## Committee for Health, Social Services and Public Safety

# OFFICIAL REPORT (Hansard)

## Health and Social Care Review

1 February 2012

NORTHERN IRELAND ASSEMBLY

# Committee for Health, Social Services and Public Safety

## Health and Social Care Review

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**Members present for all or part of the proceedings:**
Ms Michelle Gildernew (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Paula Bradley
Mr Mickey Brady
Mr Gordon Dunne
Mr Mark H Durkan
Ms Pam Lewis
Mr Kieran McCarthy
Ms Sue Ramsey

**Witnesses:**

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|---|---|
| Dr Stephen Austin | British Medical Association |
| Dr Tom Black | British Medical Association |
| Professor Scott Brown | Royal College of General Practitioners |
| Dr David Johnston | Royal College of General Practitioners |

**The Chairperson:** We now have an evidence session on the health and social care review with the Royal College of General Practitioners (RCGP) and the British Medical Association (BMA). We have Dr Stephen Austin, the chair of the BMA's consultant committee; Tom Black, the chair of the BMA's GP committee; Professor Scott Brown, the chair of the RCGP council; and Dr David Johnston, an executive member of the council. Do you want to fire away with the presentation, Scott? Fáilte romhaibh. You are all very welcome; it is good to see you again. Please make your presentation, and I will then invite questions from members.

**Professor Scott Brown (Royal College of General Practitioners):** Thanks very much, Chair. We are delighted to be here this afternoon. We consider this to be a very important session of the Committee. I will speak briefly about the college. We want to leave as much time as possible for questions. I hope that our briefing paper provided some information on the college's background. In essence, over 80% of general practitioners in Northern Ireland are members of the college. The college is a pan-UK organisation. We also have a Republic of Ireland faculty, which is very active. We have very close professional working relationships with the Irish College of General Practitioners as well.

Our principal concern is about quality and standards in primary care and general practice in particular. In the 1960s and 1970s, the college was instrumental in setting up vocational training, as it then was.

That has become the standard specialty training now for all GPs. The membership of the Royal College of General Practitioners is the yardstick by which most postgraduates gain entry into practice.

We have been intimately involved in many professional areas and issues over the years. We produced the first practice formulary to encourage rational, cost-effective prescribing and improved quality for our patients. That booklet was taken up by the rest of our college and was used extensively throughout the UK, Ireland and elsewhere. Obviously, what we are looking at is not the past but the future. The college in Northern Ireland, along with our UK and Irish colleagues, welcomes the general thrust of the Compton report, but we are now concerned about how it will be implemented. Our members are keen to become involved in the discussions and outworking of them so that our patients can continue to get high quality care delivered by well educated, motivated and sympathetic general practitioners and other colleagues in our practices.

The report raises interesting issues about resources, premises space, the need for staff mixes and more staff, management skills and funds being made available to allow general practitioners and their other professional colleagues to think through and discuss with their patients what best suits their needs.

General practice is a very complex job. Some recent information has been published by the University of Glasgow showing the degree of multi-morbidity: by that I mean the number of co-existent diseases. As our senior citizens become more senior and we face problems throughout social care and medicine — primary or secondary care — among an ageing population, it is in one sense a great achievement by the medical profession but it causes a lot of problems. The research shows that a 70-year-old presenting with one disease entity is likely to have two or three others. Management of such patients is complex. A specialist in, say, cardiology, who has outreach nurses coming into primary care and looking after the cardiological problems will do the job extremely well. But how does he mix the evidence for, say, prescribing a particular cardiac drug that will conflict with the diabetes or chronic pulmonary disease that that patient has? The people best placed to synthesise all the information and take the best decision for the patients, in their own environment and knowing the family history, is the general practitioner.

Last week, there was the encouraging information that the death rate from coronary heart disease has gone down by about 50% since the 1960s or 1970s. My cardiological colleagues said that that was partly due to rapid access to stenting procedures; I think that is only a part of the story. Part of it definitely comes about as a result of more rapid access when consulting with general practitioners. It has also something to do with the quality and outcomes framework (QOF) system and the way in which those patients are monitored, which may not have been the case before the new contract came into being.

To summarise briefly and not to go on too long at this stage, the college in Northern Ireland is very keen to see a reasoned and sensible implementation plan for the Compton report: a plan that has been discussed with patients, who are the consumers, and led by doctors working in partnership with managers and other health professionals to provide high quality care for our patients that has, as far as possible, been individually tailored for them.

**The Chairperson:** Thanks, Scott. Tom or Stephen, do you want to add anything before we go into questions?

**Dr Stephen Austin (British Medical Association):** I will say a few words on behalf of the BMA. Obviously, we represent all the doctors in Northern Ireland. I represent consultants in particular, and Tom the general practitioners. I am the deputy chairman of our council and represent junior doctors and the staff grade and associate specialist (SAS) doctors in the Province in primary and secondary care.

In general, the BMA thinks that the principles of the review are to be welcomed, but there is still a bit of an issue as to how it works in practice. There is a relative lack of detail as to how those things might be implemented in practice. There is a lot of scope for doctors, in particular, to take a leadership role and try to drive forward the changes to enhance patient safety and improve quality of care. There is no point in changing unless we have an enhancement of care and quality for our

patients. In primary and secondary care, closer integration will be helpful for improving the care that patients get. It strikes us that having doctors at the front, leading in partnership with managers, is key to driving forward the changes. The whole idea of trying to direct doctors and tell them what to do does not seem to work in practice. It has not worked across the UK or in other countries. Getting doctors keenly involved in change is the key to driving it forward, as they can use their knowledge and skills for the benefit of patients. They are working at the coalface and they understand what patients need. We should loosen the shackles around doctors so that they can drive things forward. You need managers to work in partnership with them to do that. This is a real opportunity to drive things forward for patients.

**The Chairperson:** I will open it up to questions.

**Mr McCarthy:** Thanks for your presentation. I have two questions for the Royal College of General Practitioners and one for you, the British Medical Association. I will start with yours; it is probably the easy one. You mentioned in your briefing that:

*"LCGs should be replaced by voluntary consortia of professionals from primary care across all geographical areas."*

Will you comment on that proposal in more detail?

**Dr Black:** Our view of local commissioning groups is positive. Our general view of this document is positive. The key is to engage GPs. The shift is essentially from hospitals into primary care, and general practitioners take the bulk of that. GPs are already working with local commissioning groups. You will read in this document that we now call them integrated care partnership (ICPs) and primary care partnerships (PCPs) but, to be quite frank, I am not at all hung up on the terms or names. An integrated care partnership is a partnership in which we work commissioning from the ground up towards secondary care. GPs, nurses and our consultant colleagues all have a say, and, most importantly, the local population has a say. I am not wedded to an acronym, acrostic or anything of that manner.

I am sure that the Committee spends less time discussing general practice than secondary care. The reason for that is that GP quality and access in Northern Ireland is the best in the world; you can call me to account on that. From the point of view of GPs and my committee, the most important thing is to be careful not to take a lot of work out of hospitals, put it on top of general practice and destabilise it, because general practice is working. You will hear us use the word "parallel" a lot today. We need to bring in changes in parallel with general medical services, i.e. what GPs do. Kieran asked about the structure; I do not mind what you call it, but it should be a partnership and it should work.

**Mr McCarthy:** That is useful. I have a couple of questions for the GPs. You mention the need to substantially improve facilities at many GP practices and the need for additional staff. Will you give us more detail on what you think is needed and what priorities should be drawn to the Minister's attention? With reference to the lack of detail in the review of exactly how the federation model for GP practices will operate, what is the college's view of how best to run the system of federations to obtain the best outcomes for patients and professionals?

**Dr Black:** I will take the question on staff and pass the one on federations to my colleagues from the Royal College of General Practitioners. If we are going to shift work into general practice, we need capacity. At the moment, capacity is at its limit. Everybody looks at GPs, pushes work towards them and thinks that they can take more and more. There has been a very small increase in the general practitioner workforce over the last 20 years compared with the increase in the number of hospital doctors. That is OK; we are not necessarily asking for more GPs. Again, I would regard that as a destabilising influence in general practice, which is working well. We are looking at staff, premises and training.

You make a very good point. You cannot shift this work into primary care without the staff, premises and training to do it. We need to look very carefully at how we do it. We could do it through enhanced services and GPs with a special interest or through moving staff from hospitals into the community. As you know — I am preaching to the converted — a lot of this is about keeping patients away from

hospitals. Hospitals are very expensive; people end up in beds and you cannot get them out. I will pass the question about federations to the Royal College of General Practitioners.

**Professor Brown:** I will add to that before I ask my colleague to deal with federations. It is not just a matter of looking at what additional resources are needed; it is about looking at what is currently not working efficiently. The example that I will give is the district nursing set-up and the use of health visitors, which has all been changed quite recently, as I am sure you are aware. If I, as a practising GP, have a patient whom I see on a house call about one problem but who also needs a dressing done or some nursing procedure, I now have to phone a central number. I can no longer speak to my practice-designated district nurse, who probably knows the patient intimately and may well be able to call on the way past while doing some other work. I have to wait until I hear back from that person, who transmits the message to the district nurse. That is a very circuitous professional pathway, which is frustrating and highly inefficient. I want to say to the Minister: let us look at the existing resources. Certainly, there will be questions about other resources, but let us look at the existing ones and ask whether we are using them in the most efficient way for the patients. I will ask David Johnston to take the interesting question on federations.

**Dr David Johnston (Royal College of General Practitioners):** Thank you, Scott. "Federations" is an interesting word and is a notion that the RCGP floated some years ago. Essentially, it is about how practices work together. When we first responded to the local commissioning groups (LCG) consultation over four years ago, we made the point that federations should be voluntary, flexible and organic; in other words, they should be able to grow and take on whatever they feel able to. We also said that there needed to be a bottom-up approach to getting practices working together.

The essential idea, as you have probably gleaned from what I have said, is that there is no single model that fits all. The idea is to take the practices as the building blocks and then allow those practices to work together. That will be different in different areas.

The term "federation" has been applied in the Compton report as a larger thing that pulls together practices, maybe as part of a PCP or an ICP. That is certainly one model, but "federations" essentially means getting practices to work together. From our point of view, we are not particularly hung up on the structure of how that works; the key thing for us is getting practices to work together in a way that unleashes the undoubted enthusiasm and entrepreneurial skills that general practitioners bring to the health service.

GPs are not salaried in the same way as their colleagues in other parts of the health service. For that reason, they work in different ways and do so with their expanded teams. So, the idea of federations is to get the GPs working together across practices so that they can bring together their various talents and resources for the benefit of the patient. It remains to be seen what the best model will be, not just in Northern Ireland but in the different areas across Northern Ireland.

**Mr McCarthy:** That is fine, and GPs are supportive. However, a lot of people in the community might have already experienced difficulty in getting to their GP. They have to go into a reception and get a date and time. Are you convinced, and we hope you are if you are going down this road, that the GPs will be able to provide the service that you spoke of?

**The Chairperson:** Dates for appointments are given that might be two weeks or more later, Tom. You might need a fortnight's notice of when you are going to be sick such are the length of some of the waiting lists for appointments.

**Dr Black:** I will answer that. I know that the issue has exercised the Committee in the past, and I have prepared for the question.

In general practice in Northern Ireland, we provide 10·5 million consultations a year, which is 30% above the UK average and 100% to 200% above the Republic of Ireland average. We carry out 20 million tests and write 25 million prescriptions. That is what we provide, and it is way above what anybody else provides. I refer you to the Commonwealth Fund report — from Washington DC in America; it has nothing to do with the British Commonwealth — that was published in November 2011. That report shows that we have the best rate of same-day and next-day access in the world. In the

United Kingdom, 79% of patients get same-day or next-day access and, as I pointed out, our rates are better than the UK average. We have the lowest percentage of patients waiting six days or more, at 2%. Those are facts based on data and research.

Our out-of-hours access is the best in the world, our co-ordination of care is the best in the world, our medication reviews are the best in the world, our level of medication errors is the lowest in the world and our communication with patients is the best in the world. I will not bore you. Your point, Kieran, is that there are patients who have wants, demands and sometimes even needs that are not met on the same day or even the next day, yet we provide the best service by a mile; better than Germany, better than France and miles better than America. We still get that constant pressure, despite the fact that we provide 30% more consultations than England and 100% to 200% more than the Republic of Ireland, but we need more and more. There are on average six consultations per patient per year. That is an awful lot of consultations, yet you say to me that you want even more; my response is, is that based on want or need? Remember that the Republic of Ireland averages two — it is actually 1·7 or 1·8 — consultations per year compared with our six.

**Mr Wells:** They pay for it; that is the difference.

**Dr Black:** That is correct, but as taxpayers, we are all paying for our system. The Republic of Ireland does one third the number of consultations, and their morbidity and mortality figures are exactly the same as ours. What are we buying here? Do we want to buy more of it? That is your decision, and if you want to buy more of it, that is fine. At the moment, we are performing on 5·5% of your budget — that is what general practice gets — but we are providing 30% more consultations than the UK average. Do not start me about out-of-hours services. We provide 100% more, and in some areas of Northern Ireland, 300% more — pay attention, Mark — or 400% more. In other words, for that 5·5% of your budget, we are working way in excess of what you would expect. Do you want more, Kieran? That is for us to discuss.

**Professor Brown:** If a patient is standing at the reception desk and needs to see a doctor, our members would like to be able to say, "Have a seat; a doctor will see you in a few minutes." However, the reality in a service that is free at the point of access is that there has to be some form of sifting to identify those who have a real and urgent need against those whose need might wait for a little longer. We are suggesting that what is proposed in the Compton report provides the scope for a mechanism that will allow GPs in a community to decide what is the most effective way to deal with the local population in order to get patients through quickly and decide who needs to be referred on to an appointment immediately that day. Perhaps that will be through GP federations, which are applicable to not only urban settings but the countryside, and are rural-proofed as well. We are the first to accept that there is a perception problem, but, as Tom said, despite that, a lot of work is ongoing. Our concern in the wake of the Compton report is that more of the work may be moved into primary care, which will make things more problematic for patients.

**Mr McCarthy:** That is exactly my worry. Thank you for that rather lengthy answer. I have the greatest admiration for the work that GPs and all the medical professionals do, and long may that continue. Still, as a public representative —

**The Chairperson:** Kieran, we have a lot of business to get through, and we are on a tight schedule.

**Mr McCarthy:** A lot of people find it difficult to get seen.

**Dr Black:** I know. Point taken.

**Mr Wells:** It is interesting that there are 353 GP practices in Northern Ireland, which are to be brought together into what will be called integrated care partnerships. You will say that there is already a fair bit of co-operation using that model, but it will now be formalised. I know that in my area there are some GPs who will not take part in that kind of arrangement because of the personalities involved. With those 17 partnerships being enforced, do you see a problem arising in that some GPs may be unwilling to take part? What are the implications of that?

**Professor Brown:** I am interested to know what is your definition of a personality problem.

**Mr Wells:** They have just fallen out.

**Professor Brown:** Well, yes. *[Laughter.]*

The reality is that the majority of GPs are not engaging because they think that the partnerships are ineffectual. They feel that no one is listening to what they say is needed in their area, that it is not immediate enough and that there is no real listening if ideas that are expressed are not accepted. That is perfectly acceptable. There is no feedback to say, "We are not doing this for the following reasons." They feel impotent, and they see no point in spending their precious time out of the practice when they could be doing other things that will definitely help patients, such as meeting demand or setting up new appointments. You have to make decisions about where the time is most appropriately and productively spent.

One of our hopes with the new report is that the integrated care partnerships will actually be more effective in their relationships with the local commissioning groups than their predecessors have been.

**Dr Johnston:** Mr Wells, I do not share your concerns, for two reasons. First, when GP out-of-hours organisations came into being, it was the first time that GPs actually started to work together across practice boundaries some years ago, and those fears were raised. However, when the conditions were right, the GPs did come together, worked very well together, and most of them admitted that they quite liked it. Secondly, I was involved in the Antrim and Ballymena commissioning pilot some years ago. That brought together practices that had previously been fundholding, practices that were non-fundholding and practices from a range of backgrounds. The interchange of ideas and the work that was done there were really very beneficial, and I think the GPs mourned the loss of those initiatives when they ceased. If the conditions are right and the GPs see an opportunity to achieve things for their patients, they will be there.

**Mr Wells:** You have been quite mild on the issue of accident and emergency hospitals. The report is clearly sending out a signal that we are going to go from the present 10 to perhaps seven. One of those will probably be a single hospital in Belfast on three sites, so we are down to two potential losses there. You operate in one of those areas, Dr Brown. I am surprised that you have not said anything particularly strong on that. Do you feel that, if we go down to the seven A&E model, we can continue to deliver an effective service for the people?

**Professor Brown:** I do not think that is what we said. What we said is that we want to see what is being proposed. If the proposal was to close the A&E unit in my practice area in Coleraine, for example, I and my colleagues in the college and all the local GPs would have a lot of things to say. We would want to know what would happen if there is another pandemic, and where the sick patients who formerly went to Coleraine hospital and were in the wards and the corridors were going to go. It might be difficult getting them into Antrim in the current climate. I would want to know where the procedures that are normally carried out in that hospital would take place, what work would come into the locality and how I and my colleagues would carry out some of the work that we would be happy to undertake, provided that we had staff and premises that are suitable for that. We were non-committal rather than accepting of the proposal. I want the Committee to be absolutely clear that we are not in any way suggesting that we are for the closure of any acute hospital, district general hospital or A&E unit, but we feel that there need to be discussions between that hospital and the other hospitals on general practice and primary care if that is being contemplated. Above all, our patients will want to have a say on that as well.

**The Chairperson:** I know that you wanted to meet the review team, and you met John Compton on his own but you did not get to meet the team. A discussion with the other people on the panel would probably have helped.

**Professor Brown:** You are quite right, Chair, and you very kindly made that point to the media. Indeed, I was on the air shortly after you that day and backed you up on that. That is exactly what happened. We would perhaps have preferred to have had some of the conversations earlier, but we are more than keen to do it now.

**Mr Dunne:** I welcome the panel this afternoon. Would it be fair to say that the professional organisation that you represent got a fair hearing in relation to the Compton review? Did Compton give you the time, space and opportunity to have a fair hearing?

**Dr Austin:** Our view in the BMA is that, although we did have informal meetings with some members of the review team, there has not been sufficient consultation in the whole review. We felt that there should have been a slightly wider consultation on it. Although we put our views forward in the evidence sessions that we had, since the final report came out, we have not really had the opportunity to critique it properly and give our professional opinion on all aspects of it. Obviously, we are doing a bit of that today, and that is welcome, but we feel that there has been a bit of a consultation gap. We hope that any further implementation will involve a formal consultation again so that those views could be teased out and the way in which things work in implementation and practice will be taken into account. It is probably quite vital that we do that and that we take account of issues such as equity of access for patients, enhanced quality of care, excellent care and things like that. That is the key thing that we need to ensure, so the answer is yes and no.

**Mr Dunne:** Do you feel that you have quite a bit to input into how this will pan out?

**Dr Austin:** We certainly do. There has been quite a strong focus on primary care, but the implications for secondary care are obviously quite strong. It is very important that secondary care clinicians get an opportunity to see how things work better and how they might begin to work in different settings. Consultants may be holding clinics or doing outreach work for patients in the community. They may offer hospital services and treatments in the community with supervision by a consultant in partnership with GPs. That sort of thing needs to be teased out a lot more because, as I said, some of the detail is not there. As I just mentioned, there is an issue about potentially rationalising services in some way. The key, of course, is to improve the quality of services and to make sure that care that we have anywhere in Northern Ireland is excellent and not patchy.

**Mr Dunne:** I have a couple of other points. Your briefing notes mention four areas that you are willing to participate in. Two of them are fairly well covered. Reducing the costs associated with prescription drugs is a big issue. Is there still ground to be made up on that issue?

**Dr Black:** I will take that, Gordon. I sat on the Hayes review, which was 10 or 11 years ago. I remember Sue giving a presentation in Belfast. You have not changed at all, Sue.

**Ms S Ramsey:** I may scrub that question I was going to ask about contracts.*[Laughter.]*

**Dr Black:** We spent the best part of a year producing a report. The key is the implementation. Maybe there was not the opportunity to implement it, although it was implemented to some extent. The report is fine; we now need to implement it.

To come on to your prescribing point, our target for the use of generics is 99%. I promise you that that will need to decrease because the latest generic bulletin says that we are going too far on generics and that we need to backtrack because a number of branded drugs are now cheaper than the generics. If you see us going backwards from our 99% target, do not be surprised. We will probably come back to about 95% and save more money. There is a real dynamic in prescribing. In other words, drugs come off patent every year. We hope that a couple of big targets this year will come off patent and will therefore cost the health service less. We work on that every year.

We are now close to the UK average for prescribing, which is difficult in Northern Ireland because of free prescriptions and the issues of access and so on that that raises. It is at the front of our agenda. I reassure you that huge strides have been taken in the past 18 months. The Northern Ireland formulary will be brought in, which will give us a formulary of drugs to work from. There are other things that the Minister has cooking in the background, some of which we may agree with and some we may not.

**Mr Dunne:** One other point was about the development of GPs with special interests. Do we have room for development in that regard?

**Professor Brown:** We certainly do. I will take that with GP education as a whole. Our college is endeavouring to extend the length of general practitioner training to five years to match most other speciality training. The interim objective is to make that four years. That will involve a considerable amount of discussion and resources. The Commission on Generalism reported recently. Two of the areas that were identified as being weak in most general practitioner training, taking it as an average, were mental health and child health. The RCGP is very keen to try to increase the postgraduate training of young doctors in those two areas.

There is a huge need for GPs with special interests (GPSIs). One of the big issues is the quality control for those practitioners. If a GPSI has an interest in, for example, dermatology, who determines that that GP who works in dermatology clinics is practising appropriately? It is not a dermatologist or a hospital specialist. I have spoken at length on several occasions to the doctor who is charged with looking at that issue. There is no current monitoring or ongoing training or supervision of those practitioners by a combined college body, the RCGP and the particular speciality college. There is a need for more of those individuals. There is certainly a lot that can be done in primary care environments with specialist dermatologists, specialists with an interest in ear, nose and throat (ENT), cardiology or urology. Somebody somewhere has to resource the ongoing training and professional development of the doctors. When revalidation comes in, we will face a real problem in deciding who revalidates and who decides whether their training is appropriate.

**The Chairperson:** I want to make a point before I let Mark in. My worry is that, if that is not being done, Scott, we will end up with a situation in a few years' time in which doctors make mistakes and patients suffer as a result. There are recent examples of when that has happened at a consultant level. You are flagging up that the monitoring and the ability for professional development and training is not there. That is fairly serious.

**Professor Brown:** The RCGP is in the process of finalising a document on that through London council that will, then, come out to the devolved councils. So we are working on it. However, it is likely that it will simply advise on the structures that need to be set up and hurdles that need to be jumped over in order to make any monitoring and educational system worthwhile. There will be advice. It certainly needs to be done, Chair.

**Mr Durkan:** I welcome the panel. A few of the questions that I wanted to raise have been covered. Basically, they related to the establishment or formation of the federations. Jim asked about politics. How have you crossed the bridge of politics with a small "p" in setting up federations, and resourcing — be it funding, premises, or human resources — that is required, not just for the establishment, but for the running of federations, PCPs or whatever? It is vital, particularly if we are talking about GPs who have a special interest, that they are properly resourced with the relevant apparatus to provide care in the primary setting, which is what we all aspire to. In order for that to be done properly, it has to be resourced.

One issue that has not been covered with regard to federations is how individual GP practices might preserve their own identity, so to speak, and ensure continuity of care, which is paramount to patients. Another issue is the enhanced role for Community Pharmacy that is envisaged in the Compton review. What do you think of that?

**Professor Brown:** I will ask David to deal with federations. I will then make a brief comment before I pass to you, Tom, on pharmacy issues.

**Dr Johnston:** We are not really clear what the document means with regard to federations. In the original document that the college produced some years ago, the idea was that it would flexible and that there would be different models. I am not sure what is envisaged in the document. As GPs, we would be very interested to see more detail.

I do not believe that anyone wants us to tell practices that we will break them down and make them into one super practice. The analogy that I would prefer to see is, perhaps, more like what farming colleagues do, whereby they, quite commonly, get together in what they call buyers' groups. Therefore, farmers work together. That does not mean that I would end up owning my neighbour's farm; we all work together, but we do so with common goals. That is what we want to try to achieve. However, it

needs a bottom-up, rather than a top-down, approach. My concern is that we will end up being instructed as to what they will look like and that that will be rolled out in the same way in Fermanagh as it is in Antrim or wherever. To my mind, that would not be helpful and would actually inhibit general practitioners from really achieving their optimum role in that.

**Professor Brown:** Before Tom speaks, I want to comment briefly on the pharmacy issue. I think that Mr Dunne's question was also about Community Pharmacy. We had a number of discussions with Norman Morrow and Joe Brogan at board level to really look more at how we could rationalise and make prescribing more effective. The role of the community pharmacist features strongly in that. One thing that we, as a college, would like to see put in place is a trial of community pharmacists being attached to practices. Certainly, in a GP federation, they could be attached and paid for out of savings that have been identified. I am not talking about a pharmacist who is involved in retail coming in on a sessional basis; it would be somebody with no axe to grind and no financial incentive at all who is there to look at effective prescribing.

Despite the increase in generic prescribing and the savings that have been made, the cost of statins and proton pump inhibitors for acid suppression and antidepressants is still huge in primary care. We want to employ a community pharmacist to look at repeat prescriptions for those patients who are on multiple drugs to see if they are safely being prescribed the correct ongoing medication and review all of that.

In my own practice and area, we have started looking at the prescribing of Pregablin, which is used for chronic pain. That is a very expensive drug and is very effective for some patients. However, we have already reduced costs significantly by reviewing its use for a lot of patients to see if it is worth continuing with it and if it is doing what it says on the tin. Often, it does not. That is a very specific answer to the question.

The other issue that we discussed was the prescribing of special preparations. When a doctor or GP writes a prescription for something that has not been formulated or made, it has to be made up as a special one-off. Those can be extremely expensive, and I am sure Tom will give you examples of them. We asked the board for data for the most commonly prescribed specials by GPs. We suggested writing to our members to say, "Here are the costly drugs that you may not realise are so expensive, and here is a cheap alternative." It was interesting that the board could not give us that data. It could not tell us how much specials were costing or give us a list of the drugs that we could advise members to consider prescribing in another format. So there are definite issues that a community pharmacist can help with in the practice and make the prescribing process cheaper, better and safer.

**Dr Black:** Pharmacists do a huge amount of work in Northern Ireland. You know what it is like in Derry: everybody has their GP and everybody has their pharmacist. You go to the pharmacist who knows you. They do an awful lot of good work, but they have skills and expertise that we are probably not using sufficiently, so they should be brought in.

Remember that there are three areas of care. I know you spend most of your time in hospital care, but there is also self-care, which is pharmacy over the counter, and there is general practice. Only a quarter of self-care comes into general practice. From GP to hospital care is 5%. So the end that you spend all your time on is the most acute and most serious, but it is 5% of our work, and our work is only a quarter of pharmacy work. So pharmacists do a huge amount of work.

However, I have a warning: the previous Administration brought in a minor ailments scheme in pharmacy. Where did that suck work from? They thought it would suck work from general practice and put it into self-care in the pharmacy, but it did not. We saw no decrease in our work, but when they got rid of the minor ailments scheme, did the patients who used it go from the pharmacy back into self-care? No, because they had been medicalised by the system; they needed a prescription instead of buying an over-the-counter preparation. So those patients came to general practice. That happened about a year ago, Kieran, and that is when we lost control of access to a certain extent, because we seemed to get a 5% or 10% increase in work when the minor ailments scheme disappeared.

Pharmacies seem to be a replacement for self-care; they do not seem to be a replacement for general practice. That just seems to be the way that people think. However, by all means bring them in, because they are hugely expert in their area, and we need their help.

**The Chairperson:** I bring my children into the pharmacy for things like a rash and would act on the pharmacist's advice. If they said that the child needed to see a doctor, I would take the child to the doctor. However, I am happy to do self-care. So I am a bit surprised that the minor injuries scheme did not take work away from GPs.

**Dr Black:** So was I.

**The Chairperson:** It would be interesting, Tom, to see the statistics on that.

From listening to some of the comments today, there seems to be a big imbalance between the focus that primary care has within Compton and the consultation with yourselves in the run-up to Compton. I was hoping that today you would be able to say that the balance has shifted and that you are happy with the amount of discussion that there has been since the report was produced in November, but it does not sound like that is the case. We all value primary care, and there is a high level of satisfaction with it. However, if services are moving out of hospitals into primary care, we need to see how that will work out, not just from a resources and equipment viewpoint, which is important, but from the point of view of personnel. Do you think that, if we are using less — I think that the point was made in the BMA note — that essentially fewer doctors will be needed in hospital settings and more in primary care? Last Friday, Mickey, Jim and I had a very interesting morning as Dr Una Lynch told us that, in Cuba, primary care was incentivised and it is now turned around. People wanted to work in cardiology and in sexy areas, rather than primary care, but the authorities incentivised primary care so that it is now the popular area in which doctors in Cuba want to work. Do you think that the profession is willing to make that transition? If it is not, what would it take to make that happen?

**Dr Austin:** It is not as simple as that. Think about psychiatric care. I work in the Mater Hospital, where psychiatric consultants work entirely in the community, and yet they are secondary-care doctors. Part of it is about thinking of hospital staff not as secondary-care staff, but as providing the service in the community.

Psychiatry is a classic example of the use of home treatment teams. That has been very successful. Psychiatry has been challenged and led by consultants to do that sort of new innovative therapy, and they are leading in that area. It is a complex thing: people are obviously keen to see more general practitioners in the future, but secondary care takes a change of mindset. People usually think secondary-care staff have to work in hospital, but quite a lot of secondary-care clinicians do not have to work in hospital. They can be working part of the time in hospital and part in the community in co-operation with colleagues.

Earlier, we spoke of GPs with special interests. It could well be that you have a consultant cardiologist in a large health centre doing clinics but GPSIs working very closely with him in the community and providing some support — a combined approach to care. This is about trying to change a mindset. Just because someone is a secondary-care consultant, it is not the case that they have to work in a hospital. There is something there, and there is also something about general practice and improving the access of medical students who think that they would like to be a GP.

**The Chairperson:** It certainly seems to be the focus for a lot of people to become —

**Professor Brown:** If there is going to be rationalisation of staff in the secondary-care sector with the view that some or all of them will be redeployed into primary care, it needs to be thought through carefully. The RCGP's concept, which I tried to outline briefly in my opening statement, is of a professional who functions in a slightly different way to a single, specialty trained doctor. It is like turning around an oil tanker. We cannot suddenly stop, chop off a training scheme and say that we do not need any more gastroenterologists or cardiologists. That has to be thought through carefully. Certainly, there is a lack of detail and clarity on those educational issues in the report. I referred to GP training, so I will not go over that ground again. Those are the areas where discussion and clear thinking is needed, probably for quite a long time.

**Mr Wells:** Dr Black gave a very interesting answer given to one of Kieran's points. He quoted comparisons between GP consultations in Northern Ireland and the rest of the UK and the Irish Republic. It was the first time that I heard them expressed in that way. As I rather facetiously said, because they are charged for in the Republic on many occasions, there is a value involved with going to the GP, and that makes people think twice before they burden the GP with a completely minor ailment that they could just sit at home with. What is the source of those figures? They are very useful.

**Dr Black:** It is the Commonwealth report, out of Washington DC, November 2011. Every time I meet civil servants, I make sure that there is a copy on the table before them. I had a copy last time.

**Mr Wells:** That covers the UK and the Republic of Ireland?

**Dr Black:** No. The Republic of Ireland figures came from the Public Health Agency a year or two ago. They looked at those numbers.

**Mr Wells:** There is absolutely no reason why we should be so out of kilter with, for example, Wales, where there are very similar demographics.

**Dr Black:** Wales is similar to us. We are away above the UK average, and we are way above the average for out-of-hours. It is just the way it works in Northern Ireland; it is the way that the access pattern has been over the past 20 or 30 years. You can look at a number of factors such as deprivation, the Troubles and the amount of mental health illness that we have. We do not say it as a complaint; we simply say that you are getting good value for money from us and that we are working very hard, judging by comparators with elsewhere. We are not complaining.

**Professor Brown:** Just to augment that point: the college had visitations from the Health Ministers from Malta, China and Japan in the past 12 months. They want to utilise and buy in to the sort of model that we have in the primary care system. People from abroad see that model as efficient and good value for money and want to take it to their countries. It would be an absolute shame if what we do well was destroyed or made more difficult because of an ill-conceived and poorly worked-through programme leading on from the report. We are not perfect by any means, and we are keen to do what we can to improve that. I think that it is good to finish on perhaps a slightly more positive note.

**The Chairperson:** I have another question that might scupper that a wee bit, Scott, but it is directed more at you, Tom. The BMA briefing states:

*"Local commissioning groups (LCGs), which to date have been ineffective, must have autonomy and flexibility around resources".*

Ineffective is a fairly strongly word. Why do you think they have been ineffective? How has that affected the way you work?

**Dr Black:** If you want to create squeaky-bum time at LCG meetings, you say, "What have you commissioned in the past year?", and then there is lots of shifting about on the seat. That is what I mean by that. David said that he put a response into a LCG four and a half years ago. That gives you an idea of how long they have been about. You have to create a dynamic in the service. LCGs were there, but they did not have a dynamic. This document creates a dynamic. When you go outside, you can definitely tell that the trusts realise that there is a dynamic. The board has created a dynamic, as has the Minister, and you get the impression now that people have a road map to follow; a direction of travel. LCGs are now starting to take on areas in primary care and to commission diagnostics and different things in secondary care. So there is a tailwind now. Until now, the LCGs have been there, but the dynamic did not create any change.

**Dr Johnston:** I just want go back to the response that we made four and a half years ago. Our very strong view was that I, as a GP in my practice, should relate to the GPs who sit on the LCG, which should relate to the board, which should relate to the Department, which should relate to the Minister. There was, therefore, meant to be a line of command that I felt part of so that I could move forward. Unfortunately that did not happen, for whatever reason. The GPs sitting on the LCGs were all very well-

meaning people, but they did not have a constituency as such. I did not feel that they particularly represented me and they did not feel that they had any responsibility to me.

Unfortunately, what we thought might happen if that top-down approach was adopted has happened. The difficulty is that GPs on the ground have not been engaged, and that is why the LCGs have not delivered. That is no reflection on the LCGs. It is just the way the system was set up, unfortunately. The LCGs, ultimately, have to deliver through the practices. If there is no relationship, it is not going to happen, and that is, unfortunately, what we are seeing.

As Scott said at the outset, we are looking forward, so we very much hope that the new structures do engage general practice. Every GP in the country needs to feel that they are part of this, so that their enthusiasm and entrepreneurial skills can be harnessed to provide the best care for patients. If we miss that opportunity, we do ourselves a huge disservice, because it will be about structures and process, not outcomes for our patients, which is the key.

**The Chairperson:** I do not mean to be provocative, David, but your profession probably has a bit of a chip on its shoulder about consultants and the pecking order. The LCGs are there to ensure that there is a voice for the allied health professionals and other elements, who equally may have a chip on their shoulder about GPs. I can see a pyramid here.

**Dr Johnston:** I absolutely accept that that could be a perception, but I genuinely do not think that that is the case. Most GPs I know are very happy and content in their job. At no time am I happier than when I have a nice full surgery of patients and when I am chatting to those patients and we are making some progress. If you could take the phones and the bureaucracy away, it would be wonderful. So most GPs do not have that chip on their shoulder. The college has certainly done a lot to raise the profile of general practice, and GPs are content in what they do. Most GPs have chosen that role. Some of the most able medical students who qualify now go into general practice.

It is a challenging career. In fact, it is one of the most challenging careers because we deal with undifferentiated patients; anybody can walk through my door. Any time a medical student or doctor in training spends a day or two in general practice, they come away completely enthused because they know they can be dealing with the complete range of illnesses and human conditions. So, it is a fantastic job. I love my job and I do not feel in any way defensive about that. What I do not like about my job is when I have patients sitting in front of me and I know we could do better. That is the difficulty. When I have to deal with patient complaints because they are waiting a long time for appointments, or when they perceive that there is something they should be getting and are not getting, that is what causes me distress in my job.

It distresses me to see money put into structures such as LCGs when, if there had been a bottom-up approach, in which every GP in the country had been involved and we had worked with our colleagues in other areas, we could have delivered better for our patients. I do not have any difficulty with a hierarchy with regard to hospitals and primary care. That is not an issue at all. We are very happy to work with colleagues but, as GPs, before we work with other colleagues we need to be able to work with each other.

That is why the federations and structures that allow us to work with colleagues have to be right. At the moment, there is no clarity. If I wanted to have a consultant come to my surgery and do a day of cardiology or whatever it happened to be, there is no mechanism that allows me to do that. At the moment as GPs, we are inhibited in how we take forward some of those thoughts, plans, schemes and good ideas, and I am sure it is the same for our clinical colleagues in hospital.

**The Chairperson:** OK; thank you. I feel that we could have talked for longer but the Minister is due to come in and we have kept him waiting for 15 minutes. Thank you to all of you. It has been very interesting. We may need to have more discussions on, for example, the implementation of Compton and the resources that may be needed if you are getting further responsibilities. Maybe you can think about that for the next time and about whether there is a capital cost to upgrading and providing equipment for treatment and diagnostics that people are currently going to hospital for but that you will be doing, and how we manage that in a way that makes sense.

We would certainly be very keen to see a shift away from acute with regard to its profile and resources. Sometimes we, too, feel we are beating our head against a brick wall. Thanks a million all of you for coming in; we will see you again.