Northern Ireland Audit Office

Access to General Practice in Northern Ireland

Report by the Comptroller and Auditor General

Published
20 March 2024

For further information about the Northern Ireland Audit Office:

Northern Ireland Audit Office
106 University Street
Belfast, BT7 1EU

028 9025 1000
info@niauditoffice.gov.uk
www.niauditoffice.gov.uk

© Northern Ireland
Audit Office 2024

This report has been prepared under Article 8 of the Audit (Northern Ireland) Order 1987 for presentation to the Northern Ireland Assembly in accordance with Article 11 of the Order.

The Comptroller and Auditor General is the head of the Northern Ireland Audit Office. She, and the Northern Ireland Audit Office are totally independent of Government. She certifies the accounts of all Government Departments and a wide range of other public sector bodies; and she has statutory authority to report to the Assembly on the economy, efficiency and effectiveness with which departments and other bodies have used their resources.

Dorinnia Carville
Comptroller and Auditor General

Northern Ireland Audit Office
20 March 2024

Contents

	List of Abbreviations	**7**
	Key Facts	**8**
	Executive Summary	**9**
Part One	**Introduction**	**17**
	Services in general practice are provided under a United Kingdom-wide contract	18
	Strategy in general practice takes a similar approach to that elsewhere in United Kingdom	20
	COVID impact on services	21
	Demand pressures in general practice are driven by a growing and ageing population	21
	Scope and Structure	23
Part Two	**Funding and Activity in General Practice**	**25**
	Around £375 million was spent on general practice in 2022-23	26
	While growing over the life of the GMS contract, investment in general practice fell by around 7 per cent in real terms in 2022-23	27
	Spend in Northern Ireland is lower than some other parts of the United Kingdom and is reflected in lower GP earnings	27
	There are indications of increased activity in general practice, although data is limited	29
	Around 200,000 consultations were undertaken each week in general practice in 2022-23	30
	While growing, it is unclear whether activity levels are above pre-COVID levels	32
	The Department is taking steps to improve activity data collection in general practice	32
Part Three	**Workforce and Workforce Planning**	**33**
	The GP workforce in Northern Ireland has undergone change in recent years	34
	More than a tenth of GPs on the NIPMPL left during 2022-23	36
	Published workforce data does not provide a picture of the working patterns of GPs	36
	Despite the increase in GP headcount, estimates indicate a fall in average GP sessions worked	37

	Strategy in general practice aims to build a sustainable workforce, although there is no specific workforce strategy	38
	The number of GP training places has increased substantially over the last 10 years	39
	Increasing demand in general practice would suggest the need for a further expansion in GP training places into the future	41
	The Department undertakes a number of other activities in support of GP recruitment and retention, although these are relatively small in scale	41
	Since its inception, 70 GPs have participated in the GP retention scheme	42
Part Four	**Multi-disciplinary Teams**	**45**
	Multi-disciplinary teams are a key element of transformation of primary care and wider healthcare	46
	The MDT model has been taken forward in a number of phases	46
	Progress in the delivery of multi-disciplinary teams has not matched ambitions	47
	Spend on the implementation of MDTs to March 2023 totalled around £75 million	48
	The planned evaluation of the MDT model was not completed, although early evidence did suggest some small positive impacts	49
	Staffing is identified as a key constraint in the delivery of MDTs	50
	Significant funding will need to be secured to sustain future MDT operations	50
Part Five	**Access to General Practice**	**53**
	GP practices are not evenly distributed across the country	54
	The number of GP practices has reduced in recent years	55
	The number of GP practices handing back their contracts raises concern around the sustainability of GP practices	56
	A significant number of GP practices are under severe pressure	58
	There are identified problems in patient access to general practice	59
	Internal Audit has expressed concerns over the ability to effectively performance manage GP practices	60
	In recognition of pressure in general practice the Department has established an access working group	61

Appendix 1	**Study Methodology**	**64**
Appendix 2	**Weekly Consultations in General Practice**	**65**
Appendix 3	**MDT Staff Recruitment (March 2019 – March 2023)**	**66**
NIAO Reports 2023 and 2024		**69**

List of Abbreviations

BSO	Business Services Organisation
DoH	Department of Health
GMS	General Medical Services
GP	General Practitioner
HSC	Health and Social Care
HSCB	Health and Social Care Board
MDT	Multi-disciplinary Team
NIMDTA	Northern Ireland Medical and Dental Training Agency
NIPMPL	Northern Ireland Primary Medical Performers List
PICRT	General Practice Improvement and Crisis Response Team
SPPG	Strategic Planning and Performance Group
QOF	Quality and Outcomes Framework
WTE	Whole-time Equivalent

Key Facts

1,448

The number of GPs registered on the Northern Ireland Primary Medical Performers List at 31 March 2023

2,041,000

Number of patients registered with GP practices in Northern Ireland at 31 March 2023

£375m

The total amount spent on general practice in 2022-23

318

The number of GP practices in Northern Ireland at 31 March 2023

13

The number of contracts handed back during 2022-23

5.4%

The general practice share of overall Health and Social Care spend in Northern Ireland in 2022-23

39

The number of GP practices assessed to be at risk at the end of March 2023

1 of 17

The number of GP Federations in which Multi-disciplinary Teams have been fully implemented

8% (161,000 patients)

The proportion of registered patients with access to the full range of Multi-disciplinary Team roles at March 2023

Executive Summary

1. For most people, General Practitioners (GPs) are the first point of contact with the healthcare system when they feel ill. As such, they are the gateway to the health system, providing a wide range of services to patients including advice on health problems, performing physical examinations, diagnosing symptoms, prescribing medications and making onward referrals to secondary care, where more specific investigations are required. GPs play a vital role in the healthcare system because of the acknowledged benefits of early intervention and treatment in terms of patient outcomes.

2. Services are provided by independent contractors – GPs – under contract with the Department. Doctors providing services under the contract must be registered under the Northern Ireland Primary Medical Performers List (NIPMPL).

3. GPs are a vital part of primary care services, alongside general dental services, general ophthalmic services, and community pharmacy. In recent years, the strategic direction for Health and Social Care (HSC) services as articulated in 'Health and Wellbeing 2026 – Delivering Together' has been to seek to increase provision in primary care, closer to people's homes and communities, to reduce the need for referral into secondary care services. Pressures in the wider HSC budget, as well as external factors such as the impact of the Covid-19 pandemic, have had an impact on the capacity to progress this agenda as originally envisaged.

Primary care in Northern Ireland is under extreme pressure

4. Pressures in general practice have increased, driven both by long term trends such as an ageing population and growing waiting lists in secondary care, and recent issues such as the impact of COVID. These challenges have pushed many individual practices into crisis – in the past four years, 98 practices have sought support from the General Practice Improvement and Crisis Response Team. This represents a substantial proportion (almost 1 in 3) of the total number of practices in Northern Ireland.

The numbers of practices handing back their contacts has increased

5. Between March 2022 and March 2023, 13 GP practices either handed back or gave notice to hand back their contracts. Whilst there can be a number of factors behind these decisions, stakeholders told us that concerns around securing sufficient clinical workforce; financial concerns; and reducing numbers of GPs wanting to take on the financial risk were common factors.

6. While at the time of writing alternative providers have been put in place in 9 of the 13 cases, this reflects temporary provision through GP Federations and Health Trusts. This has avoided the need for patients to be shared among neighbouring practices and potential knock-on impact to their sustainability, where they are incapable of absorbing the additional demand associated with these patients. In five of the thirteen cases, this has involved HSC Trusts taking over the contacts and the running of these practices. Whilst this is a short-term solution, it comes at a high cost to the public purse and no guarantee of a long-term resolution.

7. The Department told us that, through these actions, it has been possible to ensure that none of these practices have closed and disruptive list dispersal has not been necessary. However, there is a need to identify solutions which will be effective in maintaining sustainable GP services in the long term.

Progress in transformation has been slow

8. Whilst all general practices are dependent on a team of clinical and non-clinical staff, the establishment of Multi-disciplinary teams (MDTs) is a key element of transformation in both primary care and wider healthcare in Northern Ireland. This was identified in the March 2016 Review of GP-led Primary Care Services and the overall healthcare transformation strategy 'Delivering Together' (Oct 2016).

9. MDTs involve establishing a range of clinical staff, working alongside GPs, to both expand the services available in primary and community care and to provide improved care. This aims to reduce GP workloads by diverting activity more suited to be being dealt with by other professionals and provide a higher standard of care.

10. 'Delivering Together' envisaged the incremental roll-out of MDTs over 5 years. However, at March 2023 MDTs have been introduced in some part in 7 of the 17 GP Federation areas across Northern Ireland, incorporating some 112 GP practices (out of a total of 318 at March 2023) and 710,000 registered patients (or 35 % of total patients). Given the phased introduction of the model, there is substantial variation across these areas in terms of the degree to which teams have been delivered.

11. By the end of March 2023, MDTs had been fully implemented in only one GP Federation area – Down. MDTs were substantially in place in a further 3 areas (Derry, Causeway and West Belfast), with significant progress in one further area (Newry and District). Implementation in another two areas (North Down and Ards), at March 2023, was relatively small. Importantly, from a patient perspective, the vast majority of patients in Northern Ireland lie outside the range of MDTs. Only around 8 per cent of total registered patients (161,000 people) have access to the full range of MDT roles.

Workforce is a challenge and there are indications that attracting new entrants is becoming harder

12. The trend in GP numbers is generally upwards. Overall, between March 2018 to March 2023, the number of GPs increased by around 9 per cent. However, this headcount data masks changing patterns of GP work, indicated from GP appraisal information which shows a decrease in GP-reported average sessions worked.

13. The numbers of GPs leaving the NIPMPL[1] shows a particular increase in over 60s leaving in 2022-23, possibly as a result of some level of delayed retirements during the pandemic. It also identifies an increase in the numbers in the youngest age group (25-39 years of age) leaving in the latest, post pandemic years (2021-22 and 2022-23). In total almost 230 GPs left during 2022-23, over a tenth[2] of the total number of GPs at the start of the year. It is noted, however, that the proportion of GPs aged 55 and over in Northern Ireland has fallen over recent years from just over 25 per cent at March 2014 to just under 21 per cent at March 2023.

14. As part of its efforts to grow the GP workforce, the Department has increased the number of GP training places available. The trend in available GP training places over the last 10 years shows stepped increases from 65 per year in 2014-15 to 111 in 2018-19. Training places remained stable between 2018-19 and 2021-22 at 111, before increasing to 121 in 2022-23. This increase in places was maintained in 2023-24. A Departmental working group, established in 2021-22, is currently considering the requirements of GP training places going forward.

15. Many of the increased GP training places have been taken up by international medical graduates. However, and while a United Kingdom-wide issue, practical and bureaucratic difficulties have made it challenging for these graduates to find employment with a GP practice after completion of training.

There is a need for long term plans to reinvigorate the GP service

16. The Department has undertaken a number of initiatives to address some of the challenges that general practice is facing. It established a working group in June 2022, to consider access in general practice and to make proposals for action to improve access in the short, medium and long term. The working group's recommendations are being progressed through a pathfinder telephony project, aimed at testing how the utilisation of a modern telephony system can help better understand demand (including unmet demand), improve patient and staff experience and improve access to GPs. This, however, does not seek to directly address the wider issue of capacity in general practice.

17. In addition, the Department established a GP training places working group, in 2021-22, to consider the requirements for GP training places over the five years to 2027-28. Whilst these groups will make important contributions to primary care, there is a clear need to establish a long-term direction for the sustainable development of services.

Funding has grown over the life of the GMS contract

18. Investment in general practice has increased steadily since the introduction of the General Medical Services (GMS) contract in 2004-05, and overall by just under 37 per cent in real terms between 2004-05 and 2022-23. However, at £375 million in 2022-23, this reflects a slight reduction when compared to 2021-22 (£378 million). Similarly, funding per patient also fell slightly (from £188 to £185). This marks the first reduction in funding since 2007-08 and, given levels of inflation in 2022-23, represents a real terms cut in the region of 7 per cent compared to 2021-22.

1 Defined as those with a contract end date in a particular year, although individuals may not be permanent leavers from the NIPMPL.

2 This calculation includes locums.

19. The Department told us that increased levels of investment in 2020-21 and 2021-22 reflect the key role played by general practice during the pandemic. This additional investment ceased in 2022-23, although its impact has been mitigated by an increase in global sum payments, mainly to reflect recommended pay increases.

20. Per capita investment in general practice in Northern Ireland has traditionally been lower than that elsewhere across the United Kingdom, although there is evidence of some convergence in recent years (particularly with Wales). As a result, earnings for GPs in Northern Ireland have been lower than England and Scotland and on a par with those in Wales.

There is no specific workforce strategy for general practice

21. A key part of strategy in general practice, as highlighted in both the Review of GP-led services and the wider health transformation strategy 'Delivering Together' , is the need to build a sustainable workforce. This incorporates both the need to increase GP numbers and to develop teams to work alongside GPs. An increase in GP numbers involves increases in training numbers; wider recruitment; and better retention of the existing workforce.

22. Workforce strategy in general practice is guided by the wider HSC Workforce Strategy, published in 2018. The Strategy's related action plan does identify the need for better primary care workforce data to enhance the ability to monitor workforce trends and improving workforce intelligence. There is, however, no separate workforce strategy for general practice, nor specific targets (like those that exist in England and Scotland) for the growth of the GP workforce.

The further roll-out of MDTs has stalled

23. Many stakeholders told us that the future sustainability of primary care would be dependent on successful transformation and the roll-out of MDTs. These teams have the potential to deliver better care, reduce GP workload and reduce onward referrals to secondary care. Given the current uneven roll-out, it is harder to recruit to practices without sufficient MDTs and patients are receiving different levels of care across Northern Ireland.

24. The availability of sufficient funding for the full implementation of MDTs is an issue highlighted throughout the life of MDT programme. In identifying the order for future regional roll-out, the Department's announcement in March 2022 again highlighted that the pace of roll-out is dependent of future budget allocation.

25. Based on its original assumptions, the Department has estimated the average annual cost of MDTs at around £6.5 million per GP Federation area, and the overall cost of full regional implementation at around £116 million. As current budgetary allocations are in the region of £25 million per annum, the Department would need to find an additional £91 million per annum to sustain the operation of a full programme of MDTs across the country. In addition, the Department would also need to secure an additional £25 million to meet the capital requirements for full regional roll-out.

26. There are also significant challenges in staffing MDTs. Recruitment to core team roles to date represents only around one quarter of the total staffing complement needed for the full implementation of MDTs across Northern Ireland. In total, more than 750 additional staff would need to be recruited to achieve full MDT staff complement. Given the recruitment difficulties experienced to date, this will present a significant challenge.

27. In this context, the Department has been considering alternative options for implementation of the MDT model, which prioritise making the benefits of primary care MDTs available as widely as possible while containing costs and reducing the demand for staff in secondary care services over the next implementation period.

Conclusion

28. Many factors are impacting on the successful delivery of general medical services. A combination of increasing demand for services, workforce challenges and the impact of the pandemic have placed the sector under extreme pressure. The Department has commenced work in a number of important areas, including establishing a working group on training places and attempting to address some issues around access. However, these measures alone will not address all of the challenges in primary care.

29. It is clear that the issues impacting general practice are complex and will require a sustained, long-term response to ensure that general practice is sustainable and an attractive place to work. This will require ensuring that a plan for transformation and the roll-out of MDTs is developed; a long-term workforce strategy is put in place to ensure that sufficient, trained staff are available to meet the needs; and robust funding plans are put in place. To inform the Department's future actions, enhanced data on primary care will be required. Ultimately, effective services will only be achieved if the Department develops a longer term, funded plan that can deliver a joined-up approach to the challenges facing general practice.

Recommendations

Recommendation 1

There is a clear need to improve the collection of activity data in general practice, both to better understand the volume and nature of activity and to inform decision making. While we acknowledge the Department's intentions in this regard, this should be taken forward as a matter of urgency.

Recommendation 2

Data collected and published by the Department in relation to the GP workforce does not provide a full picture and is inadequate in terms of monitoring the workforce. Despite the acknowledged need to improve workforce data in general practice, due to capacity constraints, the Department currently has no plans to so. However, effective workforce planning and monitoring relies upon adequate and relevant information. As a result, the Department should review its workforce data needs and develop a plan for its improvement. Within this, it should explore and capture a measure which can account for the proportion of standard sessions that are provided by a GP. This should be a similar approach to the whole-time equivalent measure used elsewhere in the HSC.

Recommendation 3

While the Department has undertaken a number of actions to build and sustain the GP workforce over recent years, there is no specific GP workforce strategy. In our view, there is a need for a workforce plan for general practice, identifying the overall number of GPs needed and the implications for the number of GP training places required, and which sets targets for overall workforce growth and the timescale within which this growth should be achieved.

Recommendation 4

Given the challenges within general practice, and the need to improve recruitment and retention, we believe it is an opportune time to review and where necessary refresh the retention schemes that are currently in place, drawing where appropriate, on best practice from elsewhere.

Recommendation 5

MDTs are a key element of transformation in both primary care and wider healthcare in Northern Ireland. Progress to date, however, has not matched ambitions, as a result of both a lack of adequate funding and qualified staff. While the order for future roll-out has been identified, no timeline for full regional roll-out has been set and no action plan exists for its delivery. In the absence of sufficient funding, the Department needs to explore alternative options for the implementation of the MDT model over the coming years, and develop credible plans for the future roll-out of MDTs across Northern Ireland, taking account of the anticipated constrained funding outlook, and the availability of staff in key professions. These plans should be costed and should include an overall timeframe for delivery and key implementation milestones. There is also a need to expedite the Department's evaluation of implementation to date to inform the revised business case, learn lessons for future implementation and to ensure expected benefits are maximised.

Recommendation 6

Stabilisation of practices at risk is essential. Whilst any solution will inevitably involve long term planning, there is a significant risk that the costs associated with dealing with failing practices could have a destabilising effect across the system. We recommend that work is undertaken to stabilise GMS services, to increase the sustainability of the service and contain costs associated with supporting failing practices. This should include monitoring of the financial impact of failing practices.

Recommendation 7

Where Trust involvement in the delivery of primary care services has identified weaknesses and potential lessons that are of use to the sector as a whole, we recommend that the Department identifies the best means of disseminating this information.

Recommendation 8

There is clear evidence that patients are experiencing problems in accessing GP practices, improvement in which will present significant challenges for the Department and practices. While acknowledging the work undertaken by the GP Access Working Group and its intentions around the telephony pilot, its findings to date clearly highlight the need to increase capacity in general practice. While we appreciate that increasing capacity in the longer term in general practice is linked to wider workforce strategy, we would encourage the Department to consider what actions it might take in the shorter term to improve patient access to services, including the patient experience of accessing services. This should include implementing best practice processes in GP practices.

Part One:

Introduction

1.1 Overall responsibility for securing general medical services in Northern Ireland lies with the Department of Health (the Department), developing policy and setting priorities, commissioning services and managing and monitoring performance. Prior to its cessation on 31 March 2022, the commissioning, contract and performance management aspects of these responsibilities were undertaken by the Health and Social Care Board (HSCB). These functions (and the relevant HSCB staff) now lie within the role of the Department's Strategic Planning and Performance Group (SPPG). Policy functions lie within the Department's Healthcare Policy Group. Within the Department's structures and responsibilities, general practice forms a part of wider primary care. This also includes dentistry, pharmacy and ophthalmology services.

1.2 Services are provided by independent contractors – general practitioners (GPs) – under contract with the Department. Doctors providing services under the contract must be registered under the Northern Ireland Primary Medical Performers List (NIPMPL), which is managed on behalf of SPPG by the Department's Business Services Organisation (BSO).

1.3 For most people, GPs are the first point of contact with the healthcare system when they feel ill. As such, they are the gateway to the health system, providing a wide range of services to patients including advice on health problems, performing physical examinations, diagnosing symptoms, prescribing medications and making onward referrals to secondary care, where more specific investigations are required. GPs play a vital role in the healthcare system because of the acknowledged benefits of early intervention and treatment in terms of patient outcomes.

Services in general practice are provided under a United Kingdom-wide contract

1.4 Services provided in general practice are governed under a United Kingdom-wide contract – the General Medical Services (GMS) contract, first introduced in April 2004. Under the GMS contract, all GPs must provide 'essential services' and contracted 'additional services' to their patients. These are services required for the management of registered patients and temporary residents who:

- believe themselves to be ill, with conditions from which recovery is generally expected;
- are terminally ill; or
- are suffering from a chronic disease.

Additional services include the following services:

- cervical screening service;
- contraceptive services;
- vaccinations and immunisations;
- child health surveillance services;
- maternity medical services; and
- (some aspects of) minor surgery.

While these services are defined separately in the GMS contract, currently all GP practices contract to provide them.

Enhanced services (which are optional) are elements of essential or additional services delivered to a higher specification, or medical services outside the normal scope of primary medical services which are designed around the needs of the local population.

1.5 Payment under the contract is made up of four main elements:

- **Global sum** – a contribution towards the costs of delivering essential and additional services (including staff costs), paid in monthly instalments and calculated to reflect the relative workload associated with patients/local population (relative weighted registered population);
- **Quality and Outcomes Framework (QOF**) – a payment reflecting the quality of care provided and to fund work to improve the quality of care delivered, determined through assessment of performance against a number of indicators across four 4 domains (clinical, public health, records and systems and patient experience). QOF payments are made in two parts – an aspirational payment based on past achievement and an achievement payment adjustment based on actual performance;
- **Payments for enhanced services** – payments made in relation to identified clinical priorities and for specific commissioned services:

  priorities: in relation to respiratory conditions (Asthma and COPD), care planning for patients with chronic conditions, healthcare for adults with a learning disability, the mild to moderate depression scheme, and structured brief advice for alcohol

  commissioned services: childhood immunisation scheme plans, flu and pneumococcal immunisation scheme, violent patients scheme, minor surgery scheme and vaccines and immunisations

other services also include anti-coagulation monitoring and proactive GP care for nursing and residential homes;

- **Premises and IT costs** – payments in relation to new premises development and improvement, recurring premises costs (mortgages, rents etc.).

Payment under the GMS scheme also covers other areas such as payments in relation to locums covering sick leave, maternity leave etc.

Strategy in general practice takes a similar approach to that elsewhere in United Kingdom

1.6 Development within primary care in Northern Ireland, of which general practice forms a material part, continues to be guided by the 20-year (2005-2025) strategic framework 'Caring for people beyond tomorrow', published in 2005. This provides a long- term vision for primary care and aims to ensure modern and effective services able to meet the challenges brought by demographic change, wider trends towards care in the community, greater integration and team working in healthcare and greater focus on public health promotion (and was aligned to the newly introduced GMS Contract in April 2004).

1.7 In identifying growing demand for GP services and in recognition of challenges for patients in securing timely GP appointments, the Department (in October 2015) announced the creation of a working group to look at the problems facing GP-led primary care services. The working group's March 2016 report recognised the workload/workforce challenges within GP services and concluded that services could not continue to meet rising demand and expectations (resulting from an increasing and ageing population) without urgent action to address pressures.

1.8 In setting out a vision for sustainable and accessible GP-led services, the review identified required action to build on work to increase and support the workforce, develop teams of skilled professionals alongside GPs, and improve facilities/premises and technology. With regard to building a stable workforce, the review specifically recommended an increase in GP training places to 111 by 2019-20. In terms of developing structures and teams around GPs, and to increase the range of services provided in general practice, it also made recommendations in terms of embedding the GP Federation model and continuing to build multi-disciplinary teams. In December 2016, the (then) Minister formally accepted the review's findings and recommendations as the direction of travel for GP services into the future.

1.9 The policy direction in general practice as outlined in the review is consistent with wider health strategy, as identified in the Department's October 2016 10-year strategy 'Delivering Together', which promotes the transformation of health and social care as a means to address the increasing demand placed on services as a result of an ageing population, increased numbers of people living with multi-morbidities/complex conditions, rising patient expectations and constrained resources. In particular, shifting service provision away from hospitals and towards care in the community, together with a greater focus on public health, prevention and early intervention.

1.10 'Delivering Together' recognises the central role of primary care/general practice within the Northern Ireland health system, both in terms of the services it provides and as the 'gateway' to other services, and identifies its intentions to provide more support in primary care. In particular, 'Delivering Together' identifies the future model of primary care based around multi-disciplinary teams embedded around general practice (including GPs, Pharmacists, District Nurses, Allied Health Professionals and Social Workers) and working in a more integrated way with community services. These teams, according to 'Delivering Together' were to be rolled out incrementally over 5 years.

1.11 The Northern Ireland approach to the development of general practice takes a similar approach to that elsewhere in the United Kingdom (and indeed internationally). The broad approach applied reflects a common transformative strategy incorporating increased investment in GP services, increased training numbers, the expansion of services available through the development of the wider general practice workforce of professionals working in teams alongside GPs, together with scaling up through collective working across practices, and the encouragement of greater integration of general practice with community care, social care and secondary care services.

COVID impact on services

1.12 The onset of the COVID-19 pandemic in the latter part of 2019-20 resulted in a reconfiguration of structures in general practice. In order to ensure patient safety, services were broadly separated between COVID and non-COVID provision. Non-COVID services were retained within practices, while COVID-related provision was facilitated through COVID centres. The introduction of COVID centres, which were staffed by GPs, was facilitated through the withdrawal of certain enhanced and elective services under the GMS contract. GPs were also materially involved in the delivery of COVID vaccinations. In June 2020, the Department estimated that COVID had reduced capacity in general practice by around 20 per cent compared to 2019.

1.13 There was also a revision in service delivery mechanisms within general practice, with practices adopting a 'phone first' approach to triage. In addition, while face-to-face appointments remained available for those who needed them, the vast majority of patient contact moved to telephone and virtual consultation. The move to phone triage, in particular, led to criticism that GPs were not open for business – a misconception that needed to be countered through specific public messaging.

1.14 Like healthcare more generally, the onset of the pandemic saw a change in the public's health seeking behaviours, which (at least initially) resulted in a reduction in demand for services. Demand has increased thereafter. Despite services having moved to a more normal footing, practices have continued to adapt how services are delivered in response to increasing pressures, in particular the use of telephone triage and the availability of telephone/virtual consultation.

Demand pressures in general practice are driven by a growing and ageing population

1.15 Increasing demand in general practice results from a growing and ageing population. At March 2023, there were just over 2.041 million patients registered with GP practices in Northern Ireland. Consistent with the growing population in Northern Ireland, numbers of registered patients have increased by around 6 per cent since 2014 – over 116,000 patients (see **Figure 1a**). Over the longer term, since the introduction of the GMS contract in April 2004, the number of patients registered with GP practices has increased by some 14 per cent.

1.16 Published data also indicates that a significant proportion of the increase in patient numbers is in older age groups – over a quarter of the increase between March 2014 and March 2023 (approximately 33,000 patients) related to patients aged 75 and over. During this period, when overall patient numbers increased by around 6 per cent, numbers of older patients increased by 26 per cent (see **Figure 1b**).

Figure 1a: GP patient numbers have increased by 116,000 (6%) since 2014

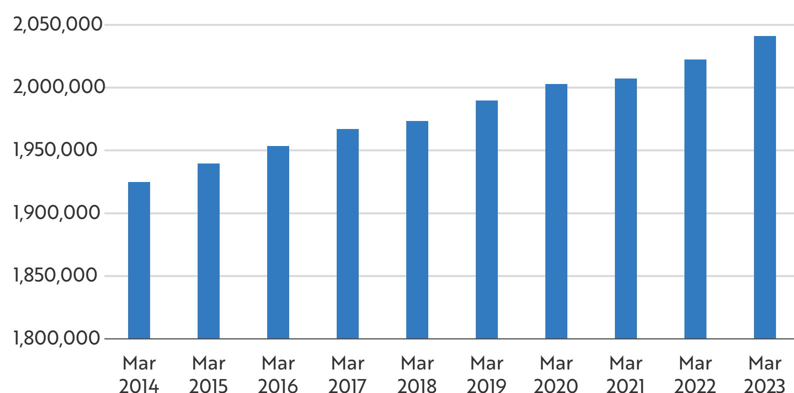
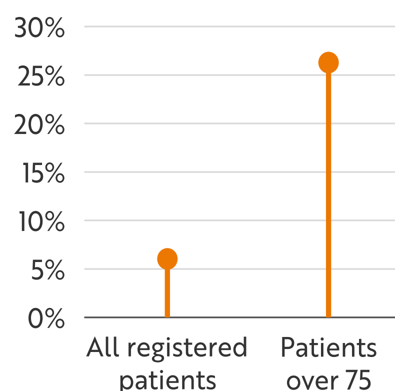


Figure 1b: There has been a particular increase in older patients



Source: BSO GMS statistics

1.17 Prevalence of long-term conditions increases with age. With people living longer, there are increased numbers of people living with multiple long-term conditions, requiring more support and care. Patient registers illustrate the increase in the prevalence of long-term conditions in Northern Ireland. As identified in **Figure 2**, the prevalence of most long-term conditions (measured per 1,000 patients) have increased over the last 10 years in Northern Ireland. Data indicates particular increases in relation to atrial fibrillation and diabetes.

Figure 2: There has been a general increase in the prevalence of long-term conditions

Clinical Register	Prevalence/1,000 patients	
	2013-14	2022-23
Atrial Fibrillation	15.12	22.23
Asthma	60.48	64.90
Cancer	19.12	30.08
Chronic Obstructive Pulmonary Disease	18.56	21.03
Coronary Heart Disease	38.81	36.67
Diabetes	54.16	69.31
Hypertension	130.50	140.96
Mental Health	8.54	9.01
Stroke	17.94	19.84

Source: DoH: Raw Disease Prevalence in Northern Ireland – 2022-23

Scope and Structure

1.18 Over the last couple of years, media and political interest has highlighted increasing concerns around the sustainability of general practice, particularly illustrated in examples of practice closures and difficulties in patients accessing practices. This report explores a number of the key aspects and issues in general practice in Northern Ireland.

1.19 The main body of the report is set out over four sections:

Part Two discusses funding in general practice and levels of activity;

Part Three explores the general practice workforce and issues around workforce planning;

Part Four considers multi-disciplinary teams in general practice; and

Part Five identifies and discusses a number of issues around access in general practice.

1.20 The report focuses on core services in general practices, those covered under the GMS contract. It does not consider out-of-hours services, which are covered under other arrangements. An overview of our methodology is provided at **Appendix 1**.

> "There are increasing concerns around the sustainability of general practice."
>
> **Northern Ireland Audit Office**

Part Two:

Funding and Activity in General Practice

2.1 This section of the report discusses the funding of general medical services in Northern Ireland and explores activity levels within general practice.

Around £375 million was spent on general practice in 2022-23

2.2 The total cost of services provided under the GMS contract was around £375 million in 2022-23, including the reimbursement of dispensed drugs (although it should be noted that the vast majority of dispensing is done through community pharmacies and appliance contractors, rather than through dispensing doctors). This is equivalent to around 5.4 per cent of overall health and social care spend in Northern Ireland. With over 2 million registered patients in Northern Ireland (measured at 1 October 2022), this equates to £185 per patient.

2.3 Just over half of all spend in general practice in 2022-23 reflected global sum payments, relating to the delivery of essential and additional services under the GMS contract (see **Figure 3**). Enhanced services, relating to identified clinical priorities and specifically commissioned services, accounted for a fifth of spend, while payments under QOF arrangements made up just under a tenth of overall costs.

Figure 3: Just over half of spend in general practice in 2022-23 related to Global Sum payments

	£m	%
Global Sum	195.4	52
Enhanced Services	75.3	20
QOF	31.6	9
Other Payments (premises, out-of-hours, IT etc.)	68.4	18
Total Investment Net of Dispensing	**370.7**	**99**
Cost of Dispensing fees and Reimbursement of Dispensed Drugs	4.1	1
Total Spend	**374.8**	**100**

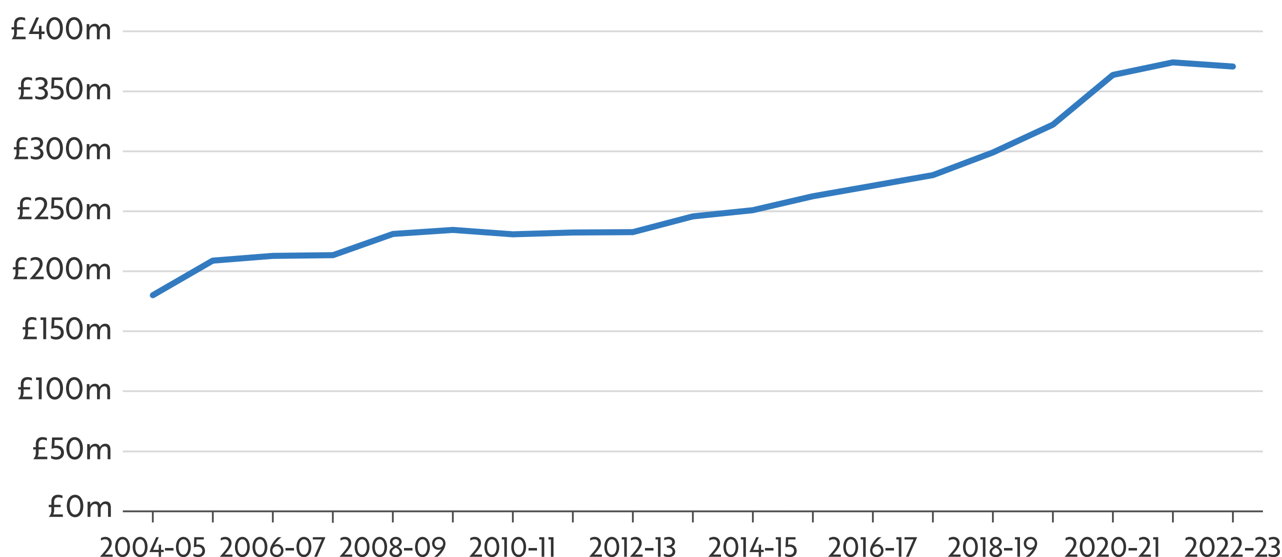
Source: DoH: Investment in General Practice, Northern Ireland 2018-19 to 2022-23

2.4 Some £68 million other payments were made during 2022-23. Of this, almost £24 million related to premises and IT costs, and a further £17 million covered other central and administered funds and services, for instance the cost of treatment room nurses. Another £28 million relates to GP out-of-hours services.

While growing over the life of the GMS contract, investment in general practice fell by around 7 per cent in real terms in 2022-23

2.5 As illustrated in **Figure 4**, investment in general practice (net of dispensing) has increased steadily since the introduction of the GMS contract in 2004-05. After taking account of the impact of inflation over time, this represents an overall real terms increase over the life of the contract of almost 37 percent. However, at £375 million in 2022-23, this reflects a slight reduction in investment of around 1 per cent when compared to 2021-22 (£378 million). Similarly, per capita funding also fell slightly from £188 and £185 respectively. This marks the first reduction in funding since 2007-08 and, given levels of inflation in 2022-23, represents a real terms cut in the region of 7 per cent compared to 2021-22.

Figure 4: Investment in general practice has increased over the life of the GMS contract



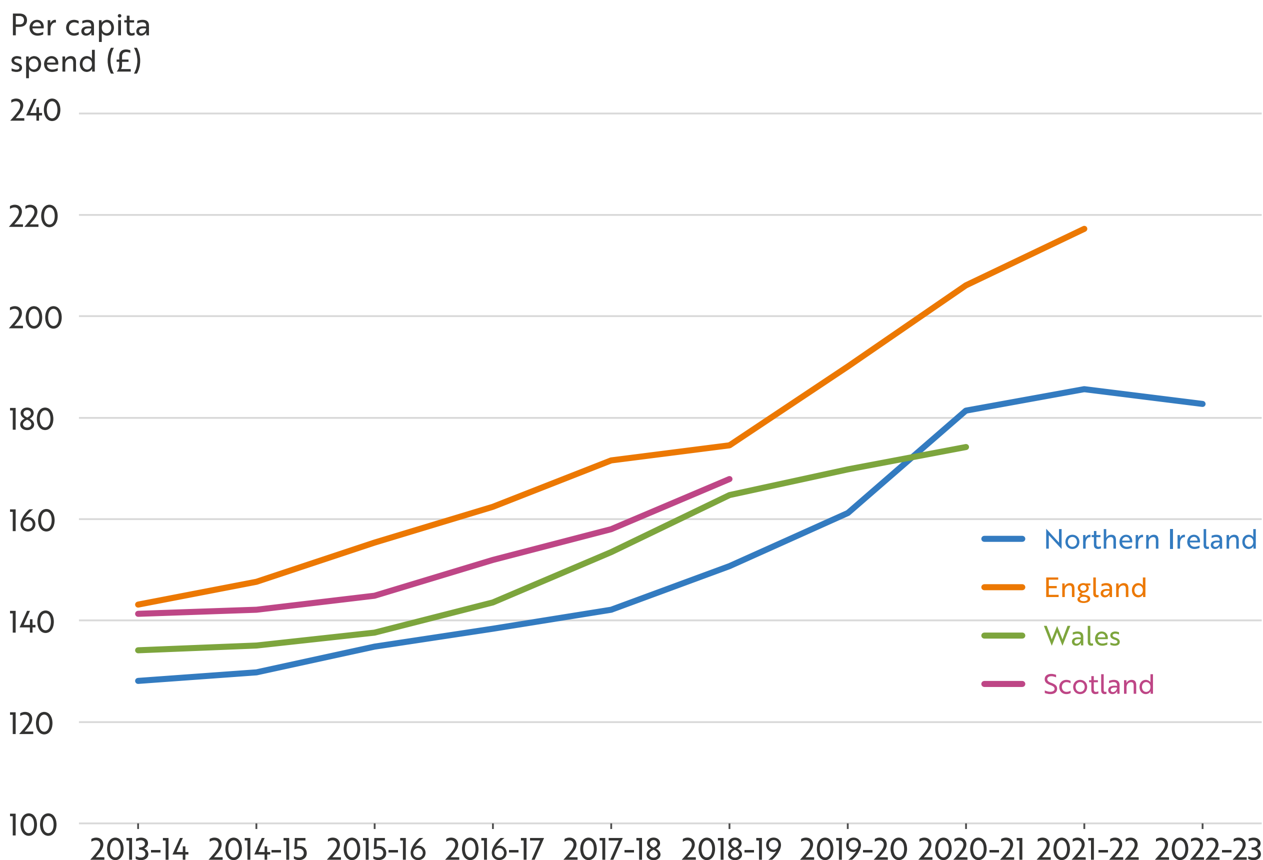
Source: DoH

2.6 The Department has noted, however, that increased levels of investment in 2020-21 and 2021-22 reflect the key role played by general practice during the pandemic. This additional investment ceased in 2022-23, although its impact has been mitigated by an increase in global sum payments, mainly to reflect recommended pay increases.

Spend in Northern Ireland is lower than some other parts of the United Kingdom and is reflected in lower GP earnings

2.7 On the basis of published data, per capita investment in general practice in Northern Ireland has traditionally been lower than that elsewhere across the United Kingdom (see **Figure 5**), although the latest comparison available for England relates to 2021-22, while for Wales it is 2020-21 and 2018-19 for Scotland. This indicates that while per capita spend in Northern Ireland would appear to have increased above that in Wales, in 2021-22 it was around 15 per cent lower than in England.

Figure 5: Investment in general practice in Northern Ireland has been traditionally lower than elsewhere in the United Kingdom



Source: NIAO

Notes:

(i) Per capita spend has been calculated using published Investment in General Practice data (net of dispensing) and mid-year registered patient totals

(ii) Published UK-wide data on Investment in General Practice was discontinued after 2018-19 because changes in contractual arrangements in each country mean payment categories are no longer directly comparable. Thereafter, countries have prepared their own reports. At the time of review, latest data available related to 2022-23 for Northern Ireland, 2021-22 for England and 2020-21 in Wales. No Scotland data is available after 2018-19.

2.8 The lower investment in general practice is reflected in lower earnings for GPs in Northern Ireland. While not taking account of hours worked, latest available data, for the 2021-22 year indicates that on average GPs in Northern Ireland earned £104,400 (after expenses, but before tax), similar to those in Wales (see **Figure 6**). It was, however, almost £6,000 less than GPs in Scotland and nearly £14,000 less than GPs in England (i.e. some 12 per cent lower). Data for earlier years indicates that, average GP earnings in Northern Ireland have been the lowest across the United Kingdom since 2016-17.

Figure 6: GP earnings in Northern Ireland are amongst the lowest in the United Kingdom

	England (£)	Scotland (£)	Wales (£)	NI (£)
Combined (salaried and Contractor GP) Earnings before Tax	118,100	110,100	104,100	104,400
Contractor GPs	153,400	119,500	115,900	115,000
Salaried GPs	68,000	71,900	70,400	58,600

Source: NHS Digital: GP Earnings and Expenses Estimates 2021-22

2.9 GP partners holding contracts in Northern Ireland earned less than their counterparts across the United Kingdom. While broadly similar to earnings in Wales, and around 4 per cent lower than in Scotland, in 2021-22 GP partners in Northern Ireland earned around three-quarters of their counterparts in England.

2.10 Average earnings for salaried GPs in Northern Ireland in 2021-22, at just under £60,000 was around half of that earned by GP partners, although again this does not take account of hours worked. In line with their GP partner colleagues, salaried GPs in Northern Ireland also earned less than salaried GPs elsewhere across the United Kingdom.

There are indications of increased activity in general practice, although data is limited

2.11 Unlike in England, there is no published data on GP activity levels in Northern Ireland. Indeed, prior to October 2020, activity data was not routinely collected and collated by the Department as this was not a requirement of the GMS contract.

2.12 As part of its monitoring of the impact of COVID-19 on health services, and to support service planning, the then HSCB (now SPPG, DoH) commenced the collection of data on the weekly number of consultations carried out by GP practices in October 2020. While there has been some change in the coverage of the data collected, the Department has continued to collect weekly data since then. This data is submitted by practices through an online form. It is acknowledged, however, that there is inconsistency in data capture and in the accuracy of data reporting across practices.

2.13 Activity data in general practice is, therefore, limited and, as such, it is not possible to identify any continuous trend in activity levels. Nevertheless, there is some evidence of significant increases in activity, and thereby demand for services.

2.14 Based on a sample of GP practices, the Department's 2015 paper 'Estimating the Volume & Growth in Consultation Rates in General Practice in Northern Ireland, 2003-04 to 2013-14' identified significant growth in consultation levels. Between 2003-04 (the year prior to the commencement of the GMS contract) and 2013-14, this estimated that the number of consultations in general practice increased by 76 per cent, from 7.22 million to 12.71 million. This covered GP surgery consultations, home visits and practice and treatment nurse consultations.

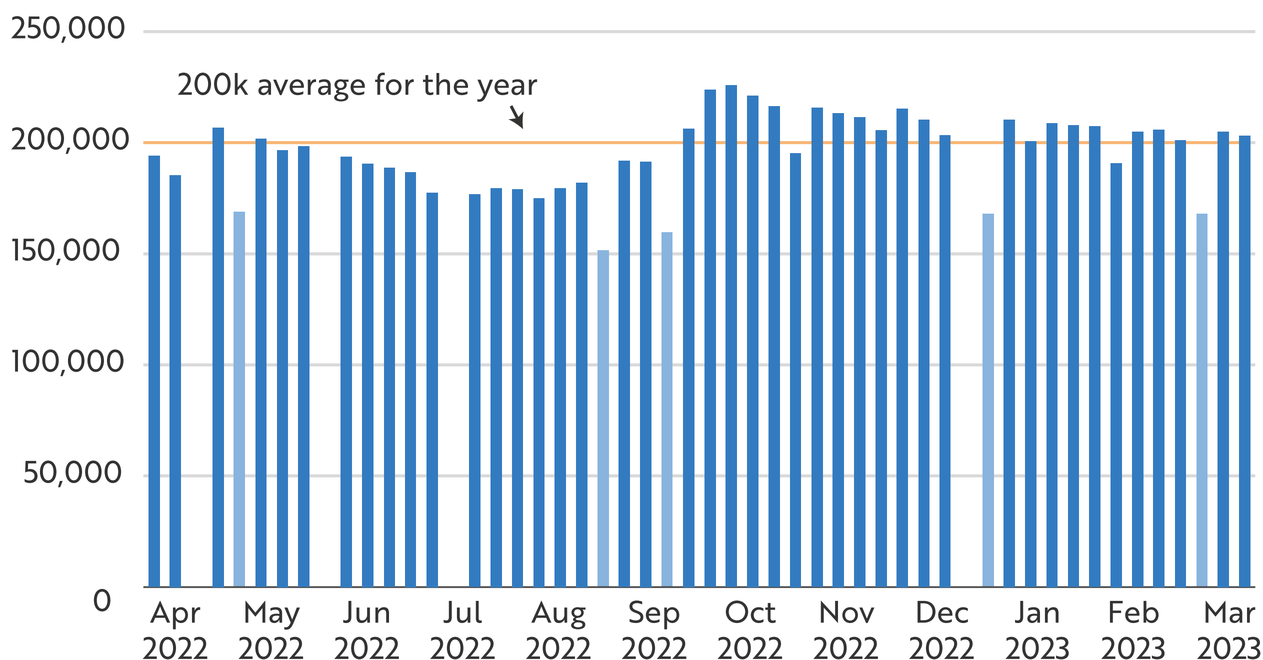
Around 200,000 consultations were undertaken each week in general practice in 2022-23

2.15 The then HSCB (now SPPG, DoH) started the collection of weekly consultation data from GP practices in October 2020. Detail of weekly consultation totals up to 31 March 2023 is provided at **Appendix Two**.

2.16 Initially, this covered GPs and practice nurses only. From October 2021 data collection was expanded to incorporate the whole practice team, including GPs, nurses (practice based and treatment room nurses) and other MDT staff, although data collection is such that separate analysis by staff group is not available. This change in recording methodology, therefore, means that comparison over time is difficult. In addition, there are a number of weeks for which no data is available, generally over holiday periods.

2.17 On the basis of data collected, and adjusting for those weeks for which no data is available, we estimate a total of 10.2 million consultations in the 2022-23 year i.e. an average of some 200,000 consultations per week. Weekly data, set out at **Figure 7**, indicates that activity during 2022-23 ranged from a low of just over 151,000 consultations in the week ending 2 September 2022 to a high of some 226,000 consultations in the week to 14 October 2022 (although it is noted that week ending 2 September included a bank holiday and therefore reflected only 4 days data). This also illustrates generally higher consultation levels in the second half of the year. In addition, given a registered patient population during 2022-23 of around 2.29 million (taken at October 2022), this would suggest that on average people in Northern Ireland visited their GP around 5 times during 2022-23.

Figure 7: The number of weekly consultations in 2022-23 ranged from 151,000 to 226,000



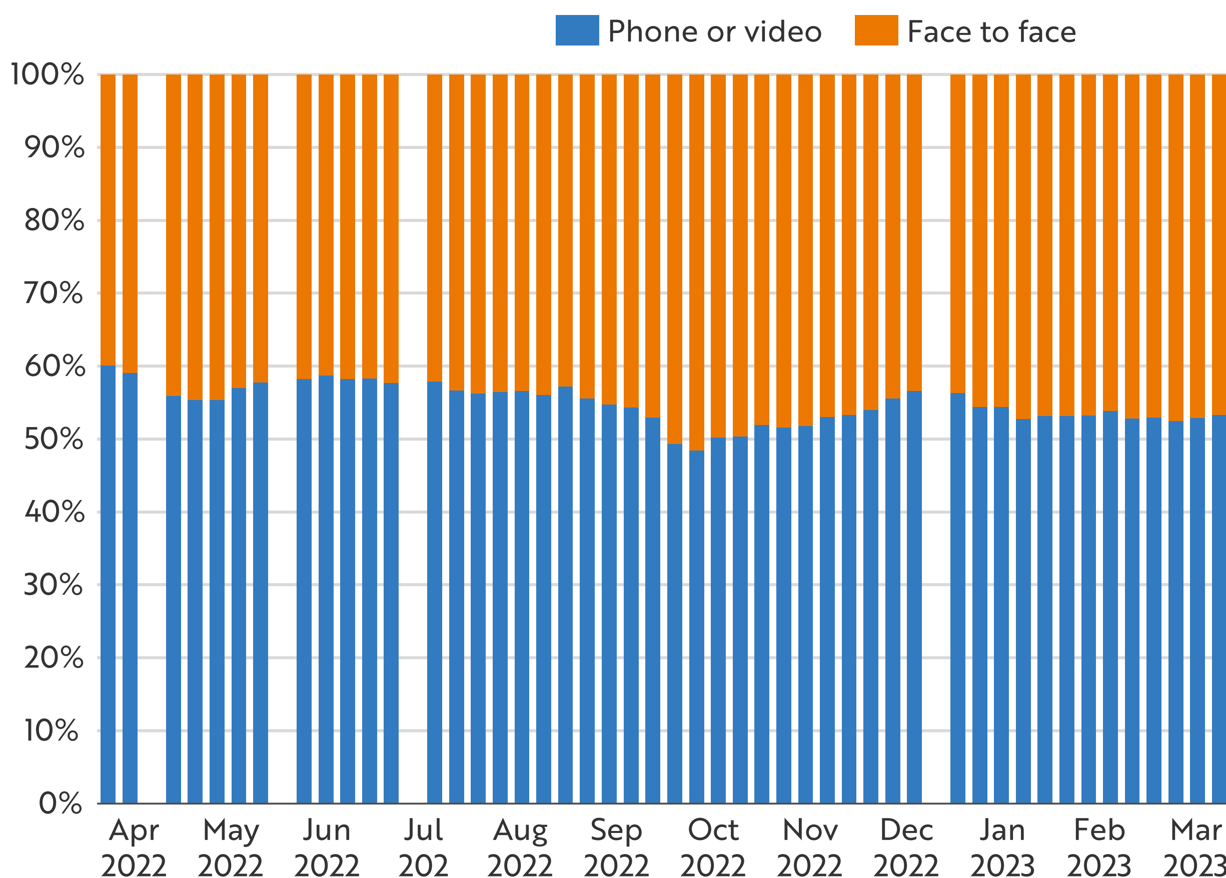
Note: Not all weeks include 5 days data - weeks with less than 5 days are coloured a lighter blue
Gaps indicate weeks without data available

Source: DoH

2.18 Recorded data also identifies that just under half (45 per cent) of all consultations in 2022-23 were face-to-face (see **Figure 8**). The majority (55 per cent) were undertaken via telephone or video. While data indicates some fluctuation in the proportion of face-to-face/telephone and video consultations throughout the year, there appears to have been some increase in the overall proportion of consultations undertaken face-to-face, from around 40 per cent in the first week of the year (w/e 8 April 2022) to 47% in the final week of the year (w/e 31 March 2023). For a short 4 week period in October 2022 face-to-face consultations made up 50 per cent or more of total recorded activity. The proportion of face-to-face consultation in 2022-23, at 45 per cent, reflects an increase of 6 per cent on levels in 2021-22 (39 per cent).

2.19 Nevertheless, comparison with data in England highlights a greater reliance on non-face to-face delivery in Northern Ireland. While increasing, the proportion of face-to-face consultations in general practice in Northern Ireland in 2022-23 remains similar to levels achieved in England during the height of the pandemic (April - July 2020). By March 2023, face-to-face consultation represented around 70 per cent of activity England.

Figure 8: The majority of consultations undertaken in 2022-23 were via telephone or video



Source: DoH

While growing, it is unclear whether activity levels are above pre-COVID levels

2.20 As a result of the change in data collection methodology, it is difficult to identify the levels of growth in consultation volumes between years. However, we estimate that the number of consultations increased between 2021-22 and 2022-23 by around 3 per cent, equivalent to around 240,000 consultations. This estimate incorporates an adjustment for the change of methodology (based around the impact of the change in terms of recorded consultations when first implemented).

2.21 As consultation data collection commenced in October 2020, no data is available for the pre-COVID period. Despite evidence of growth in activity in the post-COVID period, it is not possible to determine whether consultation levels in 2022-23 are above pre-COVID levels, although there are some indications that this is the case. Separate data collected as part of winter pressures funding (Northern Ireland Local Enhanced Services – Winter Pressures), although limited in scope, identifies activity in November 2021 around 6 per cent above that in November 2019.

The Department is taking steps to improve activity data collection in general practice

2.22 As identified above, there are clear limitations with activity data available for planning purposes. The Department does, however, acknowledge the need to quantify more accurately the volume and diversity of activity undertaken in general practice. Importantly, the Department is taking steps to improve the quality of data available through the standardisation of data collection processes (including the nomination of a practice activity data lead at each practice and the provision of training to facilitate a regionally standardised approach to the recording of data).

2.23 It is the Department's aim, once data has been quality assured, for the publication of aggregate data through regionally developed infographics. Under this process data will be extracted directly from GP systems.

Recommendation

There is a clear need to improve the collection of activity data in general practice, both to better understand the volume and nature of activity and to inform decision making. While we acknowledge the Department's intentions in this regard, this should be taken forward as a matter of urgency.

Part Three:

Workforce and Workforce Planning

3.1 In this section we explore the general practice workforce and consider issues around workforce planning.

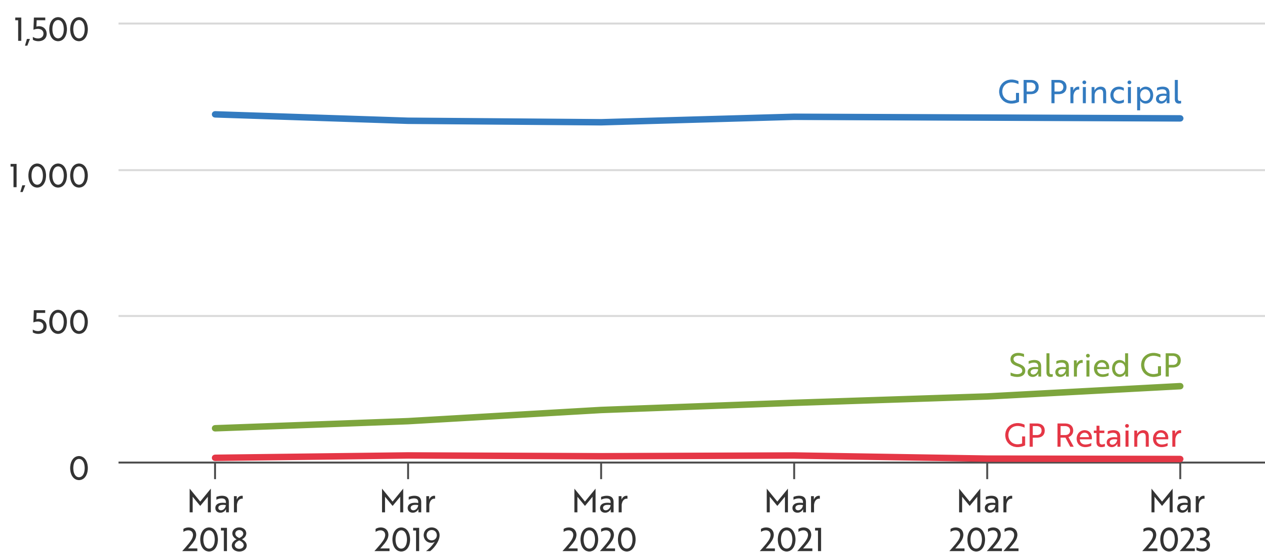
The GP workforce in Northern Ireland has undergone change in recent years

3.2 Statistics published by the Department's Arm's Length Body, BSO, are based on headcount[3]. These identify a total of 1,448 General Practitioners (GPs) on the NIPMPL at 31 March 2023. Of these, the majority (1,175) were partners in GP practices, and 261 were salaried GPs under contract to practices. There were also a small number of Retainer GPs (12) participating in the Department's GP retention programme and also under contract with practices (see later at paragraph 3.31). Over and above the 1,448 GPs there were a further 508 locum GPs, available to provide temporary staffing cover.

3.3 The trend in GP numbers is generally upwards. Overall, between March 2018 to March 2023, the number of GPs increased by around 9 per cent (excluding locums). Analysis indicates that, within the overall increase, there has been a small decrease in the number of GP partners of around 1 per cent. In contrast, the number of salaried GPs have seen particular growth (see **Figure 9** below).

3.4 Data indicates a particular increase in the number of locum GPs between March 2018 and 2022. While information on the reasons why GPs enter or leave the NIPMPL are not collated by BSO, this increase may reflect GPs returning to support services during the pandemic (for instance as 'GP vaccinators'). Detail in the Northern Ireland Medical and Dental Training Agency's (NIMDTA) 2022-23 Annual Report suggests that around 50 retired GPs returned to the workforce as Emergency Response Practitioners. NIMDTA also suggests that this may explain the reduction in locum numbers in 2022-23, as these GPs again left the NIPMPL.

Figure 9: The number of GPs (headcount) have increased in recent years



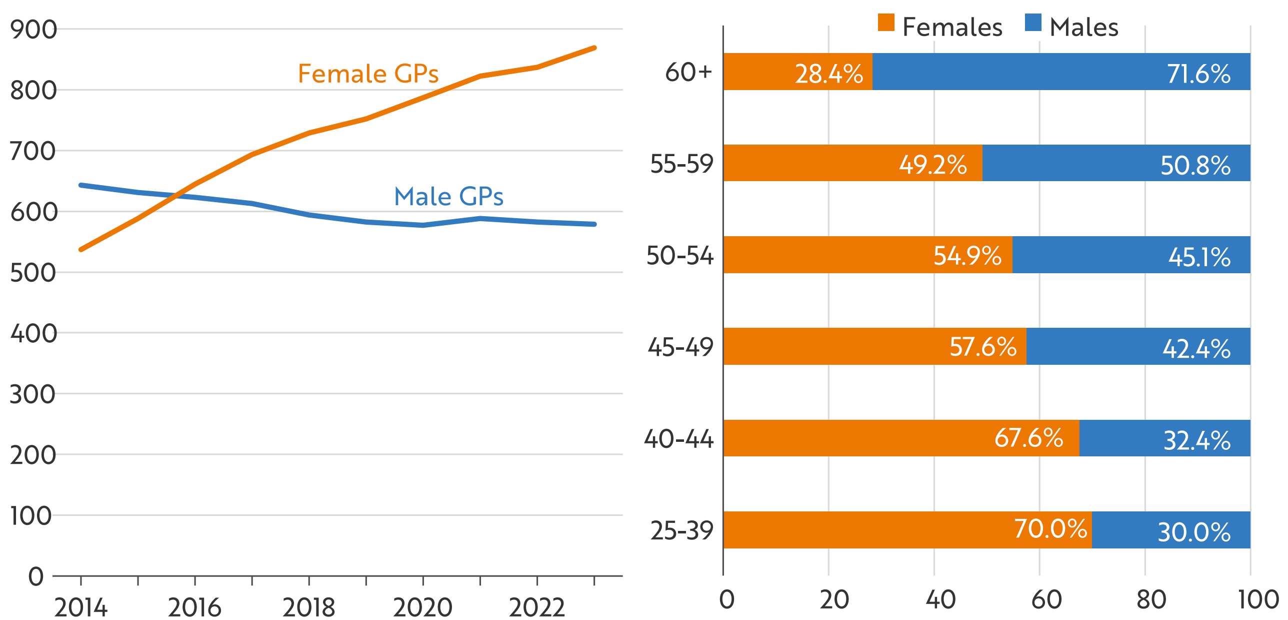
Source: BSO GMS Statistics

3 BSO statistics are based on headcount of active contracts and refer to Unrestricted Principals or equivalents, Salaried GPs and Retainers.

3.5 The longer-term trend in GP headcount is also upwards, with the total number of GPs (excluding locums) increasing by almost a quarter over the 9 years to March 2023. With a total of 1,448 GPs at March 2023, there were some 70.9 GPs per 100,000 patients (based on a patient count of just over 2.041m). At this level, Northern Ireland had fewer GPs per head than in Scotland (77.1 per 100,000 patients), but more than Wales (61.1) and England (56.4).

3.6 Over this period, there has been a reversal in the gender distribution within the GP workforce, such that by March 2023 approximately 60 per cent of GPs were female (see **Figure 10**). In addition, the increase in the number of GPs in recent years has also impacted on the age profile of GPs, with growth in the proportion of younger age groups and decline in older age groups. At 31 March 2023, the average age of a GP in Northern Ireland was 45 years.

Figure 10: The GP workforce is now predominantly female



Source: BSO GMS Statistics

3.7 While the proportion of GPs aged 55 and over has decreased in recent years (from just over 25 per cent at March 2014), at just under 21 per cent at March 2023, there remains a significant proportion of GPs in this older age group. As illustrated above, given the increase in the number of female GPs, the majority of these (and particularly those aged 60 and over) are male. This level of GPs in the later part of their careers indicates potential for a significant number of GPs to need to be replaced.

More than a tenth of GPs on the NIPMPL left during 2022-23

3.8 Detail on the numbers leaving the NIPMPL is provided at **Figure 11**. The NIPMPL includes GP contractors, salaried GPs and locums. While the data drawn from the NIPMPL suggests a particular increase in over 60s leaving in 2022-23, possibly as a result of some level of delayed retirements during the pandemic, it also identifies a distinct increase in the numbers in the youngest age group (25-39 years of age) leaving in the latest, post pandemic years (2021-22 and 2022-23). In total almost 230 GPs left the NIPMPL during 2022-23 i.e. over a tenth[4] of the total number of GPs on the NIPMPL at the start of the year (31 March 2022). On the basis of published data, approximately 150 were added to the NIPMPL (further information on this data is contained in the note to Figure 11).

3.9 Stakeholders told us that whilst reasons for leaving were often personal, consistent themes have emerged. These included burnout after the pandemic, a reluctance to accept either the finanical or clinical risk that comes with a role as a GP, or a desire for a different work-life balance.

Figure 11a: The number of GPs leaving the NIPMPL increased after 2020-21

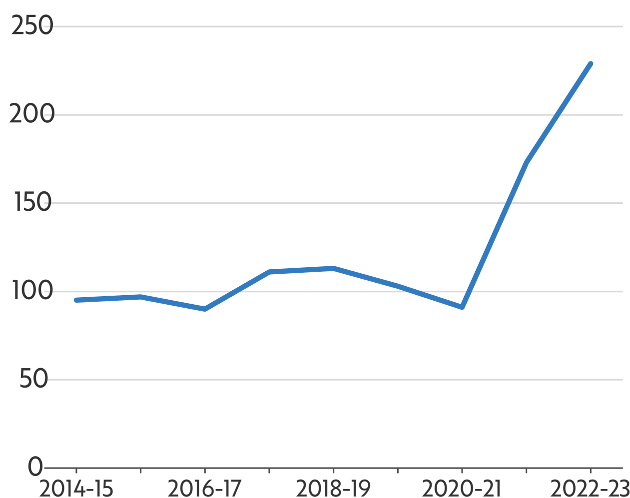
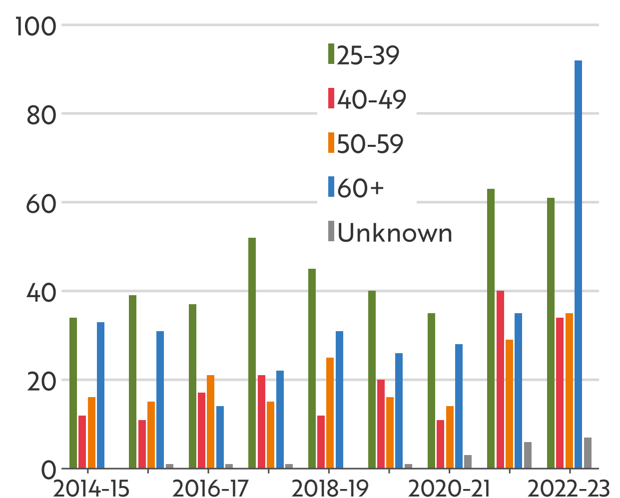


Figure 11b: Numbers leaving in younger age groups has increased in recent years



Source: BSO

Note: Data represents those with a contract end date in a particular year, individuals may not be permanent leavers from the NIPMPL and data is likely to have been impacted during the COVID period.

Published workforce data does not provide a picture of the working patterns of GPs

3.10 While BSO does publish annual statistics on the GP workforce in Northern Ireland – General Medical Services Statistics, this data (which has been applied in the analysis above) is limited to detail on GP headcount. The Department has noted that, as GPs are independent contractors and responsible for hiring, allocating sessions and duties and making payments, GP work pattern data is not captured.

4 This calculation includes locums.

3.11 The lack of an alternative to headcount, which captures work pattern data, makes it challenging to examine trends in the primary care workforce. The Department told us that elsewhere in Health and Social Care (HSC) a measure known as whole-time equivalent (WTE) is used, which calculates an individual's contracted hours divided by standard contract hours for their terms and conditions, but that an absence of standard contract hours for the GMS contract makes a definition difficult. Northern Ireland remains the only part of the United Kingdom where a proxy measure of WTE is not available.

3.12 NIMDTA collects GP-reported average sessions worked as part of the application for GP appraisal. However, this data does not form part of the official BSO statistics. It is recognised that there is not a uniform approach to collection of data in other parts of the United Kingdom or in the calculation of proxy measures for WTE for GPs.

3.13 Despite an acknowledged need to improve primary care workforce data, as identified in the action plans associated with the wider HSC Workforce Strategy ('Delivering for Our People', May 2018) and its objectives around the ability to monitor workforce trends and improve business intelligence, the Department has confirmed that, due to capacity constraints, it is not currently considering work to improve workforce data in general practice.

Recommendation

Data collected and published by the Department in relation to the GP workforce does not provide a full picture and is inadequate in terms of monitoring the workforce. Despite the acknowledged need to improve workforce data in general practice, due to capacity constraints, the Department currently has no plans to do so. However, effective workforce planning and monitoring relies upon adequate and relevant information. As a result, the Department should review its workforce data needs and develop a plan for its improvement. Within this, it should explore and capture a measure which can account for the proportion of standard sessions that are provided by a GP. This should be a similar approach to the WTE measure used elsewhere in the HSC.

Despite the increase in GP headcount, estimates indicate a fall in average GP sessions worked

3.14 The importance of WTE data for workforce planning purposes is supported in unpublished data, collected by NIMDTA as part of its GP appraisal work, which indicates that despite increases in GP headcount, GP-reported average sessions worked in general practices has declined. We do, however, note the Department's caution that this information is self-reported and largely unvalidated.

3.15 The NIMDTA GP appraisal report estimates a proxy for WTE[5]. While noting growth in total GP numbers appraised between 2014-15 and 2021-22 in the region of 9 per cent, based around data on the number of in-hours sessions delivered by GPs, NIMDTA estimated that the number of WTE GPs actually fell by around 10 per cent over the period. The majority of this decrease (accounting for a 7.5 per cent reduction in WTE GPs) arose more recently, between 2018-19 to 2021-22. NIMDTA's analysis also indicates that the fall in WTEs is mainly accounted for by a 12 per cent fall in GP partner WTEs since 2018-19. The reduction in WTE GP partners is particularly relevant, given NIMDTA's findings that GP partners provide around three-quarters of in-hours GP sessions and that on average each partner provides more sessions per week (6.5 per week) than salaried (4.9 per week) and locum GPs (3.5 per week).

Strategy in general practice aims to build a sustainable workforce, although there is no specific workforce strategy

3.16 Strategy in general practice, as identified in the 2016 Review of GP-led services and the wider health transformation strategy 'Delivering Together' (2016), identifies a need to build a sustainable workforce. This incorporates both intentions to grow the workforce in terms of increasing GP numbers and to develop teams to work alongside GPs. With regard to increasing GP numbers this involves increases in training numbers, wider recruitment and better retention of the existing workforce.

3.17 Workforce strategy in general practice is guided by the wider HSC Workforce Strategy, published in 2018. As previously noted, the Strategy's related action plan does identify the need for better primary care workforce data to enhance the ability to monitor workforce trends and improve workforce intelligence. There is, however, no separate workforce strategy for general practice, nor specific targets (like those in England and Scotland) for the growth of the GP workforce.

Recommendation

While the Department has undertaken a number of actions to build and sustain the GP workforce over recent years, there is no specific GP workforce strategy. In our view, there is a need for a workforce plan for general practice, identifying the overall number of GPs needed and the implications for the number of GP training places required, and which sets targets for overall workforce growth and the timescale within which this growth should be achieved.

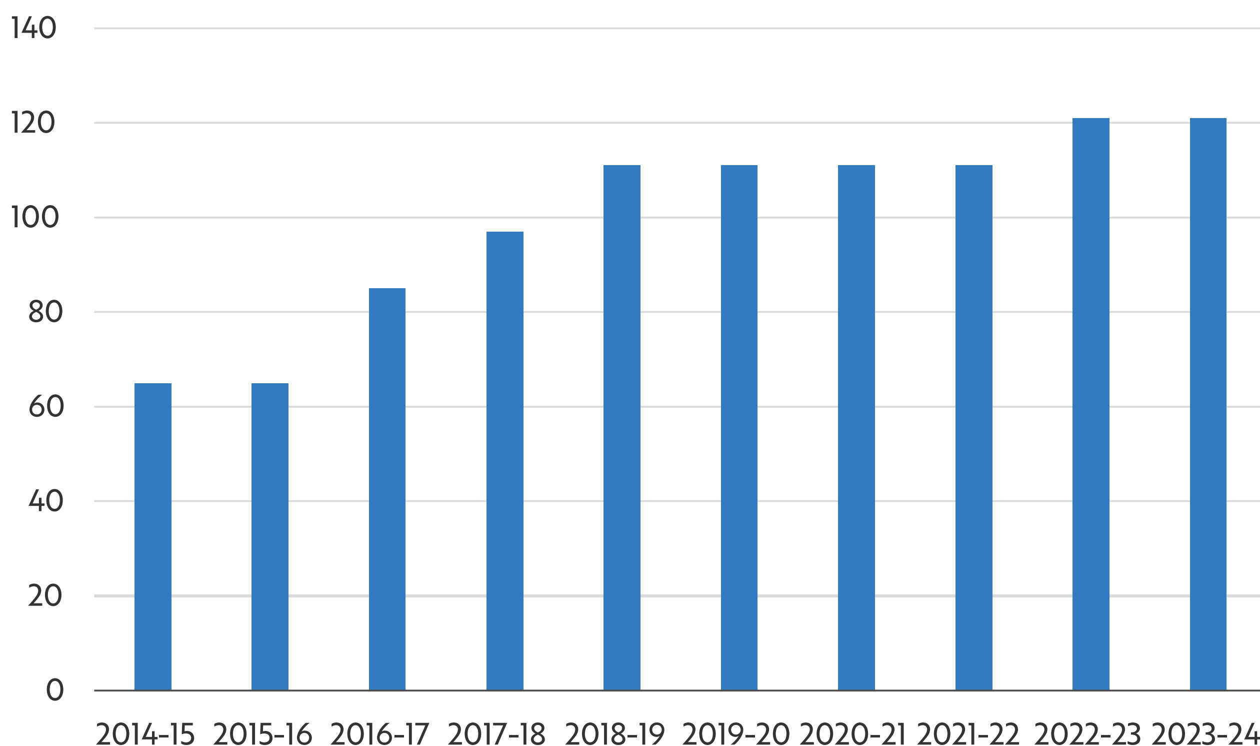
5 Using 8 sessions per week as a benchmark for whole-time (with each clinical session being approximately 4.5 hours, although this will not cover total administrative time required).

The number of GP training places has increased substantially over the last 10 years

3.18 As part of its efforts to grow the GP workforce, the Department has increased the number of GP training places available. The trend in available GP training places over the last 10 years (illustrated at **Figure 12**) shows stepped increases from 65 per year in 2014-15 to 111 in 2018-19. Training places remained stable between 2018-19 and 2021-22 at 111, before increasing by a further 10 in 2022-23.

3.19 The increase from 65 to 111 training places reflects a recommendation contained within the 2016 review of GP-led services and which originated from recommendations of the General Practitioner Medical Workforce Planning Group (June 2015). Drawing on an exercise carried out in England identifying that growth in the GP workforce had not kept pace with rising patient demand, and in assessing that demand pressures in Northern Ireland would be no less than those in England, the Group identified an under-provision of GP training places in Northern Ireland and recommended a phased increase over four years. The proposed increase to 111 places being equivalent, based on relative populations, to levels planned in England.

Figure 12: There has been an expansion in the number of GP training places available



Source: DoH

3.20 The latest increase to 121 GP training places results from a Ministerial Direction of March 2022 for a temporary uplift in places for the 2022-23 academic year. This reflected early findings of a GP training places working group, established by the Department in 2021-22, to consider the requirements for GP training places over the five years to 2027-28. The increase in training places was maintained for the 2023-24 academic year. However, the Department told us that, given the uncertainty around future budgets, it is not in a position to commit to maintaining the 121 places beyond 2023-24.

3.21 While its work remains ongoing, the working group's initial recommendations reflect an attempt to address the issue of falling supply in general practice, as identified in a decrease in the overall number of sessions provided GPs. This, alongside the increase in headcount, suggests an increased preference among GPs for less than full-time working.

3.22 The number of training places available was increased to 121 from 2022-23, however, not all of these were taken up. Only 109 of the 121 places available were filled in 2022-23 (i.e. 90 per cent uptake). At the time writing, data also indicates a further shortfall in take up in 2023-24, with 103 places filled as of August 2023.

3.23 The increase in GP training places has coincided with an increased number of international applicants (see **Figure 13**). Around 50 per cent of the commissioned general practice specialty training places filled in the 2023-24 intake (to August 2023) in Northern Ireland were taken up by international medical graduates. Such students are less likely to remain in Northern Ireland after this training, pointing to a need for proactivity to nurture their retention. One important factor in this is VISA requirements – while other medical specialties take at least five years, after which newly qualified doctors can apply for indefinite leave to remain, GP training takes a minimum of 36 months (although on average takes 44 months to complete due to trends in less than full-time working etc.). As a result, this leaves a gap of up to two years in which international graduates must secure sponsorship if they wish to remain in the country. While a United Kingdom-wide issue, practical and bureaucratic difficulties have made it challenging to find employment with a GP practice which has a visa sponsor licence in the interim.

Figure 13: The proportion of GP training places taken up by International Medical Graduates has increased significantly

	Academic Years		
	2021-22	2022-23	2023-24
Proportion of International Medical Graduates	9%	38%	51%

Source: NIMDTA

Increasing demand in general practice would suggest the need for a further expansion in GP training places into the future

3.24 The increasing demand for GP services would suggest the need for further increases in GP training places. The 2018 Northern Ireland Medical School Places Review, part of the outworking of the wider HSC workforce strategy, aimed to determine the optimum number of medical school places required per year (including GP training). This identified a shortfall in GP numbers and, given increasing demand for GP services as a result of increasing disease prevalence and predicted demographic change, estimated the need for an increase in the number of GPs of around 3.5 - 4 per cent per annum.

3.25 Projected forward, the Medical School Places Review estimated the need for an annual total of 169 training places by 2033, which represented a substantial increase (over 50 per cent) on the 111 places available at that time. The review did, however, recommend that Department should not rely solely on increasing medical school places as a means to address the shortfall in the workforce, because of the time taken for these to feed through into the workforce. It recommended consideration of other options including attracting Northern Ireland domiciles working outside the country back to work in Northern Ireland and improving retention.

3.26 In line with the Review's suggestions for a refresh after 5 years and to consider the impacts of the pandemic, the Department has indicated that it may be appropriate to undertake a further review of medical school places. However, the methodology for this review has not yet been determined.

The Department undertakes a number of other activities in support of GP recruitment and retention, although these are relatively small in scale

3.27 As part of its activities to increase the GP workforce, the Department operates a number of schemes which support wider GP recruitment and retention. These include:

- a GP Induction and Refresher Scheme, which commenced in 2014-15, provides an opportunity for GPs who have previously worked in the UK to safely return to practice after a career break or time spent abroad and for GPs qualified outside the UK to join the NIPMPL;
- a GP Retention Scheme, in operation since 2016-17, designed to support those GPs wishing to reduce their commitment (e.g. because of personal caring responsibilities or for improved work-life balance) or contemplating retirement to remain in practice, by providing a guaranteed level of work in a practice;
- a GP Mentoring Scheme which provides support to GPs facing workplace and other issues; and
- a recently introduced 'Attract, Retain, Recruit' Scheme, which supports recruitment and retention in practices that experience recruitment and retention problems through the provision of 'Golden Hello' payments.

3.28 Departmental data has indicated that the Induction and Refresher Scheme, which is demand led, has supported a total of 49 GPs between 2014-15 and 2022-23. A NIMDTA statistical review (Oct 2023) suggests that the scheme has been successful in adding to the number of GPs in Northern Ireland. This notes that, over the period 2016 to 2023, 39 GPs completed the scheme. Of these, 31 GPs remained on the NIPMPL (at Oct 2023), while 8 have left the NIPMPL. Of those remaining on the NIPMPL, 12 are currently working as GP partners, 7 are salaried GPs and 6 are locum/sessional GPs in in-hours (GMS) services. The work status of a further 6 is, however, unknown.

3.29 NIMDTA's review also indicates that around one fifth of those remaining on the NIPMPL and whose work status is known (5 of 25) work 7 or more sessions per week, while the majority (13 of 25) work between 4 and 6 sessions per week. The remaining quarter (7 of 25) work less than 4 sessions per week.

Since its inception, 70 GPs have participated in the GP retention scheme

3.30 The Department's main activity in terms of the workforce retention, the GP Retention Scheme, has been in operation since 2016 and offers 25 places at any one time on a first come, first served basis. It provides participants with stable work in a practice of at least 4 sessions per week (plus one session in out-of-hours services) for up to 3 years. While participation data indicates that this maximum of 25 places was never reached, for at least the majority of its overall lifespan (2016-17 to 2020-21) numbers involved were close to this level (between 22 and 23 participants). Participation levels have, however, significantly reduced in more recent years, with 12 GP retainers at the end of 2021-22 and 11 at March 2023.

3.31 Detail identified in a NIMDTA review of outcomes (Jan 2022) indicates that, since Spring 2016, a total of 70 GPs entered the scheme. This also notes that, while a version of the scheme for international medical graduates who trained in the UK became available in September 2022, to date there have been no applications.

3.32 Of the 70 participants, 58 have exited the scheme, the vast majority of whom (95% i.e. 55 GPs) have remained on the NIPMPL. NIMDTA's review indicates that, of the 55 scheme leavers who remain as GPs in Northern Ireland, the majority (43 GPs) continue to provide services under the GMS contract – 36 as either a GP partner (16) or salaried GP (20) in a practice, with 7 operating as locums/sessional GPs. The majority of these 55 ex-retainers provide between 4 and 6 sessions per week (33 of 55 or 60%), while 8 (15%) provide more than 7 sessions per week in GMS.

3.33 The GP Mentoring Scheme, introduced as a three-year pilot in September 2018, offers support through mentoring to address issues such as workplace problems, team relationships and work-life balance. Through the pilot scheme, GPs could avail of 5 mentoring sessions per year free of charge. While constrained in its final year by the pandemic, the pilot did successfully train a cohort of 20 mentors and provide 68 mentorship support sessions to November 2020. In this time 10 GPs completed the scheme. Subsequent to the pilot, the scheme has operated at a smaller scale, funded on a rolling one year non-recurrent basis, and has delivered a further 90 mentoring sessions.

3.34 Evidence generated through the pilot notes that participants have benefitted in terms of improved workforce relationships and interpersonal skills, work-life balance and health and wellbeing. This is however, based on a very small number of those who have completed mentoring under the scheme. An evaluation of the scheme is currently underway.

3.35 The newest of the Department's schemes in support of GP recruitment and retention, the 'Attract, Recruit, Retain' Scheme was launched in January 2023. This provides assistance in the form of 'Golden Hellos' to those GPs recruited as either GP partners or salaried GPs in practices with evidenced recruitment and retention challenges. Payments under the scheme of up to £40,000 for a GP partner and £20,000 for a salaried GP (pro rata dependent on the number of sessions undertaken), are phased over a 5-year period, with GPs required to stay with their practice for a minimum of 5 years. The scheme is demand led, with a total of some £950,000 available per annum.

3.36 While still in its infancy, the Department has indicated that, to September 2023, 14 GPs had been recruited under the scheme at a cost around £71,000. Of this total, around £58,000 related to 'Golden Hello' payments, with the remainder reflecting other costs associated with recruitment. The Department has also indicated that further support has been approved in principle, although recruitment has not yet taken place.

3.37 Given its recent introduction, the scheme has yet to be evaluated, although the Department has indicated that arrangements are currently being developed. There is some evidence that a similar type scheme operated in England – The New to Partnership Scheme – in creating in the region of 2,300 new GP partners did at least slow the decline in GP partner numbers in England.

Recommendation

Given the challenges within General Practice, and the need to improve recruitment and retention, we believe it is an opportune time to review and where necessary refresh the retention schemes that are currently in place, drawing where appropriate, on best practice from elsewhere.

“Published data does not provide a picture of the working patterns of GPs.”

Northern Ireland Audit Office

Part Four:

Multi-disciplinary Teams

4.1 This part of the report considers multi-disciplinary teams in general practice, their development and implementation across Northern Ireland.

Multi-disciplinary teams are a key element of transformation of primary care and wider healthcare

4.2 Multi-disciplinary teams (MDTs), are a key element of transformation in both primary care and wider healthcare in Northern Ireland, as identified in the March 2016 Review of GP-led Primary Care Services and the overall healthcare transformation strategy 'Delivering Together' (Oct 2016). These teams, working alongside GPs, serve to expand the services available in primary and community care, provide improved care and reduce GP workloads by diverting activity more suited to be being dealt with by other professionals.

4.3 'Delivering Together' (2016) envisaged the incremental roll-out of MDTs over 5 years. The first stage of roll-out, for implementation of teams within 2 of the 17 GP Federation areas across Northern Ireland - Down and Derry, was officially launched in September 2018. The associated business case identified intentions for teams to be fully in place in the two areas within 3 years i.e. by 2021-22, with ongoing recurrent costs (once complete) in the region of £13.25 million. In identifying particular areas of activity in general practice that could have been handled by other professionals including (among others) musculoskeletal issues, mental health issues and social issues, the business case set out plans for MDTs in general practice to include physiotherapists, mental health practitioners and social workers. Alongside this, MDTs in general practice also incorporate increases in district nursing and health visitors.

4.4 While costs associated with the initial roll-out identified in the business case were deemed affordable, with dedicated funding being provided through the Department's separate Transformation Funding for 2018-19 and 2019-20, the business case specifically noted that long term funding and the speed of roll-out were dependent on future budget settlements. The potential benefits associated with MDTs (among others) included savings in GP time, reduced referrals to secondary care as a result of expanded provision in primary care, and reduced use of emergency departments and out-of-hours services through better management of long-term conditions in primary care. These impacts and the overall effectiveness of the model were to be assessed through external evaluation.

The MDT model has been taken forward in a number of phases

4.5 The development and implementation of the MDT model in general practice in Northern Ireland to date has been taken forward in a number of phases. Early development, during 2017-18, included the establishment of governance structures for the programme and decisions around the make-up of teams. Selection of the initial areas for implementation and the development and approval of a business case for this was taken forward during 2018-19, including the formal launch of the programme in September 2018. Initial implementation during 2018-19 and 2019-20 also incorporated preparations for expansion into a third GP Federation area (West Belfast), announced in December 2018.

4.6 The second phase of the programme, announced in October 2019, saw the expansion of MDT development into two further areas, those covered by the Newry and District and Causeway GP Federations. The third phase, initiated during 2020-21, brought MDTs to two more areas (the Ards and North Down GP Federations), and the total number of areas covered by the MDT programme to seven.

4.7 To date, there has been no further extension of the model into other areas. However, a Ministerial announcement of 23 March 2022 did signal the Department's intentions for the order of future roll-out in the remaining 10 GP Federation areas. This identifies the North Belfast, South West (Fermanagh and Omagh) and East Antrim GP Federations as the next areas for the introduction of the MDTs, subject to future budget allocation. No timescale or timeline for the full regional roll-out has been set.

4.8 While a business case was prepared and approved with respect to the initial phase of the MDT programme, no overall programme wide business case has been developed. An addendum to the original business case, covering the expansion of the programme into its second phase i.e. the first five areas, was commenced. This was interrupted in March 2020 with the onset of the pandemic and not progressed further. Work is, however, currently ongoing in relation to a business case in support of the full regional roll-out of the programme.

Progress in the delivery of multi-disciplinary teams has not matched ambitions

4.9 At March 2023, MDTs had been introduced in 7 of the 17 GP Federation areas across Northern Ireland. However, given the phased introduction of the model, there is variation across these areas in terms of the degree to which teams have been delivered.

4.10 By the end of March 2023, MDTs had been fully implemented in only one GP Federation area – Down. MDTs were substantially in place in a further 3 areas (Derry, Causeway and West Belfast), with significant progress in one further area (Newry and District). Implementation in the other two areas (North Down and Ards), at March 2023, was relatively small. In total, just over 230 whole time equivalent (WTE) staff had been recruited into core MDT roles by March 2023, together with 120 nursing staff (district nurses and health visitors).

4.11 Progress in the implementation in each of the 7 MDT areas as at March 2023, measured in terms of the degree to which required staffing levels have been put in place, is summarised at **Figure 14**. This identifies that some element of MDTs are in place in 112 of the total 128 GP practices across the 7 GP Federation areas, with some 710,000 patients having access to some aspect of MDT services, approximately 35 per cent of the total registered patients in Northern Ireland at March 2023. However, with full implementation achieved in one GP Federation alone, the vast majority of patients in Northern Ireland lie outside the reach of MDTs. Only around 8 per cent of total registered patients (161,000 people) have access to the full range of MDT roles. The degree to which core MDT staff are in place in the other six MDT areas ranges from 70 per cent in the Causeway GP Federation to 15 per cent in the Ards GP Federation.

Figure 14: Progress in the delivery of MDTs varies across areas

	Down	Derry	Causeway	West Belfast	Newry & Distric	North Down	Ards
No of GP practices	13	28	18	16	29	12	12
Patient No.	77,927	206,720	108,775	92,624	159,599	83,833	80,355
No. of practices with access to MDT staff	13	28	18	16	22	9	6
No. of patients with access to MDT staff	77,927	206,720	108,775	92,624	121,075	62,875	40,178
% of practices with access to MDT	100%	100%	100%	100%	75.9%	75.0%	50%
No. of Practices with complete MDT (all 4 roles and > 80% of total WTE)	12	4	5	2	2	1	0
%. of Practices with complete MDT (all 4 roles and > 80% of total WTE)	92.3%	14.3%	27.8%	12.5%	6.9%	8.3%	0%
No. of patients with access to full MDT	71,933	29,531	30,215	11,578	11,007	6,986	0
% complete (core WTE)	**98.7%**	**66.2%**	**70.3%**	**59.0%**	**42.4%**	**22.8%**	**15.4%**

Source: DoH MDT Highlight Report (March 2023)

4.12 Overall, progress to date in the implementation of MDTs, therefore, has neither met the wider ambitions for delivery of the programme within 5 years as envisaged under the Department's health transformation strategy 'Delivering Together', nor achieved its intentions for MDTs to be fully in place in 2 GP Federation areas by 2021-22 as set out in its phase one business plan.

Spend on the implementation of MDTs to March 2023 totalled around £75 million

4.13 On its launch in 2018, the Department indicated that a revenue budget of around £15 million had been secured for the implementation of MDTs in 2018-19 and 2019-20. Overall, £81 million was allocated to the programme up to and including 2022-23. The Department has also indicated that a further £25 million has been earmarked for 2023-24.

4.14 Except in the initial year (2018-19), spend in relation to the development of MDTs has broadly matched budget amounts. In total, to March 2023, spend on MDTs totalled approximately £75 million, with some £23.5m spent in 2022-23.

4.15 In addition to revenue costs, the Department has also provided capital funding in relation to the extension and refurbishment of premises to facilitate the introduction of MDTs. While no data was available in respect of the 2022-23 year, capital spend to March 2022 totalled almost £12 million, with some £5.2 million of this spent in 2021-22.

The planned evaluation of the MDT model was not completed, although early evidence did suggest some small positive impacts

4.16 Ongoing evaluation of the impact and effectiveness of the MDT model was built into the planned programme as part of the original business case. External consultants were appointed in January 2020 to carry out a two-year evaluation between March 2020 and March 2022. This evaluation aimed to provide both a comprehensive assessment of the quality of the MDT model and the extent to which the services provided through them improved outcomes for patients.

4.17 While commenced in February 2020, its progress was impacted by data collection challenges during the pandemic and, on the basis that its original objectives could not be delivered, a decision was taken to stand down evaluation in May 2021. The Department has noted, however, that work is ongoing on an inhouse evaluation.

4.18 While not fully completed, a number of recommendations were made for the Department, although no conclusion was drawn on the scalability or sustainability of the MDT model. In particular, this recognised sustained funding and adequate workforce as key facilitators and barriers to effective teamworking and MDT implementation and, in noting that full staff complements were not yet in place, identified recruitment challenges in a number of areas. In this regard, it was recommended that the Department work with MDTs to ensure all vacant posts are filled as soon as possible and that the Department should work to secure permanent funding for existing MDTs and develop phased plans for the ongoing roll-out into other areas.

4.19 The evaluation also highlighted agreement among both service users and wider stakeholders that the MDT model should be rolled out at pace, to avoid embedding a two-tier system between MDT and non-MDT areas, both in terms of inequalities in provision and recruitment challenges where working in areas with an MDT is perceived as more attractive than areas without an MDT.

4.20 Despite planned evaluation activities being restricted, some limited evidence of improvements in health outcomes and impact on secondary care were identified. This reflected the fact that:

- based on activity data, greater numbers of patients were able to have their conditions/support needs managed within primary care where MDTs were embedded (compared to areas without MDTs);
- management and front-line staff indicated that MDTs have been beneficial in reducing pressure on GPs; and
- particularly in relation to musculoskeletal issues, data indicates some reduction in the number of referrals to secondary care services.

Staffing is identified as a key constraint in the delivery of MDTs

4.21 Progress in the implementation MDTs to date, as recognised in the emerging findings of the evaluation, has been constrained by the lack of qualified staff. It has also been impacted by the pandemic, as acknowledged in the Department's June 2020 'Rebuilding Health and Social Care Services'.

4.22 The impact of the pandemic can be identified in the build-up of staff in MDTs. Detail supplied by the Department on the numbers of staff recruited into MDTs is summarised at **Figure 15**, while fuller details are set out in **Appendix Three**. This identifies particular progress in staff recruited to MDTs in the 2019-20 year. However, recruitment slowed in 2020-21, with the onset of the pandemic, and 2021-22. Only around 15 additional WTE staff were recruited into MDTs in 2022-23.

Figure 15: MDT recruitment was affected by the pandemic

WTE Staff

	March 2019	March 2020	March 2021	March 2022	March 2023
Core MDT staff	30	164	203	223	234
Nursing staff	-	86	106	116	122

Source: DoH MDT Highlight Reports

4.23 The number of core MDT staff required reflects the population of the particular MDT area and is based on a standard formula identified at the outset of programme of 1 practice-based physiotherapist, mental health worker and social work assistant per 10,000 registered patients and 2 social workers per 10,000 patients. For the 7 areas within which MDTS have been implemented, this equates to a total core staff requirement of some 425 WTEs. In addition, the associated nursing requirement totals 104 WTEs.

4.24 As set out at **Appendix Three**, around 230 WTE staff were in place in core MDT roles by March 2023, with a further 190 WTEs remaining to be recruited. Analysis indicates particular challenges in social work recruitment, with three quarters of all vacancies (145 WTEs) relating to social workers or social work assistants. There was also a shortfall in physiotherapists (29 WTEs) and mental health workers (18 WTEs) at March 2023. Conversely, overall nursing recruitment has been achieved. Indeed, district nursing numbers were oversubscribed.

Significant funding will need to be secured to sustain future MDT operations

4.25 The adequacy of funding for implementation is an issue highlighted throughout the life of MDT programme. In identifying the order for future regional roll-out, the Department's announcement in March 2022 again highlighted that the pace of roll-out is dependent on future budget allocation.

4.26 Based on its original assumptions, the Department has estimated the average annual cost of MDTs at around £6.5 million per GP Federation area, and the overall cost of full regional implementation at around £116 million. This incorporates core team costs of £74 million and a further £42 million relating to associated nursing staff. With current budgetary allocations in the region of £25 million per annum, the Department would need to find an additional £91 million per annum to sustain the operation of a full programme of MDTs across the country.

4.27 Similarly, with a capital cost requirement estimated at around £2.5 million per GP Federation, and with total capital spend to date of £17 million (assuming capital spend in 2022-23 similar to that in 2021-22), the Department would also need to secure an additional £25 million to meet the capital requirements for full regional roll-out.

4.28 In terms of future staffing requirements, as illustrated in **Figure 16**, recruitment to core team roles to date represents only around one quarter of the total staffing complement needed for the full implementation of MDTs across Northern Ireland. In total, more than 750 additional staff would need to be recruited to achieve full MDT staff complement. Given the recruitment difficulties experienced to date, this will present a significant challenge.

Figure 16: Full Regional roll-out will require over 750 more staff to be recruited into core roles

Role	Staff Required (WTE)	Staff in Place 31 March 2023 (WTE)	Future No. of staff needed (WTE)
Physiotherapists	202	59	143
Social Workers	404	76	328
Social Work Assistants	202	29	173
Mental Health Workers	202	69	133
Total	**1,010**	**234**	**776**

Source: DoH

4.29 The Department has indicated that work is currently ongoing to develop a plan for the further implementation of the MDT model over the next 5 years. As part of this work, consideration has been given to a revised configuration of the model in the future. In recognition of funding constraints it has been proposed that practice based roles are prioritized, with a focus on nursing at a later date.

4.30 While diluting the original plans, this would lead to a reduced funding requirement and provide some reduction in terms of staffing pressures. The Department has estimated that the removal of the nursing element alone would reduce the overall annual cost of MDTs by around a third, from £116 million to £74 million. A reduction in the social work complement is expected to reduce costs further to £61.2 million.

Recommendation

MDTs are a key element of transformation in both primary care and wider healthcare in Northern Ireland. Progress to date, however, has not matched ambitions, as a result of both a lack of adequate funding and qualified staff. While the order for future roll-out has been identified, no timeline for full regional roll-out has been set and no action plan exists for its delivery.

In the absence of sufficient funding, the Department needs to explore alternative options for the implementation of the MDT model over the coming years, and develop credible plans for the future roll-out of MDTs across Northern Ireland, taking account of the anticipated constrained funding outlook, and the availability of staff in key professions. These plans should be costed and should include an overall timeframe for delivery and key implementation milestones. There is also a need to expedite the Department's evaluation of implementation to date to inform the revised business case, learn lessons for future implementation and to ensure expected benefits are maximised.

Part Five:

Access to General Practice

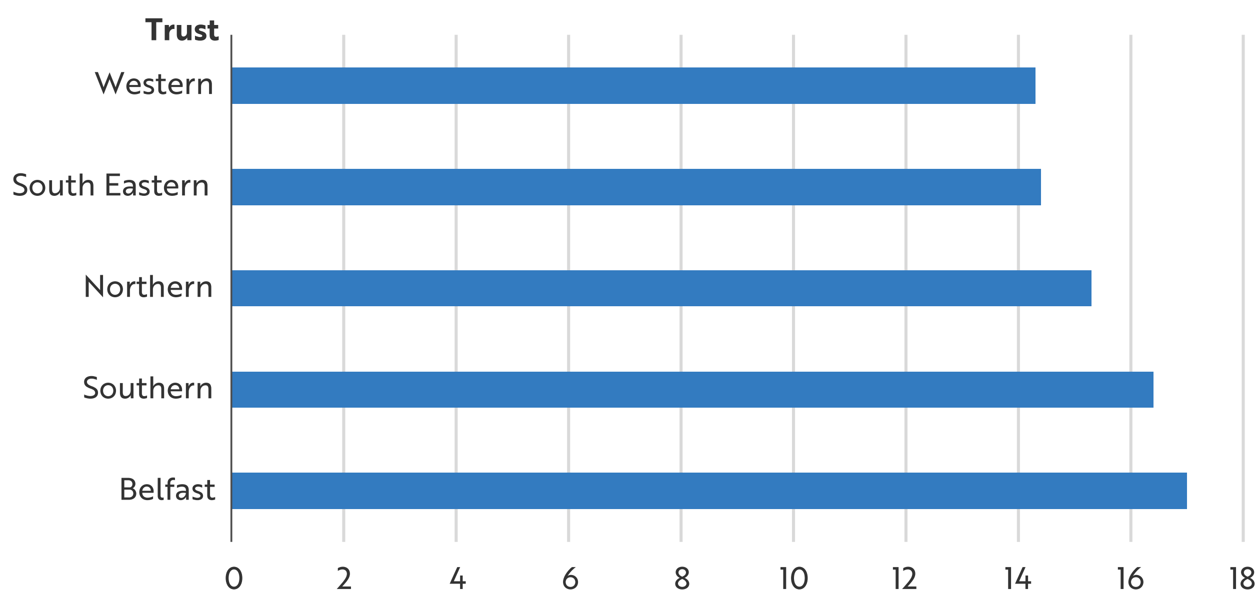
5.1 This section of the report identifies and discusses a number of issues around access to general practice.

GP practices are not evenly distributed across the country

5.2 At 31 March 2023, there were 318[6] GP practices in Northern Ireland. Given a total of over 2 million registered patients, this equates to an overall 15.6 GP practices per 100,000 patients. On average each practice has a patient list of approximately 6,420 patients. Also, with a headcount of almost 1,450 GPs (excluding locums), on average, each practice in Northern Ireland has approximately 4.6 GPs.

5.3 GP practices are, however, not evenly distributed across Northern Ireland. As illustrated at **Figure 17**, which identifies GP practices per 100,000 at local commissioning group/Health Trust area level, there are greater numbers of GP practices in the Belfast area relative to its population (17.0 per 100,000 patients). Levels are lower in the South Eastern and Western Health Trust areas. Practices in these areas, therefore, have larger patient lists. At around 7,020, average practice list sizes in the Western Health Trust area are approximately 20 per cent larger than those in the Belfast Health Trust area (5,870). Analysis at smaller area levels, such as local council district or GP Federation shows even wider ranges of variation in practice list sizes.

Figure 17: There are more GP practices per 100,000 patients in the Belfast area



Source: BSO GMS Statistics

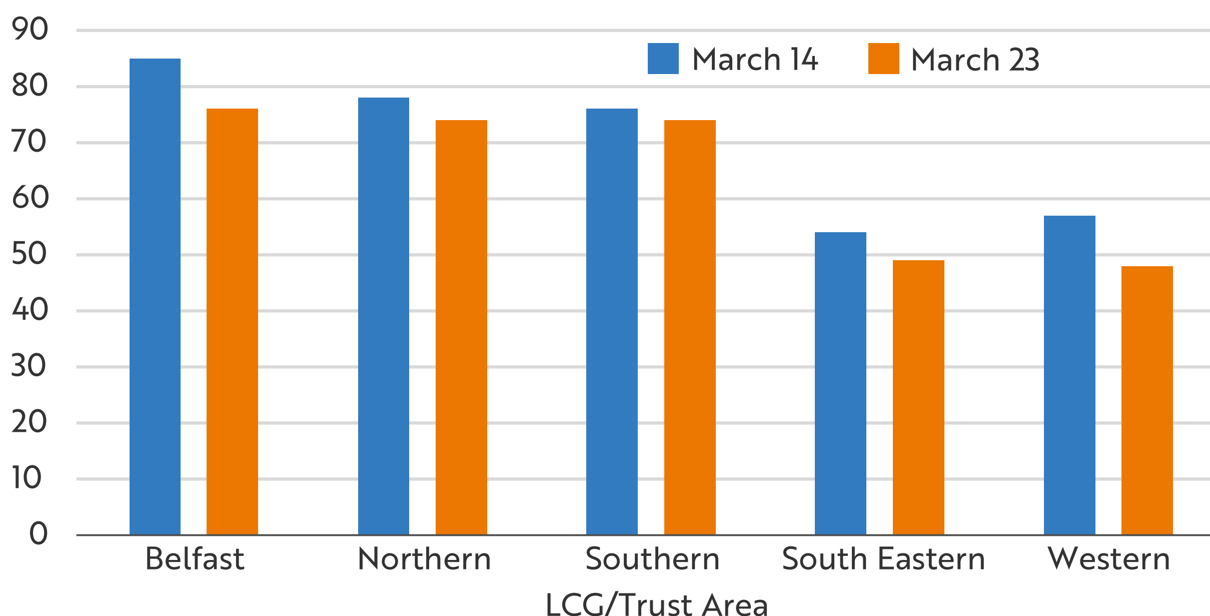
6 BSO published statistics for 2022-23 reference 317 practices at 31st March 2023. However, this figure reflects the post quarter close position and therefore 318 practices are quoted in this report.

5.4 On average, at March 2023, patients in Northern Ireland live 1.3 miles from their nearest GP practice. Almost three-fifths of all patients live within 1 mile of their nearest practice, and nearly nine-tenths live within 3 miles of a practice. Only a small proportion of patients (just over 2 per cent) live more than 5 miles from a practice. In general, distance to practice is lower in urban areas, while greater in more rural areas. Analysis at Health Trust area level indicates that patients in the Western Health Trust area live further from their local practice. While on average living 2 miles from a practice, around one tenth of registered patients in the Western Trust area live more than 5 miles from their nearest GP practice.

The number of GP practices has reduced in recent years

5.5 There has been a reduction in the number of GP practices in Northern Ireland over recent years. The 318 GP practices at March 2023 represents only a slight decrease from the 319 at March 2022. However, over the last 10 years the number of GP practices has decreased by around 10 per cent (from 350 at March 2014). While this reduction is evidenced across the country, the fall in GP practices is greatest in the Western Health Trust area (see **Figure 18**), where the number of GP practices reduced by just under 16 per cent (or by 9 practices in total) between March 2014 and March 2023.

Figure 18: The fall in the number of GP practices has been greatest in the Western Health Trust



Source: BSO GMS Statistics

5.6 The reduction in the number of GP practices, combined with increases in the number of registered patients, has resulted in a decrease in the overall number of GP practices per patient from 17.3 per 100,000 patients in March 2017 to 15.6 in March 2023. Over this period, the average practice list size grew by almost 650 patients (from 5,770 to 6,420). However, despite the fall in the number of GP practices per 100,000 patients, the level in Northern Ireland remains the highest across the UK (**Figure 19**). This, however, does not take any account of the relative size of practices (for instance the average number of GPs per practice).

Figure 19: Northern Ireland has the highest number of GP practices per 100,000 patients in the United Kingdom

	GP Practices per 100,000 patients
Northern Ireland	15.6
Scotland	15.5
Wales	11.8
England	10.3

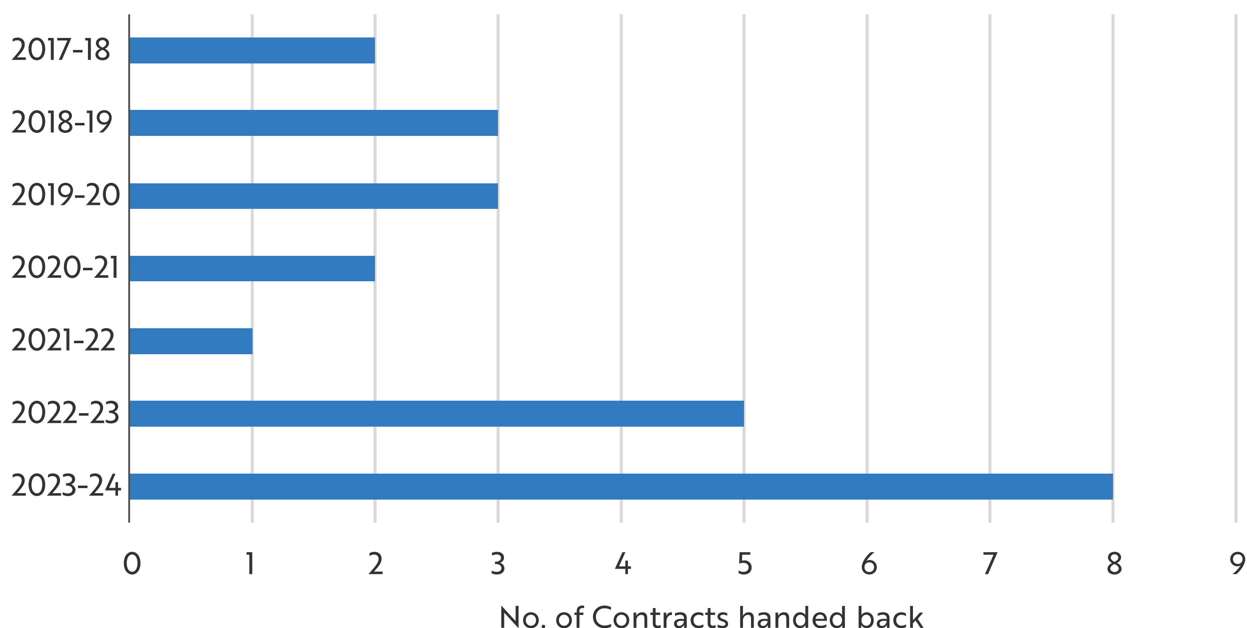
Source: NIAO (based on published statistics and information provided by the Department)

The number of GP practices handing back their contracts raises concern around the sustainability of GP practices

5.7 While latest data indicates only a slight reduction in the number of GP practices between March 2022 and March 2023, this reflects the net change in the number of practices. Where a practice closes, it hands back its contract, although the contract is generally taken on by another practice (whether newly formed or an existing practice). This can, therefore, result in no change in the overall number of practices.

5.8 Despite the number of GP practices falling only from 319 to 318 between March 2022 and March 2023, data provided by the Department in relation to GP contracts handed back indicates potential for greater reductions in the number of GP practices in the future. This data identifies a particular increase in the number of GP contracts handed back (or where notice was given to hand back) in 2022-23 (see **Figure 20**). In total, 13 contracts were handed back during the 2022-23 year, 5 of which were contracts to be handed back during the 2022-23 year and the remaining 8 to be handed back during 2023-24. This represents, around 4 per cent (or 1 in 25) of the total number of practices at March 2022. Subsequent information (up to September 2023) also identifies a further 5 contract hand backs in 2023-24 (not included in this analysis).

Figure 20: There has been an increase in contracts handed back since March 2022



Source: DoH

5.9 Of the 13 practices handing back or giving notice to hand back during 2022-23, the largest proportion (over a third or 5 practices) were located in the Western Health Trust area. Around one quarter (4 practices) were located in the Northern Health Trust area, while a further 2 contracts handed back were from the Belfast Health Trust area. One contract was handed back from each the South Eastern and Southern Health Trust areas.

5.10 The Department has indicated that, in each of the 13 instances of contract hand back, an alternative provider has been put in place. At the time of writing, 3 contracts were taken on by other (new or existing) practices and 1 contract was taken over by an existing out-of-hours provider. The remaining contracts were either taken on by GP Federations (4 contracts) or by the local Health and Social Care Trust (5 contracts). Instances where the local Trust took over the contract, three of which related to the Western Trust area, reflected temporary arrangements to secure services while an alternative provider is sought (one of which was subsequently taken on by a GP Federation). The direct involvement of GP Federations, albeit also temporary, in the provision of core services under the GMS contract marks a new development within general practice. Instances where temporary provision is put in place avoids the need for patients to be dispersed among neighbouring practices and the potential knock-on impact on their sustainability, where they are incapable of absorbing the additional demand associated with these patients.

5.11 In the cases HSC Trusts have taken on the role as contractor, this has had the effect of increasing costs, often substantially. Whilst Trusts have access to a range of staff which can help stabilise practices, GP cover is often sourced from locums. However the need to attract locums to challenging practices has resulted in high rates being paid – up to £1,000 per day. Stakeholders told us that whilst it may immediately stabilise the practice, it had the effect of distorting the locum market for other practices.

5.12 The Department told us that, through these actions, it has been possible to ensure that none of these practices have closed and disruptive list dispersal has not been necessary. However, it is recognised that this is a short-term solution, and there is a need to identify solutions which will be effective in maintaining sustainable GP services in the long term.

Recommendation

Stabilisation of practices at risk is essential. Whilst any solution will inevitably involve long term planning, there is a significant risk that the costs associated with dealing with failing practices could have a destabilising effect across the system. We recommend that work is undertaking to stabilise GMS services, to increase the sustainability of the service and contain costs associated with supporting failing practices. This should include monitoring of the financial impact of failing practices.

A significant number of GP practices are under severe pressure

5.13 In addition to the numbers of practices handing back their contracts, the Department has identified that, at March 2023, a total of 39 practices were deemed to be at risk because of challenges resulting from (among others) workforce issues, imminent retirement without succession planning in place, sickness, inability to recruit or financial issues. With 318 GP practices as at March 2023, this represents around 1 in 8 practices across Northern Ireland.

5.14 The Department can refer practices at risk or in crisis to the General Practice Improvement and Crisis Response Team (PICRT). PICRT, which is administered through the GP Federation network and operates on a regional basis, provides advice and support to practices in crisis, including the provision of locum cover to help secure continued service provision. Since its establishment in 2018, PICRT had provided support to a total 96 GP practices. Within this, we note that all 13 of the practices identified above as having handed back or having given notice to hand back their contract in 2022-23 received support from PICRT. Latest data (up to the end of November 2023) indicates that 39 practices are currently receiving support from the crisis team.

5.15 Whilst the involvement of Trusts in delivering primary care services has brought a number of financial and resourcing challenges, it does present the opportunity to learn lessons from practices that have been in crisis. This has identified potential weaknesses in governance and processes that have the potential to impact those using services. Whilst individual practices are independent businesses, the lessons learned from a greater insight into the challenges and potential solutions to practical problems could help a number of practices across Northern Ireland.

Recommendation

Where Trust involvement in the delivery of primary care services has identified weaknesses and potential lessons that are of use to the sector as a whole, we recommend that the Department identifies the best means of disseminating this information.

There are identified problems in patient access to general practice

5.16 Over the last couple of years in particular, media and political interest has highlighted problems for patients in making contact with GP practices and in obtaining GP appointments. These issues are not new to general practice, for instance a 2014 Patient Client Council report on patient access to GPs identified issues in terms of getting through to practices by phone, speaking to a doctor and the length of wait for non-urgent appointments. In addition, the rationale for the Review of GP-led Primary Care (which reported in 2016) reflected a recognition of challenges in securing timely GP appointments.

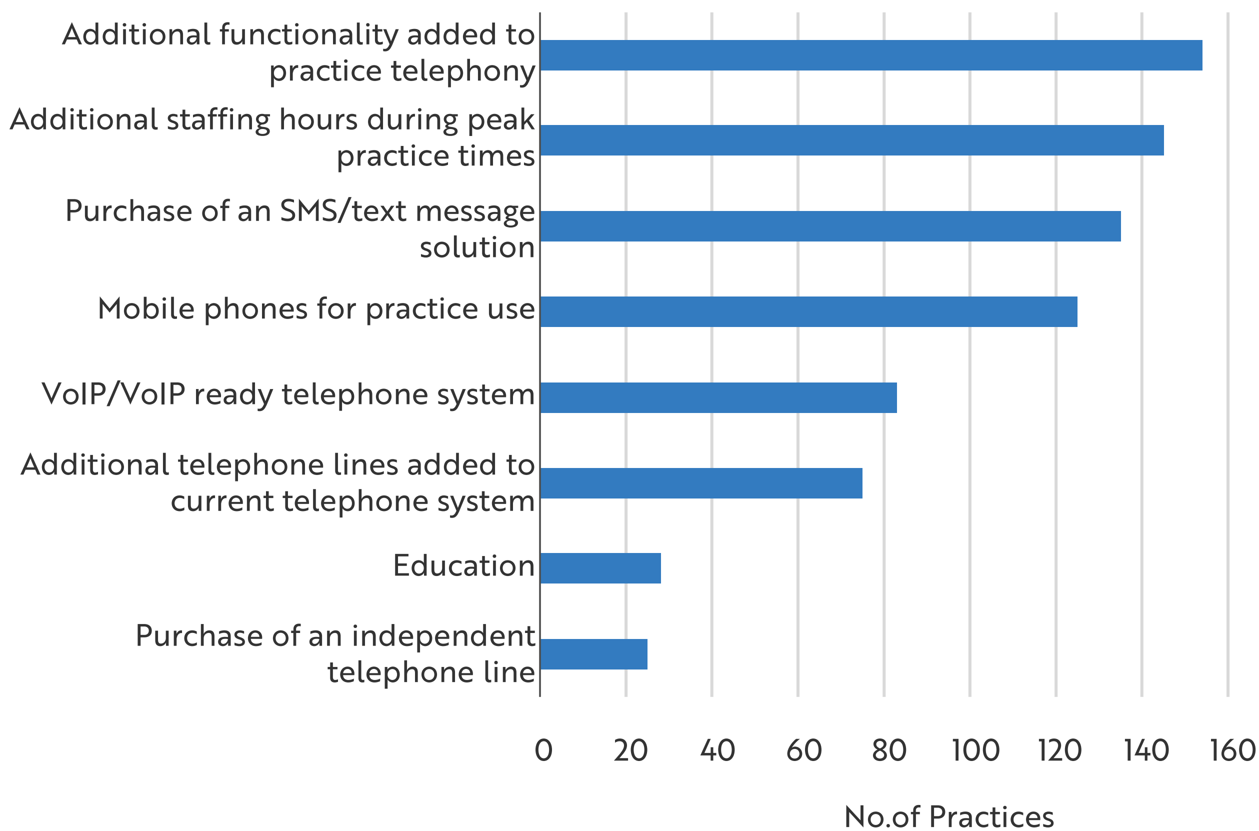
5.17 Discussions with GP representative bodies, highlight the current issues in access as a symptom of the mismatch in the increasing demand for and diminishing supply of services in general practice (as identified at Part Three). As a result, there has been a call for increased investment in general practices, with supply aspects to be resolved through the expansion of the general practice workforce (both GPs and other professionals as part of MDTs).

5.18 GP services have been experiencing sustained high levels of demand since before the covid-19 pandemic. Practices have, therefore, continued to adapt how services are delivered in response to increasing pressures. Under the general practice telephone first approach, patients make contact with practices via telephone to seek timely medical advice from their GP for both routine and urgent problems. The GP determines the most appropriate approach to safely addressing the patient's needs using their clinical expertise. The GP decides, based on their assessment, if a face-to-face appointment is appropriate, if the patient can be managed over the telephone or if they should be signposted or directed to other appropriate services. Consultations with GPs (as identified at Part Two) incorporate a mix of telephone, video and face-to-face contact. This focus on telephone contact has, necessarily, placed increased demands of practice telephone systems. The 'phone first' approach continues to be retained as a means of demand management within the existing practice workforce.

5.19 In facilitating the move to a general practice telephone first approach, the Department provided support for the improvement and upgrade of practice telephony systems. Of the £1.7 million available in each of the years 2020-21 and 2021-22, a total of almost £2.3 million was spent by practices in improving their telephone systems. With 277 practices availing of funding in the 2020-21 year and 287 in 2021-22, around 90 per cent of practices in Northern Ireland undertook spend in their telephone systems over the two years. No funding was made available in 2022-23.

5.20 Analysis of the use of telephony funding in 2021-22 (see **Figure 21**) identifies that the practices applied this funding to add functionality to practice telephone systems, purchase text messaging solutions and mobile phones, and add additional lines. Around half of practices in receipt of funding in 2021-22 used it for additional staffing hours to answer calls during peak practice hours.

Figure 21: Practices have upgraded their telephone systems and increased staffing during peak times



Source: DoH

Internal Audit has expressed concerns over the ability to effectively performance manage GP practices

5.21 While the GMS contract identifies the broad services to be provided by practices, there are no formal standards or targets of performance in terms of access to services e.g. time taken to answer calls, triage turnaround, timely access to appointments or the number of appointments made available. This was noted in a 2022 departmental internal audit review of the Department's performance management arrangements in general medical services. As a result, internal audit concluded that the current contract does not provide the Department with the ability to effectively performance manage GP practices. In identifying the need to enhance management arrangements, internal audit also acknowledged that the introduction of performance indicators would require renegotiation of the wider contract.

In recognition of pressure in general practice the Department has established an access working group

5.22 In acknowledging increased pressures on GP practices, and evidence of problems in patient access, the Department established a working group in June 2022, to consider access in general practice and to make proposals for action to improve access in the short, medium and long term. The working group, as part of its initial work undertook research in order to better understand the nature of the access challenge and patient experience.

5.23 Its initial report (the GP Access Discovery Report, September 2022) outlined a number of key findings. In noting these, it is important to be aware that the quantitative telephony data and the qualitative analysis of user experience were both based on small sample sizes[7]. Key findings noted that:

- Call demand from the public is not being met – there are insufficient call handlers to meet demand, with on average only 41- 49 per cent of calls offered being answered (based on a small sample of practices), and which can result in variable waiting times. In addition, as the number of calls which are not connected is unknown, true/absolute demand cannot be measured;
- Not all calls answered require a GP appointment – a large proportion of calls do not require a GP appointment, which might be facilitated through greater options within current telephony to triage people away from the receptionist, while also prioritising those who need to speak to a doctor; and
- The 'phone first' model is functional but sub-optimal – with the short window of access leading to exclusion, the need to redial and having lines cut off frustrating patients, and the lack of queuing information meaning that users cannot make informed decisions on whether to remain on or abandon calls. Nevertheless, as it allows a greater number of patients to access services than previous systems, it remains the most appropriate way for patients to access GP practices.

5.24 In addition, the GP Access Working Group's initial report highlighted the importance of continuity of care for users, particularly those with chronic conditions and in need of continuous care, and the perception that the 'phone first' model is perceived as a barrier to the development of a long-term trusting relationship with the GP. It also identified that patient frustration with the system of access is manifest in increased levels of hostility towards practice staff.

7 The Department told us that quantitative data was gathered by interrogating the telephony systems from 9 participating practices. In addition, further deep dives were undertaken with 4 individual GP practices. Qualitative data was collected through engagement with 42 service users on a range of issues relating to GP access.

5.25 Departmental analysis of the working group report led to recommendations about the need for investment in training and support for reception staff/care navigators, further research and analysis to understand demand for GP services and the capacity for this to be met through other means (directed away from the practice team), design work to understand and improve the patient/user journey, and the development of messaging and communication strategies to help manage patient expectations and behavioural change in how people seek access to services. The working group's report does, however, acknowledge that its work has mainly focussed on telephony and that, even if systems are improved, there is no capacity within practices to take on more appointments, and recommends further research to support the alignment of workforce capacity to meet growing demand.

5.26 The working group's recommendations are being progressed through a pathfinder telephony project, aimed at testing how the utilisation of a modern telephony system can help better understand demand (including unmet demand), improve patient and staff experience and improve access to GPs. The working group is also engaging with the Departmental Communications Team around patient messaging. This focus towards telephony, however, does not seek to directly address the wider issue of capacity in general practice (whether in relation to call handlers, the number of GPs etc. or the number of appointments available). Some of this wider work is being taken forward through other programmes/groups such as the GP Training Places Group or the roll-out of MDTs.

5.27 The pathfinder project, which has yet to commence, intends to test the potential of a new cloud-based telephone system to improve demand and capacity in general practice. The project, which is expected to run over 9 months, and involve up to 10 GP practices, is expected to cost in the region of £370,000. It is envisaged that the outcomes of the pathfinder will help inform departmental decision making on future GP telephony.

Recommendation

There is clear evidence that patients are experiencing problems in accessing GP practices, improvement in which will present significant challenges for the Department and practices. While acknowledging the work undertaken by the GP Access Working Group and its intentions around the telephony pilot, its findings to date clearly highlight the need to increase capacity in general practice. While we appreciate that increasing capacity in the longer term in general practice is linked to wider workforce strategy, we would encourage the Department to consider what actions it might take in the shorter term to improve patient access to services, including the patient experience of accessing services. This should include implementing best practice processes in GP practices.

Appendices

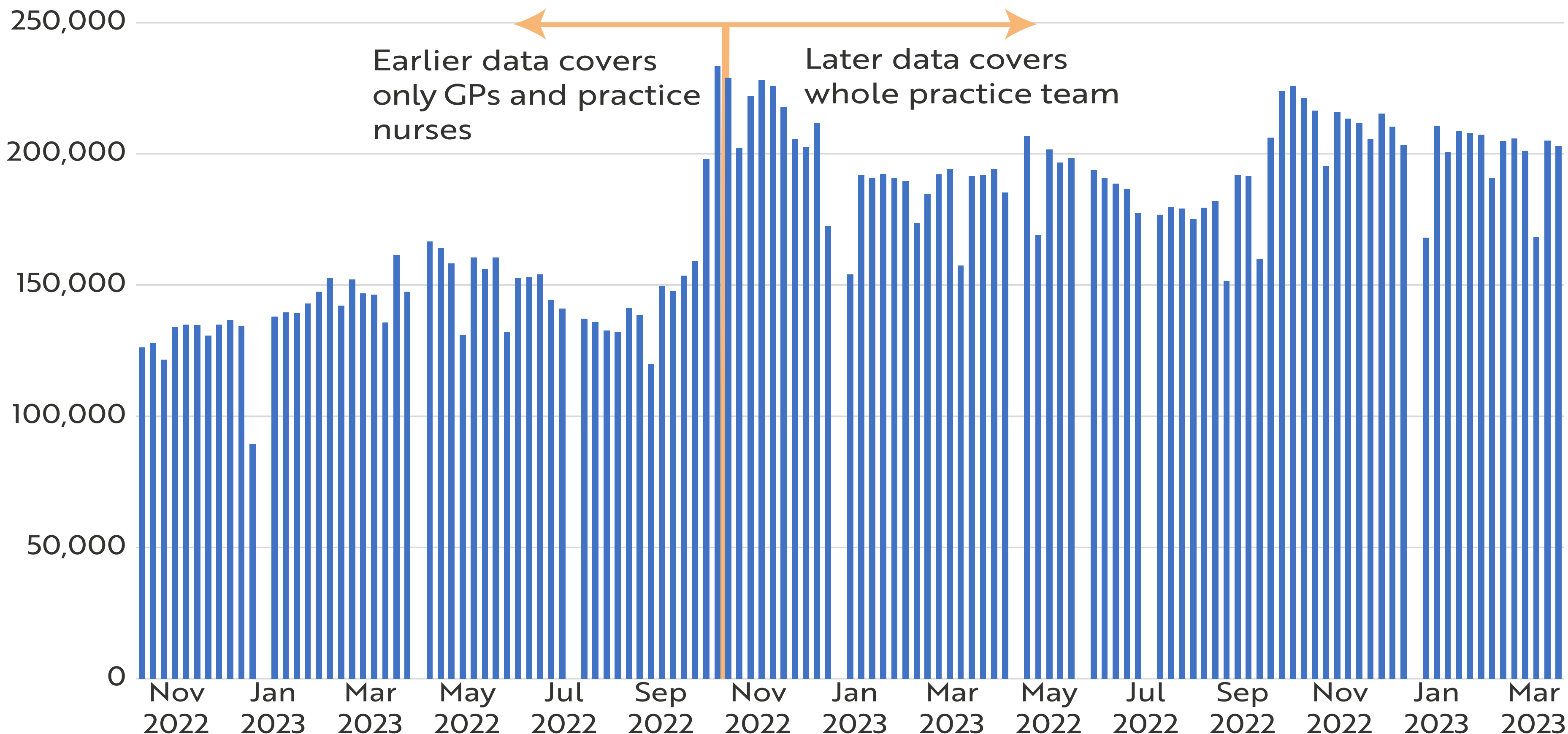
Appendix 1: Study Methodology (Paragraph 1.20)

In gathering evidence for this study we:

- Reviewed a range of key strategy and policy documents produced by the Department;
- Examined a number of reviews, reports and other policy documents produced by other stakeholder organisations;
- Reviewed and analysed key data, statistics and financial information relating to general practice provided by the Department; and
- Interviewed key staff at the Department and engaged with a number of stakeholder organisations.

Appendix 2: Weekly Consultations in General Practice (Paragraph 2.15)

Week ending 16 Oct 2020 to 31 March 2023



Source: DoH

Notes:

1. There are a number of weeks for which no data is available. These generally reflect a holiday period (Christmas, Easter etc.)

2. Because of bank holidays etc., not all weeks reflect 5 working days. In these weeks, consultation levels will be lower

3. Data to Oct 2021 covers GPs and practice nurses only. Thereafter, consultations cover the entire practice team.

Appendix 3: MDT Staff Recruitment (March 2019 – March 2023) (Paragraph 4.22)

(i) Overall Staff Numbers (analysed by Role)

Role					MDT Staff (WTE)
	Mar 2019	Mar 2020	Mar 2021	Mar 2022	Mar 2023
Physios	24.20	41.80	47.60	57.70	59.00
Soc Workers	6.00	59.00	64.98	66.00	76.39
Soc Workers Ast	-	17.25	28.70	36.90	28.96
Mental Health Worker	-	45.70	62.00	62.50	69.40
Core Staff	30.20	163.75	203.28	223.1	233.75
Nursing (District and Health Visiting)	-	85.61	106.39	116.31	121.77
Total	**30.20**	**249.36**	**309.67**	**339.41**	**355.52**

Source: DoH MDT Highlight Reports

(ii) Overall Staff Numbers (by MDT area)

(a) Core Staff

Federation Area					Core MDT Staff (WTE)
	Mar 2019	Mar 2020	Mar 2021	Mar 2022	Mar 2023
Down	13.50	40.70	42.68	42.20	41.40
Derry	10.00	65.35	68.80	72.80	71.12
Causeway	-	22.00	33.70	39.10	40.33
West Belfast	6.70	22.20	27.90	27.20	29.30
Newry & District	-	13.50	30.20	28.30	35.10
North Down	-	-	-	7.60	10.00
Ards	-	-	-	5.90	6.50
Total	**30.20**	**163.75**	**203.28**	**223.10**	**233.75**

Source: DoH MDT Highlight Reports

(b) Nursing Staff

Federation Area					MDT Nursing Staff (WTE)
	Mar 2019	Mar 2020	Mar 2021	Mar 2022	Mar 2023
Down	-	17.02	19.22	18.22	18.65
Derry	-	30.54	40.08	37.68	42.01
Causeway	-	6.15	7.96	5.46	7.06
West Belfast	-	22.00	23.00	24.50	23.50
Newry & District	-	9.90	16.13	16.90	17.00
North Down	-	-	-	6.90	6.90
Ards	-	-	-	6.65	6.65
Total	**-**	**85.61**	**106.39**	**116.31**	**121.77**

Source: DoH MDT Highlight Reports

(iii) Staff shortfall at March 2023

Staff Requirement (WTE)

	Total	Down	Derry	Causeway	West Belfast	Newry & Dist	North Down	Ards
Physiotherapists	88.20	8.80	21.70	11.90	10.40	17.00	9.40	9.00
Social Workers	169.10	16.60	43.30	22.80	19.60	32.90	17.30	16.60
Social Work Ast	81.10	7.80	20.70	10.90	9.30	16.00	8.40	8.00
Mental Health Worker	87.70	8.80	21.70	11.90	10.30	17.00	8.90	8.50
Total Core Staff	**425.50**	**42.00**	**107.40**	**57.50**	**49.60**	**82.90**	**44.00**	**42.10**
Health Visitors	59.10	7.30	12.80	6.50	10.5	11.20	5.50	5.30
District Nurses	46.30	11.00	25.80	-	1.00	8.50	-	-
Total Nursing Staff	**105.40**	**18.30**	**38.60**	**6.50**	**11.50**	**19.70**	**5.50**	**5.30**
Other (admin)	1.00	-	-	1.00	-	-	-	-
Total Staff Requirement	**531.90**	**60.30**	**146.00**	**65.00**	**61.10**	**102.60**	**49.50**	**47.40**

Source: DoH MDT Highlight Report (March 2023)

Staff in Post (March 2023)

	Total	Down	Derry	Causeway	West Belfast	Newry & Dist	North Down	Ards
Physiotherapists	59.00	7.80	13.60	11.60	9.70	6.80	5.50	4.00
Social Workers	76.39	16.40	26.69	12.00	7.00	12.30	1.00	1.00
Social Work Ast	28.96	8.00	9.93	4.73	1.00	4.30	0.50	0.50
Mental Health Worker	69.40	9.20	20.90	12.00	11.60	11.70	3.00	1.00
Total Core Staff	**233.75**	**41.40**	**71.12**	**40.33**	**29.30**	**35.10**	**10.00**	**6.50**
Health Visitors	57.33	7.65	16.17	5.46	10.50	8.00	4.90	4.65
District Nurses	64.44	11.00	25.84	1.60	13.00	9.00	2.00	2.00
Total Nursing Staff	**121.77**	**18.65**	**42.01**	**7.06**	**23.50**	**17.00**	**6.90**	**6.65**
Other (admin)	-	-	-	-	-	-	-	-
Total Staff in Post	**355.52**	**60.05**	**113.13**	**47.39**	**52.80**	**52.10**	**16.90**	**13.15**

Source: DoH MDT Highlight Report (March 2023)

Staff Shortfall (March 2023)

	Total	Down	Derry	Causeway	West Belfast	Newry & Dist	North Down	Ards
Physiotherapists	29.20	1.00	8.10	0.30	0.70	10.20	3.90	5.00
Social Workers	92.71	0.20	16.61	10.80	12.60	20.60	16.30	15.60
Social Work Ast	52.14	(0.20)	10.77	6.17	8.30	11.70	7.90	7.50
Mental Health Worker	17.70	(0.40)	0.80	(0.10)	(1.30)	5.30	5.90	7.50
Total Core Staff Shortfall	**191.75**	**0.60**	**36.28**	**17.17**	**20.30**	**47.80**	**34.00**	**35.60**
Health Visitors	1.77	(0.35)	(3.37)	1.04	-	3.20	0.60	0.65
District Nurses	(18.14)	-	(0.04)	(1.60)	(12.00)	(0.50)	(2.00)	(2.00)
Total Nursing Staff Shortfall	**(16.37)**	**(0.35)**	**(3.41)**	**(0.56)**	**(12.00)**	**2.70**	**(1.40)**	**(1.35)**
Other (admin)	1.00	-	-	1.00	-	-	-	-
Total Staff Shortfall	**176.38**	**0.25**	**32.87**	**17.61**	**8.30**	**50.50**	**32.60**	**34.25**

Source: DoH MDT Highlight Report (March 2023)

Note: figures in brackets represent an over provision against staff requirement.

NIAO Reports: 2023 and 2024

NIAO Reports 2023 and 2024

Title	Date Published
2023	
Planning Fraud Risks	01 March 2023
Public Procurement in Northern Ireland	25 April 2023
Ministerial Directions in Northern Ireland	27 April 2023
Pre-school Vaccinations in Northern Ireland	05 May 2023
Mental Health Services in Northern Ireland	23 May 2023
Reducing Adult Reoffending in Northern Ireland	13 June 2023
Innovation and Risk Management - A Good Practice Guide for the Public Sector	27 June 2023
Developing the Northern Ireland Food Animal Information System	28 June 2023
School Governance - A Good Practice Guide	04 July 2023
The Judicial Review Process in Northern Ireland	04 July 2023
Overview of the NI Executive's response to the Covid-19 pandemic (3rd Report)	27 July 2023
Continuous Improvement Arrangements in Policing	10 August 2023
Approaches to Achieving Net Zero Across the UK - Report by the four Auditor Generals of the UK	15 September 2023
Tackling Waiting Lists	10 October 2023
Local Government Auditor's Report 2023	15 December 2023
Comptroller and Auditor General's Report on Financial Audit Findings 2023 - Central Government	20 December 2023
2024	
Tackling the Public Health Impacts of Smoking and Vaping	30 January 2024
Major Capital Projects: Follow-up Report	27 February 2024
Child Poverty in Northern Ireland	12 March 2024

Independence and excellence in audit to improve public services

Northern Ireland Audit Office
106 University Street, Belfast, BT7 1EU • 028 9025 1000 • www.niauditoffice.gov.uk