Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Local Commissioning Groups' Commissioning Plans for 2011-12

12 October 2011

NORTHERN IRELAND ASSEMBLY

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

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Members present for all or part of the proceedings:
Ms Michelle Gildernew (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Michaela Boyle
Ms Paula Bradley
Mr Mickey Brady
Mr Gordon Dunne
Mr Mark H Durkan
Mr Sam Gardiner
Ms Pam Lewis
Mr John McCallister
Mr Kieran McCarthy

Witnesses:

Dr Nigel Campbell	)	South Eastern Local Commissioning Group
Dr Brian Hunter	)	Northern Local Commissioning Group
Mr Sheelin McKeagney	)	Southern Local Commissioning Group
Dr Brendan O'Hare	)	Western Local Commissioning Group
Dr George O'Neill	)	Belfast Local Commissioning Group

The Chairperson:

I am very pleased to welcome Dr Brendan O'Hare, who is the chair of the Western Local Commissioning Group; Dr Brian Hunter, who is the chair of the Northern Local Commissioning Group; Dr Nigel Campbell, who is the chair of the South Eastern Local Commissioning Group;

Dr George O'Neill, who is the chair of the Belfast Local Commissioning Group; and Mr Sheelin McKeagney, who is a pharmacist. Interestingly, the commissioning chairs are all doctors except for Sheelin. We will do a wee bit of probing on that. Sheelin is maybe especially welcome in that case. He is from the Southern Local Commissioning Group.

Mr Durkan:

I wish to declare an interest as a former member of the Western Local Commissioning Group.

Mr McCarthy:

Madam Chair, I must rush off shortly, but I would welcome the opportunity to ask my doctor, Dr Nigel Campbell, a question.

The Chairperson:

Is it about your constituency, Kieran? Of course it is. I will indulge you before we open the questioning up to other members. Do you want to ask your question now, before the presentation?

Mr McCarthy:

No, I will wait to hear what he has to say.

The Chairperson:

You will be in first after the presentation, Kieran.

Who will do the presentation?

Mr Sheelin McKeagney (Southern Local Commissioning Group):

I will. I am not sure whether it is a reflection of my professional standing, but I got the job of doing it.

We thank you for the welcome and the opportunity to speak to the Committee. You have introduced everyone, so I will not repeat that. As you said, I am the only pharmacist among us; my colleagues do not practice demarcation, I have to say.

We want to take this opportunity to set out the role of the local commissioning groups and to

say a little bit about the opportunities and our ideas for the future. You asked specifically about how we link to the general commissioning plan. We will talk about that and about how things are different now from a year ago. I refer you to the paper that we submitted for further detail on that.

The local commissioning groups were set up under the Health and Social Care (Reform) Act (Northern Ireland) 2009. Prior to that Act, there were seven. That number was reduced to five under the review. The five local commissioning groups cover the same footprint as the five health and social care trusts: namely, northern, southern, western, south-eastern and Belfast. We are subcommittees of the Health and Social Care Board. We meet publicly, nine times a year. The minutes and agendas of those meeting are advertised.

The committees are unique in that they are primary care and community focused. Each committee has 17 members, six of whom are based day-to-day in primary care: that is to say that they are dentists, GPs and pharmacists. Four members are locally elected councillors, and two represent the community and voluntary sector. The others are a professional public health consultant, a nurse, an allied health professional (AHP) and two social workers.

The local commissioning groups (LCGs) are strategic decision-making bodies. We are not hands-on: we do not treat patients in any way. However, we have operational access to staff in the Health and Social Care Board, in the commissioning directorates and through the Public Health Agency (PHA). Our role is to assess health needs, to plan and prioritise services and to look at ways to secure services to meet the needs of the people whom we serve. It was interesting to hear the Committee's conversation earlier; we get our information from and hear things in different places.

The LCGs predominantly commission services from the health and social care trusts, but we also commission from independent providers and from the community and voluntary sector. The Department of Health, Social Services and Public Safety's framework document states that LCGs have full, delegated authority to discharge the responsibilities of the assessment, planning and securing of services. We have significant ability to direct resources and to spend funds. The funds are allocated across the local commissioning groups, based on a capitation fair-share basis for each group. Each local commissioning group can see what its capitation spend will be.

Identification of local priorities is taken very seriously. We do that by taking the views of patients, clients, carers and service providers through various methodologies: meetings, focus groups and meeting clinicians in different forums. That is a very useful way of shaping and designing services for the future.

That brings me to the concepts that we use to develop the commissioning plan. The commissioning plan that the Health and Social Care Board produces should reflect the decisions and recommendations of the local commissioning groups in relation to how that money — the capitation-based fair-share funding — is spent. That said, not everything is commissioned locally. Earlier, we heard about a specific issue that is of such specialism and small number that it is commissioned in a central-type process. Other examples are such provisions as regional paediatric cardiac services, for example. They involve very small numbers and are specialised. All cardiac transplants are done across the water. So, it is done in different ways for different things.

How does an LCG, which is a non-operational, part-time committee, deliver all of those services? As you know, the Department provides annually the priorities for action, which inform the direction of the travel of the health and social care service in Northern Ireland. Based on that, the Health and Social Care Board determines, in consultation with the local commissioning groups, the range of services that we choose to prioritise and delivery regionally. Subsequently, we identify the budgets from which such services are to be commissioned. Within the Health and Social Care Board are regional commissioning teams, which advise the LCGs on professional matters and on ideas about how, in totality, a service might be provided across the five trust areas.

There is the Health and Social Care Board (HSCB) commissioning plan. There are also five local commissioning plans, which are produced by my colleagues and I and our teams in the local offices. Those plans reflect the flavour, the local priorities and the slightly different ways in which things can be provided. Here in Belfast, for example, people live close together. My area, the southern area, however, is a lot more rural — even more rural than the west.

The LCGs are supported by integrated teams within our local offices. You will be aware that we have the Health and Social Care Board and the Public Health Agency. Within the local offices, those boundaries become very blurred, and there is a lot of intersectoral working going on across each of those different areas. The Public Health Agency, for example, sits on the local

commissioning groups, as does the Patient and Client Council. There is a lot of good intersectoral working there.

With regard to public/patient involvement, we spend a lot of time developing action plans and working with local groups and local stakeholders to ensure that their views are well represented in our thinking and our local plans.

This is obviously a very cyclical process. The system does not stop; this work is ongoing all the time. We are looking forward to the next series of priorities for action — hopefully, they will be out this side of Christmas — and will begin the cycle again.

Looking at the major challenges and objectives for the LCGs, we all know that we are facing a difficult financial settlement for 2011-12. In cash terms, it is broadly similar to last year. However, there are significant cost pressures ongoing year on year and health service inflation. We reckon that we need to look at a cost pressure in the Health and Social Care Board of somewhere in the region of £130 million. That is a significant challenge for all of us to deal with. By doing so, we aim to maximise all the available resources coming to us in the coming year and to ensure that we use those resources in the best possible way.

We are facing other demands. There is an inexorable increase in the demand for emergency department use and the out-of-hours services. The management of medicines is a matter close to my heart. We need to manage medicines carefully in primary care and in secondary care, ensuring that we prescribe the appropriate medication at the appropriate time. Sometimes, that means an increase in prescribing certain things. However, we can also look at reducing waste, which is another significant issue for us in prescribing in the pharmacy sector. We have a significantly higher prescribing spend in Northern Ireland, and that is something that we need to look at across the piece. It might be better if we could justify that higher spend by saying that we had better health outcomes but, unfortunately, that does not ring through in the figures. We also have to make sure that our performance around waiting lists, waiting times and access to review appointments is similar and within target for the current year.

We need to be mindful of the additional costs of specialist medicines. You will have heard of the anti-TNF drugs for arthritis and the new anti-cancer medicines that are used. Those are coming on the market constantly, and it is entirely appropriate that we find the money for them,

because they are good medicines, and they make a massive difference to people's lives. It is a big issue, and there are very significant cost pressures.

One way in which we are addressing that is by engaging with clinicians who work with patients daily. We see significant improvements in quality and demand management when we bring primary care clinicians — GPs, pharmacists and others — together and get them working closely. Through patient pathway redesign, peer review and comparison of information on measures of different practice, we can begin to reshape and look at how the service looks and feels for patients and clinicians. There is significant variation in practice across different areas. By doing those things, we can improve results for patients.

The paper refers to areas that pathfinder groups looked at in previous years, specifically prescribing. In my area, we looked at oesophogastroduodenoscopy referrals and were able to make a significant difference in one area to prescribing and demand. To that end, we are seeking to develop a series of primary care partnerships. Those are local federations of primary care practitioners who will look at provision and demand.

We have appointed 17 primary care practitioner leads across the five local commissioning group areas. They will deal with and meet our local colleagues to lead and to compare patterns of demand, prescribing and clinical practice. Those groupings are beginning to get structures around them and to do work. We fully expect that they will develop significant changes within year by working closely with their secondary care colleagues to look at how things are done in primary care. Hopefully, reducing demand but improving the pathways of patients follows through into secondary care.

Local commissioning groups are relatively new — as new as two years can be. They are patient-focussed committees. All of us are on-the-ground practitioners looking after patients on a near-daily basis, except when we are involved in our LCG work. We are tasked with assessing health needs, planning for and securing health provision for our local populations.

There are significant challenges for health and social care services, which I will not rehearse in this room, as you will be well aware of them — probably more so than I. However, we are determined to manage and deal with the pressures and demands in the best way possible. We believe that, through real local engagement with clinicians and communities, we will adapt to best

fit the needs of our populations to the way that we can best deliver services.

We are obviously here to take any questions and to give you any further detail that we can.

The Chairperson:
Thanks a million, Sheelin.

Dr George O'Neill (Belfast Local Commissioning Group):
I want to back up what Sheelin said. I will not be as eloquent as he was. Sitting in front of you here are people who have 135 years' experience at the coalface. We are practising clinicians. We know health and social care backwards. We know it very well. We know where the problems and difficulties are. We work in an illness service, not a health service. By the time you come to me, it is too late. We really want to try to focus on a wellness service, and that is the gist of the point that Sheelin was trying to make.

We also have to look at what the health service contributes to a person's health and well-being. It is only about 20%. All the rest comes from other influences: the justice system, education, housing and the environment. Local politicians have a major input to make. Nobody elected us. You all have an electoral mandate. We need your support to deliver this and to improve the outcomes for the people that we represent.

Earlier in this meeting, we heard about the child and adolescent mental health services (CAMHS). If you think that mental health is the Cinderella, CAMHS is even further down when it comes to it. There are lots of issues that we think we can address locally, but we need your help and support to do it.

The Chairperson:
OK, George, I would not disagree with any of that. The fact is that we would have preferred it had some of you been on the review group. I do not think you were in for that.

Dr G O'Neill:
We were not asked.

The Chairperson:

No, and that is the sort of experience that we need to be helping us to shape the future and helping the Minister in a very difficult job.

As Kieran, Michaela and Mickey have indicated that they need to leave, I will skip protocol by inviting questions from those three members first. Other members may ask questions after that. I will leave my questions to the end.

Mr McCarthy:

I thank you for your presentation. Your name is local commissioning group. I like the word "local". In fact, I hang my hat on the word "local" because that is what it should be.

My questions are for you, Dr Campbell, because you are the chair of the South Eastern Local Commissioning Group, which is my local group. I have four brief questions. I have your plan in front of me, which I have studied from back to front. There is one very important element, which concerns the project to locate pharmacists in each GP practice — yes?

Dr Nigel Campbell (South Eastern Local Commissioning Group):

Here we go. *[Laughter.]*

Mr McCarthy:

It is here in black and white:

"A project to locate pharmacists within each GP Practice across the LCG to assist practices with medicines".

How will you do that given that pharmacies are underfunded and in view of the real threat that exists to local pharmacists and chemists up and down our streets?

My next question is about the patient/client experience. The document refers to inviting groups to do work shops and so on. Are there any plans or reports for publication of the activities of those groups?

My third and fourth questions are to do with mental health and learning disability. You all know what the Bamford report and 'Equal Lives' are all about. We are told that, in 2010-11, a further £1·2 million will be invested by the south eastern group on mental health and learning disability services. That will build on service investments in 2009-2010 and will include autism services and respite care. Perhaps you could elaborate a wee bit more on the investments and

those details.

My final question is about learning disability services. The document states that LCGs will scrutinise trust plans to modernise day care facilities in the north Down and Ards area. You will be aware that there is a plan to provide two adult training centres in the Ards and north Down area instead of three. I have a vested interest in this, because my daughter goes to one of those centres. I want nothing but the best for her and all her colleagues in as soon a time as possible. Can you tell me and the Committee just how far we have got with that project?

Dr N Campbell:

I was trying to pre-empt the questions, but I would not have come up with a list of that length. The issue of pharmacists who are employed is quite a different thing to pharmacists who work on the high street in the community. Funding comes to general practices, and we are to look at the management of medicines in practices. On the back of a scheme that existed in the old Eastern Health and Social Care Board, we have chosen to allow practices to employ pharmacists on a sessional basis. They are not necessarily pharmacists who work on the high street; they can be pharmacists who work in a hospital setting, or they can be from anywhere, really. They help us to address prescribing issues in the practice. They are quite separate practices to those in the high street —

Mr McCarthy:

So it is not an alternative?

Dr N Campbell:

No. They will not dispense; they will just advise. Can I move on from that, if that is all right?

As regards patient experience, we have met a lot of different groups, which we detail in our commissioning plan. It is not for us to report on their activities. We have met them and taken advice from them. We certainly feel that we have built up knowledge of the localities where we operate to the point where we can challenge policy as it comes down from the Department and through the board, because we feel that we have been out and have met people in the communities in which we work. We know what they have been saying to us, and what we know from our work in the community. I cannot really say that we have published anything that they have come up with, because they publish their own material. We certainly have access to a lot of

their materials.

There is a very specific plan on mental health in the South Eastern Trust that was consulted on last year. The acute units will be reduced from three to one, which will become the Lagan Valley site. That was consulted on, and we supported it, having taken a lot of soundings from the community in which we work.

Mr McCarthy:

Some of my constituents, particularly those from the tip of the Ards peninsula, did not support it. They will now have to travel to Lagan Valley for that service.

Dr N Campbell:

We heard from people on the Ards peninsula. We went down to meet — you will forgive me if I have forgotten; I think that it was Kircubbin where we met —

Mr McCarthy:

Kircubbin? That is the capital of the Ards peninsula.

The Chairperson:

It is the centre of the universe.

Dr N Campbell:

I had the right name then, obviously. We met people in Kircubbin, and we had a lot of representation from there. That has been the area from where the most concern has come, really because of the travel issue. Travelling from Kircubbin to Lagan Valley, which is where the acute mental health facility will be, is difficult. We spoke to rural transport folk at that meeting as well, so we are conscious of that concern. I will be happy to discuss that further at another time, but we certainly take that on board.

Mr McCarthy:

There is a lot of concern about that. I have a constituent from the tip of the peninsula who had to go to Lagan Valley. First of all, the charge was going to be £21. That was acceptable, but the man was then told that it was going to be over £50, which was not acceptable. The guy was not able to make his appointment.

Dr N Campbell:

That is one of the ways in which the LCG has made a change. We went back to the trust on those proposals and said that, from talking to the communities, we had heard that transport was going to be a problem and that we wanted the trust to guarantee that it was going to fix that in the proposals. That is one of the ways that local commissioning actually makes a difference, which was your earlier point, because we know what is going on on the ground.

The final point was about the reduction of adult learning centres from three to two. I do not know whether you have had an opportunity to visit the new centre in Lisburn.

Mr McCarthy:

I have; it is excellent.

Dr N Campbell:

It is a superb facility. We are trying to bring the other three up to that standard. The proposal is that the service is to be reduced to two providers, although I am not sure what stage that process is at. We want those two to be as good as what we have in Lisburn. We wanted to make sure that there was no diminution of service if the number were reduced from three to two. We also heard very strongly from the community that respite was a big problem in that area, so we have directed the trust to that and said that we need to work out that there is no respite facility for our residents.

Mr McCarthy:

Can you tell us where the business case for that reduction from three to two is at the moment? A business case was submitted to the board, and people want to know about it.

Dr N Campbell:

I am going to talk in terms here, and I hope you do not ask me what they all mean. Is it OBC2? There is a strategic plan to start with, and then there is an outline business case. I think it is at the second phase of that. It is quite far advanced.

Mr McCarthy:

OK. Thank you very much.

Ms Boyle:

Thank you for your presentation. I can vouch for Dr O'Hare. He works very much on the ground in my own area, and he comes to council to present from time to time.

I know that one of the key objectives of the local commissioning group is to support independent living at home, particularly for the elderly. Most members here spent the best part of the summer recess being lobbied by carers and people in the community about the cut to home help hours and care in the community. I know from your statement that you are working with some of the trusts and with community and voluntary organisations to promote the services so that people do not have to go into long-term residential care. It is a big issue, particularly in my area, where the hours have been cut. How can we help you to help those people who need that vital service?

Dr G O'Neill:

I can speak for Belfast. We chair the Belfast healthy ageing strategic partnership, and we work closely with the six older people's forums in Belfast. We had a standing item on the LCG called the third generation. We have a very vocal group that appears and makes its wishes clear. We have a good response from the officers of the board and the Public Health Agency who sit on the LCG, and we try to address the issues, such as home helps. One of the big issues is podiatry. If you want to make an old person independent and safe on their feet, cut their toenails. That issue came up locally, and we are trying to look at how we can address it. If you expand that, you can train local people to cut toenails and provide local employment. You can encourage the community.

Remember, we have a big resource in our communities that we do not use. Lots of health and social care is delivered by community and voluntary groups and charities. We tend to underestimate their value. In Belfast, we are unique in that we have very strong community groups, but we do not really use them to full effect. We try to give them a voice in the LCG and to support them. We have an interesting project starting in the west of the city, Healthy Hearts, which is financially supported by the LCG and the Public Health Agency. That project aims to target those deprived areas where there is an unacceptable percentage of premature deaths due to heart disease. Not a lot of money is involved, and the community is almost in assertive outreach mode in seeking out the individuals for whom, hopefully, the outcomes can be improved.

We also work closely with the Belfast Trust, and that is one of the big advantages of local commissioning groups. We see our role as bringing together those who provide health and social care. Madam Chairman, I heard you on television saying that everyone in hospitals, primary care and secondary care work in silos. Our job is to break down those walls and to focus on the patient and get a user's-eye view of what happens. The aim is to break down the walls so that everyone operates for the benefit of the person for whom we are trying to improve the outcome. That has been the greatest thing that has happened with the LCGs. You will not see anything brilliant, or flashing lights or some Pauline conversion, but we have conversations going on between primary care, community care and secondary care and the voluntary and charity sectors to look at whether there are different ways of doing things. I am sorry for going on for so long.

The Chairperson:

No, that is grand.

Mr Gardiner:

I congratulate Dr O'Neill, because that is the most commonsensical statement that I have heard in a long time.

Dr G O'Neill:

Can you speak to my wife?

Mr Gardiner:

It is brilliant.

The Chairperson:

Thank you for that, Sam.

Dr Brendan O'Hare (Western Local Commissioning Group):

I can possibly help Michaela, because I am the chair of the group in her area. It certainly is a challenge, and we believe that the funding shortfall that is needed to address all the need might be as much as £2·5 million. You may be aware that we launched a major prescribing initiative. It began in the Castlederg area and has now been rolled out throughout the west. Figures that we got this morning show that we have saved around £4 million on prescribing, two thirds of which will come back to us for investment through the LCG. The area that you highlighted will be one

of our priorities. Our community has flagged it up. Obviously, we cannot meet £2·5 million, but we can ensure that the threshold can come down a little bit and that the most needy will have their needs addressed adequately.

Ms Boyle:

I commend you for that.

Dr Brian Hunter (Northern Local Commissioning Group):

In the Northern Trust area, a pot of money called demography money is distributed across the population. It is made available every year and is designed to try to tailor needs to some of the changes that have taken place in the population's age profile. As an LCG, we have had the opportunity to direct some of that money. That is one area, and it is not only for carers of elderly people but for people with physical disability and impairments. We have gone from the stage where that was sent out centrally with a vague remit to the stage where it is done through the LCGs. The idea is that, as many of us are practising clinicians in the relevant areas, we are more in touch with the people who deliver the service, so we can determine the way in which that money flows. As an LCG, in discussion with the trust, we were able to channel the extra pot of money that is being distributed to where we saw a perceived need.

Mr Brady:

I apologise for missing the presentation; I had to go out and speak to students. This is a bit of a role reversal, because usually it is Dr O'Neill who asks me the questions, but that is another story.

We in Newry are lucky to have a strong voluntary sector. For instance, the volunteer bureau has a sitter service that gives respite to carers. That could probably be widened. We were talking about working in silos, and that area is cross-cutting. It applies not necessarily just to the elderly; it can apply to young people. For example, Home-Start can often help families with young children by preventing the worsening of mental illness, because mothers who suffer from particular conditions are given respite, for example. That is a very important point, but recognition through mainstream funding, and so on, is not always given to the voluntary sector. Perhaps that could be taken on board, and, from what you have said, I am sure that you have done that.

Dr G O'Neill:

I am very sympathetic to voluntary and community organisations and charities because of the way that they are funded. Their funding is non-recurrent, so they spend half the year chasing funds for the next year.

There is one very good example of an integrated service in Belfast for children and young people. It was funded initially from the Office of the First Minister and deputy First Minister (OFMDFM) and through the Department of Education, and, I cannot remember which, but one of the other government bodies is funding it now. You mentioned holistic treatment, so rather than send a child who is a problem to the statutory sector, I would refer them to this particular group.

The Chairperson:

What is that group called?

Dr G O'Neill:

It is the Integrated Services for Children and Young People. It is on the Shankill and in other parts of west Belfast. It is well funded, although I am not sure by how much. It deals with school problems. You talked about education, and this group deals with family problems, it helps the child, and it looks at any interactions with the justice system, and, if necessary, it refers on cases to statutory services. We were able to introduce the CAMHS consultants to that service.

This is another example of the right hand not knowing what the left hand is doing. We feel strongly about the need to join up these areas. It is about breaking down the barriers, not only in the health service but in various Departments. That is because many other people other than just the health service contribute to health and well-being. That is one thing that you, as the elected representatives, can drive forward by helping us to deliver the outcomes that we want.

The Chairperson:

Michelle McIlveen and I were at an event today in the Long Gallery today about Health in Mind. That is about the Department of Culture, Arts and Leisure (DCAL) and libraries working to help people's mental health. That is just one example of such work. You are right, however, that there is not nearly enough of it.

Mr Brady:

You mentioned joined-up government. I also sit on the Committee for Social Development, which takes the lead on neighbourhood renewal. Other Departments need to buy into that at a much greater extent to make it that much more effective. It is effective, but they could make it a lot more effective. That just illustrates your point.

Dr Hunter:

I should say, Chair, that, in your former guise as Minister of Agriculture, you bought into this well. We have been seen standing in fields and markets in different places.

The Chairperson:

I remember it Brian; it was teeming.

Dr Hunter:

The illustration that that gave is something that needs to be rolled out throughout the Assembly. Health is not the preserve solely of the Minister of Health. The cost of delivery and the concentration of expertise mean that some services have to be centred in a particular place. For example, there are transport difficulties around Kircubbin that we need to work with Roads Service to resolve. We cannot run a country with people looking after their own corner and not integrating.

The lead that you have given is reaping rewards, to mix a metaphor, because the Department of Agriculture and Rural Development (DARD) continues to have an interest in this. The work that I started with Yvonne Carson and you as the Agriculture Minister looks as though it will continue. I congratulate the Chair on that.

The Chairperson:

Thank you. We had a pot of money that we wanted to make the best impact with, and we ended up impacting over 100,000 people's lives. We negotiated the £10 million that we had in the first pot to £16 million the second time around, again recognising fuel poverty, rural transport and all the other issues that you are hearing about, such as access to benefits and services and the childcare scheme. However, the point is that we need to make sure that that happens.

When the Minister in the previous Executive was giving out about money that we were

spending in DCAL, I made the point that, if people are involved in sport, their mental as well as their physical health will improve. You will not need that money to build a new hospital; we can use it to keep people well. The aim was to get that point across. We can do so much more of that, but there are still too many silos.

It is very refreshing to hear this view from you. LCG comprises the entire remit of health professionals, and that is why your approach to this is miles better than that of many people we have heard from in the past. I appreciate that, and we are very keen that the focus be on wellness as opposed to illness.

Mr Dunne:

Thanks, Chairperson. I welcome the delegates. The meeting has been very informative. It is important that people like you talk to elected representatives. You are all very busy people, and we all recognise that. How do local commissioning groups influence and steer the trusts? That is probably one of your main objectives, and how you do that is important.

Mr McKeagney:

As Mickey will know, we in the southern area have a very close working relationship with the Southern Trust. We meet on a weekly basis to discuss problems and issues as they arise.

Mr Dunne:

Do you do that as the chairman?

Mr McKeagney:

Yes, with my assistant director. I am not at every weekly meeting, but I am there when I need to be.

The other area where we deal with the trust is under the performance management and service improvement (PMSI) unit in the Health and Social Care Board. We are part of the measurement of waiting times, quality of care and those types of matters, and we measure those and interact with the trust to try to solve those sorts of issues.

Mr Dunne:

Do you feel that you have a real influence with the trust?

Mr McKeagney:

Absolutely.

Dr G O'Neill:

In Belfast, we work closely with the Belfast Trust. You will have heard of primary care partnerships. Those are at a developmental stage and are well supported by the Belfast Trust.

I got a text message before I came in here from one of my colleagues who ran an ear, nose and throat (ENT) clinic in the Holywood Arches. That colleague is a GP with a special interest in that area, and he worked with the trust in running that clinic. He is one of the first to remove the need for people to go to hospital, with the result that they can be dealt with locally. I do not have all the details, but the clinic appears to have been a universal success, and we intend to roll that out in other areas. We will be very cautious and careful in doing so, and we will run pilot schemes before running them across Belfast. That is one aspect of what you can do when you work with the local communities, who want to have a say. We work closely with local pharmacists, GPs and our colleagues in secondary care.

Only when you get leadership from clinicians will you change the delivery of health and social care and improve the outcomes. It is crucial that you, as politicians, encourage that clinical leadership.

Dr N Campbell:

In the south-east area, our staff meet on a weekly, if not a daily, basis with the trust on various issues. The big issue in our area at the moment is obviously the accident and emergency departments. There is joined-up thinking between the two on the best way forward. We talked about demography money that came to us, and we had a big influence in how that will be spent in our area. The trust made proposals that we were not keen on, and we said that we wanted something different. We feel that we have the ability to change the direction of travel.

Mr Dunne:

So, you are influencing the decisions of the trust. That is good.

Unless other members may want to come in on that point, the Minister has launched the health

and social services care review. How do you feel you can influence and have a major input into that?

Dr Hunter:

The anticipation is that we, as LCG chairs, will be involved in it. There will be a consultation with us, as there should be, and there will also be input on a broader basis from GPs. Very often, the pivotal point for a patient is where they go from the initial contact with a GP or primary care services, so it would be beyond belief that the service would be shaped without that input. I think that the intent is that we will have an input.

Mr Dunne:

I think that it will be vital that you have an input. There is a very short time frame.

Dr G O'Neill:

A meeting has been arranged for the last Wednesday in the month at which the review team will meet with the LCG chairs.

Mr Dunne:

As a group?

Dr G O'Neill:

Yes; just the five of us.

Mr Dunne:

I hope that you will get the time to deliver what you have to deliver.

Dr G O'Neill:

I think that we will.

Dr Hunter:

Gordon, just to flick you back to the trust situation, I think that there is a healthy tension between us and the trusts. As GPs, we refer patients to trusts, but we are not beholden to them. You should not read anything into the fact that I am on my third chief executive. *[Laughter.]* That would not be indicative of the level of tension.

There is a respect for what the trusts are doing, and respect and credibility are given to us, because, as GPs, we are patient advocates and are aware of the delays and variations in access to care. Working in conjunction with the trusts, we are seeing changes in patient pathways into care. In the northern area, that is coming across in the work on A&E waiting times and waiting list initiatives. We are having those discussions, and we have the credibility, in a sense, because we are not office bound. We base our experience on clinical contacts.

Mr Wells:

Madam Chairman, my life is complete. I always wanted to meet David Healy and Brendan O'Hare, and I have now met both. *[Laughter.]* I wanted to meet Brendan O'Hare not because he scored 35 goals for Northern Ireland but because he caused a considerable stir in this Committee about nine months ago, and I think you know why. It was only when you mentioned Castlederg that I realised that it was the same Brendan O'Hare that we were dealing with. Brendan, you carried out a pilot project in the Castlederg area that saved £360,000 in five weeks.

Dr O'Hare:

To be absolutely clear about it, we instituted changes over a five-week period that resulted in an annual saving of £312,000.

Mr Wells:

It seemed too good to be true that you were saving that sort of money over five weeks.

Dr O'Hare:

Five weeks' work resulted in an annual saving.

Mr Wells:

Still, that caused a big stir in this Committee, because it was a rethinking of how you used prescription drugs and how you prescribed generally. Your being here today is too good an opportunity to miss, so will you tell the Committee a bit more about how you did that? Were you doing that in your capacity as chair of the local commissioning group or as a local GP?

Dr O'Hare:

I piloted it in my practice to see whether it was possible, with a view to rolling it out. We did it

by switching people directly from expensive branded drugs to generics, if they were available, moving them to other drugs that were similar and that had become generic and were much cheaper. We stopped giving out lots of stuff for which we felt there was no good reason to continue giving out, and we became much more focused. I have to say that that was not intended to deprive people of proper treatment in any way. I think that we are running an even safer service; we are so focused on medicines management that we have reduced even further any possibility that there may have been of drug interaction and side effects, and so forth.

We took our work and developed a project in which we managed to involve 54 out of the 58 practices in the west. This morning, we received our figures up to the end of June, which show that our spending is down to £195 a patient a year, which is lower than the spend in Wales. We are quite pleased with what we have done. Two thirds of that saving comes back to us, so working with our communities and our own public representatives, we will be able to prioritise and highlight areas where that money can go back in to meet need and support services.

Mr Wells:

The BBC obviously seized on your story and extrapolated that, if we could roll the scheme out throughout Northern Ireland, we could make savings of anything from £14 million to £30 million. Others said that you were starting from quite a high usage of non-generics and that, therefore, it was a false situation.

Dr O'Hare:

No. I hold my hands up; Dr O'Neill never fails to remind me that, as a practice, we were quite high prescribers. However, we were on the Northern Ireland average, and we got ourselves down. We are significantly below the Welsh level, but our area is down to the Welsh level.

Mr Wells:

So, if you roll out the Castlederg model throughout Northern Ireland, what are the potential savings without front line care being affected?

Dr O'Hare:

From where it was, I calculated it somewhere in the region of £40 million. It has come down a bit through a variety of initiatives that have started all over. Indeed, my colleagues are taking lessons on board from that, and we continue to push in all areas to bring costs down.

Mr Wells:

No disrespect to Castlederg; I have only been there twice in my life, and it is somewhere out west and really is very far away. The fact that the initiative could be successful in a rural, dispersed community such as Castlederg is quite remarkable. Clearly, that means that it can be rolled out in areas where it must be much easier to have a more realistic prescribing budget. Presumably, you have a lot of rural deprivation and a lot of need.

Dr O'Hare:

Yes, we have a very deprived community. It is interesting, however, that in the Strabane area, which is more deprived than ours, the practices have very low prescribing costs. Do not ask me why, but they do. It is not as simple as it looks, and there are probably historical and other reasons for that. We were an average practice, and we got down to a low level while maintaining and even improving the quality of patient care.

Mr Wells:

That is very interesting.

Dr G O'Neill:

I support Brendan on that. We can make improvements in prescribing. In Belfast, the lowest prescribers are mostly in the west of the city, despite the fact that it has the highest deprivation markers.

A word of caution: a single drug, among the whole range that the pharmaceutical industry is about to release that may have a significant influence on treatments that we have used for a long time, could wipe out any savings, unless we cautiously manage that drug's entry into the system. Therefore, we must be cautious not to run away with ourselves. Treatments will come in that will be of great benefit to our population, yet they may wipe out savings made in prescribing.

I will make another point — this is something that I am interested in. The cost of alcohol to our community is twice the drug budget. That is the sort of thing that we should focus on. It is important that we deal with the drug budget. However, we spend more on treating the damage caused by alcohol than we do on the family practitioner services, which include all GPs, opticians and pharmacists. We have to put things in perspective and to add the caution that drugs may

come along that could wipe out any savings almost overnight.

Mr Wells:

But that £40 million would go a long way towards meeting the shortfall that we have at the moment.

Dr G O'Neill:

Absolutely; I agree.

Dr Hunter:

There is another way that many of those savings can be affected. I have done work with the Patient and Client Council. I have brought copies, which I can leave with you, of a presentation that I made to the council just last week. GPs in the Northern Local Commissioning Group were asked to complete a questionnaire on issues such as whether generic substitution should be done automatically, with patients who wish to do so paying the difference to have a branded product, and whether that should be done at pharmacy level.

An argument can be made that that approach would enhance patient choice. If we simply give everyone generic products, some may, for some reason, prefer a branded product, even though its constituent agents are proven to be the same. At the minute, my patients do not have that choice. So, I will have to switch to the use of a branded product at additional cost, or I can dig my heels in and tell my patients that it is generic and they can take it or leave it. If we were to bring about a situation in which generic drugs were automatically covered by the cost of the prescription but a patient was free to pay the additional cost of a branded product, we would make considerable savings. The response received to the Patient and Client Council's questionnaire was that there was a general agreement to put some sort of charge on prescriptions again. The Minister has alluded to that fact. It would be seen as a handling charge, not a cost-of-drugs charge.

Those are other issues that the Committee would do well to look at. George is absolutely right: some of the drugs that will come out within the next year have the potential to wipe out savings. If we build something into the system to take certain drugs that can be bought over the counter off prescription entirely, their use becomes a matter of personal choice and does not add to the drugs cost. Such products may include cod liver oils, glucosamine and so on. Those are all things that I cannot do as a GP or a commissioner. They must be dealt with at a political level

and through the Department. So, there is a button on that.

Dr N Campbell:

I want to make the point to Jim that deprivation and high costs do not necessarily go together. I reside over the area that has the highest prescribing cost of the LCGs. That is partly to do with the fact that it is a retirement area. North Down and Ards has a very high prescribing cost, yet it is an affluent area. That is because there are a lot of nursing homes in the area and many patients with multiple morbidities, a lot of chronic diseases with associated drug costs that inflate our prescribing cost. Conversely, high deprivation often has a low prescribing cost.

Mr McKeagney:

It would be remiss of me not to make some comment on prescribing. I am the chairman of the lowest prescribing LCG area. The issue is about making the appropriate, safe choice of medication, which may or may not be the generic product. We must ensure that we pick the right drug at the right time for that particular patient. I am most interested in getting to where that originates — does it come from primary care or secondary care? Sometimes, the more expensive drug is the best choice. However, we need to be careful about how we do it, when we do it and which drug we choose.

We have noticed a change in the frequency of people getting prescriptions. For some reason, people in this part of the world get lots of prescriptions, and there is a higher frequency of people getting prescriptions here than in Scotland, Wales and England. We have to get to the bottom of that. Why is it happening? Whatever the reason may be — the noise in the system or whatever — there has been an unexplained downward trend in the cost and frequency of prescriptions over the past three to four months. We do not quite know why that it is. We are obviously watching it very closely. It is a good sign, so we hope that it will not be reversed any time soon.

The Chairperson:

OK. Thanks, Sheelin. On the subject of generics, I talked to my GP, who is in Sheelin's local commissioning group area — my constituency takes in Brendan's area as well — about the issue of people in hospital being put on a course of treatment even though there is a generic alternative. The Castlederg model was a great example. However, it is not just GPs who are responsible for prescribing generics. Hospital consultants have a role to play. My GP said that, if somebody is put on a generic drug after being on a branded one, they have to have a counselling session to

explain to them the reason why they have been put on the generic drug and the fact that it is exactly the same as the branded one. That takes time and costs money. I made the point that that would not happen if people were put on generics in hospital as opposed to being stuck on whatever is handiest. I have become so cynical is this job, because I have heard about the perks and all the rest of it from drugs companies. I do wonder why people are put on branded drugs when there is a generic alternative. It needs to happen in hospitals as well. It is not a panacea that only GPs or pharmacists can provide.

Dr G O'Neill:

It goes back to the idea that everyone works together towards the same aim of improving outcomes for patients in secondary care and primary care and in the community with local pharmacists.

Mr McCallister:

On the issue of prescribing, what are your thoughts on how to make sure that patients are managing their medicines? How do you ensure that they are not trying to stretch out a course of medication or that they do not have a small pharmacy in their kitchen cupboard? All of those issues contribute greatly to the whole pharmacy bill. As George rightly said, the primary focus in all of this should be the outcome for the patient.

Mr McKeagney:

Absolutely.

Mr McCallister:

I know that you have a very special interest in and knowledge of how to manage that.

Mr McKeagney:

A number of things can be done, one of which is medication reviews with patients, whereby you sit down with them every period of months — six months to a year — and review what is required. What tends to happen as patients move through different pathways is that different clinicians add different things at different times. Patients who have diabetes, for example, may have other diseases as well. With the best will in the world, certain drugs will not work with other drugs or will interfere with them. Sometimes, a rational look in the cold light of day at what medications people are on can make significant savings and significant improvements to a

patient's health, by removing side effects, for example. So, it is worthwhile somebody's sitting down to do that. Obviously, pharmacists, practice nurses and GPs do that. It is entirely appropriate that that is done, because it improves safety, quality and outcomes for patients, which really is what it is all about.

Dr G O'Neill:

The evidence is clear: the more drugs you prescribe, the less likely patients are to take them. Some of the reports show that about only 50% of drugs are taken appropriately and effectively. You will probably get about 80% compliance or concordance, as it is called now, for one drug. We are all like that. Do we all take our antibiotics? Do we all take our medication as we should? We tend to forget. Sometimes it is difficult.

I suggest that there is a major role for community pharmacists to play, because they have contact with patients. They can have that discussion with them. They also have information about whether somebody is on 10, 15 or 20 drugs — there are people who take that amount because they have a lot of co-morbidities. Can you rationalise those drugs and make it easier for the patient to remember to take their medication? There is also a possible role for telemedicine in helping to remind people to take their drugs.

Mr McCallister:

Do you see yourselves playing a massive role in driving some of the less exciting areas? We react very quickly to issues involving hospitals and secondary care. We had a discussion earlier about meals on wheels. I always have a concern when the pressure is really on what may be described as the softer services. Suddenly, a physiotherapist is not replaced and somebody is not getting that treatment. George quite rightly said that someone getting their toenails cut can have a huge impact. We may not think that, but it may be the case for someone at a certain age. How do you drive that? Can you have real teeth with the trusts without having money to follow that up?

Dr Hunter:

That is a valid point. You are right: a lot of what lubricates change is money, even with regard to bridging funding to move through a transition. Looking at the financial situation we are in now, either you say it is hopeless or you see opportunity. We are doing what we are doing in addition to our clinical responsibilities because we are in the half-full rather than half-empty mode. We feel an obligation to try to do the best with what is available.

The big message that we want to get out is that you cannot spend the same money twice. So, we have to be in a shrewd relationship with the trusts in making requests that are deliverable and measuring things that are important to measure. There is a perception that if you measure something, it will get done, and if you do not measure it, it will slip away. We have been caught in the past with the waiting time for first appointments being prioritised but review appointments slipping. A review appointment can be every bit as important as that initial appointment.

We need to be careful that we are not patching something up here but taking the patch off somewhere else to do that. That is why we need to be working together. I cannot deliver this as a local commissioner. You cannot deliver it in isolation either.

Mr McCallister:

Are you more trusted on the ground locally? There is always the issue of the trust saying something or something going out to consultation and it is a done deal beforehand. Nigel will know about changes to A&E at Downe Hospital. Is there more trust because you have that local connection? All of you work in the local areas and listen to patients all the time.

Dr N Campbell:

Yes, absolutely. Sixty per cent of the health service spend is in the community, not in secondary care, yet I am sure that the focus around your table most of the time is on secondary care. All those softer issues that you talk about are important to us because they are important to our patients. For example, we had a team of people go round giving new slippers to older folk in Newcastle. That seems a simple thing to do, but it prevents falls. It is that shift left agenda; let us prevent people from having fractured hips instead of them walking about in slippers that are three sizes too big. We want to keep the focus on those softer things such as meals on wheels and care in the community.

Michaela asked what you could do to help us with that. One thing is to keep the focus on local needs and those softer community needs and not always to be dealing with the high-item tickets, particularly in secondary care.

Mr McCallister:

The Chair has mentioned, and I think that her predecessor mentioned, that we spend an inordinate

amount of time on secondary care and not enough on primary care.

Dr G O'Neill:

Remember, 95% of health and social care is delivered in primary and community care, not on the acute site. I will give you examples of what we are talking about. We are looking at the amount of money that all agencies put into Mount Vernon estate, a small, loyalist estate off the Shore Road. The figure that we got up to was about £4 million. We are going to start working with the Belfast Trust first, and the local community, to see whether they could deliver the services better to the same quality and use local people to do that.

The trust has taken that on board and has accepted that. If that is successful, you can move it on to things such as cutting the grass. The Housing Executive has a contract for cutting the grass. Why could that not be done locally? The painting and redecorating and the maintenance of the buildings are other things for which you can move forward to use the local community and the funding that is going in to try to deliver better outcomes for the people who live there.

One resident said to me that the Housing Executive had improved everything — there were new windows and doors and everything had been repainted — but they still have the same problems. That really struck me. People are still dying prematurely, there are still alcohol and drug problems, and there are still difficulties with suicide and mental health. We have not addressed that, and maybe this is a different way of looking at things.

Mr McCallister:

If somebody comes in and does it, there is no building of civic pride, responsibility or sense of community in those areas.

Dr G O'Neill:

Giving people ownership empowers them to improve their environment and community. It is better if it is led by leaders in the community.

Mr Durkan:

I will pick up on that local aspect. How much autonomy do the LCGs have? How much of what you do is dictated to or bound by departmental — sorry, ministerial — objectives?

Dr O'Hare:

It is fair to say that priorities for action come down and that determines the direction of travel for the entire health service. One of our roles is to bring issues up and to ensure that they feature in planning and, indeed, in priorities for action. We have an opportunity to do that. Also, we ensure that they are expressed in a way that is appropriate for our locality. An example is the provision of palliative care services 24 hours a day. If you have five patients in west Belfast, that is easy to do because they live within a mile of each other. I might have three patients who are 35 miles apart. That is a much greater challenge. Therefore, we will deal with it differently. Our role is to ensure that those sorts of initiatives are appropriately developed.

We are living in tough times. There is no getting away from that. When the LCG concept was developed, it was in a time of growth of 4% a year. We would have done our needs assessment, taken the new money and applied it to the areas that we felt were most appropriate. Those days are over. We have to make the best of what we have. I believe that we can be very effective in ensuring that resources are targeted where need is greatest.

Mr Durkan:

The timing of the conception of LCGs was unfortunate. I thought that the "C" might have changed from standing for "commissioning" to "cuts".

The Chairperson:

Well, you could look at it another way. The timing will maybe help some of the most vulnerable people from falling off the edge and being forgotten. I am a glass-half-full kind of girl.

We have met a number of groups over the past lot of weeks. I have eight questions. I will ask them all in a row. Will someone answer each question? Is that OK? My first question is on priorities for action and how they have changed since the beginning of the new mandate. Has a change of direction filtered down from the new Minister yet?

We heard a lot about self-referral and early intervention from public health professionals; for example, that people should not have to wait and necessarily go through their GP for podiatry or physiotherapy when they know what the issues are and could refer themselves. Your opinions on that would be helpful.

Yesterday, I spoke at a carers' conference. They said that the lack of consistency in approach was frustrating them. I made the point that where there is inconsistency and we try to have uniformity, everyone must come up to the gold standard as opposed to coming down to the bottom rung. Carers still feel undervalued. They know that society could never afford to pay for the work that they do. It would be interesting to hear your views on that. Sheelin, I know that your area probably has more domiciliary care packages than others. I welcome that and support the trust in that decision. However, we understand the difficulties. It would be good to hear how you work with the trusts on that.

Another area is the demand for emergency care. Again, I sympathise with the Minister because of the amount of pressure that is on A&E departments. It is the issue that makes headlines. You are all health professionals. Is there not a better route for people into hospital than to be sitting in triage in accident and emergency, creating trolley waits and all the rest of it? Is there a better way to do it?

You mentioned the rural transport issue. I met a group of people from Fermanagh who have eyesight problems, visual impairment and blindness. They used to go to Belfast for injections, and they could get the bus. When the service shifted to Altnagelvin Area Hospital, suddenly, they could not travel by themselves any more. They had to ask friends or neighbours to take them. That took away some of their independence. Are decisions made on a holistic basis? I think that I know the answer to that. If decisions are not made on a holistic basis, why is that? There is a clear example of a blind person who can get a bus to Belfast City Hospital but cannot go to Altnagelvin because there are no bus routes.

We heard from the Alzheimer's Society last week, and it said that Belfast has the highest rate of referrals to the society for help, but it has the lowest rate of buying that service and contributing to it. Can there not be a better way of ensuring that the areas that are big users of the service also pay for it?

I recognise that, out of a membership of 17, one member of your group is an allied health professional. Is one enough? They cover such a wide range of therapies. Are we getting enough from that side of the house on the LCG?

Lastly, I got an e-mail today to say that a constituent had been told by their GP that they

would now have to pay a fee of £10 for their prescription to be boxed up. Is that something that you are aware of? I suspect that that may be in response to the cuts that we are not allowed to talk about. If that is the case, that is not good enough, and it is not fair.

I know that that is an awful lot to throw at you at this time of the evening, but I am afraid that we might lose our quorum.

Mr McKeagney:

You mentioned the Southern Trust's provision of domiciliary care. We have invested very heavily in older people and those with physical disability and sensory impairment who need additional help in their homes. Very deliberately, if we can keep people well and keep them able in their homes, we will have fewer people stuck in our hospitals, and that then allows us to get more people through the front door. For example, the A&E unit in Craigavon has the lowest waits of anywhere across departments. Keeping the hospital clear of people is a very deliberate ploy to keep the whole system moving. So, we get them out and keep them well. We try very intensively to get people back into their homes, to get them active and to keep them active for all that time. Therefore, that is a very specific and determined thing that we do. That then feeds into our emergency departments, as we now call them, and keeping them free of people because people can get on to the wards again. It is all part of the same pressures.

I will deal very briefly with the boxing of prescriptions, in as much as I am allowed to speak about it. There is a contractual dispute at the moment. It is a process that was never commissioned or paid for. It was done very much as part of an additional service provided by community pharmacists. It has never been described as a service paid for by the health service. I think that a number of people are struggling at the moment and see it as one way of reducing costs. The terrible thing is that, in many ways, very vulnerable people are being discommoded or hurt by it. A cynic might say that it is a deliberate ploy, but it is not. It is seen as something that is not currently being paid for, and, unfortunately, in times of stricture, that is the first thing to be cut. Does that answer your question?

The Chairperson:

Yes, it does. I accept that we cannot talk about the cuts with the judicial review pending, but if that is how community pharmacists deal with the cuts, that is an issue that the Minister has to take up. I said to him yesterday about pharmacies closing as a result of it, but that is not the way to fix

it.

Mr McKeagney:

No, for sure. I absolutely agree with you on that.

The Chairperson:

I recognise the amount of work that community pharmacists do that they are not paid for and the goodwill that exists. It is about providing a service to their community. I recognise that and am a big user of community pharmacy.

Dr G O'Neill:

I will answer the carers question in relation to Belfast. There are 11,000 carers in Belfast, who provide about 50 hours a week of essential care, in partnership with the health and social care services, to look after our population. We could not do without them. We undervalue them, we do not appreciate them, and we need to develop better ways of supporting them. It is one of the ways of keeping people out of emergency departments. However, if you look at the figures, you see that about 700,000 people attend our emergency departments every year. Eight and a half million people go through our GP surgeries every year, and lots of those people also consider themselves to be emergencies.

So, we should look at the whole picture. We should also look at what happens to the people who go to emergency departments. I am very optimistic that what is happening in Belfast will improve the outcomes for our patients, reduce trolley waits and ensure that elderly people are not in inappropriate circumstances in accident and emergency departments, where they should not be, because of the circumstances of other people in those departments. I think that you are aware of what I am talking about.

Dr O'Hare:

I will add to the A&E point because I have done a reasonable amount of work on how we might improve the service. In a lot of rural primary care surgeries, GPs will suture people and their staff will treat burns and so on. They are as busy as any other practices, yet you quite often find that the practices near an A&E do not offer those services. That could be addressed.

I spent time working in the A&E in Altnagelvin and looked at the case mix that came in and

how the department dealt with it. I personally dealt with a lot of patients. There is a perception that everybody who goes to A&E is an accident or an emergency. That is far from the truth. The vast majority are neither. It would be far better and more efficient for experienced general practitioners, rather than junior doctors who have one or two years' experience, to deal with those people. One potential solution is proper co-location with a single point of triage. When people present, they are classified as either GP out-of-hours service or A&E. You will find that GPs at a GP out-of-hours service will assess and treat people with the minimum of investigations and do it much more quickly and efficiently than in the A&E. The total attendance in Belfast in a day at all the A&Es is around 400 people.

Dr G O'Neill:

That is the average figure. Sometimes it is less, and sometimes it is greater. Of those 400, about 100 require admission to the three A&E departments. Of those who are admitted, 36% are discharged after one day. I have spent time on both sides of the curtain, with the staff and with the people in the waiting room. Everyone there considers themselves to be an emergency, and we cannot be patronising and pejorative about that. We have to develop a different way of dealing with the angst that people feel that makes them go to an A&E department. In my experience, people do not go there out of choice. Brendan's example is one way of doing it.

Dr Hunter:

We are working at pathways into secondary care. For example, bleeding in early pregnancy is not appropriately managed in A&E. It is a difficult situation that can be painful and emotionally fraught. So, we have looked at a way in which those women can be taken through in a faster and more appropriate way to take them out of the normal A&E situation. In Antrim, we have looked at ways to deal more effectively and efficiently with people who are suspected to have deep vein thrombosis. Again, we take them out of the main stream entrance to A&E. We are looking at a route whereby people with suspected cardiac chest pain could go directly for a cardiological assessment with someone who has a level of training that is perhaps greater than that of the initial clinician contact in an A&E department. So, those things are ongoing.

In many ways, we are nearly reinventing a previous wheel because, when I was a junior doctor, as a houseman, I was accepting GP admissions straight to a bed. We got to a stage where we could not offer that any longer, and we set up what was, in essence, a Belfast model where what was on take was the A&E department and everything went through A&E. We have, in a

sense, been trying to reclaim what happened previously for patients. I have had discussions with chemotherapy patients who, although they see the sense in avoiding crowds and potential sources of infection, are being filtered through an A&E department. So, there are streams that are taking people out of A&E, and we, as LCG clinicians, and the GPs who are working as clinical leads in the subgroups are looking at better ways of doing it.

The Chairperson:

We would welcome that and support you in doing it.

Dr G O'Neill:

We are also working with the secondary care clinicians. In Belfast, if you have significant chest pain, for example, you will be in the catheterisation lab within two hours. That is all down to clinical leadership from the cardiologist who took that on to provide a 24/7 service. That is a major sea change in how we deal with chest pains, and it should be rolled out across the Province.

Dr Hunter:

We may be flitting about and not answering some of your questions.

The Chairperson:

This is the beginning of an engagement with you and not the end, so, even if we do not get answers now, this has been a very helpful and useful session. We want to work with you to see how we can help to influence and shape matters. We recognise that these are very financially constrained times, but there are better ways of spending the money that is available so that we get better outcomes. The questions on priorities for action (PFA) and on the direction that is to be taken in the new mandate are of interest. I have heard the Minister talk about preventative care, and that sounds good, but the focus from the Department still seems to be that it will not take that direction. It will be interesting to see whether that has filtered down to your level. That sounds very patronising, but I do not mean it to be.

Dr Hunter:

I detect that, to be sure that we all get home on the same day that we left this morning, none of us wants to talk about PFA. There is nothing in the priorities for action that we do not support. It is important to get the message out that some of them are not deliverable simply through the Health Department but have to be bought in to by other Departments. Issues such as unplanned

pregnancy among young women and alcohol abuse have to be seen as an Assembly-wide responsibility and not simply as a priority for the health service. There is a role for the Department of Education and nearly every other Department. For example, that might involve introducing a minimum price for each unit of alcohol. Other areas cannot wash their hands of such issues.

If you were to put the 'Priorities for Action' document in front of a bunch of GPs, they would laugh at some of it, because they would say that, although some of the priorities are laudable, they do not have the tools to deliver them. They would say that minimum pricing needs to be sorted out a political level and that it is not the GPs who will go to the local off-licence and ask it to put up the unit cost of alcohol. That has to come from this House.

Dr G O'Neill:

One of the good things about the LCG system is that local politicians sit on the LCGs and support us. From our point of view, that is very helpful. They really can help us to deliver what we want, and it is powerful to go along with a local politician when you are dealing with anyone else in the health and social care family.

Dr N Campbell:

I will cover the question on AHPs. We have 17 members on our LCG boards, and it would make the boards very unwieldy if all the AHPs were represented. My experience is that they work well together as a group, so the representative who sits on my group will take back issues to the other AHPs where those matters are relevant. Through them, we get the opinions of the other professions. I hope that that is enough, in that we have access to other opinion, but we have only one AHP representative, as you say.

Dr G O'Neill:

I reinforce that. Our allied health professional is the one who is most sought after by the public at our public meetings, and that is the person who is grilled about changes that happen throughout the community service.

Mr McKeagney:

The LCG is a body corporate, and everyone around the table has an equal voice. When you are there, you are a member of the LCG; you do not represent a constituency behind you. You bring

your expertise to the table, and we are all equal. It would be wrong to feel that anyone is underrepresented, because it is not like that.

The Chairperson:

They did not say that, but there are 11 or 12 codes under that umbrella, so cognisance of a wide range of areas has to be taken.

Dr Hunter:

If there were a need for a particular opinion on, for example, occupational therapy, there would be nothing to prevent us from contacting someone or giving the AHP who is on the LCG the opportunity to open the discussion and bring someone else in. It is flexible enough to do that.

Ms P Bradley:

The plus is that there are two social workers in each group.

The Chairperson:

You get your spake in.

Kieran was very keen on the idea of music therapy. He will not mind me saying this, but his daughter benefited from it, so when the Department pulled the service, he was very vexed. He saw the value of the service and felt that it had not been taken seriously enough. When it comes to the commissioning of those kinds of services, if you are not getting the feedback from user groups, it is no wonder that they are cut. We wrote to the Department to try to persuade it to reinstate the service, but to no avail.

Dr N Campbell:

I am pleased that Kieran has been to see the facility in Lisburn, which is excellent, as he said himself. We want to put the same facility that his daughter attends in the locality.

Mr Brady:

There are gaps. In Daisy Hill, there is a very good mental health day facility with cognitive behavioural therapy, which I think is recognised as being one of the better ways of dealing with depression. So, there are gaps that, if filled, could help prevent longer-term stays in hospital.

One of the statistics that we have is that people living in Belfast city centre have a life expectancy that is eight years less than that for those who live south Belfast. You made the point about areas of deprivation having lower prescription rates. So, the problem is not necessarily about medication; it seems to be about lifestyle. Sometimes, you feel that there is not enough education. Obviously, we have welfare reform coming, so people may not be able to afford fresh food and fruit, but education is something that needs to be looked at.

Dr G O'Neill:

The headline figure is five or six years difference in life expectancy. However, not everyone living in those deprived areas is in difficulty. A sufficiently high percentage of people in those areas die very prematurely — 20 years early — and that is usually due to lifestyle. Those deaths are preventable and are related to the deprived background and the low economic status that those people have, which reduces the average age of life expectancy of the whole population in their areas by about five or six years. That is the gross inequality. I am interested in life inequalities, not just health inequalities.

Mr Brady:

Life expectancy is also affected by the way that people have historically lived their lives when it comes to alcohol and the type of food they eat. It is not necessarily all about money; it is about people not looking after themselves. Doctors can advise, but they cannot impose what you would like them to. That is the difference.

Mr McKeagney:

Unfortunately, although people are living longer on average, the gap between the haves and the have-nots is not getting any smaller. It should be, but it is not.

The Chairperson:

It is ironic that, 10 years ago, the budget was half what it is now, yet the outcomes are not much better.

Dr G O'Neill:

In absolute terms, everybody is living longer. In relative terms, the well off go one way and those who are not so well off go the other way.

The Chairperson:

Lads, I very much appreciate your evidence. I hope that you do not feel that we are getting you up here for an interrogation. This has been a useful exchange of views. If you keep us in mind, we may bring you back up for an informal session, perhaps one morning, to talk out some of the issues that have come to our table.

Obviously, we will be seeing you in various different places. I do not know whether you spend much time around Pomeroy, but no doubt we will bump into you in other places. Thanks a million for taking the time out of your busy schedules to come up today and engage with us.

Dr G O'Neill:

Thank you for listening to us.