

FRAMEWORK FOR IMPROVING QUALITY IN PRIMARY CARE

July 2006

Family Practitioner Services
Northern Health & Social Services Board

FOREWORD

Reform and modernisation continue to be key themes for the HPSS in the next five years and Primary Care is engaging to make our health and social services more efficient, effective and economical.

The Review of Public Administration will have a very significant impact on the future organisational structure across the health and care sector.



The new Health and Social Services Authority (HSSA) will replace the four existing Health and Social Services Boards from 1 April 2008. The Authority will be responsible for day-to-day performance management of the health and personal social services and will be accountable to the Department of Health, Social Services, and Public Safety.

The new HSSA will provide an excellent opportunity to consolidate and build upon the recent reforms of the health and social care system. Achieving this will require a continued focus on delivery and on the funding of priorities which genuinely reflect the needs of people and their communities.

The introduction of Integrated Clinical Assessment and Treatment Services (ICATS) is a central plank in the DHSSPS elective reform programme. It will introduce new arrangements for managing referrals into secondary care from GPs and other sources involving the use of multi-disciplinary teams to assess and, in many cases, treat patients. By providing these functions, ICATS will be carrying out much of the work previously done by specialist hospital consultants thus ensuring that only those who genuinely need the services of a consultant are referred for an outpatient appointment. It is a very significant change in the delivery of the Health Service.

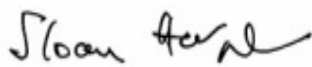
The Health Minister indicated that substantial investment will be spent on Health and Care Centres. These will provide facilities such as GP practices, nurse-led consultation space, diagnostic and treatment rooms for specialist services, dental clinics, accommodation for visiting practitioners including hospital consultants, allied health professionals and social care professionals, and a community pharmacy.

The new contractual arrangements for General Practitioners and potentially for dentists and pharmacists too, will complement the work of existing and new HPSS organisational structures in developing integration across organisational and professional boundaries. Only by working systematically and on an integrated basis can the HPSS successfully redesign service provision to meet the needs of our population in the 21st century.

The Framework for Improving Quality in Primary Care is a document of strategic intent, developed to inform and give direction to the future work of key stakeholders against a background of rapidly changing policy context; regulatory framework; technological developments and growing public expectations and demands within Primary Care.

This Framework is reviewed annually to recognise new policy initiatives such as the DHSS&PS's Primary Care Strategy and changing needs and expectations.

It gives me great pleasure in presenting this Framework document to you and I wish you and your organisation well in your endeavours to develop Primary Care.

A handwritten signature in black ink, appearing to read "Sloan Harper". The signature is written in a cursive, flowing style.

Dr Sloan Harper
Director Primary Care

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* to be included in Phase 2



Section 1

INTRODUCTION

1.0 INTRODUCTION

- 1.1 This paper relates to Goal 2: Action 10 Results 10.4 of the Northern Board's Corporate Plan 2005/06, which is to continue to develop a Primary Care Quality Improvement Framework.
- 1.2 For some time it has been recognised that there is a need to develop a strategic framework for Primary Care with the aim of improving the quality and range of services provided. In 2002/03 the Board's Family Practitioner Unit (FPU) produced an initial Framework for Improving Quality in Primary Care document (Framework). Its main purpose was to give direction to the future work of the Board, Local health and Social Care Groups (LHSCGs) and Community Trusts against a background of a rapidly changing policy context; regulatory framework; technological developments; and, growing public expectations and demands.
- 1.3 Annual updates of the Framework were published in 2003/04 and 2004/05. This document rolls forward the Framework that was produced in 2004/05. As Health and Personal Social Services enter a period of unprecedented change in Northern Ireland with the implementation of amongst other things: the Review of Public Administration (RPA); Developing Better Services (DBS); Agenda for Change (AfC); and Caring for People Beyond Tomorrow, the importance of documenting what is happening now so that progress can continue to be made in the future, irrespective of the organisational context, is greatly increased.

This document is made up of the following:-

Section 2: Background to Framework for Improving Quality in Primary Care;

Section 3: Quality Assurance in Primary Care – A New Framework;

Section 4: What has been happening in Primary Care – An Overview of the past 12 months;

Section 5: Improving Quality in Primary Care Initiatives*;

Section 6: Investments in Primary Care Development 2005/06;

Section 7: Glossary

*To be included in Phase 2

A collage of four images illustrating primary care. The top image shows a doctor in a white coat examining a young child's mouth with a stethoscope. The middle-left image shows a woman in a blue swimsuit swimming in a pool. The middle-right image shows a group of people, including a man in a purple jacket and a woman in a blue jacket, walking outdoors. The bottom image shows a doctor in a white coat examining a baby's head with a stethoscope.

Section 2

Background to Framework for Improving Quality in Primary Care

2. BACKGROUND TO FRAMEWORK FOR IMPROVING QUALITY IN PRIMARY CARE

2.1 Objectives

The purpose of this Framework is:

- To assist in the development and implementation of regional Primary Care policy and strategy;
- To inform, develop and provide a strategic context for the delivery of Primary Care services in the Northern Health and Social Services Board area over the next three years bearing in mind the operation of the new GMS Contract and possible similar developments for Community Pharmacy and General Dental Services;
- To help LHSCGs through regular in-depth consultation to work with the FPU to implement the framework as part of their Primary Care development role;
- To assist Health and Social Services Trusts and Independent Contractors in their planning of service developments in Primary care; and
- To document developments in the improvement of quality in Primary Care.

2.2 Context

- Approaching 90% of care is delivered in Primary care with less than 30% of the resources available to the HPSS;
- This Framework is the culmination of work led by FPU over the last five years;
- The Framework takes on board inputs from a range of Independent Contractors, local Trusts, LHSCGs, Board Directorates and DHSSPS;
- A new nation-wide GMS Contract has been implemented from April 2004 which provides opportunities to develop high quality services of benefit to both patients and practitioners. Similar developments are anticipated for Community Pharmacy and General Dental Services;

- In October 2005 the Department of Health, Social Services and Public Safety (DHSSPS) issued a Strategic Framework for the development of Primary Health and Social Care for public consultation; and,
- In November 2005 as part of the Review of Public Administration the DHSSPS announced plans for the biggest ever reform to the HPSS in Northern Ireland to strip out bureaucracy and waste and redirect resources to frontline services.

2.3 The Changing Needs of the Northern Board's Population (2005-2025)

"Prediction is difficult especially about the future"

Albert Einstein

2.3.1 Demographic Change

It is estimated that over the next decade the Board's population will increase by some 26,000 people. That is a growth of the order of 6%. Growth will not be uniform across the Board's area. For example in the Magherafelt District it is predicted that the population will grow by some 12%.

Over a decade the population will become older. The number of children (under 16 years of age) will fall by an estimated 16%. Again the fall will not be uniform across the Board's area, for example in the Cookstown District the fall is projected to be 28%. There will be more people over 65 years of age. It is estimated that this older age group will increase by around 17% though in the Antrim Borough the increase will be of the order of 41%. However, the most rapid growth will be in the over 85 age group which could increase by up to 30%. The significance of the growth of the senior citizen population is that on average people over 65 years of age consume twice the NHSS resources of an adult under 65. For a person over 85 the figure is five times an adult under 65.

It is expected that people will live slightly longer than they currently do. Over the decade female life expectancy could increase by 2 years from 79 to 81. For males, life expectancy during the next 10 years could increase from 74 to 76 years.

In contrast to most of the rest of the United Kingdom the working population in the Board's area is set to continue to increase by around 10%. In the Magherafelt District the increase is likely to be even higher, around 18%.

2.3.2 Morbidity

Patterns of disease and ill health among the Board's population will continue to be like the rest of the United Kingdom and indeed Europe. Essentially it could be described as the poor health of an affluent society. Recent research suggests that by around 2015, 1 in 3 people will be affected by: obesity; alcoholism; smoking; drug abuse; stress or poor diet. As a consequence there will be increased incidence of: cardio-vascular disease; diabetes; bowel cancer; lung cancer (especially among females); and, depression. Indeed it is predicted that by 2015 depression could well be the biggest cause of ill health in Western Europe.

Oral health, particularly among children, in Northern Ireland is the worst of any region of the United Kingdom. This could well continue to be the case in the next decade.

The Province has higher levels of disability in comparison to Great Britain. In Northern Ireland the figure is 17% compared to 14% in Great Britain.

2.3.3 Social and Lifestyle Changes

A recent publication highlighted a number of key social and lifestyle trends which will undoubtedly have implications for health and social services over the next decade. For example, while the incidence of smoking is falling within the population this masks the fact that the decline is largely amongst men, where as with women incidence of smoking is actually increasing. Across the population as a whole there is increased alcohol consumption and drug misuse. For the past two decades there has been a significant reduction in physical activity amongst the population. Consequently, 37% of adults are categorised as overweight and 19% as obese.

Over the next decade the population will continue to be better educated. It will be better informed and a more demanding population with a 24/7 lifestyle being much more common. On the basis of current trends the population will become socially and ethnically much more diverse.

2.3.4 Anticipated NHS Resource Utilisation By 2015

Research published in 2003 estimated that in a decade's time over 40% of NHS expenditure is likely to be going on the treatment of: Alzheimer and Parkinson diseases; cardio-vascular disease; depression; epilepsy; rheumatological diseases; migraine; and, prostatic cancer.

2.3.5 Public Expectations and Rating of Primary and Community Care Services

The Public's key expectations for future developments in Primary Care are focused around:-

- Improved access – more flexible opening hours;
- Increased length of consultation;
- Improved quality of care; and,
- A wider choice of treatment.

The public also give primary and community care services a high positive rating. A survey in 2003 found over 80% of patients/clients rated the quality of service as excellent or good and over 75% rated access as excellent or good.

2.3.6 A Paradigm Shift for Primary Care?

A consensus has been building in recent years of the key shifts that need to happen in Primary Care over the next decade. The service will need to move from one which is fragmented to an integrated service. It will need to move from one of professional isolation to one of excellent team working. There will need to be a shift from a provider focus to one which is person centered. It will also need to move from a service which in the past has been tradition-based to one which is firmly evidenced-based. It will need to move to service where staff moral is consistently high and from a variable range of services to a convenient range of services which as are equitably delivered. The focus will need to shift from one primarily based on diagnosis and treatment to one that focuses on population health.

Primary Care will need to move from an information poor service to one were it is readily makes available information to aid decision making and service provision. Finally, the great variability in the quality of services and patient outcomes will need to move to one of consist high quality with first class outcomes.

2.4 Need for a Strategy

The purpose of this Framework document is to inform debate, progress action and document achievements in this key area of Health and Social Services.

The Framework will over time need to develop to include General Medical Services (GMS), General Pharmaceutical Services (GPS), Dental Services (GDS) and General Ophthalmic Services (GOS) and their key interfaces with the rest of the Health & Personal Social Services (HPSS).

The factors which underpin the need for a strategy and which influence the direction of travel include:-

- The national and regional policy thrust that more clinical and social care can and will be delivered at a practice and community level (Our Health, Our Care, Our Say: A New Direction For Community Services – DOH, London, January 2006);
- The need to create a vision for the future which LHSCGs and successor organizations can own and help implement including the development of Integrated Clinical Assessment and Treatment Services (ICATS) and Local Enhanced Services (LESs) in partnership with local practices;
- Significantly increasing patient expectations and demands;
- Recent Government policy and sponsored initiatives including:-
 - HPSS Priorities for Action 2005/06;
 - Health and Social Services Reform and the Review of Public Administration – speech by Minister for Health and Social Services, Mr Shaun Woodward (November 2005);
 - Caring for People Beyond Tomorrow (October 2005) – Strategy framework for the development of Primary Health and Social Care;
 - Review of Public Administration (October 2005);
 - Independent Review of Health and Social Services in Northern Ireland (also known as the Appleby Review) (August 2005);
 - Waiting Lists – speech by Minister for Health and Social Services, Mr Shaun Woodward (July 2005);
 - Putting Patients First – speech by Minister for Health and Social Services, Mr Shaun Woodward (June 2005);
 - Governance in the HPSS - Clinical and Social Care Governance: Guidelines for Implementation (January 2003); General Practice (February 2005).
 - Oral Health Strategy for Northern Ireland – Consultation document (September 2004)
 - New GMS Contract (April 2004); and
 - Making it Better - A Strategy for Pharmacy in the Community (February 2004);

- Investing in General Practice: The New General Medical Services Contract (February 2003 and December 2003);
 - Building the Way Forward in Primary Care (December 2000); and the setting up of LHSCGs (2002/03);
 - Working for Healthier People (2001) and A Healthier Future (December 2004);
 - Developing Better Services - Modernising Hospitals and Reforming Structures (June 2002);
 - Review of Community Care - First Report (April 2002);
 - Investing for Health (March 2002);
 - Hayes Review of Acute Services (June 2001);
 - Best Practice, Best Care (April 2001); and,
 - Confidence in the Future for Patients, and for Doctors (October 2000).
- Recent Board Strategies and Initiatives including:-
 - Equity Strategy 2005-2010 - Planning for the Future (May 2005);
 - All Our Futures (December 2005)
 - Ringing the Changes (December 2002) - a strategy for older people;
 - New Directions, New Opportunities (September 2002) - a strategy for promoting the Wellbeing and Independence of people with a physical disability and/or sensory impairment;
 - Children's Services Planning - a framework for the delivery of services during 2002-2006.
 - Commissioning a Modern Mental Health Service (1999) - a strategy for people with mental health problems;
 - Promoting Ability (1998) - a strategy for the development of care for people with a learning disability; and,
 - Towards a Better Future (1998) - a strategy for acute care.
 - Use of Primary Care Information to Commission Services.

The work currently being undertaken by FPU particularly with respect to information coming out of the Quality and Outcomes Framework is being made available to support the work of LHSCGs, Independent Contractors and Trusts.

2.5 The New GMS Contract

On 1 April 2004 a new GMS Contract was put in place between the Board and all its practices. It represents the most fundamental and far reaching change in Primary Care for over 50 years. Implementation will undoubtedly have a profound effect on the shape and realisation of the vision for Primary Care.

Overtime the new GMS Contract will result in radical changes to the way Primary Care services are provided and will place a heavy responsibility on the Board, as the Primary Care Organisation (PCO), to support providers in delivering quality care equitably for the whole Board population.

The key underpinning principles of the new Contract are:-

- Significant additional funding resulting in record investment in general practice from £31.4m in 2002/03 to over £50m in 2005/06;
- The contract is practice based rather than with individual Principal GPs and patients register on a practice list;
- All NHSSB practices were entitled to opt out of Out-of-Hours care from 1 January 2005;
- The 'Red Book' (Statement of Fees and Allowances) has disappeared along with the majority of item of service fees and has been replaced by a Statement of Financial Entitlements;
- For essential and additional services practice income reflects the practice list size and the relative workload and costs they represent and does not depend on the number of partners or level of staffing in the practice. This allows greater flexibility in configuring the skill mix in practices;
- High quality care is being rewarded through a new evidence-based Quality and Outcomes Framework (QOF) covering four domains: organisational and clinical standards, additional services and the patient experience; and incorporating 146 separate indicators. During the first year of the new Contract Northern Board practices delivery on average 1010 points out of a total 1050;
- Primary legislation allows PCOs to act as providers of care in addition to their current commissioning role;
- New premises flexibilities enhance the cost/notional rent scheme;
- Practice IT equipment and maintenance are now a Board responsibility and are 100% funded;
- A more flexible career structure with better career development opportunities for GPs and practice staff; and,

- Facilitating the possibility of portfolio careers for GPs.

For the Board, as the Primary Care Organisation, the major benefits, opportunities and challenges of the new Contract are:-

- Expanding and developing the Primary Care Sector by rewarding and encouraging of shared working at practice and interpractice levels, across the wider Primary Care sector, with intermediate and secondary care, and with social care;
- Reforming emergency care by commissioning or providing an integrated system for urgent care Out-of-Hours;
- Supporting practices to develop a wider range of practice-based Enhanced Services and thereby achieve resourced secondary to Primary Care interface shifts resulting in reduced pressures on the acute hospital services;
- Meeting local health care needs, tackling local problems and encouraging innovative new developments in Primary Care by commissioning Local Enhanced Services;
- Assisting Primary Care service providers in the development of more appropriate skill mix;
- Encouraging the improvement of practice management; and,
- Improving the management of chronic disease and encouraging high levels of practice achievement in the Quality and Outcomes Framework thereby helping to reduce out patient referrals and emergency admissions to hospital.

These sweeping developments have required a significant amount of new investment in Primary Care. They have major implications, not just for Practices, but also for Boards, Trusts, the Central Services Agency and Out-of-Hours (OOHs) Providers.

Fitting all this new work in with other major developments such as GP appraisal, the new system for dealing with underperforming doctors, the development of LHSCGs and their evolving commissioning role with GMS practices and with the whole Clinical and Social Care Governance agenda, continues to be a huge challenge for everyone working in Primary and Community Care.

With patience, and by working together to share knowledge and expertise, it should be possible to use the new GMS Contract to provide a safe working environment in which professionals feel challenged and enthused to provide even higher standards of care for patients.

In addition, Primary Care will also be significantly impacted on by Agenda for Change, Review of Public Administration, Developing Better Services and Caring for People Beyond Tomorrow implementation.

2.6 Services and Activity Levels in Primary Care

GMS covers the provision of essential services to registered patients and temporary residents, additional services, Enhanced Services commissioned by the Board. GMS Out-of-Hours provision became the responsibility of the Board from 1 January 2005 and is delivered by Dalriada Urgent Care.

These services are provided in the Northern Board area to a combined list size of 425,706 (at January 2006) by some 266 GPs and their staff organised into 82 practices operating from 70 locations. Some 2.5 million consultations are delivered annually in general medical practice in the Northern Board area. Expenditure in GMS increased from £31.4m in 2002/03 to £38.7m in 2003/04 and £43.5m in 2004/05. Projected expenditure for 2005/06 is circa £51m.

Pharmaceutical services are provided by 109 community pharmacies in the Northern Board area. These pharmacies dispensed 3.7 million prescription forms for 6.3 million drugs or pharmaceutical appliances during 2004/05 and expenditure on GPS was £93.8m. It is estimated that 58% of the population visit a pharmacy on a weekly basis, which means there are some 13 million visits in a year. Many of the adults who visit community pharmacies are older, vulnerable or socially disadvantaged people.

Within the NHSSB there are 181 dentists providing primary dental care and most of these practitioners work in the Board area. There are 85 General Dental Practices (i.e. high street practices) which provide dentistry to the general public. However, around 10% of the Board's dentists work in the Community Dental Service (CDS) either in Causeway or Homefirst Trusts. The CDS is responsible for providing dental care to adults and children with special needs as well as carrying out oral disease screening programmes in schools and care homes.

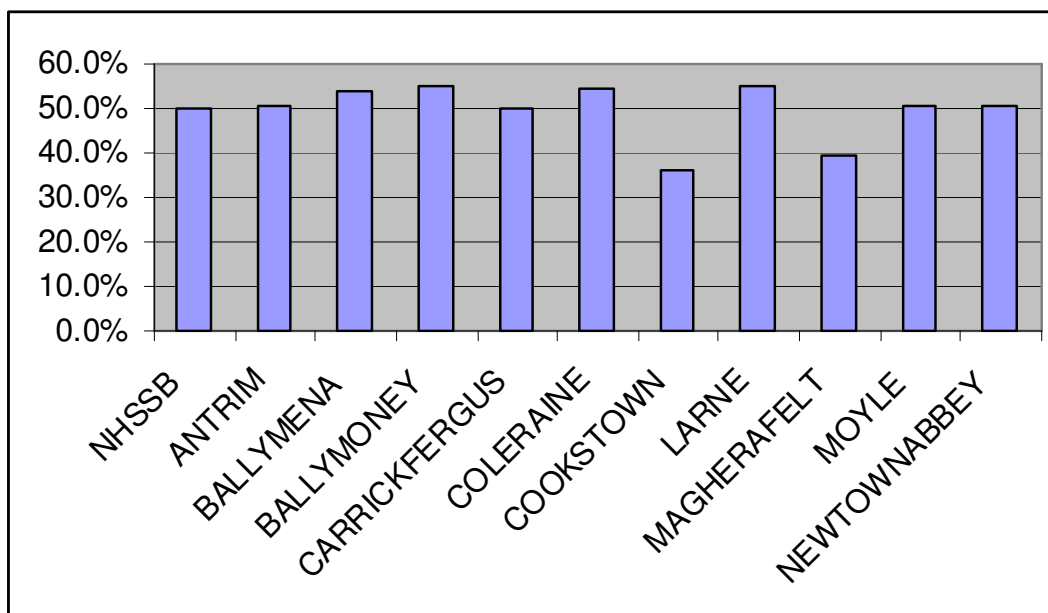
In September 2005, 160,500 adults aged 18 and over were registered with a General Dental Practitioner (GDP). This represents approximately 47% of the total adult population of the Northern Board. Similarly, 70,172 children (i.e. those aged less than 18 years) were registered with a dentist. This represents approximately 66% of the Board's child population. In all age bands the proportion of the NHSSB population registered with a GDP is higher than the Northern Ireland average (table 1). However, while registration figures for children within the NHSSB have remained steady over the last few years, they have dropped by approximately 3% for adults. This means that there are now around 10,000 fewer adults registered with a Health Service dentist than there were 3 years ago.

Table 1: Dental registration data for the NHSSB area and for Northern Ireland as a whole.

	Total children	Adults Under 65	Adults 65 & Over	Total adults
Number NHSSB residents registered	70,172	137,971	22,529	160,500
% of NHSSB population registered	66.19%	49.63%	36.77%	47.31%
NI average % registration	61.92%	47.02%	36.35%	45.16%

The Board-wide average registration figures conceal significant intra-board variation with September 2005 data showing that only 36% of Cookstown adults under 65 years registered with a dentist compared to 56% of those living in Larne (figure 1).

Figure 1: Proportions of adults aged under 65 years registered with a dentist.



In 2004/05 the total cost of providing General Dental Services (GDS) in the NHSSB was £18.8m, a rise of £0.112m over the previous year's figure. Also in 2004/05 the average cost per course of GDS dental treatment in the NHSSB was £48.39. This compares with a figure of £19.41 for England and £16.40 for Wales.

In the last year, across almost all of the treatment types, there has been a reduction in the volume of work carried out under the General Dental Service (table 2). This may reflect a move by dentists to increase the amount of dental care they provide privately.

Table 2. Numbers of common treatment items provided in the NHSSB area 2003/04 to 2004/05

	2003/04	2004/05	% change
exams	182098	178610	-1.92%
fillings	195144	187342	-4.00%
crowns	21366	20984	-1.79%
bridges	3213	3082	-4.08%
extractions	51996	51367	-1.21%
sedation	11994	11731	-2.19%
dentures	15917	15538	-2.38%

There are 131 Ophthalmic Practitioners providing General Ophthalmic Services (GOS) from 61 practices in the Northern Board area at a cost of £3.2m (expenditure) in 2004/05. It is estimated that £3.3m will be spent in 2005/06. In 2004/05 there were 81,505 sight tests and 556 domiciliary visits provided in the Northern Board.

The total Family Health Service expenditure for 2004/05 was therefore £159.3m and in 2005/06 it is to increase to over £167.5m.



Section 3

Quality Assurance in Primary Care – A New Framework

3. QUALITY ASSURANCE IN PRIMARY CARE - A NEW FRAMEWORK

3.1 Introduction

Assurance on quality requires firstly, that there is an agreed set of standards to be achieved and/or objectives met and secondly, that adequate methods exist to monitor and review performance against these standards.

3.2 Setting standards

The setting of standards is now the task not only of traditional bodies such as the General Medical Council (GMC) and academic professional bodies generally, but also of new organisations recently established such as the National Institute of Clinical Excellence (NICE) in England, the Scottish Inter-Collegiate Guidelines Network (SIGN) in Scotland and the Standards and Guidelines Unit (SGU) in Northern Ireland. All three bodies work through the production of frameworks called National Service Frameworks (NSFs) in Great Britain and Service Development Frameworks (SDFs) in Northern Ireland. NSFs in Great Britain have been developed to cover key areas of work e.g. Coronary Heart Disease, Mental Health and Diabetes. Standards are also extensively covered in the NSFs and are also embedded within the quality components of the new General Medical Services (GMS) Contract and of the Personal Medical Services (PMS) type practice based contract already in extensive use throughout England and Scotland.

Recognition that standards are being properly met requires a broad based approach ranging from the well known techniques of Audit and Peer Review to newer approaches using newly developed organisations acting in the context of an explicit regulatory framework both for General Medical Practitioners and, in time, all Independent Contractors.

3.3 Regulatory Bodies

The new Regulatory Bodies which have been brought into being are, in England, the Healthcare Commission (HC); in Scotland, the Clinical Standards Board (CSB); and, in Northern Ireland, the Regulation and Quality Improvement Authority (RQIA) which has been operational from April 2005.

Additionally, in the Northern Health and Social Services Board a Local Advisory and Investigative Panel (LAIP) has been established specifically to investigate and address issues where there are concerns in relation to professional performance by GPs or GP practices; formal complaints will continue to be dealt with through the Board's Complaints Procedures. This panel has membership drawn from a range of appropriate bodies i.e. Northern Local Medical Committee (NLMC), Royal College of General Practitioners (RCGP - NI), Northern Ireland Medical and Dental Training Agency (NIMDTA), Local Health and Social Care Groups (LHSCGs), Board Directorate of Primary Care and lay representation from the Northern Health and Social Services Council (NHSSC). Its remit is to ensure, as far as possible, that the standards and objectives of the SGU and GMC are being met and, if not, seek appropriate remedies through various initiatives ranging from training, development of the infrastructure in practices and in some cases referral to the GMC. The services of the National Clinical Assessment Authority (NCAA) a body set up nationally to carry out independent assessments of individual Practitioners and practices when requested by a competent NHS Health body has now become available to all Boards and Trusts thus the LAIP.

In relation to community pharmacy, the DHSSPS is working with the professional body, the Pharmaceutical Society of NI, and community pharmacy advisers from the four HSS Boards to develop standards and an audit tool for pharmacy practice.

3.4 Other Approaches to Underpinning Quality

Supplementing the above are many other approaches some of which are listed below, which aim to ensure the attainment of quality:-

- Visits to practices carried out by Boards on the basis of QOF, Probity or development work;
- The development of Risk Management throughout Primary Care using such methods as Critical Incident Reporting (CIR) and Significant Event Auditing (SEA); which are part of the Quality and Outcomes Framework (QOF) of the new GP Contract including a specific process for the reporting of potential adverse incidents involving medications to NHSSB;

- Implementing systems of Clinical Governance at Practice, LHSCG and HSS Board Primary Care Directorate levels. In the case of practices this has now become a contractual obligation and working in collaboration with the Clinical and Social Care Governance Support Unit of DHSSPS(NI) and the Primary Care Directorates of other Boards a template has been produced which is being used at annual Contact Visits to Practices as a means of assessing practice based clinical governance activity on a regional basis. To support further developments in this area a Primary Care Clinical Governance Partnership is to be established in 2006, similar in composition to the LAIP and focusing initially on General Medical Practice. It will have the services of an Executive Officer in the form of a Primary Care Clinical Governance Facilitator also to be appointed in 2006.
- Supporting training and development both for individual Practitioners and practices through support generally and in NHSSB the Local Education and Training Scheme (LETS) initiative whereby practices are able, on a protected time basis, to work on developing programmes and protocols involving all disciplines covering all areas of Primary Care. Working in collaboration with NIMDTA's Primary Care Division through the newly established Primary Care Education Consortium and;
- Appraisal and Revalidation: All GPs throughout the UK are now required to undergo an Annual Appraisal, and a regional scheme is to take over the work of Boards hitherto in this area under the auspices of NIMDTA from April 2006. Revalidation awaits the results of the CMO's (DOH) working party due to report March 2006 set up following Dame Janet Smith's Shipman Enquiry.

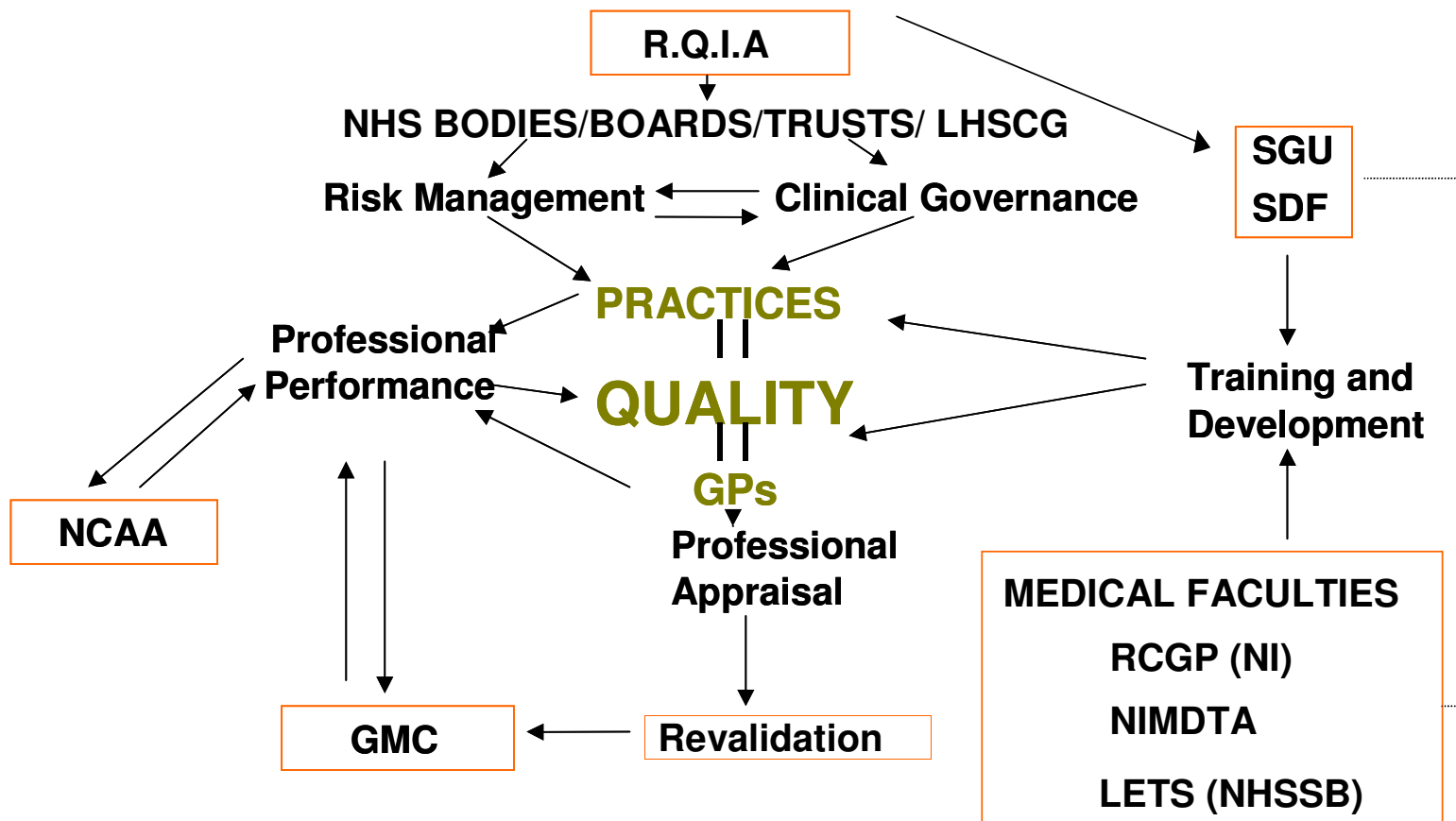
3.5 Conclusion

The establishment of the various new bodies and processes (Figure 1) is at an early stage and progress to date varies greatly throughout the UK. The comment in 1972 by Robert Kessner "the question is no longer whether there **will** be intervention in Health Care to assure Quality, but simply **who** will intervene and **what methods** they will use" is now being thoroughly addressed.

Figure 1

*Under consideration by the CMO (UK)'s Special Advisory Group to report to DH(UK) by March 2006

Quality in Primary Care - A Developing Agenda





Section 4

What has been Happening in Primary Care – An Overview of the Past 12 months

4. INTRODUCTION

4.1 New General Medical Services

The GMS Contract has been with us now for nearly two years, early predictions of the demise of General Practice have proven to be greatly exaggerated. The 82 GMS practices in the Northern Board area have risen to the challenges set within the well-thumbed pages of the hallowed 'Blue Book'.

Whilst the degree of change does not quite match the words of WB Yeats, '*all changed, changed utterly, a terrible beauty is born*', there has been a major transformation in the way that services are provided and all staff have had to adapt quickly to new technologies and imaginative and novel ways of resourcing practices.

Implementation of the Quality and Outcomes Framework (QOF) has been very successful with practices averaging 1033 in 2005/06 and 1009 in 2004/05 quality points out of a maximum of 1050. When the buzzwords in the Health Personal Social Services (HPSS) are reform and modernisation, Primary Care has been one step ahead in justifying anew investment by demonstrating quality improvement. There is a clear message here for other parts of the Service.

A range of Enhanced Services (17 in total) was funded by £4.1m from the Northern Board in 2005/06, offering practitioners the option of accepting or declining new work and providing a total funding package with opportunities to vary skillmix and expand into new areas of work.

The GMS Contract is now in its second full year and practices are becoming more confident at managing innovations such as QOF and Enhanced Services specifications. Family Practitioner Unit staff have completed the 2005/06 Annual Review visits which included, for the first time, practice assessment by a Lay Assessor and a clinical governance review. The Board is grateful to the Northern Local Medical Committee for the advice which members offered in developing

the visit agenda. The visits provided support for practices and provided essential feedback for FPU staff.

The information revolution will eradicate paper based clinical records and here again, Primary Care is leading the way. When networked, the Payment, Calculation and Analysis System (PCAS) clinical information system will provide practices and Public Health with a wealth of useful benchmarked information.

It has not all been plain sailing with difficulties for the Board in commissioning services for violent patients. Practices have also had to adapt to new rules governing the registration of patients.

However, this is a new era for General Practice and provided practices continue to show the added value of their work through rigorous audit and evaluation, then it will be difficult to deny them new investment.

4.2 “Caring for People Beyond Tomorrow” or Primary Care Strategy

“More needs to be done to create effective high quality and modern primary care services, which will be responsive to people’s needs, provide greater access and be more integrated making the best use of the skills of our health and social care professionals”. With these words Minister Shaun Woodward in October 2005 launched ‘Caring for People Beyond Tomorrow’, setting out a longterm vision for Primary Care Services in Northern Ireland.

Developed following discussions with leaders of our Primary Care professions, provider organisations, commissioners and users, the DHSSPS has provided us with an aspirational vision, based on a set of design principles and core values, which will guide and direct the activity of those involved in the commissioning and provisions of Primary and Community Care for many years to come. Its arrival is welcome and timely.

The Strategic Framework embodies a number of policy directions, some of which are current, while others, such as the Pharmacy and Dental Contracts, await final agreement. All have the potential to open up the provision of Primary Care services to a range of providers, stimulate innovation through competition, a more imaginative approach to securing funding streams and drive forward integration and break down unhelpful professional and organisational boundaries.

4.3 Out Of Hours Service

On 1 January 2005 the Board took over responsibility for providing the local population with Out of Hours Services. The services have been delivered by Dalriada Urgent Care, under contract to the Board and in the first year this has generally been successful.

The standard and quality of services has been maintained despite problems in getting sufficient local doctors to provide the medical staffing levels required. This has meant the move to employing sessional doctors, including non-UK nationals but this has allowed the service to continue on a safe basis for users and other staff working in Out of Hours.

There continues to be close cooperation between Boards to maintain some mutual support structures and common approaches to service provision, particularly at holiday periods and it is intended that this will continue.

Staff at Dalriada Urgent Care have developed proposals for new premises in Ballymena, to replace the existing cramped accommodation at Garfield Place and have been successful in getting their Business case for capital funding accepted. Work has now started to convert an existing building to new premises for the delivery of urgent care services to the Antrim/Ballymena locality, to re-house the Board wide Relief of Dental Pain clinic and provide call handling, call triage and management accommodation.

4.4 Reform and Modernisation

The overarching theme is a more efficient patient journey, achieved through greater integration, breaking down professional boundaries and providing services in the most efficient and cost effective way. New referral options and trust flagship proposals, Developing Better Services plans for both Acute and Primary/Community Care, and new managed clinical networks, are part of a plethora of initiatives which have the potential to transform service provision, resourcing the treatment of patients at home rather than in hospital, putting Primary Care at the heart of our service redesign.

Central to success will be the building and maintaining of strong relationships between professional representatives and those who manage policy, strategy and operational workings in the HPSS, particularly as we will soon be embarking on the restructuring of health organisations and the inevitable turbulence which will accompany the process. We can do this through inclusivity in work up service redesign, ensuring that the HPSS rewards good practice and invests in those parts of the Service which measure and achieve quality in service provision.

The GMS Contract offers a model for service monitoring across the HPSS which has the potential to address many of the problems highlighted in Professor Appleby's report. Essential elements include:

- Evidence-based performance indicators agreed with professional representatives;
- Use of electronic information systems to monitor provider performance and garner information on public health;
- On site visits by commissioners to verify standards and contractual commitments; and,
- Incentives and sanctions to encourage good practice.

Early signs are that our reform and modernisation initiatives have the potential to do much of the above. It will require

patience, co-operation and flexibility from everyone in the Service but has the potential to transform efficiency and access to acute hospital services, to the huge benefit of our population. It needs to happen.

While managers and clinicians will continue to articulate and debate their differing views, the primacy of patient needs demands that we work together to enhance the contribution and position of Primary Care at the heart of our services. 'Caring for People Beyond Tomorrow' will guide us on that journey.

*"Honest differences are often a healthy sign of progress."
M. Gandhi (1869 – 1948).*

4.5 Prescribing Support within NHSSB 2004/05

The Prescribing Support Team works within the Family Practitioner Unit to maximise patient care through the promotion of high quality prescribing. The team consists of seven Prescribing Advisers, four Prescribing Support Assistants, and one Nurse Prescribing Adviser. They apply their collective knowledge and expertise to provide independent advice, support and training in all aspects of prescribing.

(i) Prescribing Strategy 2004/05

The Prescribing Support Team consulted with GPs, and practice staff from across the Northern Board to develop their strategy and focus on areas for the year ahead.

Full details of the activities of the team are detailed in the NHSSB Prescribing Support Team Report 2004/05, which can be viewed at www.nhssb.n-i.nhs.uk/prescribing

(ii) NHSSB Performance Against Prescribing Budget 2004/05

The primary care prescribing budget 2005/06 for NHSSB is £81.2 million. This covers prescribing by GPs and other prescribers in 82 Practices, to 420K patients. In 2002/03, NHSSB prescribing budget was underspent by 1%.

However, in 2003/04 and 2004/05 overspends were 3% and 7% (5.6K) respectively. This trend is mirrored across NI and rest of UK and in part reflects the significant impact of the new GMS contract. It is estimated that within NHSSB the increase in prescribing costs attributable to the new contract in 2004/05 was £2.7m.

The primary care prescribing budget has become increasingly difficult to manage for a number of reasons including its ring-fenced nature (it is not possible to move money from or into prescribing budget from other resources) and changes to the budget setting guidance issued by the Department of Health and Social Services and Public Safety (DHSSPS) which effectively disadvantaged those practices that had previously under spent.

There are new cost pressures which influence on prescribing spend including the new GMS contract. Longer established demands and problems linked to the management of the budget include poor access to non-therapeutic management strategies and delay in receiving prescribing information for analysis.

The Prescribing Support Team have analysed 2004/05 prescribing information to investigate some of the reasons why it has been difficult for primary care prescribing to remain within budget. Where applicable, actions/projects undertaken by the Prescribing Support Team were documented and recommendations on future actions made.

This issue has been discussed with NHSSB Senior Management Team, NLMC and with colleagues within primary care in other Boards and actions identified which need addressed regionally have been highlighted to DHSSPS colleagues.

4.6 GP Annual Appraisal

PfA requires that all GPs should participate in annual appraisal by 31 March 2006. The Board working with GPs and the Local Appraisal Group, continues to facilitate implementation of the appraisal scheme and promote local quality assurance processes.

Since April 2003 GPs across Northern Ireland have been required to participate in an annual appraisal by a peer. As a formative process, Appraisal leads the GP and the Appraiser to identify and agree educational needs for the following 12 months along with local problems with service delivery.

During 2005/06 the Northern Local GP Appraisal Group has overseen the quality of appraisal and worked with the FPU on the production of the second Annual Appraisal Report. From 1 April 2006 this function is to be carried out by NIMDTA funded centrally by DHSSPS. NHSSB input remains through membership of the regional GP Appraisal Group which will oversee NIMDTA's work and the regional appraisal co-ordination will require to seek the Board's assistance and support in dealing with serious GP underperformance issues arising from the appraisal process.

4.7 Review of 2004/05 GMS Investments

The introduction of the New GMS Contract on 1 April 2004 has resulted in an unprecedented level of investment in primary care – over 3 years an extra £44 million will increase total Northern Ireland spend on primary care by 33%.

There have been radical changes in how resources are allocated from DHSS&PS to Boards and then practices and indeed for the first time each Board has received a cash-limited sum for GMS.

The overall Board expenditure for the first year of the New GMS Contract can be summarised as follows:

Description	2004/05 Actual £000
Total GMS expenditure	43,409
Less: DHSSPS Allocations received	(40,768)
Shortfall funded by Northern Board	2,641

This shortfall of £2.641m on Departmental funding was funded by the Board on a non-recurrent basis and related to the following main areas:

- **Quality and Outcomes Framework - £784,000** average achievement was 1,008 points but Departmental funding covered only 909 points i.e. a difference of 100 points;
- **National Enhanced Services - £426,000** – the Department made a total of £500,000 available for all 4 Boards but Northern Board expenditure alone was £546,000;
- **Seniority £293,000** – this represents a shortfall of 31% on the level of funding provided by the Department;
- **Out of Hours £994,000** – of which £392,000 was for Nurse Triage and £502,000 was the additional cost of funding the service from 1 October 2004 rather than 1 January 2005.

4.8 Prevention, Detection and Management of Under Performance in General Practice

The final Report of the Shipman Enquiry contained a large number of recommendations and the DHSSPSNI has been actively considering how best to ensure their implementation in the NI context from August 2005. Many areas relating to Professional and Practice Performance are affected by this report but to date the main emphasis has been to stipulate the development of Clinical Governance systems at both Board and Practice level. Support has been by the Department's Clinical and Social Care Governance Unit working with a specially created Regional Group of Primary Care Medical Advisers. Training in this area has also been provided by NIMDTA in collaboration with the Board's own Medical Advisers and offered to all practices in the Autumn of 2005.

The legislation required to allow temporary suspension by Boards of a General Medical Practitioner on the grounds of serious concerns in relation to standards of professional performance (similar to that existing for some years in the UK) is to be introduced in NI as part of a composite package covering various aspects of Primary Care during the Parliamentary session of 2005/06. The use of this legislation in practice at Board level will require the active involvement and use of the LAIP set up in 2004.

The National Clinical Assessment Authority (NCAA) has now been contracted by DHSSPSNI to provides its services to Trusts and Boards in Northern Ireland and the LAIP will be therefore able to tap into it's special expertise in the assessment of General Medical Practitioner performance.

Finally, the appraisal process has the potential to allow issues of serious concerns about any individual Practitioner's performance and/or competencies to be raised by the Appraiser approaching a Board Medical Adviser and asking for the issues to be appropriately considered.

4.9 General Pharmaceutical Services

February 2004 marked the launch of a joint strategy document for community pharmacy called "Making it Better". Since then, Board pharmacists have been working with Departmental officers and with their counterparts from other Boards to develop an implementation action plan which will be taken forward in parallel with consultation on a completely new local contract for community pharmacists. The new contract is expected to incorporate many of the key themes from the strategy, but it will be some time before the contractual negotiations are completed

The Board has continued to work with community pharmacists, LHSCGs and Pharmacy Locality Groups to promote the development of innovative pharmacy schemes across the area. For example the:

- Development and implementation of a Minor Ailments service which was launched in November 2005;
- Promotion of 'flu vaccination through a winter health campaign;
- Provision of specialist smoking cessation advice and support;
- Support for intravenous drug users through a supervised dispensing service;
- Establishment of a Palliative Care network of 12 community pharmacists funded by the Big Lottery Fund; and,
- Organisation of a number of successful training events which were delivered in co-operation with officers from the Central Services Agency, Counter Fraud Unit and other bodies.

4.10 What Has Been Happening in Dentistry Over the Last 12 Months

2005/06 was the third year of the DHSSPS Quality Improvement Scheme for dentistry. The focus this time was on patient safety and the NHSSB was allocated £245,800 to distribute among its health service dental practices. Also this year, for the first time, it was agreed regionally that the amount allocated to each practice was to be based on the number of

GDS patients registered with each practice on 1 April 2005. On this basis grants awarded ranged from £541 to almost £12,000. Seventy-eight out of the 85 NHSSB dental practices applied for a grant and all applications met the required eligibility criteria. Proposed projects included low-cost items such as dental handpieces through to digital x-ray systems. Payment of the grant takes place when proof of purchase is received by the Board. To date we have been able to pay grants to 50 NHSSB practices.

Northern Ireland children continue to have the highest levels of dental decay in the UK and among the highest in Western Europe. Tooth decay levels in the NHSSB are on a par with the Northern Ireland figures. As a consequence of these high disease levels, last year over 1,100 children in the Board area received a hospital general anaesthetic to have teeth extracted. Each of these children had, on average 5 teeth removed. The Community Dental Service (CDS) across the Board area has a number of longstanding tooth decay prevention programmes aimed at reducing the need for dental general anaesthetics. In an added boost to these efforts, this year the Board, working in collaboration along with the CDS in Causeway and Homefirst Trusts, was successful in obtaining over £31,000 recurrently over the next 3 years to fund new evidence-based decay reduction programmes.

One of the key roles of the Board's dental practice advisor is to carry out inspections of the General Dental Practices. During these visits the practice advisor will make thorough checks of practice health and safety procedures and the required quality assurance processes. This year the Board has provided additional funding for these visits and this has allowed a fourfold increase in the number of visits carried out over 2004/05 figures.

In August 2005 the DHSSPS issued a circular to the Boards and to all Northern Ireland GDPs setting out a new process for the post-payment verification of dental claims. Planning and arranging the current programme of claim-to-record-checks (CRC) has consumed a considerable proportion of the NHSSB dental probity officer's time and has reduced the time spent on

routine screening of payment data. By the end of December 2005 we expect that 2/3 of the Board's GPs will have gone through the CRC process, considerably more than in any other of the three Boards.

Over the last year access to health service dentistry across Northern Ireland has been an issue that is gaining prominence not only in the media but also among local politicians. Under the terms of the current GDS contract, dentists are free to opt out of the health service either completely or to a limited degree. Undoubtedly, in all four Northern Ireland Health Boards the proportion of primary dental care provided privately is increasing. At the same time there has been a reduction in the availability of health service dental care. Where this has happened among a number of practices in an area, local residents without access to a car may find themselves unable to find a health service dentist willing to treat them. In the NHSSB this problem is most acute in the Mid-Ulster area. To address this issue the Board has organised a discussion event open to all dentists in the Mid-Ulster LHSCG area and continues to explore options with the CDS of both Homefirst and Causeway Trusts. An outline bid for funding for a salaried dentist to work in the area has been submitted to the DHSSPS. If successful this would be the first scheme of its type in Northern Ireland.

4.11 Primary Care Dental Strategy

The Primary Care Dental Strategy, along with the Oral health Strategy, will provide the drivers to address some of the pressing problems in dental service provision: improving access to NHS dentistry and reducing the very high levels of dental decay in our children, the worst in the UK, will require a degree of lateral thinking and cooperation if we are to deal with these unacceptable problems.



Section 5

**Improving Quality in
Primary Care Initiatives**

***(To Be Included in
Phase Two)***



Section 6

**Investment in
Primary
Care in 2005/06**

6. INVESTMENTS IN PRIMARY CARE 2005/06

6.1 Summary

Within the four Family Practitioner Services, the overall projected expenditure for 2005/06 is £167 million and this represents approximately 24% of the Board's total expenditure.

The table below shows a four-year summary of Family Practitioner Services expenditure and highlights the fact that there has been a 31% increase during this period.

	2002/03 Actual £000	2003/04 Actual £000	2004/05 Actual £000	2005/06 Projected CYE £000
Medical	31,362	38,729*	43,498*	51,064*
Dental	17,785	18,695	18,807	18,950
Pharmaceutical	75,863	87,542	93,817	94,000
Ophthalmic	2,855	3,175	3,216	3,250
Total	127,865	148,141	159,338	167,264

**Includes IT Capital expenditure*

The Sections below provide detailed analysis of projected expenditure for General Medical Services within two main categories:

- A - New GMS Contract**
- B - Prescribing Support Team**
- C - New GMS Contract Expenditure Plan Updated**

A – NEW GMS CONTRACT EXPENDITURE PLAN

The expenditure proposals for 2005/06 are outlined below together with comparative figures for 2004/05:

	Description	2005/06 Projected FYE £000	2004/05 Actual £000
i	Global Sum	19,177	19,703
ii	Correction Factors	3,885	3,891
iii	Premises (recurring)	3,566	3,297
iv	Quality and Outcomes Framework	11,193	7,010
v	IM&T Revenue	1,282	574
vi	Directed Enhanced Services	2,812	2,614
vii	National Enhanced Services	599	546
viii	Local Enhanced Services	479	421
ix	Seniority and Locum payments	1,708	1,482
x	Out-of-Hours	4,978	3,155
xi	Other Services	349	197
	Total	50,028	42,890

NB: During 2004/05 a further £519,000 was paid to practices in relation to the old 1990 GP Contract.

Overview

The costs identified for 2005/06 are based on the Full Year Effect (FYE) i.e. the estimated maximum funding required to ensure that sufficient resources are available on a recurring basis to maintain the various services. For example, the costs for Quality and Outcomes assume that practices will achieve 1,050 points and that the Service Level Agreement for IT maintenance are fully operational.

However, it is recognised that there will be slippage on these projected costs during 2005/06 and the Board will continue to monitor expenditure to ensure that potential underspends are identified at an early stage to enable funds to be reinvested in GMS services.

In addition to Departmental funding, the Board has made available a recurrent allocation of £500k to fund Prescribing Advisers, Enhanced Service Developments, Clinical Governance and GP Practice training programmes.

Planning Assumptions and Financial Considerations

The main assumptions and considerations included within these costings are outlined below:

- (i) **Global Sum £19.18m** – Under the terms of the new Contract there has been no % uplift in 2005/06 to the amount payable for each weighted patient.

It should be noted that whilst both annual figures are stated net of the 6% deduction for the Out of Hours opt-out, in 2004/05 practices were only able to opt-out for the 6 month period from 1 October 2004 onwards.

- (ii) **Correction Factor £3.89m** – to ensure that no practice lost out as a result of the new allocation formula, the Contract included a Minimum Practice Income Guarantee (MPIG). The MPIG was calculated by comparing income for essential and additional services under the new contract at 1 April 2004 (Global Sum) with the equivalent income previously received under the old Red Book (Global Sum Equivalent).

If the Global Sum was more than the Global Sum Equivalent then there was no need for the MPIG. However, if there was any shortfall, income is protected by the MPIG and the practice will receive a Correction Factor payment.

It should also be noted that Correction Factors have been re-stated in 2005/06 to reflect the fact that funding for GP Appraisal is now allocated on the basis of a practice's weighted population rather than the number of GPs.

- (iii) **Premises £3.57m** – Beyond the current programme, no additional resources have been made available to the Board by the Department and this will severely inhibit the future level of development opportunities. Staff within the Family Practitioner Unit have been working on a business case to secure additional Board funds, but no final decision has been taken yet.
- (iv) **Quality and Outcomes Framework £11.19m** – Based on an average list size and patient profile each point achieved will be worth £122 in 2005/06. This represents an increase of 61% from the 2004/05 price of £76 and funding for QOF now accounts for 22% of the overall GMS envelope. It should also be noted that the Quality Preparation Payments of £0.28m (£3,250 per average practice) ceased in 2004/05.

- (v) **IM&T Revenue £1.28m**- Negotiations have been continued with suppliers to secure the necessary contracts that will enable the Board to sign Service Level Agreements (SLAs) with practices. However, it is expected that the earliest date for the SLAs being operational is 1 April 2006 and in the meantime existing maintenance arrangements will continue. In addition, funding of £0.15m has been allocated for training and detailed work on these plans is ongoing to ensure effective delivery of IT training.
- (vi) **Directed Enhanced Services £2.81m** – Boards **must** ensure that these services are provided for patients of practices in their area. The funding for 2005/06 is:

Description	2005/06 Projected FYE	2004/05 Actual
Improved Access Scheme	£459,000	£441,000
Childhood Imms and Pre-School Boosters	£966,000	£927,000
Influenza and Pneumococcal Immunisations	£776,000	£644,000
Minor Surgery	£561,000	£473,000
Violent Patients	£50,000	£Nil
Quality Information Preparation Scheme (ceased in 2004/05)	£Nil	£129,000

These are based on national pricing, terms and conditions.

- (vii) **National Enhanced Services £0.60m** – Boards **may** seek to commission these services, however, this is dependent on funding available. The funding for 2005/06 is:

Description	2005/06 Projected FYE	2004/05 Actual
Anti-coagulation monitoring	£387,000	£357,000
Intra-Uterine contraception devices	£55,000	£51,000
Near-patient testing	£157,000	£138,000

- (viii) **Local Enhanced Services £0.48m** – Boards **may** seek to commission these services in response to specific local needs or innovations and is dependent on funding available. The funding for 2005/06 is:

Description	2005/06 Projected FYE	2004/05 Actual
Prescribing Substitution	£79,000	£57,000
Minor Injuries	£160,000	£82,000
Mumps	£132,000	£30,000
Neo-natal Checks	£23,000	£Nil
Expanded Near Patient Testing	£75,000	£Nil
Implanon	£8,000	£Nil
Violent Patients	£2,000	£Nil
Winter Pressures	TBC	£250,000

These are based on local pricing, terms and conditions.

- (ix) **Seniority and Locum Payments £1.71m**

Description	2005/06 Projected FYE	2004/05 Actual
Seniority	£1,413,000	£1,229,000
Other payments to GPs	£295,000	£253,000

Other payments include locum payments for maternity and paternity leave, sickness leave and doctors retainers scheme.

- (x) **Out-of-Hours £4.98m** – The Board has been statutorily responsible for delivering an Out of Hours service from 1 January 2005.

As part of the Contract negotiations, it has been agreed that £21m should be set aside regionally to cover the costs for Out of Hours in 2005/06. Each Board will receive an allocation based on the following 2 components:

- Actual share of 6% Opt-Out of £5.5m
- Capitation share of £15.5m – 24.22% in 2005/06

However, due to the nature of the Global Sum allocation formula, the Northern Board has received approximately £120,000 less than it would have received if funds had been allocated fully on a capitation basis.

- (xi) **Other Services £0.35m** – In addition to the main categories there are a number of other significant areas of GMS expenditure. The funding for 2005/06 is:

Description	2005/06 Projected FYE	2004/05 Actual
Practice Training Programmes	£100,000	£64,000
GP Appraisal – Appraisers costs	£137,000	£133,000
Clinical Audit Co-ordinator Scheme Phase III*	£40,000	N/A
Practice Development Programme Phase III*	£25,000	N/A
Other initiatives including Clinical Governance*	£47,000	N/A

**Funded from non-recurring Board slippage i.e. outside the scope of normal GMS expenditure.*

IM&T Capital allocation

A Capital allocation of £941k was issued by the Department on 16 June 2005 and it is currently expected that this will be fully spent in-year.

B – PRESCRIBING SUPPORT

The Prescribing Incentive Scheme Circular for 2005/06 was issued to Boards on 15 July 2005 and included a change in the method for allocating savings achieved. The proportion of savings that practices may retain remains at 60% but Boards may now use the remaining 40% to fund Prescribing Advisory Teams with any excess held back to offset overspends.

However, there is considerable uncertainty regarding the level of actual savings that will be achieved and in addition, figures will not be finalised until June 2006. Therefore £350,000 has been identified from within existing recurrent and non-recurrent Board allocations during 2005/06 to fund the Prescribing Support Team as follows:

- **Prescribing Support Staff £258,000** – this includes a Prescribing Adviser and Support Assistant to provide support for practices in each locality.
- **Projects/Initiatives £92,000** – examples of the projects to be undertaken in 2005/06 include:

Description	2005/06 Projected FYE
Practice Publications	£12,000
Practice/Prescribing Support Team Training	£13,000
Local Prescribing Groups	£17,000
NHS Benchmarking Club Membership	£2,000
IT Equipment	£2,000
Prescribing Advice Development Projects	£10,000
QUB Nursing Home Project	£8,000

C – NEW GMS CONTRACT EXPENDITURE PLAN UPDATED

The expenditure plan as shown in Section A has been updated in this Section to reflect in year monitoring of projected GMS slippage and pressures and the latest financial position for 2005/06 as at 7 March 2006 is outlined below:

	Description	2005/06 Projected FYE £000	2005/06 projected CYE £000	Change £000
i	Global Sum	19,177	19,204	27
ii	Correction Factors	3,885	3,885	0
iii	Premises (recurrent and non-recurrent)	3,566	3,599	33
iv	Quality and Outcomes Framework	11,193	11,080	(113)
v	IM&T Revenue	1,282	942	(340)
vi	Directed Enhanced Services	2,812	2,780	(32)
vii	National Enhanced Services	599	599	0
viii	Local Enhanced Services	479	693	214
ix	Seniority and Locum Payments	1,708	1,698	(10)
x	Out of Hours	4,978	5,293	315
xi	Other Services (excluding Prescribing Advisers/Support/Projects costs)	349	350	1
	Total Revenue Expenditure	50,028	50,123	95
	I T Capital Expenditure	941	941	
	TOTAL	£50,969	£51,064	

Note: () denotes a net decrease in expenditure

Assumptions and Financial Considerations

The following assumptions and considerations refer to the **changes** made to the above areas of expenditure and should be read in conjunction with the planning assumptions and financial considerations detailed at section A.

- (i) **Global Sum £19.20m** - reflects actual expenditure based on four quarterly payments made in 2005/06.
- (ii) **Correction Factor £3.89m** – no change from planning figure.
- (iii) **Premises £3.60m** – early in 2005/06 non-recurrent slippage of £300k had been identified mainly from premises projects that did not require full year rent and rates funding for 2005/06 and this slippage was taken into the centre together with other areas of initial slippage as detailed below.

From this Board slippage, funds totalling £333k were made available late in 2005/06 to address premises pressures. £35k was used to assist a GP Practice with premises improvements in respect of Disability Discrimination Act and health and safety requirements and a further £298k was used to assist Dalriada Urgent Care with improvements to Out of Hours premises at Arena - costs exclude work associated with the provision of a secure violent patient area (see (vi) below) and relief of dental pain facilities.

The above slippage and service pressures resulted in a net increase in expenditure of £33k.

- (iv) **Quality and Outcomes framework £11.08m** – slippage of £113k has been identified based on Practices achieving on average 1040 points out of a potential 1050 points.

- (v) **IM&T Revenue £0.94m** – slippage of £500k has been generated as a result of the Service level Agreements not being in place during 2005/06.

A potential pressure of £160k has been identified in respect of VAT on existing support arrangements.

IM&T slippage and pressure detailed above resulted in a net decrease in expenditure of £340k.

- (vi) **Directed Enhanced Services £2.78m** - In the absence of a Violent Patient DES being in place (though a local enhanced service was) slippage of £45k plus other Board slippage has been used to meet infrastructure costs of £51k associated with the provision of facilities for the management of violent patients in Arena Out of Hours Centre.

Further slippage of £38k has been identified in respect of Influenza and Pneumococcal Immunisations.

The net position of the above changes resulted in a reduction in expenditure of £32k.

- (vii) **National Enhanced Services £0.60m** – no change from planning figure.
- (viii) **Local Enhanced Services £0.69m** – slippage of £36k has been identified in respect of Substitute Medication LES (£6k) and Mumps LES (£30k).

Local Enhanced Services costing £250k have been commissioned to enable Practices to provide (a) Enhanced General Medical Services Support for Domiciliary Care and (b) Improved Patient Access to surgeries on a pilot basis (22 Practices participated).

The net position of the above changes has resulted in an increase in expenditure of £214k.

- (ix) **Seniority and Locum Payments £1.70m** - the original planning amount in respect of Seniority Payments has been reduced by £50k based on updated projected costs.

A liability of £40k is being created for locum superannuation costs in respect of 2005/06.

The net position of the above changes has resulted in a reduction in expenditure of £10k.

- (x) **Out-of Hours £5.30m** – additional pressures amounting to £315k comprise the following:

- £200k - potential overspend on OOHs Contract
- £12k - 13th July cover
- £19k - OOHs Registrar Trainer costs
- £84k - OOHs Winter Pressures

- (xi) **Other Services £0.35m** – The original planning amounts have been updated, where necessary, to reflect the current position as follows:

- £100k – Practice Training Programmes
- £137k - GP Appraisal Appraiser costs
- £15k - Clinical Audit Co-Ordinator Scheme Phase III (amount changed from £40k to £15k)
- £25k - Practice development Programme Phase III
- £30k - INR Home Monitoring Pilot
- £43k - Other Initiatives including clinical governance

IM&T Capital allocation

A Capital allocation of £941k was issued by the Department on 16 June 2005 and it is expected that this will be fully spent by 31 March 2006.



Section 7

Glossary

7. GLOSSARY

A&C	Administrative & Clerical
A&E	Accident & Emergency
AfC	Agenda for Change
AHP	Allied Health Profession
AMRAP	Antimicrobial Resistance Action Plan
CDM	Chronic Disease Management
CDS	Community Dental Service
CIR	Critical Incident Reporting
CMO	Chief Medical Officer
COPD	Chronic Pulmonary Obstructive Disease
CPA	Community Pharmacy Adviser
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse
CRC	Claim-to-record-checks
CSB	Clinical Standards Board
CYE	Current Year Effect
DBS	Developing Better Services
DDA	Disability Discrimination Act
DES	Direct Enhanced Service
DFP	Department of Finance and Policy
DHSSPS	Department of Health, Social Services & Public Safety
DIS	Directorate of Information Services
DMARDs	Disease Modifying Anti-Rheumatic Drugs
DOH	Department of Health
DRGP	Data Retrieval Group in General Practice
DUC	Dalriada Urgent Care [Formerly Dalriada Doctor on Call]
ECDL	European Computer Driving Licence
ELS	Emergency Life Support
EOD	Expression of Dissatisfaction
FOI Act 2000	Freedom of Information Act 2000
FPU	Family Practitioner Unit
FYE	Full Year Effect
GDS	General Dental Services
GMC	General Medical Council
GMS	General Medical Services
GPAS	General Practice Assessment Surveys
GPCF	General Practitioner Commissioning Facilitator

GOS	General Ophthalmic Services
GPS	General Pharmaceutical Services
GPC (NI)	General Practitioners Committee (Northern Ireland)
GPwSI	General Practitioner with Specialist Interest
HC	Healthcare Commission
HIP	Health Improvement Plan
HPSS	Health & Personal Social Services
HSSA	Health & Social Services Authority
HWIP	Health & Wellbeing Investment Plan
ICATS	Integrated Clinical Assessment and Treatment Services
ICT	Information, Communications & Technology
IfH	Investing for Health
ILS	Immediate Life Support
IMM	Integrated Medicines Management
IM&T	Information Management & Technology
IOS	Item of Service
IPA	Indicative Prescribing Amount
IPS	In-Practice Systems
IT	Information Technology
LAG	Local Appraisal Group
LAIP	Local Advisory & Investigative Panel
LES	Local Enhanced Service
LETS	Local Education and Training Scheme
LMC	Local Medical Committee
LTAP	Local Tobacco Action Plan
MA	Medical Adviser
MUH	Mid Ulster Hospital
NAPF	Northern Area Prescribing Forum
NCAA	National Clinical Assessment Authority
NES	National Enhanced Service
NHSSB	Northern Health & Social Services Board
NHSSC	Northern Health & Social Services Council
NLMC	Northern Local Medical Committee
NICE	National Institute of Clinical Excellence
NICPPET	Northern Ireland Centre for Postgraduate Pharmaceutical Education & Training
NIMDTA	Northern Ireland Medical and Dental Training Agency
NIPU	Northern Ireland Prescribing Unit

NOF	New Opportunities Fund
NPCDT	National Primary Care Development Team
NPCR&DC	National Primary Care Research & Development Centre
NSFs	National Service Frameworks
NVQ	National Vocational Qualification
OT	Occupational Therapy
OTC Medicines	Over The Counter Medicines
OOHs	Out-of-Hours
PAs	Prescribing Advisers
PCAS	Payments Calculation and Analysis System Project (replaced QMAS)
PCO	Primary Care Organisation
PCIP	Primary Care Investment Plans
PES	Public Expenditure Survey
PEST Analysis	Political/Economical/Social/Technical Analysis
PfA	Priorities for Action
PGD	Patient Group Direction
PHCT	Primary Health Care Team
PIS	Prescribing Incentive Scheme
PLG	Pharmacy Locality Group
PoC	Programme of Care
PMCP	Primary Medical Care Performers
PMS	Personal Medical Services
PPP	Professional Performance Panel
PwSIs	Practitioners with Special Interests
QMAS	Quality Management & Analysis System
QOF	Quality & Outcomes Framework
QIP	Quality Information Preparation
RCGP (NI)	Royal College of General Practice (Northern Ireland)
R&D	Research & Development
READ Code	Coding Classification for Recording Patient Clinical Information
RIS	Regional Interpreting Service
RPA	Review of Public Administration
RQIA	Regulation and Quality Improvement Authority (formerly Health and Social Services Regulation and Inspection Authority)
SDFs	Service Development Frameworks
SEA	Significant Event Auditing

SEAL TPP	South East Antrim Total Purchasing Pilot (former)
SFA	Statement of Fees & Allowances
SIGN	Scottish Inter-Collegiate Guidelines Network
SGU	Standards & Guidelines Unit
SLA	Service Level Agreement
SOP	Standard Operating Procedure
SWOT	Strengths/Weaknesses/Opportunities/Threats Analysis
SQS	Sustained Quality Scheme
TBC	To Be Confirmed
TC	Tobacco Control
TCG	Tobacco Control Group
TSN	Targeting Social Need
UHT	United Hospitals Trust
UPCI	Unique Patient Client Identifier (referred to now as Health and Care Number)
VAR	Value Added Reseller
WTD	Working Time Directive
WTE	Whole Time Equivalent