November 2025

Department of Health (Northern Ireland) - Northern Ireland Neighbourhood Model of Care: Call for Evidence

Background

The Royal College of General Practitioners (RCGP) is the main professional membership body for GPs in the UK. Our role is to encourage, foster and maintain the highest possible standards in general medical practice. The Royal College of General Practitioners Northern Ireland (RCGPNI) represents more than 1400 GPs across Northern Ireland and is grateful for the opportunity to respond to the call for evidence surrounding the Neighbourhood Model of Care.

Introduction

We welcome the opportunity to respond to the Minister's Call for Evidence on a Neighbourhood Model of Care. RCGP NI acknowledges the Minister's vision to stabilise Northern Ireland's health system, to deliver care closer to patients' homes, improve integrated working and reduce demand on our hospitals.

The call for evidence centres on approaches that have brought together alliances of service providers in response to a specific need within a neighbourhood.

The College asserts that general practice itself is the most noteworthy example of such a service and continue to emphasise that any new models of neighbourhood care must be built with GPs as core partners, not just participants.

Role of the GP and the practice

General practice is the cornerstone of primary care and the front door to our health system. Across more than 300 practices in NI, GPs and their practice teams deliver over 90% of the care a patient will need over their lifetime. Despite the ongoing funding pressures, ageing population with growing complexity and multimorbidities, and an increasingly pressured workforce, our patients continue to receive the very best care general practice can deliver – with GPs and their teams delivering 200,000 appointments per week in NI.

In September 2023 the Royal College of General Practitioners defined the unique role of a GP in the context of UK general practice, affirming that those who gain accreditation and registration as a GP are expert medical generalists and specialists in general practice, and restating the need for legislative change to merge the GMC medical registers to formally recognise this.

This definition, supported by the BMA and GMC, underlines the pivotal work that GPs deliver within our communities and neighbourhoods:

> *"A GP is a doctor who is a consultant in general practice. GPs have distinct expertise and experience in providing whole person medical care whilst managing the complexity, uncertainty and risk associated with the continuous care they provide. GPs work at the heart of their communities, striving to provide comprehensive and equitable care for everyone, taking into account their health care needs, stage of life and background. GPs work in, connect with and lead multidisciplinary teams that care for people and their families, respecting the context in which they live, aiming to ensure all of their physical and mental health needs are met."*

Due to the structure of general practices, GPs are uniquely placed at the heart of our communities to deliver relationship-based generalist medical primary care. These cradle-to-grave relationships, create trusted and continuous partnerships between GPs and their patients (characterised by empathy, and mutual trust, without bias or judgement), thus improving health outcomes of the patient population.

The current GP partnership model and the structure of GP federations already provide community focused care for our population. Any new approach must be able to demonstrate clear pathways and better outcomes for patients whilst still protecting the independent contractor model and continuity of care for patients which general practice provides, and which has already proven its merit.

Within this context, it is vital that general practice is the cornerstone of any proposed change in community-based care. As experts in continuity, complexity and risk management, GPs are indispensable to any model of care. The Minister and the Department of Health (NI) must ensure that general practice is recognised for the pivotal role that it has played in the provision of neighbourhood care for almost 78 years, innovating and developing to meet the changing needs of almost 200,000 patients every week. GPs must be at the forefront of decision making and play a key role in shaping any changes to community services.

General practice – the lynchpin of patient care

The work of general practice daily exemplifies an alliance of service. Within practices, medical, nursing and administrative staff work together to deliver over 90% of the care that a patient may need in their lifetime. In addition to the core practice team of GPs, nurses, and health care assistants, patient care is enhanced by federation employed pharmacists, MDTs where they are rolled out and some practices also directly employing other staff such as counsellors. Practice administrative staff

can support with care navigation to help patients access the right care at the right time, Staff in general practice are already at the centre of a primary healthcare system which is embedded in our local communities.

GP practices serve as the lynchpin and conduit for information and data transfer as holders of the patients whole of life medical record, often working with out-dated, unintegrated and inadequate digital infrastructure. Despite this, practice staff collaborate and connect across many care settings including with other primary healthcare providers and across primary, secondary and community care interfaces. GPs form therapeutic alliances with primary, secondary care, AHPs and colleagues across the system whilst remaining as the consistent thread of continuity for patients as they navigate the system. This coordination and continuity of care that GPs provide is vital to ensure patients receive the care they need as quickly and as close to home as possible.

Access and continuity are often viewed as competing priorities, particularly in areas of high demand. However, with appropriate planning and resourcing, both can be achieved together. There is strong and growing evidence that continuity of care in general practice is linked to more appropriate use of services, including lower rates of unnecessary testing and prescribing, as well as greater overall efficiency and productivity.[i]

Managing complexity, risk and continuity of care

GPs have distinct expertise and experience in providing whole person medical care whilst managing complexity. GPs are unique in that they can integrate knowledge from different dynamic areas to help the individual patient in front of them, dynamic and responsive to patient needs whether it be a one-off interaction, or ongoing management of complex long-term conditions. These factors combine to understand a way forward that best meets the needs of the individual patient at the time.

GPs are experts in managing uncertainty and risk associated with the continuous care they provide. GPs have an enduring role, managing the consequences of illness – diagnosed or not – in their patients' long-term interests, and integrating proactive and preventive care principles to prevent people from developing illness or experiencing deterioration of managed conditions. One of the key roles of a GP is to use these multiple skills and medical knowledge to simultaneously manage many types of risk.

For example, patients frequently present with symptoms that may be undifferentiated, perhaps early in an illness and not necessarily specific to any one condition. GPs are trained to establish if a symptom represents illness that is mild, self-limiting, or even a sign of a life-threatening condition.

Experienced GPs are highly effective at picking out who needs to be further assessed or admitted. Where a GP is satisfied that a patient is not unwell or deteriorating, they may monitor progress, rather than make unnecessary use of investigation and treatment. GPs are highly skilled at supporting diagnosis as an illness evolves, while managing a patient's symptoms and illness longitudinally.

Continuity of care is one of the core defining strengths of general practice. This cradle-to-grave care has been proven time and time again to have indisputable positive benefits for patients and the healthcare system. Continuity of care has been proven to deliver a wealth of benefits to individual patients and the NHS, having been associated with lower death rates, fewer hospital admissions and emergency department attendances, reduced health inequalities, improved vaccination and screening

uptake, less complaints and litigation and higher patient satisfaction. As Sir David Haslam, past Chair of NICE and past President of RCGP wrote 'Continuity of care in general practice reduces emergency admissions, unnecessary investigations and mortality rates, and raises patient satisfaction. If a drug had been shown to have all those benefits, there would be outcry if it was not available for the NHS'.

Continuity enables GPs to deliver personalised care, as GPs know their patients, families and the communities they live in. This understanding is invaluable to interpreting symptoms and managing illness in the context of a patient's particular circumstance, something no other part of the health care system can provide.

It is therefore vital that any proposed changes to primary care ensure that continuity of care and patient relationship-based care that has been built over years in GP practices is not undermined but enhanced.

Continuity of care by general practitioners has myriad benefits for patients and the healthcare system at large, as previously outlined. Research has shown that care fragmentation has an association with higher levels of morbidity, mortality and prescription of inappropriate medications than in patients with low levels of care fragmentation (as evidenced by regular contact with usual provider, less transitions in care and better co-ordination). It is imperative that any change in delivery model does not lead to care fragmentation and thus worse outcomes for patients. Approaches that prioritise activity volume over continuity, such as simplistic access targets, may risk fragmenting care, increasing duplication, and driving further administrative burden. Policymakers and commissioners should therefore place continuity and relationship-based care at the heart of system design, ensuring that efforts to improve access and efficiency strengthen, rather than weaken, the GP–patient relationship.

It is also essential that any change in delivery model prioritises preventing further health inequalities in our population. In areas of high deprivation, GPs often face greater patient demand and complexity, larger patient lists with higher patient to GP ratios, and less funding per patient due to funding formula shortfalls. Such a model must be open to local flexibility and must take into consideration the vast differences in GP practices, such as size of patient lists, socioeconomic background of patients, levels of deprivation in patient population, rural/urban locations and the scope of MDT within the practice.

It is essential that GPs retain their role as the 'front door to the health service', with a central role in primary medical care and as gatekeeper to most secondary care services, to ensure care is clinically appropriate and coordinated. GPs act as the first point of contact for most patients, providing expert assessment and directing individuals to the right services at the right time.

General practice at scale

GP Federations began with the aim of communities of practices, in a not-for-profit community interest company structure, working together to ensure that their patients and teams could reap the benefits of economy of scale, while maintaining their autonomy as individual practices. The Federation model covers all practices in NI, with each practice nominating a member Director from which individual federation boards are constituted, ensuring that the building blocks of our 17

Federations are their individual practices. The delivery of practice-based pharmacists to all practices was one of the early, but major successes of the model, again a multiprofessional collaboration.

The development of **Elective Care Services (GPECS**) has ensured that all patients in NI can access care by a GP with enhanced interest and skills in a particular area for example dermatology, musculoskeletal medicine, gynaecology and sexual & reproductive health specialist care, ensuring that patients do not languish on secondary care waiting lists, but are dealt with in a primary care setting, close to home. Vasectomies are now carried out by highly skilled and trained GPs, within local practices. Since its inception more than 75,000 patients have been treated in a service that has local access close to home but designed with a regional footprint.

The recent announcement relating to recurrent funding for the majority of GPECS services is welcome and improves stability for the core GPEC service delivery as well as the ability to work with secondary care partners and commissioners to further strengthen existing pathways of care for patients. It also allows for the development of new services that fit within a neighbourhood model bringing care closer to home. Whether in Castlewellan or Castledawson, access to a quality service can be afforded to patients regionwide.

The number of GP practices in NI has dropped at an alarming rate. In March 2025, there were 305 active GP practices, which is 40 fewer than in 2014 (a reduction of 14%). Unsurprisingly the average list size for a GP in NI has risen significantly over the same period. The reasons for practice closures are manifold and complex, but workforce and workload pressure, coupled with insufficient funding to deliver the necessary services are the main factors cited in partnerships making the very difficult decision to hand back their contracts.

The Practice Improvement and Crisis Response Team **(PICRT)** was developed in 2018 through the Eastern Federation Support Unit, with the aim of bringing together a team of experienced general practice staff, both clinical and administrative, who could come to the assistance of the practices across NI who were 'in crisis' and at risk of collapse. PICRT staff assist practices to develop a recovery plan which is unique to them and can provide clinical and administrative advice and clinical cover. Since its inception 134 practices in NI (43% of all practices) have availed of support from PICRT and as a result the majority have been able to remain viable as practices and continue to deliver care to their patients.

While the rollout of MDTs has been slow and has undoubtedly led to inequality across Northern Ireland, with a real postcode lottery for patients determining whether or not their GP practice has access to these healthcare professionals within their team, the development of these teams has been borne from strong links across practices, federations and trusts, with the aim reducing pressure on GPs and their teams, and ensuring that an individual patient can see a healthcare professional appropriate for their symptoms early in their journey. Where MDTs in NI are embedded in practices, they too are an excellent example of the development and delivery of a service which is an alliance of providers.

Challenges faced by general practice

While a successful neighbourhood model should encompass improved GP access, integrated care & streamlined patient records and care close to home, with funding targeted upstream and a higher

proportion of funding allocated to primary care to enable GP teams to deliver continuity of care with a focus on prevention, there are many challenges to overcome to make this a reality.

Funding

General practice is the most cost-effective part of the health system. Lord Darzi observed in his report 'Independent investigation of the National Health Service in England' (Sept 2024), "As independent businesses, General Practices have the best financial discipline in the health service family as they cannot run up large deficits in the belief that they will be bailed out". Yet despite this, general practice has been chronically underfunded over the last decade. The NI Audit Office reported in 2023 that just 5.4% of the health budget was allocated to general practice, a gross underinvestment given the volume and complexity of care provided.

A significant uplift in funding is essential initially to provide stability for practices, but subsequently to allow general practice to deliver new initiatives, improved either within the independent contractor practices or indeed at scale across localities. The proportion of spend on general practice must increase to allow our surgeries to thrive as the centre of a neighbourhood model, and while it is important that additional services and new pathways of care are developed, our GP practices, already at the heart of our communities must have adequate resource to create stability and longevity within their communities to allow them to better deliver the routine care that our patients (and the entire NHS) requires.

Across the other devolved administrations, there are credible steps to stabilise and invest in general practice, as leaders across the UK recognise the importance of the care that GPs provide in our communities. For any proposals or changes to primary and community care, it must be underpinned with an uplift in funding for general practice.

GP Workforce

In April 2024 RCGPNI published its Retention Strategy, 'A Workforce Fit for the Future', outlining the significant pressures facing GPs across Northern Ireland. Almost 18 months later and there has been no improvement in the situation - workload, stress, burnout, high level of risk associated with working in general practice, lack of investment in digital technology, insufficient core funding, negative public narratives, outdated premises and general lack of support are all affecting the delivery of general practice in NI.

There is also a severe and ongoing shortfall in the general practice workforce which continues to compound the challenges GPs face. GPs are being asked to do more with fewer colleagues, creating unsustainable pressures on the profession.

The already additional workload in general practice, created by the ongoing shift left of care into the community, without the additional funds and resources to deliver this, has already taken its toll. If a new Neighbourhood model is to further increase this workload it is imperative that the GP workforce is healthy, supported and sustainable. For this to happen, a long overdue (10 Years+) comprehensive workforce review of primary care, and within that general practice is needed.

While the increase in training numbers to 121 is welcome, the NI GP training places Task and Finish Group have recommended that training numbers are further increased to 161 to return whole time equivalent GP numbers to 2014 levels. Merely increasing training numbers will not be sufficient to bolster our workforce in a meaningful way. Recruitment of GPs to training schemes must be matched with meaningful efforts to increase the retention of our highly trained and skilled GPs, from early, through middle and to late career GPs. We know that the demand for our services grows daily, and GP partnerships must be adequately funded to ensure that they have the resource to either employ salaried GPs or invite GPs into partnership. In May 2025, the College published its GP partnership principles paper, seeking to offer a framework to strengthen partnerships in general practice for the future, while protecting the core values of traditional GP partnership model, which have been shown to benefit patients, GPs, and the wider healthcare system.[ii]

Challenges with GP premises, estate and infrastructure

The College will continue to call for greater investment and support for upgrading general practice premises. Our previous member survey of GPs across the UK found 34% of GPs considered their premises unfit for purpose, and 84% said a lack space limits their ability to take on GP trainees.[iii]

RCGP have consistently called for funding for practices to address these issues and make space for new staff. Investment and a review of existing NHS buildings would also help to facilitate co-location of community and voluntary services with practices, where this works for the local population and services. The challenges faced by practices in relation to physical space to accommodate MDTs cannot be underestimated and solutions to support roll out often do not go far enough to future proof practices in relation to teaching and training or indeed practice growth.

Additionally, a challenge for some smaller sized GP practices, alongside a lack of core funding, workforce and fit for purpose premises, is the lack of 'back-office' administrative capacity such as HR and IT. This can add to workload and financial pressures, potentially limiting their roles in the community's health.

Challenge of the multi-disciplinary teams (MDT) rollout

As already discussed, multi-disciplinary teams (MDTs) have been a welcome addition to patient care within a select number of practices, however the slow pace of implementation has resulted in increasing health inequalities within our patient population. This inequality of healthcare provision will no doubt have a detrimental effect on the implementation of any new model of care, that is focused on both local and wider population needs. Whist the proposal is to start the implementation phase of the Neighbourhood Model next April, the full roll out of MDT's will not be completed for approximately eight years. The impact that this will have on those geographical areas cannot be underestimated and must be addressed as part of the planning process.

GPs have distinct expertise and experience in providing whole person medical care whilst managing the complexity, uncertainty and risk associated with the continuous care they provide, and they should therefore be supported with the resources (protected time, workforce and budget) required to lead and work with the members of the MDT to treat and support patients with complex and multiple conditions.

As the core purpose of the Neighbourhood model is to address local needs within different geographical locations, the need for flexibility within this structure is apparent – no one size will fit all, nor will substantial success be measurable within the short term, as time to embed is important for sustainability and outcome assessment. With the introduction of a multiyear budget, it is essential that any financial forecasts also incorporate this flexibility to meet changing demands.

Digitisation -System Integration & Interoperability

GPs are the holders of 'cradle-to-grave' patient records, and our advanced clinical systems already hold all data derived from general practice, but also much of the record of a patient's entire journey through secondary care. General practice faces daily challenges due to fragmented record systems, with the relatively new Encompass system not currently integrated with GP clinical systems. In addition, Encompass has been rolled out to hospitals and trust services only, leaving various and voluntary sector organisations who contract from HSC trusts (e.g. nursing and residential homes, hospices and pharmacies) with no access to either read or add to Encompass. The RCGP will be seeking assurances regarding the safeguards in place to protect patient data and safeguard vulnerable patients. We also have concerns regarding compatibility between systems across the nations of the UK.

A truly integrated neighbourhood model of care should see seamless interoperability between IT systems and clinical records, and timely information transfer between providers. Opportunities to improve communication between providers and the patient is key to improving patient journeys, patient safety and driving efficiencies within the system.

System interoperability also supports continuity of care, enabling GPs to make informed decisions based on the latest clinical interventions, test results, and care plans. Without this connectivity, critical information gaps can compromise patient safety, hinder proactive management, and lead to inefficiencies that impact both outcomes and practice resources.

Implementation of e-prescribing

It is essential that e-prescribing is rolled out to GP practices in NI as a matter of urgency, to reduce inefficiencies. Northern Ireland has been left behind, as the only part of the UK and Ireland without e-prescribing either in place, or actively being rolled out. Introducing e-prescribing, with robust and integrated digital systems across primary and secondary care settings, would deliver immediate benefits for patients, GPs and other practice staff, by releasing clinical time and improving service delivery.

Conclusion

To realise the DoH (NI)'s ambitions around a Neighbourhood Model of Care, general practice must be at the centre of any proposed remodelling of services, which continues to shift to care into the community. GPs are experts in continuity, complexity and risk management, with GP practices exemplifying an alliance of service. It will be essential to have representation from general practice meaningfully, included at all decision-making levels through redesign and reform processes, and

ongoing. It is also important that any new structures and commissioning systems for primary and community care are evaluated in real-time, to ensure they are improving patient care, and to identify and mitigate any unintended consequences.

Recommendations:

- The independent contractor status must be recognised as fundamental to the delivery of cost effective and excellent General Practice.
- The role of a GP must be protected in its current form as the only part of the health care system that delivers whole person care across a lifetime for our citizens.
- The proportion of health service funding for general practice must increase to realistic levels, to enable stabilisation and future delivery of services.
- Funding must move into primary care to enable the shift from secondary to community care.
- DoH (NI) must work in partnership with GPs to deliver a general practice strategy, as a matter of urgency.
- Not only should general practice be at the centre of any proposed new service design which continues to shift care into the community, but GPs must have a key role in leading at every level in the design and implementation.
- Fragmentation of care must be avoided and any new model based on continuity and relationship-based care.
- Changes to any model of delivery of care must not widen the inequalities already present in our system and perpetuated by the stalled MDT rollout.
- E-prescribing must be rolled out to GP practices in NI, to streamline GP workflow and facilitate more time for patient care.

November 2025

References:

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[ii] Royal College of General Practitioners. (2025). GP partnership principles. https://www.rcgp.org.uk/representing-you/policy-areas/gp-partnership

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