Northern Ireland Assembly

Public Accounts Committee

Report on Access to General Practice in Northern Ireland

Ordered by the Public Accounts Committee to be published 27 November 2025.

This report is embargoed until 00.01am on 4 December 2025

Report: NIA 87/22-27 Public Accounts Committee

Contents

Powers and Membership

Powers

The Public Accounts Committee is a Standing Committee established in accordance with Standing Orders under Section 60(3) of the Northern Ireland Act 1998. It is the statutory function of the Public Accounts Committee to consider the accounts, and reports on accounts laid before the Assembly.

The Public Accounts Committee is appointed under Assembly Standing Order No. 56 of the Standing Orders for the Northern Ireland Assembly. It has the power to send for persons, papers and records and to report from time to time. Neither the Chairperson nor Deputy Chairperson of the Committee shall be a member of the same political party as the Minister of Finance or of any junior minister appointed to the Department of Finance.

Membership

The Committee has 9 members, including a Chairperson and Deputy Chairperson, and a quorum of five members. The membership of the Committee is as follows:

- Mr Daniel McCrossan MLA (Chairperson)
- Ms Diane Forsythe MLA (Deputy Chairperson)[4]
- Mr Cathal Boylan MLA
- Mr Tom Buchanan MLA
- Mr Jon Burrows MLA[1,2,3,6]
- Mr Pádraig Delargy MLA
- Mr Stephen Dunne MLA[5]
- Mr Colm Gildernew MLA
- Mr David Honeyford MLA

[1]With effect from 5 March 2024 Mr John Stewart replaced Mr Robbie Butler

[2]With effect from 21 October 2024 Mr Colin Crawford replaced Mr John Stewart

[3]With effect from 31 July 2025 Mr Colin Crawford resigned

[4]With effect from 16 September 2025 Ms Diane Forsythe replaced Ms Cheryl Brownlee as Deputy Chairperson

[5]With effect from 23 September 2025 Mr Stephen Dunne replaced Ms Cheryl Brownlee

[6]With effect from 6 October 2025 Mr Jon Burrows replaced Mr Colin Crawford

List of Abbreviations and Acronyms used in this Report

BMA	British Medical Association
C&AG	Comptroller and Auditor General
GP	General Practitioners
MDTs	Multi-disciplinary teams
NI	Northern Ireland
NIAO	Northern Ireland Audit Office
ONS	Office for National Statistics
PCC	Patient and Client Council
PHA	Public Health Agency
RCGPNI	Royal College of General Practitioners Northern Ireland
SPPG	Strategic Performance and Planning Group
The Assembly	The Northern Ireland Assembly
The Committee	Public Accounts Committee
The Department	Department of Health

Executive Summary

1. The Public Accounts Committee met on 27 February 2025 and 6 March 2025 to consider the Northern Ireland Audit Office's (NIAO) report "Access to General Practice in Northern Ireland". The main witnesses were:

<u>27 February 2025, the British Medical Association NI, Royal College of General Practitioners NI and the Patient and Client Council</u>

- **Dr Ciaran Mullan,** British Medical Association NI;
- **Dr Frances O'Hagan,** British Medical Association NI;
- **Dr Ursula Mason,** Royal College of General Practitioners NI;
- **Dr Emma Murtagh,** Royal College of General Practitioners NI;
- **Mr Peter Hutchinson**, Patient and Client Council;
- **Ms Katherine McElroy**, Patient and Client Council;
- **Ms Meadhbha Monaghan**, Patient and Client Council;
- **Dorinnia Carville**, C&AG, Northern Ireland Audit Office; and
- **Stuart Stevenson**, Treasury Officer of Accounts, Department of Finance.

<u>6 March 2025, the Department of Health</u>

- **Mr Peter May,** Department of Health;
- **Mr Gearóid Cassidy**, Department of Health; and
- **Dr Margaret O'Brien**, Department of Health.

Access to Primary Care must be urgently improved for patients

2. Getting access to a GP is a cornerstone of basic medical care for everyone. However, even this basic step has felt impossible for many in Northern Ireland. Evidence given to this Committee has demonstrated that too often patients face a series of hurdles that do not appear to be related to medical need.

3. Improving access to Primary Care for patients is vital. The Committee recognises, though, that improving access can only be achieved by stabilising a sector that is in crisis. The current situation, of a sector in seemingly irreversible decline, is not sustainable.

4. The evidence provided to the Committee has made it clear that improvements in access to Primary Care will be dependent on strong and effective working relationships between the Department and GPs. These relationships aren't currently in place. It is incumbent on all involved to work together to deliver better outcomes for those in need.

The 'patient's voice' needs to be better understood

5. The Committee heard that whilst there are mechanisms in place to collect information from the public, they are not being exploited to their fullest. Evidence received by the Committee demonstrates a lack of interaction between the Department and the Patient and Client Council (PCC), especially in the area of access to Primary Care.

6. As a result, the Committee is convinced that more could be done to understand the patient experience at a regional level. Much more could be done to recognise good practice, understand what is working well and try to replicate it. The Committee welcomes the Department's acceptance that it could increase the extent to which the 'patient's voice' feeds into plans to increase the public's ability to access their GPs.

7. Members took the significant step of carrying out a survey regarding Primary Care services, which ran alongside the Committee's Inquiry. This survey was open to all members of the public in Northern Ireland. It is unprecedented that over 15,000 respondents took part in the survey. This overwhelming response emphasises the power of the patient voice and just how important access to GPs is to the general public.

The Department must take strategic action to improve access to Primary Care

8. In evidence provided to the Committee, much has been made of the number of actions now undertaken by the Department and its Strategic Performance and Planning Group (SPPG). The Committee, however, is left with the overwhelming impression that these actions have been piecemeal, uncoordinated and not driven by a strategic, long term plan. In the Committee's view, it is now essential that action is taken to improve access to Primary Care, and that this action is guided by a revised strategy.

9. The Committee welcomed the evidence it received outlining the need for healthcare transformation. For too long, transformation has been thought of as solely an issue for secondary care and the location of services. Our healthcare system is interlinked, and transformation to provide better services in Primary Care is needed as much as in secondary care.

10. The Committee's work has identified a number of actions that the Department should commence now, both short and long term, to stabilise the sector and improve access for patients to GP services in Northern Ireland. These actions must be underpinned by a comprehensive strategy for Primary Care in Northern Ireland.

A workforce strategy for Primary Care is urgently needed

11. During the evidence session, the Department was unable to provide basic information relating to the workforce in Primary Care in Northern Ireland. For instance, the Department still does not know the number of full-time equivalent GPs who work here. This is a basic factor in understanding the limitations on accessing Primary Care.

12. Given the lack of information about the current workforce, the Department was unable to provide clarity around the number of GPs that it needs to train. Without reliable workforce data on the number of full-time equivalent GPs who work in Northern Ireland, it is extremely difficult for the Department to make informed decisions about the number of trained GPs it requires each year.

13. The Committee were told that there is no workforce strategy for Primary Care in place in Northern Ireland. Such a strategy should serve to underpin all plans regarding the recruitment and retention of GPs, and provide a foundation from which important decisions regarding the GP workforce can be made.

The variation in accessing GPs throughout Northern Ireland is unwarranted and must be addressed

14. Much of what we were told in the survey was about a confusing patchwork of approaches that had developed over time and was rarely aimed at improving the service that patients receive. This level of unwarranted variability – phonecalls at 8:30, queuing outside practice buildings or waiting for call backs – adds more challenges for patients. One clear message from the huge numbers of patients who responded to the survey was that there was significant and often unwarranted variation in accessing GPs across individual practices.

15. The Committee's survey also highlighted that heavy reliance on telephone systems, and limited alternatives such as online or digital routes, further contributed to these difficulties for many patients.

16. The Committee believes that consistency and fairness should be a welcome goal for both the Department and GPs themselves. The Committee recognise the role of GPs as independent contractors but is strongly of the view that the Department must engage further and work with GPs to ensure that access is fair and appropriate for all.

The Department needs better oversight of patient access to GPs

17. Despite patient access being such a critically important issue for many, the Department has virtually no measure of it. The Department told the Committee it remains very difficult to secure reliable data regarding patient access to services. In the Committee's view, this is unacceptable. The Department should have oversight of this sector. Yet the evidence provided to this Committee is that it has little idea of the demand for its services. The Committee cannot see any reasonable way in which the Department could possibly plan to deliver an effective service without an estimate of demand.

18. Whilst the Department felt this was 'too difficult', elsewhere there are well-established means of measuring patients access to GPs. The Office for National Statistics' (ONS) Health Insights Survey – which has been running roughly once a month for close to one year – tracks data relating to patient access to GPs. In our view, this demonstrates that the Department has not prioritised issues that are important to patients.

The Department must lead on developing new models of service delivery for Primary Care in Northern Ireland

19. The Permanent Secretary confirmed that Northern Ireland had now moved beyond there being only one model for General Practice. The Committee recognises this change – but we note that it hasn't been driven by proactive leadership from the Department, by a strategic or policy decision, but by short term reactions to various crises.

20. Amidst the current crisis, there have been some positive moves in developing and innovating the delivery model for Primary Care. Nevertheless, innovation and change has been relatively slow and small scale to date. To safeguard services, and begin to build for the future, it is the Committee's belief that the Department should now be more proactive in leading the conversation on future delivery models if they would be better for patients, better for the public purse, and better for attracting and retaining GPs.

21. The Committee notes that feedback from the survey also demonstrated public support for more consistent and modernised access arrangements.

The use of locums needs to be carefully managed

22. Locum doctors can often provide an important service, allowing practices to cover planned gaps, offer additional capacity or cover absences. Any system is likely to require some locum use. However, the Committee were concerned by the manner in which locums were used when contracts were handed back, and the subsequent costs.

23. The Committee heard that 'in many instances' contracts have been handed back by partners who have then been immediately re-employed in the same

practices as locums. The Committee do not believe that it can be appropriate to re-employ the same staff, to do the same job as a GP – without the responsibility of running a practice – but at such a significantly high rate of pay. This is not an acceptable way to manage public money.

Plans for the roll-out of e-prescribing need more urgency

24. The increasing pace of IT change does not appear to have been matched by an increased pace of delivery across the Health sector. The Department must consider how placing a greater focus on innovation and delivery of important IT projects more broadly can increase productivity and improve public services. The Committee is of the view that a particular focus must be given to hastening the introduction of e-prescribing.

The roll out of multi-disciplinary teams in Primary Care needs urgently evaluated

25. The establishment of multi-disciplinary teams (MDTs) is a key element of transformation in both primary care and wider healthcare in Northern Ireland. Progress in the delivery of MDTs to date has been exceptionally slow. While originally launched in September 2018 aiming for incremental roll out across the country over five years, by September 2024 MDTs had been introduced in only seven of the 17 GP Federation areas in Northern Ireland. Disappointingly, MDTs were fully implemented in only one area.

26. The Committee has concerns over the lack of ambition in the Department's plans for future roll-out in this crucial transformation programme. Even after another five years, MDTs will only reach two-thirds of the population. Ten or more years into what was intended as a five-year programme, one third of the population will still be without an MDT. The Department's plans will serve only to prolong the inequality of service faced by a significant proportion of patients in general practice, although we acknowledge the Department's efforts in targeting its separate programme for the development of nurse practitioners towards areas without MDTs.

Summary of Recommendations

Recommendation 1

The Committee recommends that the Department should implement more targeted education to ensure that the public have a greater awareness of the most appropriate avenues of care, whether that be the GP, pharmacist, emergency department or minor injuries unit. The Department must develop and roll out a public education programme within a year of this report's publication. The Committee also expects the Department to develop monitoring mechanisms in secondary care to measure attendances that could have been dealt with elsewhere, including in primary care settings. Such mechanisms should be put in place during 2026.

Recommendation 2

The Committee recommends that the Department reviews all the data it currently holds on patient experience in primary care. Particular focus should be given to complaints about GP practices with relevant information shared to enable trends to be identified and improvements to be made.

The Committee also notes that the findings from its citizen space survey demonstrated the value of systematically capturing and analysing patient feedback and considers that this underscores the need for a more coherent and comprehensive approach to monitoring patient experience.

Recommendation 3

We recommend that the Department produce a strategy for Primary Care in Northern Ireland within a year of this report. This should set out the future direction for services and reflect the Department's aspirations for a strong Primary Care sector, which is accessible to those when they need it and have strong focus on meeting the needs of patients. The strategy should:

- have the patients' voice at its heart. The Committee recommends that necessary work is undertaken and plans are put in place to ensure patient experience about access to services is well-understood at

departmental level. This should include, but not be limited to, having regular engagement with PCC to allow it to better utilise information from patients in its service design.

- be focused on a fair and equitable access across Northern Ireland, including for those who face higher barriers to accessing services.

- ensure consistency in access to and quality of GP services across Northern Ireland. The Committee recommends that, in partnership with GPs, the Department works to set minimum standards, achieve the full roll-out of the best practice guide and identify alternative access routes to Primary Care.

Recommendation 4

As part of the overall Primary Care strategy, the Committee recommends that the Department produces a workforce strategy for primary care. This strategy should encompass not only GPs, but also the multitude of skills required for delivering a modern, effective primary care service, including those in the MDT programme.

Recommendation 5

The Committee recommends that the Department ensures the future Primary Care strategy is based on reliable data regarding both the level of access to GPs which the public requires and current Primary Care workforce levels. To enable this, the Committee expects the Department to:

- identify, collect and utilise data regarding the current GP workforce levels. This will be crucial to any future plans which the Department makes about the workforce, including regarding training and retention of GPs.

- actively engage with GPs to develop innovative solutions that would support recruitment and retention.

Recommendation 6

The Committee recommends that the Department seeks to secure reliable data regarding patient demand for and access to services. Work should be undertaken to learn from the ONS Health Insights Survey about how to capture this information in Northern Ireland. The Committee expects the Department to have arrangements in place to capture information within six months. This will enable the Department to make informed decisions regarding patient access to GP services and demonstrate improvements to access.

Recommendation 7

The Committee recommends that the Department carries out an immediate review to consider the reasons behind contract handbacks to date. This review should consider whether there are any incentives, real or perceived, which may be incentivising handbacks such as high locum rates. It should also consider whether Trusts have sufficient capability and capacity to deliver effective primary care services, given the very limited success of removing these contracts.

Recommendation 8

The Committee recommends that the Department expediates the consideration and implementation of suitable alternatives to the current model for delivering Primary Care. This should form part of the Department's Primary Care strategy.

Recommendation 9

The Committee recommends that the Department introduces e-prescribing as a matter of urgency. The current pace of delivery is unacceptable. As an initial stage, the Committee expects the Department to have completed a business case within six months.

Recommendation 10

The Committee recommends that the Department uses the learning from its evaluation of the MDT model to inform the pace and extent of the future roll-out. Consideration must also be given to the additional support that

can be provided to practices without an MDT, to ensure fairer access for patients.

Patients are experiencing significant difficulties in getting basic access to their GP

27. Primary Care services are critical for the health system to function effectively. GPs play a crucial role in not only providing care, but also referring and signposting patients to secondary care, social care and specialist treatment. It is absolutely vital that Primary Care services operate as effectively as possible and provide good value-for-money for citizens here. Crucially, people need to feel not only that their GP provides a quality service but also to be able to access the service without undue difficulty.

28. However, recent years have seen members increasingly hear from constituents in despair at failed efforts to reach their GP. The Committee recognises that this has caused untold distress to patients, their loved ones and also adds pressure to those working in GP practices. Members also find the scale at which they have been contacted as elected representatives, by patients who feel incapable of accessing their GP, to be totally unacceptable.

29. The Committee's survey echoed these concerns, with many respondents reporting repeated unsuccessful attempts to contact their practice and describing similar levels of frustration and distress. These challenges show that this is a sector in crisis.

There is a huge demand for patient access and much is unmet

30. The Committee understands the huge strain on resources right across the healthcare system, both in terms of demands for services and on the available funding for them. The scale of services provided by GPs is also striking. The Committee were told that on average GPs in Northern Ireland have around 200,000 patient contacts in a standard week and more than that during the winter. This represents around 10 per cent of the population in Northern Ireland.

31. Whilst the Committee recognises that comparisons across different jurisdictions and with different health systems are challenging, the scale of demand placed on Primary Care in Northern Ireland appears to be greater than elsewhere. For instance, the British Medical Association told the Committee that in Northern Ireland, on average, a patient sees a GP nine times a year, whereas in the Republic of Ireland it is three times a year. Whilst meeting some of this demand is vital, managing the demand for Primary Care is also important to ensure access for those who need it most.

32. There is ongoing concern that patients are often accessing healthcare services inappropriately, such as attending emergency departments for issues that could be managed by a GP or visiting a GP when a pharmacist could have provided suitable advice and care. Whilst the Department told us that it makes efforts to prevent against this with general messaging regarding the availability and scope of services in different settings, officials also acknowledged that the Department needs to supplement that with more personalised, one-to-one guidance. Furthermore, the Committee is concerned that the Department does not monitor data in this area. We do not believe that the Department's assertion – that it could be challenging to capture as well as bureaucratic and time-consuming – is a sufficient reason not to explore better monitoring.

33. However, feedback from the Committee's survey also highlighted the extent of unmet demand, with many patients reporting that they were unable to secure timely access even when seeking care appropriately.

Recommendation 1

The Committee recommends that the Department should implement more targeted education to ensure that the public have a greater awareness of the most appropriate avenues of care, whether that be the GP, pharmacist, emergency department or minor injuries unit. The Department must develop and roll out a public education programme within a year of this report's publication. The Committee also expects the Department to develop monitoring mechanisms in secondary care to measure attendances that could have been dealt with elsewhere, including in

primary care settings. Such mechanisms should be put in place during 2026.

Through its survey, the Committee heard a loud and unanimous voice expressing public concern

34. Members took the significant step of releasing a survey regarding Primary Care services, which ran alongside the Committee's Inquiry. This survey, which closed on 27 March 2025, was open to all members of the public in Northern Ireland. It is unprecedented that over 15,000 respondents took part in the survey which generated over 13,000 free-text comments. The Committee regards this as a significant source of evidence on how access arrangements are operating in practice and emphasises how important access to GPs is to the public.

35. The survey's findings are stark regarding patient access, highlighting the significance of the problem in Northern Ireland. Respondents consistently reported difficulty contacting their practice by telephone, limited appointment availability and high levels of dissatisfaction with access overall. More than half rated their experience as poor, with only a small proportion reporting positive experience in accessing GP services in the past year.

36. The Committee also notes that the survey provided new insight into aspects of patient experience not fully captured in departmental data or stakeholder evidence. These included clear indications of digital exclusion, with only a minority reporting access to online booking and many citing barriers linked to disability, limited digital skills or inadequate mobile coverage. The responses also pointed to uneven impacts on particular groups, including carers, working parents, people with mobility issues and those managing long-term conditions.

37. Comments further highlighted the wider personal consequences of access difficulties, including stress, anxiety, repeated unsuccessful attempts to secure appointments and, in some cases, financial costs associated with private consultations or extensive telephone calls. These accounts provide important context on the cumulative impact of access barriers.

38. The Committee notes that some respondents identified examples of more effective practice—such as structured call-back systems, online triage forms and hybrid digital/telephone approaches—which were viewed positively where available. These examples demonstrate that more consistent and accessible models are achievable.

39. Overall, the survey results reinforce the Committee's conclusions regarding the scale and impact of current access challenges, while also providing new evidence on digital barriers, unequal experiences and the wider effects on patients.

The 'patient's voice' needs to be better understood

40. The Committee heard how important including the 'patient's voice' is in healthcare service design, both from witnesses and its own survey. Receiving feedback from service users is an important means assessing the quality of the services being provided and driving improvements. The Department has its own Arm's Length Body to provide it with this information, the Patient and Client Council.

41. However, the evidence received by the Committee demonstrated a lack of interaction between the Department and the Patient and Client Council (PCC), especially in the area of access to Primary Care. This raises concerns that the 'patient's voice' is not being sufficiently heard in the design and delivery of services. This underpins the critical importance of co-production and co-design. The Department is failing to make best use of the public services it funds.

42. One clear example of this was around patient complaints about Primary Care services. The evidence provided by the PCC outlined how it has seen a rise in complaints about GP services in recent years, by 70 per cent from 2022 to 2023. In contrast, however, the Department's own Strategic Planning and Performance Group (SPPG) has seen a downward trend in the number of complaints it has received regarding GPs during this time. The scale of the response to the Committee's own survey demonstrates that there are huge levels of concern about patient access. This raises concerns that the

Department's oversight is not sufficient to give it a accurate view of the issues impacting the sector.

43. The Committee finds it extremely disappointing that an Arm's Length Body of the Department can hold these statistics, which appear to contradict data held by another part of the Department. This raises concerns about the effectiveness of SPPG which should be alert to key complaints data trends of this nature. The Committee believes this situation requires immediate remedy through greater collaboration between the PCC and SPPG regarding complaints about GP services.

Patient experience needs to be better understood

44. The Committee heard that whilst there are mechanisms in place to collect information from the public, they are not being utilised to their fullest potential on behalf of Service Users. The PCC highlighted the Care Opinion platform which is a regional patient experience platform run by the Public Health Agency (PHA). The Committee was told how 68 stories, in relation to GP services, were posted on Care Opinion last year, the majority of which are wholly positive. The PCC called this one mechanism through which the patient experience is heard across the region.

45. The Committee however strongly agrees with the PCC who stated that more could be done with GP and primary care services to understand the patient experience at a regional level. The PCC outlined that much more could be done to either harness the patient experiences in GP practices that we are hearing about and elevate them to a regional level or embrace the patient experience, more broadly, to recognise good practice and understand what is working well and try to replicate it. The Committee welcomes the Department's acceptance that it could increase the extent to which the 'patient's voice' feeds into plans to increase the public's ability to access their GPs. The Committee is in agreement with both the PCC and the Department in this regard.

46. However, the Committee recognises that for this to occur successfully, there is a reliance on GP learning from their patients through active engagement with them. Findings from such engagement can then be fed back to the Department,

which can then ensure the 'patient's voice' is heard and acted upon. The Department told the Committee that it is planning to introduce this requirement in contract negotiations with GP representatives. The Committee welcomes this and encourages the Department to continue this approach.

Recommendation 2

The Committee recommends that the Department reviews all the data it currently holds on patient experience in primary care. Particular focus should be given to complaints about GP practices with relevant information shared to enable trends to be identified and improvements to be made.

The Department must take strategic action to improve access to Primary Care

47. Much of the evidence that the Committee heard showed that the Department's actions were piecemeal, reactive and uncoordinated. It is clear to the Committee that a successful Primary Care sector requires strategic long-term leadership and a clear direction. In our opinion, the Department is not currently delivering this.

48. The Committee welcomed the evidence it received outlining the need for healthcare transformation. For too long, transformation has been thought of as solely an issue for secondary care and the location of services. Our healthcare system is interlinked, and transformation to provide better services in Primary Care is as needed as elsewhere.

49. Whilst there are many short and long term improvements that must be made to Primary Care services, which are outlined both in this report and in the evidence heard by the Committee, it is important that they are consistent and driven by a coherent policy direction for the entire health sector in Northern Ireland. This should give confidence to both those who work in Primary Care and to the patients who rely on Primary Care, that the Department has a long term plan for the sector.

Recommendation 3

We recommend that the Department produce a strategy for Primary Care in Northern Ireland within a year of this report. This should set out the future direction for services and reflect the Department's aspirations for a strong Primary Care sector, which is accessible to those when they need it and have strong focus on meeting the needs of patients. The strategy should:

- **have the patients' voice at its heart. The Committee recommends that necessary work is undertaken and plans are put in place to ensure patient experience about access to services is well-understood at departmental level. This should include, but not be limited to, having regular engagement with PCC to allow it to better utilise information from patients in its service design.**
- **be focused on fair and equitable access across Northern Ireland, including for those who face higher barriers to accessing services.**
- **ensure consistency in access to and quality of GP services across Northern Ireland. The Committee recommends that, in partnership with GPs, the Department works to set minimum standards, achieve the full roll-out of the best practice guide and identify alternative access routes to Primary Care.**

50. In its evidence, the Department told the Committee that it had plans to drive improvements to access through a move towards minimum standards for service provision. While the Department said it "will not get there this year", it does aim to reach a position where such standards are agreed in contract negotiations with GP representatives.

51. The Committee believes setting such standards will decrease the likelihood of unwarranted variance in access to Primary Care services throughout Northern Ireland. This will also provide accountability in cases where specific GP practices fail to meet acceptable standards. It is essential that the Department aims to agree minimum standards with GP representatives as quickly as possible.

52. The Committee welcomes the Department's work producing a best practice guide for GPs on "Making all contacts count", which aims to provide strategies to improve the performance of GP practices. The Committee expects that this and other efforts will result in measurable improvements regarding patient access to GPs. Furthermore, the Department must ensure that GP practices are provided with sufficient assistance in implementing the best practice laid out in this guide.

There are key gaps in the Department's understanding of the Primary Care workforce

53. During the evidence sessions in this inquiry, the Committee heard that there are around 2,000 GPs on the 'performers list' in Northern Ireland. This list includes all GPs who work in General Medical services, including GPs in training. However, this number is a headcount and does not reflect the total amount of full-time equivalent GPs working in Northern Ireland.

54. During the evidence session, the Department was unable to provide basic information relating to the workforce in Primary Care in Northern Ireland. For instance, the Department still does not know the number of full-time equivalent GPs who work here. This is a basic factor in understanding the limitations on accessing Primary Care. As a result, the Committee is at a loss to understand how the Department can have any understanding of the current capacity of the Primary Care workforce. If this is not rectified, the Department will continue to be significantly hampered in all decisions relating to both patient access and workforce needs.

55. The Committee is incredulous that the Department is attempting to oversee the development of the Primary Care workforce without this basic information on current capacity. This needs to be urgently improved through better collaboration between the Department and GP practices. Once arrangements are in place to collect this information, it is essential that ongoing monitoring of this information occurs on a regular basis, to ensure details held by the Department regarding workforce remain accurate.

56. The Department advised the Committee that it has now engaged with the Northern Ireland GPs Committee on two planned workforce surveys, relating to GPs who are working in practices and also the full range of other staff working in Primary Care.

57. The Committee hopes the findings of these surveys will result in a greater understanding on the part of the Department around the Primary Care workforce in Northern Ireland and its potential capacity. It is of concern, however, that until now the Department has been providing strategic direction to a service that it does not have a full understanding of.

The number of training places for GPs has increased

58. Given the lack of information about the current workforce, the Department was unable to provide clarity around the number of GPs that it needs to train. When asked by the Committee, the Department did not provide a specific number but said “we know that we have increased the number that we need to train". The Department advised the Committee that the number of GPs in training has increased 86 per cent since 2015. Last year, the Committee was told, all 121 GP training places were filled. The year before that, 119 places of the 121 which were offered were filled.

59. The Committee recognises and welcomes the work done by the Department to increase and fill training places. However, without reliable workforce data on the number of full-time equivalent GPs who work in Northern Ireland, it is extremely difficult for the Department to make informed decisions about the number of trained GPs it requires each year.

A workforce strategy for Primary Care is urgently needed

60. The Committee were told that there is no workforce strategy for Primary Care in place in Northern Ireland. The Committee feels that it is unacceptable for the Department to try and deliver such an important service without an underlying strategy to guide the recruitment and retention of those who provide it. Such a strategy would serve to underpin all plans regarding the recruitment and

retention of GPs, and provide a foundation from which important decisions regarding the GP workforce can be made.

61. The Committee takes the view that this strategy must also take note of the public's demand for Primary Care services, to inform decisions regarding GP numbers. It is the Committee's view that improved data regarding both demand for access to GPs and the current GP workforce capacity is crucial for a prospective strategy in this area to be effective. It is also important that any Primary Care workforce strategy takes account of MDTs and the funding, and work, which is needed for them to be accessible across Northern Ireland.

Recommendation 4

As part of the overall Primary Care strategy, the Committee recommends that the Department produces a workforce strategy for primary care. This strategy should encompass not only GPs, but also the multitude of skills required for delivering a modern, effective primary care service, including those in the MDT programme.

The Royal College of GPs produced its own strategy relating to workforce

62. The Committee also heard from the Royal College of GPs that, last year, it released a document called, 'A Workforce Fit for the Future: RCGPNI Retention Strategy', which contained 17 recommendations it believes would create short to medium-term stability. However, the Royal College acknowledged that this strategy relied on additional investment and a proper workforce plan for the future.

63. Both the Royal College and the BMA told the Committee there are significant issues around workload for GPs. In part, this is the result of the pressures on hospitals and the "huge amounts of work that probably need to be done in the secondary care setting" but ends up with GPs. It also stressed the importance of digitisation, namely e-prescribing as a means of introducing potential efficiencies that reduce some of the burden on GPs.

Northern Ireland needs better schemes aimed at sustaining the Primary Care workforce

64. Whilst training more GPs to work in Primary Care will be important to stabilise the sector, the retention of those who are already there is vital. As such, the Committee sees retention schemes as an important piece of any future workforce planning. When asked about work to retain GPs, the Department advised the Committee that it has "a number of schemes in place". These include a GP retainer scheme which the Department said "offers a flexible and supportive framework for experienced GPs who wish to continue practising without committing to full-time hours". The Committee heard how this supported the retention of "skilled professionals who might otherwise leave the profession".

65. The Department also told the Committee about its GP mentor scheme, which it called an "independent, supportive and safe mechanism for individual GPs as they navigate the pressures of delivering general medical services". In addition, the Department said its Attract, Recruit, Retain scheme "has retention elements", as well as potentially helping practices "to obtain either a partner or salaried GP" through financial incentives. There is also an induction and refresher scheme for GPs.

66. In addition, the Department have put in place a regional GP fellowship scheme, which is hosted by the Northern Trust Federation. The Department told us that it has put in place a further GP fellowship scheme in the Southern Trust area, to help to recruit and retain GPs in that geographical area, in order to assist us in respect of practices that handed back their contracts."

67. Whilst these schemes are welcome, the Committee also heard that the impact to date was relatively limited. The Committee agree with the Royal College that there is scope to create novel solutions to support recruitment and retention, especially in areas where it is currently hard to recruit.

68. The Department outlined that it collects data regarding a number of the retention schemes that it operates. In the Committee's view, it is essential that the effectiveness of these schemes is rigorously assessed by the Department.

Such monitoring work will enhance learning and identify how to improve the various schemes aimed at sustaining the GP workforce.

Recommendation 5

The Committee recommends that the Department ensures the future Primary Care strategy is based on reliable data regarding both the level of access to GPs which the public requires and current Primary Care workforce levels. To enable this, the Committee expects the Department to:

- **identify, collect and utilise data regarding the current GP workforce levels. This will be crucial to any future plans which the Department makes about the workforce, including regarding training and retention of GPs.**
- **actively engage with GPs to develop innovative solutions that would support recruitment and retention.**

The variation in accessing GPs throughout Northern Ireland is unwarranted and must be addressed

69. One clear message from the huge numbers of patients who responded to the survey was that there was significant and often unwarranted variation in accessing GPs across individual practices. Whilst the Committee is supportive of innovation and processes that are tailored to the individual needs of service users, much of what we heard was a confusing patchwork of approaches that had developed over time and was rarely aimed at improving the service that patients receive. This level of unwarranted variability – phonecalls at 8:30, queuing outside practice buildings or waiting for call backs – adds more challenges for patients.

70. The Committee's survey also highlighted that heavy reliance on telephone systems, and limited alternatives such as online or digital routes, further contributed to difficulties in access for many patients.

71. Whilst the Committee recognises that proposals will be negotiated through the contract process, we believe consistency and fairness should be a welcome

goal for both the Department and GPs themselves. The Committee recognise the role of GPs as independent contractors but is strongly of the view that the Department must engage further and work with GPs to ensure that access is fair and appropriate for all.

72. The Committee also believe that, based on the response to the survey, the Department and GPs should work together to identify and implement alternative access routes rather than just telephones. Developing a more consistent range of access options will better support all patients, including those with additional needs, and help reduce the variation currently experienced across practices.

The Department has no measures of patient access to GPs

73. NIAO's report on Access to General Practice in Northern Ireland highlighted clear evidence that patients are experiencing problems in accessing GP practices. Despite this, however, the Department told the Committee it remains very difficult to secure reliable data regarding patient access to services.

74. The Department told the Committee that it does not have a means of measuring the number of people who cannot access the service because their attempts at reaching their GP practice by telephone have been unsuccessful. Likewise, the Department told the Committee that where people are in a queuing system, they can measure the data, but it is very hard to measure the total number of calls. As a result, officials stated that this has made it challenging to demonstrate any improvements in relation to patient access since the NIAO published its report in March 2024.

75. In the Committee's view, this is unacceptable. The Department should have oversight of this sector. Yet the evidence provided to this Committee is that it has little idea of the demand for its services. The Committee cannot see any reasonable way in which the Department could possibly plan to deliver an effective service without an estimate of demand.

76. Whilst the Department felt this was 'too difficult', elsewhere there are well-established means of measuring patients access to GPs. The Office for National Statistics' (ONS) Health Insights Survey – which has been running

roughly once a month for close to one year – tracks data relating to patient access to GPs. The survey is being used by health authorities in England, as their main benchmark, to establish whether patient access is improving. It seeks to determine if patients were able to contact their GP practice when they tried, how easy it is to contact practices using a variety of methods and the speed at which appointments were offered. In addition, the survey aims to gauge patients' perception of their overall experience when attempting to access GP services.

77. As a result of collecting this data, health authorities in England will be able to assess trends over time – in relation to patient access to GPs – on a countrywide basis. This will support informed decision-making about performance levels and enable officials to implement best practice. The survey will also, for instance, highlight variations in performance across different parts of England to identify any inequality of access based on location.

78. In contrast to this, the Committee questioned the Department on several important areas of access, including about GP access based on rurality in Northern Ireland. The response from officials was to question whether there was an evidence base to support that such an inequality exists. The Committee is concerned that the Department is hiding behind a lack of data which will highlight poor quality services. This is not acceptable.

79. The Committee notes that the findings from its public survey also pointed to notable differences in patient experience across practices and areas, further illustrating the need for more comprehensive and reliable access data.

Recommendation 6

The Committee recommends that the Department seeks to secure reliable data regarding patient demand for and access to services. Work should be undertaken to learn from the ONS Health Insights Survey about how to capture this information in Northern Ireland. The Committee expects the Department to have arrangements in place to capture information within six months. This will enable the Department to make informed decisions regarding patient access to GP services and demonstrate improvements to access.

Action must be taken to help prevent further contract handbacks

80. The Committee heard that Primary Care is a sector in crisis. More concerningly, the message received was that without change, the situation was likely to get worse. There are a number of signs of this crisis – none stronger than the news that 129 practices have sought support from the General Practice Improvement and Crisis Response Team since its establishment in 2018. This represents more than 1 in 3 practices in Northern Ireland. At the end of March 2024 alone, 39 practices were deemed to be at risk across the country.

81. Contract handbacks by GPs should be a red flag that the system is in desperate need of improvement. There is evidence that for many GPs, handing back a contract is only done when they no longer have any other choice given the impact on GPs, on practice staff and on patients.

82. The number of practices handing back their contract has increased in recent years. During 2022-23, 13 practices handed back or gave notice to hand back their contracts. In the following year, 11 practices handed back or gave notice to hand back their contract, with a further 5 during 2024-25. The 29 practices that have handed back their contacts over the last 3 years represent around 9 per cent of the total number of practices in Northern Ireland. Whilst the Committee is grateful that the number of handbacks this year has reduced, we do not believe that the sector is now stabilised.

83. Until recently, in each of the instances of contract handback, an alternative provider has been put in place, ensuring that none of the practices closed and disruptive list dispersal was avoided. However, in the majority of cases – 14 out of 26 instances – this was achieved through temporary arrangements where local Health and Social Care Trusts or GP Federations took over contracts to secure provision while an alternative provider is sought. The Committee note that the closure of a practice at the end of October 2024 was the first instance, in recent years, when no alternative provider could be identified. As a result, patients had to be transferred to other local practices.

84. The Committee heard that Trusts were “a port of last resort” when contracts were handed back. However, given the lack of appetite amongst GPs to act as partners, and the limited capacity of the Federations to take on additional practices, it appears that Trusts have now become the first point of call when a contract is handed back.

85. Some Secondary Care Health Trusts have stepped up to run Primary Care services in light of these contract handbacks. The Committee echoes the view of the Permanent Secretary that the involvement of these Trusts has been vital to prevent the collapse of services in some areas. The involvement of Trust-run practices is greater in certain parts of Northern Ireland. The Committee is concerned about the concentration of the use of Trusts to cope with contract hand backs in specific areas – notably Fermanagh and South Armagh. The Committee is clear that this should not result in an inequality of access for patients in those areas.

86. The Committee recognised the contribution made by secondary care Trusts in running GP services. These Trusts may not be best placed to run primary care services, but it is clear to the Committee that in many areas there is effectively no exit plan. Given the lack of success in attracting new partners for Trust run practices, it is imperative that the learning from arrangements put in place is not lost. If the sector is to rely on Health Trusts, then Health Trusts must have adequate capacity and capability to deliver effective Primary Care services.

The use of locums needs to be carefully managed

87. Locum doctors can often provide an important service, allowing practices to cover planned gaps, offer additional capacity or cover absences. Any system is likely to require some locum use. However, the Committee were concerned by the manner in which locums were used when contracts were handed back, and the subsequent costs.

88. While Trusts have access to a range of staff which can be used to stabilise practices, GP cover is often sourced from locums. The need to attract locums to practices in challenging circumstances has resulted in high rates being paid and has distorted the locum market for other practices. Whilst the Committee heard

that the Department have recognised the danger of paying these high rates, and have attempted to reduce them, any reductions to date have been marginal.

89. The Committee heard that 'in many instances' contracts have been handed back by partners who have then been immediately re-employed in the same practices as locums. The Committee do not believe that it can be appropriate to re-employ the same staff, to do the same job as a GP – without the responsibility of running a practice – but at such a significantly high rate of pay. This has the potential to incentivise practices to hand back their contracts, with GPs instead choosing to work as locums.

90. This is not an acceptable way to manage public money. The Committee is extremely concerned about this as it risks causing further destabilisation to GP practices in crisis. The Committee also cannot agree with the Department that "there was nothing they could do" regarding this issue. There is a risk that employing staff in this manner could cause wider problems for all local practices by increasing the cost of locums and pushing more practices towards crisis.

Recommendation 7

The Committee recommends that the Department carries out an immediate review to consider the reasons behind contract handbacks to date. This review should consider whether there are any incentives, real or perceived, which may be incentivising handbacks such as high locum rates. It should also consider whether Trusts have sufficient capability and capacity to deliver effective primary care services, given the very limited success of removing these contracts.

The Department must lead on developing new models of service delivery for Primary Care in Northern Ireland

91. The Permanent Secretary confirmed that Northern Ireland had now moved beyond there being only one model for General Practice. The Committee recognises this change – but we note that it hasn't been driven by proactive leadership from the Department, by a strategic or policy decision, but by a short term reaction to a crisis.

92. Amidst the ongoing crisis, there have been some positive moves in developing and innovating the delivery model for Primary Care. Salaried GPs have been employed, most successfully in the Western Trust, which has offered doctors the opportunity to work in both Primary and Secondary Care, developing additional skills and providing services across the Health and Social Care sector. The support and expertise provided by the GP Federations in running practices is also welcomed.

93. Nevertheless, innovation and change has been relatively slow and small scale to date. To safeguard services, and begin to build for the future, it is the Committee's belief that the Department should now be more proactive in leading the conversation on future delivery models if they would be better for patients, better for the public purse, and better for attracting and retaining GPs.

Recommendation 8

The Committee recommends that the Department expediates the consideration and implementation of suitable alternatives to the current model for delivering Primary Care. This should form part of the Department's Primary Care strategy.

Plans for the roll-out of e-prescribing need more urgency

94. Whilst addressing workforce issues will require time for staff to be trained, increasing productivity of services is also key to successful service delivery. The Committee was told that the Department is leading an e-pharmacy programme, aiming to transition from the current paper-based prescription system to an electronic one. The Department told the Committee that budgetary constraints, especially in relation to its capital budget, have meant that definitive timescales have still not been confirmed for the e-prescribing programme.

95. The Committee is alarmed at the pace of change in this area, and in the delivery of IT projects in general. Whilst we recognise that the Department would like to introduce this system, it has not yet appeared to progress to actual plans for delivery. The Committee is astounded to have learnt that a more efficient system, that could help to reduce GP workload, such as e-prescribing

could take 10 years to implement. The importance of digitisation in driving increased productivity does not appear to have been recognised. This is hugely disappointing to the Committee.

96. The increasing pace of IT change does not appear to have been matched by an increased pace of delivery. The Department must consider how placing a greater focus on innovation and delivery of important IT projects more broadly can increase productivity and improve public services. The Committee is of the view that a particular focus must be given to hastening the introduction of e-prescribing.

Recommendation 9

The Committee recommends that the Department introduces e-prescribing as a matter of urgency. The current pace of delivery is unacceptable. As an initial stage, the Committee expects the Department to have completed a business case within six months.

Progress in the roll out of multi-disciplinary teams in general practice has been slow

97. The establishment of multi-disciplinary teams (MDTs) is a key element of transformation in both primary care and wider healthcare in Northern Ireland, facilitating the expansion of services available in general practice and reducing GP workloads. The BMA and RCGP Northern Ireland also emphasised to the Committee the important role of MDTs in providing stability in practices as they can help to better meet the needs of the population, and drew attention to the fact that the majority of recent contract handbacks arose in areas with no MDTs.

98. Progress in the delivery of MDTs to date has been exceptionally slow. While originally launched in September 2018 aiming for incremental roll out across the country over five years, by September 2024 MDTs had been introduced in only seven of the 17 GP Federation areas in Northern Ireland. Disappointingly, MDTs were fully implemented in only one area – the Down GP Federation – although they were also substantially in place in a further four areas (Derry, Causeway, Newry & District and West Belfast). Implementation in the remaining two areas (North Down and Ards), in terms of staff in place, was relatively small.

99. At the end of September 2024, around 756,000 patients had access to some aspect of MDT services, representing approximately 37 per cent of the just over 2 million registered patients in Northen Ireland. However, only around 8 per cent (164,000 patients) had access to the full range of MDT roles. As a result, the vast majority of people in Northern Ireland still lie outside the reach of MDTs. As highlighted through the Committee's survey, many patients reported greater challenges in accessing timely appointments and follow-up care and in managing long-term conditions, reinforcing the significance of expanding MDT coverage.

100. Poorer access to services for those patients in practices without an MDT was noted by the Patient and Client Council. It highlighted that, if it were possible to have an MDT in every practice across the region, people would have direct access to a physiotherapist, a social worker or whatever specialist they require, and that, in turn, would probably free up more appointments. As a result of the patchy implementation to date, therefore, there are clear inequalities in access to services for those patients in practices without an MDT.

101. The adequacy of funding for the implementation of MDTs is an issue highlighted throughout the life of the programme. Current spending levels, at around £25 million, fall well short of the Department's original estimate of £116 million per annum for full implementation across the country (around £6.5 million per GP Federation area). On 4 March of this year, the Finance Minister announced additional funding of £61 million to take forward the next phase of MDT roll-out. Through this funding, made available from the Transformation Fund, the Department intends to complete the implementation of MDTs in the original seven GP Federation areas and expand provision into a further five areas. The order of expansion follows that announced by the Department in March 2022. Over the next four-five years, this next phase of delivery is intended to make MDTs available to around two-thirds of all patients registered with GP practices in Northern Ireland. The Department also told us that it is currently developing plans for MDT implementation in remaining areas, although it indicated that this will not be addressed until after the end of the current phase.

102. Staffing is recognised as a key constraint in the delivery of MDTs. While some early progress was made in the recruitment of staff to MDTs this slowed with

the onset of the pandemic. By the end of September 2024, 260 core staff (physiotherapists, social workers and mental health workers) had been recruited across the seven GP Federation areas in which MDTs have been introduced. This represents, around three-fifths of the total (WTE) core staff requirement, although the degree to which core staff are in place varies across Federation areas. Particular challenges have been noted in relation to the recruitment of social workers. In addition to core staff, just under 110 WTE nursing staff had also been recruited into MDTs.

103. While welcoming the additional funding being made available for the implementation of the next phase of MDTs in general practice, the Committee has concerns over the lack of ambition in the Department's plans for future roll-out in this crucial transformation programme. Even after another five years, MDTs will only reach two-thirds of the population. Ten or more years into what was intended as a five-year programme, one third of the population will still be without an MDT. The Department's plans will serve only to prolong the inequality of service faced by a significant proportion of patients in general practice, although we acknowledge the Department's efforts in targeting its separate programme for the development of nurse practitioners towards areas without MDTs.

104. The Department told us that the reason it will take so long to roll out MDTs reflects the limited number of healthcare professionals available, and that moving more quickly would risk exposing services in secondary care where staff transfer into MDTs. It did, however, indicate that it aims to recruit between 60 and 70 healthcare professionals into MDTs over the next 12 months.

105. The Department also told us that the £61 million funding allocation from the Transformation fund includes some £3.7 million investment in additional university places (for 2024-25 and 2025-26) to provide a workforce pipeline in key professional groups that are included in MDTs at GP practices, such as physiotherapists, social workers and other allied health professionals.

106. Nevertheless, in planning the introduction of MDTs, it would have been obvious to the Department that more specialist staff (allied health professionals such as physiotherapists etc.) would be needed. While the Department's cautious

approach is understandable, it reinforces the Committee's views on the long legacy of poor workforce planning for general practice in Northern Ireland.

107. In progressing towards further roll-out of MDT's, it is important that any lessons learned from implementation to date are considered. The Department has indicated that an evaluation of the MDT model to date is well advanced, and that it hopes complete and publish the evaluation in the coming weeks or months. While not yet finalised, the Department shared some early indications of the positive impact of MDTs. This noted that, in 2023-24, some 300,000 patients were seen by MDTs, and that there is evidence of an overall 12 per cent reduction in referrals to trust services by practices with MDTs (when compared to non-MDT practices). The reduction in adult mental health referrals, we were told, was even greater, at 32 per cent, clearly illustrating the potential benefits of early intervention associated with MDTs.

108. The Committee has noted that, as part of the future implementation of MDTs, the Department intends to revise its MDT model. This includes reducing the social worker input and removing the nursing support element from the programme. This, it told us, reflects learning from what works and also takes account of wider system needs, particularly the pressures on the availability of social workers in secondary care. It also recognises that MDTs should not be a purely medical model and that they should have a connection to services that can be delivered by the voluntary and community sector.

109. While recognising the need to learn from implementation to date, the Committee is concerned that the planned revision of the model risks a dilution of the potential benefits to be derived from MDTs. The Committee expects that Department will carefully monitor the impact of these changes.

Recommendation 10

The Committee recommends that the Department uses the learning from its evaluation of the MDT model to inform the pace and extent of the future roll-out. Consideration must also be given to the additional support that can be provided to practices without an MDT, to ensure fairer access for patients.

Links to Appendices

Appendix 1: Minutes of Proceedings

View Minutes of Proceedings of Committee meetings related to the report

Appendix 2: Minutes of Evidence

View Minutes of Evidence from evidence sessions related to the report

Appendix 3: Correspondence

View correspondence issued and received related to the report

Appendix 4: Other Documents including Citizen Space results report

View other documents related to the report

Appendix 5: List of Witnesses that gave evidence to the Committee

- **Dr Ciaran Mullan,** British Medical Association NI;
- **Dr Frances O'Hagan,** British Medical Association NI;
- **Dr Ursula Mason,** Royal College of General Practitioners NI;
- **Dr Emma Murtagh,** Royal College of General Practitioners NI;
- **Mr Peter Hutchinson,** Patient and Client Council;
- **Ms Katherine McElroy,** Patient and Client Council;
- **Ms Meadhbha Monaghan,** Patient and Client Council;
- **Mr Peter May,** Department of Health;
- **Mr Gearóid Cassidy,** Department of Health;
- **Dr Margaret O'Brien,** Department of Health;
- **Ms Dorinnia Carville**, Northern Ireland Audit Office; and

- **Mr Stuart Stevenson**, Department of Finance.

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