Northern Ireland Assembly

Committee for Health

# OFFICIAL REPORT (Hansard)

## Briefing by the Royal College of General Practitioners

13 October 2016

# NORTHERN IRELAND ASSEMBLY

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**Members present for all or part of the proceedings:**
Ms Paula Bradley (Chairperson)
Mr Gary Middleton (Deputy Chairperson)
Ms Paula Bradshaw
Mr Robbie Butler
Mr Gerry Carroll
Mr Trevor Clarke
Mr Mark Durkan
Mr Ian Milne
Mr Pat Sheehan

**Witnesses:**

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|---|---|
| Dr Grainne Doran | Royal College of General Practitioners |
| Dr John O'Kelly | Royal College of General Practitioners |

**The Chairperson (Ms P Bradley):** I welcome Dr John O'Kelly, chair of the Royal College of General Practitioners (RCGP); and Dr Grainne Doran, NI chair elect and deputy chair of policy at the Royal College of General Practitioners. I hand over to you.

**Dr John O'Kelly (Royal College of General Practitioners):** Thank you very much, Chair, for having us along today to brief the Committee collectively on the current general practice landscape and the challenges affecting our profession. We have a short presentation of less than 10 minutes, if that is OK with you. Grainne will start, and I will finish. We are more than happy to take questions.

**Dr Grainne Doran (Royal College of General Practitioners):** Thank you very much. I am sure that most of you will be familiar with the work of the Royal College of General Practitioners; we are the professional membership body for family doctors in the UK and overseas. In Northern Ireland, RCGP NI represents 1,300 GPs, which is over 85% of all family doctors in the region. As a college, we are committed to improving patient care, to clinical standards, and to GP training. You will know that general practice services are vital to every constituent and that people want to be cared for in their own community, by their own family doctor and to avoid unnecessary hospital attendance. General practitioners provide 90% of patient contact with the health service, yet GP services receive only 8% of the budget.

Unfortunately, general practice in Northern Ireland is in crisis; we do not have enough family doctors to meet the growing demands of our population. Therefore, GPs do not have sufficient time to focus on patient care as they want to. Morale in the profession is plummeting, and GPs are struggling to provide the quality of service that they want to provide for the population. The role of GPs has changed considerably over time. People now have multiple complex conditions that have to be

managed, often over the course of their lifetime. As they get older, they accumulate more long-term conditions, which need to be managed by doctors with the expertise to manage complexity. General practitioners, with their expert generalist skills, are well equipped to deal with that complexity, but demands on the services have been continually rising, leading to increased workload pressures. In the last 10 years, the number of GP consultations has increased by over 60%, and with that growing workload come increasing paperwork and bureaucracy.

We need to look at new innovative ways of working to transform how patient care is delivered. Through our Put Patients First: Back General Practice campaign, the college has been calling for action to address the pressures in general practice since 2013. Our patients must be at the very centre of everything that we do. In our latest Ipsos MORI survey, GPs said that their top motivations for working in general practice are face-to-face time with their patients, working as part of a team, and improving patient outcomes. We regularly hear from our patients their frustrations about getting a suitable appointment, not having enough time to spend with their doctors, delays in the system, and out-of-hours services. Patients' challenges echo the challenges that doctors face. We would like to spend more time with our patients to ensure that they get the care that they desire.

Sadly, in a survey of GPs carried out by ComRes earlier this year, 93% of GPs agreed that their workload affects their ability to deliver high-quality patient care, and 95% said that they worried that a lack of resources is putting patient care at risk. In our Northern Ireland group blueprint 'Delivering change for general practice: A strategy for improving patient care in Northern Ireland', launched in September last year, the college outlined key actions that we feel need to be addressed to ensure that general practice here is sustainable in the long term and that it provides high-quality services to patients. The six priority areas that we have identified include GP workforce, workload and GP time, innovation, the general practice team, infrastructure and investment.

In April this year, NHS England released 'General Practice Forward View', which sees a significant commitment to general practice and primary care, with £2·4 billion in additional funding being allocated by 2021. We are calling for equivalent focused investment here to address our pressures. Northern Ireland faces significant challenges for the GP workforce: we have the oldest GP workforce in the UK, with one in four family doctors aged 55 or over. Despite a number of GP workforce reports from the Government since 2006 acknowledging the need to train more GPs, we still do not train enough. We welcome the increase in GP training places from 65 to 85 announced in January of this year, but there is much more to do. We call for that number to be increased to at least 111 per year, as a matter of urgency, in line with the Department of Health's own recommendation. The college has estimated that we need to increase the GP workforce by 400 full-time equivalent posts by 2020 in order to fill the existing shortfall and to meet the growing demand from an ageing population. We also need to take action to ensure that medical students get sufficient exposure to general practice. We hear from medical students that general practice is sometimes looked at less favourably than other specialities, so there is work to do to ensure that medical students get a proper insight into the challenging, diverse and exciting career that being a GP can bring. The college's latest Think GP campaign aims at debunking some of the negative myths about a career as a family doctor. RCCGP has been working closely with the GP Society at Queen's University Belfast to promote general practice as a career.

Thank you. I will hand to John to finish.

**Dr O'Kelly:** Although the recruitment challenges are right across Northern Ireland and, indeed, across the UK in general, there is a particular crisis in Northern Ireland facing rural and small practices. Our calls to increase the number of GPs and GP training places are part of a long-term solution to the workforce problems. The crisis in rural areas, such as Fermanagh, is happening right now. We need urgent measures put in place to support practices at risk of closing. If a rescue plan is not implemented, practice closures will be inevitable. There are several different models used elsewhere to support rural and isolated GP practices. The factors influencing recruitment to rural practice need to be addressed if existing practices are to be saved from collapse under the burden of spiralling lists. The current trend carries unacceptable risks to safe patient care, and we ask that the Department of Health and the Health and Social Care Board examine the situation with urgency and facilitate innovative approaches to supporting new GPs with supportive models of practice in areas of need across the Province.

Over the past decade, we have witnessed a sustained period of chronic underinvestment in general practice and primary care. Although the trend has been UK-wide, Northern Ireland has been more adversely affected. For instance, in 2013-14 general practice attracted 8·3% of the total health budget; in 2014-15, that fell to 8·18%, but has since risen slightly to 8·24% in 2015-16. The college

has been calling on the Health Minister to increase funding for general practice to 11%. That increase in investment would improve patient care and GP services, allow for patients to be treated and cared for more effectively in their own community, increase the number of GP training places, and allow GPs to spend more time with patients as part of a wider skilled and multidisciplinary practice team.

Significant investment has been promised in England, where elected representatives have acknowledged the vital services that family doctors provide and have attempted to deliver improved patient health outcomes by supporting primary-care services. An independent analysis by Deloitte a few years ago illustrated how, by investing in general practice, there could be substantial savings to the health service in the short, medium and long term. The entire system needs to be overhauled. We need innovative, radical solutions to be considered in order to avoid waste of money and resources and to improve outcomes for our public. We need to look at the core of these issues and rebalance resources from secondary to primary care to ensure that we can care for people in their homes and in their local community.

On her desk, the Health Minister has the GP-led working group report outlining nine recommendations, each with several key actions, that primary-care professionals have developed alongside the Department of Health. The college is calling for this report to be fully costed and implemented as a matter of urgency. The practice nursing framework has also been released, outlining a series of recommendations to address nursing challenges in the primary-care sector. Together, those reviews and recommendations have the capacity to rejuvenate general practice and ensure that we have sustainable, thriving services for the future. In July of this year, we presented an open letter to the Health Minister, Michelle O'Neill, signed by almost 170 GPs, asking for the report to be implemented and for our 10 priority asks to be immediately resourced. You should all have had a copy of the letter for your information.

I wish to reinforce that any increase in investment that we are asking for is to increase the capacity to provide patient care and services; we are not talking about GP salaries. GPs are highly trained and qualified medical professionals. Any additional resources that we are calling for are to improve health outcomes for our patients and to ensure that the primary healthcare system is equipped to deal with growing demand.

Over the years, several reports have confirmed that a shift of resources and services towards primary care is the way forward to deliver the best outcomes. Transforming Your Care outlined that path; unfortunately, resources did not follow. We await the findings of the Bengoa review and the Health Minister's plan. The Health Minister has said on several occasions that she intends to address the imbalance between primary and secondary care. We now need to see action.

Once again, I thank you for the opportunity to brief the Committee on general practice. We hope that each of you will support family doctors and patients by ensuring that primary care and general practice remain a top priority for the Committee during this mandate. We fully intend to continue campaigning for general practice and to make sure that patients and health services in our community remain at the very heart of the health debate.

**The Chairperson (Ms P Bradley):** Thank you, John and Grainne. We have met on several occasions to discuss those very issues. You will be aware that I laid a petition in the House on Monday, signed by 33,000 of your patients, calling for reform and more money. Some of the facts and figures that you have given us, previously and today, are extremely worrying, especially for rural areas. I do not think that we, as Belfast representatives, should get too comfortable, as we will also be under immense pressure.

I want to hone in on a few issues. I know that bureaucracy and paperwork are eating into a lot of GPs' time that could be spent doing other things. You talked about wider skilled multidisciplinary teams working together, which is the way forward; we should be doing that. We have already started that with our pharmacists being based in GP surgeries. Will you provide a bit more information on how that would improve things? You also talked about the rescue plan. How do you see that coming into effect? What do you need to get it up and going to save the services in crisis?

**Dr O'Kelly:** We need to identify the practices that are under extreme difficulties. You are quite right: although we have been concentrating a little bit on rural areas, mainly because they have a higher proportion of small practices, it will have a domino effect; it will eventually affect urban areas.

As with any rescue plan, there is a need to fund it, but it needs to be funded in an appropriate manner. Older GPs are becoming more demoralised. One in four is over the age of 55, but that is probably

slightly higher in small practices. It is very difficult to get a young doctor to take over a small practice where the pressures are great; they have to manage the day-to-day practice and they may not get holidays or locum cover. We need to think about innovative ways to support those practices. Perhaps we could encourage our older doctors to stay on in a reduced capacity to mentor younger doctors coming into the service and perhaps assist with the management of the practice. Post-certificate of completion of training (CCT) fellowships could be offered to young doctors to come in so that they could have guaranteed work, time off, support and ongoing training. Those are the sorts of things that can be used. We can look to use advanced nurse practitioners, our pharmacists and physiotherapists. We need to look at new ways of referral; we need to look at stopping our hospital discharge letters; we spend countless hours sorting out and following up our patients; and we need much better communication.

You are quite right: there have been some steps forward. My practice is part of the first wave with the practice pharmacist. We are quite excited about working with them.

**The Chairperson (Ms P Bradley):** I also know — you have briefed me before — about the innovative work being done, especially in Fermanagh and places like that, where we have GPs who have to change the way they work slightly. They have been quite innovative. That needs to be commended. I know that they are working under immense pressure. They have developed different systems. Will you explain them a little bit to the Committee?

**Dr Doran:** It is very important to understand how GPs work. We work for our patients; they are our priority. One of the reasons that we have got to where we are now is that GPs have been covering for one another and the community for a very long time. Despite the messages about needing change, because GPs have been sucking up the workload, it has not reached the stage where people have said, "We need to do something". Up to now, GPs have been saying, "I can't let my patient not have this; therefore I will do that extra work", or, "That practice is in difficulty; I'll help them out". We have been covering for one another for a very long time, but it has now reached the stage where there is no capacity for more cover. Therefore, the GP practices that are already strained are in the very communities that are in crisis. That is one of the reasons why recruitment into those practices is difficult.

Locums see the difficulties; they see how hard GPs work. They say, "Well, you know, I'm locuming here. Do I really want to spend 14 hours a day doing this when I can just continue to locum?". Because there are so few doctors in the mix, there is competition for locum work. When I was a locum in 1989-90, I went for a month and a half without any work. There was a desire to get a post in general practice, because it provided job security. GPs worked very hard — I knew that they did — but I wanted a post because it provided me with job security. Locums are looking at the immense workload that GPs are under and thinking, "I have job security in the limited market that there is. Why would I go into that practice?" That is the situation that we are truly in. We cannot fix that immediately, because what we need is a lot more GPs available so that the workload is less and people are more interested in taking up the posts. However, that will not happen tomorrow.

**The Chairperson (Ms P Bradley):** We want to get to the stage where a locum is not guaranteed a job every day of every week.

**Dr Doran:** Market forces are part of the pattern. We also want to make the job more appealing, so that they want to move out of the locum market and into general practice. The difficulty is that GP recruitment will take some years to address. It should have started 10 years ago; we should have done it, but it has not happened. We are then faced in the next five years with real difficulties. I was in practice this morning, before we came here, and the GPs in the health centre were aware that I was coming to talk to you today. They immediately said, "Please say this." and "Please say that." All of it was what we were going to say anyway. What they felt needed to be said was that, although we have a recruitment crisis coming, we are building up a difficulty with very good GPs who are working very well at high efficiency. They are now saying, "Do you know what? I might take early retirement, because this is burning me out." The statistics that we are looking at now are not real statistics. Those GPS will be dropping off the end more quickly, which will create a bigger problem. The issues are live and kicking, and the worry is that the solutions will not necessarily be quick enough. That is the worry for GPs, and I am talking about leafy north Down, not rural Fermanagh.

**The Chairperson (Ms P Bradley):** I remember you speaking about the issues in Bangor, with the closure of a practice and things like that.

Very quickly, before I bring members in, you talked about exposure for medical students. I know that that has been an issue. Can you explain what you have done to give medical students much more exposure, so that they want to work in general practice?

**Dr O'Kelly:** The college has worked quite a lot on that this year. At about 5%, Queen's University students spend amongst the least time in general practice of any university in the United Kingdom. That has been recognised. We have been in discussions with the Department, and with various stakeholders, and were successful in getting a primary-care expansion group set up. Queen's is looking at changing its curriculum, which it has to do, because next year its curriculum will be looked at by the General Medical Council.

We have helped to set up a GP society for medical students at Queen's, and we have had a great response from enthusiastic young people who are getting involved in it. We appointed two medical undergraduate champions, Adrienne Keown and Peter Ryan, to work with them to come up with innovative ways in which we could help. We sponsored voluntary electives in a number of practices for students going into their final year, and the altruism of our membership in setting those up was absolutely great.

As you are aware, we had medical students following me for a day. I did not put them off totally, fortunately. We had some meetings with you, and they found it quite mind-blowing that that was part of a career in general practice. I can remember one medical student following me around. She was a very nice young girl, but she had a capacity for talk that was unbelievable. The only time that she shut up was when we were in a studio and I was giving an interview.

There are ways in which to engage. Over the United Kingdom, the college has launched its Think GP campaign. We will be going with that over the next year. I know that Gary was at our dinner in the Guildhall, where he saw the video launching that campaign just slightly ahead of the launch. The college has recognised that, and it will be a major priority in the UK and in Northern Ireland over the next year. We will engage with all parties to promote general practice.

**Dr Doran:** The other area is school age. One of the difficulties with general practice at university, which has been identified across the UK, is that there is almost an insidious, "ending up in general practice", attitude to careers in medicine. People will say, "Oh, no: I do not do that", but, in fact, it has been shown in evidence that they do. Trying to get students to think about general practice before they embark on their career in medicine is also a priority in the college. The only way to get that to happen is through work experience in general practice at school level. There have always been issues around it due to child protection and confidentiality. GPs work in a room on their own, for want of a better term. The college has developed a toolkit to support GPs with that. It is something that we hope to take up and run with over the next while as well because it has always been a difficulty for school-aged children to get work-experience placements with general practitioners.

**The Chairperson (Ms P Bradley):** I know. I commend you because I know that you have been doing an awful lot of hard work to try to build up the numbers over the years. I hope that we get to the stage within the next few years that we need to get to. As you say, it is to protect the patient. That is paramount. Sometimes, we forget about that. We need to keep that as our central focus.

A few people wish to come in. First, is Gerry; then Gary, Trevor and Paula. If any other members want in, they can signal. Gerry, do you want to go ahead?

**Mr Carroll:** Thanks for your presentation. Obviously, you are painting a grim picture, but there is no doubt that it is an accurate one. I am certainly contacted, as I am sure that other members are, about patients waiting, sometimes for a week or longer, to get an appointment. That explains some of that crisis.

There is a lot in the action points about alleviating pressure and ensuring that there is better flow of the service. Do you feel that they are being adequately addressed by the Minister? You mentioned the curriculum's being looked at. Do you also see increasing the number of admissions of medical students into universities as something which could help to alleviate pressure as well and encourage more people to go into general practice? In the summer, I was made aware of plans by GPs to effectively resign — "resign en masse" was the term given to me — if adequate or effective action is not taken by the Minister. I think that next year was the date given. Can you comment on that and give us an update?

**Dr O'Kelly:** I will start with the resignation bit. Is that OK? I think that it is extremely regrettable that it has come to the stage that colleagues in the General Practitioners Committee (GPC) are going out to consult with the profession over resignation from the General Medical Services contract. It reflects the environment that we have at the moment. I still think that there is a lot of scope to prevent it from happening. I think that we are all awaiting the announcement later in the month of the Health Minister's plans in response to the Bengoa report. My hope is that the GPC will sit down with the Department and get that sorted out. I do not think that resignation is really what any of us wants. I am hopeful that it will not come to that, to be honest. It reflects the fact that morale in general practice is probably at the lowest that it has been for the last 30 years that I have been a GP.

We are looking at innovative ways of getting appointments and stuff like that. In my practice — I do not know why I am always putting a hand up to trial things — we are trialling a thing called askmyGP, which is a new model. It does not deal with demand — demand is still there and is still rising — it is just a different way of managing it. If you ring in for an appointment with a doctor, you will be told by the receptionist that one of us will phone you back and discuss your issue. This is not about stopping you having an appointment but about trying to triage better. It is a difficult one. Large sections of my practice population think that it is great. A few do not like it because they go through to our receptionists who do a little bit of triage first, which is an effort to try to prioritise how we ring back. It has reduced the number of face-to-face patients. My concern is that certain groups of individuals might lose out, such as more vulnerable groups, those who find using the telephone and email difficult. I am concerned about our vulnerable groups getting access to me as needed. Certainly, for those in the working community, it is brilliant in that they can ring up and are guaranteed to be seen and to have their problem dealt with. I am still an old-fashioned GP. My younger colleagues like it. I have some concerns, but it is a model and it is helping. It is not a solution but part of a solution.

**Dr Doran:** One of the difficulties in general practice is that demand is very hard to measure because "access in" limits what you can see of the demand, if you know what I mean. For example, yesterday, I had 60 telephone calls. That was limited by the fact that we start putting anybody who phones after 11.00 am onto tomorrow's telephone list, unless it is an emergency of course. That list of 60 in the morning was limited by how many patients could get on the phone lines between 8.30 am and 11.00 am. Sixty people managed it, and that was only 60 who wanted to speak to me, never mind all the other ones who wanted to get prescriptions or get things sorted out with reception. That is a huge demand on a telephone system in any morning. That was not an unusual morning; and it would be after you have done your two-hour surgery, your prescriptions and while your house calls are still waiting to be done. Think about how long it takes to do 60 phone calls; it just does not fit into a day.

One of the difficulties with the new systems is that they are designed around not allowing any space for waiting. They are saying, "Let us not measure demand. Let us just say that we will deal with everything on the day". This means that, instead of a patient phoning in and us saying, "A doctor will phone you back tomorrow", we will phone the person back that day. Everything is done on the day. That is fine but you might have 250 phone calls that day. That is fine if all your staff are in every single day but, if somebody is sick, what happens? It is a massive capacity issue. For example, if somebody has a holiday booked and you cannot get locum cover for them, the whole thing falls down.

We were at the annual conference of the RCGP in England last week and they talked about this very thing. Doctor First is the system there, which is very similar to askmyGP. There was a really mixed response. For some practices, it was transformational but, for others, it collapsed their practice and they had to go to something else. There are no simple solutions, and one of the difficulties is that we tend to work on processes. We do not look at outcomes. It is really about looking at whether we are getting the right outcome. It does not matter what the system is; we need the flexibility to allow practices and patients to work within that system. As long as the outcome protects the safety of patients and what they see as their needs, that is what we need to concentrate on.

Patient demand is the wrong term. I would love to be able to walk into my GP's office and be seen tomorrow. That is what I would like, but it is not necessarily what I need. It may be OK for me to wait two or three days if I have a sore throat. I always say, "Come back when you are worse". Do you know what I mean? I see patients when their condition is so undifferentiated that all I can do is say, "Let us wait and see. We will bring you back in a couple of days or next week". If we had a system whereby they would be confident in thinking, "It is OK for me to wait a couple of days and see my GP then", that would be good, but there is a demand and an expectation that it is actually their right to be seen today. It may be their right to be seen today, but they may not need to be seen today.

There is a huge amount to do with regard to educating the population in self-management. We have lost that over the last number of decades, and it has a lot to do with the loss of family units and all the

rest. Granny's advice is not there a lot now. There is a huge amount to do from the point of view of public education in self-management. There is also a huge amount to do with other professionals helping. Pharmacists, practice nurses, mental-health workers and mental-health hubs all working together can be exceptionally helpful in self-directed patient care and supporting that, but it still does not get away from those patients who actually need to see a doctor. At the moment, because of the difficulties in recruitment, we are concentrating a lot on that. It does help, but it does not get away from those patients who still need to see a doctor.

**Dr O'Kelly:** Your last question was about medical students. Certainly, there was an announcement by Jeremy Hunt about increasing the number of medical students in England. Yes: that certainly would be of use. There are, of course, discussions about a new medical school in the north-west, in Derry. Part of what we have to do is continue our work with our medical students, because the danger is that I will come along and say how bad things are at the minute and a medical student will say, "I am not doing that".

What I want to emphasise here is that I have been a GP for thirty years and love my job. It is a fantastic job. It is an honour to do it. It has variety. You build up relationships with patients and the community that no other branch does. It is extremely funny at times. You will get the best of laughs. It is completely frustrating, but it is never boring. I want to put on record that general practice is a fantastic career to get involved in despite all the problems that we have had.

**Mr Carroll:** That is good to hear; never boring.

**The Chairperson (Ms P Bradley):** Trevor, you wanted to come in on a point. Do you want to wait because there is only Gary in front of you?

**Mr Clarke:** I will come in on this point because I do not want to lose it. Grainne, you talked about when people need to see a doctor and you send them away.

**Dr Doran:** No, I am not talking about sending them away at all.

**Mr Clarke:** No: you tell them to wait until it develops further. I think that sometimes in Northern Ireland we are the victims of our own success. There is so much advertising telling you that if you have this symptom or that symptom, go to your doctor. Even take the stuff that the Chest, Heart and Stroke is doing about your face and all the different aspects of that. Also, if you have chest pains, you should go to your doctor. It might not necessarily be what is actually wrong, but people are being encouraged to go to the doctor. Then, what you are saying is — I am paraphrasing what you said — that basically you need a system in place. When should that system not be GP-led? On the one hand, we have an advertising campaign saying, "Act F.A.S.T". On the other, we have a doctor saying, "I do not think that there is very much wrong with you. Come back in a few days to we see whether this develops". There is a mixed message here.

**Dr Doran:** Traditionally, no matter what comes out, everything ends with, "Ask your GP". Do you know what I mean? Every morning, I look at new guidelines about whatever in the papers and the bottom line is always, "If you are in doubt, ask your GP". That is what people do. It may be to do with housing: it is not necessarily always to do with medicine. Asking your GP is very often the bottom line.

There is no doubt that — it is one of the things that we have in our papers — whenever any policies or guidelines come through, it is highly important that GPs are involved in their development so that their design reflects where care should be delivered or where access should be. We often get things, even in social services or social prescribing, where they will concentrate on the issue of people coming to GPs and say, "We know that you are overburdened, so what we will do is allow you the ability to refer patients into this instead". I say, "Yes, but why should they have to come to me to be referred into this at all? Why can they not refer directly into it themselves?" In the design, they say, "We need GPs to be able to refer patients into this", and we are saying, "No, we do not need GPs to refer patients into it; we need patients to be able to refer into it". So, let us open this up and allow patients to be able to directly seek end services.

**Mr Clarke:** Then, of course, you are basically pushing the burden onto someone else.

**Dr Doran:** All that I am doing is saying, "Yes, I agree that you need the service. Here is permission".

**Mr Clarke:** But, there needs to be some form of filter in the system, or else everyone will just go straight to the other system that you are talking about and which is not actually there — the one that you refer patients to. You are the professional, and you decide whether I need that intervention or not.

**Dr Doran:** Yes, but if it is not a medical intervention —

**The Chairperson (Ms P Bradley):** I know that, as MLAs, we get people in looking for housing adaptations, whatever those might be. If they are starting at the beginning, we will say, "OK. You need to go to your GP because you will need a referral to the occupational therapist, the social worker or whoever". I get what you are saying: people should not be going to you to get referred on to those other places because there is not another way of doing that self-referral. I get that.

**Dr Doran:** One of the things we are working on is having navigators or signposters who would be able to advise patients on whether this is a service they need; and we are talking about non-medical services. A lot of our time is spent on navigating patients to such services.

**Dr O'Kelly:** I think that there is certainly a role for improving things here. We talk about patient participation, and I think that something general practice could do much better is have expert patients engaging with our community groups. We do that, and I have done it in my local area quite a bit as well.

One of the problems we have had from top-down campaigns such as the stroke campaign and the lung cancer campaign was that consideration was not given to the potential increase in demand for our services. This makes it much more difficult to filter out those who really need to be seen and referred on. A case in point was the lung cancer campaign, which said that, if you have a cough for more than two to three weeks, go and see your GP. So, I get a procession of 25- and 30-year-old non-smokers with a cough for three weeks after a cold who are concerned that they may have lung cancer. This is the unintended consequence when you do not think things through. That is why we need to be in there at the very start.

The difficulty for me is in getting a GP to go to the PHA when it is developing a strategy, because we are full up with our work. If you are not at your practice, you need cover for the practice because nobody else is doing the work, and we do not have that cover. So, sometimes, we get asked, but we are not able to fulfil. I am not about patients and the public not contacting the GP, but there is an element here where we can, if you like, educate our patients — it is called "literacy", "health literacy" or whatever way you want to put it — to take more responsibility for their symptoms and health. We can do that with a lot of the community groups that are already doing it out there.

**Dr Doran:** The other thing I will say is that a lot of these campaigns are very important. Identifying stroke early is very important. It is not that we are against the campaigns at all; what we would like is the capacity to deal with them. We end up arguing over small elements of workload, but all these things are aimed at reducing overall burden in the health service, so if we can get a stroke patient identified early, get them into hospital early and get the right bed in the hospital for them early, they can get home, and the GP can manage them in the community with the help of a community stroke team earlier, and they will actually do better. Those things are very important for stroke patients. Every single time a campaign comes out, there is considerable additional workload involved in siphoning through to identify the real patients, and the GPs are the ones who deal with that every single time, because it is very difficult for the public to decipher those symptoms.

**Mr Middleton:** The Bengoa report has only been mentioned maybe once or twice. I know that the Chair has her views on how wide-ranging it will be and how big an impact it will have, and I share in that. I follow you on Twitter, John, so I saw your comments. This question comes directly from that. You mentioned that this is a real opportunity for real change. How has your organisation fed into that process? I do not want to hear what you want to see come out of this so much as what you expect to see and how it is going to impact on the challenges that we have raised.

**Dr O'Kelly:** We have had some input. I have met Professor Bengoa. We have produced a few documents on our vision for the health service in Northern Ireland, including 'Delivering Change for General Practice' last September. I have had consultations with most of the people around this table, the Health Minister and the permanent secretary. I have a position on the strategic leadership group where I can also put forward the view of primary care.

We have had so many reports. Half of Norway's forests must be here somewhere. We have had Donaldson, Transforming Your Care — we could go on and on. Reports are great, but they have not been acted on. We are a small country. We are 1·9 million people. We have fewer people than London and most parts of England. We know one another. Surely we can all come together and get this right. Professor Bengoa talks well and has good ideas. I do not know what will come out, but I expect it to be radical. It is important then that we all get on board and support it. There will be things that I welcome strongly and things that I find quite difficult and challenging. It will be the same for each one of you around the table. However, we have to work together.

There has to be a move from the hospital-based service, which is an expensive, clumsy service that was designed for the 1950s, to more community-orientated services. All the studies from the King's Fund and Nuffield, which are UK-based, and the Commonwealth, which is international, say that primary care is most cost effective but, more importantly, gives better outcomes. That is a challenge for me as a general practitioner, because the way that I have to work is going to change in the next five to 10 years. The way that I work with my hospital consultant colleagues will also change. There are great challenges. It is potentially quite exciting if we all get on board. However, it will only be exciting if we get a commitment that this is the way that we are going to go and resources follow, rather than those resources getting hoovered up into supporting hospital services that we really cannot justify any more.

**Dr Doran:** This is not just about resources; it is about the efficient use of resources. It is about processes and collaborative working. Unfortunately, up to now, the health service has been run in little silos of secondary care, community care and general practice. Until the last three years, those have never really worked in tandem. The integrated care partnerships have certainly been a lead into collective, collaborative thinking on in-care pathway planning. I hope that what comes out of the Bengoa report and the Minister's office is a new way of thinking about how we deliver the health service that gets us out of that rigid pattern. I hope that it will allow people to think more collectively about pathway planning rather than about "protecting my budget", "protecting my budget", "protecting my budget", which is how the system has been working to date. I hope that it will allow people to communicate better with each other. It is not going to be secondary care and primary care any more. It is, hopefully, going to be a continuum. That may mean consultants coming out of secondary care to support community care. It may be general practitioners expanding their practice teams to support community care. It may be more investment in a middle ground between primary care and secondary care. I am delighted that something is happening, but I hope that what comes out of it is actually acted on and we get real change that is outwith the old thinking, which has got us nowhere.

**Mr Middleton:** I agree with that. I suppose that we all want to see that. I praise the work of GPs in the community, because that is where we want them to be. Ideally, I would like to see one-stop shops, to which you can go if you have debt issues or are homeless. It all feeds into mental health and that sort of care. It all needs to be dealt with. I listened to the response to the innovation question about askmyGP. In response to a question to the Minister at a recent Question Time, the impression was given that the app is going to be rolled out to quite a few more practices. I am concerned, however, that vulnerable people are missing out on access. It may be something that we as a Committee need to monitor over the next while.

**Dr O'Kelly:** The response to the question earlier highlighted my personal concerns about vulnerable groups and those who find access difficult. For example, how does a deaf person use askmyGP? We had to modify that in our practice to ensure that deaf people have access. It is not a solution; it is help. It is finger-in-the-dyke stuff at the moment.

**Dr Doran:** The other thing to say is that it is a pilot at the moment. It is about ensuring that, as with all these things, it is adequately assessed at the end and that it is not just allowed to be rolled out because it looked at the beginning as though it might be a good idea on paper. With most of these things, you need to look at the outcomes. You need to assess, from the people carrying out the service and the people receiving the service, whether it is going to work and whether it is projected to be a successful model.

**The Chairperson (Ms P Bradley):** When is that due to finish?

**Dr O'Kelly:** I am not quite sure. I know that rolling out a second wave is being talked about. I have not seen a full evaluation of the first wave, in which we have been involved. I have not been talked to formally about it. Anything that you hear about GP support for it is anecdotal. Anecdotally, in my practice, some love it, some find it OK and some do not.

**The Chairperson (Ms P Bradley):** When did you start using it, John?

**Dr O'Kelly:** We started it in the early part of the summer. I am interested in seeing how we cope over the winter period with the winter increase. Monday morning is one hell of a morning, let me tell you. I can see the app helping, but I still have reservations about it. We have adjusted it slightly. I would like to see a proper evaluation of the pilot before —

**The Chairperson (Ms P Bradley):** We would like to see that as well at some stage.

**Dr O'Kelly:** — it is rolled out fully.

**Mr Clarke:** I just do not know how to say it. John, you talked about the rainforest's worth of reports, and you described yourself as being old-fashioned. There have been lots of reports, but they have not been acted on. Whether Bengoa is old-fashioned or futuristic, we all have to accept that we cannot continue doing the number of reports that we do. Someone has been brought in to try to shape the way in which we are going to go. I have not seen it — I have no idea what is in it — but we are just going to have to do it. It is a case of suck it and see.

**Dr O'Kelly:** Absolutely. I think that —

**Mr Clarke:** Sorry, John. Let me develop this point. You both talked about there being bits that you like and bits that you want. You also said that there were good ideas and that some might not be so good. Whatever is in it is what is in it. We all have to get behind it and make it work. The point that I agreed on was that every one of us around the table has been critical of some aspects of the previous reports. That is why they get shelved: because there is no political will to move forward with them. However, you and other parts of the health service are in crisis. We have to move with this.

**Dr Doran:** One of the things that you have to remember is that, no matter what we do, it has to be organic. A lot of things are stopped at the very beginning because they do not satisfy 100% of the people. They are never going to satisfy 100% of the people. They should therefore be implemented in a way that is organic and that, going along, allows feedback so that the system is allowed to adjust. In general practice, we are eternally reassessing how we do things. We will have an idea, we will implement that idea, we will look at how it has worked and we will adjust it as we go along. We will say, "At the beginning, we thought that this was the outcome, but, in fact, it is not. It is this, so we will adjust". Most of the plans that we have are so rigid. They are followed through, but, by the time that they are implemented, practice has changed. If what is coming through is allowed to be organic, I think that we will get better buy-in and more success out of it.

**Mr Clarke:** John made the point about being an old-fashioned GP. There are GPs who are old-fashioned but are extremely good GPs.

**Dr Doran:** Absolutely.

**Mr Clarke:** There are ones who are modern, and old-fashioned people do not like modern GPs. Ultimately, we still have to —

**Dr O'Kelly:** I am not that old-fashioned.

**Mr Clarke:** I am just using your words, John. There are old-fashioned GPs, and people like old-fashioned. Some people do not like modern, and we have modern GPs. Whatever the service looks like and however people describe themselves, that is how they are, and they are good at what they do. I am not trying to be cruel towards you, John. I am sure that you are very popular; otherwise, you would not have been doing the job that you have been doing, representing your organisation for this period of time. I am trying to be positive about this at the same time. However people describe themselves, all will have their own view on things. It is the same with Bengoa. Some people will say, "This won't work", and they will approach it with that view. We have to approach it with the view that we have to make it work.

**Dr O'Kelly:** I agree totally that we have to make this work. I am stepping down as chair next month, and maybe I am speaking for Grainne, but the college will work positively with Bengoa and with the Health Minister's plan. That is our intention. When the Donaldson report came out, we said, "We

accept all of the recommendations. Let us get on with it". We then had a hiatus. It is the same with Bengoa. I have not seen the report — none of us has — but we all have to get on with it and make it work, as you said. I do not think that you will find the Royal College of General Practitioners wanting.

**Dr Doran:** We are excited about the prospect of getting involved and actively supporting change.

**Mr Clarke:** Even if it gives you more work.

**Dr Doran:** The point is that GPs are adaptors and adopters. In the whole of the health service, we are the adaptors and adopters. We have been doing it for centuries. Some of the changes come from above, and we just make them and get on with it. We complain, but we get on with it. Some of them come from within. A lot of change that happens in your practice comes from within your practice. The other day, we were talking about how, in the 1950s, GPs worked in their own house in a back room on their own. Through general practice itself, not through the health service, the board or the Government, GPs have grown from being individual practitioners to being team players. We now have practice managers, receptionists, practice nurses and nurse practitioners, who are all employed by the GPs out of their own pocket, and, over the past number of decades, they have grown that service to support their patients.

**Mr Clarke:** Some of that has been a bad change. I am old-fashioned. I used to sit in a GP surgery on the day that I was sick. You went in the morning at 9.00 am, and you took your position in the queue and waited until you were called. You went at 6.00 pm after you had come from work, and you waited on your turn. You now have to ring your GP two weeks in advance. You have to know that, in two weeks' time, you are going to be sick.

**Dr Doran:** No, I disagree —

**Mr Clarke:** That is because of some of the managers in your practices.

**Dr Doran:** The difficulty is that the reason that the GP has changed over that time is that what we deal with has changed over that time. In 1948, when the health service started, GPs were working mainly to address infection. If you got a chest infection, you went to see your GP. If you got a leg infection, you went to see your GP. Now we are dealing much more with chronic disease management and with multi-morbidity in patients who come through the door. When I was training, my diabetics were all dealt with by the hospital, as were my asthmatics and my COPD patients. Every single one of those patients is now dealt with by me in addition to all the people who wake up in the morning feeling unwell and want to be seen. There had to be a change in order to manage that, because the original model of general practice, where you phoned your GP, and, if your GP could not deal with it, you were referred to the hospital, is not the model that is there now. The model now is that GPs deal with everything, and it is only the very rare things that they refer to the hospital. That is why 90% of consultations happen in general practice.

**Dr O'Kelly:** Owing to the fact that the population is getting older, we are getting more and more conditions of what we call multi-morbidity. If you go to hospital to see a cardiologist, he will look at your heart and deal with that. If you have a bowel condition or arthritis, you will go to a hospital. I am dealing with patients who have chronic chest problems, ischaemic heart disease, heart failure and depression, and maybe early dementia and arthritis. What we have to do, as generalists with an expertise in that, is to tease out the most important things, because if you treat one thing, you can damage another. If you put someone with heart problems who is already asthmatic on a drug called a beta blocker, you could trigger that. In the 1950s, it was scarlet fever, tuberculosis and a whole host of other conditions. If you had cancer, you died. Cancer has become a long-term condition. People are living for the long term with cancer, and they do get problems post cancer therapy. General practice is about managing that. That is the future, because nobody else can deal with multi-morbidities. The hospital-trained doctors are not trained to deal with them.

**Mr Clarke:** I will just put you both right. Grainne talked about the 1940s, and you talked about the 1950s. I was born in the late 1960s, just in case you think I was born in the 1940s or 1950s. I started going to my GP in the late 1960s or early 1970s.

**A Member:** You have had a hard life.

**Mr Butler:** Point of accuracy.

**The Chairperson (Ms P Bradley):** I get that point on long-term conditions. We are reminded of that day and daily in here as well.

**Dr Doran:** The 10-minute appointment system that we have currently to deal with that is complete madness. As I was saying to John, I had a very bad day on Tuesday. My surgery starts at 8.30 am. I see my first patient at 8.30 am, so I am in from 7.45 am in order to get test results out of the way first. My first patient at 8.30 am, walking into a 10-minute appointment, was suicidal. There was no way on this earth that I could have dealt with that in a 10-minute period. That was my first patient. By the time that I had him sorted, it was 9.15 am. The waiting room was then overflowing. I saw the next couple of patients. The next patient after that was actively having a heart attack. Was that dealt with in 10 minutes? No. At that point, I was an hour behind in my surgery. The next patient came in and said, "I was waiting an hour" and started laying into me. I settled him down and tried to explain where we were coming from. He did not realise that his appointment is for 10 minutes or that the eight or nine patients before him had got only 10 minutes. He came in expecting that I had all day to deal with his problem. When it was explained, he settled down, and I went up to the waiting room and made everybody else aware, because I was fighting time trying to catch up for them. After he left, the next patient who came in was suicidal. That is my morning. It is not sore throats, headaches, sore tummies or rashes. We love those patients. It sounds like a terrible thing to say, but they are easy patients for general practice. What we deal with are very complex cases that are dealt with in a 10-minute window, and that is every day.

I hope that that gives you a little bit of an idea that, if you are sitting waiting in your GP's waiting room and are being held up by 20 or 30 minutes, the GP is not having coffee. Sometimes I think that patients get the impression that the reason that they have to wait is because we are not working efficiently.

**Mr Clarke:** I would like to put it on the record that that is not the point that I am making. My point is that people are booking appointments with their GP two or three weeks in advance. How do you know that you are going to have a chest infection, a bad tummy or whatever —

**Dr Doran:** You do not, and that is not what that system is for. That system is for planned review-type appointments or for people who, for example, have had knee pain for six months and decide on a Monday that they want it seen to. You could say that they are entitled to be seen on the same day, but, if they cannot be seen because of what my day is like, it is OK for them to wait a couple of days: they have had their knee pain for six months. If, however, they phone in today and say, "I have acute chest pain today", they will be seen today. They will not be asked to wait for two weeks. If patients are being asked to wait for two weeks when they have conditions that need to be seen on the day, that is something that they need to sort out with their GP. The way in which we work is to see people on the day who need to be seen on the day and to allow a bit of slack for forward booking.

The other thing is that, through the askmyGP system, patients phone in, and you say, "Come down today and I'll see you", and they say, "It doesn't suit me to come down today. Next Tuesday would suit me better". The askmyGP system does not suit that. It suits you coming down today to be seen today. Then there are people who say, "I have taken a day off work today, so I want you to see me today", instead of understanding how the system works. It is the not understanding how the system works and the expectation that you have when you lift the phone to speak. If you understand how the system works, you can use the system better. It is about educating patients to make sure that, when they ring through, it is apparent that they need to be seen today or that they are worried enough to think that they need to be seen today or that they are quite happy to wait.

I am a female GP, and a lot of patients want to see a female GP and are prepared to wait to see a female GP. I have constant arguments with them and say, "Don't wait to see me. Go see somebody else, because what is wrong with you might need to be seen quicker. Don't be afraid to say, 'Can I see another doctor if there is a wait for Dr Doran, because I think that I need to be seen quicker?' You do not have to wait to see me. If I retired tomorrow, you would find another GP whom you would be quite happy to see". There is therefore a degree of inbuilt loyalty with some patients. We build up a degree of trust, which is important, but that trust can be built up in the practice rather than with individuals in order to allow that level of flexibility.

**Ms Bradshaw:** I met you at the start of the summer, John, and you were my first meeting in a long series, but I wish that I had met you at the far end. What I found that, when I met the MS Society, the Huntington's Disease Association and a wide range of others, what was very commonly said to me was that GPs do not understand the condition. I am talking about ME and others that I mentioned.

How does the royal college go about ensuring that GPs understand the very wide range of conditions brought to them? I am thinking of the situation of a mother for whom it took over two years to be diagnosed with MS. A lot of it is done by elimination. I cannot even find the proper word, but you know what I mean. It is diagnosis by elimination. How do you ensure that your GPs understand the wide range of issues?

**Dr O'Kelly:** As a college, we work with various groups and have run courses. We have done it with Autism NI and Cancer Research UK, and we work with Macmillan and Marie Curie. We do work with outside agencies. There is a difficulty, in that we are not specialists in conditions that have a very low prevalence. It can be difficult in a lot of those cases to get a diagnosis. You mentioned MS. I am not going to be the person who diagnoses MS; rather, I am going to raise the possibility. The referral goes to neurology. Do you know how long the waiting list is to see a neurologist?

**Ms Bradshaw:** Then you find out that it is not that, and then you move on to a different thing.

**Dr Doran:** One of the issues that a lot of GPs worry about from a safety point of view is that, when we refer to hospital now, we need to know what is wrong with patients before we refer them. Again, going back several years, we had generalists in the hospital. Therefore, if there was a bit of fuzziness about what was wrong, we could refer a patient, and that person would then have access to diagnostic tests that would allow a diagnosis to be made. Now we have to refer patients to different departments to get the diagnostic tests. If they go into ENT with something that we think might be throat-related, but it is not throat-related, the ENT surgeon will refer them back, and we will then refer them elsewhere. They will wait nine months for their ENT appointment to start with, another nine months to go to the next one and another nine months to go to the next one, because the waiting lists are so long. That puts incredible pressure on GPs to decide very early on which tack they are going to take.

Therefore, there can be a lot of waiting around and waiting for the development of symptoms to make sure that you are referring them to the right department. That, in itself, can be seen as delay by patients, whereas what you are doing is trying to ensure that you are referring them to the right area. We deal with such multi-morbidity and complexity, so it is very, very difficult for GPs to keep up to date with absolutely every medical area. There will be GPs who have special interests in some areas, and, in practices, there will be GPs who have special interests. That is why, in a group practice, very often people may come in with symptoms, and the GP may not be as expert in it as his colleague, and he may say, "Do you know what? It might be better for you to go and see Dr So-and-so about this". That is the GP's way of making an internal referral. If you are a single-handed general practitioner, you do not have the luxury of doing that, and, as such, it can be exceptionally difficult to work your way through the little ladder to decide which speciality you are going to refer to, knowing that, at the moment, most of those referrals could take a year.

**Dr O'Kelly:** You mentioned the chronic conditions fibromyalgia and chronic fatigue. They are extremely difficult to manage, because there is no diagnostic test, and they often present over time. Sometimes you need that time to confirm the diagnosis. There is no drug to cure them, and we sometimes end up putting people on multiple medications of dubious efficacy. In a lot of cases, it is a case of self-support and support in the community with non-drug therapy. As a college, we try to engage with as many groups as possible. Often, they produce information that we can facilitate being transferred to our members. The college is very active in postgraduate education. It has a website with educational programmes and toolkits, so the college does quite a lot in that area. I quite agree through that it is challenging.

**Ms Bradshaw:** I have just one more question, Chair. It is on mental health problems, and I think you might have touched on it, Grainne, in your description of your day on Tuesday. Given the high number of people in Northern Ireland on antidepressants, for example, and the length of time that they can be on them, I wonder how GPs will deal with that in the future. People can be on them for years, but they might benefit from CBT or some other talking therapy. When you mentioned increased investment, is that the sort of the stuff that you were talking about?

**Dr Doran:** Not just for mental health, because there are a lot of conditions where the rule set for management changes all the time. GPs are very active in trying to ensure that their practice is as up to date as possible. There is a challenge in going back to find the patients who are not just presenting with conditions. For example, if I have a patient whom I am considering putting on antidepressants, we will go through the talking therapies. There is quite an in-depth assessment performed, because every patient is different. At the moment, if patients are going on to antidepressants, we tell them that it will be for a limited time — usually four to six months — before we attempt to get them off them,

because, by that stage, they will hopefully have had the supportive therapies that might help them continue without antidepressants.

I have patients who were seen 30 years ago, when none of that existed, so they were put on their antidepressants then and are possibly still taking them 30 years later, although maybe not. There is a challenge in general practice to take on the workload of looking at that backlog. It might be a considerable workload to call in all those patients to go through a withdrawal programme and go through a referral for the support that they need to come off antidepressants. For example, a lot of practices have done it with diazepam already, and that has been very helpful. It was done with Librium quite a number of few years ago and is now being done with SSRIs. The difficulty is in being able to access timely supportive therapies to help patients through, because it is not something that is easy to do for patients. The medication is a crutch that they have been used to taking for a very long time, so there is a psychological dependence as well as a chemical dependence with some of it. There is a community support element involved as well, and mental health services in Northern Ireland are not well when it comes to money and support. We are increasingly relying on the voluntary and community sector to support us with our mental health patients.

**Mr Butler:** Thank you for your presentation. John, I met you in the summer, and I am certainly very supportive of many of the things you talked about then and gave us in the presentation. I have three questions to ask; I will just fire them out to you, and you can answer them at the end. The third question is probably the most controversial, if there is a controversial one; I hope it is not.

We discussed when we met in the summer the common patient database that will be shared between all GP surgeries. We talked about confusion and communication difficulties. I know information about how GPs are accessed, how they prescribe, how you book an appointment and patients' information is not collected in one manner. It is a cost to the health service, but GP surgeries will also have to deal with that. What is the royal college's recommendation, and what work have you done on that?

Last week, the Northern Ireland Association of Social Workers published a report called 'Above and Beyond', which measured the net financial benefit social workers provide in working above and beyond their paid hours. You mentioned that. It quantified it as 742,000 unpaid hours, saving a potential £11·4 million. That was an excellent piece of work that arms social workers well in their argument for their slice of the pie. Have you done any work like that?

I will now come to the controversial question. I was reading through the report, and I really appreciate the hard work GPs do. You two have portrayed a really professional image. You said that you love the patients and the relationship you have with them. However, 44% of the GPs who qualified between 2010 and 2015 are sessional. There are no sessional MLAs. I came from full-time work in the Fire Service, where there was no option to be sessional. Does the royal college support 44% of that workforce being sessional? I might be green on this; there might be a financial benefit to being sessional, but I do not think I can see it. What I see, potentially, is an increased financial burden, because a lot of them will be locums. You two talked about loving the patients. If you are providing a locum or a sessional, how do you build up that rapport and long-term contact? Nobody knows the patient better than someone who has spent time with them.

**Dr Doran:** I will deal with the controversial bit first, because it is probably —

**Mr Butler:** I do not mind.

**Dr Doran:** Locum GPs are essential. I cannot go on holiday without one. The way GPs provide services is that if we are not there, we have to put someone else in to do the job we do. If a consultant goes off on holiday, he goes off on holiday and his surgeries or clinics are cancelled. I cannot do that. If I go off on holiday, I cannot cancel my clinics, so I have to put somebody else in to do that work for me. The person who does that work is a sessional GP, or a locum GP, as we used to call them. They are essential to allow general practice, as it stands, to work. We have said there are not enough of them. The rural GPs in Fermanagh cannot get their holidays, and they are working full-time round the clock with no holidays. In my practice, we draw lots for who gets one day off at Christmas. We cannot get cover from locums because there is an insufficient number of locums out there. For general practice to work, we have to have sessional doctors. Those sessional doctors, remember, are not a cost to the health service because their pay comes from me. They do not cost the health service anything, and that needs to be remembered.

**Dr O'Kelly:** That is locums. Not all sessional doctors are locums. They can be employed by the practice, and they build up that continuity. It allows some of the older doctors to do other types of work. Some of the sessional doctors are working as GPs with special interests. There are doctors who are working in the Prison Service, although they are not all full-time. There are doctors who provide services assisting neurologists with headaches or who provide eye services. I did a lot of work in respiratory medicine, although I was a partner at one time. So, you are maybe going to find a sessional doctor in a practice who may be an academic doing research or working within the federation in leadership. I do not think there is one model all the time. Our younger doctors seem to want more variety in looking at core general practice but working within the health service a lot. Remember that the trusts employ a lot of young GPs —

**Mr Butler:** We talked about that.

**Dr O'Kelly:** — because they are trained in generalism and have that range of skills that no other doctors are providing. For me, the whole thing is more GPs, and they will find the different ways of working.

**Mr Butler:** Just to close that one out, hopefully, I understand and appreciate what you said about the need for holidays and that. If the trend was to continue that 44% of all the qualifying staff over five years are sessional — over 20 years that would be your staff — I do not think 44% of GPs in sessional employment would be providing good value for money.

You talked about flexibility. A lot of people like to take sessional work because it is more flexible and family-friendly. I welcome also that we have now achieved almost a 50:50 gender balance. That is commendable; it is really good.

**Dr O'Kelly:** If you want more GPs within practices, fix it.

**Mr Butler:** Fix it. Do you mean more money?

**Dr O'Kelly:** No, fix the environment — the things we talked about already. Create an environment that is attractive.

**Mr Butler:** There is a balance to be had, if you do not mind, John, because it is a professional job, and, as I said, we are not sessional. You cannot have that. This is sometimes possibly the least attractive job in Northern Ireland. You guys are under a lot of pressure too, and I accept that.

**Dr O'Kelly:** You asked about social workers, and yes, we would be supportive. There has often been a them-and-us attitude, which has been awful. Social workers and GPs should be together. I would be all for having access to social work services within my practice. I think they can do an awful lot.

**Mr Butler:** Sorry, the question was more about the piece of work social workers did and the report that was published last week. It was a really good piece of work. They had figures showing 742,000 unpaid hours. I am sure, and I know GPs do unpaid work —

**The Chairperson (Ms P Bradley):** I would expect nothing less than a good piece of work from social workers. *[Laughter.]*

**Dr Doran:** I think you would be astounded if we did the work on general practice.

**Mr Butler:** It was a good piece of work, that was my point.

**Dr Doran:** GPs do not regard themselves as working with any hours.

**Dr O'Kelly:** Yes, it is not a nine-to-five job.

**Dr Doran:** I cannot tell you what my working hours are. I am in at 7.45 am, yesterday I was home at 6.45 pm, and I then did another two hours on the computer doing hospital letters and reports. That is not an unusual day. The difficulty with general practice is that you can only guesstimate what a full-time general practitioner's hours should be on paper. They should be the same as anybody's full-time hours, but nobody is working those hours.

**Mr Butler:** Paula mentioned mental health. I would also be concerned for the mental health of professionals. The royal college obviously has a responsibility in that. I am not sure it is acceptable for anybody in a high-pressure job to be going in at 7.45 am, getting home at 6.45 pm, and spending those extra hours on the computer. I want to know what the royal college is doing to support GPs on the face of that. Is it acceptable that, as a GP, you are expected to do that extra? I know the answer will be no, but I want to know what the royal college will be doing and recommending for its members.

**Dr O'Kelly:** GPs have access to occupational health in Northern Ireland, which is positive, because that had not been the case here or in the rest of the UK. There are also charities such as the Cameron Fund and the Royal Medical Benevolent Fund. As a college, we have highlighted tiredness and overwork, and we started doing work on that this year under our chair, Maureen Baker, because it has safety implications as well.

You are not going to ask an airline pilot or a HGV worker to do those hours. It is not just us as GPs. You highlighted social workers. Having met an approved social worker when we were going to section someone, I saw the work they have to do in going at 8.00 pm to a patient's home with the police. It is in all areas of health that we expect our health professionals to go above and beyond the call. As we often say, everyone is allowed to be ill except the health professional.

**Dr Doran:** Resilience training is one of the other things the college has been looking at over the last year. Part of the GP forum review for England includes funding for mental health services for GPs. That was highlighted as part of the GP forum review because it is recognised there are issues there. It is a silent issue because nobody really wants to raise it; if you raise it, those GPs who are doing all that will say, "Do you know what? I cannot do that, but who is going to do it? There is nobody else to do it". Again, it is us having covered for ourselves for such a long time, and if we all stopped doing it today, the service for the patients with drop off.

**Mr Butler:** That is fine. What about question no 1?

**Dr O'Kelly:** Was that on the database?

**Mr Butler:** We talked about this before, but I want to hear what you think.

**Dr O'Kelly:** General practice in the UK traditionally has the best source of data. Our computer systems are more advanced than those in the rest of the health service. At the minute, we have the electronic care record (ECR), which allows some coordination. There are certainly plans to produce what is called an electronic healthcare record, which is an all-encompassing record. There are big plans to have a record from cradle to grave that encompasses the health, social care and mental health that all health professionals access.

That is the plan from the Department, and I know there is a working group; we have a representative on it. We will wait to see how that develops over the next number of years.

**Mr Butler:** The only reason I ask about that again is because I am dealing with a couple of issues locally; it is about someone who has transferred from one trust to another. That migration was handled really poorly.

**Dr O'Kelly:** There is an ongoing trial in the transfer of records between practices. At the minute, if you register with my practice where I live, I will wait forever to get your medical records. They are trialling electronic transfer.

**Dr Doran:** That will work well within practices that share the same computer system. The difficulties we have are with the two main computer systems in Northern Ireland. The computer companies need to work together to allow easier data transfer. The transfer from GP to GP is a technical problem that the computer people have to sort out.

There is a more interesting problem with sharing GP information with other people, as there is a major confidentiality issue for the patient. The patients have to give permission to allow their information to be shared. We have a minimum data set, which is how we talk about it, that goes into the electronic care record, and that is really just about your allergies, because it is very important to know what people are allergic to, and what medication you are on. It does not include your past medical history. There are patient confidentiality issues that are important for that sharing, whereas the GP-to-GP

transfer is a simple, practical computer problem that needs to be sorted, and there will be a solution to that.

**Mr Sheehan:** Thanks, John, and thanks, Grainne, for coming in today. It has been very interesting. Grainne, you raised the point about a patient coming in but you are not particularly sure what the problem is, and you talked about you do not want to refer them in case that consultant is not going to deal with the referral. You talked about referring internally within the practice if there is a GP with specialist knowledge but said that if you are on your own you cannot do that. Is there no structured collaboration or cooperation between practices in an area?

**Dr Doran:** I work in Bangor Health Centre, and there are five practices in that health centre. I regularly get a call from a GP down the corridor saying, "Would you ever come in and have a look at this, because I am not quite sure?" It might be a rash or another condition, and that is an example of a very flexible, professional ability to share information. If you work in rural Fermanagh, it might be 50 miles to your next GP surgery, so you do not have that ability.

At the moment, there is no shared patient care in practices. You are responsible for your patient. It is really only out of hours that has that level of shared care through its service. Through the federations, there are plans to try to improve that level of communication and the level of skill set that is available to a community rather than to an individual practice. That is something the federations are looking at, but it is wee while coming yet. It will not be at a GPSI/specialist level but on a GP-with-more-knowledge level.

**Mr Sheehan:** It seems that cooperation and collaboration are the way forward. In the constituency I represent, research was carried out in education where schools collaborated and cooperated, and there was an overarching inspection. The result has been a phenomenal rise in educational outcomes. It strikes me that you could have similar positive outcomes in medicine.

**Dr O'Kelly:** I agree with you on that. The college launched a document a few years ago called 'The Future Direction of General Practice: A roadmap', which has been incorporated in Northern Ireland. We now have 17 federations, but they are at a very early stage. You are quite right: that is the way to go. That allows us to work at scale and to —

**Dr Doran:** I can give you a very practical example of how that works. Again, the difficulty is with capacity. The Northern Trust, for example, had a 75-week wait for a dermatology appointment. If you came in with a lesion, it was 75 weeks before it was seen. That is just awful. In my area, it is worse than that at the moment, but that is what it was in the Northern Trust. It tackled that by getting 12 GPs who felt they had a little bit more confidence in dealing with dermatology to volunteer to support the other practices. Those GPs did sessions in other practices, as well as supporting their own practices, to see patients who had conditions that other GPS who were less confident dealing with but that could still be managed in primary care. They stuck with eczema, psoriasis, acne — I cannot remember the others, but there were five conditions. In addition, they set up a photo screening for lesions, where if you came in with a lesion, a photograph was taken and was seen by a consultant who then said, "Yes, that is fine. I do not need to see that", or, "Yes, I want to see that". With that system of sharing support within general practice combined with the photo triage, the trust got that waiting list down to nine weeks. Having said that, it took about three years to get there because of the difficulties with securing investment to cover the capacity issues.

**Mr Sheehan:** A lot of it just sounds like common sense.

**Dr Doran:** It is pure common sense. In the integrated care partnerships, we are working with the federations and the GPs to try to see whether we can use that model for other conditions it is suitable for. It is not suitable for all. One of the big ones is cardiology, for example. If you come in with chest pain, you still need tests done. If you come in with palpitations, you still need tests done. Sharing information amongst the general practitioners does not really help solve that waiting list issue. It needs some other outside-the-box thinking. Diagnostics are very often the thing there, and direct access to diagnostics will help.

**Mr Sheehan:** The other question is about the expansion of the role of community pharmacists. To me, it makes sense that a lot of work that GPs do could be carried out by community pharmacists. Even an expansion of the minor ailments scheme would help. Having spoken to some pharmacists, I

know they seem to be of the opinion that GPs are resistant to or reluctant about the idea of handing over work or types of work they are already doing. Could you comment on that?

**Dr O'Kelly:** Can I express a conflict of interest? I am married to a pharmacist. *[Laughter.]*

**Mr Sheehan:** That is a conflict.

**Mr Middleton:** This is being recorded by Hansard, so be careful.

**Dr Doran:** The minor ailments programme works very well, but the difficulty is that it is not well publicised or well financed. Things that were on it have now been taken off. The minor ailments scheme was working very well. The difficulty with a lot of this is, again, that to access it the patients come to the GP first to be told to go to the minor ailments rather than it being a system that goes straight to community pharmacy. The community pharmacists supply a huge amount of the smoking cessation support we have. In my practice, we send all our patients to our community pharmacists for smoking cessation support. There is a huge amount the community pharmacists can do. I am a great advocate of that, and I think the community pharmacists should be supported to do it. There is still the difficulty of patients being able to access it only if they come to the GP first to be referred through.

**Mr Sheehan:** I suppose I am asking you this: are there some things that community pharmacists could do that GPs do not want them to do? That seems to be the impression some of the pharmacists have.

**Dr Doran:** I do not think so. There are some things there is concern about. For example, you can take medicines reconciliation, which is when somebody looks at what medication you are on and says, "Do you know what? I think you should not be on this drug", or "This drug interferes with that drug". A lot of work has been done on that over the years that has raised the workload for GPs. When the pharmacist looks and says, "I think you need to speak to your GP about these medications", and then the GP says, "Yes, but we know about that interaction. We have had this conversation with the consultant. You have to be on that medication, and we are taking the risk with that". That led to an increased workload for GPs and an anxiety for patients — in some cases. That experience, for some GPs, put them off that service being used in the community because the community pharmacists did not have access to the medical records. If the community pharmacists had better access to patients' records, their ability to do those reviews would be better. But they are locked out of it; they do not have access to even the ECR. Again, that was one of the things that, if GPs had been involved at the beginning and in the design of it, they could have influenced how it was done, and there would be more ownership between the two. I know that is one of the areas there were concerns for GPs about pharmacists doing medication reviews in isolation. There were some issues with that.

But the problem is not with the community pharmacists doing the reviews; it is their access to doing the reviews in the whole-patient setting, which, without a doubt, they are well placed to do if they have access to the right information. That may come more now through the practice-based pharmacists, who will be in practice as part of the practice team and will have direct access to the patient information and the GP in the same building. Some of that work will now be done by the practice-based pharmacists.

There are endless amounts of minor ailment work in the community that pharmacists can do and, let me say, have been doing for years. But the patient pathway to it needs to be increased.

**Mr Durkan:** Thank you John, and I congratulate you, Grainne, on your election to chair.

**Dr Doran:** Thank you.

**Mr Durkan:** You have not taken over yet, but at least that is one resignation letter we are guaranteed John is going to submit. *[Laughter.]* I was just listening to the conversation today and your description of the opportunity for real change that we are on the cusp of. Obviously, we are, but this is not the first time there has been an opportunity for real change. That is why it is vital this one happens. I am certainly not going to go as far as Trevor and say, "Whatever Bengoa says, let us go along with it". That might be a wee bit hasty, and I think it shows why the Bengoa report should really have been published before now. It is going to be published in tandem with the Minister's interpretation of it, and I do not think we should hamstring ourselves to say that there will be nothing in her recommendations we cannot challenge or that, for the next five or 10 years, when any unpopular decision is taken by a

Minister, whoever that might be, or a trust, they can just say, "Bengoa made me do it". I do not think we can do that.

We need to see investment to ensure that, whatever the recommendations are, they are brought forward to become reality. You said, I think, John, that you want to see resources follow the recommendations. I would rather see resources go ahead of the recommendations so that it really is investment to save, whereas Transforming Your Care (TYC), which should have been that and was that on paper, ended up just being cutting, basically. I think that was a most unsatisfactory experience for everyone involved, for your profession certainly, for ourselves as elected representatives and for none more than patients on the ground or in residential homes who were being told, basically, "Get out, because people want to be cared for at home, even though we do not have a care package for you to get at home". You have reiterated that today and made very clear the challenges facing general practice. They are symptomatic of the problems that we have throughout the health service. Your report, which is currently on the Minister's desk, has 10 priority asks: have you prioritised them? Have had you any indication from the Department of what its answer to those asks might be?

**Dr O'Kelly:** It is a bit like treading water as we wait for the Bengoa report. There are two separate things: the release of the Bengoa report; and what actions the Minister plans to take. The GP-led working review looks at a whole range of recommendations and actions that are required for general practice. Some of that has started already, to be fair to the Department — I am not one always to be fair to the Department. We have had some investment in practice pharmacists, who are trialling askmyGP, and the Department has put some investment into GP out of hours, but that has to be an absolute priority before it just falls apart. An initial increase of 85 in our workforce started in August, although we did not get all 85 because it was advertised so late. As we said earlier, we have asked for 111 just to keep treading water, or our heads above water, so to speak. There is a list of those priorities. I will paraphrase: "It's the economy, stupid" was a phrase coined during Bill Clinton's campaign; for me, "It's the workforce, stupid".

**Mr Durkan:** Yesterday, John and I spoke on Radio Foyle about the prospect — hopefully, the probability — of a new medical school in the north-west. Maybe the Committee should do some work on that, or at least have a discussion to see how we can ensure that it happens. The need for it could not be clearer. You have outlined the need to increase the number of training places to 111.

On the administrative burden facing GPs, Grainne touched on the fact that you get home from work at 7.00 pm and then do a couple more hours. Is there anything more that could be done by the Department to take that bit of the workload off you guys? I know that you are medical professionals, but, increasingly, you are having to run a business, and it might be part of the deterrent to people coming into the profession.

**Dr Doran:** I do not think that the Department can do anything about the clinical burden, other than making the communications between primary and secondary care better. It is essential, for example, that we receive discharge letters, because we have to read them. Clinical letters still have to come to us because it is essential that that communication is done. Some of the burden lies in acting on the requests in a discharge or clinical letter. There is work to be done in the primary care/secondary care interface to ensure that there is not a lot of dumping on primary care to follow through on requests from secondary care. However, the administrative load of reading the letters is a necessary one because the letters still need to be clinically read. There is work around the referral processes to non-medical things. I spoke earlier about direct access: rather than me having to write a referral letter, if we could get direct access to those services for patients, or signposting through a navigator for those services, that would help with some of the administrative burden. We have looked at it and looked at it, but it is very hard to reduce the clinical administrative burden for doctors.

**Dr O'Kelly:** Direct access to physiotherapy for acute back problems, for instance, would be helpful. If you come and see me, I can give you painkillers and refer you to physiotherapy, but it would be better for everyone if you had direct access. You will get better quickly. That is the simple way. The referral process is often clunky. When a patient does not turn up, the onus is back on us to re-refer to the system. It could be that the patient did not turn up or did not get the letter because it went to the wrong address, or it might be a mistake by the hospital when a clinic has been cancelled by the consultant because he had something else to do. Someone might write to me and say, "Please refer to x, y and z". My response is this: "No, if you feel that that is needed, you do it". I do not mind reassessing a patient to decide whether a referral should be made, but I do mind being instructed to go through the hoops of re-referring.

We also need to give consideration to the staff working in general practice. Our receptionists are not just receptionists: they are now quite highly trained and often triage as well. Our practice managers are absolutely key to general practice, and they need support and training. We need to invest in that area, because it is the practice manager or administrative manager who keeps the whole system going. Clinically, we have to do it; that is our job. Hopefully, we can do it to the best of our ability.

**Dr Doran:** It is a matter of trying to create space to do it. GPs work every single day in clinical practice. If we took time out to do our administrative work during the day, we could not do as much clinical work. Having the flexibility for GPs not to do as much clinical time face to face, to allow them to do their administrative load during working hours, means fewer appointments for patients. That just adds to waiting times, which makes us feel worse about ourselves and our practice. Therefore, we do not do that. We could dramatically cut back on the number of face-to-face clinical consultations in order to get all the work done during the day, but that would need to be supported.

**Mr Durkan:** There are clear needs, and you touched on the difference between need and demand, albeit from a patient perspective. You said that you need an urgent financial injection. I certainly support that and an increase in your percentage of the health budget to around 11%. I am not sure how much of a role the Committee will have in the budget process this year, but it is certainly something that I will support and argue for. There will be others, naturally enough, arguing for a bigger slice of the cake, and we will have to ensure that mental health gets more than its current meagre allowance. However, it is easy for general practice to make the argument that it is not the case that, if you get a bigger slice, someone else has to get a smaller one. If you get a bigger one, others will not need as big a slice.

Finally, I touched on the administrative burden and the challenges facing general practice. That is indicative of what the discussion is about today — that is what you are here to talk about — but it is really all we have to talk about. I would like, at a future Committee meeting, to get an opportunity to chat with the sector about the challenges facing your patients. There is a huge increase in demand. Where do you see that? Do you see it in mental health? Are there any areas in particular that you think we and the Department should be focusing on?

**Dr O'Kelly:** We, as a college, have had talks with the Patient and Client Council to make ourselves aware of them. I have also had consultations with various voluntary groups. An area in general practice that we can do better in is patient involvement and participation in practice. We have our own group in RCGP NI to promote that. We are keen to use that group to develop patient groups in practices in order to support and give feedback to practices. When they work well, they work very well, but, sometimes, they do not work particularly well. If we had support for practices to develop their patient participation, that would be very positive indeed. It is something that we, as general practice practitioners, could do much better. The college is very supportive of it. We would welcome any support in that field.

**Dr Doran:** There is a huge amount of very good work in the community and voluntary sector that GPs are not necessarily aware of or do not have access to. We are trying to improve how GPs can access that. At the moment, the patient comes to them first, so they need to know what is there and how to access it. That is hard for GPs, in the middle of all the other things that they are doing. It is about trying to find a way of navigating towards that. The integrated care pathways (ICPs) have been doing a lot of work on that front. Some of it is really revolutionary: for example, a GP can phone up and say, "Look, I'm really worried about this isolated little old lady", and someone else will say, "Do you know what? There are a huge number of services we can offer to that lady. I'll go out and speak to her". Rather than the GP having to say, "There's some sort of service, but I can't remember. I'll try to find out and get back to you", they are able to do that immediately. They are making use of the vast resources that we have in our communities to help our patients. Those resources are very underused at the moment.

**Dr O'Kelly:** You might be aware of the social prescribing programme —

**Mr Durkan:** Yes.

**Dr O'Kelly:** — which we are involved with as well. That has been very useful. Our practice has been very involved in that. One of my partners, Angela Loftus, is keenly involved. You rightly highlight that those are the areas that we, as GPs, need to get more involved in.

**Mr Milne:** Thanks for your presentation. I found it very interesting. Mark must have been reading my notes, because he dealt with quite a few of my questions. He asked about the response from the Minister. You seem to be content that there are movements from the proposals that you put to her. The point that I want to make — Mark touched on it as well — is about the 11%. You said that general practice should account for 11% of the total health and care budget. Have you found an area in the health service where that could be taken from? As was explained, for someone to get more, somebody else has to get less. Have you thought that through? Where might it be?

I also want to ask you about GP recruitment. You need to recruit 111 GPs yearly. Will you be fit to do that with people from the North? You also talked about recruiting abroad. Does that mean that you feel that you will not achieve that number here and will have to go overseas? At present, how many GPs here are from outside the Six Counties? I have a couple of other bits and pieces, but I will come back to you.

**Dr O'Kelly:** First, on the investment of 11%, the total health budget is over £4 billion. It is about how we spend our money and what the direction of travel is. We are constantly told of the move to community services. A few years ago, an analysis by Deloitte showed potential savings from investing in primary care. Deloitte did that work in 2014-15 for us, and we can certainly share that document with you. If you can deal with the problem upstream, you stop the torrent hitting the hospital sector downstream. When the money is spent in hospitals, it is much more expensive. Think of minor surgical procedures, such as removing an ingrowing toenail: the cheapest way to do that is in your practice. If you have a GP who is skilled in that, he or she will take it out for approximately £60 to £70; if you go to a hospital consultant, it will cost you maybe £90 to £100; and, if you go to the private sector, you can add on a little more. If you can get us doing a lot of that work, there are inherent savings for the health service. It is about using money much more wisely. The NHS England 'General Practice Forward View' looks at increasing the percentage — maybe not up to 11% — and, if they deliver what they promise, it will be around 10·6% or 10·7% of the budget. It is not that taking money from other services makes them bereft; it is about doing things much better. The service being more cost-effective frees up my consultant colleagues to do things that are more appropriate for them to do. That is where we are coming from.

**Dr Doran:** I suppose that we are not —

**Mr Milne:** Do you find that kind of thinking in the Department or the health service? Do people want to develop it further, or are you finding obstacles?

**Dr O'Kelly:** If you had asked me that question three years ago, I would have said an emphatic no, but we have managed to change the conversation. The recurrent stresses faced by, for instance, the emergency departments, the out-of-hours services and the Ambulance Service have made them think along this line. The evidence is there from The King's Fund, the Nuffield Trust, The Commonwealth Fund: all the evidence points that way, and it is what we have spent the past three years doing. We have strong evidence for our argument. It is now about taking the plunge, so to speak, and that is what I hope to see with Bengoa. I am not talking about the sudden stripping out of hospital services; it is about giving people a service that will be much better for them in the long run. If we can deal with patients in their own community and general practice, it is much better than them having to go 40 or 50 miles to a hospital to have their problem dealt with.

**Mr Milne:** I suppose that it ties in with what you were saying, Grainne, about working in silos.

**Dr Doran:** Absolutely.

**Mr Milne:** Maybe it has to be developed now over the next short period.

**Dr Doran:** We are not saying that it will be easy — not at all. I get annoyed talking about money all of the time, with everybody talking about 11% or people saying, "You just want to take money out of secondary care and put it into GPs' pockets". Talking at that level annoys me slightly because it sounds like I want to be paid more, but that is not what we are talking about; we are talking about services in the community. They may not necessarily be delivered by me; they may be, as in the Northern Trust model, delivered by another practice on my behalf, by another practitioner, or by a sessional doctor who has been well used in that way. It is about looking at different models of care where there is evidence of the outcomes. I keep stressing this: it is not about throwing money at another scheme; it is about a sensible use of money on services where the outcomes are what we are

looking towards. I do not want money put into any service that will not provide outcomes that bring about change.

To date, we have continuously thrown money at existing services that do not provide the outcomes. All we are doing is putting more and more money into the same systems, which, historically, have been shown again and again not to be efficient. We need to ask, "What are we looking to buy? Are we looking to buy a service, or are we looking to buy an outcome?" If we are looking to buy an outcome, we need to make sure that the service that we buy will deliver it. That service might not be based in secondary care; it might be a community-based care service. That is exactly what we are talking about, and 11% may not be enough; it might need more. If, however, it is designed properly, it will be a very efficient use of resources. If, for example, the Northern Trust were to deliver a waiting list reduction from 75 weeks to nine weeks, you could not argue with that, and it will have cost less than the service *[Inaudible.]*

**Mr Milne:** What about GP recruitment?

**Dr O'Kelly:** We have been calling for 111 positions. For the previous 65 GP training positions, there were usually between 130 and 140 applications. We believe that we need to train more ourselves, and that can attract young doctors from all around the United Kingdom. Traditionally, we have had doctors from the Republic of Ireland, which is an area that I work a lot in. Graduates from University College Galway have come here. There are ways that we can work with the Republic of Ireland, which has a GP training system very similar to ours. It is slightly more difficult with the rest of the EU because, in certain parts of the EU, family doctors do not deal with children, gynaecology or obstetrics. It tends to be slightly different, but we have had a number of very successful doctors from Poland, for instance, who provide a very useful service. The onus is on the Department to have an induction programme to allow these doctors to be trained up to work. A little more training might be required for a doctor from eastern Europe, but I do not think that it takes very much for someone who has been through the GP training system in the Republic of Ireland through the Irish College of GPs, whose training system is very close to ours. There is absolutely no doubt that it has created difficulties. Part of that was because of EU regulations and UK regulations. The Department of Health cannot do it on its own; it needs to look at it on a UK-wide basis.

**Mr Milne:** Finally, GPs who are trained here initially go into practice here. Do you have figures on the leakage after two or three years?

**Dr O'Kelly:** The one thing that the college was able to put to bed was the notion that we train GPs who all trundle off to surf on Bondi Beach. Our figures show that over 97% remain in the system. Going back to what we were talking about earlier, I do not think that that necessarily means that they are working in general practice. A percentage are working for a health and social care trust and some do sessional working, which means that they do some work in general practice and some work in out of hours. Sessional working is almost like a portfolio career, which seems to be the trendy way forward at the minute. We may have to adapt to that, and we have to recognise the demographic that over 50% of qualified GPs are women, and they will have children in their thirties and forties. We need a mechanism whereby we can support them through that and get them back in. We are losing that group of female doctors in their late thirties and early forties, and we tend to lose male doctors in their early fifties.

**Dr Doran:** It brings us back to retention and ensuring that the very experienced GPs who work in the system at the moment feel enabled to continue to do that job for as long as they can, which goes back to the original problem of the pressures. There is a little domino effect going on whereby GPs who would normally have worked until the age of 65 or 70 now leave at the age of 60, and they would not have considered that in the past.

**Mr Milne:** Thanks very much. Thanks for your presentation.

**The Chairperson (Ms P Bradley):** You will both be very glad to know that everyone has asked the questions that they wanted to ask. Thank you for your time today.

**Dr Doran:** Thank you very much for allowing me to come along today. I know that you know John very well, and a lot of you have met him individually. I will be new to you when I start, and I hope that you will be open to meeting me to get to know me, too. I hope that you see the college as an information resource for you, because there is a lot of conflicting information out there.

**The Chairperson (Ms P Bradley):** Thank you very much, John and Grainne.