RCGP NORTHERN IRELAND

Safeguarding the future of general practice in Northern Ireland

Contents

Introduction

Northern Ireland's health and social care system is operating under prolonged and intensifying pressure, with the longest elective care waits anywhere in the UK.[1] This sustained strain forms the backdrop to the challenges facing general practice today, and the impetus for the recommendations set out in this report.

The return of the Northern Ireland Assembly in 2024 offered a long awaited opportunity for political stability. However, years of stop-start governance has repeatedly interrupted momentum for reform, and deep structural issues have been left unresolved. Within this context, general practice, despite being the health system's front door, and the most financially efficient part of the NHS[2], has experienced a relative reduction in funding, growing financial instability, and an absence of strategic direction.[3]

This erosion of investment has left many practices struggling to meet basic running costs and the subsequent undermining of GP recruitment, retention, continuity of care and long term service sustainability. The rise in contract hand backs amongst independent contractors, with around one in 20 practices handing back their contract over a two year period, has become a visible symptom of services' fragility.[4]

Furthermore, general practice continues to operate without a clear strategic framework. Northern Ireland remains the only UK jurisdiction without a dedicated GP workforce strategy. The absence of coherent workforce planning has left practices without the tools needed to stabilise staffing, expand training capacity, or retain much-needed GPs.

This gap is particularly stark given the Department of Health's Reset Plan, which sets out ambitions to "shift left" towards building neighbourhood based models of care. These reforms depend fundamentally on a strong, stable general practice service, yet the foundations required to deliver this change are neither commensurate nor secure. Compounding this instability, the imposed GP contract for 2025/26 became contested, leading to collective action by GPs across Northern Ireland. At the time of writing, no contract has been agreed for 2026/27.

Scrutiny of general practice has also intensified, with a strong focus placed on GP access, reflecting public frustration with delays and the wider system's reliance on general practice to absorb unmet need. However, access challenges cannot be separated from the underlying conditions shaping GP capacity. Without addressing these root causes, reasonable expectations for GP access risk becoming disconnected from the realities of service delivery under current conditions.

General practice in Northern Ireland is at a critical juncture. As the Department of Health seeks to reset and reform services, safeguarding the future of general practice must be a central priority. Without decisive action, the system risks the future of one of its most effective, efficient, and trusted services.

Methodology

Our policy recommendations have been informed by extensive engagement with GPs, Practice Managers and patients across Northern Ireland.

GP engagement

In February 2026 we launched a survey which received 305 responses from across the GP career journey, from GP registrars beginning their careers through to retired GPs. We also held engagement sessions with over 70 GP registrars, exploring what matters to them as they enter the GP workforce and their vision for the future of general practice.

In addition, we hosted online engagement sessions with GPs and members of the Royal College of General Practitioners NI Council. These discussions provided first-hand insight into the challenges GPs face, their priorities for safeguarding the future of general practice and what they value about their role as a GP.

Practice Manager and patient engagement

We also sought the perspectives of patients and Practice Managers to understand the wider challenges they experience and what they value about general practice. We held engagement sessions with both groups and launched a Practice Manager survey, which received over 60 responses from both urban and rural practices across Northern Ireland.

A patient survey was shared within the RCGPNI Patient Network and supported by the Patient Client Council, who circulated the survey among their membership schemes. The patient survey received over 80 responses.

Summary of recommendations

1. Prioritise continuity of care

Continuity of care by GPs must be embedded as a core system objective, placed at the centre of policy development, commissioning decisions, and service design, and recognised as a defining professional value of general practice that delivers measurable benefits for patients, clinicians, and the wider health system.

2. Increase investment in general practice

Strategic investment must be enhanced by increasing the proportion of the Health and Social Care (HSC) budget allocated to general practice, to reflect the volume, complexity and totality of the care delivered by GPs across a patients' whole life.

3. Build workforce capacity for improved patient access

Urgent action is required to grow the GP workforce through improved funding to allow practices to expand their teams.

Improve GP recruitment and retention

Make Northern Ireland an attractive place to train and work as a GP who feels valued, through targeted resources and support to ensure GPs working in NI are not disadvantaged compared to the rest of the UK and Ireland.

4. Safeguard the partnership model

The security and long-term viability of the GP partnership model - which is the primary model in Northern Ireland - must be safeguarded to ensure the continued delivery of effective patient care to meet the region's specific challenges.

5. Improve digital and physical infrastructure

Commit to sustained investment in digital and physical infrastructure to support a modern, sustainable general practice. Improve integration and interfaces with the wider HSC system and invest in improved data capabilities to reduce unnecessary workload and enhance the ability to deliver high-quality clinical care for patients.

6. Produce and deliver a general practice strategy

Develop and implement a standalone, fully costed and comprehensive general practice strategy aligned to population need and fully integrated with wider health and social care planning.

1. Continuity of care

Continuity of care sits at the heart of general practice in Northern Ireland. It is best understood as the ongoing, trusted relationship between a GP, their team and the patient, where information is shared appropriately and care is organised smoothly over time, particularly as a patient's needs change.

This relationship based model is a defining strength of general practice and a foundation of safe, effective, and trusted healthcare. It is also central to the efficiency of the wider health system.

Yet delivering continuity is becoming increasingly difficult. To deliver continuity, practices require sufficient resourcing, stable clinical teams, and enough GPs to maintain ongoing relationships. However, chronic underfunding, workforce shortages, and rising demand have steadily eroded GP capacity. The number of GP practices has fallen by almost 13% since 2014, while patient numbers continue to grow. Since 2014, the patient population has grown from 1.92 million to 2.07 million; as of March 2026, this is an increase of 7.7%. This means on average the number of patients per practice has increased by 24%[5] therefor each practice is caring for significantly more people than a decade ago. At the same time, increasing political emphasis on speed of access risks prioritising rapid appointments over the continuity of care patients value.

The result is a widening gap between what patients expect and what the system and GPs can reliably provide. Action to protect continuity must therefore be a central priority for the future of general practice; without this, one of the most effective and valued elements of patient care risks being lost.

1.1 Why continuity of care matters

Better patient outcomes

There is strong and consistent evidence that patients who regularly see the same GP have better health outcomes. Research shows they have lower mortality rates, are less likely to die prematurely, less likely to attend an emergency department or be admitted to hospital, and more likely to receive safe, effective care.[6]

Continuity also helps people manage long-term conditions, take their medication properly, and avoid unnecessary hospital visits.[7] In contrast, when care is fragmented and patients do not have an ongoing relationship with a GP practice, outcomes are worse and use of urgent care services increases.[8]

Expert management of risk and resources

Continuity supports more effective use of healthcare resources. When GPs know their patients well, they are better able to balance clinical risk and uncertainty, making informed decisions that reduce unnecessary interventions while maintaining patient safety.[9] This includes avoiding over-investigation and overdiagnosis, reducing inappropriate referrals and hospital admissions, identifying deterioration at an earlier stage and using limited resources in a targeted and proportionate way.[10]

Continuity across the life course

Unlike specialist services, general practice provides continuity across the entire life course. GPs have responsibilities across prevention, early diagnosis, chronic disease management, mental health, frailty, multimorbidity, and end-of-life care. In addition, they act as a constant presence within an increasingly complex and fragmented system, ensuring coordination, follow-up, and advocacy for their patients.

The GP role in providing continuity is particularly important for individuals with complex or long-term conditions, who rely on consistent clinical oversight to navigate multiple services. GPs provide coherence in care that might otherwise be dispersed across providers, helping to avoid duplication, confusion, and gaps in treatment.

1.2 The unique role of GPs in delivering continuity of care in Northern Ireland

The GP perspective

Our engagement with Northern Ireland GPs emphasised that continuity of care is clinically important, integral to quality, and something to be protected rather than replaced. In addition to the clear clinical benefits for patients, it provides a source of professional meaning, with evidence showing that when GPs are able to build ongoing relationships with their patients, they experience greater job satisfaction.[2] This is because continuity allows GPs to practise the kind of medicine they are trained to deliver - personal, holistic care where they can see the impact of their work over a lifetime.

Findings from RCGPNI's 2026 GP survey underline the strength of this consensus, presenting a clear and consistent message about the value of continuity:

97% of respondents agreed that continuity of care leads to better patient health outcomes.

Over 95% reported that being able to provide continuity improves their job satisfaction, highlighting its importance for retention and morale.

More than 98% agreed that GPs play a vital role in managing long-term conditions, multimorbidity, and undifferentiated illness.

These findings demonstrate that continuity is not only valued in principle but is seen as essential to both clinical effectiveness and system sustainability.

The patient perspective

Continuity of care also remains a core expectation for patients in Northern Ireland, with over 97% of patients responding to our survey noting that it is important to see a GP who knows them when managing their health and wellbeing. When asked, what they value most about their GP practice, patients in our survey responded:

This highlights how continuity remains a defining feature of good care, rather than solely a preference. Patient feedback through our survey also highlights access to general practice, as an aspect that patients value. Our survey shows that, when asked what they value most about their GP practice, patients frequently highlighted:

Taken together, these responses show that patients value both continuity and timely access and suggests they see them as interdependent foundations of a good general practice service.

Strengthening continuity of care in the long term also improves patient experience and GP access.[11] Therefore, the themes of continuity and GP access must remain central to any future model of care and be included in any future GP strategy.

1.3 Continuity of care under threat

Fragmentation of care

At a system level, continuity of care is being weakened by a growing emphasis on speed of access, at the expense of ongoing relationships between patients and their GP. Declining relational continuity, shifting workload models, and disjointed interfaces between general practice and other parts of the NHS, all lead to increasing patient morbidity and system inefficiencies.[12]

Whilst the Department of Health in Northern Ireland's aim of expanding Multi-Disciplinary Teams (MDT) is to increase the number of available consultations, increase ease of access for patients and reduce pressure on GPs, the benefits depend on how well MDTs are integrated into general practice. During our engagement with GPs, there was a growing concern that MDT expansion, if not grounded in a strong general practice service with sufficient GP capacity, will result in patients being seen by whichever clinician is available rather than by someone who knows their history.

Without explicit safeguards for continuity, multiprofessional involvement can fragment care, with key context or follow up slipping between contacts and the role of the named GP becoming increasingly diluted.

Over 97% of GPs agreed that fragmented care has a detrimental impact on patient health outcomes.

This underscores the strength of professional concern and the widely recognised importance of continuity in delivering safe, effective care.

Financial consequences

When care is less coordinated and split between more professionals, it can lead to duplication of work, such as repeated consultations, tests, and referrals, which increases unnecessary spending. A lack of continuity can also result in poorer early management of conditions, leading to more costly interventions, including hospital admissions and emergency care.

Almost 93% of GPs agreed that fragmenting care leads to increased costs for the health service.

This is particularly worrying when general practice and the wider health service are already under significant financial pressure and reinforces the view that continuity is essential for the efficient use of healthcare resources in Northern Ireland.

Digital systems

Digital systems in Northern Ireland currently fall short of fully maximising continuity of care due to constrained interoperability between general practice and other parts of the health and social care system. Timely information transfer, real time data sharing, and clear governance arrangements remain limited. As a result, GPs are constrained in their ability to track patient care appropriately across pathways, limiting oversight of ongoing treatment and outcomes.

This in turn hinders GPs in engaging with other healthcare professionals across the health service in a timely, safe and efficient way, for the benefit of patients. These gaps can lead to repeated work, slower care, and poor coordination across different parts of the health service, showing the need for better-connected digital systems to support GPs to deliver safer, more joined up, patient focused care.

Recommendation 1:
Prioritise continuity of care

Continuity of care by GPs must be embedded as a core system objective, placed at the centre of policy development, commissioning decisions, and service design, and recognised as a defining professional value of general practice that delivers measurable benefits; for patients, clinicians, and the wider health system.

This can be achieved by:

- **Embedding continuity in system design:** Build continuity into commissioning and service design, prioritising long-term GP-patient relationships over purely access driven models.
- **Strengthening workforce capacity:** Align recruitment, retention, and workforce planning with continuity goals by investing in GP capacity and stability.
- **Avoiding fragmented access models:** Limit standalone or parallel healthcare schemes that bypass GP relationships and risk creating disjointed care.
- **Integrating MDTs effectively:** Ensure multidisciplinary teams are fully embedded within practices, supporting, not replacing continuity, and enable ongoing development of GP leadership.
- **Ensuring digital systems support continuity of care through improved interoperability:** Design digital tools that make it easier for GPs to coordinate care for patients, track care appropriately and engage with other healthcare professionals in a timely and efficient way.

2. General practice funding

As the foundation of the HSC system, general practice provides the vast majority of patient contacts, accounting for over 90% of patient contacts within any given day in our health service.[13] From prevention and first presentation through to complex long term management and end of life support, GPs deliver comprehensive, coordinated, and cost effective care within communities.[14] Yet the current funding model does not reflect the value general practice delivers.

General practice in Northern Ireland has experienced more than a decade of sustained underinvestment, compounded by rising demand, persistent workforce pressures, and the ongoing impact of inflation. Fundamentally, funding has not kept pace with need, leaving services increasingly fragile and placing long term service sustainability at serious risk.

The mismatch between the scale and complexity of care delivered and the proportion of system funding allocated to general practice has created a service that is no longer sustainable.

2.1 General practice funding structures

Overview of the Funding Framework

General practice in Northern Ireland is funded primarily through the General Medical Services (GMS) contract, under which GP practices operate as independent contractors providing services on behalf of Health and Social Care.

This core funding is supplemented by a range of additional payments, including those for enhanced services, some staffing, premises, and IT infrastructure. However, while the overarching contractual framework has remained broadly consistent since its introduction in 2004, the composition, stability, and adequacy of funding within it have increasingly come under strain.

This has made it harder for practices to be financially secure, and limits their ability to plan ahead, invest in services, and make lasting improvements.

Despite acting as the front door to our health system, the proportion of the total HSC budget allocated to general practice has remained persistently low. According to the NI Audit Office (NIAO), in 2022/23, general practice accounted for approximately 5.4% of total HSC expenditure.[15] This proportion is consistently reported as lower than in other UK jurisdictions, contributing to comparatively lower GP earnings and reduced system resilience.[16] Put simply, the part of the HSC system that delivers the most care, is funded the least.

The NIAO concluded that investment has not kept pace with demand, that workforce pressures are directly linked to funding instability, and that a dedicated GP workforce and funding strategy is urgently required.[17]

As a result, practices now operate within a financial environment marked by insufficient core funding and the absence of a coherent strategic model. These structural weaknesses threaten continuity, equitable access and the wider ambitions of HSC reform, as well as workforce retention, with only around 55% of newly CCT qualified GPs remaining on the Northern Ireland Performers List after three years.[18]

93% of GPs said that general practice is not adequately funded.

Over 95% of GPs said that current funding levels have a direct impact on the stability and sustainability of practices.

There is a growing number of GPs leaving or considering leaving the profession due to financial and workload pressures.

Without stable and protected investment, efforts to expand the general practice workforce, improving access and shifting care into community settings will remain constrained.

Wider primary care investment

Alongside core GMS revenue, targeted investment has supported infrastructure improvements, the roleout of GP pharmacists and the expansion of MDTs. MDTs play an important role in improving access and supporting more holistic care.

Current MDT funding is concentrated in a limited number of federation areas, with £61 million in Executive Transformation Funding allocated from 2023 onwards to support further growth.[19] It is important to note that this investment is not part of or linked to core practice funding.

A full regional rollout would require substantially higher recurrent funding than is currently available, with total costs set to rise significantly as MDTs are expanded across all federations. The current staggered implementation has led to significant inequality in service delivery for patients as well as a disproportionate impact on GP workload in areas that have no or limited access to these additional staff.

Our engagement revealed shared concerns among GPs:

- There was anxiety among respondents that targeted funding for MDTs, new models of care, and trust run services is diverting resources away from core GP provision.
- There is concern at investment being directed toward ***"everything but doctors,"*** weakening the GP workforce base.
- There are views that additional unfunded costs associated with MDTs are overlooked by the Department of Health NI (e.g. premises, utilities, supervision, management time), which inevitably need to be absorbed by GP practice budgets.

The MDT Implementation Plan indicates that full regional rollout would cost approximately £83 million per year and deliver around 1 million additional MDT appointments annually.[20] While this represents a meaningful expansion of community access for patients, it must be viewed in the wider context of general practice activity. GP practices already deliver around 200,000 appointments every week - over 10 million per year - supported by a £380 million GMS budget.[21] Feedback from GPs in our survey indicated that while MDTs can enhance care, they do not replace the scale or centrality of GP delivered clinical work.

The success of a primary care MDT embedded within GP practices is predicated on a secure and sustainable core GP service and not the converse. Securing proportionate funding to reflect the system's requirement of general practice is paramount.

2.2 High levels of deprivation and inequity

Northern Ireland experiences the most deprivation of any country in the UK.[22] Evidence also shows that Northern Ireland has some of the widest gaps in healthy life expectancy in the UK, with people in the most deprived areas experiencing significantly higher levels of long term illness and disability.[23]

Practices in both deprived and rural areas face significantly higher workloads and more complex patient demand without receiving commensurate funding that recognises these pressures.[24] This is because the current funding model does not adequately reflect the realities of deprivation, rurality, or populations with complex needs.

The GMS funding formula is used to allocate core practice funding in Northern Ireland and is intended to distribute resources based on population need. It does this through adjusting for factors such as age, gender, morbidity, deprivation, and additional workload. However, the formula's structure means it remains heavily driven by demographic weighting, with only limited adjustments for socioeconomic complexity or rural disadvantage. Analysis by the Department of Health revealed that the formula does not sufficiently compensate practices serving populations with high levels of long term illness or multimorbidity.[25]

Additionally, rural regions face persistent GP recruitment challenges, contributing to instability, higher rates of contract hand backs, and fewer GPs per head of population. Recent Northern Ireland Statistics and Research Agency data show that several rural Local Government Districts have some of the lowest GP per 100,000 patient ratios in Northern Ireland, alongside longer average travel distances to the nearest practice, highlighting the structural disadvantage faced by rural communities.[26]

This creates an imbalance where those working in the most challenging contexts are under resourced, increasing the risk of widening health inequalities and undermining the sustainability of care in communities with the greatest need.

Recommendation 2: Increase investment in general practice

Strategic investment must be enhanced by increasing the proportion of the HSC budget allocated to general practice, to reflect the volume, complexity and totality of the care delivered by GPs across a patients' whole life.

This can be achieved by:

- **Stabilising core funding:** Establish a secure, predictable baseline budget for general practice that protects core services and prevents year to year volatility.
- **Increasing real terms investment:** Ensure annual funding uplifts exceed inflation so that practices can maintain purchasing power and meet rising costs.
- **Rebalancing the HSC budget:** Increase the proportion of total HSC expenditure allocated to general practice beyond the current 5.4%, reflecting the value, volume, complexity, and totality of care it delivers.

3. Workforce capacity, recruitment and retention

3.1 GP capacity

General practice in Northern Ireland is experiencing a sustained and widening gap between patient need and available clinical capacity, with the number of whole time equivalent (WTE) GPs falling by around 10% since 2014.[27] This is despite the actual headcount of GPs going up, with the decline primarily due to reduced GP Partner sessions, driven by escalating workload intensity, increasing clinical complexity, and rising levels of burnout and moral distress.[28]

Over 80% of patients we surveyed said that Northern Ireland needs more GPs to improve patients' ability to get appointments when they need them.

GP session length and workload have also increased significantly. It is now recognised that one GP session (with a full day represented by two sessions) generates approximately 6.2 hours of work, meaning a GP working six sessions per week is effectively working full-time hours.[29] At the same time, health service reforms have shifted substantial volumes of care from hospitals into primary and community settings without a corresponding expansion in GP workforce capacity or investment.[30]

The impact on practices is clear. Findings from the RCGPNI 2026 GP survey demonstrate a consistent and urgent message, that without increased GP workforce capacity, access, continuity, and sustainability will continue to deteriorate:

96% of GPs and 92% of Practice Managers reported that escalating workload is negatively affecting their practice.

80% of GPs and 81% of Practice Managers agreed that increasing WTE GP capacity would improve patient access.

89% of GPs and 87% of Practice Managers said higher GP to patient ratios would improve patient outcomes.

88% of GPs and 90% of Practice Managers stated that increased GP capacity would support retention.

3.2 Absence of a GP workforce strategy

Despite repeated acknowledgement of general practice's central role within the health and social care system, Northern Ireland still lacks a dedicated, funded GP workforce strategy. Existing workforce plans, such as the HSC Workforce Strategy 2026 and the HSC Three Year Plan, reference general practice but do not provide GP specific solutions or deliver the programmes required to stabilise the workforce.

Despite the NIAO recommending the development of a specific GP workforce strategy in early 2024, there has been no substantive progress.[31] This is despite unanimity across the profession that such a strategy is essential.

In addition, Northern Ireland's position as the only UK jurisdiction without a permanently funded, wide ranging indemnity solution, combined with less competitive terms and conditions than elsewhere, presents a significant risk. The RCGPNI GP survey highlights the urgency of this issue:

> **79% of GPs expressed concern about workforce reductions at their practice and the impact on care quality.**

A dedicated workforce strategy is essential to reverse these trends and provide a stable foundation for recruitment, retention, and long term workforce planning.

3.3 Recruitment: Training capacity, development and early-career retention

Northern Ireland's GP training pipeline is not keeping pace with projected workforce needs in general practice. The 2018 NI Medical School Places Review identified a requirement for 169 GP training places annually by 2023, yet the current intake remains at 121 places, leaving a significant and persistent gap which continues to compound future workforce risk.[32] In addition, funding for postgraduate GP training has also failed to keep pace with rising delivery costs, putting further pressure on practices and GP trainers.[33]

An increasingly mobile early career workforce is likely to seek improved opportunities in other parts of the UK, the Republic of Ireland or further afield unless these disparities are addressed. Approximately 50% of GP specialty training posts in 2023–24 were filled by international medical graduates (IMGs).[34] IMGs make an essential contribution to the workforce, however after qualifying as a GP, it is recognised they are less likely to remain in Northern Ireland with visa restrictions and subsequent limited sponsorship support as well as the current working environment cited as issues.

Workforce shortages are most acute in areas of high socioeconomic deprivation, rural communities and border regions, where recruitment difficulties are compounded and GP contract hand backs are disproportionately concentrated. The development of region specific recruitment and retention initiatives would enable local solutions to local problems and support proportionate universalism to reduce health inequalities.

3.4 Retention: Protecting the existing workforce

Retention is now one of the most critical determinants of workforce sustainability. It is also strongly linked to current workforce capacity, and the RCGPNI GP and Practice Manager surveys highlight the interdependence between recruitment, workload, and wellbeing.

GP partners deliver approximately 75% of all in hours GP sessions, averaging 6.5 sessions per week compared to 4.9 for salaried doctors.[35] In 2018, GP Partners accounted for 89.9% of the overall GP workforce; however as of March 2025, GP Partners accounted for 75.2% of the GP workforce.[36] Their declining numbers therefore are likely to have a disproportionate impact on overall capacity.

> "We need an improved GP:Patient ratio that allows us to work in a safe and manageable environment. At present it is unsafe and destroying those that are staying, others are voting with their feet and leaving"

Burnout and moral distress are escalating. RCGPNI GP survey data reveals the extent of this issue.

Yet, Northern Ireland remains the only jurisdiction in the UK and Ireland without access to a Practitioner Health Programme, leaving GPs without tailored mental health and wellbeing support. This absence contributes directly to burnout and low morale, ultimately leading to workforce attrition as GPs are forced to reduce their sessional hours or leave the profession without targeted assessment and treatment.

40% of GPs feel unable to cope with stress at least weekly.

63% of GPs reporting insufficient time to build effective patient relationships.

3.5 Multi-Disciplinary Teams

Patients were broadly positive about the role of the wider MDT within general practice with 69% of respondents in the RCGPNI patient survey agreeing that being seen by other healthcare professionals in their practice improves their health and wellbeing.

While MDTs are highly valued, they must complement, not replace, GPs. The scope of MDTs must be clearly defined with supported governance practices put in place. GPs consistently told us they cannot replace the need for sufficient GP capacity. MDTs work best when built on a strong foundation of GPs who lead their practice and hold the risk and overall clinical responsibility for their patients.[37]

3.6 Targeted workforce support for high-need areas

As mentioned earlier, workforce shortages are most severe in deprived, rural, and border regions, where recruitment challenges are compounded by socioeconomic need, geographic isolation, and higher levels of multimorbidity.[38] Contract hand backs are disproportionately concentrated in these areas, reflecting the difficulty of sustaining services under current conditions. Region specific recruitment and retention initiatives are essential to support proportionate universalism and reduce health inequalities. GPs working in high need areas consistently report the greatest difficulty sustaining services, underscoring the need for targeted intervention. At the same time, it is essential that any support measures introduced do not disadvantage other areas due to unintended consequences.

Recommendation 3:
Build workforce capacity for improved patient access

Urgent action is required to grow the GP workforce through improving funding to allow practices to expand their teams.

This can be achieved by:

- **Developing and implementing a dedicated GP workforce strategy:** This should include clear targets for GP workforce growth and actions to address recruitment and retention. It should be published without delay, aligned to population need, and integrated with wider HSC workforce planning.
- **Increasing and sustaining GP training capacity:** Commit to a phased increase in GP training numbers to meet projected need, review funding for training practices to ensure delivery costs are met and protect the long term viability of GP speciality training in Northern Ireland.
- **Delivering MDTs safely and effectively:** Ensure that the expansion of MDTs is fully funded and implemented at pace, complements the role of GPs rather than replaces, and is underpinned by robust governance, training and clearly defined scopes of practice.

Improve GP recruitment and retention

Make Northern Ireland an attractive place to train and work as a GP who feels valued, through targeted resources and support to ensure GPs working in NI are not disadvantaged compared to the rest of the UK and Ireland.

This can be achieved by:

- **Stabilising and retaining the existing GP workforce:** Immediate action to reform and strengthen the GP Retention Scheme, including equitable maternity and sickness reimbursement, expansion of flexible working and portfolio career options within general practice and measures to protect GP partners.
- **Improving retention of international medical graduates:** Support practices with Health and Care Worker visa sponsorship and advocate for national reform of visa rules affecting newly qualified GPs to prevent the loss of trained GPs immediately post CCT.
- **Introducing a permanently funded indemnity solution:** Implement a state backed, comprehensive indemnity scheme covering all GPs, including locums.
- **Establishing a Practitioner Health Programme for Northern Ireland:** A dedicated Practitioner Health Service must be commissioned to support GP mental health and wellbeing, recognising wellbeing as fundamental to patient safety, retention and workforce sustainability.

4. Future contractual models of care

4.1 What is the GP partnership model?

The independent contractor model remains the foundation of general practice in Northern Ireland. Under this arrangement, GP partners own and manage their practices as autonomous businesses, holding the formal contracts with Strategic Planning and Performance Group (SPPG) for HSC service delivery.

Practices operate either from premises owned by the partners or from leased facilities. As self-employed contractors, partners collectively share in the profits of the business while also carrying joint and individual liability for its financial and operational risks.

The partnership model underpins the flexibility, continuity, and professional stewardship that characterises general practice provision across Northern Ireland.

4.2 The contractual model landscape in Northern Ireland

Financial efficiency

Around 95% of all practices in Northern Ireland are run as independent contractors and are proven to be one of the most efficient parts of the health system.[39] General practice accounts for a disproportionately small part of Northern Ireland's total health spending, yet provides care for more than two million registered patients, demonstrating the value of investing in a sustainable partnership model.[40] This equates to around £185 per registered patient per year.[41] At the same time, general practice remains the front door of the health service and manages the overwhelming majority of patient contacts.

In addition to the traditional partnership model, Northern Ireland also has a small number of practices operating under alternative contractual arrangements. Eight practices are run as fully salaried services under Federation Community Interest Company (CIC) contracts, and a further eight are operated directly by HSC Trusts following contract hand backs.[42] CIC run practices continue to operate within standard GMS contractual mechanisms, with funding reported through routine Northern Ireland Statistics and Research Agency GP payment statistics.[43] Funding for Trust run practices is not reported in NISRA's GP payment data, creating a lack of transparency around the cost and sustainability of these arrangements.[44] However, figures reported at the NI Health Committee showed a doubling in funding required to run one particular Trust-run practice in 2023-24.[45]

Contractual instability

This efficiency sits alongside growing instability, jeopardising the partnership model. General practice in Northern Ireland currently operates without an agreed contract, with contract negotiations for the current financial year still ongoing at the time of writing. This uncertainty places additional pressure on practices already working under significant strain.

Partnerships typically become unsustainable when workload pressures escalate beyond safe levels, recruitment is challenging, or financial viability deteriorates due to rising costs and stagnant funding. In Northern Ireland, these pressures have contributed to a marked rise in contract hand-backs with official statistics revealing that around one in 20 GP practices handed back their contract over a two year period, reflecting a growing fragility in the system.[46]

Furthermore, evidence shows that when GP partnerships become unsustainable and contracts are handed back, some replacement arrangements in HSC Trust-run practices have required locum payments of up to £1,000 per GP per day.[47] This highlights the strong financial management and the associated cost-effectiveness the GP partnership model can offer when it is properly resourced and supported.

The lack of adequate core funding for general practice is fundamentally undermining its stability due to the significant impact on the recruitment and retention of GPs. Deficient funding means that practices are struggling to meet basic running costs, driving them to make difficult rationing decisions regarding staff recruitment and the delivery of care services offered.

4.3 The future of the contractor model

These conditions have led to increasing concerns amongst GPs regarding the risks associated with partnership, with one younger GP in our survey describing the partnership model as a *"huge leap of faith"*.

Despite the concerns around financial risk and overburdening bureaucracy associated with running a practice, appetite for partnership remains strong. 64% of GP registrar respondents to our survey said they wanted to be a GP partner in five years' time. Their reflections suggest that the challenges of the partnership model are not inherent flaws in the model itself, but symptoms of sustained underinvestment. As one GP registrar explained:

> "Most of us only consider salaried work because of the instability. When asked, most of us who want to work within general practice ultimately want to take on a partnership, myself included."

This reinforces how deeply embedded the partnership model remains within GP professional identity in Northern Ireland.

As consideration is given to new and innovative ways to deliver care within general practice, it is critical that the core functions of the partnership model are protected and promoted and that the inherent virtues of independent contractor status are retained. One GP noted that:

> "Moving away from independent contractor status risks further fragmentation of care, reducing efficiency in general practice and losing relationship-based care."

Safeguarding the partnership model is therefore imperative. Around 87% of GPs and 90% of Practice Managers believe increased funding would make partnership a more attractive option. Furthermore, 70% of NI GPs surveyed said that maintaining an independent contractor model is important for the delivery of quality care for patients.

Ensuring it remains a viable and attractive option for future service delivery will allow GPs to continue meeting the needs of patients across Northern Ireland and preserve the foundational elements of general practice that patients and clinicians value most. The traditional autonomous and independent GP partnership model should be improved and modernised while retaining its core strengths. This could be achieved by exploring ways to mitigate the unlimited personal liability exposure involved with being a GP partner, and options to reduce the financial risks associated with owning or leasing premises.[48]

Recommendation 4:
Safeguard the partnership model

The security and long-term viability of the GP partnership model - which is the primary model in Northern Ireland - must be safeguarded to ensure the continued delivery of effective patient care to meet the region's specific challenges.

This can be achieved by:

- **Reviewing the unlimited personal liability** exposure involved with being a GP partner
- **Scoping options to reduce the financial risks** associated with owning or leasing premises

5. Communication, digital infrastructure and workforce intelligence

A modern, sustainable general practice requires digital infrastructure and communication systems that support safe, efficient, and integrated patient care. Many GP premises also require investment and modernisation to ensure they remain safe, accessible, and fit for the delivery of high-quality clinical care. Alongside investment in the general practice workforce, there must be sustained investment in the digital and physical infrastructure that underpins service delivery.

Northern Ireland has undergone a major digital transformation programme through Encompass, the new single electronic care record for HSC Trusts. The system was originally projected to cost around £300 million, but more recent estimates place total programme costs between £343 and £400 million, with some analyses noting even higher cost escalations.[49]

Over this period, investment in GP digital infrastructure has been constrained and repeatedly deprioritised, leaving practices without modern tools for interoperability, real time data sharing, or streamlined communication. This widening digital gap undermines integration across the system and limits general practice's ability to deliver efficient, coordinated care.[50]

5.1 Digital infrastructure and interoperability

General practice relies on timely and effective communication with the wider HSC system. However, communication between general practice and other parts of the health service is often slow, inconsistent, and fragmented. GPs described spending increasing amounts of time *"chasing secondary care"* because of poor communication and accountability. Interface failures, including delayed correspondence and the completion of adverse incident forms, generate significant additional administrative work. These inefficiencies place additional pressure on practices that are already operating with limited capacity and detract from time that could otherwise be spent delivering direct patient care.

The consequences extend beyond administrative inconvenience. Long waiting lists and delays in accessing investigations can leave general practice absorbing unmet need and managing unresolved clinical risk while patients await secondary care. During our engagement, Practice Managers described this as creating a *"revolving-door effect"*, with patients repeatedly returning to their practice because they have nowhere else to turn. Clearer lines of responsibility, more reliable communication and greater accountability across the primary-secondary care interface are therefore essential to protect GP capacity and support safe, coordinated care.

The rollout of the 'Encompass' digital health record across all five HSC Trusts represents a significant investment in Northern Ireland's health service. The lack of a commensurate focus on GP IT systems during this time has left significant challenges in integration, interoperability and support for GPs and their teams during and beyond the rollout.

Digital systems should support, rather than hinder, clinical care. GP and Practice Manager engagement highlighted gaps in the technology available, which waste valuable clinical time and create avoidable breaks in the patient journey. Well-designed technology can reduce administrative burden, streamline workflows, improve communication between healthcare professionals, and enhance coordination of patient care.

Investment must also be made directly in GP IT systems and the supporting infrastructure on which practices rely. These systems must be modern, reliable and capable of improving communication with patients and facilitating access to services through appropriate digital channels. This investment must take place alongside work to ensure effective interoperability between general practice and wider HSC systems. Both are essential to enable the secure and efficient flow of information, reduce duplication and support safe, coordinated patient care.

5.2 Workforce Intelligence

Alongside improvements in digital infrastructure, better workforce intelligence is essential to support effective workforce planning and service delivery. At present, there is a lack of comprehensive, up-to-date data on the general practice workforce in Northern Ireland. This limits the capacity of policymakers and system leaders understand current workforce capacity, identify emerging pressures, and plan effectively for future demand.

Northern Ireland does not currently publish a routinely reported or validated measure of WTE GP numbers. However, as referenced in this report, analysis of available workforce sources - including Performers List data and practice returns - indicates that WTE GP capacity has fallen by approximately 10% since 2014.[51]

Existing published statistics primarily report GP headcount, while acknowledging limitations in their ability to reflect actual workforce capacity. Accurate workforce intelligence, including data on WTE GP numbers, workload, demographic trends, and projected future demand, is essential to inform evidence-based workforce planning and investment decisions. Comparable workforce data are already routinely available in many other areas across the UK, enabling more effective monitoring of workforce capacity and emerging pressures. Northern Ireland should have access to the same level of timely and comprehensive workforce intelligence.

Strengthening digital infrastructure, improving communication across the HSC system, and developing robust workforce intelligence are fundamental enablers of a sustainable general practice service in Northern Ireland. Investment in these areas will improve efficiency, reduce avoidable workload, support safer and more coordinated patient care, and ensure that future workforce planning is based on accurate and meaningful data. Together, these measures will help build a modern general practice that is equipped to meet the changing needs of patients and the wider health system.

Recommendation 5:
Improve digital and physical infrastructure

Commit to sustained investment in both digital and physical infrastructure to support a modern, sustainable general practice. Improve integration and interfaces with the wider HSC system and invest in improved data capabilities to reduce unnecessary workload and enhance the ability to deliver high-quality clinical care for patients.

6. A strategy for general practice

The challenges highlighted in this report demonstrates a clear and urgent need for a standalone, fully costed, and comprehensive general practice strategy for Northern Ireland. Despite the central role that general practice plays within the HSC system, there is currently no single, coherent plan that sets out a long-term vision for the service, aligned to population need and backed by sustainable investment. This gap has resulted in fragmented reform, short-term interventions, and a lack of strategic direction.

6.1 Providing clear direction and long-term stability

A dedicated general practice strategy would provide a clear roadmap for the future development of GP services. It should set out a shared vision for high-quality, accessible, and relationship-based care, alongside practical actions to stabilise and strengthen the service.

Crucially, the strategy must move beyond short-term funding cycles and piecemeal reforms. General practice requires long-term certainty to plan workforce, invest in infrastructure, and maintain safe and sustainable services. A fully costed plan would give practices and policymakers the clarity needed to make informed decisions and deliver meaningful change.

6.2 Aligning services with population need

Any future strategy must be grounded in a clear understanding of the health needs of the Northern Ireland population. Rising levels of chronic disease, an ageing population, and increasing multimorbidity are placing sustained pressure on general practice.

The strategy should ensure that services are designed to meet these challenges, with a strong focus on prevention, early intervention, and the management of complex conditions within the community. This will require the appropriate resourcing of general practice to reflect its fundamental and foundational role within the health service.

6.3 Integrating general practice within the wider HSC system

General practice does not operate in isolation, in fact, it is the foundational component of our health service, deserving wider system respect and integration. A comprehensive strategy should strengthen links between general practice and the wider HSC system, ensuring that patients experience joined-up and coordinated care.

This includes improving communication pathways, clarifying roles and responsibilities across services, and ensuring that policy decisions in other parts of the system do not inadvertently increase pressure on general practice. Integration must be practical and meaningful, supporting GPs in their role as coordinators of care rather than adding further complexity.

6.4 Supporting workforce, infrastructure and sustainability

A successful strategy must address the key enablers of general practice: workforce, infrastructure, and resourcing. This includes a clear plan for GP recruitment and retention, investment in premises and digital systems, and action to reduce unsustainable workload pressures.

Without addressing these underlying challenges, it will not be possible to deliver the level of service that patients need or to protect core aspects of care such as continuity.

6.5 From vision to delivery

Finally, the strategy must be deliverable. This requires clear timelines, defined responsibilities, and transparent monitoring of progress. Previous commitments to transform primary care have often not been fully realised. A renewed approach must focus on implementation as well as ambition.

Recommendation 6:
Produce and deliver a general practice strategy

Develop and implement a standalone, fully costed and comprehensive general practice strategy, which is aligned to population need and fully integrated with wider health and social care planning.

Conclusion

It is clear that general practice is in crisis and that the health and social care system in Northern Ireland is at a crossroads. Political aspirations to transform services and shift care from hospitals into our communities cannot happen without first ensuring general practice is stabilised and strengthened.

We call on the Minister of Health to prioritise the urgent implementation of the six recommendations to safeguard the future of general practice in Northern Ireland, to ensure GPs are enabled to provide the safe, accessible and high-quality care our patients deserve.

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