Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Health and Social Care Review: Allied Health Professions Federation Northern Ireland

28 March 2012

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Sue Ramsey (Chairperson)
Ms Paula Bradley
Mr Mickey Brady
Ms Pam Brown
Mr Gordon Dunne
Mr Samuel Gardiner
Mr John McCallister
Mr Kieran McCarthy

Witnesses:

Mrs Liz Cavan	Allied Health Professions Federation Northern Ireland
Ms Kerry Clarke	Allied Health Professions Federation Northern Ireland
Mrs Janet Fletcher	Allied Health Professions Federation Northern Ireland
Ms Alison McCullough MBE	Allied Health Professions Federation Northern Ireland
Mr Tom Sullivan	Allied Health Professions Federation Northern Ireland

The Chairperson: OK. We are going to go straight into the presentation from the allied health professionals (AHPs). I asked them to sit in on the previous presentation, because I knew that some issues would come up. Thank you very much for your paper; it was actually quite useful. It allowed us to get into a discussion earlier with the Minister and his team. I will hand over to you to make an introduction and presentation, and then we will open the session up. We have probably lost a lot of questions, because we got some of the answers from the Minister.

Mr Tom Sullivan (Allied Health Professions Federation Northern Ireland): That is fine, Chair. I will give just a brief introduction. You raised a lot of the issues already, and, during the question and answer session, we can elaborate on some of the solutions that we believe we can provide for the healthcare system in Northern Ireland. I thank you for the opportunity to present to you today and for giving us a voice, because that voice is not always heard or present across the health and social care system.

We believe that the skills of allied health professionals have a unique part to play in providing solutions to the way in which health and social care is delivered across the system. We are determined to play an integral part in providing services of enhanced quality, improved efficiency and financial

sustainability, but we need to have the opportunity to do that across the system, and it needs to be driven at the high strategic level. You touched on that. We still have concerns, as you correctly pointed out, that, from 1 April, there will not be an AHP lead officer at the Department to provide appropriate advice for our professions.

Everyone touched on the recent issues with A&E, but that is only part of the problem. As you rightly pointed out, Chair, it is not just about A&E; it is the whole-system approach. We believe that we can and do have the requisite skills, if they are properly deployed, to resolve some of those issues. We completely understand the pressures that our medical and nursing colleagues are under with A&E, but if we address other parts of the system to allow patients to move more freely through the system and prevent them from going into hospital in the first place, that will provide part of the solution for what is manifesting itself as a crisis in the accident and emergency service.

We want to be positive here today, because we can provide solutions to a lot of the problems if the skills and unique experience that AHPs have are properly deployed across the system. However, that requires strong leadership and strategic direction at the highest level across all the health and social care organisations that are tasked with ensuring that those people — your constituents, as you rightly said — can access the right care, at the right time and in the right location. We believe that we have a lot of the solutions for that. On that note, I will hand over briefly to Liz Cavan, who is chair of the Allied Health Professions Federation. She will highlight some of the issues in Transforming Your Care.

Mrs Liz Cavan (Allied Health Professions Federation Northern Ireland): Thank you very much. We, as allied health professionals, want to say at the very beginning that we really welcome Transforming Your Care. We want to play our full part in the process, and we want to be involved in every aspect of it. We passionately want to provide the best possible care for patients that is cost-effective and that is what patients really need and want.

Today, we would like to give you a few examples of some of the ideas that we have, which we feel could be put into practice to make care better and to help Transforming Your Care become a reality. We are going to start with Janet Fletcher, who will talk a little bit about community diagnostic and therapeutic hubs and what we can do with those.

Mrs Janet Fletcher (Allied Health Professions Federation Northern Ireland): The Minister has highlighted the need for increased diagnostics in the community. He mentioned a few sites, including Ballymena, which will have diagnostic facilities on site. Currently, Portadown Health Centre has a diagnostic radiographer who is seeing around 20 to 25 patients a day. That is a good service, but the capital cost of implementing diagnostics is expensive, and we could be missing the point. If the role is enhanced by providing a reporting radiographer with reporting facilities in low activity times — early in the morning, when GPs have not referred — he or she can undertake reporting, not only for their trust or patients, but, as the Regulation and Quality Improvement Authority (RQIA) report from last year stated, for the managed clinical network for radiology.

The reporting radiographer could also undertake reporting for other allied health professions (AHPs) through direct referrals, such as for patients who self-refer to physiotherapy and who then need diagnostics. That would mean that they could go away with a written report. In other words, we want to transform the health centres into not only therapeutic but diagnostic hubs that will alleviate pressures in the acute sites, have patients referred from GPs, allied health professions and nurse practitioners, and realise the goals of 'Transforming Your Care'.

Mrs Cavan: I will speak briefly about direct referral systems. I know that you realise that direct referrals to physiotherapy is the norm in Scotland, and has been for approximately four years. It is very much the norm in large parts of England and in Wales. We have not had it here, and I feel that it is something that could help take our care forward. Some of the benefits are evident in the evaluations that have taken place. It has been proven that direct referral reduces waiting times; it saves GPs time as they do not have to spend that time with the patients; it saves approximately £12,000 of each GP practice's drug budget. We have around 350 practices in Northern Ireland. My maths is not very good, but I think that that is around £1·5 million.

Mr Sullivan: It is over £4 million.

Mrs Cavan: Is it? Gosh, my maths is very bad. There is a definite saving to be made. Almost more importantly, it is a much more satisfactory service for the patients. The patients feel that they can get treated quickly; they can get their problems addressed immediately. That is its main purpose. I was struck by something that you said, Sue, about prevention. An unexpected discovery of direct referral was that men were happy to refer themselves to a physiotherapist. Those were men who perhaps did not really want to go to the doctor. To go to a physio is considered more macho.

The Chairperson: They can let on that they were at the gym and pulled a muscle.

Mrs Cavan: Yes, because you can hurt yourself at the gym or by overdoing it in the garden or when painting and decorating. Men do not like to go to the doctor, and direct referral picked up some interesting things, particularly to do with men's health. That is an unexpected extra that direct referral brought up. It is something that we have to think about if we are going to transform care in Northern Ireland.

Kerry Clarke will now talk to you about prescribing and AHP prescribing, because that is a natural follow-on from direct referral.

Ms Kerry Clarke (Allied Health Professions Federation Northern Ireland): My two colleagues talked about diagnostic and therapeutic services and about linking those to direct referrals and the impact on the referrals going through the system. That leads us very much to the rehabilitation line and to reinforcing and supporting all the services. With therapeutics and rehabilitation, in particular, comes non-medical prescribing.

We are hopefully starting to see some non-medical prescribing come into action. In answer to some of the questions raised earlier, there are now two therapeutic radiographers in the Belfast Health and Social Care Trust who prescribe, and one who has just returned from maternity leave. Therefore, there is action and movement there.

There have been a few issues on the physiotherapy and podiatry side. Some of those are focused on governance and policy decision-making at trust level. We appreciate that that does take time to put into action. There are a few other sticking points on the community side, and I just want to pick up on a few issues that we may need some assistance with to drive forward. The first issue concerns access to prescription pads for those based in a rural community or community setting. Although that is up and running in the Belfast Trust, it is very much hospital-based. The issue is being managed in secondary care, but on the community side in primary care, there are still issues with access to prescription pads and access to budgets. There are also some general issues for everybody with common patient records. If we are to improve prescribing on the ground for all, the area of common patient records needs to be looked at and addressed for all concerned.

As I say, we have three therapeutic radiographers in the Belfast Trust who prescribe. The South Eastern Trust and the Northern Trust are ready to sign off on their governance procedures and policy, and that will see podiatrists and physiotherapists coming on board. I have had no word back from the Southern Trust, so I do not know what is going on there. Nobody from the first cohort of trained students was put forward from the Western Trust, so its progress is behind. However, it is hoped that its policy and governance procedures are being putting in place so that it is ready for that to happen.

One of the issues that we want to raise for consideration is the move towards independent prescribing. Representatives of podiatry and physiotherapy are meeting to present to the Commission on Human Medicines (CHM) in England on 17 and 18 May, and we are expecting a decision very shortly afterwards on whether podiatry and physiotherapy will be the first wave of health professions to have independent prescribing rights.

On the supplementary prescribing process in Northern Ireland, it took six years for us to get from approval in England to our having the correct amendment order and the educational requirements in place to be able to progress. As we are now aware, independent prescribing is on the move, and it

looks very positive. If there is a positive move in May, we would like to focus on the legislation around that and for you as a Committee to work towards having that legislation ready, if we get approval. Hopefully, non-medical prescribing will then underpin all the other issues that we are focusing on in 'Transforming Your Care'.

Mrs Cavan: I would now like to move on to another area that we are very involved in and that is a major problem for our health service: long-term conditions. Alison McCullough will say a few words on what we would like to do in that area.

Ms Alison McCullough (Allied Health Professions Federation Northern Ireland): We welcome the recommendation that the multidisciplinary teams will form an essential nucleus of healthcare professionals. The issue for us with TYC, as I heard it referred to —

The Chairperson: I thought that it was JLS. *[Laughter.]* I thought that JLS were sitting there when they said "TYC".

Ms McCullough: It is new to me, too. I thought, "TLC? That is in a yoghurt ad", but it is actually TYC.

We feel that the traditional ways of working are obviously not going to deliver TYC. Therefore, we would like to see a proper needs assessment of patients done. From listening to the presentations, there are certainly questions that we need to ask ourselves about, for example, admissions. What were the needs of the individuals turning up to admissions? Were their needs looked at? Would some of the issues that we raised, such as self-referral, have stopped somebody from going to A&E in the first place? We also need to look at the issue of discharge, which Paula mentioned. In respect of the workforce, it is about addressing the likelihood and the imminent prospect of having a very elderly generation who will need integrated care. As allied health professionals, we are integrators of care. We work with other professional groups and with other sectors and voluntary organisations, so we are very well placed. It is encouraging to hear John Compton say that he will consider our contribution to expert panels, because we feel that we have been sidelined to a certain extent, and we want to give our input into long-term conditioned planning and say how the needs of people with long-term conditions will be met into the future. That is encouraging, but, so far, we have not been able to influence that commissioning pattern.

There are opportunities for role development and for better use of AHPs, and we consider that we are already trained as specialists on long-term conditions. If we are to look at the needs of the population, we should surely look first at the existing workforce to see whether it has the skills to deliver for the population rather than train additional healthcare professionals to do jobs, because we could already provide that support for people with long-term conditions.

We would like to think that our value in integrated care partnerships will be considered. For example, some of our colleagues have mentioned the fact that we can assist in delivering joined-up, integrated patterns of working. There were examples of reablement practice by occupational therapists, and 53% of patients were discharged early because those programmes were led by an occupational therapist who was able to do a full assessment of the individual's needs in the home setting and in the work environment. Our concern is that we are not being fully being utilised in the reablement programmes. Other examples are at Daisy Hill and Craigavon hospitals, where physios and occupational therapists were part of the triaging system in accident and emergency and were able to deal with elderly people coming into accident and emergency by looking at the total picture and providing support. Those people did not need to go through the whole process. They were taken out of the system at an opportune time rather than having to sit in accident and emergency for a long time.

We certainly feel that we have much to share. We want to see a greater focus on identification of needs and look at the skills that are required of the workforce to meet those needs before planning services. Unfortunately, as we said, it is a bit like Groundhog Day for us. We are here again, and we are still talking about the lack of representation and input from AHPs into planning and commissioning in all aspects of care. We really hope that that will happen sooner rather than later.

Mrs Cavan: Most of you are aware that we now have the long-awaited strategy for allied health professions, and we were very glad to hear Andrew say that he will work at sorting out the position in the Department that becomes vacant on 1 April. That is very important, because, to drive through the recommendations, we will need a central push, and, with around 600 civil servants, we wonder why only one is appointed to be part of the allied health professions. We feel that it might be good to look at the spread in DHSSPS and whether that part of the Department needs a bit more of a boost, some clerical support or needs to bring in people for individual pieces of work. We are looking for support on that.

In conclusion, we really want to play our part, and we can do that if we have a voice at all the right levels. Our plan is to ensure that our professions play their full part in providing cost-effective, good care for our patients in Northern Ireland.

The Chairperson: OK. Thank you and, once again, thanks for the paper. It was quite useful, not only for this presentation but for the previous one and stuff that we will be continuing to do. I was keen for you to be in to listen to the Minister, the permanent secretary and the head of the Health and Social Care Board (HSCB), so that you can understand where we are coming from. We have been talking about stuff for years. I am glad that the Minister made that point about feet, because, I lay this morning thinking that we will probably be on film 'Happy Feet 27' before this is sorted out. *[Laughter.]* However, I now think that if we get this sorted, there will be a lot of happy feet out there. The cost-effectiveness of a simple procedure will save a lot of money in the long term, so I do not think that you will get any arguments from people around this table.

It is frustrating when you hear a senior official say that we are talking about it "over the years", and, come 1 April, we are in this position. We need to get it sorted, and I think that the Minister has given a clear commitment that he will look at it. It is also frustrating that good ideas coming from you, as professionals, and from people on the ground do not seem to filter down to that level. Is there a breakdown in the relationship, or has there been such a breakdown? Can you see this as a change in leadership level at the Department, whereby it is easier to deal with? I will ask the Minister and John Compton for a response on the issues that you have raised, and we will filter their response back to you. Groundhog Day was mentioned, and you are probably right, but does the attitude of the three top men give you any confidence that this will move forward?

Mr Sullivan: In 'Transforming Your Care' generally, there are a lot of positives for allied health professionals and specific recommendations that recognise the value and contribution of our profession. Again, I think that it needs to be driven at the strategic level. There needs to be better joined-up policy co-ordination at departmental level than there is at present. There is a deficit there. Even if the AHP lead-officer post were filled tomorrow, there would still be a capacity issue. That one individual has to perform a range of functions similar to those of his or her nursing and medical colleagues, which is huge. It is even more complicated for allied health professions, because we work across so many other sectors, such as criminal justice, social development, education, environment, and so on. You could argue that our needs are more complex and should attract additional resources rather than just the one person out of 600 who is tasked with a job that is, at times, impossible to do. It also means that, at a strategic level, that input and those ideas about service development do not get fed into the system. Our professions come to it usually after those decisions have been taken, and we have to make provision for and try to meet, as an afterthought, services that have already been commissioned and planned.

However, from the statements today, I think that there is room for optimism. The message is starting to filter through that you need to include our professions if you want genuinely to challenge the status quo as to how services will be delivered in the future. You will have to better utilise the resources that you have, and that is not happening. There is lots of optimism, but we need your support.

The Chairperson: We will keep you in the loop, based on the response that we get to this paper. We are not shying away from some of these issues either.

Mr Sullivan: I do not know whether any of my colleagues want to come in on that.

The Chairperson: That was a good general point. I will open the meeting to members' questions.

Mr Brady: Thank you very much for the presentation. As Sue said, the paper is very useful. It seems to me that one of the biggest challenges facing the health service now and in the future is the care of the elderly. I am sure that some of us on this side of the table, including me, will probably avail ourselves of it at some stage. There is nothing that we can do about our age. *[Laughter.]*

The Chairperson: Fetishes on this side.

Mr Brady: And ageism on this side.

Mr Gardiner: I do not have that head of hair. *[Laughter.]*

Mr Brady: That has nothing to do with ageing, I can assure you. However, your paper states that allied health professions:

> *"working across health and social care actively support older people and those with complex needs to live independently in their own homes or in a homely setting".*

Surely one of the cornerstones of Compton is to keep people in the community. The paper goes on to say that leaders across health and social services have to include allied health professions. Our elderly population is estimated to double by 2020. Obviously, people are living longer but not necessarily more healthily. Is there a long way to go before achieving that? I know that it was alluded to that those leaders will include you to the extent that it should.

On integrated care services, we talked about the diagnostics, and we are apparently going to get a new one in Newry. It will be great when it happens.

The Chairperson: And a new roof. Do not forget the new roof.

Mr Brady: A new roof, yes. Nothing else, just the roof. It will levitate, presumably. What are your own views on that? Do you see that as a really forward step or is it already happening in a sense because, as I mentioned, in Newry we have community occupational therapy (OT) services, which are very effective, and other effective services in the Health Village, such as diabetic facilities. Do you see that as a forward step if all of this other stuff is put in place? It does seem a good idea, but only if people buy into it and everybody works together. We talked about joined-up thinking. We all talk about that a lot, but it does not always happen. That could be a way forward, but it needs people such as you to be included. Not just to be there but to be included in the policy side and the decision-making.

Mr Sullivan: I will ask Liz to comment on that because she used to be a director of allied health professions services in Newry and Mourne.

Mr Brady: Yes, we did meet before.

Mrs Cavan: Yes, we have met before.

Mr Sullivan: Liz was involved in the commissioning arrangements some time ago that I am sure Sue will remember, when they were talking about local health and social care.

Mrs Cavan: The elderly, as you say, will be one of the biggest problems in health over the next few years. Centres such as the centre that the Minister talked about will be essential. You need to have the right people there and be able to pick up problems before they become huge problems. There is no point in picking up a problem when people have totally gone off their feet. If they have a little problem that can be looked at and supported, we can keep them on their feet in their own home with their family for as long as is possible.

It is very important that we are there at every level because sometimes we can be forgotten. It is doctors and nurses, and the allied health professions are sometimes a bit of an add-on.

Sometimes, too, we look to specialist nurses for some specific problem-solving when some of the allied health professions actually have those skills. We do not need those additional staff. If you put in the right skills in the right place to support the professions, nurses and allied health professions can work together as teams utilising each other's skills. The idea of us all being under one roof, supporting and referring to each other, would be a great advantage and a great step forward.

Mr Sullivan: Mickey, we welcome the shift in care being delivered more locally at a community level, where it should be done. You had the Royal College of General Practitioners (RCGP) and the British Medical Association (BMA) up speaking about 'Transforming Your Care'. It struck me that one of the things that Dr Black mentioned at the time was that if are going to shift work into general practice and primary care, we need capacity. His quotation was:

"At the moment, capacity is at its limit."

We understand entirely the pressures that our GP colleagues are under. Why not then introduce self-referral to take some of that pressure off? We will open up additional capacity, move people through the system more effectively and reduce prescribing costs and waiting times. GPs need to be factored in.

Self-referral could be introduced tomorrow, if the will is there. A business case is not needed. We are not asking that there be additional staff, although other staffing issues would come about as a result of it. It would be a different entry point for patients. Patients would not have to go to their GP first to be told that they need a physiotherapy referral and be put back into the system. They could refer themselves. It is a better way for our health professionals to deal with that self-referral. They would then look at patients and decide that they may not need physiotherapy but may need a referral to somewhere else. It is just a better way of dealing with the system. It is about capacity. We are positioned to provide care closer to the patient's home, but we need to have the opportunity to be able to do that.

Ms K Clarke: It is about looking at the skills that are out there and making use of the skills that you have. A prime example that we can give is the recent GP and nurse training in diabetes and vascular assessment. The people giving that training are the AHPs. Therefore, why are we not being used to do it ourselves, instead of us providing that training to GPs and nurses for them to do it, which increases their capacity?

Mr Brady: On diabetes, there was an item last week or the week before about the number of people who had had to have amputations. Having listened to that, it seems to me that people with the skills that a podiatrist has could have prevented a lot of that through self-referral. Presumably, some of those people had to go to their GP and then go on a waiting list to get to see a podiatrist or specialist diabetic nurse, by which time things might have advanced to the point at which amputation was the only possible solution. I think that there were 200 amputations in one year. That is an awful lot.

Ms K Clarke: Absolutely. Podiatry can play a big role in long-term conditions, not just for diabetes but for rheumatology. That is something on which you could see a very quick turnaround in the management of patient caseloads, if you had more hands on deck.

The Chairperson: That was one of the points made in the previous presentation. It does not necessarily have to be a resource issue if you train people but do not pay those further up the scale. There is a lack of common sense in a lot of these things. There is a lack of common sense around this table, too. *[Laughter.]* Just on that side of the table. *[Laughter.]*

Ms P Bradley: I thought that about the top part of the table.

Mr Gardiner: Thank you for those compliments, Madam Chairperson. *[Laughter.]* Ms McCullough referred to this in her report, and I appreciate what she said. However, how long ago did you write the letter to which you have had no reply? Was that written to the Minister or to the Department?

Ms McCullough: We started asking about AHP representation in 2006. We have had a sequence of temporary appointments to the position. Originally, we did have a permanent AHP in post, but she went off on sick leave and was replaced by a seconded person. Since then, we have not had a permanent officer at the Department. Therefore, we have been raising this as an issue with the Department since then.

Mr Gardiner: When was your last contact with the Department in writing?

Ms McCullough: In 2009.

Mr Sullivan: Yes, in 2009.

Ms McCullough: We got a response from Michael McGimpsey to say that he was going to look at staffing levels. He stated that he was hoping to appoint two additional members.

Mr Gardiner: And nothing has happened?

Ms McCullough: No.

Mr Gardiner: I wonder whether we could follow that up. That is not a good service. If the Department has been dragging behind since 2006 and then 2009, and you still have not got a satisfactory reply, I think that we, as the Health Committee, are honour-bound to follow that up, given the nature of the work that you are doing. We should write to the Department and support your case. We want something positive to come from this.

The Chairperson: I agree with you, and that is in the paper. We have asked the Department to come back to us.

Mr Sullivan: The Committee has raised that matter on numerous occasions. We thank you for that, and we hope that you will continue to raise it. The issue is just about getting some action on it. This is not happening through the lack of your raising it.

The Chairperson: The Minister has a copy of your presentation, as do John Compton and Andrew McCormick. We will come back to it, but not in 10 years from now.

Mr Gardiner: Definitely not. We do not want a letter; we want action.

The Chairperson: In fairness, they have a copy of the presentation. We need to give them time to come back on it, but it will not happen in 50 years' time. OK, Sam?

Mr Gardiner: Yes; as long as we are acting on it.

Mr McCarthy: Thanks very much indeed. It is a pity that the three guys who were here did not remain to hear the presentation that has been —

The Chairperson: They have a representative in the room.

Mr McCarthy: I hope that that representative is listening intently. No one can deny what was said. We are very supportive of everything that has been said. What you described is an absolute disgrace, and we need to raise it in the Assembly. Tom said that there was a sense of optimism about. I believe that, and I wonder why. I can tell you why. You congratulated the Minister on the statement that he made yesterday, but, until the debate in the Chamber on Monday, they were just jollying along. For some reason or another, however, things have now changed. In his first sentence today, Minister Poots advised us that he had a "scheduled meeting" on, I think, Tuesday with the chief executives and chairs of all the trusts. He emphasised the word "scheduled". I wonder whether that meeting came about as a result of the impassioned pleas that were made around the Chamber on Monday. He made a statement to the media after that meeting. I think that they have got a bolt up —

The Chairperson: Keep it clean.

Mr Dunne: Order.

Mr McCarthy: — and they are moving. Let us keep that pressure on, because what we just heard is ridiculous.

The Chairperson: I am not here to answer for either the Minister or the Department. We gave a copy of your document to the Minister and the senior officials. We will come back and look at it, but that will not happen in a year from now.

Mr McCarthy: Absolutely. John Compton responded to my question about the input. You cannot be happy with that. Are you happy with it? No, you are not, because you said that you were not.

Mr Sullivan: We said that it is about what happens at all levels. That means not just at departmental level but in the trusts, the local commissioning groups and the integrated care partnerships. They will take quite serious decisions about what is commissioned, how it is commissioned and what services are delivered. We need to be well represented in the integrated care partnerships so that our message and voice are properly articulated and can translate into direct services to patients. At the end of the day, it is what patients want that matters. As the Chair rightly said, your constituents hold you to account on delivery. We have heard on numerous occasions that the Department and other health and social care organisations value the AHPs' contribution, but you are held to account on the basis of what you do, not necessarily on what you say. We would like to see the same rule apply to those organisations.

The Chairperson: We will be coming back to that, Kieran.

Mr McCarthy: I am just wondering how that will be monitored. We could go on and on without the input that you want there, but we would not know about it.

The Chairperson: The allied health professionals know that the door is always open and has always been open. We will be monitoring them as well. I am not here to speak for the Department. We gave it the presentation, and, in fairness, it is the first time that it has seen it. It is probably well aware of other issues, but the Minister said that he did not know about the issues to do with feet. He is going to look at that. So, we will come back to this once we get a response.

Mr McCarthy: You talked about consultants and specialist practitioners. Should they be appointed in each of the 12 allied health professions?

Mrs Fletcher: I will give you an example of a consultant practice in NHS Ayrshire and Arran. It concerns a radiographer who has become a consultant in reporting. She now heads a team of four reporting radiographers, and this a summary of her work. She said:

> *"In my first year, along with two advanced practice radiographers, we reported approximately 25,000 images, most of the work taken from an outside contractor, thereby saving the board significant amounts of money in outsourcing of reporting."*

The radiographers, not the radiologists, have set up a recall system to communicate urgent and unexpected findings, which are the Royal College of Radiologists guidelines for 2009, so that they report urgent findings to referrers in a timely manner. That has proved significant, at least for cost containment, if not for cost savings.

There are other examples of consultant practice, and I will give you another from the South Tyneside Trust, which has completely transformed care pathways for patients arriving at A&E with suspected fractured hips. The consultant reporting radiographer has set up a system of work alongside specialist nurses, whereby if a patient arrives at the door of A&E, the nurse practitioner assesses and refers them to X-ray. The radiographer, of any grade, X-rays the patients and writes an initial report. If they

see a fracture, they admit the patient to the ward. In that hospital in South Tyneside, 97% of fracture patients now get from the door of A&E to the ward in less than an hour. Obviously, they are not then blocking the pathways. All that is overseen by a consultant radiographer.

At the same hospital, where all grades of radiographers do the initial reporting, there has been a reduction in missed fracture rates. Missed fracture rates means that, for whatever reason, patients have not had fractures identified. It dropped from 7% to 1%. However, that is only an initial comment, and it may not be the result of the detailed report that is given later by a consultant radiographer or a reporting radiographer, but the initial observation has reduced missed fractures from 7% to 1% by implementing a consultant radiographer-led reporting service.

The Chairperson: Nobody would disagree with you. Over the years, what has happened with allied health professionals is scandalous. If we are talking about keeping people out of the acute sector, we need to lift our heads out of the sand and look at what is in the community sector. We need to move on from what was supposed to happen in 2006 and 2009. We have given your document to the Department, and we need to see about moving it on. Although it is about taking our heads out of the sand, we are also drawing the line in the sand. From today, we will be asking where that is at, because, if you are not a component part of Compton, it will fail. We will come back to that.

Mr McCarthy: The answer to my question is yes, 100%, and I hope that whoever is in the back is listening. Tom, you mentioned your anxiety and concerns about GPs in all this. Although GPs are welcoming it, I said previously in this forum that I am concerned, because constituents are already coming to me to tell me how difficult it is for them to get an appointment with their GP. If GPs are going to be forced to take that much of an extra load as a result of TYC, I am not convinced yet. If you have a role to play to get over that, let us go for it.

The Chairperson: Allied health professionals have a very important role to play in supporting what is happening in the community and in the primary, secondary and acute sectors. Today is the start of our work. We need to look at that.

Ms P Bradley: Thank you for your presentations. As you heard me say when the Minister was here, I am definitely a firm believer in this being an integral part of the 'Transforming Your Care' document. I know that, because I have worked with most of the allied health professional disciplines. I will pick up on the point about the amalgamation of the trusts under Agenda for Change. From working in the health service, I know that we were under different trusts and that things were very difficult. On a lot of issues, people said, "That is yours, not mine, and we are not doing that because someone else should be doing it.". Have you found that Agenda for Change has made a big difference, with everyone coming together under the one umbrella to create smoother running in multidisciplinary working and so forth? From my perspective, I can say that it made a big difference and was very positive, but I just want to hear about that from other health professionals.

I zoned out a little bit, because I am not 100% again today. I do not know whether anyone brought up the physiotherapy pilot again. Did they, Chair?

The Chairperson: Just go ahead anyway.

Ms P Bradley: What is your point of view about the physiotherapy pilot that we mentioned to the Minister earlier? Have you come against any opposition to prescribing on the clinical side? When I have mentioned this to any of my friends who are from a clinical directorate, they have said, "Why would someone else be prescribing when we are prescribers?" Have you come up against any opposition to it? If so, what have we done to try to ease it?

I agree with what you are doing. Allied health professionals keep people out of acute care and in the home. Recently, reablement has been talked about here over and over. My brain tends to think a lot about the social care aspect of that. You forget that there is a whole other aspect of reablement and that it is not just about the social care side.

So, have you noticed a change? Are multidisciplinary teams working much closer and better together now than they were when it was a "them and us" scenario? Also, what are you coming up against in prescribing?

Mr Sullivan: I will ask Alison to take the question about multidisciplinary working.

Ms McCullough: Obviously, it was traumatic for everyone when we reduced capacity. As professionals, we lost a lot of very highly skilled capacity in what happened.

There was also the question of where AHPs sit in the different directorates in the trusts to consider. The situation is not uniform across the five trusts in Northern Ireland; AHPs can sit in different directorates. One of the challenges that we have faced is determining which directorate they should sit in. If you have only one director of allied health professions, should you put them in critical care or the children's directorate? If you put them in critical care, are you missing out on the community care aspect?

It still comes down to a capacity issue, with one or two individuals in a trust having responsibility for sitting around planning tables discussing where AHPs can fit in to the delivery of services. Others may feel differently, but I think that, as AHPs, we still face that challenge in the reorganisation of the trusts. In my own profession, 80% of speech and language therapists' caseload involves working with children. However, our AHP director will not sit in the children's directorate. When trusts are planning children and young people's partnerships, how do we influence the planning of services for children with complex needs, for example? Are we forgotten about sometimes because we sit in another directorate?

There have been benefits in looking at integrated care pathways, but we still have challenges. Member McCarthy asked about our concern. Yes, 1 April is very soon, and we do not have somebody at the Department taking responsibility for working out who will sit on the working groups and the expert panel as of 1 April. Will the Department direct one of the AHP directors from the trust to sit on the implementation group? The appointment process for that position will probably take at least three months. Who will sit on that panel in the interim when all these groups are being formed?

I suppose the answer is that there have been pros and cons in what has happened in the trusts. Our allied health professional directors will say that they themselves have capacity issues with trying to be at all the meetings that they should be. I know that our AHP commissioners also feel that very much, because it is not the case that some just have a responsibility for a profession; some also have a responsibility for a condition, long-term conditions or children's services. So, they cannot be in all places at all times, and there is a capacity issue. By contrast, many more managers of nursing services and medical managers go to those meetings or have someone who fills in for them, but we still feel that we are left out of the loop.

Mr Sullivan: The Chartered Society of Physiotherapy (CSP) has had informal discussions with the Department and the Minister's adviser about self-referral. There is no objection, ideologically, to introducing a pilot for self-referral. We sensibly took the approach that we would pilot it in Northern Ireland, because the circumstances here are different to those in Scotland, Wales and England where it has been introduced. We could learn from that experience so that we could apply it here more coherently and consistently. There is no ideological opposition to it, as it is in a lot of the party manifestoes. It is in the DUP and Alliance manifestoes, for example, and I do not detect any opposition from any of the other political parties.

The Chairperson: We did not listen to it last summer in our manifesto.

Mr Sullivan: We would welcome the Health Committee's support in determining where the blockage is on that.

The Chairperson: I want to try to wrap the session up, because I have a suggestion to make at the end of the presentation as to how the Health Committee can take this matter forward. So, Paula, are you finished?

Ms P Bradley: I just want to ask about prescribing. I want to know whether they have any opposition to that.

The Chairperson: I will incorporate all that as well.

Ms K Clarke: Just to marry the two questions, I think that where you have the larger number of AHPs as a group fully integrated into a care team, you will have seen progress. So, you have the radiotherapists, who, at the minute are in the Cancer Centre in Belfast City Hospital, and they have been fully integrated, are working well and have a good level of capacity, so it has worked. We are seeing difficulty where you have less capacity and where the teams are not as well integrated as a result of those changes. Perhaps that answers those two questions. There have been barriers in development from the educational side. To be fair to our colleagues, I have to say that the barriers have not come from the doctors — the GPs. I was anticipating that, but it did not happen. The barriers came from other areas.

Ms P Bradley: Can you elaborate on that?

Ms K Clarke: If you take the GPs out of the equation, it highlights a few other areas. However, not just to focus on nursing colleagues, there has been turf-territory warfare going on over prescribing. I hope that we are overcoming a good bit of that.

The Chairperson: Do you need a Good Friday Agreement, then? *[Laughter.]*

Ms P Bradley: Or a St Andrews Agreement.

Ms S Ramsey: Or whatever. It depends on what mood you are in at that stage.

Mr Dunne: Thank you all very much for your presentation. Most of what I wanted to ask about has been covered, but I just want to ask about the Compton report. You welcome Compton, but do you feel that you got a fair wind from it? The impression was that the review involved lots of consultation and gave lots of opportunity for it. Do you feel that that was the case for you?

Mr Sullivan: I think that a lot of organisations feel that they did not either get a fair wind or the opportunity to input to Compton; it is not just the Allied Health Professions Federation that feels that. There were routes in for some allied health professions that were probably not available to others. Some of the allied health professions, such as the CSP, are both a trade union and a professional body. We were able to engage through the partnership forum with Compton and through some of the discussions with the panel on that. Other AHPs probably did not have the opportunity to do that as directly as us. Others were invited to go along and speak with the Compton review panel directly. So, it is sort of patchy — some did get a fair wind, and some did not.

Mr Dunne: Did you feel that it was not very consistent?

Mr Sullivan: No.

Mr Dunne: You are keen to get involved in the implementation stage. Do you feel that we have a role to play in ensuring that that happens? Do we need to monitor that to see whether you are being involved?

Mr Sullivan: Absolutely. We have always welcomed the support that Committee has given to our professions, and, in the absence of being represented elsewhere, it is crucial that we have your support. I bring it back to the fact that it is about services for your patients at the end of the day. That is what it all boils down to. We very much welcome a strong input and strong support from members here in ensuring that we have a voice and are represented in the implementation groups that are tasked with taking the Compton review forward.

Mr Dunne: Why has a lot of this change not been done before now? Are managers so busy managing the day job that they are not managing and implementing change? We heard a lot about lean techniques. There was evidence of lean techniques in place at the A&E, by the way, when we went there on Monday. Surely, this should be an ongoing process. Continuous improvement should be part of the processes that are carried out. The commitment towards quality should be a drive towards continuous improvement. Yet, it does not seem to have worked out as such. People in the health service tell us that they are frustrated with the amount of paperwork and paperwork-driven processes. The onus is now on that rather than on caring for the patient. Does that need to be addressed?

Mrs Cavan: I think that that is something that the health service should do more of. There are lots of examples of really good practice. Maybe the health service is not quick enough to pick up on those areas of good practice and to translate them to other areas. So, maybe that is something that we should be thinking about.

The Chairperson: I will say the same to you, Liz: we have managers on top of managers, so somebody is not getting it right. It is a leadership issue.

Ms K Clarke: There are some areas in which specific examples have been flagged, but they seem to go so far and then stop. One example is that, since 2003, podiatrists have had the right to prescribe under the exemptions order. No podiatrist in Northern Ireland is using that right, and I do not think that there is any budget for that. Yet, since 2003, we have had a full workforce out there that is trained to do that. That is something that could be taken up as part of the national prescribing move. I believe that some work has been done on prescribing nutritional supplements in dietetics. A business plan was put in order for that, but that has not met its end yet. I think that it commenced about five years ago. So, there are a number of areas that have been flagged, but we have not got beyond a certain stage.

The Chairperson: We are well aware of it. I want to try to get to the end of the session so that we can move things on.

Mr Dunne: OK. That is fine.

The Chairperson: I think that it is important that we get in at that level. There are issues around which you will save money in the long term. As I said time and time again, I gave your document to the Minister and John Compton. They will come back to us with specific answers. You heard us question the top three decision-makers in the Department about specifics. To take this presentation forward, I suggest that we come back to the matter at our next meeting. That will allow the Minister and John Compton to come back with a possible response. We can bring forward a draft Committee motion, which we will take forward if we are not happy with the response from them on TYC. So, this Committee is going to take a hands-on approach. We are not going to wait 29 years to get an answer. It is important that you keep your contact with us on that. Are members OK with that?

Members indicated assent.

The Chairperson: Thank you very much.

The Committee stood suspended —