



Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Cooperation and Working Together

4 March 2010

NORTHERN IRELAND ASSEMBLY

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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)
Mr Thomas Buchanan
Dr Kieran Deeny
Mr Alex Easton
Mr Sam Gardiner
Mrs Dolores Kelly
Mr Conall McDevitt
Mrs Claire McGill

Witnesses:

Mr Tom Daly)
Mr Colm Donaghy) Cooperation and Working Together
Mrs Bernie McCrory)

The Chairperson (Mr Wells):

This evidence session is with representatives of Cooperation and Working Together (CAWT). Colm Donaghy is well known to many of us as someone who wears several hats. He is the chief executive of the Northern Health and Social Care Trust and director general of Cooperation and Working Together. Mrs Bernie McCrory is the chief officer of Cooperation and Working Together, and Mr Tom Daly is from the regional development department of the Health Service

Executive (HSE) West, and he is a member of CAWT management board. Some of you are experienced hands, having appeared before the Committee for Health, Social Services and Public Safety in the past, so you know the routine by now. I invite you to make a presentation of about seven minutes, after which members will ask questions.

Mr Colm Donaghy (Cooperation and Working Together):

We are delighted to be here and to have the opportunity to inform the Committee about CAWT's work. I will run through our presentation quickly and then allow members to make comments and ask questions. I want to give you an idea of CAWT's role and remit. I will outline some of our current activities and past achievements and then brief the Committee on the significant work with INTERREG IVa, which we are in the midst of putting together and implementing.

As stated in the presentation that has been circulated to members, CAWT straddles the border. We cover a land mass that comprises about one third of the island of Ireland and has a population of some 1.6 million. CAWT is a partnership organisation, which is sometimes misunderstood in that it is primarily a virtual organisation. Members of the CAWT management board work in the health services in the Health Service Executive in the South of Ireland and in the Western Health and Social Care Trust and the Southern Health and Social Care Trust. The Health and Social Care Board and the Public Health Agency are also now represented in CAWT's organisational structures.

There is a small CAWT development centre, which is led by Bernie McCrory and takes forward some of our work. Rurality and peripherality are the drivers behind CAWT. In 1992, the health and social care services closest to the border realised that the further they were from the seat of government, whether Belfast or Dublin, the more their infrastructure suffered; that is well rehearsed in research. CAWT was established to get together and share resources within the constitutional frameworks of the Governments, North and South. The aim was to ensure that we learn from each other's expertise and that a pooling of resources meant value for money for the public purse. We are also conscious of the need to reduce duplication of scarce resources, and, as we go through the presentation, I hope that members will see how we have achieved that.

CAWT was established in 1992, and, to date, it has implemented over 50 cross-border projects with EU funding. In the previous round of INTERREG IIIa and Peace II funding, a series of projects was funded through both Health Departments and, ergo, CAWT. Under the latest

tranche of European funding, INTERREG IVa, 12 large-scale projects are to be completed by 2013. The sponsoring bodies for those large-scale projects are the two Health Departments. The lead partner is the Department of Health, Social Services and Public Safety (DHSSPS), and the Department of Health and Children is a participating partner. CAWT implements INTERREG IVa on behalf of the two Health Departments.

I shall give you an idea of the organisational structure of CAWT. As I said, it is a virtual organisation in that the management board, which I chair, comprises representatives from the organisations that I outlined earlier. I have the grandiose title of director general, which simply means that I chair the meetings, and Bernie reports to me on an operational basis. The secretariat comprises people who work in those organisations, and the CAWT development centre comprises a team of people that Bernie manages and which does much of the implementation work behind the scenes on how CAWT's projects are taken forward. We also have provision for European funding for project management infrastructure for the 12 cross-border projects during the period of INTERREG IVa.

From time to time, CAWT has been invited by the North/South Ministerial Council and both Health Departments to facilitate other work. Examples of projects that CAWT facilitated are the provision of radiology services in the north-west and access for patients in Donegal to radiotherapy services in Belfast City Hospital. We have been involved in other pieces of work such as North/South emergency planning and, in the area of suicide prevention, the establishment of a self-harm register to ensure that we improve the statistics on recurring self-harm in both jurisdictions.

I do not intend to go through all 12 projects, but I have listed them in our presentation, and I am happy to take members' questions on individual projects. The projects that we have put in place range across acute and primary care, and prevention and secondary care are also included. The projects are consistent with the strategic priorities of both Health Departments. Both Departments indicated their priorities for the projects, which will receive European funding.

The presentation highlights the process and genesis of the latest round of INTERREG IVa funding for CAWT and for CAWT's role in that. A wide range of consultation was carried out on behalf of the two Health Departments so that they could make proposals. That was a "closed call" by the Special EU Programmes Body (SEUPB) to both Departments, which asked CAWT to

facilitate that work on their behalf. The closed call meant that the business planning process was approved by both Health Departments, and it involved much local community engagement on the projects.

In June 2009, both Health Ministers formally announced a budget of €30 million for the cross-border health initiatives. We have been working hard to recruit and appoint project staff for each of the projects that are now being implemented on a cross-border basis. As you can imagine, those projects are at different stages of development.

Our goals for the next period will be to meet the EU targets for all the projects that we put in place. We are conscious of the need to continue to demonstrate value for money for the public purse. The focus is on long-term benefits to patients and clients. Therefore, much of CAWT's focus will be on how those projects are sustained as we progress and how to ensure that they "mainstream" — to use some jargon — and become an integral part of how we deliver ongoing health and social care. When European funding ends, we will focus on embedding cross-border collaboration at policy level and in organisations in the health sector. CAWT pre-dated European funding and will post-date it through the cross-border initiatives.

The Chairperson:

That is very interesting. I want to tease out the amount of additionality for patients in the Republic and in Northern Ireland. How much additional EU money does CAWT leverage that would not have been available to both health services?

Mr Donaghy:

We leverage €30 million.

The Chairperson:

Is that the net total? Is no match funding required from the Health Department here or in the Republic?

Mr Donaghy:

No; we will use match funding to sustain the projects when the European funding finishes in three or four years' time. CAWT's partners are people who sit on management boards, including the Health and Social Care Board, the Public Health Agency and the HSE in the South. We are

working with our partners to ensure that we have an ongoing commitment to the projects that we put in place, which have been properly evaluated and have been shown to benefit patients and clients.

The Chairperson:

The additional money that has resulted from the co-operation is welcome. However, our budget is £4.3 billion, whereas the budget in the Republic is well over £10 billion or, perhaps, €10 billion. Members of the Select Committee on Health and Children in the Republic visited us recently to discuss that matter. Given that €30 million is a small proportion — approximately 1% — of the combined overall budgets, is it possible to increase that sum?

Mr Donaghy:

As the Committee knows, the SEUPB is the determining body for INTERREG IVa. Therefore, that programme is funded on a European basis. For the funding for the well-being programme under INTERREG IVa, the closed call indicated that it was limited to €30 million in the context of the fair distribution of European funding across all regions of Europe. Therefore, the additionality totalled €30 million.

The Chairperson:

Is that roughly £27 million?

Mr Donaghy:

The exchange rate causes some complications when we draw down funding.

The Chairperson:

Are you involved in any non-EU programmes?

Mr Donaghy:

Yes, we are; as I said, CAWT pre-dated, and will post-date, European funding. Many existing projects have resulted from CAWT's work, such as in Letterkenny General Hospital and Altnagelvin Area Hospital. Some of the services at Altnagelvin are sustainable only because the population in the South of Ireland uses them. CAWT facilitated that development, which, to a large degree, secures the sustainability of hospital services in the north-west.

In my former patch, Daisy Hill Hospital provided renal dialysis for patients in the northern part of the former HSE – North-Eastern Area who would otherwise have had to travel to Dublin for dialysis. Our colleagues in the South paid the capital and revenue to provide the care, and we provided the space to ensure that people did not have to travel too far to access dialysis. Those examples, and others, pre-dated European funding. The advent of European funding gives us greater opportunities to consider our options on a cross-border basis. I mentioned radiotherapy earlier: CAWT facilitated access to that service at Belfast City Hospital.

The Chairperson:

When the Dáil Committee visited us, its members expressed the view that there is surprisingly little co-operation apart from CAWT's work.

I will go back to your old stomping ground of the Southern Health and Social Care Trust; it strikes me as strange that, even when people in County Louth live within a stone's throw of Daisy Hill Hospital, they still tend to go towards Drogheda and Dundalk for their care. Do any institutional problems cause difficulties with doing that? Are there physical barriers that stop people availing themselves of that care and, presumably, the other way round — people hopping across the border for treatment in counties Donegal, Cavan or Monaghan?

Mr Donaghy:

There are several reasons for that. Quite a large part of the population in the HSE Dublin North East region uses Daisy Hill Hospital for obstetric services, for example. Each year, between 250 and 300 women from the South have their babies delivered at Daisy Hill Hospital. That service is provided on the basis of the insurance scheme that operates in the South of Ireland.

There are issues with the capacity of each hospital to deal with their respective populations. Another example that, perhaps, illustrates the point is our GP out-of-hours service, which currently runs as a cross-border pilot scheme between Newry and Castleblayney in the context of the Southern Trust. Its principle is that people should be able to access the GP out-of-hours service that is closest to them, regardless of which side of the border it is on. We started that project some time ago. It is now in place primarily to serve the population of the Castleblayney, Newry and south Armagh area.

The pilot indicated that there were barriers to making it work, which apply to many services

that we provide, North and South. There were issues such as indemnity and professional regulation. There was also the issue of how to deal with services that are charged for in the South but not in the North. We identified those barriers and were able to remove them through dialogue with both Health Departments.

For example, the general medical services (GMS) contract that was put in place in Northern Ireland, with which Dr Deeny will be familiar, ensures that we now have regulation that means that we can encourage the population in south Armagh to use the Castleblayney centre, even though some of its doctors are not covered by the GMS contract. That change in regulation allows mobility and enables the population to flow.

I believe that your point is, as I said at the outset, that CAWT works within the policy framework of both Governments. Therefore, wearing my old hat as the chief executive of the Southern Trust, I was charged, on behalf of the Government here, to plan for the population inside the border of Northern Ireland, which I did. I did not have the imprimatur or permission to plan for the population beyond the border. However, we can co-operate closely with our neighbours in areas in which we believe that we can both benefit. That does not mean that we are planning for a larger population. It means that we can ensure sustainability in our services, North and South.

The Chairperson:

Members are interested in the issue. I will start the round of questions with the Deputy Chairperson. I believe that all members want to ask questions.

Mrs O'Neill:

I will wear my councillor hat. Bernie and Tom have visited Dungannon and South Tyrone Borough Council, and I have heard their presentation previously. I want to pick up on a couple of points. One of the commissioned projects is the North/South feasibility study. Are there terms of reference for that study? Can we see them?

Mrs Bernie McCrory (Cooperation and Working Together):

At present, the feasibility study is being reviewed by the two Ministers. I am not sure when it will be circulated.

Mr Donaghy:

Allow me to provide some background. That feasibility study was conceived because both Health Departments wanted to examine areas where it made sense to co-operate or collaborate to the mutual benefit of the populations, North and South. The study has been taken forward over a period of time. CAWT's role is simply to facilitate the development of the study. That work is now complete, and the study is with the two Health Departments. They will decide how it will progress.

Mrs O'Neill:

Regardless of one's politics and the constitutional issue on this island, it makes obvious sense to share our resources. I welcome many of CAWT's projects, particularly those that concern obesity and suicide, issues that the Committee has been considering. Can the Committee influence any of CAWT's work? I am thinking, for example, of perinatal services, which are lacking across this island and in which I am interested. If the Committee had an issue that it would like CAWT to consider, should it go directly to your organisation or to the Minister?

Mr Donaghy:

That goes to the crux of CAWT's role. If perinatal services were a matter for the population of the island of Ireland, both Governments would have to make a determination because those services are a policy issue. CAWT has no role in determining policy, but it works within the policy constraints that it is given in the North and the South. An issue about an all-island service must be raised through both Departments and through both Governments.

If the Committee wanted to raise a service delivery issue that is local to the border through CAWT, please remember what I said at the outset: CAWT is not a separate entity from those organisations that deliver care on the border. In fact, CAWT is a virtual body that is comprised of those organisations. In that context, a conversation with Tom, Bernie, me or other members of the CAWT management board would be relevant. If the Committee wanted CAWT or its component organisations to consider other issues, we would be happy to do so.

Mrs O'Neill:

May we have more details about CAWT's project to support people with disabilities by considering alternative models of day services?

Mrs McCrory:

That project is about empowerment and trying to use existing community networks — community and voluntary agencies, and so on — to put the person with a disability at the heart of decision-making. Therefore, it will not be a one-size-fits-all approach. The initiative will involve working with various groups to find out what exists and what can be done in their indigenous areas. Not everyone wants day care.

Mrs D Kelly:

It is good to see Colm, Tom and Bernie at the Committee. I am familiar with CAWT. I am interested in a couple of points that were raised. You said that CAWT is tied into European funding and that it hoped to be mainstreamed. Under the auspices of the North/South Ministerial Council, it is expected that health and social care will be put on a sounder footing as a result of better co-operation in the interests of people on both sides of the border. What evidence does CAWT have? Are obstacles or restraints put in the path of CAWT's expanding work programme? Some projects have been detailed, but, above and beyond what Michelle asked, are there any constraints on their expansion? I am interested in the multi-level alcohol harm reduction project, which, alongside improving outcomes for children and families, is very much in the news? Will you tell members more about those projects?

Thirty million euro may be a small amount of money in the context of overall spending on health, but the Committee examined economies of scale in relation to contracts and purchasing. Is there evidence to suggest that CAWT's draw-down of additional money from Europe impacts on waiting lists on both sides of the border? Has CAWT created new service delivery jobs, other than those of project managers?

Mrs McCrory:

There is evidence that, even in a short time, CAWT has had an impact on waiting lists for acute services. There is about €8 million to support acute services, which has resulted in the creation of approximately 180 jobs, a number of which have already been filled, including clinical, nursing and project managers' posts. For example, in April 2009, more than 2,500 people were waiting for their first ENT appointment in the HSE Dublin North East area. Over 2,000 patients have already been seen there. Four hundred outpatients have been seen in the Southern Trust as a result of the appointment of two ENT consultants, one of whom is part-time and the other is full-time.

We are working on a pilot in the Western Trust between the Erne Hospital and Tyrone County Hospital to utilise theatre sessions that are not currently funded and use that to address waiting lists in the Western Trust area and HSE West. We have tangible numbers. There is a similar situation with genito-urinary medical services. Those are the two longest established projects.

In the Southern Trust, a specialist nurse has already seen 50 patients in the first six to eight weeks of his employment, thereby benefiting many clients and patients and reducing the waiting list. In the HSE Dublin North East area, some patients had been on a waiting list for three to four years. The waiting list has decreased dramatically, and the people who had been waiting the longest were the first to be given an appointment

The Chairperson:

I will ask an awkward question: does our Department assume that CAWT will receive the additional €8 million for acute services when it allocates money to the Southern Trust? Is it additional money? Or does the Department of Finance and Personnel say that, because CAWT receives €8 million, it will lop that off your budget?

Mrs McCrory:

No; one of the criteria for EU funding is that we must demonstrate that it is additional money. The patients who have been seen in the current tranche would not have been seen within the current envelope of capital available to any of the partners.

The Chairperson:

So Sammy Wilson knows nothing about that €8 million? *[Laughter.]*

Mr Donaghy:

The funding for the projects is a North/South issue, so much of the funding comes from the South rather than from the Government here. The funding to sustain those services is a commitment from our colleagues in the South, not a commitment from here.

The Chairperson:

Sammy Wilson definitely knows nothing about it. That is good.

Mr Donaghy:

One constraint in CAWT concerns policy. We adhere to the policy of our Government in the North and the Government in the South, and we do not stray outside that. One limiting factor is planning for a bigger population.

Mrs D Kelly:

Are there great projects sitting on your desk that would deliver for the well-being of our citizens but a lack of political will in policy development or official will at departmental level, North or South, is acting as an obstacle to their delivery?

Mr Donaghy:

There are no such projects at the moment. The feasibility study will indicate the areas in which it would make sense to co-operate.

Mrs D Kelly:

The Minister refused to answer questions, which was pointedly put by my colleague Conall McDevitt and me, on that subject. It is interesting that the question of whether the study exists has still not been answered. Perhaps we can ask for a copy.

Mr Donaghy:

Funding is another obvious constraint for CAWT.

Mrs D Kelly:

Are there any issues about the multi-level alcohol harm reduction project and improving outcomes for children?

Mrs McCrory:

That project is about supporting vulnerable families and trying to tap into the strong community and voluntary sector. We get better value for invested money if we do not replicate existing services in the community. We examine several facets and support affected families so that we can decrease acute admissions, and so forth. It is about early intervention. Young people will be involved in the project before alcohol becomes a problem for them.

Mrs D Kelly:

Do your innovative cross-border work practices have lessons for the health trusts, North and South?

Mr Donaghy:

Yes, absolutely.

Mrs D Kelly:

How is information shared and that good practice celebrated?

Mr Donaghy:

The HSE is a partner, so responsibility for sharing and learning from those practices, from the management board perspective, is on the HSE representatives. They share information and good practice with their colleagues.

In our context, the Health and Social Care Board and the Public Health Agency are now also members of our management board and secretariat. In that way, we promulgate sharing and learning from CAWT.

Mrs McCrory:

We do our best to visit all the district councils. We are attending this Committee meeting, and we welcome all such opportunities.

Mr McDevitt:

It is nice to see Mr Daly back here in another capacity, so soon after we last saw him. I want to pick up on the issue of acute hospital services. Before I do so, may I ask how long you believe that the feasibility study has been with the two Health Departments? I do not want to push you into an area wherein it would be inappropriate to answer.

Mr Donaghy:

CAWT's involvement with the feasibility study concluded about —

Mr McDevitt:

Was it about a year ago?

Mr Donaghy:

Yes, it was.

Mr McDevitt:

I do not want to have a conversation about the feasibility study; that would not be appropriate. However, I want to ask for Colm's and Tom's opinions specifically about the opportunities for efficiencies in acute services in the CAWT region. Try to think beyond your current programme's remit and look ahead to the next 10 to 20 years. Where do you see big opportunities for efficiencies? Where are the opportunities for potential savings to both Exchequers by pooling resources more effectively?

Mr Tom Daly (Cooperation and Working Together):

First, I will deal with new service requirements or sustaining existing services. I can refer to a couple of practical examples. The neonatal service for Donegal was always provided from Dublin, which meant a special ambulance transfer and, for many years now, that service has been provided on the basis of an additional 0.5 neonatal cot at Altnagelvin, which our system funds. That is a small, but important, example of the value of that service to the population of Donegal. Altnagelvin is also being funded to provide it.

There was a major sustainability issue around the oral and maxillo-facial services at Altnagelvin, in which two consultants were involved. It would not have been sustainable in the future. We came to an arrangement with counties Donegal, Leitrim and Sligo, and that is now a fully sustained service involving three consultants, with limited outreach clinics to Letterkenny and Sligo. Our system pays a substantial revenue contribution to that, and a good service has bedded in exceptionally well.

A development is planned for what will effectively become a subregional cancer centre at Altnagelvin. We started with an arrangement whereby, through a negotiated process, Belfast City Hospital provided a service, on a referral basis, to cancer patients in Donegal. In recent years, numbers have not been huge, but it is an important service development and a viable option for that population.

In forward planning for the North, capacity will be exhausted by 2015. The Altnagelvin

option has now become viable, and we will have an input to the development of the business case for the cross-border stream of that service. The jurisdiction in which I work will make a capital and an ongoing revenue commitment to that service. The provision of linear accelerator machines, and so on, will take the population of both centres into account, which resolves a problem for both systems. The location of radiotherapy services was a huge issue in my jurisdiction.

The issue is more to do with finding reasonable solutions through good levels of co-operation rather than greenfield planning of new facilities. It is more about coming up with creative solutions to deal with scarce specialties, particularly in outlying areas. None of those examples depends on European funding, which has been a concern for some people. A strong revenue commitment from both systems would mean, for instance, that if staff are put in place at Altnagelvin, the service that they provide will be sustainable.

Dr Deeny:

It is nice to see Bernie again, and I thank Tom and Colm. Acute hospital services is the first item in your presentation, so I cannot resist asking you this question. The distance from Dublin to Derry is 150 miles, and it is 170 miles from Dublin to Letterkenny. However, since the acute hospitals in Monaghan and Omagh were closed, there are no acute hospitals on that lengthy stretch of road, which is a major route to the north-west and, thanks to EU funding, is due to become a dual carriageway. We can imagine the number of tourists who will be travelling to Donegal. Are you concerned about the possibility of a major incident on that stretch of road?

In January, when the Dáil's Select Committee on Health and Children visited Stormont, I raised that concern with a member, who told me that he had not thought about that before. Some years ago, I worked in Newry for three years, and I was told that the acute hospital there would always be safe because it was on a main route to the north. The road to Derry and Letterkenny is the second main route to the north, yet there is no acute hospital for almost 170 miles. I hope that I am wrong, but there is bound to be a major event on a road of that length. Should we not be looking into that possibility, and should it not concern Europe?

Mr Donaghy:

I understand Dr Deeny's point. However, from CAWT's perspective, decisions about where to locate hospitals are for the relevant Departments and the Governments in both jurisdictions. In

light of such decisions, we work to ensure that care is provided on a cross-border basis. In other words, our job is not to undermine or second-guess government policy decisions but to ensure that we work in accordance with those decisions to improve care where we can. I know that that sounds like a fudge; however, recently, for example, when there were major road traffic accidents in Monaghan, with which Dr Deeny may be familiar, there was no barrier to the emergency services taking injured people by ambulance to Craigavon Area Hospital. In such circumstances, to ensure that people who are affected are provided with the optimum level of care, the emergency services respond by going to the nearest, best-equipped hospital.

Mrs McCrory:

It is also worth mentioning that, for the past three years, CAWT has facilitated major cross-border emergency planning exercises, centred on the two ambulance services and involving military personnel and blue-light services from the North and the South. The exercises enabled hospitals to test their major incident plans, and, as a result, they have a close working relationship with each other. We also ran advanced life support (ALS) courses for ambulance personnel. There is now agreement that, in the event of a major incident, emergency services on both sides of the border will help each other.

We replicated a severe incident in a three-day exercise at Magilligan, which involved 400 people from our health services and the military. We are in a good state of preparedness should something happen, and we are trying to sustain that. A few weeks ago, we held a conference at which we comprehensively examined incidents such as the Haiti earthquake. Senior military and clinical personnel were able to share their experiences with nurses, doctors and ambulance staff, North and South. We are focused on holding regular practical exercises at least once a year, and we have managed to sustain that for three years.

Dr Deeny:

We know that there will be much more traffic on the route from Dublin to Derry and Letterkenny in future. CAWT is working on a cross-border basis — it is about time that that happened — and if you have concerns, you should raise them. It sounds as if you are doing your best to deal with an issue that could cause serious problems. If I was travelling on a German Autobahn, or on any main route with loads of traffic in a so-called developed country, I would be shocked to discover that there was no hospital within 170 miles. I am thinking about the future, but decisions have been taken, North and South, without any joined-up thinking. That needs to be examined, and

people who have concerns should raise them.

Mrs McGill:

I want to follow up on Dr Deeny's point. I do not mean to be disrespectful, but is it the case that you have only limited influence? You said that the projects that you were involved in were determined by the two Health Departments. Is that the case?

I am interested in the GP out-of-hours service. I represent the Strabane area as an MLA and the rural part of that area as a district councillor. I do not see anything in your presentation to suggest that CAWT or the Departments are considering the out-of-hours service in that area. You gave an example of how it is working in the Southern Trust area. I was contacted today by someone who said that there is a rumour going around that the out-of-hours service in the Strabane area is in serious difficulty because doctors will not be available after 6.00 pm and patients will have to go to Derry. For some people who live in Strabane, it would make sense to go to Lifford, which is just over the so-called border. That issue has been raised on many occasions. I am disappointed that that option has not been included in the projects that you spoke about. How much will the pilot exercise involving Newry and Castleblayney cost?

Donegal is hard done by for cancer services provision. Is it the case now that, because of the change in provision, people from Donegal will have to go to Galway? I heard that issue mentioned in the media.

Mr Daly:

The current position is that Galway is the nearest centre for radiotherapy services in our jurisdiction, which is why negotiations are taking place with Belfast City Hospital. I hope that the business case for the development of the new centre at Altnagelvin Area Hospital will be fully accepted. It will embrace that area, which is obviously closer to a large part of the population of Donegal.

Mrs McGill:

I would not hold my breath. Mary Harney gave a commitment to work with Belfast City Hospital some time ago, and I am not sure that that commitment was implemented. If you can swing that one, Tom, fair play to you.

Mr Daly:

Our input into the development of the business case is live. Work is going on, albeit quietly, because it has to go through certain processes here.

Mr Donaghy:

I will answer Claire's question about influence. Both Health Departments were identified by the SEUPB as the partner organisations for the closed call for €30 million. CAWT worked up the proposals in detail through an engagement process with the organisations that make up CAWT and with the local communities in the CAWT area. The proposals were processed through both Departments for approval and were submitted to the SEUPB for funding. The Departments and CAWT were interviewed by the SEUPB on the business case proposals. Although the two Departments are the sponsoring partner organisations, the details of the business plan came from CAWT.

Mrs McGill:

I want to go back to Dr Deeny's point. If a case is made that is justified and valid, and there is a call for it, what is your role in that situation? I asked you about the GP out-of-hours service in Strabane and Lifford. The situation in the district that I represent is going to get so much worse. Dr Deeny made a point about acute hospitals and your influence. I note that the project board members come from the relevant trusts, the Western Trust and the Southern Trust. I am surprised that the situation of the out-of-hours service in Tyrone and Donegal has not been raised in any meaningful or forceful way. I would welcome some feedback on that, Colm.

Mr Donaghy:

I will revert to the hat that I wear on a normal operational day. I was the chief executive of the Southern Trust. The Western Trust has to make decisions on out-of-hours services in Strabane. The pilot project that we put in place was evaluated by the Centre for Cross Border Studies and the University of Ulster and was found to be beneficial to populations, North and South. The two Health Departments will decide whether the pilot is rolled out across the border region. The cost is £20,000.

Mrs McGill:

Twenty thousand pounds for whom?

Mrs McCrory:

That is the cost per patient that the Health Service Executive would pay to Northern Ireland and vice versa. It costs around £20,000 to sustain the numbers that go across from the Southern Trust to Castleblayney. There might be a one-off set-up cost, but that is not an issue. The running costs are not very high.

Mr Daly:

The feasibility study identified that, in the border area, approximately 70,000 people might benefit from an out-of-hours service if the arrangements were put in place to allow access either way. The pilot studies tested that analysis. At some stage, a policy decision will have to be made as to whether there is a way to move forward on behalf of that identified population, whether it will be publicly accepted and whether it can be funded. A pilot is also running in the greater Derry city and Inishowen areas, but the take-up is not as strong as it is in Newry, south Armagh and Castleblayney.

The Chairperson:

I am sure that that will look well in the 'Strabane Weekly News'. Given that we are tight for time and that we have kept Michelle McIlveen waiting, I ask that Mr Buchanan, who is the last member to speak on this point, be brief. I am sure that he will not raise any issues relating to Omagh. *[Laughter.]*

Mr Buchanan:

I will be brief. I wish to focus on acute services. You said that a number of specialist acute hospital services will be enhanced. Will you tell us to which hospitals you are referring? You also said that there will be additional consultant support staff for ENT services. Again, will you tell us where those staff will be placed? Do you believe that the decisions of either the Western Trust or the DHSSPS have had a detrimental impact on what you are seeking to deliver? I ask that because, before the removal of acute services from Tyrone County Hospital, many cross-border patients used the ENT services there.

I also wish to raise the issue of the utilisation of theatre facilities at the Erne Hospital and Tyrone County Hospital. I think that Altnagelvin Area Hospital should be included in that arrangement, because the biggest problem is the backlog there. Altnagelvin could free up its waiting lists if it were prepared to move patients who require ENT procedures to either Tyrone

County Hospital or the Erne Hospital. One simple way to make efficiencies is to free up theatre facilities.

Mrs McCrory:

I will answer those questions one at a time. There are three different areas: vascular, urology and ENT. First, the vascular project is, in essence, a lateral one between Altnagelvin Area Hospital and the Western Trust area and Letterkenny General Hospital. Secondly, the urology project follows practically the same format except for the small number of urology services that go from North to South and South to North in HSE Dublin North East and the Southern Trust. Thirdly, the ENT project operates across the border corridor as well as in the Western and Southern Trusts.

The pilot project for ENT procedures that is starting at the Erne Hospital and Tyrone County Hospital in the Western Trust seeks to bring work to both those small hospitals. We have already had discussions with Tyrone County Hospital, and the staff there are very willing to participate. There are theatre vacancies, and, in a short time, those hospitals will be able to take day cases and treat outpatients, thereby benefiting people not only in Omagh and Enniskillen but Letterkenny.

The main reason that we received the €8 million was to fund the pilot between Letterkenny General Hospital and Tyrone County Hospital, although some pieces of work were done at Altnagelvin. Before that pilot was introduced, about 2,500 people were on the waiting list for their first appointment at Letterkenny General Hospital, for which people can wait up to four years. The INTERREG IIIa funding provided for the appointment of a consultant as well as a support team of secretaries and some nursing input. For one year, we were able to reduce the waiting list time to just over a year. Inpatients were happy to travel for procedures at Tyrone County Hospital, and outpatients were happy to attend appointments there. Subsequently, we successfully used that model to try to get some more money for the three areas that I described. The staff at Tyrone County Hospital and the Erne Hospital have said that they really want to work with us on that. We have just sent an interest circular to all consultants in the Western Trust, and many of them have offered to fill the empty theatres slots for vascular, urology and ENT procedures.

As members know, complex operations cannot be performed either at Tyrone County Hospital or the Erne Hospital, but the staff there are happy to perform AV fistulas and procedures

for vascular problems and varicose veins. We must get the best out of our physical resources and use the finance to engage staff and ensure that the local population, as well as those across the border, have better access to those services.

The vascular project is particularly pertinent because there are three very good vascular surgeons in Altnagelvin but none in Letterkenny. If someone had an aneurysm, and one tries to transport the patient to Dublin, by the time that he or she arrives, the situation will be difficult. We are trying to have such patients come across, as emergencies, to Altnagelvin. The Western Trust works well with us at the moment. Joe Lusby has dedicated himself to doing all this work, and he is on CAWT's secretariat. That is coming along well.

Urology procedures can also be done locally. Up to 16 procedures can be done in a day case setting. We are appointing specialist nurses, as well as consultants and staff grades. We can see outpatients and perform some of the day case procedures locally. However, theatre capacity at Altnagelvin is a problem, and we must look to it for more complex surgery.

Altnagelvin Area Hospital does send patients to the Erne Hospital. In the pilot scheme on the Erne Hospital site, we are assessing the treatment of varicose vein cases. That frees up some capacity in the main theatres at Altnagelvin. It is about getting the very best fit. If we can use the day theatres in the smaller hospitals to capacity, it frees up some of the main theatres. There are seven main theatres at Altnagelvin, and they are under pressure because of the size of population that they serve. However, we are trying to address that problem.

Mr Buchanan:

The operating theatres are under pressure because day cases are not being sent for treatment in the other hospitals. Operations are being carried out on some cases that should be sent on.

Mrs McCrory:

That is what the pilot scheme at the Erne Hospital and Tyrone County Hospital is all about. The scheme is only in its first week in the Erne Hospital, and already some 37 varicose veins patients from the Derry area have been sent to be assessed and treated there. That frees up accommodation in Altnagelvin. We want to bring business to the other hospitals and from across the border to sustain services at those hospitals. We need to mainstream that in the future. The CAWT management board is committed to that.

Mrs D Kelly:

I want to ask about an issue that was raised last week, which is physiotherapy services for aggressive MS. Could CAWT look at that project?

Mrs McCrory:

This funding is all spoken for. However, I recently gave a presentation to the European Commissioner for Health and Consumer Protection and the SEUPB. Planning has already started for INTERREG V, which goes beyond 2013. If there are any ideas, I will capture them and ensure that the SEUPB knows what is needed.

The Chairperson:

That presentation provoked some lengthy questions, and it was very informative. Thank you all for coming along and bringing the Committee up to date. We knew the name of your organisation, and now we know what has been going on behind the scenes. Your attendance and contribution are greatly appreciated.