



Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Cooperation and Working Together

1 June 2011

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:

Ms Michelle Gildernew (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Michaela Boyle
Ms Paula Bradley
Mr Mickey Brady
Mr Gordon Dunne
Mr Mark H Durkan
Mr Sam Gardiner
Mrs Pam Lewis
Mr Kieran McCarthy

Witnesses:

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

Mr Joe Lusby) Western Health and Social Care Trust

The Chairperson:

Tom, Joe and Bernie, tá fáilte romhaibh. You are very welcome. I am delighted to see you here and, having spoken to you previously, I know about the important work in which you are engaged. The Committee is anxious to hear about the level of ongoing work and the co-operation in providing services to our constituents and the wider public in the North. Tom, I will kick it

over to you.

Mr Tom Daly (Cooperation and Working Together):

Thank you for the opportunity to make a presentation to the Committee on the work of Cooperation and Working Together (CAWT). CAWT is best described as a virtual organisation that was formed in 1992 by the then health boards along the border corridor, North and South. Next year, it will have been in existence for 20 years.

Members have some documentation that, if they wish, they can follow as a rough guide. I want to outline the areas that we hope to cover. We will cover some aspects of current cross-border health and social care activity, and we hope to describe the rationale for cross-border collaboration. We want to give members an update, particularly on the implementation of the current EU INTERREG IVa programme.

Members will be familiar with the INTERREG programme, which has had a health and social care stream for a number of years. We were pleased at the introduction of that stream to the programme. On the strength of that, a significant amount of project activity is under way that will run until the end of 2013. We hope to highlight some achievements and challenges and talk a little bit about the future.

Membership of the CAWT partnership in this jurisdiction is drawn from the Southern Health and Social Care Trust, the Western Health and Social Care Trust and the Northern Ireland Health and Social Care Board. All those agencies have management board representation, and the Northern Ireland Public Health Agency is involved at secretariat level. The primary partner from the Republic of Ireland is the Health Service Executive (HSE), but composed of two distinct areas: the West area, which extends from Malin Head to Foynes harbour in Limerick; and the Dublin North East area, which runs south from the Dundalk area and includes the north side of the River Liffey. It is the border area component of those respective areas that is primarily represented through this work.

The original rationale for collaborative working for the then boards, which has been continued by the trusts and by the Health Service Executive in the other jurisdiction, is that around 1.6 million people live in the border corridor area. The health and social care status in both jurisdictions is similar. Some of the challenges are the same, which are mainly those of a rural

population. There are a number of access difficulties to do with travelling for health services. We will deal with that issue more specifically later on. Even at the foundation of the organisation, there were challenges about available finance, particularly for service developments and for meeting gaps in services, and so on. I do not suppose that that has changed.

Issues arising from the recruitment of specialist staff into peripheral areas were a consideration, and it was felt at the time, and has been proven since, that the combined populations, when there is mutual agreement about needs and how to meet them, can in some instances create the critical mass to justify a new service or, in some cases, to sustain a service that has perhaps become vulnerable. Economies of scale that could be achieved through joint approaches were another consideration.

As well as the service requirements that are identified from within the partnership, the Department of Health, Social Services and Public Safety (DHSSPS) and the Department of Health and Children have engaged CAWT to take forward some work on their behalf, including work on cross-border and emergency planning. A significant project is service development in paediatric and general cardiac surgery, over which there was a sustainability issue in Belfast. A joint approach is being worked up to sustain that service on the island of Ireland.

The development of access to radiotherapy services at Belfast City Hospital for the Donegal population was an important initiative in the sense that it tested a lot of issues concerning patient pathways and access. It became the forerunner for the subsequent proposal to look at catering for part of the population in the other jurisdiction in the development of the radiotherapy service at Altnagelvin Area Hospital, which has been strongly supported by the Minister here.

We were also asked to engage in the registry of self-harm attendances in A&E departments. There was also a significant Driving Change project in both jurisdictions. It was a road safety project that involved the public agencies, including the gardaí and the PSNI.

Bernie will talk more specifically about some of the project work that we are undertaking. Given that we are involved in the delivery side of the services, it is critical that we seek to achieve added value for both systems and to work in a proactive but practical way around the issues that arise on the ground in the area that we cover. We have been in existence for 20 years, and apart from funded project work, there are a number of good examples of joint services being up and

running on a mainstream basis with service level agreements in place. They are working effectively from the point of view of the population that they serve.

Mrs Bernie McCrory (Cooperation and Working Together):

I will cover INTERREG IV. It is a major achievement for cross-border health co-operation because the European Union has invested €30 million in that aspect of our work. The Putting Patients, Clients and Families First project has 12 distinct strands. Those strands reach anywhere from acute hospital services to diabetes to eating disorders.

I will take this opportunity to give you a flavour of those 12 strands. We have a sexual health project which is known as the GUM (genito-urinary medicine) project. Without the investment, we would not have a sexual health clinic from Donegal round to Dundalk, and there would not have been any sexual health clinics in the southern part of the former Sperrin Lakeland Trust, which covered Tyrone and Fermanagh. The project has a beneficiary target of 5,000 people, and there are a number of clinics up and going, which are well attended and much needed.

We have an alcohol project, which has a number of strands. It is about intervention with families and empowering and engaging communities. It is linked to alcohol abuse in pregnancy and all that goes with that. There is engagement with health visitors, and so on, across the region.

We have a social inclusion project, which is working with our most vulnerable people, such as women with cancer and Travelling communities. It has a beneficiary target of about 1,600 people. We are working to try to train Travellers to continue to continue that work in their communities. A cross-border Traveller community health worker network will be established. That is well advanced.

We also have a project that is aimed at preventing and managing obesity. It is trying to adopt a community-focused approach, and it is working on trying to tackle obesity in families and young children. It has a beneficiary target of 1,700 people.

An eating disorder service is being developed. Twelve specialised eating disorder healthcare professionals will work with young people and families and, in particular, with those with a moderate eating disorder so that we can prevent that problem from escalating into a much more serious eating disorder.

There is also a project for improving outcomes for children and families, which is about trying to establish an approach so that all agencies work in an integrated way. That will mean that we can get the very best services, in education, health or whatever, for our children. All those social aspects mean that we will not work in a vacuum; we will have an integrated approach and model so that everybody can access information and benefit from it.

We are working to try to support people with a disability. Rather than continuing to work within the traditional model of day care services for people with a disability, it is about citizenship and enabling such people to make choices about where they want to spend their day, as you and I can. Perhaps it is a social aspect or to do with new learning or whatever. It is about working with the person who has a disability and trying to see where best we can target the funding to make his or her life more enriched.

Acute hospital services is probably the longest established of the strands. It is hugely successful at this point. It concerns ear, nose and throat (ENT), urology and vascular services. We have pilots across a number of areas in the border region. We have a well-established vascular pilot scheme in the Erne Hospital in Enniskillen. It is good at being in a state of preparedness for people who are used to crossing the border for services. I am thinking particularly of the new acute hospital. People travel quite easily from Sligo for AV fistula procedures in the Erne Hospital.

The ENT service is well established between the Southern Trust area — Craigavon — and Dublin North East. Two of the consultants whom we have appointed to the Craigavon rota of ENT surgeons have now seen over 3,500 patients from the Dublin North East area as well as almost 1,000 of the indigenous population of the Southern Trust. We are about to appoint a urologist in Letterkenny General Hospital. We have already enhanced the urology service in Altnagelvin Area Hospital, and there has been a significant investment in new equipment in Altnagelvin and Letterkenny hospitals to support that.

That project is probably overachieving and underspending, so there was a little slippage at the end of last year. We decided to enhance that acute strand because it was within the scope of the original objective. We are now undertaking ophthalmology developments and oral and maxillofacial developments. We are in the process of appointing two ophthalmologists to the

Dublin North East area, in Monaghan and Louth, and we are also working with the Southern Trust to do that. Up to 4,000 people in Dublin North East are waiting for their initial assessment, so that will be important. We continue to support the oral and maxillofacial development in Altnagelvin because it currently supplies the service to Letterkenny and Sligo. We now have some more money to invest in equipment for both sides of the border and to increase the sessional commitment from the oral and maxillofacial surgeons.

As well as working with patients and clients, we have workforce mobility. We also believe that it is important to ensure that the people who work in the services, North and South, have the necessary skills. We are undertaking projects such as back care passports, which means that if someone is trained to deliver a service and the health and safety aspects have been covered on one side of the border, it will be consistent and will be applied in the same way if that person goes to work on the other side of the border. It is also about working towards a consistent approach to training.

We also have pre-pregnancy care, which mainly concerns diabetes. The INTERREG programme is not only about the border region but all of Northern Ireland with the exception of the greater Belfast area. There is an exception that means that money can be invested if a service is regional. We are about to invest £700,000 in insulin pumps for young children who would normally have had to go into hospital to be stabilised, and so on. That will be across Northern Ireland and the border corridor.

Mr Joe Lusby (Western Health and Social Care Trust):

I want to cover three areas very quickly: the challenges that we continue to face with cross-border working; an identification of what has worked really well, adding to what Bernie and Tom have said; and a sense of our next steps.

Before I discuss the current challenges, I want to emphasise the importance of cross-border working. It is absolutely invaluable to the services that we provide, and we see that daily in the border regions. Bernie mentioned the oral and maxillofacial service, and, a number of years ago, we relied on two consultant surgeons working out of Altnagelvin to carry out that service, one of whom, who had worked with us for many years, was about to retire. Those surgeons were doing a one-in-two rota, and we could not replace that post even after advertising it a number of times, as new consultants coming out of training and elsewhere were not prepared to commit to that type

of work:life balance. On the basis of the cross-border work that Bernie identified, with the Western Trust working with hospitals in Sligo, Letterkenny and elsewhere, we were able to attract and fill those posts with no difficulty, and we now have a complement of four consultant surgeons and a much better, robust and sustainable service.

Another example of invaluable cross-border working is in the area of emergency planning, and the relationships that we have built up on a cross-border basis stand us in good stead on a weekly basis. For example, there was a major road traffic accident some weeks ago in Swanlinbar, which, unfortunately, resulted in a fatality. There were also five or six very seriously injured patients and both ambulance services, Cavan General Hospital, the Erne Hospital and the Royal Victoria Hospital in Belfast worked together to treat those patients. There was no border in the delivery of a first-class service to those injured people, and it worked extremely well. Those are some of the day-to-day examples of situations in which cross-border working is so important to the delivery of services on both sides of the border.

There are challenges, and we must be realistic because we are dealing with two different health and social care organisations and systems that are not entirely coterminous. We have made huge progress in breaking down some of the barriers, but some still remain, and further work must be done in those areas. Another challenge that we face is the fact that both systems are undergoing a process of reform and modernisation. The HSE and the Republic of Ireland are undergoing a major reform process, the outcome of which is uncertain, and we have a continuing reform and modernisation agenda in Northern Ireland. It is a challenge for us to maintain a consistent approach when all that is happening, and we are fortunate to have had Tom Daly in CAWT from the start to maintain a centre of gravity for us. However, although the situation creates a challenge for us, it is not insurmountable.

As to what is working well, we clearly have a shared agenda. We can also see the benefits of daily cross-border working, and we are delivering high-quality services. All the projects that Bernie outlined will be subject to a thorough and full evaluation, and we will then look at the projects that were given a positive evaluation to see if they can be mainstreamed. From the start, we were careful to tie commissioners from both sides of the border into our submission of proposals that secured €30 million worth of European investment. Further down the line, there will be an issue about the mainstreaming of funding that we will need to address, but we will do that from the basis of positive evaluations and an assessment of those projects that have made a

difference to people's lives. One of the major benefits of our current 12 projects is that, despite the financial realities with which we all struggle, the focus on early prevention and intervention was really helpful. I hope that the evaluations will demonstrate the worth of that.

With regard to the next steps, we will have to make sure that, as part of that evaluation process, we demonstrate that we have met the objectives that were clearly outlined at the outset, and we are confident that we will do that. In that process, we will demonstrate value for money and effective cross-border partnership working. The focus has been, and always will be, on longer-term relationships, sustainability and the mainstreaming of those projects that demonstrate real value for money and positive outcomes.

The Chairperson:

Thanks a million, Joe. For the record, I should say that Tom Daly is the director general of CAWT, Bernie McCrory is the chief officer, and Joe Lusby is the deputy chief executive of the Western Health and Social Care Trust. Tempting as it is to monopolise the question-and-answer session, I am going to open it up to the floor and encourage members to ask questions.

Mr McCarthy:

Thanks very much for your presentation. Of course, we welcome every effort to bring a better health service to Northern Ireland and to the Republic. Nobody referred to autism, which is mentioned in the paper. That is a big concern for people in the North. We have an autism centre in Armagh. What facilities are you providing there because it has come in for criticism?

Mrs McCrory:

The centre at Middletown is distinct from the work that we are trying to do. Basically, CAWT is targeting 750 clients and their families and undertaking activities such as providing some respite for parents, summer schemes and trying to work with parents in common with the citizenship project, on an individual basis with healthcare professionals, to try to see what we can do for those identified clients to enhance their lives. It is not an educational piece of work, although parts of the summer scheme are educational. There may be an overlap, and we have no difficulty with that.

Mr McCarthy:

Do you find that respite is important for people with autism and their families?

Mrs McCrory:

Yes, it is. The project is primarily about transition, and anybody who is familiar with the condition will know that if a young person moves, say, from primary to secondary school, that change is a difficulty. It is about youngsters trying to support themselves and their families through those changes and establish a social-type network for those youngsters so that if they choose, for example, to go to a cinema or a computer club, we will support them. It is individually focused for those clients who have been identified to us from the health trusts and the HSE.

The Chairperson:

Members are all very shy. This is only our second meeting.

Mr Brady:

Thanks for the presentation. You mentioned projects starting in 2009 in which a number of patients were treated at Daisy Hill Hospital in the Southern Trust area. I am aware, from dealing with people from Dundalk who attend the renal unit for dialysis, that the benefit is that, rather than having to travel to Dublin and leave very early in the morning and spend the whole day there, they were able to access dialysis in Newry, have that within two or three hours and be back home for lunch.

Having spoken to some of the people involved in that and those on whom it impacts, I know that it was beneficial to them. That service has probably been available for nearly 10 years, and that is only one of the benefits that I have seen. You say that even more is coming down the line. As someone who represents a border constituency in Newry and Armagh, I cannot say enough about the benefits for people on both sides. A relative of mine needed a bypass operation and was able to go to Dublin to have it simply because there were no places available in the North.

In my constituency, I have experience of a number of young people with eating disorders. When they become really bad, they have to access facilities in England. You are saying that preventative measures are in place, including counselling and support. That is important, because I know of at least three cases of young people whose lives have been taken over by an eating disorder. Had preventative measures been put in place earlier, they possibly would not have reached the stage at which they had to access facilities in England and were in an almost terminal

state. So what you have said is very encouraging.

Ms Boyle:

You are very welcome. Bernie, my question is similar to that from my colleague Mickey. There are 12 therapists for eating disorders. In the area that I represent — Strabane — that is a big issue. I know that there are three therapists in each area; are they are in place and how does one contact them?

Mrs McCrory:

The first point of contact is to come through the CAWT development centre in Derry. We will give you all the details. However, to be honest, we have had difficulty in recruiting those 12 therapists, quite simply because they are so specialist in their area. Strabane is one of the areas in which there is very likely to be concentration. However, the three therapists in any area will travel to where they are needed. They are mobile, in line with the requirement for their services. They work with the primary care teams and all those who are already involved in the statutory agencies. So they provide an additional resource and are not trying to replace what is already there. It is definitely additional.

Ms Boyle:

Do they do face-to-face referrals?

Mrs McCrory:

Yes, they do.

Ms Boyle:

You mentioned the €30 million EU investment. Given the next steps and the way ahead, that €30 million will not be long in drying up. What are the next steps for financing that after that happens?

Mrs McCrory:

It is not just about the €30 million; it is about economies of scale and about working together. It goes a lot further than I thought initially because, for example — I go back to Mr Brady's point — in Dublin North East and Daisy Hill, people who already work on either side of the border, such as the nurses, practitioners, and so on, are being given additional resources. For example,

we originally had four ENT consultants in Craigavon who were spread right across the Southern Trust area. With two more appointed, there is now a rota of six. So if consultants are allowed to work in their sub-specialty, there is more value for money. If a specialist were to be brought in from Belfast or wherever, the cost would be high, whereas, in this way, a skills base is built in each partner area. The first step is beginning to work together in a more effective and efficient way to get the very best out of the skills that we have.

We have already made some progress in mainstreaming in so far as the HSE has committed €400,000 to sustain that consultant investment even beyond the lifetime of the measure. Similarly, with GUM services, we have already had a commitment from the Southern Trust that the specialist nurse there will continue to be employed, and in HSE Dublin North East and HSE West, there is a commitment of over €400,000 to continue the GUM services. So there is ongoing discussion between the partners, and the management board is keeping a close eye on the issue. It has been programmed into future planning, because none of the strands of this project came about in isolation to what was already going on. The programmes for government, your health and well-being investment plans and your trust delivery plans all informed that. We are not doing anything other than what, had there been more money in the pot, the trusts and the HSE would not have done in the longer term anyway.

Mr Lusby:

It is also important to point out that, although INTERREG IV is clearly bounded — we have to deliver against those projects, and we are confident that we will deliver against them — there is a hope that there will be an INTERREG V beyond 2013.

Another strand of work that we have under way, which is running alongside this project work, is looking to the future and bringing colleagues from both sides of the border together across all the specialties to look for opportunities in areas that we have not looked at. For example, we have had work undertaken on cystic fibrosis, where there is a real potential, beyond 2013 or 2015, for both jurisdictions to work together in the interests of populations on both sides of the border. That is important work.

We have some six strategy groups in place working across all those areas so that we are prepared that, if there is a call for INTERREG — whatever it is called the next time — we will be in a position to put robust cases forward.

Ms Boyle:

Thank you for the presentation. I know the benefits of the two jurisdictions marrying to increase the benefits for people. I declare an interest as a former chairperson of the disability awareness programme in CAWT.

Mr Durkan:

Michaela touched on an issue, and it is important that we investigate how we can make this work more sustainable for both health services going into the future, rather than simply relying on EU funding.

You clearly outlined how the work of the CAWT partnership has a positive impact on people, such as those who live in my area — the Western Trust area — and the border region. As a former member of a local commissioning group, I would like to know how that work was captured in local commissioning plans and in the formalised regional commissioning plan.

Mr Lusby:

With regard to the new structures and the new commissioning arrangements in place, we have made sure that the commissioner representative is tied in as a full member of the management board. So there is no opportunity for people not to understand the direction and the progress being made, and so on. For us, that is the ideal way to capture it.

As well as in individual projects, we are trying to involve commissioners at different levels to make sure that people are clear on what progress has been made and what the opportunities are.

Mr Daly:

Significantly, on the delivery side, the people who populate the project groups — chairpersons, in particular — are senior people in the system from either or both jurisdictions and from across all the professions. So a strong managerial and clinical cohort is directly involved in the planning and delivery of projects. We could not really do this work without their engagement in a very open way.

Mr Durkan:

That is good.

Joe, you touched on the issue of cystic fibrosis. I had heard rumblings about future collaboration between the health authorities on both sides of the border on a potential cystic fibrosis unit. I am aware that some discussion has taken place. Will you give us an update on the position with that?

Mr Lusby:

We have done quite a bit of cross-border work on cystic fibrosis and have produced a report. The analysis clearly demonstrates that cystic fibrosis services in Northern Ireland for children and adults are based in Belfast. With regard to the potential numbers coming from across the border, there is no sense that we would move children's services in Northern Ireland out of Belfast; it makes good sense for children's services to be based there because it has a specialism.

However, with regard to adult services and the number of people who come from Donegal and elsewhere to Dublin, it is estimated that Belfast will reach its full capacity by 2015. So by 2015, there will be an opportunity for us to look at a satellite service outside Belfast that will also cover the Republic of Ireland. There is already a policy commitment to that with the Republic of Ireland.

Mr Daly:

I shall explain the situation in our system. In Donegal, for example, about 14 people under 16 years of age require the service at any one time. That service is currently provided from Dublin. The adult population also travels to Dublin, and it is the adult cohort that we are looking at from a planning point of view. That is probably more of a medium-term project from the point of view of the development funding that is required. The Pollock report on our system recognised that a cross-border solution might apply to some population cohorts, and that has been accepted by my organisation and the Health Service Executive.

We have done some work on the ground with the clinical services primarily involved. Some changes in how the service is delivered would be required because of the distance from, for example, Letterkenny General Hospital, where there is a shared care facility for adults, who get their mainstream service from Dublin. In this jurisdiction, there is no shared care model. Primary care is provided by the centre of excellence in Belfast.

All of those who have an interest, particularly the families and the service providers in both jurisdictions, would accept that it makes sense at some stage to seek to provide a satellite service, perhaps at Altnagelvin, and that a patient cohort of 50 adults would sustain that service. That cohort would be available, probably on a ratio of 2:1 from the Northern system to our system, even currently. It really is about the identification of development funding and revenue funding. The commissioners in the North have indicated that the funding will not be available in the short term, but it is still a live possibility. It is also well supported by the likes of cystic fibrosis associations.

Mr Lusby:

The probable date for capacity planning is in and around 2015, so, as Tom said, it is not for the immediate future but the medium to longer term. The work being done on cystic fibrosis is very much like the work that was done on radiotherapy in that it involves people working together for the common good of the patient. It is not about organisations, boundaries or competition. We are not in the business of competing with other organisations to take business and services away from them. It is a matter of what makes sense for patients on a complementary basis, and the cystic fibrosis work is another key example of that working extremely well.

Mr Dunne:

Welcome, panel, and thank you for your informative presentation. Some of the issues that I shall raise may have been covered earlier. Is it true to say that you are generally supplementing existing services, or are you providing new services in areas where there is a shortfall?

Mr Lusby:

Everything is additional. There is no substitution.

Mr Dunne:

Is there no risk of duplication?

Mr Lusby:

We have been very careful. The process of securing European funding was extremely robust, as you can imagine.

Mr Dunne:

It generally is.

Mr Lusby:

We thought that we would never reach the finishing line. The good discipline in the process means that it covers such issues and asks us to demonstrate that we are sure that we are not substituting or duplicating services. All such issues were well covered, even in securing the funding. We are confident that we will demonstrate that again on the back of the evaluation process.

Mr Dunne:

The intention, then, is to submit a further bid for European funding.

On a general point, is there an exchange of costs from Northern Ireland to the Republic for services provided?

Mr Daly:

There are a number of models. In the case of the INTERREG-funded projects, the service provider is compensated appropriately for the service provided and for the project work, so that is straightforward. There are mainstream services, outside of EU-funded projects, such as the oral and maxillofacial service, which Joe mentioned earlier and which Altnagelvin was in danger of losing. By ceding the population of Leitrim, Sligo and Donegal to Altnagelvin Area Hospital's catchment area, that service has been sustained and developed. Now, a very good trauma service and planned elective service are provided to both jurisdictions. That service is provided by Altnagelvin to my jurisdiction on the basis of a direct revenue exchange that is negotiated and regularly reviewed. It involves a payment from one jurisdiction to the other. That is one model.

There is a similar arrangement on a much smaller scale for the critical neonatal service for County Donegal. For many years, Altnagelvin has provided that service on the basis of the planned utilisation of 0.5 of a neonatal cot. Again, our jurisdiction makes a revenue payment to Altnagelvin for that service. That was mentioned in relation to the renal dialysis service, for example, whereby people from Newry can access the service in Daisy Hill Hospital. That is a negotiated service level agreement that is arrived at on the basis of the capacity of one system to provide a service to another. However, it is an economic arrangement, and all such arrangements

are monitored.

Generally speaking, something such as the oral and maxillofacial service, because of the nature of it, is a predominantly mainstream service with four consultants, arrangements for outreach clinics, and so on. That is a highly consolidated service. A service such as the renal dialysis service is reviewed every two years because demand may change.

Mr Dunne:

What method is engaged? Is it an ongoing process?

Mr Daly:

Absolutely. It has to be monitored because the capacity in either jurisdiction could improve at any point, which may mean that access to the other jurisdiction for the service would not be required. The models vary greatly, and they are built around the need, the size of the gap and the best way to close that gap through local collaborative, co-operative arrangements, some of which are small in scale.

In future, the radiotherapy service will be a significant and major service, and I hope that it will come to fruition. Similarly, the paediatric congenital cardiac surgery service, which involves a link between Belfast and Dublin, will be significant in terms of the capital investment and revenue costs that will be required ad infinitum to support it.

Mr Lusby:

We have been highly successful in developing pragmatic solutions for those services. As Tom said, for the oral and maxillofacial service, Altnagelvin provides the consultant input, and any inpatient activity is, therefore, billed for accordingly. When our consultants provide the clinics in Letterkenny and Sligo, HSE provides the nursing staff, receptionists and appointments process. We have tried to be pragmatic and demonstrate value for money in the process.

Mr Gardiner:

Thank you very much for your extremely professional presentation. Is there any Department or anyone in the establishment who does not co-operate with you, or with whom you do not co-operate? Do you wish to highlight anything that we, as the Health Committee, could move forward or improve?

Mr Daly:

Our experience is that, when engaging in connection with a service gap or a need, we face no barriers or lack of co-operation. On the ground, engagement between the services is of a high-quality nature and level. We do not engage in the policy side. We work in two separate jurisdictions, each of which has its plans and priorities. Our challenge is to identify service gaps in the area that we cover and to stay true to the policy requirements of both jurisdictions.

In many situations, the objectives, aims and targets are similar, but that is not always so, and we have to take account of that. Our overall experience is that, when there is a pragmatic solution to a real issue for people, we receive co-operation from within the services. The two Departments have a strong working relationship. I should acknowledge that the lead agencies in the suite of 12 projects are from the DHSSPS and the Department of Health and Children in Dublin, and we are bringing the work forward on their behalf. In the past, both Departments have been influential in ensuring that a health and social care stream was introduced into the INTERREG programme, which is a significant achievement in itself, in that, traditionally, INTERREG concentrated on other sectors, such as agriculture, economics, tourism, and so on. Nevertheless, it has been highly beneficial to the health and social care sector, particularly over the past six years.

Mr Gardiner:

Thank you. I welcome your reply.

Mr Brady:

I want to go back briefly to cystic fibrosis. In the previous mandate, there was an issue with Cherry Tree House and the Allen ward in the Royal. The Belfast Trust appeared to make a unilateral decision to downgrade the cystic fibrosis facilities. The Deputy Chair's constituents were affected, as were mine. It is an important, long-standing regional service. The youngster with whom I dealt was 11 years of age and had spent four and a half years of his life in that ward because of the nature of his condition, and there was the risk of cross-infection. You mentioned setting up an all-island cystic fibrosis initiative. That would make sense, because there is a relatively small number of cystic fibrosis patients throughout Ireland. Only the likes of the Cystic Fibrosis Trust fought long and hard to maintain the service, and, although it was downgraded slightly, the Cystic Fibrosis Trust was relatively happy with what was retained. It seems that cystic fibrosis is one condition for which the co-operation that you mentioned would be extremely

beneficial. It is a traumatic condition, particularly given that young people suffer. Fortunately, advances in medicine mean that those young people can look forward to longer lives.

Mr Daly:

It certainly merits practical consideration, and it is a matter of when resources become available.

Mr Wells:

Although I probably know the answer to this question, I will ask it anyhow. If we had reached the situation whereby the funding for Altnagelvin was a few million pounds short, I presume that there is no way that any of CAWT's funding could be used to bridge that gap?

Mr Lusby:

No. The approval process clearly delineates projects.

Mr Wells:

I suspected that. On a more serious note, you have basic programmes, but I presume that you can also deal with any ad hoc issues of cross-border co-operation that arise. A particular issue cropped up when the Committee was discussing the Safeguarding Board for Northern Ireland, particularly vis-à-vis children's protection. Although the guards will share hard intelligence on people convicted or prosecuted for child sex offences, the problem is that they are not prepared to provide soft intelligence, such as unsubstantiated reports or prosecutions that never reach court. It strikes me that that is a major anomaly and that your body is designed to try to advise as much co-operation as possible.

Claire McGill used to be on the Committee, and we used to talk about what I called the camel's hump-back bridge — I do not know whether it is still called that in Strabane — whereby an offender could drift from the Republic into Strabane. Even if there was strong soft intelligence that he was a highly undesirable individual, the authorities here would have no way of knowing that. Is that the sort of issue with which you can deal?

Mr Daly:

Members may be aware that child protection has been an area of special interest to the North/South Ministerial Council. A great deal of work has taken place between jurisdictions, not only between the Health Departments but between the Justice Departments, and a child protection

hub has been developed. The issue that you mentioned has been given significant attention through that mechanism.

In our jurisdiction, the Department of Health and Children will be split into the Department of Health and a new separate Department, the Department of Children, which will be tasked with bringing forward that work in the future, as well as the setting up a separate agency for children's services. From the HSE's point of view, that area will not form part of our future brief. However, significant work has already been done on a North/South basis. I am not sure whether I feel comfortable dealing with the issue that the member raised about gardaí/ PSNI co-operation and soft intelligence. Bernie can, perhaps, add something.

Mrs McCrory:

We have been approached by DHSSPS to take on a piece of work in connection with the child protection hub and have agreed to do so, although I have not yet been made aware of the details. Quite often, we are asked to take on additional work commissioned by the two Departments. Some examples of that work, such as child protection, the self-harm registry, emergency planning and radiotherapy pathways, have been mentioned.

The view of the previous director general, Colm Donaghy, and the new director general is that CAWT existed long before European funding. It is here to promote cross-border work, and if we can help in any way, we will be happy to do so. CAWT will exist beyond the end of the European funding stream. However, I imagine that the issue raised is more for the Department of Justice, the PSNI, gardaí, and so on. We do not have any direct involvement, but we have multi-agency connections for areas such as emergency planning.

Mr Wells:

Here, of course, child protection falls very much within the bailiwick of the Department of Health, Social Services and Public Safety. On a practical basis, if CAWT could help to solve that problem and prevent one child from being abused by someone whom we could not track, it would be much appreciated by the Committee. Although childcare and child protection in the Republic fall within a different Department, that should not stop CAWT's becoming involved.

The Chairperson:

First, like many Committee members, I am from a border constituency and, therefore, recognise

the value of co-operation and working together. One of the earliest high-profile pieces of work in which CAWT was involved was access to out-of-hours services. That was some 18 or 19 years ago, which demonstrates how the provision of healthcare in the border region has been transformed in the time that CAWT has been in existence. I would like to thank formally all the people involved over those years for their vision and for bringing in something that was not easy to do in the beginning. The people who lost out and suffered when health policies were devised and implemented in a way that resulted in back-to-back working were those living in the border counties. I welcome the fact that that back-to-back mentality has gone.

I welcome the response to Sam's question about barriers. It is important that the Department of Health, Social Services and Public Safety recognise the work that CAWT does in providing services to people outside Belfast. I ask that you keep your mind on that for a wee minute.

On the issue of evaluations, I know that you are building capacity in health provision in rural areas. However, we know that one of the difficulties for the next phase of the process will be how you have evaluated the service provided and how we can sell it. If European funding has to be mainstreamed, it is important for that service to be evaluated in a way that shows the obvious benefits in carrying on with that approach. Both Departments, North and South, are under financial pressure, but it is hugely important for that excellent work not to suffer or drop away because of a lack of funding arrangements. Therefore, the evaluations are crucial. Are you involved in an ongoing evaluation?

Mrs McCrory:

We recently appointed an evaluation team. That team is independent, which is a requirement of the European Union's funding, and we recognise its importance. Management did not want to receive a final evaluation that we could have done certain things better. Therefore, we engaged the evaluation team at a very early stage, and it has started to work with the project managers and each of the project boards. The team is involved in helping us to refine our baseline data. It is not just about the number of beneficiaries. We could say to you that we know that we will exceed our target of 21,000 beneficiaries; we already know that to be the case because of overachievement in certain areas. However, we want to include other factors, such as the barriers that were overcome, dual registration, mutual recognition of qualifications and any legal issues surrounding the implementation of cross-border work.

Therefore, we have an evaluation team, and it is very much engaged. The team gave a presentation to the management team, and it is well aware of what it has to do. It will conduct an interim stage evaluation, and if we are doing anything wrong at that stage or can do something better, we can take corrective action before the end-stage evaluations.

In our specification for evaluation, we have been careful not to leave everything to the end, when it will be too late to do anything. We want the evaluation to inform the business case for INTERREG V, and we have to take into account elements such as patient and client feedback and the views of staff, and we will have to see how services were re-engineered as a result. All those elements are clearly specified in the evaluation documents. We are happy to let the Health Committee see those documents and the extent of the work done in advance of appointing a team.

The Chairperson:

I am trying not to be parochial, but we recognise the value of your work in the acute sector. Primary, social and acute care are also important. There are strong bilateral links between Sligo, Cavan and the Erne Hospital. Is there any difficulty with the funding arrangements that we should know about? Is it easier for patients to transfer in other areas than in that location? I heard that there were difficulties with the funding arrangements for cross-border patients being treated in Enniskillen.

Mrs McCrory:

No, there have not been any difficulties. Everything undertaken as a result of this measure is automatically reimbursed once auditors have formally vouched for it. Therefore, there is no question of any hospital North or South losing out through being engaged in such work. There is an easy flow from Enniskillen down to Sligo and from Sligo back to Enniskillen. This time last year, for example, young children awaiting ENT operations went to Sligo for their inpatient surgery. That freed up some accommodation for other activities in the Erne Hospital or the Tyrone County Hospital. The same is true of patients coming across here. Some patients who have waited for an extremely long time for simple day surgery, such as vascular surgery, are happy to come to the Erne Hospital. Patients from Ballynahinch, the Northern Trust area and as far away as Manorhamilton have come to the Erne for assessment and returned for treatment. As they have been waiting for some time, they are more than happy to get to the nearest, most accessible service. Therefore, it is an easy flow.

We do not perceive any difficulty because we are extremely accommodating. We have a number of dedicated sessions in theatres and day procedure units, and we can take advantage, right across the border corridor, of any downturn in theatre activity. For example, it is normal in the Republic of Ireland to reduce theatre use for two to three weeks in the summer. We view that as an ideal opportunity to get other patients or Northern patients into those theatres, staff the theatres and make the best use of that capacity.

The Chairperson:

That is very good to hear. In relation to the recruitment of staff, the example given earlier was of consultants in Altnagelvin working on a one-in-two rota. We know how difficult it has been in the past to recruit staff, particularly the further you go from the Royal. The Cooperation and Working Together model has resulted in the situation being better than it would be otherwise, but, as far as I understand, there are still difficulties with recruitment at times. Again, you have helped to cushion some of the difficulties through being able to maximise theatre space and ensure that capacity is built into the border areas. Had it not been for your work, we would probably be facing a much worse situation.

Mr Daly:

We have gained much experience in employment issues, such as the requirement for dual registration when someone provides services in both jurisdictions. So far, we have been able to find practical solutions to all such issues.

Mr Lusby:

I suppose that it is not surprising, but it amazes me at times how quickly any lack of certainty about the future for services and facilities radiates to clinicians and other staff. They say, for example, that they will not move their family from England to an uncertain future in the South of Ireland. You are probably aware that, a couple of years back, we had difficulty recruiting to particular specialties in the Erne Hospital. There will always be, and currently is, a national shortage in particular specialties such as radiology, paediatrics. However, it is a national problem with which everyone must grapple, simply because too few qualified people are coming through the system.

A couple of years back, we were dealing with pressures on all sorts of specialties in the Erne Hospital. However, once there was a commitment to building the new hospital, the number of

applicants increased, and the calibre of applicants improved. It is a much changed situation for us. It is a matter of having that vote of confidence in the future. That is really important when people are deciding what their career path will be.

The Chairperson:

I have one last question, if I may. You dealt with the cystic fibrosis issue earlier. If you were certain now that you would get INTERREG V funding and that the work on cystic fibrosis would continue for a period, what would be the priorities for phases 2, 3, and so on?

Mrs McCrory:

I will recount what consultants tell me. One important aspect that has come up is the notion of ICU and high dependency unit (HDU) departments talking to each other via technology. It is particularly difficult, for example, to recruit anaesthetists and intensivists. We have been told about systems all over the world in which one intensivist can monitor four or five ICUs or HDUs. We have to think about all the hospitals in the border region, and smaller hospitals do not necessarily have to have someone 24/7. It would be useful for us to have some money to invest in the high-end technology that supports ICU and telemedicine in general.

I also keep hearing about orthopaedics. Many elderly people, particularly in the border region, both North and South, are waiting for hip replacements, and so on. That also extends to social care and the support that they have at home. Instead of keeping people in hospital for four or five days after a hip replacement, we should have a system in which a peripatetic team — a physiotherapist, a nurse, and so on — rehabilitate those people at home. We would love a seamless service, whereby such patients go into hospital for perhaps a 23-hour stay and are back in their home and community fairly quickly. Those are the kinds of subjects about which consultants talk a great deal.

Mr Lusby:

As well as there being the opportunity to develop some services that we currently have on the ground, we mentioned therapists for the eating disorder service, which will, we hope, have an impact through early intervention. However, there will always be a need, and, unfortunately, it is an increasing need, for specialist units. As there are currently no such units in Northern Ireland, anyone requiring that type of service must go to England, Scotland, or wherever. That means that there is an opportunity, and the same applies to sexual health services. Even with the services

that are on the ground now, there will be development opportunities for their further expansion, because demand is growing almost by the week.

The Chairperson:

A few years back, in the Southern Trust area, there was a fairly serious increase in the number of reported syphilis cases. Previously, testing had not been routinely carried out as part of antenatal care. After the test was introduced about seven years ago, quite a few cases were detected. It is hugely important that GUM services are provided locally. The knock-on from that is that capacity in Belfast should be enhanced. Also, nobody should have to wait for any longer when those services are provided in Daisy Hill Hospital, or wherever. Has the number of cases that you have been seeing increased, and has that number exceeded expectations?

Mrs McCrory:

When all services are on the ground — we are about to establish a clinic in Letterkenny — we will have five additional clinics in the border region. They are very well attended, and, in a number of areas, we have a walk-in service, which, by the very fact that it is accessible, has resulted in increased numbers. As I said, there had been no service at all from Letterkenny to Dundalk. Presumably, therefore, people would have had to cross the border to Altnagelvin or Belfast, or travel to Dublin. The two professors who are the chairs — Professor Dinsmore and Professor McConkey — would say that the very fact of establishing a clinic automatically means that there will be more demand.

The Chairperson:

Unless anybody has any burning issues to get off their chest, I will say go raibh míle maith agat. I thank the three of you very much for coming today. It has been enlightening to see what we can do when we work together. We have gained an insight into the efficiencies and best value for money that we can achieve through delivering an enhanced health service to people in the areas that you cover. Thank you very much, and we would be delighted and interested to receive further reports and ongoing evaluations. Keep up the good work.