COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

GP Out-of-hours Provision in Northern Ireland

25 March 2010

NORTHERN IRELAND ASSEMBLY

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

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Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Mrs Michelle O'Neill (Deputy Chairperson)
Dr Kieran Deeny
Mr Sam Gardiner
Mr John McCallister
Mr Conall McDevitt
Mrs Claire McGill

Witnesses:

Mr John Farrell	)	
Mr Peter McAuley	)	Department of Health, Social Services and Public Safety
Dr Miriam McCarthy	)	
Dr Sloan Harper	)	Health and Social Care Board

The Deputy Chairperson (Mrs O'Neill):
I welcome Dr Miriam McCarthy, the deputy secretary of the healthcare policy group, Dr Sloan Harper, director of integrated care on the health and social care (HSC) board, Mr John Farrell, head of the primary medical services branch and Mr Peter McAuley from the primary medical services branch. I invite you to make your presentation. You will have around 10 minutes, after which members will ask questions.

Dr M McCarthy (Department of Health, Social Services and Public Safety): Thank you for inviting us. I shall cover some of the generalities around the issue of out-of-hours services and then ask colleagues to add a few details to that.

Out-of-hours services have been in place since the inception of the Health Service, but in recent years, some fairly fundamental changes have been made to how those services are provided. With the introduction of the new GP general medical services (GMS) contract, the out-of-hours service was no longer seen as a fundamental part of GP provision, and, therefore, it became a separately commissioned service. In that respect, it was set up to be commissioned by the boards and it was provided in Northern Ireland by five out-of-hours providers. During the session, we will provide more detail on that fundamental change to the system that was in place before 2004.

The five out-of-hours providers have been providing services across Northern Ireland for a number of years. Three of those are trust-based organisations, and two are mutual organisations. They provide quite a significant quantity of patient care in that, in 2008, for example, 520,000 calls were made to the out-of-hours service. That gives you an idea of how busy the out-of-hours service is at nights and at weekends. Of those 520,000 calls, around 270,000 received advice over the telephone, which is often sufficient and entirely appropriate for patients and parents of sick children.

Out-of-hours centres received 213,000 visitors. Numerous out-of-hours centres, most of which are relatively easy for people to reach, are located across Northern Ireland. In addition, there were quite a number of home visits.

Many clinical issues are urgent and arise late at night, in the middle of the night or at weekends. Those are dealt with in a variety of ways, including through telephone advice, people visiting out-of-hours centres or GPs making home visits. Each call that comes in is triaged to determine which are urgent and which are more routine. Very urgent cases tend to be dealt with within one hour, and the less urgent ones are dealt with within two hours. The quality standard is for routine, non-urgent cases to be dealt with within six hours.

Out-of-hours provision is a responsive and effective service that is tailored to need. Feedback from patients who utilise the out-of-hours service is entirely consistent with our view that the

service is responsive and effective. The vast majority of people indicate that they have been content with the out-of-hours service when they have utilised it. Only one in ten people who took part in the most recent questionnaire raised concerns.

Recently, we looked at out-of-hours provision with an eye to ensuring that it is as effective and, indeed, as cost effective as possible. We have embarked on a review of the service to determine the best method of provision. We want to maintain all the service's quality and responsiveness but make it even more cost effective. We have heard that people would like the service to have a single telephone number across Northern Ireland, so that they know the number to call whether they are in their hometown or visiting their aunt or their mother in a different town. At the minute, each local out-of-hours service has a different telephone number. We are looking at practical measures.

We have asked our HSC board to take forward detailed work to recommend changes that would ensure the service's effectiveness. In particular, we want the HSC board to advise on what aspects of the current service we can reasonably provide on a regional basis, whether that is calls coming in, calls handled or the service provided. Undoubtedly, improvements could be made to both quality and cost effectiveness if some aspects are dealt with regionally. I will hand over to my colleague Dr Harper, who is best placed to say a little more about that.

Dr Sloan Harper (Health and Social Care Board):
As director of integrated care in the regional health and social care board and a representative of the commissioning organisation, it is my responsibility to ensure that the service that is delivered by the five providers is safe and cost effective and that it makes best use of its resources and meets the standards that we set. That is how we judge any changes that we plan or make in the provision of out-of-hours services in Northern Ireland.

Essentially, we try to make the service as effective as possible. We do that by bringing the five provider entities together on a regular basis and carrying out on site visits. We have agreed with the trusts a service specification that sets out some of the access standards that Dr McCarthy referred to. We ensure that the provider organisations have well-established clinical governance processes; that their medical directors report serious adverse incidents to the board through their staff; that they have a complaints process; and that they can respond effectively to calls that come into their service.

The budget that was established for the out-of-hours in service when it was first commissioned by the four health and social services boards in 2005 was supplemented by bridging funding, which allowed the boards to establish the new organisations.

We regularly compare our services to those of similar organisations and providers across the UK. Some of those comparisons are included in the written evidence that the board has provided.

In 2007, we established a regional project on out-of-hours provision to respond to the Department's requirement to develop a more regionalised service. That project considers the cost of services on a regular basis, and it establishes better working processes and better operational protocols in the out-of-hours service to ensure that it works in a way that is safe for the public in Northern Ireland.

The project's third strand is to future-proof the model of provision to ensure that it meets the needs of the twenty-first century. The younger generation now uses websites, helplines and telephones to find information. We are working with the Department of Finance and Personnel (DFP) on a project to consolidate the IT servers. At the minute, the five providers use five different servers. For example, in order to create a single telephone number for the Northern Ireland public to use, we need to establish a single IT server. Those are some examples of the ongoing work. I am happy to answer questions on the detail of the service provision.

The Deputy Chairperson:

The Committee has been keen to talk to you about out-of-hours provision. Sloan said that the Department has submitted a bid to DFP for a new IT server that will enable you to introduce a single telephone number. What is the timescale for that?

Dr Harper:

That process has a number of steps. It is important to be careful when developing a new IT system in the Health Service, because we work across different organisational boundaries. Therefore, we need to establish a model that manages the development in a way that allows us to divide work across Northern Ireland to ensure that if one area is particularly busy and another area is quiet, those calls can be triaged and handled in the areas where capacity exists. We need to consider a different organisational construct. Even though the five trusts are separate, they

work together, share rotas and co-operate in various ways. However, we need to manage that system in some way if the project is to be effective.

The Chairperson (Mr Wells):
It is a case of the mobile Chairman. *[Laughter.]*

Mrs O'Neill:
It is not the first time that it has happened; I am multi-talented.

You said that although you want to maintain quality and responsiveness, you need to meet efficiencies and work more effectively. Given the number of centres that have out-of-hours services, is there a danger that people might attend A&E departments because they feel that out-of-hours provision is not easily accessible? Could that have a knock-on effect for A&E departments?

Dr M McCarthy:
Our existing out-of-hours provision is very good, and it is important to maintain that standard. As Sloan said, there are ways to do that, such as through the monitoring of adverse incidents and keen observation of operations on a day-to-day basis. People will, inevitably, choose where to go for emergency care, and for some injuries, it will be entirely appropriate to go to an A&E department. For example, people with factures will need to have an X-ray.

There are examples in Northern Ireland where our out-of-hours services work in conjunction with A&E services and the Ambulance Service to ensure that people are directed to the most appropriate location. For example, during a pilot study in the Dalriada region in the Northern Trust area, emergency calls to the Ambulance Service were redirected to out-of-hours provision when that was an appropriate course of action.

There is something about people being aware, and often people being redirected or re-educated, about the best and most appropriate way to access urgent care. However, people will exercise their own discretion, and often very sensibly.

Mrs O'Neill:
The Committee recently examined an Audit Office report, which looked at GP out-of-hours

provision. It highlighted that the cost of the out-of-hours services was £6 million in 2003-04, which was the last year of universal GP provision. In 2007-08, that had risen to £19·5 million. There was a similar story in England. How do you explain that?

Dr M McCarthy:
On the last day that I attended the Committee, we touched on that subject. It is recognised that when the out-of-hours service was embedded within the 24/7 GP contract, it was probably assumed that expenditure was about £6 million. However, the expenditure was hard to define, as it was just part and parcel of a GP's work.

When the contract brought in a new system and we accurately costed provision of the out-of-hours service, it came to around £16 million or £18 million. It is fair to say that prior to the introduction of the contract, we may not have expected it to cost so much. Some aspects, such as the introduction and development of the infrastructure and ensuring that all the personnel were available, were included in that cost.

Since then, we have taken steps to ensure that we have delivered efficiencies in the service, and we have helped to curtail the cost and the growth of that cost. We are conscious of the need to get the best value for money.

Mr McDevitt:
Hello everyone. I wish to pick up on Mrs O'Neill's last point.

The fact is that while the cost of the service is rising, the number of people available for that critical red-eye shift that lasts from midnight to 8.00 am is diminishing. How many GPs were available for that a year ago? How many will there be in two or three months' time? Can you give us the figures by board area?

Dr Harper:
I am happy to answer that. For the red-eye shift, there were, a year ago, about 13 GPs available. As a result of changes that have taken place in the Northern Trust area, and which are planned for the Western Trust area, that will change to nine or 10 GPs.

Mr McDevitt:
How has it changed in the Northern Trust area?

Dr Harper:
It has changed from four GPs to two GPs, plus nursing input and nurse triage.

Mr McDevitt:
In the Western Trust area, how has it changed?

Dr Harper:
Provision is planned to change from five GPs to three GPs, plus nurse triage.

We know from the Northern Board's pilot scheme that nurses can reduce the workload of the doctors by around 70%, so they are dealing with those calls without reference to a doctor.

Mr McDevitt:
How do primary care providers in the Northern and Western Trust areas feel about that change?

Dr Harper:
As director of primary care in the Northern Board, I was involved with that change when it took place in the Northern Trust area. Those changes were proposed by the provider organisation.

Mr McDevitt:
How did GPs feel about it?

Dr Harper:
During the change process, we consulted with the local medical committee, whose members are the elected representatives of the GPs. They were concerned about any change in medical input, but we explained how the process would work and we set up a series of reports to ensure that the provider organisation, Dalriada Urgent Care, continued to meet the access standards. We reported not just to the GP representatives but to local councils in the mid-Ulster area, and we continue to meet those access and service standards.

Mr McDevitt:

You must introduce the Committee to these GPs; they are not the ones to whom I speak. Let me take the Western Trust area, which stretches from Derry City all the way to Fermanagh. Are three GPs going to be able to provide adequate out-of-hours cover from midnight to 8 am for that entire area?

Dr Harper:

The number of calls coming in to Western Urgent Care during that period is around 30 to 35. Of those calls, around 18 require face-to-face consultations. When we introduce nurse triage into that area, I anticipate that that will reduce the workload of GPs by around 50% to 60%. As Dr McCarthy explained when she referred to the access targets, it is an urgent care service, not an emergency service. Some of the calls received by Western Urgent Care are of an emergency nature, and the response standard for those calls is three minutes. Those calls are diverted to the Ambulance Service and to hospital as appropriate.

It is a changing service, and it is very different from the way services were provided 10 or 20 years ago. That is partly because medicine has changed, and with the advances in thrombolytic drugs for patients who are having a cardiac event or a stroke, one of the priorities is to get them to hospital as quickly as possible and not to delay that journey with an inappropriate response. That is different from the way it was 10 or 20 years ago.

Mr McDevitt:

Is the service five times more expensive?

Dr Harper:

The service that existed before 2005 included 24-hour care as a required part of the GP contract, and the nationally negotiated contract agreed to extract a certain amount of money from GP income. It was part of their job; there was no separate identified payment for out-of-hours care.

Mr McDevitt:

I will resist the temptation to go into the debate on the GMS contract again. It basically boils down to the fact that we pay more and we get less.

Dr Harper:

We certainly pay more. As Dr McCarthy said, we get a high-quality service, but it is provided in a different way.

The Chairperson:

Dr Deeny may have some experience in that area. *[Laughter.]* You may have to declare an interest.

Dr Deeny:

I declare an interest as a GP. In relation to Conall's point, for five years, I worked on a one-in-two frequency, and it nearly killed me.

The Chairperson:

Are you a member of a commissioning group?

Dr Deeny:

Yes, I am.

The Chairperson:

You had better keep yourself right and mention that as well.

Dr Deeny:

I am a member of the Western Local Commissioning Group.

The one-in-two frequency is why, in rural practices, one could not keep it up. It is a different system.

You are very welcome, Miriam and gentlemen. On a different issue, you said that it is not an urgent care service. From a GP's point of view — everyone else will be coming at it from another point of view — when I worked, there were a number of people who called in and did not use the out-of-hours provision as an urgent service. It was a routine service. Are you getting that feedback?

For example, there were a number of people who would call in to the out-of-hours service

after coming back from Donegal for the weekend to say that they had had a cough for three weeks and wanted it to be checked out and for them to be given a prescription. The service saved them having to make an appointment with their GP during the week. I sense frustration among GPs because of that; the fact that the provision was not treated as an urgent care service. As a result of that, has there been any disillusionment among home-based GPs working out of hours. This is not a racist remark, because I know that our overseas doctors are very clinically competent, but sometimes we get people coming in during the week because they did not understand what they had been told. Communication was the problem.

Finally, how does the out-of-hours facility work on a cross-border basis?

Dr Harper:

In relation to inappropriate demands being made on the service and that affecting the input of the experienced local GPs, one of the priorities in Northern Ireland was to retain the interest of experienced GPs in doing that work. Often they are doing that work on top of their day job, so we have to be mindful to ensure that when they work, they are not overly tired and are fit to work, and that they do not run consecutive sessions, because that would cause a workforce problem. We have been fairly successful in doing that. However, we have had to supplement some of the rotas, particularly in the Southern Board area, but also in the Western Board area, with doctors who have come from outside Northern Ireland. From time to time, their language skills are raised by users of the service, but not frequently.

The current rules mean that the General Medical Council (GMC) is not in a position to check the language skills of European Union citizens, but it can do so for doctors who come from outside the EU. The GMC has communicated with us about that issue this very week. We require the providers to ensure that any doctors who join their organisation have the required competencies, including being able to speak English, to deliver the service.

Dr Deeny:

Do you have a percentage breakdown of native and overseas doctors who provide the out-of-hours service?

Dr Harper:

It varies with each provider. About 95% to 97% of the doctors in the Dalriada area are local GPs.

I think that about 5% to 10% of doctors in the Southern Trust area are from outside the local GP community. It was more difficult to attract local GPs into the service in some areas, particularly the Southern Trust area.

Dr Deeny:

What about cross-border work?

Dr Harper:

Colleagues in the Department regularly meet the Health Service Executive (HSE) and the Department of Health and Children in the Republic of Ireland. The relevant centres are with the HSE and the Department in the Republic of Ireland. The centres that are relevant are in Castleblayney and Altnagelvin, where folk who live in Donegal can use that service.

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

The cross-border out-of-hours pilots came into being in 2007. Dr Harper mentioned the Donegal/Derry pilot, which commenced in January 2007. The south Armagh/Castleblayney pilot commenced in November 2007. Since then, the usage numbers have been fairly static. In each calendar year since the south Armagh/Castleblayney pilot began, about 372 patients have made use of it. Approximately 121 patients a year make use of the Donegal/Derry service. When the Donegal/Derry pilot was established, not all the GP practices in the Inishowen and Buncrana area wanted to take part. That meant that the geographic area in Donegal was reduced by approximately half.

We have been speaking to officials from the Health Service Executive and the Department of Health and Children. Some of the issues that were present in 2007 with the Buncrana GPs may have been resolved. We have asked the Health Service Executive to see whether the Buncrana GPs want to take part in the pilot because the number of patients who use the service is quite low. If 372 people use the service in one year, that works out at approximately one person a day. Coming the other way, one person every three days makes use of the service. We want to get more robust data and information about the cross-border out-of-hours service. If people who live in a pilot area ring the out-of-hours service, they will be asked whether they want to attend the out-of-hours centre in Northern Ireland or the Republic of Ireland, and vice versa. They will be asked whether they want to make use of and travel to the out-of-hours centre in the other jurisdiction.

GPs from Northern Ireland cannot make a home visit in the Republic of Ireland, and doctors from the Republic of Ireland cannot make a home visit in Northern Ireland. That is because of the regulation of the profession and the requirements of the Irish Medical Council and some of the other professional bodies in England. That issue needs to be resolved.

There is also an issue in respect of cross-border workers. If people live in one European country and work in another, they are entitled to the healthcare in the country in which they work, so — *[Interruption.]* Somebody who lives in Donegal and works in Derry would be entitled to healthcare in the North under the cross-border workers' scheme.

If that person were to make use of the out-of-hours service, it would not be picked up in the cross-border pilot scheme because he or she would be entitled to do so. We do not know whether information, such as that about cross-border workers, is masking the number of people who are making use of the service. We are trying to gather more data and information about that, but, as I said, in the two or three years of the pilot scheme, the numbers have been quite low. We will continue to monitor the situation and to work with our counterparts in the Department of Health and Children.

The Chairperson:

Thank you for the candour of your answer. About a month ago, Cooperation and Working Together (CAWT) painted a rosier picture of how the system is working out, but you have exposed some of the difficulties with it. Given such a low throughput, it is not difficult to explain why it costs more. Having so few people using the system must be a waste of resources. However, it is important to see whether the system can be beefed up, so that information is very useful.

Mr Gardiner:

I wish to place on record my appreciation for the information that you have given us. Dr McCarthy and Dr Harper touched on the emergency telephone number for health call outs. Will you elaborate on how far down that line you have gone? Will you link that number to the 999 service, or will you give it a separate number, such as 111? I can imagine the difficulty that an elderly person whose husband or wife has fallen upstairs might have in trying to get a number, so that is a brilliant idea and I would welcome and urge its speedy introduction.

Dr M McCarthy:

I shall make a general comment about the cross-border out-of-hours service pilot scheme. A key element of the scheme is to evaluate and determine its benefits. Then, depending on the outcome, we will be able to act appropriately and decide whether to introduce the service elsewhere. The challenge that we face is that the pilot scheme's low throughput makes it hard to draw critical conclusions, so we need to keep an eye on the situation. Nevertheless, we are very keen to do that because, as with all pilot schemes, we need to learn, and in order to learn and draw realistic conclusions, we need data.

In principle, we agree that introducing a single telephone number seems to be the sensible thing to do. However, there is a question — and I shall ask Dr Harper to speak about it — about what the number should be. The 999 number has always been designated for emergencies, such as heart attacks, serious accidents and road traffic accidents. Although everybody knows that number, we need to be quite precious about it, because when people dial 999, they need immediate access to police, fire or ambulance services. There is a process by which we will identify a number, and we will then ensure that everybody knows about it. Perhaps Dr Harper will say a little about that process.

Dr Harper:

In reaching a final model, it is the board's ambition to move eventually to a single number. It is not only elderly patients who find themselves in emergency situations. Relatives of elderly users of the service who visit them in a different area raised a number of points. When their relative was unwell, they could not find or did not know the appropriate number, and that caused some confusion. Initially, we thought that we could set up a system based on the source of the call, which would then be diverted to the relevant local office to be triaged and dealt with. Unfortunately, mobile telephones do not work on such a system. Such calls cannot be diverted because one does not know where the caller is. The Department of Health in England has been looking at introducing a three-figure number, which would be the easiest arrangement for everyone to remember. The technological requirement for that is a common server. In addition, a common management system would be required to manage calls, because someone in Fermanagh will ring the same number as someone in Belfast, so those calls have to reach the point at which the work will be done. Therefore, a central organisational construct will be required.

We look at the possible options in great depth all the time, because we do not want to make any change to the way in which the service is provided that puts the service at risk. One option is the Ambulance Service, the centre for which in Knockbracken handles emergency calls, urgent calls and some not so urgent calls. It is possible that it, or another Ambulance Service centre, could do what is called call-streaming, by which calls would come in from all over Northern Ireland and then be diverted to a local office to be dealt with by the doctors and nurses there. However, we are mindful of the impact that that sort of change would have. For example, it would have an employment impact for staff who already do that in rural areas, and there would be all sorts of personnel and HR consequences to take account of.

A three-figure number would be ideal. A capital investment will have to be made to make that happen. However, we would like to move to that number as soon as possible.

The Chairperson:
Do you have any idea how much that would cost?

Dr Harper:
The capital cost of a consolidated server is approximately £800,000, with a revenue cost of approximately £80,000 to £100,000. The Department of Health in England is looking at the cost of a three-figure number. An initial proposal was made for access to the three-figure number that is used by different Departments to be applied to the out-of-hours situation. However, it was felt that that would be too confusing for patients.

Mr Gardiner:
Patients need a simple number, such as 111. That is particularly important if someone is in distress — for example, if a baby is not well and the husband in out on night duty. It is the right idea and one that I would encourage.

Dr Harper:
Thank you.

Mrs McGill:
Can the Committee Clerk confirm that the Western Trust did not provide exact details? Did it

give a reason for that?

The Committee Clerk:
It said that it was a matter for the Western Local Commissioning Group.

Mrs McGill:
Can you confirm that it is the Western Local Commissioning Group that should provide that information to the Committee?

The Committee Clerk:
The Western Trust said that, in its opinion, it was a matter for the local commissioning group to provide the information.

The Chairperson:
Perhaps you want to come in on that Dr Harper?

Mrs McGill:
I represent West Tyrone, an area that is covered by the Western Trust. Last night, in Strabane, my party colleagues and I held what I might call a health issues event. The out-of-hours service was a theme of that event and views were expressed. Clearly, in Strabane and in the rural parts of Strabane District Council, changes and proposed changes to out-of-hours provision is very much a live issue. Will you take me through what the situation is in the Western Trust, in particular, in Strabane District Council? That would be very welcome.

Dr Harper:
The Western Trust is not involved in the provision of GP out-of-hours services. The service in the western area is provided by Western Urgent Care, a mutual organisation that was established in late 2004. It has a steering council that involves GPs and a clinical director, who is a local GP, and it employs the staff who work in the different centres.

I know that, historically, the original budget that was allocated to the Western Board — the legacy board — had to be significantly supplemented to provide the service in that area. Recently, that budget and efficiency has had to be looked at and reviewed. Proposals were made, which were consulted on with the local councils, to change the medical input between midnight

and 8.00 am. We discussed that with Mr McDevitt. That will effect a change from five doctors to three doctors, but will add nurse triage. We know from the model in the Northern Trust area that that has the potential to reduce the workload of the doctors by up to 70%.

However, it is crucial that we ensure that we do not make those changes unless we are confident that the service can continue to meet the access standards. The Northern Ireland quality access standards are based on UK-wide standards originally developed by the Department of Health.

Mrs McGill:

Mr McDevitt and Dr Deeny have said that the Western Health and Social Care Trust area stretches from Limavady to the far end of Fermanagh — a vast geographical area, a lot of it rural. At the meeting in Strabane last night, there was some acceptance that the volume of calls to GPs during certain hours would not justify maintaining the service as it was, change would probably happen. There was particular concern about how people in rural areas could respond to being advised to go to hospital. If, as proposed, the number of out-of-hours GPs available to visit homes in rural areas is cut from five to three, and one GP on call is in Limavady while the other two are at the other end of Fermanagh, what happens to somebody in rural Strabane?

The follow-on to that concern is: would it not be better for the patient to just go to Altnagelvin Hospital's accident and emergency department? The patient's dilemma, and a theme of that meeting, was whether to phone Altnagelvin or their GP. The response was that people should still phone their GPs.

Dr Harper:

It is important to remember that the urgent care service in that area is a telephone-access service, the purpose of which is to direct the patient to the appropriate response. We do not want to engender people inappropriately presenting to A&E at Altnagelvin. Therefore, the national standard that we stand by for urgent calls is to see the patient face-to-face within an hour. With three doctors on the ground and three more as second on-calls who can be brought in as necessary, we believe that we have sufficient manpower to deal with an issue within an hour if the patient has to be visited to avoid inappropriate use of the Ambulance Service.

I emphasise that we have experience of adopting that approach in another area. The

Ambulance Service regards the Northern Health and Social Care Trust as just as difficult to cover because of its population distribution, even without the urban build-up of Derry. Since those changes were implemented in the northern area, there has been no increase in complaints to the provider and it rarely has to call in the second on-call doctor. Hence, that service has worked very well. Dalriada monitors standards weekly and reports to the board monthly to ensure that the service is safe for patients.

Mrs McGill:

Finally, Chairperson —

The Chairperson:

Can you be very quick? Unfortunately, we will soon have a problem of maintaining a quorum.

Mrs McGill:

I could leave my question, if you like.

The Chairperson:

The Committee has a difficulty in that it has to discuss a very important issue on which members must make a decision later in the meeting. We have just heard that Sam Gardiner must leave the meeting, and the Deputy Chairperson is not present. If you were content —

Mrs McGill:

No, Chairperson, I would not be content: I must ask a lot of other questions. However, I will respect your judgement.

The Chairperson:

I have dropped my questions. We will send a list of questions that we have not had time to ask to the Department. I am more than happy to include anything that you wish to add. I have just become aware of a situation that is developing in the Committee. Mr McAuley, I hope that you are not too annoyed. You did not seem to get much of a crack.

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

Everything was covered by my colleagues.

The Chairperson:

I remind members that the Regulation and Quality Improvement Authority is carrying out an investigation into out-of-hours service provision. We expect that to report in mid-May. Members will have the opportunity to come back on this important issue when that report is made available. I thank the witnesses for their expertise and time.