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Assembly

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Primary Care Partnerships

29 November 2011

NORTHERN IRELAND ASSEMBLY

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

Witnesses:

Mr John Farrell	)	Department of Health, Social Services and Public Safety
Mr Eugene Rooney	)	
Dr Sloan Harper	)	Health and Social Care Board

The Chairperson:

I invite Mr Eugene Rooney, Dr Sloan Harper and Mr John Farrell to the table. Sloan and John, I do not think that I have met you before. I happen to know Eugene from all of Saturday night past; that sounds very bad, doesn't it? *[Laughter.]*

Mr Eugene Rooney (Department of Health, Social Services and Public Safety):
We will say no more.

The Chairperson:
We will leave them wondering, won't we, Eugene? Are you leading on the presentation, Eugene?

Mr Rooney:
I will make some opening remarks, Chair.

The Chairperson:
No problem. However, before you do that, I must say that we are disappointed that the briefing paper came so late. We asked for it a good while ago, and this evidence session has been on the forward work programme since September. The Department of Health, Social Services and Public Safety (DHSSPS) has had almost three months to prepare the paper, but we got it only yesterday at 3.00 pm. I know that our meetings are generally held on Wednesdays and that we have taken this session forward by a day, but that does not excuse the fact that the Committee got the paper extremely late for perusal. This is not the first time that that has happened. It is a bit unfortunate that, on your first time in front of the Committee, you are getting a chewing. That is a better word than the one that I was going to use.

Our statutory duty and obligation is to scrutinise the Department's work. If we do not get papers in time, it makes that job much more difficult. Given the importance of primary care partnerships (PCPs) and the impact that they could have on our constituencies, we obviously want time to have a proper evidence session on the matter. Eugene, why was the paper delivered so late to the Committee, despite the fact that over two months' notice was given? When was the Minister provided with a copy of the briefing?

Mr Rooney:
Apologies for the lateness of the paper, Chair. Clearly, if there are issues that the Committee wishes to come back to, we will be very happy to do that after today.

The paper is a joint one between the DHSSPS and the Health and Social Care Board (HSCB). We were trying to make sure that it is as up to date as possible, so, rather than sending it two months ago, we left it until the last week or so. It has just taken time to get it processed and

through to the Committee.

The Chairperson:

Did the Minister get the paper before it came to us? Has he had sight of it at all?

Mr Rooney:

The Minister has had sight of it.

The Chairperson:

We could have been given the paper a considerable time ago, and the updates could have been in an annex or appendix to the original paper. Some Committee members, including me, are new to health issues, and perhaps we do not have the knowledge that others have acquired over a period of time. We appreciate getting papers on time so that we can give them proper consideration. I know that that message will go back to the Department. We do not mean to give you a slating, but this is not the first time that this has happened. I hope to God that it is the last, because it is a habit or routine that is now starting to creep in. We are keen to work constructively as far as possible with the Department and the Minister, but this makes it difficult.

The Health Minister is answering oral questions at 2.30 pm, so we will do as much work as we can until then. We will adjourn the meeting for half an hour to allow us to get to the Chamber for the Minister's questions, and then we will come back. That will give you a chance to get a break, and we will probably come back to the evidence session at 3.00 pm, if that is OK. Fire away, Eugene, please.

Mr Rooney:

Thank you, Chair. Thank you for inviting us to brief the Committee today on primary care partnerships. I introduce Sloan Harper, who is the director of integrated care in the HSCB, which has oversight of primary care partnerships, and my colleague John Farrell, who is the head of the commissioning branch in the Department.

The concept of primary care partnerships was introduced in 2010 with the purpose of exploring new and innovative approaches to enabling the effective commissioning of health and social care services, particularly where integrating care and designing and delivering services around patient need is concerned. It is a new approach, and the concept is being piloted across

the five local commissioning groups (LCGs). There are 15 pathfinder pilots, which address issues as diverse as dermatology, oral nutritional supplements, ultrasound diagnostics, medicines management and mental health. Further details of the services and the areas in which the PCPs are working are in the briefing paper that has been provided to the Committee.

The objectives of a primary care partnership are to improve integration and co-ordination between primary and community care, hospital specialists and social services and to identify alternative care pathways for patients that develop services around their needs and secure a more efficient and effective use of resources. That requires a vehicle to bring together all those involved to analyse demand and redesign local services.

Another objective is to identify and implement more cost-effective prescribing to address the upward trends in prescribing volumes and costs and to ensure the effective implementation of the Northern Ireland medicines formulary across primary and secondary care.

PCPs are the conduit to delivering service improvements in health and social care. They are not a separate entity in the health and social care structures. PCPs are established by the parent local commissioning groups and are based around natural community areas. They are led by a clinical lead. Therefore, they are networked groups of service providers that are not in themselves commissioners but that act as voluntary alliances of health and care professionals and voluntary and community sector bodies. The work is directed by and informs the decisions of LCGs in taking forward more effective commissioning.

Last month, the chairs of the five LCGs provided a briefing to the Committee that included details on developing PCPs in their respective areas. A fundamental aspect of the approach to more effective local commissioning is the LCGs' ability to identify and agree areas in which services could be provided more effectively and efficiently around the needs of patients, including the costs of delivering those services. LCGs, therefore, are responsible for identifying health and care pathways to be addressed. They work with the PCP clinical lead to agree the terms of reference for the project and to ensure that health and care professionals form part of the project team. Those professionals include community and voluntary representatives, as well as those from primary, secondary and community care, who have a direct interest and involvement in a particular care pathway being addressed. The approach ensures that services' representatives review and redesign services across a continuum of commissioning and service provision,

delivering joint needs assessment, planning, commissioning and accountability.

PCPS are not managed by the commissioners. They have a freedom to determine how best to develop their own leadership roles and responsibilities. PCPs identify service problems and solutions in their geographic area and agree with their LCG how best to use resources to take those forward in the context of local and regional strategic frameworks. The HSCB provides the PCPs with advice, information and expertise to enable them to fulfil their roles.

When a revised service delivery model is embedded in the system, the PCP clinical group could be stood down. That approach ensures that changes evolve continually across the health and social care system. More importantly, it ensures that health and social care professionals with the relevant competences and skills feel that they have ownership of service design and implementation through membership of a PCP and that they can focus on an area of care that is important to them.

In delivering on their objectives, PCPs can contribute to improving clinical performance and to reducing the health and social care system's reliance on referral to secondary care through enhancing the role of primary and community care. Key in that is the design and delivery of services that are built around patients' needs, with care and treatment being provided at the right time and in the right location by the most appropriate healthcare professional.

GPs and primary care teams, acting as gatekeepers to health and social care services, are a major determinant of healthcare utilisation in the model of care that a patient receives and in how patient choice is exercised. Linking the gatekeeper with clinical and financial responsibility has the potential to raise standards of patient care, improve provider efficiency and make the services that they provide more responsive to patients.

Demand is an indicator of expressed need, so demand management is an integral part of commissioning. Utilising PCPs to review, redesign and integrate service provision helps to inform future commissioning decisions of the Health and Social Care Board, its five LCGs and the Public Health Agency.

It is important to mention that, in considering proposals from a PCP, its LCG will ensure that it has secured the involvement of all stakeholders, including trusts, across a particular care

pathway and that account has been taken of their duty of public and patient involvement.

PCPs are at a pilot stage, and an evaluation report will be done shortly. An interim evaluation was carried out in April, after the pilots had been operating for approximately four months. That evaluation concluded that, in the short time that PCPs had been operating, they had been successful in engaging with stakeholders and agreeing service improvements. However, the evaluation also noted that the financial benefits from the PCP initiative will take longer to identify where pathway reform is required and that significant work is needed to communicate and explain the nature of PCPs to the wider provider system. Those issues will be picked up in the current evaluation, which the HSCB will receive in December and which will then be used to inform the board's business case to the Department for the future development of the initiative.

The Chairperson:

Thanks a million for that, Eugene. You said that it might be a wee while before the financial benefits are seen. Although financial benefits are welcome, we are more interested in outcomes and health benefits. Whenever we talk to stakeholders, we find that people are generally very happy with the level of service that their GP provides. They trust their GP, and they think that they provide a kinder service. However, the big difficulty and the elephant in the room, if it is not mentioned today, is the length of time that people have to wait for an appointment. Primary care is a critical part of our healthcare delivery. We do a fantastic job at primary care level. We have GPs working in the system, and I sometimes wonder whether we have enough. In some surgeries, people nearly need to give two or three weeks' notice of when they are going to be ill before they can get an appointment. As I have said in Committee previously, I am lucky that my surgery is very flexible, and people can generally get an appointment on the day or the next day. However, that is not the case for an awful lot of people.

We are keen for primary care partnerships to deliver better outcomes and a quicker service. Issues such as surgeries having flexible opening times and being open for a couple of hours in the evenings or on Saturdays will have to be reintroduced into the primary care system to meet the needs of our community. I also welcome and recognise the role of specialist nurses and the people who can deliver more services in the surgery than they do currently.

Are there plans for a two-stage PCP model? It is very clear that what works in urban areas will not necessarily work in rural areas. I am very keen on the idea of PCPs if they are done

properly. I think that they have to be voluntary alliances, as Eugene pointed out. If the system were mandatory, it would be much more difficult to implement. In the short time that you have been involved in the issue, have you thought through what the rural end would look like compared with the urban set-up that has been developed?

Mr Rooney:

I will comment, Chair, and then bring in my colleagues. These are pilots that are running across the five LCG areas. The information that comes from those will inform the evaluation that is under way so that we can take stock of the lessons learned and how it has worked in particular geographic areas and with particular services. We fully agree that it is about improving patient care. The fact that PCPs can perhaps do things more effectively and efficiently is also a benefit. However, the objective is to ensure that patients get the right care in the right place at the right time. That is an undercurrent of the initiative.

I will ask Sloan, who is familiar with the way in which the pilots have operated on the ground, to comment on your points about the contrasts between areas.

Dr Sloan Harper (Health and Social Care Board):

We have thought long and hard about the rural issue. We believe that PCPs will be relevant to all areas of Northern Ireland. In fact, some of our most successful groups are in the Western LCG area, which is our biggest rural setting. In the west, there are a large number of single-handed practitioners who need support from others. The traditional model of general practice is based on small businesses working in rural areas, and at times they are professionally isolated. The fact that those practices are in a PCP means that they can support one another. They can also challenge one another, which will lead to improvements in the quality of care provided. I think that PCPs will support rural areas rather than marginalise them.

The Chairperson:

I accept that the west is the biggest rural area. However, if the pilots in the west are all in Derry or Strabane, you would not necessarily get a feel for the challenges facing a dispersed rural population.

Dr Harper:

That is right. The pilots in the Western Local Commissioning Group area looked at a couple of

issues, one of which was improving the efficiency of prescribing. I know that you previously took evidence from my colleague Dr Brendan O'Hare, who works in the Western LCG area and has been very successful in respect of prescribing. Another area is access to radiology, which was identified as an issue by GPs not only in Derry but in other parts of the Western LCG area. As a result of their pathfinder pilots, they have been able to give their patients much improved access to ultrasound and MRI scans. That is a service for all patients in the Western LCG area, not only those in an urban setting.

The Chairperson:

Can you give us examples of surgeries in very rural areas that have participated in the pilot?

Dr Harper:

Yes, I can. Castlederg, which is in the western part of the Western LCG area, has been very much involved in prescribing initiatives. I think of the Down area and Downpatrick, where proposals are being worked up for an excellent development in dermatology. A GP with a special interest in dermatology visits surgeries and sees patients in their local surgery rather than the patients having to go to hospital. They are helping to educate doctors and improve their knowledge and awareness of dermatology issues to try to reduce inappropriate pressure on the hospital system. That is working well in the Down area.

Mr John Farrell (Department of Health, Social Services and Public Safety):

Primary care partnerships and the projects that they take forward will not result in a one-size-fits-all outcome. The important thing about primary care partnerships is that they will address care pathways. Therefore, as local commissioning groups, they will look at the analysis of patient flows into the services, be they in primary, secondary or community care. They may identify where there are delays or where the service could be improved. They will then work with the clinical lead in the primary care partnership to agree terms of reference and a project to look at a particular care pathway. By looking at that care pathway, they will identify the flows from the patient into secondary care and where the delays are.

We sometimes think of primary care partnerships and the projects that they undertake as being akin to continuous improvement. That is not new; it is utilised in the private and public sectors quite regularly to look at how we deliver services to our customers, or, in this case, our patients. If we are looking at a particular care pathway in a rural area, we could identify ways in which the

service could be improved and delivered so that it will benefit patients and provide for better integration across primary, community and secondary care. That model could be different from a model in an urban area because the patient flows are slightly different. There will not be a one-size-fits-all solution; it will enable and support the effective local commissioning of services by allowing LCGs to identify the care pathways that need to be addressed in their area and the proper way to deliver services to patients.

The Chairperson:

We spoke to George O'Neill recently about PCPs. I mentioned rural areas, and he said that what works in Belfast will not work in Carrickmore. I said that my surgery is in Tynan, which is far more rural than Carrickmore. It has to be recognised that there are towns and villages that can support a health centre, and there are villages that cannot; they have only a single practice. I am glad, John, to hear you say that it will not be a one-size-fits-all outcome. It is not even a two-pronged approach; it is a multidisciplinary approach so that we get the right size and so that there can be networks around small hamlets that have traditionally had a doctor's surgery but perhaps do not have many links with others.

Dr Harper:

The Portadown health and care centre is an important development; it is an excellent facility. The facilities there are available to the 40,000 patients who are registered at that centre and to patients from other practices. It is not practical or fair to the local population to move a GP surgery to Portadown, but those patients can still access the facilities and services at the health and care centre. That is what we call a hub-and-spoke model. It will allow rural areas to avail themselves of the new services and developments in the future.

Mr McCarthy:

Thanks very much for your presentation. I understand that one of your pathfinder projects on medicine management in the South Eastern LCG region has been completed. Will you describe the results and comment on how you intend to take forward the findings? Will you be able to replicate the results across the other PCPs in the South Eastern LCG area?

Dr Harper:

Yes, indeed. That has been very successful. It is an ongoing project; medicines management never stops. For a more intense period, we were able to find some non-recurrent funding and put

that into extra pharmacist support for practices. Those pharmacists have assisted doctors in making the prescribing practice more efficient and of a better quality. We apply that in other areas; it is not unique to Belfast. We were able to enhance the pharmacists who work for the board and visit practices to ensure that prescribing is efficient and appropriate, but we were able to add, through the recruitment of local pharmacists, some who work in community pharmacies and others who perhaps work part-time in the hospital system.

Mr McCarthy:

Have you any other new projects that could be undertaken in the four PCPs in the South Eastern LCG area?

Dr Harper:

Yes, indeed. We have worked with all the GP practices in that area. As part of their general medical services (GMS) or GP contract this year, practices are required to meet to discuss improvements in the way that services are provided. The dermatology project in Down probably has the best prospects. We also ran a very important project in nursing homes in north Down and Ards, where we have more nursing homes than in any other part of Northern Ireland. We recruited pharmacists to go in there and work not only with patients but with their carers on improving oral nutritional supplements, and so on, to ensure that patients and their carers are bought into their treatment, which could influence the clinical decisions being made.

Mr McCarthy:

So it is working well and is a success.

Dr Harper:

Yes, indeed. Savings and efficiencies are being delivered.

Mr McCarthy:

Good.

Mr McCallister:

Would you really just describe it as a much quicker and more responsive way of dealing with local needs? John Compton was at the Committee last week, and we chatted about the difficulty of getting pathways right. That is often where the health service lets patients down. It obviously

works very well for some people, but, for others, that is where the system tends to break down. It may be a case of identifying a need in a local community that is very different in a rural area and an urban area. The needs of more deprived areas and more affluent areas could also be slightly different. Do you see PCPs as a responsive way of dealing with that?

Mr Farrell:

Local commissioning groups have responsibility for commissioning services in their areas. They will look at data and information on the patient flows in their areas. If they identify an area in which the pathway is complex or complicated, they could work with the clinical lead in the primary care partnership to put together a team comprising the right healthcare professionals. Importantly, given that this is a voluntary alliance of healthcare professionals from primary, secondary and community care and patient representatives from the community and voluntary sector, we have the right nucleus of people who can sit down and identify the problem and how the service can be changed to make it more responsive to a patient and build the service around a patient's needs.

Through that work, those people can identify an alternative pathway. The next stage is to embed that pathway. The primary care partnership project group would work with all the healthcare professionals to get their support to embed the alternative pathway, and it then becomes the new way of doing things. Therefore, there is a move away from how services are delivered now to an alternative way that the primary care partnership project team has helped to develop.

Mr McCallister:

Are you noticing that not only are outcomes getting better but we are cutting down on the numbers of people being admitted to hospital inappropriately and identifying a better pathway for them? Perhaps "inappropriately" is not the best word; "unnecessarily" might be better.

Mr Farrell:

The objective of commissioning is to ensure that a patient is treated in the right place at the right time by the most appropriate health professional. We want a patient's care to be delivered in the right place. If care is still needed in a hospital setting, that will be identified through the pathway. However, that will happen only when it is appropriate for a patient to attend a hospital. Sometimes, much more patient care can be provided in the primary or community care setting. It

is very difficult to prejudge the outcome of each project. However, it is all built around the needs of patients, with their services delivered in the most appropriate setting and by the most appropriate healthcare professionals.

Mr Rooney:

PCPs have been running only for little over a year. There are a lot of lessons to be learned and information to be gathered and shared to ensure that we identify the most efficient and effective way of running the initiative.

Perhaps Sloan will add to John's comments about particular examples of how that has been working well.

Dr Harper:

John identified one of the big challenges for the health service. The public perhaps view the health service as one organisation, but it certainly is not. It is a series of agencies, some of which are statutory. We have 1,500 independent small businesses that are primary care providers. It is about pulling all that together and allowing them to work with the voluntary and community sector and others. For example, a project on mental health in west Belfast identified the fact that over 50 organisations are involved in providing mental health services to people in west Belfast. Many of those are voluntary and community organisations. GPs can refer to 85% of those organisations, but they do not know that because the formal communication channels are not there. It is about better co-ordination, improving flow and ensuring that all parts of the care pathway, including health promotion and disease prevention, are included. So often, health promotion is the Cinderella of the service.

When PCPs come to the board and the LCGs with their proposals, we will insist that they involve all parts of that care pathway, including public and patient involvement and health promotion. It is potentially a complete system change, but one that will lead to more co-ordinated and more integrated services for patients and clients.

Mr McCallister:

That would be particularly useful if you identified areas of deprivation in which perhaps diet or the whole thing was wrong. How do you tie in getting issues such as housing right? I am not suggesting that we need to solve all the problems, but cracking the nut will mean that you will get

housing and diet right. Health, alcohol and all of those things are linked. It is a very good model because you could really focus on a particular issue in a certain area.

Dr Harper:

The important thing is that we are now in a position to identify the problems on the ground. From my position in board headquarters, I cannot do that; I need input from clinicians and others on the ground. That is why we are establishing the networks. It is the intelligent arm of commissioning, and it is giving us the information. If the problem in a specific area is obesity, we are well placed through the LCGs and the PCPs to make those changes because we have elected representatives on our LCGs, and they can feed into the whole discussion on how other Departments, whether on issues such as education or housing, can assist. We have a way through the local commissioning groups of tying that all together and making sure that it is fair and transparent.

Mr Dunne:

Thank you very much for your evidence today. We had a recent evidence session with the chairs of the local commissioning groups. I think that we were all impressed by their enthusiasm and hands-on approach. It was somewhat refreshing for all of us. The Compton review is pending. I am sure that you have heard of it and are very much aware of it. As members of the Health Committee, we do not know an awful lot about the role of GPs, but our understanding is that the role will change. Would it be fair to say that there will be another revised service delivery model? The service is likely to change at this stage, so obviously the role of the PCPs will be even more critical. Is it a fair assumption at this stage that that could well be the case?

Dr Harper:

I would not like to prejudge the outcome of the Compton review, but there has been a focus, certainly in recent media coverage, on the role of general practitioners and others — I do not limit it to GPs. As a health economy in Northern Ireland, we have relied heavily on hospital services over the years. That model is changing. We are part of an overall system; it is not primary care being separate to hospital care. If hospitals evolve and change because technology is changing, GPs have to be in a position to pick up the work that shifts.

Inevitably, work is being carried out more in the community. If that change is to be safe and done in a way that is open and that everyone understands, we need a more coherent way of engaging with GPs and other primary care providers. That is why we are setting up the 17 PCPs.

As Eugene said, we are piloting this because we need to ensure that the benefits and the business case are delivered. Those are financial, but also non-financial, as regards quality of care, and we will be completing the process in January. However, it is very important for the changes that we face into.

Mr Dunne:

You feel that the PCPs will help to deliver the change that may result from the Compton review.

Dr Harper:

I feel that they will and that they will help to deliver change in a safe way, however difficult the financial climate.

Mr Dunne:

I am a new Committee member, so can you clarify for me who serves on PCPs? Obviously, there are medical professionals, but who else serves on PCPs?

Dr Harper:

It is not just medical professionals. It is whoever is involved in solving a pathway problem. We have to think of clinical problems. If the issue is the diabetic service, the diabetologist from the local hospital would be involved, along with local GPs and representatives of community nursing, particularly the specialist diabetic nurse. We might also involve representatives from the British Diabetic Association (BDA) in that area, along with selected representatives on the LCG.

Mr Rooney:

As Sloan outlined, it is not just primary care professionals who are involved in PCPs. It can involve other professionals from secondary care, the voluntary and community sector, and community care, depending on the issue that the PCP has been established to look at. It is a flexible model that brings in all the key contributions that need to be made. The annex to our briefing paper tries to identify the main professional groups in each of the PCP areas that are involved in delivering the project for that area.

You mentioned the health and social care review. The opportunity to take into account the conclusions of that review in the business case work that Sloan and his team will be putting together, which will also take into account the evaluation of running PCPs for a year, will be a

very useful business case to draw in the various strands from the review and from the evaluation and, from the lessons learned, to see the best way to develop PCPs further. That will be quite an important element of the business case that will be brought forward in January.

Mr Dunne:

Compton has quite an emphasis on quality of care and quality outcomes. Your mention of continuous improvement ties in with that. To me, that would have been an initiative that we could follow through. You are obviously in line with Compton on those issues. Is that a fair assumption at this stage?

Mr Rooney:

This is all about improving healthcare and making it more effective in how it operates locally on the ground. It is entirely in line with the objectives of continuing improvement.

Mr Durkan:

I am a great advocate of PCPs, and I love the clarification from Eugene that improved efficiency and improved care are not mutually exclusive. We should aspire to a patient-centric model of PCPs. Would it be safe to assume that increased investment in PCPs would lead to increased improvements, both in efficiency and care? I believe that it would, but I would like your opinion on it. I am thinking about capital investment, equipment and apparatus to allow GPs to perform more minor procedures in the primary care setting and, therefore, the relief that that would give to hospitals.

Mr Rooney:

A small amount of money has been going into the PCPs. Sloan can identify exactly how that is used, along with the needs of the PCP funding.

Dr Harper:

We have invested some non-recurrent funding in backfilling the time of clinicians, GPs, pharmacists and others who were involved in those projects. However, what you are probably getting at is the wider investment in service change and in service developments. We are moving from a model that has served us well in the past but which was based on GPs providing basic primary care services. We are now developing a new system that involves intermediate care provision, which will require more sophisticated facilities for the practices based in those

facilities and the other small practices in rural areas that can link in and secure those services.

The concept of integrated clinical assessment and treatment services (ICATS) has been around for a number for years. It allows GPs to become more involved in some of the elective care procedures and the outpatient-type consultations that were traditionally done in district general hospitals. There is an increasing centralisation of surgical specialisms, but medical care, particularly for the elderly, needs to be done locally. That is what we are trying to preserve.

The Chairperson:

Supplementary to that, with increased responsibilities possibly going to primary care, we would expect the budget to follow. We have heard, for example, that in April 2012 some of the responsibility for osteoporosis will be devolved back to GPs, but that will put pressure on the amount of scanners that we have for high-risk assessments. Therefore, if we are to follow the PCP model and GPs are to deliver more services in their areas, it sounds as if there will be a need for some capital money for equipment. It is not all about having GPs with an interest or specialty in, for example, dermatology. If those GPs need equipment to carry out that work, we need to find a way to provide that equipment. You said that there was a small amount of money. How much is available?

Dr Harper:

The backfilling of the time of the clinical leads would amount to about £500,000 in a year.

The Chairperson:

Considering that some of the machinery is quite expensive, that seems to be quite a small amount of money.

Dr Harper:

In the greater scheme of things, yes. On the issue of capital spend, we have ultrasound and plain X-ray facilities in the Portadown health and care centre, and there is a capital cost for that. At the moment, we do not have huge development resources. The new system will require a redeployment of our baseline resources; a high percentage of those resources are locked into the hospital system, and we will need to move them. That is a sensitive subject, and it must be done carefully and safely.

The Chairperson:

It can be done in a way that does not jeopardise the viability of hospitals. We keep hearing that too many people present at A&E departments. I think that it was John who was struggling to find a word, but people being "inappropriately" admitted to hospitals is probably the best that we can think of. If people are presenting at accident and emergency departments or at hospitals, with conditions that could be dealt with in their GP surgery, there is an expectation — if Committee members disagree, they are welcome to say so — that the ability to do more will have to be funded. That money will have to come out of the acute services budget, because that is where it is at the moment.

A doctor such as the GP in south Down with dermatology expertise could see 20 or 30 people in a day for the equivalent of about £40 a pop. However, if those people were to go to an outpatient department in a hospital, that cost would go up to around £100 a session, and probably only half of the people would be seen. There are immediate efficiencies on paper that will mean that some of the money will move from acute care to primary care. I agree with that movement of finances, but it can be done in a way that does not put the frighteners on communities that their hospitals will close as a result.

Dr Harper:

That is right. The clinical protocols must be agreed when services such as that are moved, and everyone needs to know what everybody else in the system is doing. The X-ray department in the Portadown health and care centre carried out about 8,000 X-rays in its first year. Those X-rays would previously have had to go to Craigavon Area Hospital, and Craigavon's size restrictions mean that it would have been under great pressure. Moving it to the health and care centre facility, with X-rays being transmitted back to the radiologists electronically, took pressure off the hospital system.

The Chairperson:

This is harder to evaluate, Sloan, but presumably that also improves outcomes for people who need to be in accident and emergency, as they can be seen quicker.

Dr Harper:

That is right. A GP is able to send a patient who has worrying symptoms such as a cough or coughing blood, the patient could have an X-ray there and then, and the result is requested

urgently. A GP could look at the X-ray and give some reassurance while awaiting the expert report from Craigavon.

The Chairperson:

I am mindful of the time. At the beginning of the meeting, we agreed that we would suspend and come back at 3.00 pm after the Minister's Question Time. Not all members have come in with questions yet, so the witnesses can get a cup of tea and settle themselves for a wee minute.

The meeting was suspended at 2.32 pm.

On resuming —

The Chairperson:

We are now quorate. Thanks for that, members. It was an interesting Question Time, so I am glad that we took the time to go to the Chamber to do that with the Minister.

We will pick up where we left off. I invite Eugene, Sloan and John back to the table.

Mr Brady:

I have to leave at 3.20 pm, Chair. I am speaking to the next motion in the Chamber.

The Chairperson:

OK. Michaela, the floor is yours.

Ms Boyle:

Thank you, Chair. Thank you for the presentation. Part of the PCPs' remit is to review and redesign services and to identify current service problems in each area. I was notified quite recently that there have been slight problems in my area with young mothers trying to access services out of hours and being redirected elsewhere. Obviously, part of the PCPs' remit is to identify problems and perhaps review and redesign services. I would like to see greater enhancement and better utilisation of GPs' surgeries. How will that be managed? The out-of-hours and red-eye services in my area of Strabane have been switched to Altnagelvin. There have been problems with people from rural areas around Strabane accessing their GPs services locally. I am referring to two quite recent incidents in which two young children from separate families had to be nebulised during the early hours of the morning. They are from a particularly rural area

near Strabane, and they could not make contact with the GP locally and had to go to Altnagelvin. Will that be looked at through commissioning and the redesign and redevelopment of services?

Dr Harper:

I am happy to take that question, Chair. Unscheduled care and the unscheduled care pathway, which is how we describe the services that you alluded to, is one of the most important priorities for primary care partnerships. The interface between GP in-hours services, GP out-of-hours services and A&E departments is important, as is ensuring that we allow appropriate access for the whole population.

Although we have been talking today about ideas and proposals flowing up from the primary care partnerships into the LCG, direction, guidance and changes can flow in the other direction. On behalf of the board, the LCGs, which are committees of the Health and Social Care Board, identified GP out-of-hours and A&E services as a priority. We have asked the LCGs to sit down and discuss with the PCPs not just the priorities as they see it but the regional priorities. One of those priorities is access to GP out-of-hours services and A&E departments and ascertaining whether patients who, just by dint of location or because they are not sure of the system, turn up at the wrong place. Therefore, the question is whether we can have some kind of reasonably streamlined, fair and humane way of directing such patients to the right service. The GP out-of-hours service is on the Altnagelvin site and is very close to the A&E department, so if patients turn up inappropriately at Altnagelvin, for example, we can triage appropriately and direct them to the right place.

We still have a mobile GP out-of-hours service and GPs carrying out home visits 24/7. Therefore, if lack of transport means that a patient is simply not able to get to the service that they need, we would expect the GP out-of-hours service to respond to that. Unfortunately, that means that we cannot have just as many on-site locations as we had in the past. That has a lot to do with the need to live within our budget and our means. It means more mobile services, with a slight reduction in fully manned locations, and I think that there has been an impact in Strabane and Limavady as a result of the changes that we had to make.

Ms Boyle:

Do you agree that the patient or the carer will be given the option to be seen at home through the red-eye service?

Dr Harper:

If it is clinically appropriate; that is right.

The Chairperson:

This is the last call for members to ask the panel further questions. You are all very quiet today.

I am sorry; if we had known, we could have cleared that up in the previous session. However, I wanted to give everybody the opportunity to ask a question. I appreciate your taking the time to come up and for waiting for that half hour while the Minister answered oral questions in the House. No doubt, we will hear more about PCPs and how they will impact on the most vulnerable and on those who need those services. We recognise the valuable and good work that GPs do. I notice that you did not answer me when I asked whether we had enough GPs. I know that our GP numbers have remained quite static over previous decades, while those in other areas have grown substantially. Could we be doing with more GPs, and is it difficult to attract people into general practice?

Dr Harper:

There are usually in the region of 200 to 300 locum GPs in the system. They are not all young doctors looking for posts; some of them are recently retired doctors who work on a part-time basis. We are fortunate in Northern Ireland in that we always have a surplus of GPs. We leave it up to the individual practices to determine how many doctors and nurses they have in their practice, because that is the way that the GP contract is written. So, it is very much left up to the individual practice. If we develop the new ICATs or intermediate type services, there will be a workforce issue and we will need more general practitioners. As more work is taken on and resources flow towards the community, there will be an opportunity to recruit more doctors into the system.

The Chairperson:

Thank you very much Sloan, Eugene and John. Go raibh míle maith agaibh.