RCGPNI response to the Northern Ireland Affairs Committee inquiry into funding for key public services

Background

The Royal College of General Practitioners is the professional membership body for GPs in the UK. Our purpose is to encourage, foster and maintain the highest possible standards in general medical practice.

We support GPs through all stages of their career, from medical students considering general practice, through training, qualified years and into retirement. In addition, we set the standards for competency of entry to our profession through our examination process.

In Northern Ireland, RCGPNI represents more than 1500 GPs, more than 75% of the general practice workforce.

Introduction

We welcome the opportunity to respond to the Northern Ireland Affairs Committee inquiry into funding for Northern Ireland's key public services and to highlight the need for investment in general practice, which is the foundation of the health service.

We deeply regret that due to the political paralysis in Northern Ireland, the opportunity of a multi-year budget was lost, and we have reverted to a single-year budget. A multi-year budget would have provided an important opportunity to plan, deliver and transform our Health and Social Care (HSC) services more effectively and it is disappointing this is no longer possible.

The impact of the political impasse on public services in Northern Ireland cannot be overestimated. The lack of a functioning Executive and Assembly at Stormont impacts on basic service delivery and the ability to transform, which is deeply frustrating for our overwhelmed and exhausted healthcare staff. We would urge all political representatives to set aside any political differences and work together to deliver more effective, equitable and sustainable public services for all patients in Northern Ireland.

We are conscious that the Northern Ireland Affairs Committee inquiry will be considering funding for the whole of the public sector and its scope is not limited to health, or specifically general practice. We recognise that extremely difficult decisions will need to be taken in the months ahead and we understand that there have already been cuts to services such as the Healthy Minds programme in our schools. As the health professionals closest to patients and families, with GP practices at the heart of communities, it is essential that capacity is built in general practice to ensure GPs can be there for patients when they need us.

With falling GP numbers and escalating workload we are calling for an increase in the GP workforce both in terms of more training numbers and an effective recruitment and retention strategy; while that will not fix the short-term acute problem of clinical capacity, the full roll out of the Multidisciplinary Team model would go some way to supporting struggling teams to deliver more first-contact care into communities.

Investment in general practice

Along with previous reviews of Health and Social Care in Northern Ireland, the Bengoa Review and Delivering Together 2026[i] set out pathways for significant transformation of HSC services. These expert reviews made clear the need to invest in the community and to deliver more care for patients close to their homes, but the resources or staff required to deliver this did not follow. For example; the Multidisciplinary Team model was commenced with transformation funding, as part of the Confidence and Supply agreement, and has not yet received long-term funding. Building capacity in the community and in general practice is central to the success of meaningful transformation.

Prior to the collapse of the Executive in February 2022, we welcomed the fact that previous Executive Ministers had agreed to prioritise the funding needed for the Department of Health and our wider health service[ii]. The proposed budget settlement of £21billion over the following three years would have represented a 10% increase. This was a long awaited and vital opportunity to deliver essential reform to our health service, but alas has not come to fruition.

Historically, there has been an imbalance of financial resources, with a significantly greater proportion of funding allocated to secondary care. Approximately 90% of a person's healthcare over their lifetime will be delivered by general practice, with less than 10% of the overall healthcare funding. We suggest that this is inequitable, unsustainable and must be addressed. RCGPNI urge the Department of Health to redress many years of underfunding in primary care and properly invest in general practice as a priority, ensuring our practices are sustainable and GPs have the tools they need to care for patients. The World Health Organisation has said that when health systems invest in primary care, the results are overall lower use of secondary care resources, reduced overall health costs and less health inequity.[iii]

Supporting practices

The last 12 months have seen a significant rise in the number of GP practices in difficulty as 10% of all practices in Northern Ireland are currently receiving support from the Practice Improvement and Crisis Response Team, with 14 practices taking the difficult decision to hand back their contracts. The variables in such decision-making are many but issues already cited including workforce and workload are at the forefront. Adding to these challenges are the additional financial pressures of running a business in a cost-of-living crisis with no new investment and rising overheads. As a small business with very limited opportunity to seek other income streams outside the GP contract, practices are seeing increased overheads across the spectrum including but not limited to staff wages, utilities and consumables all needing met within a stagnated budget. These real-terms cuts to finances will invariably lead to greater instability in already struggling practices. There is a very real concern that in order to survive, practices will have to further cut front line services to balance the books. We appreciate that finding efficiency savings is difficult across the health service spectrum, but where larger organisations can benefit from economies of scale, this is simply not an option for GP practices. For many practices, they simply do not have the capacity to weather this financial storm. Our patients can ill-afford to lose further general practice services at a time when capacity is already shrinking.

Workforce

In addition to our funding challenges, across our health service, chronic workforce shortages are putting services and staff under extreme pressure. These workforce challenges must be addressed, otherwise we will not be able to deliver a sustainable primary care service that meets the needs of patients.

RCGPNI urge that consideration is given to investing in proper, strategic workforce planning and delivery to rebuild workforce that is fit for the purpose. This has been outlined as a priority in the Health and Social Care Workforce Strategy[iv], but this work has been stalled due to Covid-19. It must be prioritised again.

The shortfall in the general practice workforce is not just impacting on patient care but the very model of care is under threat. There has been a severe shortfall in the GP workforce in Northern Ireland for many years. This problem is not new, but its impact today is much greater given the current and compounding challenges around demand, an increasingly multimorbid and ageing population and the impact of out of control waiting lists, among others. Trying to do much more with much less is not only impacting on patient care but has put the very model of care delivery under threat.

College data suggests that 26% of GPs in Northern Ireland are over the age of 55 and intend to retire in the near future. Coupled with this, we also have single-handed GP practices in Northern Ireland and poor workforce planning means that if action is not taken urgently, these practices will be forced to shut their doors. Losing practices year on year, from 350 in 2014 to 319 today, has devastating consequences for patients and the wider community as well as increasing the strain and risk of destabilisation on adjacent

practices who are left to pick up the additional demands often without the ability to recruit additional manpower.

We would urge a comprehensive workforce review within primary care, to ensure our workforce is fit for the future. A key part of this must be the review of GP training places. There is a clear and worrying demand-capacity mismatch in general practice and, put simply, we need more GPs working in Northern Ireland. To reach GP whole time equivalent levels seen in 2014, the GP Training Places Task and Finish Group estimate that recruitment needs to reach a total of 161 per year. While we welcomed the retention of an additional 10 places granted by the Health Minister Robin Swann for this financial year, it is simply not sufficient. With training places at their current level of 121, we are falling further behind with each passing year. Further increases to GP training places must be a priority for the next few years coupled with a commitment to regular review and revision as transformation develops and the health needs of our population change.

We also urge that there is cognisance of the growing number of GPs seeking to undertake a portfolio career which combines working in practice with additional primary care-related roles, supporting our wider health service. Recognition of such is important so that the work of GPs is not counted solely on what is provided within the confines of GP GMS contract. The totality of the valuable input that GPs give to the HSC system needs to be appreciated within the wider context of workforce planning.

GPs and their teams are passionate and dedicated teachers to future professionals. The Heath Education England (HEE) Future Doctor report[v] states that future doctors must have generalist skills. Our practices are the perfect training ground for future doctors to learn not only about disease but also about relationship-based care, patients and families. The QUB C25 curriculum moves towards 25% of year four teaching to be delivered in general practice. The new Ulster University Graduate Entry Medical School (GEMS) sets out a significant proportion of teaching to be performed in general practice. GPs and their practice teams are essential for the teaching and training of all future doctors. The current challenge of delivering this vital teaching role to the future generations of doctors is taking place against the backdrop of workforce and workload constraints.

While recruitment of new GPs and other staff in primary care must be a priority, we also urge a refocus on retention strategies. GPs and practice teams have been working beyond capacity for many years, but it would be remiss of us not to acknowledge the impact of two years of the Covid-19 pandemic on health care staff. They are exhausted and many of them will seek to retire earlier than planned. A General Medical Council (GMC) survey of staff considering early retirement suggests that stress is a key factor, with 24% of respondents citing burnout. Strategies must be put in place to prevent staff burning out and leaving our workforce.

The issue of pensions for GPs must also be addressed. In response to a 2021 survey[vi], 67% of RCGP members in Northern Ireland cited pension concerns as a reason for early retirement. While we welcome the fact that the most recent budget has sought to address this by abolishing the lifetime tax allowance and increasing the annual allowance, there are still issues outstanding that must be addressed. These include the need to fix a needlessly complex taxation system and other pension issues in the purview of the Northern Ireland Executive, including the retire and return scheme.

Workload

There is a clear and worrying demand-capacity mismatch in general practice and resultantly, GP workload is simply unmanageable. The reason that GP services continue to operate is due to the tireless work of GPs, who are deeply dedicated to their communities and are going above and beyond to manage demand. As admirable as this is, it is not sustainable and there are very real concerns from GPs that the sheer volume of demand is creating an unsafe service. While the solution to the workload crisis is invariably rooted in a sustainable and adequate workforce, a reform of workload is also required. GPs often carry out tasks that are best performed by others both within and outside of the health care system. Reducing bureaucracy and improving investment in GP services would make a tangible difference.

General practice was dealing with unsustainable workload, and practices were struggling to recruit sufficient numbers of GPs and practice staff to handle demand before the pandemic. Covid-19 has only exacerbated these pressures. This has resulted in GPs feeling burnt out and leaving the profession before they planned to and will lead to practices closing their doors for good. This cannot be allowed to happen.

The escalating demand for services is multifactorial in origin and any move to deliver on transformation will invariably impact on the workload of GPs and their teams. Soaring waiting lists and the knock-on effect of managing the worsening morbidity associated with this directly contributes to a GP's working day and the growing mismatch of capacity and access.

We desperately need to see a review of GP training places to expand our struggling workforce, as mentioned above. In addition, an accelerated roll out of MDTs to all practices will enable vital clinical support.

Multidisciplinary Team model

The Multidisciplinary Team model (MDT), which sees mental health workers, social workers and physiotherapists embedded in general practice is a key anchor of the transformation agenda in health and social care. The rollout of this model to include an additional 100,000 patients was a specific commitment in New Decade, New Approach, which was signed up to by the five main political parties in Northern Ireland in 2020 and has not been enacted. To give this figure some context, only one out of 17 GP Federation areas (Down) has a full complement of MDT in the four years since the programme was launched. With seven of the 17 Federations having partial rollout, we are left with patients in 10 Federations having no access to these important first-contact practitioners in their communities.

While the evaluation of the model is still in its initial stages and has been significantly hampered by Covid-19, early data and patient and service user feedback shows that MDTs are having a positive impact on patient experience and outcomes.

We are deeply concerned that the MDT model is currently stalled and is unable to recruit staff, due to a lack of budgetary commitment. Delays in the delivery of this crucial transformation programme leads to uncertainty for the staff needed to make it work. Recruitment processes have necessitated time and effort from stretched GPs and if successful MDT candidates are left on recruitment waiting lists, expiry of these creates uncertainty about the Department of Health's commitment to the entire direction of travel.

The stagnation of this model puts our transformation agenda at risk and exacerbates the already deep inequalities in healthcare provision across Northern Ireland. Patients living outside an MDT area are at a disadvantage and cannot access services that those living in neighbouring areas can. The stagnation of the MDT model also means that newly qualified GPs will be more likely to seek to work in an area with a functioning MDT and this will lead to further destablisation of the practices which do not have an MDT.

While the policy and budgetary responsibility for MDTs sits primarily with the Department of Health, a successful MDT rollout will have much broader socio-economic benefits, and it is our view that this project should be a priority across the whole of the public sector. MDTs are critical vehicles to tackle health inequalities in local communities, drawing on existing community and charitable resources, preventing patients from becoming more unwell and allowing people to be treated closer to home.

We urge that the following actions must be taken as soon as possible.

- The current MDT Federation areas must be completed as a matter of urgency and the model rolled out at pace to all remaining GP Federation areas to enable all patients to access this enhanced delivery of care. This will ensure equity of service provision for patients and equity of workforce support for GP practices.
- A sustainable funding model must be found, so staff can be recruited and services planned on a long-term basis

Health inequalities

It is important to note that the role of the GP is multi-faceted and complex. In recent years because of the demand-capacity mismatch, this has created huge challenges particularly around unscheduled need. This was seen most acutely in the last six months with the rise in respiratory winter viruses concurrent with the outbreak of Group A streptococcus infections. With a finite capacity in the system, when such a rise happens there is a resultant necessary downturn in the other care that GPs deliver. Without a sustainable workforce and resources, there is a threat to GPs' capacity to deliver good quality chronic disease management, and proactive and preventative care when the acute demands alone outstrip the capacity to manage.

General practice plays a huge part in the public health of our population, not just vaccination and screening, albeit the delivery of such is vital. Each and every day, GPs are maximising public health messages and delivering preventative medicine in our surgeries despite the challenges, but the reality is that in an under-resourced system there will be a less opportunity to do so. What is most concerning is that this is happening at a time when the need for preventative healthcare is dramatically increasing. Instead of people getting healthier and living longer, recent figures[vii] show that life expectancy is, at best, stalled and for some in the most deprived areas is falling and our citizens are living more years in poorer health.

The current cost of living crisis is driving more and more of our population into poverty and with that comes poorer health outcomes. In accepting the role of social determinants on the health and wellbeing and the need to address them it is important to recognise that a strong and stable primary care has a positive impact on population health; reducing not only all causal mortality and mental health outcomes, but also reducing total hospitalizations and avoidable admissions.

In current MDT areas within Northern Ireland, GP Federation MDT teams are not only working as first contact practitioners, but are engaging on an at scale basis in partnership with patients, other local practices, and community and voluntary sectors organisations to improve health and wellbeing through locally run initiatives. This underscores the importance of a full rollout of the multidisciplinary team model to address health inequalities.

Infrastructure

Infrastructure, including both physical and digital infrastructure, is simply not fit for purpose within general practice. While it is important to note that good digital access is vital moving forward both for patients and for GP teams, it will not solve the manpower gap that currently exists with regard to clinical service provision.

In addition to the digital resource and investment needs across general practice, we suggest that the Department of Health give full consideration to physical space and infrastructure requirements in primary care. There is a very real need to acknowledge the capital investment required to deliver enhanced training capacity and physical space to house the MDT model in general practice, which are two vital elements of HSC transformation. Despite funding challenges, such as workforce commitments and funding for service delivery, we urge the various Departments to consider how any surplus capital budget might be invested within primary care to ensure service transformation can be implemented.

Digital infrastructure in general practice too often is simply inadaquate. Practices have had to adapt to provide more remote consulting as a way to help meet increased demand, but many of our GP practices are trying to run a 21st century service using 20th century technology. It is not working and causing both frustration for practice staff and distress for patients, who often cannot get through on the telephone. We welcomed a £1.7 million investment[viii] in GP telephony at the latter stage of 2021, but unfortunately, this is a drop in the ocean compared to need. The high levels of uptake[ix] for the £1.7 million investment suggests that the need is there and GPs are committed to upgrading services to provide better patient access, if support is available. This must be a priority in the upcoming budget.

Waiting lists

It is welcome that a commitment to tackling the appalling waiting lists in Northern Ireland was a priority for the previous Executive and within this budget settlement. However, we are concerned that waiting lists in Northern Ireland have been allowed to escalate without any true accountability. While funding must be identified to urgently address our waiting lists, this must be accompanied by a thorough reform of the systems that have allowed us to get to this stage.

As the healthcare professionals closest to communities, GP see first-hand the distress languishing on waiting lists, often for more than five years, causes to our patients. Indeed, we are deeply concerned to hear from patients who feel they have no choice but to seek care in the private sector, which will widen health inequalities and create a further divide in access to care as seeking private healthcare is simply not an option for so many of our patients. It is difficult to conclude anything else than the health service is failing patients at present. This must be addressed urgently.

We suggest that general practice must be a key part of finding a solution for these waiting lists; addressing not only the problem of our current waiting lists but in bringing about new innovative ways to tackle the demand and capacity mismatch. In isolation, more money will simply not fix the problem and our waiting lists will continue to grow. Best outcomes for patients can be achieved when true collaborative working occurs with professionals treating each other as equals, each with an important role to play.

GPs have demonstrated their ability to improve primary care capacity to manage demand across a range of clinical conditions through the GP Elective Care Reform Service. These Federation-based services in vasectomy, gynaecology, muscuolskeletal medicine, dermatology and primary care surgery have allowed patients to be managed in a safe and effective way within primary care by GPs with enhanced skills. While for some of these pathways the service is available regionally, the rollout of others has been stalled due to lack of funding. The services where available allow access to treatments through locality hubs closer to patients' homes in a timely fashion. The vasectomy service in primary care has achieved excellent outcomes for patients, surpassing the secondary care model, where men waited more than five years for the procedure, and delivering more than 9,000 procedures in the community. This is just one example of the innovative ways primary care is rising to the challenge of meeting the health needs of our patient population. GP Elective Care Services are already delivering excellent outcomes and much more could be done with adaquate support. In addition, more than 56,000 elective care procedures have been delivered in primary care since November 2018, despite a lack of funding. We therefore urge consideration for long-term investment and expansion in this area to fully enhance capacity in general practice for delivering elective care treatments in the community. Elective care reform must take a patient-centred approach, and by providing treatment in the community where possible, it is often more efficient and, crucially, provides a better patient experience.

The impact of escalating waiting lists on the workload in general practice is extreme and cannot be underestimated. GPs are the only accessible health care professional available to patients who are languishing on lists waiting for treatment, often with worsening pain and anxiety linked to their condition. Many of these patients require ongoing support for their primary condition such as pain management while an increasing number also develop secondary conditions related to the impact of not being managed in a timely fashion. Much of this additional morbidity is centred around poorer mental health but the risk of development of other physical morbidity is very real, particularly for those whose mobility is impacted. While cancer surgery rightly gains most focus, the wait times for many other interventions which are equally time-dependent are worsening. Diabetic control, dementia and pain escalation all have knock on impacts which frequently fall on general practice to manage. The societal impacts of time lost from work due to pain and impaired function are enormous and include reduced ability to care for other family members. GPs are frequently left with little alternative other than Emergency Department attendance or formal outpatient referral. Therefore, it is essential that funding to tackle waiting lists also includes increased support for GP practices, to allow them to care for patients with improved referral pathways that are reactive to changing needs of patients and are accessible by GPs and their teams.

Conclusion

We welcome the opportunity to respond to this call for evidence and thank the Northern Ireland Affairs Committee for their interest. As we have outlined, general practice in Northern Ireland is facing an unprecedented crisis and the service is at risk of destablisation, leaving more communities without the vital and valued service we provide. This crisis is decades in the making and it is crucial that action is taken as a matter of urgency.

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[i] https://www.health-ni.gov.uk/publications/health-and-wellbeing-2026-delivering-together
[ii] https://www.finance-ni.gov.uk/news/executive-draft-budget-prioritises-health-murphy

[iii] https://www.who.int/docs/default-source/primary-health-care-conference/phc---economic-case.pdf

[iv] https://www.health-ni.gov.uk/publications/health-and-social-care-workforce-strategy-2026
[v] https://www.hee.nhs.uk/our-work/future-doctor
[vi] RCGP Tracking Survey for England, Scotland, Wales and Northern Ireland (March - April 2021) .
[vii] https://www.health-ni.gov.uk/news/health-inequalities-annual-report-2023
[viii] https://www.northernireland.gov.uk/news/health-minister-announces-vital-package-support-general-practice
[ix] http://aims.niassembly.gov.uk/questions/printquestionsummary.aspx?docid=361018