Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

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GP Out-of-hours Framework:
Department of Health, Social Services and Public Safety and Health and Social Care Board

11 June 2014

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Roy Beggs
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr Fearghal McKinney

Witnesses:

Mr Stephen Galway	Department of Health, Social Services and Public Safety
Dr Sloan Harper	Health and Social Care Board

The Chairperson: Unfortunately, Heather Stevens had to go to get a flight, so apologies for the delay. We have here Stephen Galway, primary care medical services branch; and Dr Sloan Harper, director of integrated care at the Health and Social Care Board (HSCB). You are very welcome. The procedure is that you make a 10-minute presentation, and then we will open it up to comment or observation.

Mr Stephen Galway (Department of Health, Social Services and Public Safety): Thanks very much, Chair, for the invitation today. I am grateful to have the opportunity to provide evidence to the Committee on the strategic framework for GP out of hours. We will outline briefly the context of the framework and what the main aims are designed to achieve.

GP out of hours is an urgent care service. It is for urgent primary care conditions that cannot wait until a person's GP surgery is next open. It can only deal with primary care conditions, and it is not appropriate for people with, for example, strokes, heart attacks, fractures etc, who should go to an emergency department or phone 999. Currently, there are five providers in Northern Ireland, with one in each trust area. Three are provided by the respective trusts, and two are provided by mutuals.

Prior to 2004, GPs in Northern Ireland provided an on-call service to their patients. However, after the introduction of the general medical services contract in 2004, all GPs opted out of that service, and the then four health boards took on responsibility for it. The Department then asked the boards to bring forward proposals for a more regional out-of-hours service with potential to align the service more closely with other urgent care services. In the meantime, Health and Social Care was restructured, and the work was then taken forward by the Health and Social Care Board. The strategic framework is the culmination of those efforts.

As part of the development process, a regional out-of-hours project was established, a project manager was appointed and a steering group was set up. An options appraisal was carried out and consulted on. The options appraisal identified a number of options but settled on a preferred option for the out-of-hours service, which was the regionalisation of call handling and triage and the development of a regional out-of-hours nurse triage, whilst maintaining the clinical GP service with existing providers. The service was to be underpinned by a single telephone number.

In taking that forward, there have been three aims: first, to have a patient-centred service, effective access and demand management; secondly, to have learning, accountability and organisations focused on quality and health outcomes; and, thirdly, to have innovation and coordination. That is translated into three areas of work: simplifying access to the service; improving operational efficiency; and improving service alignment with other healthcare services.

On simplifying access, there are five providers and, in fact, seven telephone numbers, so the development of a single telephone number would simplify patient access to the out-of-hours service and help them access the most appropriate service for their clinical needs, thereby improving their overall experience of the service. The single number is also consistent with proposals contained in 'Transforming Your Care' (TYC), which recommends a single telephone number for urgent care in Northern Ireland. Other mechanisms to simplify access would include improved communication with the public and better telephony to manage all the call handling workload across Northern Ireland.

On operational efficiency, there have already been significant enhancements in technology for the service, which the board will continue to build upon. For example, a website for GP out of hours is now in place, which is intended to improve the service further through enhanced technology that is intended to coordinate and facilitate home visits and to coordinate workload amongst call centres at busier times as well as consolidating the number of triage centres at times of low demand after midnight.

Improved alignment would include, for example, agreeing protocols with the Northern Ireland Ambulance Service on the transfer of calls to and from it. It would also include consideration in due course of further broadening the service provision to cover call handling for social services and mental health.

Based on the preferred option identified in these broad areas of work, in April 2012, the Minister agreed that the board should go to public consultation on the strategic framework. The Committee was informed, and copies of the strategic framework and consultation documents were supplied. During the consultation period, the board held nine meetings to take views. At the close of the consultation period in December 2012, it had also received 50 written responses, including one from the Committee. Those responses were collated in a summary document, and the strategic framework was revised by the board, taking on board the comments received. In January 2014, the Minister agreed that the board could release the revised framework and the consultation response document to those who had responded to the consultation and other key stakeholders, including the Committee.

The key message from the engagement with stakeholders and consultees is that there is broad support for the strategic framework and the direction of travel. Now that that direction is set, the board will lead on the implementation of it. An outline time frame has been set, and the first significant milestone is the scoping of the single telephone number for September this year. As part of that work, officials are monitoring the position in relation to NHS 111 in England and in other parts of the UK. However, it is crucial to note that a key difference between what is happening in England and what is proposed in Northern Ireland is that, in England, triage is carried out by non-clinical staff, whereas, in Northern Ireland, triage will continue to be delivered by clinical staff.

I should also highlight the fact that all of the detailed proposals that we developed under the aegis of the strategic framework will require a robust business case to justify any additional funding that might be needed. There are also a number of other challenges, apart from funding, that will need to be tackled, not least how to manage demand at peak times, how to recruit and retain staff and how to ensure that service delivery is of high quality while any new arrangements are put in place.

It is clear that out-of-hours provision is known about in Northern Ireland. There is a high level of public awareness and usage here, which is significantly higher than in England, Wales and Scotland. We also know from surveys done by the Regulation and Quality Improvement Authority (RQIA), Primary Care Commissioning (PCC) and Ipsos MORI polls that it is well regarded by service users. Therefore, it is a case of building on what works at the minute but making sure that it is as easy to access as

possible, runs as efficiently as possible and fits coherently the wider landscape of urgent care provision.

I hope that that has been helpful. We are happy to take questions.

The Chairperson: Thank you, Stephen. One thing that jumps out of your paper is the number of patients who are using GP out-of-hours services, which has increased by over 18% in the last five years, whilst emergency department activity has decreased by 2% over the same period. The Committee has consistently been told that a large part of the problem associated with emergency departments is that there are more and more people.

Mr Galway: It is not just about the number of people, but about how they are managed, dealt with and triaged. Some of the patients who attend out-of-hours may be directed towards emergency departments, but some of them may be advised to contact their GP the following day or to see a doctor that night. However, it is about how they are managed when they are there and how they access emergency departments.

The Chairperson: This is not necessarily your remit. Consistently, we have been told that there has been an increase in the number of people turning up at accident and emergency with what has been referred to on many occasions as "anything and everything" and there is an increase in our elderly population going through emergency departments. Effectively, you are telling us that there has been a 2% decrease over the last five years.

Mr Galway: From the data that we have pulled together, yes, there has been.

Dr Sloan Harper (Health and Social Care Board): Maybe, Chair, I could add to that. You are absolutely right; it is slightly less than it was five years ago. There has been a flatlining or a slight decrease. That is a regional figure and, within that figure, there are differences in the five different trust areas. In the Western Trust, the Southern Trust and the South Eastern Trust areas, there is an increase in numbers, but, in the Northern Trust and the Belfast Trust, there has been a decrease in attendances at emergency departments, which outstrips any increase in that other area.

The Chairperson: So, there is a decrease in the Northern and Belfast trusts.

Dr Harper: That is correct. Individual hospitals may see an increase, because of a change in the number of emergency departments.

The Chairperson: That is very interesting. Thank you for clarifying that. Currently, does the Department know currently whether it can afford to implement the framework?

Mr Galway: As I said in my opening statement, there are elements and building blocks in the framework, and each of those has to be brought forward, for example, the single telephone number, and it is only through the business case process that we will be able to determine what funding will be needed to provide that. It is about looking at the overall budget that we have for out of hours at the moment, what aspects of development we need to put in place and how much that is likely to cost.

The Chairperson: So, it has not been costed.

Mr Galway: No, not all the individual items that will be needed. There has been a financial review done of out of hours as it is at the moment, but going forward, there are no firm estimates of the costs attached to individual areas of work, but that will be taken through as part of each element in the business case for each area of work that we want to do.

The Chairperson: By way of the timeline, the responses to the public consultation that you referred to ended in October 2012. A summary of the responses was issued in November 2012. Yet it was not until January 2014, which is 13 months later, that the Minister gave the approval for the implementation. What was the cause of the delay?

Mr Galway: There was no specific reason other than just being aware of what the board was putting through in the consultation, looking at it to ensure that it was the right direction of travel and taking account of what was happening in England. There are a lot of issues around NHS 111. What did that

mean? Was it a single telephone number? It was just about making sure that we got that correct and that we were not going to go down the same route. So, it was about being aware of any issues that have been highlighted through that development and implementation in England and Scotland. The Minister had some individual queries that he wanted clarification on. It was just back and forward. There was no specific reason. It probably could have been done a lot earlier.

The Chairperson: If there was no specific cause, has there been an impact as a result of the delay?

Mr Galway: There probably has been. We would have been a bit further ahead than we are at the moment, but the steering group is reorganised again. It is meeting this week. There has been work going on in the background on the single telephone number. Members of the steering group have been working away and are closely involved with England and what is happening there, looking at how that business case can be developed. There have been slight areas of delay, but, in the background and running alongside, there has been work going on. So, it has not been a total loss.

The Chairperson: Finally, one of the issues around the Transforming Your Care agenda that has been highlighted through the likes of the Royal College of GPs is that the shift left has not been supported by a move left in investment for GPs. The participation, for want of a better word, through general practice has increased dramatically, but that has not been followed by investment or the fact that we are now looking for the system at that early intervention level to do more. How do you respond to that criticism? Is that accurate?

Mr Galway: In essence, it is outside of out of hours and what we are here today to talk about. However, in terms of TYC, there is a move in looking at identifying the funding that needs to shift with it. There has been a lot of work done on integrated care partnerships (ICPs), signing individual funding for the development of those, making sure that they are able to operate and that posts are backfilled to allow GPs to get closely involved in the development of ICPs and the care pathways that they need to develop. There is a plan with the Department that that money will transfer with that workload. It has to in order to be able to support the workload.

The Chairperson: I think that it is linked if we are looking at out-of-hours services, almost with a view to taking some of that focus away from emergency departments when people are in more drastic need of intervention. So it is linked to that process. I am interested in your thoughts around how that system is supported.

Dr Harper: Maybe I could add to that, Chair. In 2013-14, the board invested an additional £1·05 million in the GP out-of-hours service, which is coming under strain. It is the same workforce of doctors who work during the day whom we require to volunteer to work in those services at night. It is not a different service. As they get busier during the day, and with the changing nature of the workforce, with medical students and higher numbers of female doctors, it puts the system under more pressure. We bid for some 5% additional funding in 2013-14. Of the £160 million that has been bid for as additional funding for 2014-15, £2 million is intended for GP out-of-hours services to boost numbers. As I said, you can only stretch an elastic band so far, and a medical workforce planning group is looking at the number of GPs that we train in Northern Ireland, which was previously 60% male and 40% female. Now, those ratios are reversing, and that has an impact as female doctors look to family-friendly hours and so on.

The Chairperson: OK. I appreciate that.

Mr Dunne: I have just a couple of quick points. What are the advantages of the new phone system over the more localised system that exists at the moment? Sitting here, you would think that we are getting into a huge organisation, where people will join queues and speak to computers rather than to a real person, and they will have to sit for some time while trying to get a response to their medical need. Is there a risk of going backwards rather than making improvements?

Dr Harper: There is always a risk with any system, but we have been looking at evidence from other places. We looked at Scotland, where they have NHS 24, which is a single number. It was a difficult number to remember, so they have changed it to 111. That works well there because they have what is called a virtual telephony network, so people do not have to move out of their local areas for the jobs. The telephony network operates in a way where every receptionist who is taking a call can see all of the calls in the system, and they can be taken off in chronological order. That would mean that, whether receptionists were working in Derry, Belfast or Armagh, they could deal with demand from the

whole of Northern Ireland. That makes the system more efficient and effective. People should be able to get through quicker, and we should be able to monitor that better as well.

Mr Dunne: So, it will be one centre?

Dr Harper: No, there will be different centres. It will keep the workforce in their local areas, but they will all be linked in one telephony network, so they are all linked up by computer. That is how it would work.

Mr Galway: It the demand is higher in one area, then another area, where demand at that time of night is lower, can take some of the pressure off by addressing the calls and triaging them accordingly, but it will be dealt with primarily, in the first instance, in local areas.

Mr Dunne: Right. Is it the intention to go to an outside provider to get this service?

Dr Harper: There is no plan to do that at this stage. There are a number of options, one of which would be procurement; another would be to go to a trust. There is also the regional Ambulance Service Trust, which has a telephony network; that is another possibility. It could be one of the existing providers that have a telephony system whereby they receive calls, nurses operate them and ring patients back, so, there are different options but there is no specific plan as to who the provider would be.

Mr Dunne: Are the GP contracts under review?

Mr Galway: The GP contract is negotiated annually. General medical service provision during the day —

Mr Dunne: I mean the out-of-hours contracts.

Dr Harper: The doctors who work in the GP out-of-hours service are a mixture of salaried doctors and doctors whose services are retained on an as-and-when-required basis. Their pay, since the initiation of this service in 2005, has been linked to the consultant contract, so uplifts that are applied to that should be applied to the doctors.

Mr Dunne: Right. They will be or they are?

Dr Harper: They should be. If they are not we *[Inaudible.]*

Mr Dunne: They tend to be quite overloaded, so what about managing the demand? How are we going to make improvements to that to help manage it?

Dr Harper: As Stephen said, the advantage of one single network is that you can use all of your capacity all of the time, so if the centre in Derry is under pressure, but Newtownards is not, then, because they are linked through the telephony network, the staff there can come in and assist with some of the pressure. That is the way that it works in Scotland. The big centre there is in Edinburgh, but if there is pressure on Ayr, then the Edinburgh folk can come in and assist with the triage of calls.

The bid for funding is dependent on the £160 million coming through. That would significantly improve the number of doctors and nurses available.

Mr Dunne: Are you sharing the workload then?

Dr Harper: Sharing the workload across Northern Ireland. To do that effectively you need what is called a directory of services so that you can ensure that someone who is doing triage in Belfast understands whether pharmacists are open in Strabane or Omagh and can direct the patient there. There is some management with that.

Mr Dunne: I still think that people will be concerned about moving away from the local service. In the north Down area we are stuck in with the folks over there in Ards.

Mr McCarthy: You are in good company.

Mr Dunne: We have to go to Newtownards. There is a risk, of course, as the Chair said, that people do not go. If you live in Holywood you are going to go over the hills to the A&E rather than travelling away to a far out place like Newtownards. That is an issue as well. Trying to change those trends is going to be difficult.

Dr Harper: There are certain core principles of the GP out-of-hours service, and one is that doctors will continue to do home visits.

Mr Dunne: Do they still do home visits?

Dr Harper: Yes they do; 7% of the contacts result in home visits.

Mr Dunne: Is it only in the middle of the night that they do them?

Dr Harper: They must do them some time. For example, at the minute, if you live in Armagh and you phone up after midnight, you will speak to somebody in Ballymena, but if you need to see the doctor or be seen at home by the doctor, it will be a local doctor that you will see in Armagh or at home.

Mr Dunne: What is the response time; is it a week? *[Laughter.]*

Dr Harper: We do monitor the response times. We divide the calls into urgent and non-urgent. For urgent calls, getting back to the patient within an hour is the target, and that is 90% to 95% achieved. Where we are slipping and are concerned at the minute is on the level of delivery on the non-urgent calls, because a headache that appears to be non-urgent may then develop into something. In a couple of the areas where they are having difficulty getting doctors to work at night, and over weekends and bank holidays in particular, the non-urgent response times have become unacceptable, so we are visiting those providers in southern and western areas. We are testing a pilot in the western area, which will involve extended-hours surgeries by GPs. The majority of doctors in that area have agreed to extend their opening time beyond their contracted 6.00 pm. That will allow the out-of-hours centre, when it gets the calls, to send the patient to their local surgery. We are testing that — it should start over the next month — in the western area and then we hope to extend it to the southern area. Those are the two biggest recruitment and retention problem areas at the minute.

Mr Dunne: Will that be extended across the Province?

Dr Harper: Yes, to the other areas as well.

Mr Dunne: We are likely to see our GPs with evening surgeries again.

Dr Harper: That is what we hope and what we plan. They are not compelled to do it, because their contract says that they work up to 6.00 pm, but, with additional investment and funding, we believe that there will be a good level of interest in that.

Mr Dunne: Is that being driven by Transforming Your Care?

Dr Harper: It is driven by concerns about the out-of-hours service, the level of pressure on it and the difficulty of getting doctors, who stay in their surgeries until 7.00 pm or 8.00 pm. You may not see them as a patient at that time, but they do work on tests, diagnostics and so on. It is becoming more and more difficult to get them to go straight from the surgery to the out-of-hours centre and work until midnight.

Mr Dunne: I appreciate that. I am talking to doctors in my local trust area. We as MLAs think that doctors are not that busy, but when you go and talk to them and spend some time, you realise that they are busy people. It will be interesting to see how you are going to manage to get them to reopen their evening surgeries, which I think is a positive thing and something that should certainly be explored.

Dr Harper: The other issue is patients who are discharged from hospital at weekends and bank holidays. Traditionally that has not really happened. With the pressure on beds, we need to keep the flow going through the hospitals, and that helps the emergency departments — the whole system is connected — and helps the staff in hospitals to have confidence that, when they discharge a patient

on a Sunday afternoon, that patient will receive a booked visit that evening. That means more capacity in GP out-of-hours services, because, in those circumstances, they are not acting as an urgent care service. It is a planned visit regime. We call it intermediate care. We need to make investments to make that happen as well.

Mr Beggs: Thank you for your presentation. In the information that you have given us, you told us that the service in 2012-13 was costing approximately £21·6 million. You have also indicated that there is a variety of costs per head and per call. The call costs vary from £36·65 to £49·75. That is about a 33% variation; it is quite large. The cost per head varies from £10·18 to £17·34. That is roughly a 70% variation. Can you account for why there is such a large variation in costs? Is it Belfast/urban as against rural/travel distance? What is the reason for those variations?

Dr Harper: The rural/urban thing is a big part of it. If you are in the call centre in Forestside, most of your calls will be within a five-minute drive whereas, if you are in Causeway and you get a call to Torr Head or the glens of Antrim, dealing with that takes a doctor and a driver out for up to a couple of hours. So you need more drivers and more cars; you need three, where you have two in Belfast, and that accounts for up to a 50% variation. The way that the organisations run their work and secure the services is a factor as well. We allocate funding for out-of-hours services, and we hope that it is all spent there. We presume it is, but there might be some variation in the efficiency. The western area has five centres, whereas the northern area, with a bigger population, has four. That was a legacy from the previous boards, and also reflects the fact that the western area has greater distances. You can only have a certain distance if doctors are going to go out to people's homes, or you expect people to come from their home in the middle of the night into a centre. So, those sorts of variations account for the difference.

Mr Beggs: Do you see some efficiencies coming in with your new model?

Dr Harper: Certainly, with the virtual telephony network, there is the potential to not have to staff up to the maximum level of demand in every centre all the time. Currently, that is what we have to do. It is reasonably predictable, but it can take off unexpectedly.

Mr Beggs: Gordon mentioned the nature of the contracts. I had the experience of using the out-of-hours services. I will describe exactly what I needed. I had had a minor operation on my back, and I was told that I might need a couple of stitches removed over the weekend because of infection. I phoned the out-of-hours services who told me, "yes, come in". So, two hours later, I went into out-of-hours services, stripped off, showed them my stitches and they agreed that, yes, I needed two stitches; but the doctor then told me, "we don't do that". Are you looking at the nature of the contract, so that doctors do not send patients to A&E because of really basic issues in the nature of the contract that has been awarded? I felt that I did not have something that warranted a trip to accident and emergency, but that is where I was sent to by the out-of-hours services.

Dr Harper: I appreciate that. That would require the urgent nature of the service to change, and it becomes more like a primary care service out of hours. And we need to do that, because it is not appropriate for something like that to go anywhere other than the community.

Mr Beggs: So are you reviewing —

Dr Harper: Yes, we are reviewing the alignment of the GP out-of-hours service with all the other services; not just something like surgery, but also mental health services and the protocols with the Ambulance Service as well. People are being taken in an ambulance who could have been dealt with and had their problem addressed by the out-of-hours service. Developing protocols with the Ambulance Service is something that we have already started; we got one agreed last week. So there are elements of this strategy that we are already implementing. We have implemented a consolidation of the servers; each of the different providers had a different computer server, so you could not link them up and you did not have the potential to have a single telephone number. As well as that, when they went down, the support for the servers was not as good as it could have been. Now, they are linked into the main Health and Social Care server, based in the Royal and City hospitals.

Mr Beggs: Just for clarity, I was not concerned about my treatment; I was concerned about pressures on A&E which the nature of the contracts currently generates.

Mr McKinney: I have just a couple of points. I assume that this is about driving efficiency, if you like, in the process, but also about removing pressure on A&E. So is this a priority strategic framework?

Mr Galway: Yes.

Mr McKinney: How much does it cost? I know that you said that the framework does not contain an assessment of the cost of implementation but, in a ballpark, what would that be?

Mr Galway: It really is difficult to say. In terms of infrastructure, we have already put in place regionalisation and consolidation of the servers, as Sloan said. With the telephony system, it could be anywhere. It depends how you provide that service: is it run as a contract or provided in-house? It depends where you get it. It is difficult to say.

As regards the actual funding for the out-of-hours service, as Sloan mentioned earlier, we have already put in £1·9 million. There is another bid for £2 million for the out-of-hours service as part of the £160 million deficit.

Mr McKinney: So, not only is it subject to availability, but the funding is not there.

Mr Galway: Well, the funding is there at the moment to provide the service as it is.

Mr McKinney: No; I understand that. Obviously, what I mean is that the overall objective is to streamline the system in order to take pressure off A&Es. We are seeing all of those pressures erupting. Yet, you might expect that to be high priority. I am not putting words in your mouth. Maybe you could tell me whether it is a high priority.

Mr Galway: It is a high priority. However, as we mentioned at the start, the level of out-of-hours activity has increased dramatically. So, as we see it, that has already taken pressure off emergency departments. The funding to deliver the strategic framework has not been either formally deep down into detail or secured to drive it forward. Given that it would be a priority, hopefully the funding would be secured to support it.

Mr McKinney: What is the category under which it was bid for?

Mr Galway: I do not have that with me. I can find it and get it for you.

Mr McKinney: Is it consistent with its importance, or is it somewhere down the list?

Mr Galway: I will check and get that information for you.

Mr McKinney: You can see the direction of travel here. We are seeing a project that, on the face of it, is high priority and of strategic significance. It may relieve A&E pressures. Of course, that would reduce some of the costs of A&E. Yet, money is not available and we do not have a sense of how much it would cost. I do not know that there is much more to be said from my point of view. Those are some big question marks.

Dr Harper: Maybe I can add to that. The funding to consolidate the servers was capital funding. Around £700,000 was spent on that. As regards the virtual telephony network, the capital requirement will be less than £1 million. What you have to do, rather than just bring in the tin boxes, is ensure that your organisational arrangements are in place. That will require discussion with the staff side on how it will affect staff in the different centres. We have to be careful about that.

Mr McKinney: Yes, but if you are getting your ducks in a row otherwise — you are spending money on the capital side, both for the servers and the telephony, or whatever — but you cannot find the resources elsewhere, what is the value of the money that you have spent? It may be able to be used in the future. Obviously, there are some big question marks hanging over whether this will be implemented. That raises some other bigger question marks over how consistent that is with the overall plan and why it is not being prioritised from a funding perspective.

Dr Harper: It is a matter of getting through the business case process and submitting that to the Department. We are working through that now. As I say, the sensitive negotiations with staff will take time and cannot be rushed.

Mr McCarthy: I share the concern of other members round the table about the working of this new service. When will it kick in? I think you said that 2005 was when the initial out-of-hours service was provided. I remember well the enormous kick-up and hiccups that there were with that service for a long time. Are we in for another period when it just does not work and public representatives will be inundated with complaints, etc? Will the telephone staff be qualified people? At the moment, as I understand it, when you ring up, they ask you what is wrong, and all the rest of it. That has been very frustrating for a number of patients in the middle of the night. Will these people be qualified to say what is wrong — come in or stay at home or what?

Dr Harper: The call handlers are trained. Most of them are not clinically qualified, but they are trained to deal with the public. They take the details and record them on the computer system, and it goes through to triage. That will either be a call back by a GP or a nurse: it will always be by a clinical person.

If you bring in any new system, you have to ensure that there has been tremendous communication with the public. If we were doing this, we would be using a number that is easy to remember. Over the years, we have received a number of complaints from people. For example, if someone lives in Comber and visits an elderly relative in Enniskillen who turns out to be unwell, they may not know how to get in touch with the out-of-hours service over the weekend. With this new system, there will be a number that is easy to remember, so we think it will be safer, more responsive and more accessible.

Mr McCarthy: When is this going to kick in? Is it all dependent on the funding, as Fearghal inquired?

Dr Harper: It is certainly dependent on business case approval, but we are putting this on quite a long project period because of the sensitivities and concerns that people have about change to the service. The initial plan is to look at the red-eye period when the number of calls is quite small, move that over, and then extend it gradually to the rest of the evenings and weekends. It is 2016 for the red-eye period, and then 2018 to 2020 for the remainder of the out-of-hours period.

Mr McCarthy: So we are going to be saddled with what we have — good, bad or indifferent — until 2016.

Ms Stevens: Until 2020.

Mr McCarthy: OK.

Dr Harper: We will press on this as hard as we can, but there is a sensitivity about changing something that is stable and is working pretty well. It is far from perfect, but it is well received by the public and has a 75% satisfaction rate. Change to that needs to be done carefully and safely.

The Chairperson: If the June monitoring bid is successful, how much of the system will that impact on? How much of the new framework can be implemented?

Mr Galway: The majority of the money bid for in June monitoring is to provide additional funding to increase the level of GPs who come in to provide the service, so it is about providing a better resource level within the current set-up. It will not pay GPs more; it will provide more funding to allow more GPs to come in to help with the service and manage the demand. That will not have a direct impact on the strategic framework, because those elements will have to be dealt through a business case process. The money bid for in June monitoring is primarily for that area.

The Chairperson: OK. Sorry, Kieran, I interrupted you.

Mr McCarthy: I hope that, at the end of the day, the patients will be better off with the system that you are talking about. It is the patients who we are all very much concerned about, rather than saving a few pound here and there.

Dr Harper: Very much so. Where we have seen it working in Scotland and England, it has not always been perfect. England changed from NHS 24 to a different organisation, NHS 111. That was not without its troubles, so we have learnt from that. As Stephen said earlier, our triagers — the people who deal with the public — will be clinically qualified.

I have seen the system used by NHS 24 in Scotland, and it works extremely well, because they actually use it as a 24-hour service. When a public helpline has to be put in place, for pandemic flu for example, they can get messages out very easily to the public 24 hours a day, not just during the out-of-hours period. When there is a worry about a medication or a drug side effect — that sort of thing — and people are concerned, the service can act as a helpline for the public. That is something that the public in Northern Ireland would benefit from.

Mr Gardiner: Thank you for your presentation. Are there any GPs working from 6.30 pm to 7.30 pm to relieve the pressure on the hospitals?

Dr Harper: In the Eastern Board area, there have been a number of initiatives around extended hours opening for surgeries, but only in that area.

Mr Gardiner: I welcome and encourage that, because it will ease the situation in the hospitals. If somebody cuts their finger, they have to go to the hospital or go to their GP — when you talk about GPs considering it, it would not for every night of the week, surely? It would be on stipulated nights, say a Wednesday or a Friday or something like that.

Dr Harper: That is right.

Mr Gardiner: I welcome that. When is it going to be implemented?

Dr Harper: The extended hours opening, which we are starting in the Western Board area, should be starting in the next month to two months.

Mr Gardiner: Could the Craigavon area come in on the third month, then? *[Laughter.]*

Dr Harper: We looked at that.

Mr Gardiner: Will you please note that?

Dr Harper: We will.

The experience of the Eastern Board, when it ran evening surgeries, was that sometimes the same people who were there during the day were booking into the evening surgeries, which was not all that helpful. It is people who are busy working and cannot get out of work to see their doctor during the day. The extended hours opening would be for the out-of-hours centres to slot people into their local surgery. That really would help the emergency departments.

Mr Gardiner: But your local surgery will only be open certain nights in the week. It will not be every night.

Dr Harper: It will not be every night.

Mr Gardiner: It will be mainly midweek and maybe a Friday or Saturday evening.

Dr Harper: Tuesday, Wednesday and Thursday.

Mr Gardiner: Not the weekends.

Dr Harper: Possibly weekends as well.

Mr Gardiner: That is when the hospitals are bunged with people going in, either being drunk or something like that. They do not need to go to the hospital to get sorted out.

Dr Harper: Yes, so we are in negotiation with —

Mr Gardiner: I welcome the move, I really do.

The Chairperson: I thank you both. From the Committee's point of view, this is a hugely important framework. However, you have heard the issues that have been raised here about the costing, the delay in the process to date, the shift left and the lack of resources. I request that we get access to an update as this develops, particularly with regard to the business case and how it is progressed over the next number of months. Thank you for your time today.