment Tool - Stage Two	November 2012
Review of the Implementation of the Cardiovascular Disease Service Framework	November 2012
RQIA Baseline Assessment of the Care of Children Under 18 Admitted to Adult Wards In Northern Ireland	December 2012
Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland, Overview Report	February 2013
Independent Review of the Governance Arrangements of the Northern Ireland Guardian Ad Litem Agency	March 2013
Independent Review of the Management of Controlled Drug Use in Trust Hospitals	June 2013
Review of Acute Hospitals at Night and Weekends	July 2013
National Institute for Health and Care Excellence Guidance: Baseline Review of the Implementation Process in Health and Social Care Organisations	July 2013
A Baseline Assessment and Review of Community Services for Adults with a Learning Disability	August 2013
Review of Specialist Sexual Health Services in Northern Ireland	October 2013

Review	Published
Review of Statutory Fostering Services	December 2013
Respiratory Service Framework	March 2014
Review of the Implementation of NICE Clinical Guideline 42: Dementia	June 2014
Overview of Service Users' Finances in Residential Settings	June 2014
Review of Effective Management of Practice in Theatre Settings across Northern Ireland	June 2014
Independent Review of Arrangements for Management and Coordination of Unscheduled Care in the Belfast Health and Social Care Trust and Related Regional Considerations	July 2014
Review of the Actions Taken in Relation to Concerns Raised about the Care Delivered at Cherry Tree House	July 2014
Review of Actions Taken in Response to the Health and Social Care Board Report Respite Support (December 2010) and of the Development of Future Respite Care/Short Break Provision in Northern Ireland	August 2014
Child Sexual Exploitation in Northern Ireland - Report of the Independent Inquiry	November 2014
Discharge Arrangements from Acute Hospital	November 2014
Review of the Implementation of the Dental Hospital Inquiry Action Plan 2011	December 2014
Review of Stroke Services in Northern Ireland	December 2014
Review of the Implementation of GAIN Guidelines on Caring for People with a Learning Disability in General Hospital Settings	December 2014
Baseline Assessment of Access to Services by Disadvantaged Groups in Northern Ireland (Scoping Paper)	December 2014
RQIA Quality Assurance of the Review of Handling of all Serious Adverse Incidents Reported between January 2009 and December 2013	December 2014
Review of the Care of Older People in Acute Hospitals	March 2015
Review of the Diabetic Retinopathy Screening Programme	May 2015
Review of Risk Assessment and Management in Addiction Services	June 2015
Review of Medicines Optimisation in Primary Care	July 2015
Review of Brain Injury Services in Northern Ireland	September 2015
Review of HSC Trusts' Arrangements for the Registration and Inspection of Early Years Services	December 2015
Review of Eating Disorder Services in Northern Ireland	December 2015

Review	Published
Independent Review of Implementation of the Palliative and End of Life Care Strategy	January 2016
Review of Advocacy Services for Children and Adults in Northern Ireland	January 2016
RQIA Review of Community Respiratory Services in Northern Ireland	February 2016
An Independent Review of the Northern Ireland Ambulance Service	March 2016
RQIA Review of HSC Trusts' Readiness to comply with an Allied Health Professions Professional Assurance Framework	June 2016
Review of Quality Improvement Systems and Processes	June 2016



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