Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Departmental Briefing on Capital/Infrastructure Programme

20 May 2010

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Dr Kieran Deeny
Mr Alex Easton
Mr Sam Gardiner
Mr Conall McDevitt
Mrs Claire McGill

Witnesses:
Mr John Cole) Department of Health, Social Services and Public Safety
Mr Stephen Galway)

The Chairperson (Mr Wells):

First, we will make life easy for you by congratulating you on Downe Hospital's success in winning a Royal Institute of British Architects (RIBA) award. Such awards are always pleasant, particularly when they come Down District Council's way. When members visit the hospital later this afternoon, they will see that it is a magnificent structure compared with what used to be down the road, which was Victorian in its architecture. We are very proud of the new hospital; it is super. I am sure that you will pass that on to the folks there.

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

The clients — the South Eastern Health and Social Care Trust — are sitting in the Public Gallery, and they had a major role, but we all worked together and are very proud of our achievement.

The Chairperson:

It is certainly deserved. The building fits in well with the backdrop of Downpatrick, and the views are magnificent. We hope that service provision will get busier and busier.

You addressed the Committee for Health, Social Services and Public Safety previously; the last time you were in Committee, you spoke about sustainability. You have 10 minutes in which to make a presentation. We are keen to hear about Desertcreat police college.

Mr Cole:

I am not covering the college in my presentation; I intended to deal with questions afterwards. However, if you wish, I will brief members.

The Chairperson:

There was a £30 million commitment, which is important for the overall scheme. The new women and children's hospital in the Royal Victoria Hospital (RVH) complex is a burning issue, which we discussed last week. It would be nice if you were to give us good news about that; I doubt that that will be the case, but it would be nice. You would make history if you had good news.

Mr Cole:

It would be nice if I had good news, because I like producing these buildings.

Can you hear me? Are the microphones turned on?

The Chairperson:

It is a recording system, not a PA system. If you were to announce that building work on the new women and children's hospital is to start on Monday, we will hear you.

Mr Cole:

I thank the Committee for inviting me to give you some background on the capital/infrastructure

programme. I have met most of you before, but for those of you who do not know me, I am John Cole; I am a deputy secretary and the chief estates officer in the Department of Health, Social Services and Public Safety (DHSSPS). I am joined today by Stephen Galway, who is head of the capital resource branch in the Department.

I will provide some background on the overall provision of health and care buildings. The service is dependent on buildings that are functionally suitable, efficiently designed, properly located and capable of providing an environment that allows for all the technologies and modern services that underpin current clinical practice. You are all aware of the complexities of laminar flow theatres, positron emission tomography (PET) scanners, magnetic resonance imaging (MRI) scanners, computed tomography (CT) scanners, sterile production facilities and everything else that underpins modern clinical practice.

On the capital side, the problem is that those technologies and practices are changing at an ever-increasing rate, and they need a constant source of investment to keep up to date. If we are to have the facilities that the people of Northern Ireland require to deliver a high-quality health environment that is safe and up to date, we need the funding to build, maintain and operate those facilities. At present, that is a significant problem for the Department.

I will digress slightly. In the same way that practice and technology have changed, so have the locations in which services can be offered. Increasingly, services that would previously have been provided only in a hospital environment can now be provided in local settings that are closer to community and primary care. The Department's policy is to try to provide services efficiently, effectively and economically, and closer to where patients live rather than in hospital environments. It is hoped that that will provide a better focus for health promotion, illness prevention, management of chronic disease and earlier diagnosis, which leads to better outcomes.

A key element of our recent capital programme was to provide a primary care environment that would facilitate a range of community health centres that have the critical mass to provide those out-of-hospital services; that is referred to as the primary and community care infrastructure (PCCI).

At the same time as primary care is being rolled out, we are also investing in acute and local hospitals, as evidenced by the new Downe Hospital. It is among a wide range of investments that

we need to make in the acute and local hospitals sector. Again, the fundamental constraint is our financial ability to deliver those investments.

We are also trying to focus capital investment on provisions for mentally ill people and for those with learning disabilities. In the past, that tended to be referred to as a Cinderella service. In recent decades, it has not received as much investment as other parts of the service and is lagging behind somewhat. One of our focuses is to try to improve services in that area through significant investment when it is available.

It is important that the Committee understands that those are the three large categories of buildings that we provide under the capital programme. Our annual capital allocation must also pay for general capital, which keeps the trusts running: minor works such as repairs to roofs, ceilings, windows, and so on; the purchase of all items of clinical equipment in hospitals; regional initiatives such as the purchase of bowel cancer screening equipment and the decontamination strategy; the maintenance of existing services in facilities where wiring, medical gas or ventilation needs to be replaced; the design, procurement and installation of all ICT systems in the Health Service, which alone needs investment of over £400 million during the next number of years; the ongoing replacement of all Fire and Rescue Service vehicles and their equipment; and finally, the most relevant cost, perhaps, for 2009 was funding for emergency planning, which includes pandemic antiviral medicines.

All that comes out of the capital budget before we can start to spend money on buildings such as those that the Chairperson mentioned earlier: the women and children's hospital, and the integrated training college at Desertcreat. Funding for those services, rather than newbuilds, amounts to around £100 million of the capital allocation each year, which is against a current background of around £200 million of capital each year.

The estate is the largest public sector estate in Northern Ireland, with a huge variety of type, size and complexity of buildings. It has more than 1,600 individual blocks of buildings. Its floor area is more than 1·6 million square metres. It has an estimated replacement value of more than £10 billion. That demonstrates the size of the task that we are trying to manage.

The majority of hospitals are acute hospitals, which were designed and built in the late 1950s, 1960s and early 1970s. They were designed for a period that was quite different to the present

with regard to technological demands, public expectations and the range of services that are currently provided in them. Most of them are now 40 to 50 years old and are reaching the end of a useful life. They should have been part of an ongoing replacement programme over time. They do not facilitate the delivery of modern services in a modern way.

Some parts of the estate are even older, such as Holywell Hospital, which provides services for people who have mental-health difficulties. It dates from the 1880s and 1890s. Our key objective is to try to bring people out of those settings, which are institutional and inappropriate, to resettlement in the community where possible.

As recently as 2001, the annual allocation of capital to the Department was only £63 million. That is against a present background of now needing about £100 million to stay as we are, before starting to pay for any buildings. In the current comprehensive spending review (CSR) period, 2008-2011, our allocations have averaged £200 million, but approximately half of that goes on non-building issues. During that period, we seek to make the best use of our money and have been able to deliver quite a few successes: the redevelopment of Altnagelvin Area Hospital; the new Downe Hospital that members will see today; the new orthopaedic and trauma centre at Craigavon Area Hospital; the maternity, critical care and renal dialysis buildings at the Ulster Hospital; the cancer unit and isolation ward at Antrim Area Hospital; a renal unit at Daisy Hill Hospital; and a new imaging centre at the Royal Victoria Hospital.

Projects currently being constructed in the hospitals sector include a new neurology ward at Musgrave Park Hospital; a new critical care block at the RVH; a palliative care unit at Antrim Area Hospital; new theatres at Lagan Valley Hospital; and the new south-west acute hospital in Enniskillen, which is being delivered as a private finance initiative (PFI). Under PCCI programme in the CSR, we have created community health and care centres in Portadown, Knockbreda and on the Shore Road in Belfast, and children's homes at Carnview in Newtownabbey and in Newry. Projects for similar centres are also under way on the Shankill Road in west Belfast.

In the mental-health and learning disability sector, we completed the Bluestone psychiatric unit at Craigavon; the Bayview resource centre for learning disability at Bangor; the regional child and adolescent psychiatric unit at Forster Green Hospital; the Lisburn mental health assessment centre; and Newry social education centre, which was completed in the past month or

so. Projects under way in that sector include the new Gransha mental health crisis unit in Londonderry.

That is what we have been doing, but what is needed? In our most comprehensive estimate of need — carried out in 2008 with the full range of commissioners, trust and our policy colleagues in the Department — it was estimated that, to satisfy only the top 12 priorities of the trusts in the service, it would required approximate investment of £7·8 billion at 2008 prices. That is the capital element alone. The estimate excludes the revenue costs of running or maintaining those buildings or of making PFI payments. That £7·8 billion requirement compares with an investment strategy for Northern Ireland (ISNI) allocation of £3·3 billion over the 10-year period from 2008 to 2018. Therefore, the allocation was less than half that identified as needed to meet the top 12 priorities in each trust.

Not only was the allocation less but its profile was hugely restricted. In the years 2013-14 and 2014-15, the level of annual investment allocated to the trusts was only £120 million in the future. Given that we need approximately £100 million to meet annual costs, £20 million would be left to deal with all major projects. That rendered it impossible for us to deal with any of the major demands on the system, such as the projects that have been referred to, particularly the women and children's hospital. That period became known in the Department as the "valley of death", because the capital profile dropped to virtually zero, meaning that it was almost impossible for us to deliver. We sought to change that profile but were unable to do so.

The women and children's hospital will cost £350 million, and in each of those two years, we were down to a total annual spend of approximately £20 million to £30 million. That demonstrates the difficulty of profiling the provision of that facility, never mind the range of other facilities that make up the £7·8 billion needed to match the profile.

Unfortunately, I cannot deliver any good news to the Committee. As we look forward, we have even less confidence than previously about the ISNI allocation. All members know the difficult circumstances that we are currently experiencing, and we are aware of significant pressures to cut budget allocations in the next CSR period, 2011-14. We have heard a range of predictions about the possible depth of those cuts, and the worst of the projections are absolutely terrible. It is inevitable that cuts will be made. However, at the moment, nobody can tell us what those cuts will be or how much money we will have. In effect, that renders irrelevant the original

10-year ISNI allocation from 2008 to 2018, because the Department of Finance and Personnel and the Strategic Investment Board (SIB) are seeking to conduct a review and publish a new allocation that reflects their predicted cuts and the contractual commitments across the entire Northern Ireland block for capital.

I am the person in the Department who is responsible for planning the allocation of resources, and I find it virtually impossible to do my job when I do not know how much money I will have or when I will have it. We are not allowed to commit to spending money that we do not have in our allocations.

The Minister of Health, Social Services and Public Safety remains committed to a wide range of significant investment priorities across the areas that I outlined. Those priorities include investment in facilities in regional hospitals; acute hospitals; local hospitals; primary and community care; mental-health services; learning disability services; the Fire and Rescue Service; and the Ambulance Service.

The problem is that we do not know how much money we will have to deliver on those priorities, and no one is telling us how much we will have. That uncertainty is likely to continue until the CSR in England and the subsequent division of the Northern Ireland allocation. That will probably happen at the end of this year and will be the first time that I know how much money we have for the 2011-14 planning period. Against that background, it is almost impossible to make promises on a wide range of projects with which we are progressing and are ready to move on. There is a huge question mark over what money will be made available to us.

The final part of my presentation concerns the existing estate. Thus far, I talked about the availability of capital. We are also aware of the need to manage the existing estate and minimise the cost of running such a huge area. We seek to achieve optimum efficiency through a range of reviews and exercises to save energy, in particular, and rationalising, withdrawing from and disposing of any surplus or underused property that we identify in the entire sector. We have a major exercise to tease out whether there are any spare buildings that we can move out of.

Where possible, we apply capital to reduce revenue because of the huge pressures on the revenue budget, which the Committee will hear about next week. As part of that, we are finalising and populating a new estates management information system that will allow us to

observe much more closely how the trusts are managing the estates on our behalf.

I hope that that gives the Committee some idea about the current position. I know that the outlook is not a very cheery one.

The Chairperson:
Apart from that, everything is fine.

Mr Cole:
Apart from that, yes.

The Chairperson:
Oh dear. That is not the news that we wanted to hear. We have provided you with magnificent surroundings in which to announce the new women and children's hospital. The press would have been very keen to deliver the good news. Obviously, we are nowhere near even considering that.

We flagged up the issue of the Desertcreat training college. Although I am using that title, I am sure that it will not be called that when it is built.

Mr Cole:
I think that that title is being used.

The Chairperson:
I thought that it would have had a grand title rather than being named after the townland.

You know the situation. We were told that the business case for the £210 million package does not stack up without the £30 million contribution from the Department for the Fire and Rescue Service element. I understand that there may also be an Ambulance Service element.

Mr Cole:
Some training could be provided at the college, but there will not be an element that is specifically designed for the Ambulance Service. However, the Ambulance Service will certainly avail itself of the facility.

The Chairperson:

The worry is that, without match funding from the Department, the entire project will be in peril. That would be disastrous not only from a policing point of view but for the construction industry west of the Bann, which would bite your arm off to get cracking at the project, because of its size and the employment that it would provide.

The match funding is for a two-year period, so it would be about £15 million each year rather than a single £30 million allocation. Is the Department able to state with certainty that it will provide the match funding?

Mr Cole:

I referred to the problem earlier: we do not know what the profile and availability of capital for health will be. The Minister says that, although he supports the scheme and the project, he cannot make an absolute commitment until he knows his allocation and his priorities. He is waiting to find out what his allocation will be.

The business case process is not yet complete, so we are waiting for that to go through the Department of Health, Social Services and Public Safety and the Department of Justice.

The Chairperson:

However, somewhere along the line, a commitment must have been given, because the SIB and the Policing Board definitely take the view that the money was promised. They feel that the Department is, perhaps, reneging — I use that word in a mildly pejorative way — on a commitment on the basis of which they have proceeded.

Mr Cole:

Under the allocation of £3·3 billion, we had lines in for the profile of that expenditure. That £3·3 billion is no longer assured. We have not yet been told that formally, but we have been told that there are likely to be significant cuts, and the Department of Finance and Personnel and the Office of the First Minister and deputy First Minister, through the SIB, are reviewing the allocation of capital. The Minister has not welshed on a commitment of any sort; the £3·3 billion was in the line that we were given, but it looks as if that money is not forthcoming.

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

We have to take into account that a revenue cost is also attached to the project, along with the overall revenue pressures on the Department.

The Chairperson:

It is approximately 1% of £3 billion over two financial years. I am sure that it could even be spread over three years if required. You have not landed a whale, but you will land a tiddler, and the money required is a very small proportion of your capital budget.

Mr Cole:

Until we know what money we have, it is impossible for the Minister to make a definitive commitment.

Mr Galway:

If that is set against the priorities across the rest of the health sector — in mental health, acute and primary and community care — it is a question of where it sits in the Minister's constrained budget.

Mr Cole:

It looks as if we will have to stop projects all over the place if the money is cut as badly as is expected. The Minister needs to examine his budget to see how he can prioritise.

The Chairperson:

If the Department cannot deliver, the consequence, according to the SIB, is that the project will stop dead in its tracks. That will have a knock-on effect on police training and your own staff who undertake fire-drill training on the Boucher Road on a Sunday afternoon in totally unsatisfactory conditions.

Mr Cole:

I accept that. Ideally, a scheme would proceed, but priorities are the issue. Significant health priorities are not being addressed in the budget. You mentioned the women and children's hospital; that is one priority, but there are another 30 to 40 projects competing for desperately needed resources to maintain a Health Service. For example, if we do not provide new facilities for radiotherapy services at Altnagelvin Area Hospital, it will not have the capacity to meet the

current requirement for cancer treatments. All projects depend on how much money we receive in the next CSR period. Nobody is telling our Department how much money it will receive, only that it is likely to be significantly less than the current budget.

The basis of the original planning assumption was against a budget of £3·3 billion. If that money is not there, all issues will have to be reviewed for prioritisation purposes, which could affect the police college or a critical facility for health provision.

Dr Deeny:

Thank you, John and Stephen. You spoke about prioritising, and at a time like this when money is a problem, surely we have to prioritise according to need. You said that you have to wait until you receive the money, but who decides what is needed? Will it be the Minister?

I wish to refer to primary and secondary care. Let us get real and honest with the people: there is no point in saying to the health sector that everything will be shifted from secondary care to primary care. John, perhaps you have no say about prioritisation, but either money will be put into primary care or it will not or cannot be. The public must not be led to believe that everything will be done in the community when I know, from speaking to health professionals in the community — not only GPs — that that will not happen. Buildings that were prioritised under PCCI programmes and community health and care centres are now off the menu. It cannot be done. The provision of secondary care treatment in old buildings will be an increasing problem. The alternative is to move those services into the community, but that cannot be done without investment. We must get real.

You talked about the Department's commitment and what it is doing. Given that Tyrone has lost three acute hospitals, the hospital in Omagh is one of my priority concerns. The Committee is about to visit the new hospital here in my native town of Downpatrick, and I am delighted about that. However, Downe Hospital was prioritised. In recent days, I have seen that the Omagh hospital is the third priority on the Western Health and Social Care Trust's list of 12. What happened there? Money is limited, but who decides where it goes?

Mr Cole:

Ultimately, the Minister decides on the final designation of priorities. In reaching that decision, he takes advice from policy colleagues, the commissioners, the trusts and us. There is a broad

policy to move services into the community, and, to some degree, that is starting to work. I totally accept the point that that policy was based on a much more heroic view about what might happen in primary care.

At one stage, 42 new health and care centres were planned for Northern Ireland. Two of those are nearing completion, so by the end of this year, nine of those 42 will be completed. The others are now battling in a totally different economic environment in which capital is not likely to be available. We seek every possible method to add to our capital assets by disposing of surplus estate assets. Again, in the current environment, selling the health estate is not necessarily the wisest thing to do, because we would be selling it at the bottom of the market. I know that the Chairman wishes to ask me about a particular site, and I will be happy to provide that information.

However, the reduction in available capital has come on us all of a sudden. Many of those facilities were built into the original programme, which we are now revising and reviewing. A new capital priorities review will kick off in the next month to deal with the new environment in so far as we can possibly anticipate it. The fundamental information that we need — how much money will be available once we look at the prioritisation — is unlikely to be known until the end of the year. Until then, we will not have firm capital plans for 2011-14.

Dr Deeny:

It concerns me that you did not answer my question on the Omagh hospital.

Mr Cole:

I am sorry. Omagh Hospital is still —

Dr Deeny:

That fact that you did not mention it concerns me, because you mentioned many other priorities —

Mr Cole:

I am sorry. I think that I referred only to the —

Dr Deeny:

— in the south-west, and you talked about Altnagelvin and other hospitals —

Mr Cole:

I talked about the south-west acute hospital in Enniskillen because it is being built. The Minister is still fully committed to a hospital in Omagh. I reiterate: the fact that the money that we thought we were promised is unlikely to materialise in that £3·3 billion puts a question mark over all our schemes. We understand that it is a national rather than a local issue. Ultimately, how the money is divided up locally is a local issue, but the decision will inevitably affect the size of the Northern Ireland block grant. If the money is not forthcoming, no matter what the Minister wants to do, is committed to doing or would like to do, we cannot build those facilities.

In light of the fact that what capital funding covers in health was not fully recognised, the Department feels that its capital has been under-provided in proportion to other Departments. We needed much more capital, and we need the Committee to support our case. Members ask for, and legitimately expect, certain things to happen, but they will not happen unless we have the necessary money. Fundamentally, we cannot do it without the money.

Dr Deeny:

Therefore, even a priority as high as number three out of 12 may not be met.

Mr Cole:

Yes. The women and children's hospital was the RVH's top priority.

The Chairperson:

The problem is that it is a huge chunk of the capital budget.

Mr Cole:

That is so of all the projects. All the priorities — £100 million, £50 million, £90 million, £350 million and £30 million for Desertcreat training college — quickly add up.

Mr Galway:

We are tied into contractual commitments for those developments that are under construction. John mentioned the fixed costs that we try to deal with, such as day-to-day maintenance and

running costs. To consider a long-term construction project, we must examine the availability of funds after those fixed costs have been met.

Our biggest constraint is the profile that was given to us in the investment strategy. There are two years in which our allocation drops to £120 million. It will be difficult to meet our annual needs with that allocation.

Mr McDevitt:

Is £3·3 billion the Investment Strategy for Northern Ireland (ISNI) figure?

Mr Galway:

Yes.

Mr McDevitt:

Is that an indicative figure?

Mr Cole:

It was in 2008.

Mr McDevitt:

It was, however, only ever indicative.

Mr Cole:

ISNI gave us a profile and an amount for each year. The figure was more than indicative, in that it was written down.

Mr McDevitt:

The ISNI states that the figure was indicative, and I simply want to be clear about its legal standing.

Mr Cole:

I did not say that the figure represented a legal commitment.

Mr McDevitt:

One year of the current CSR period remains. In the revised health budget, your hit is 2·1% of capital. Is that correct?

Mr Cole:

What do you mean by "the hit"?

Mr McDevitt:

I mean the amount by which your budget has decreased.

Mr Galway:

No, the decrease is about 9%, which equates to £21·5 million.

Mr McDevitt:

The Department is now down by £21·5 million, rather than £16·5 million. Is it correct to say that funding for the Desertcreat project was never allocated in the current CSR period?

Mr Galway:

In 2008, when the health budget was published, the project was identified for 2010-11. However, delays in the scheme —

Mr McDevitt:

Does that mean that it will not be included in the spending plan that we may or may not see?

Mr Cole:

Do you mean the spending plan for this year?

Mr McDevitt:

Yes.

Mr Cole:

No, it will not.

Mr McDevitt:

So, the Desertcreat project has dropped out of the spending plan.

Mr Galway:

As the project was delayed and the business case for it had not been approved, no money could be spent on it.

Mr McDevitt:

Has that given you a cushion to progress other projects?

Mr Cole:

The money was realigned.

Mr McDevitt:

When was it realigned?

Mr Cole:

It was realigned as soon as we knew that the money would not be spent.

Mr McDevitt:

When was that?

Mr Galway:

It happened as part of our review of priorities at the beginning of 2008.

Mr McDevitt:

Therefore, the money that was allocated to the project in the 2008 CSR was realigned in the same year.

Mr Galway:

That money was part of a package. It is a moveable feast, in that we regularly review our priorities.

Mr Cole:

There has been movement in the business case for the Desertcreat scheme. The expectation of when it will happen has been changing, but we are not managing that process.

Mr McDevitt:

The proposed training college for the Police Service and Fire and Rescue Service is a convenient negotiating point, because it is a cross-departmental project. Until recently, one of those Departments was not devolved. I wonder whether it remains part of your negotiating strategy to keep that project outside until you receive a settlement.

Mr Cole:

We have no such negotiating strategy.

Mr McDevitt:

Do you have any negotiating strategy per se?

Mr Cole:

We certainly do not have one for the Desertcreat project.

Mr McDevitt:

The Desertcreat project is of strategic importance to the region and is a headline project politically. Are you saying that it does not figure in any way in your discussions with other Departments or with DFP?

Mr Cole:

I am not quite sure —

Mr McDevitt:

My point is that the Desertcreat project is an obvious project to single out as a bartering tool. The Department could say it that will not settle a current spending plan or future CSR plan unless it receives extra money to enable it agree to the Desertcreat project.

Mr Cole:

We are not in a position to settle our spending plans or our future CSR plans. DFP tells us how

much we will get, and we work within those allocations. We constantly complain about the amount that we are given, as I have done here today, because it is inadequate. However, having been given the money, we try to optimise its use to the best possible advantage. I return to Dr Deeny's earlier comment, and I repeat that we prioritise on the basis of need, which is what should drive our capital programme. We are not playing games.

Mr McDevitt:

Under the 2010-11 spending plan, what will be the capital allocation this year?

Mr Galway:

It will be just over £200 million.

Mr McDevitt:

As a result of that level of allocation, what projects will have to drop off your priority list?

Mr Cole:

Many projects have already slipped.

Mr McDevitt:

Will you list some of them?

Mr Cole:

We will come back to the Committee on that. The projects were in the process, but no business cases had yet been made for them. However, we have had to delay projects because of the level of that allocation.

Mr Galway:

Some £21·5 million has already been removed from the health budget. Next month, another Budget paper will address the additional £6 billion of savings that have to be made this year in the UK. The Department will, therefore, take another hit.

Mr McDevitt:

Will you come back to the Committee with information on the impact of the 2010-11 allocation?

Mr Cole:

The projects have been pushed back, rather than stopped.

Mr McDevitt:

I understand that.

Mr Gardiner:

Thank you, John, for your presentation. We, as a Committee, are not moving fast enough or acting positively to try to help the Health Service deal with the cuts. We cannot point our finger at the Minister, who, with all due respect, does his best. As members of the Committee, we have never raised our heads to say that we should write to the Minister of Finance and Personnel to ask him to reconsider his position on future allocations to the Health Service and the Fire and Rescue Service. Our present Minister of Health, Social Services and Public Safety tries to work within his budget. If he does not have the money, every Department will be affected. We deal with human beings who are suffering, and, as far as I am concerned, health is first and foremost in the line of services to the community.

The Chairperson:

Do you have a question, Sam?

Mr Gardiner:

I am thanking the witnesses for their presentation, sympathising with their situation and suggesting what the Committee should do to help.

The Chairperson:

I do not detect a question, but do you wish to comment on what Sam said, Mr Cole?

Mr Cole:

I thank Sam for his support, because there is an issue about the relative prioritisation of capital funding for health.

Mr Easton:

You mentioned the possibility of having to transfer some of the capital to revenue.

Mr Cole:

No.

Mr Easton:

Right. You said that revenue was coming under increasing pressure.

Mr Cole:

Yes, my implication was that, when a new building is under construction, a revenue tail is attached to the services that are developed therein. If it provides new capacity or new services or covers a larger area than the original building, there are charges for cleaning, facilities management, electricity, power, heat and equipment. Those are all revenue charges and come on the back of the capital allocation. My point is that we cannot consider the capital allocation in isolation. Every time that the Department constructs a building, someone must say that the required revenue exists to run it. Without the money to run a building, its construction is virtually pointless. That poses a real risk to the Department.

Mr Easton:

That has cleared that up. Next week, the Minister will tell the Committee about the £113 million. Have you been involved with the Minister in deciding how much capital will come out of that £113 million?

Mr Cole:

The amount of capital is the £21·5 million to which Conall referred.

The Chairperson:

The Department has no option, because that amount has already been set.

Mr Galway:

The budget has already been realigned to take account of that.

The Chairperson:

I presume that you know what will happen to the £21·5 million.

Mr Cole:

We have existing plans to spend £210 million. We will remove the £21·5 million and replan everything. All projects move down the line and drop into next year, thereby knocking other projects out. When we get to the valley of death, a project falls off the cliff.

Mr Easton:

What has been knocked back as a result of that £21·5 million?

Mr Galway:

Mr McDevitt asked us about that.

Mr Easton:

OK. How much is being taken out of the capital allocation to pay for the PFI for the new hospital in Enniskillen. A private company is building the hospital, and the Department will rent it back. How much per annum will the Department pay?

Mr Cole:

The capital element amounts to about £100 million, which the Department will pay on the day on which the hospital opens. In that sense, it is not all PFI money. We are borrowing that £100 million only for the short term of the construction period. When the hospital opens, we pay that money directly to the PFI bidder. For the rest of the period, we pay — I do not have the figure today, but it is in the region of £12 million to £13 million. If you take that on account, I will provide the yearly figure. That figure includes the costs for the hard facilities management, as well as for the —

Mr Easton:

Is that £12 million spread over 20 years?

Mr Cole:

It will be spread over 30 years, but do not take £12 million as the precise figure. It is of that order, but I do not have the exact figure with me. I will provide that to the Committee. We will start paying that only when the building has been completed.

Mrs McGill:

You are both welcome, and I thank you for your presentation. In the Assembly this week, I asked the Minister about the point that was raised by Kieran Deeny. Will Mr Cole remind me of the size of the budget that was set aside for the Omagh hospital?

Mr Cole:

When the hospital was first envisaged, the original figure was £190 million. That covered the cost of the hospital, a range of enabling works, a mental health facility, a renal dialysis unit, a central sterile supplies department (CSSD), an energy centre and other related facilities on the site. That budget would be reviewed anyway, because it was based on earlier prices. Since then, construction costs have fallen, and, therefore, the figure to carry out exactly the same work would not be the same today.

Mrs McGill:

Thank you, John. On Monday, the Minister said that he remains committed to the Omagh project, among others. I warmly welcome his commitment, as, I am sure, do all of us in West Tyrone. Am I right in saying that £190 million may not be required to put that local hospital in place?

Mr Cole:

Yes. We will undertake a competitive procurement process and seek to minimise the cost of the project, as would anyone. The original budget for the Omagh hospital was £190 million, but that is probably no longer accurate, because constructions costs have dropped significantly from their peak a couple of years ago.

The Chairperson:

I want to follow up on the issue of costs. When our counterpart Committee from the Dáil visited us, it said that the keenness of competition in the Republic at present means that major hospital contracts were coming in at 21% lower than three years ago. It is ironic that the best opportunity to secure the lowest possible contract price comes when we have the least amount of money to do so.

Mr Galway:

You are absolutely right.

The Chairperson:

In the case of the Omagh hospital, lower construction costs and competition could knock £20 million or £30 million off the original figure of £190 million, because contractors would bite your arm off to get that contract now.

Mr Cole:

If we were able to say that the money was available, we would have huge competition for the project. The problem is finding that money.

Mr Galway:

It does not exist.

Mrs McGill:

What is the position with the Omagh hospital? How much has been spent?

Mr Cole:

We obtained the land by internal transfer, so it did not cost anything. We have demolished buildings and carried out a series of enabling works on the site. The design work is complete, and we are in the middle of compiling the business case, which will come to completion over the next few weeks.

Mrs McGill:

Why is the business case not complete?

Mr Cole:

The trusts are still making final adjustments to the business case. Unfortunately, it is a demanding process that includes going to DFP for approval. However, when the trusts examine the model of care and constantly review the detailed requirements for a hospital, they find that service needs constantly ebb and flow. The inclusion of a GP practice in the building, for example, is a new option. All such developments must be incorporated into the business plan. Every development alters the figures, which means that the business case must be reviewed and arguments must be made for that development's inclusion.

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Mrs McGill:

When will the Department receive that business case?

Mr Cole:

We have it now.

Mr Galway:

We are working on it in conjunction with the trusts.

Mr Cole:

We are at the stage of making final amendments. There are iterations between us and the trusts until the business case is finalised, after which it goes to DFP to be signed off.

Mrs McGill:

When does the Department expect that business case to be complete?

Mr Cole:

We hope that that will happen over the next few weeks.

Mr Galway:

It is hoped that the business case will be complete in the next week or so, after which it must go to DFP as the overall approving authority. The scale of the project is such that it must go to DFP for formal sign-off after our Department has signed it off. The project must be viewed in the context of the Minister taking decisions on what can be done with the amount of money that is available to him in his budget.

Mr Cole:

At the time at which we seek DFP approval, we must be able to state that the building is affordable and that we have the money to build it. That part is proving troublesome, because we do not know how much money we will have next year.

Mrs McGill:

The £190 million had virtually been ring-fenced, the Minister said that he was committed to the project, and it is possible that the project will not cost as much as £190 million. Therefore, I

cannot understand why the whole matter has not been settled.

Mr Cole:

Any projection of capital is subject to approval by the Government of the day. The CSR lasts for only three years. As Conall pointedly identified, the ISNI capital programme merely indicated how much the Department might receive. The CSR can change at the whim of a new Government.

The change of Government means that the £190 million that we thought that we would receive over the next three years could be taken away tomorrow. Our Minister has no control over that. The Executive have control over how they allocate the capital that comes to Northern Ireland, but they will not be able to control or influence how much capital England gives to Northern Ireland in the block grant.

Until those decisions are made, we cannot act. We cannot spend money that we do not have. There is no money sitting in a safe that we can take out and put towards a new Omagh hospital. We can spend only the money that we have been allocated in the budgetary process. That process has not yet happened, and the picture will not be clear until the end of this year. That is the fundamental difficulty for the Department.

Mrs McGill:

Forgive me, John, if I am missing the point, but I foolishly thought that the £190 million was sorted within the current CSR period. You have articulated a different view. I want to be clear that the money for a new Omagh hospital has not been completely signed off. Is that what you are saying?

Mr Cole:

The Minister is committed to the project. He is waiting to find out what allocation of capital he will receive over the next three years. If he had the money —

Mrs McGill:

Are you talking about the next CSR?

Mr Cole:

Yes, and that will start in April 2011.

Mrs McGill:

Nothing can be finalised until after April next year. Is that the position?

Mr Cole:

No definitive decision can be made until the Minister is told later this year whether the Executive will give him the money, over the next three years, to build the new Omagh hospital. It is not his decision.

Mrs McGill:

I misunderstood. I thought that the £190 million was ring-fenced in the present CSR.

Mr Cole:

The £190 million was contained in the 10-year indicative ISNI allocation, which covers a series of CSR periods. Every three years, the Government in power change that. The current economic circumstances have changed the expectation of our allocation, and it is not the same as the ISNI predicted. That is the problem that we find ourselves with, and it affects every project, not only the new Omagh hospital.

Mrs McGill:

On more than one occasion in the Chamber, I thought that I heard the Minister say that, if people did not want the new hospital at Omagh, he was ready to spend the money elsewhere. That is not verbatim, but it is similar to what he said. He was directing his comments at MLAs from West Tyrone who were asking about the new hospital. Therefore, I felt, obviously incorrectly, that he was going to go ahead with the new Omagh hospital almost as soon as the enabling works and all other necessary preparations had been completed. Your comments today have provided clarity. Thank you.

The Chairperson:

We must be careful that we do not shoot the messenger.

Mrs McGill:

I am not.

The Chairperson:

Had we been doing so, he would be dead by now. Mr Cole is not directly responsible for the situation in Omagh. However, in defence of my West Tyrone colleagues, if I lived in Tyrone, I would feel extremely sore on account of the lack of acute provision in the area.

Mr Cole:

Only recently, the Minister re-expressed his commitment to the project. The question is when he will be given the money.

The Chairperson:

We need to move on, because the meeting must finish at 4.00 pm.

If you have no money coming in, you can create funds through the disposal of assets. The other day, we examined the situation at Belvoir. It was a hugely valuable asset, but its value has now fallen off a cliff.

Mr Cole:

It is now valued at £11 million.

The Chairperson:

Given that the site had planning permission for 212 houses, £11 million is a pitiful valuation.

Mr Cole:

I believe that we sent the relevant planning permission to the Committee.

Mr McDevitt:

We saw that last week.

The Chairperson:

Is it not an option to sell that asset, but with a clawback provision? You could take the £11 million, and should the market turn and the value rise, you would receive, for argument's sake,

50% of the capital appreciation?

Mr Cole:

The clawback mechanism has been used. It has been somewhat discredited, because, in some degree, of the public sector's inability to manage the sharp boys in the private sector. Some processes, particularly in England, have not worked out to the benefit of the public sector. The clawback mechanism is on our palette of options. Whether to use it is a matter on which we would take advice from LPS and our external advisers. They will advise the Department on how to optimise the disposal of all such sites.

As you will see, our first step is to try to obtain outline planning for the sites, without which the banks will not even begin to lend to developers. That is also the advice from the Treasury in England. Therefore, we are trying to prepare a series of sites for when put them on the market and get some money for them. Sometimes, a balance must be drawn between whether money in hand is better than holding on to a site in the speculative hope of making a killing.

Unfortunately, at one stage, the Belvoir site was valued at closer to £50 million. In the current market conditions, its value has dropped right down to £11 million. Neither the Minister nor anyone else could have predicted that.

The Chairperson:

It is similar to what happened with Crossnacreevy. At one stage, it was valued at £200 million. That money would have solved many problems. What is it worth now?

Can you not consider putting important projects, such as the hospital at Omagh into public private partnerships (PPP) or PFI contracts?

Mr Cole:

We could, and we have considered those options. Originally, Omagh was to have been a PFI project, but that was when all lending in the markets stopped. That caused us great difficulties in finalising the Enniskillen scheme at that time.

It must be recognised that PFI has a revenue consequence. The revenue bill in health is under as big, if not bigger, pressures than the capital bill. Alex asked how much the Department will

pay in revenue. The Enniskillen hospital will cost around £12 million or £13 million each year. All those amounts come out of revenue and, effectively, out of patients' services.

If we take that money out of revenue as opposed to capital allocation, we have to cut back on the current spending on patients' services. Therefore, we must constantly balance the benefits of having a new building for patient care against the reduction in the available revenue to provide that patient care.

The Chairperson:

We have talked almost entirely about the lack of money. Therefore, let us change the subject and send you away a bit happier. Do you future proof buildings? It is my turn to be slightly parochial: when lobbying for the new Downe Hospital, Down District Council's health committee demanded sufficient capacity in the building. The idea was that, when the hospital was able to secure additional services, such as a full-blown maternity wing, rather than one that is midwifery-led, those could be bolted on. Unfortunately, the opposite has happened, and there has been a battle to keep existing services, and, in fact, some have been lost. Have you built in additional capacity in other projects to ensure that buildings do not become congested or burst at the seams within five years of opening?

Mr Cole:

Our perspective is one of considering various scenarios for future expansion or reduction. We try to plan the spaces in buildings flexibly. At present, in our primary care facilities, we have a modular approach that facilitates between 30 and 40 interchangeable uses for accommodation. Rather than being limited to a single use, those are multi-use spaces that can be altered to reflect the changing nature of a building.

As regards expansion, given the paucity of capital, it is difficult to build additional space for which there is no current use. We prefer to invest that capital in other projects for which there are clear uses at present. In our planning briefs, we use flat slab construction in most hospitals. Therefore, services for any different type of facility, no matter how complex, can be fitted into those buildings in the future. The grid that we use allows flexible and changeable use. However, that is much easier said than done. The construction of flexible buildings is not that easy, although our aspiration is to make them as flexible as we can.

The Chairperson:

Finally, for the purpose of clarification, the only figures that appear in the Department's budget for the Enniskillen site are for the management programme and design. I have been to the Enniskillen site to witness that construction in progress. The builder is constructing the hospital. Does the Department not pay a penny until the ribbon has been cut?

Mr Cole:

We pay nothing other than the ongoing charges for our project management team.

The Chairperson:

That must be £1 million here and £1 million there, which, in the overall scheme of things is not a huge amount. When the ribbon has been cut and the hospital is open, you said that the Department will pay £13 million per annum.

Mr Cole:

No. The Department will pay £100 million as a down payment. That was arranged to reduce the revenue repayments. The cost of the hospital is approximately £235 million. A bullet payment, or balloon payment, as it was called, was made at the outset. We decided to put a combination of the Department's capital and the bidder's capital into that. On the day that the hospital opens, £100 million comes out of the Department's capital budget, and that reduces the revenue implications, which would, otherwise be almost double. That is another constraint. Thereafter, the Department will pay £13 million per annum.

The Chairperson:

Where does that £100 million sit at present?

Mr Cole:

It sits in the future budget.

The Chairperson:

You are saying that, as far as Tyrone is concerned —

Mr Cole:

The commitment had already been made in the previous CSR.

The Chairperson:

You do not, however, know where you will get the money to pay for that.

Mr Cole:

DFP asked the Department to provide a list of all the contractual commitments that span the CSR period. DFP will not give us money for new commitments in the next CSR period. However, if the Department has committed to definite future expenditure — most hospitals run long-term projects that span more than three years — that money is included in the next CSR period. DFP will take that money off the bottom line as a commitment that is already in place. It will not, however, allow us to sign new contracts now.

The Chairperson:

Why did you not commit to expenditure for Omagh when you would have been guaranteed the money?

Mr McDevitt:

It is a matter of regret that the Desertcreat police college, given that it was in the CSR from the beginning, did not become a committed line.

Mr Cole:

It cannot become a committed line until it has been contractually signed up.

Mr McDevitt:

I understand that, and that is the matter of regret, because otherwise you would be project ready.

Mr Galway:

The procurement process for Desertcreat has not even started.

Mr McDevitt:

I am aware of that.

The Chairman:

How much money is the Department already contracted to pay in that type of balloon payment?

Mr Cole:

That is the only balloon payment for PFI projects, but the Department has running commitments that extend into the next CSR period.

Mr Galway:

Our contractual commitments in the next CSR period probably amount to somewhere between £200 million and £300 million.

Mr Cole:

That money has already been committed for projects that were signed off in the last CSR period.

Mr Galway:

In addition, the annual costs that John mentioned amount to possibly £100 million, which amounts to a further £300 million in total.

The Chairperson:

Before the door of the hospital has opened, the Department has committed £100 million. You cannot get out of that commitment.

Mr Cole:

That money is for a range of purposes: to replace fire engines and equipment, maintain buildings, energy costs, the costs of pandemic flu, viruses, and so forth. The money for all those requirements comes off the allocation before we start to spend on buildings. That may not be widely known, and it is not well appreciated in the allocation process.

Mr Galway:

As John mentioned, ICT is critical. It is a key enabler for efficiency and changing the way in which the Health Service works. The identified need was more than £400 million over a 10-year period. At the moment, we allocate somewhere between £15 million and £20 million each year to try to provide good IT facilities and infrastructure across the health and social care system.

The Chairperson:

I have good faith in my colleagues from west of the Bann. I could not believe the huge area from

which acute services were absent. You said that the Omagh hospital will cost in the region of £230 million.

Mr Cole:

No. That is the cost of the Enniskillen hospital.

The Chairperson:

Sorry, the figure for Omagh is £190 million. However, that cost is spread over a long period of perhaps 10 or 12 years. Presumably, you give the builder —

Mr Cole:

If we were in a position to start, we would be on site within a year, and it would probably take about two and a half years to build the hospital.

The Chairperson:

Is there no mechanism to spread that payment over 10 years?

Mr Cole:

If we were to build the hospital in phases, the payment could also be phased. Those are the kind of options that we will have to consider, depending on the financial allocation for the hospital. We try to do our best with whatever money we get.

The Chairperson:

I hope that we have not been too hard on you. You have not delivered a particularly pleasant message to the Committee. Nevertheless, it has been an extremely helpful session.

Mr Gardiner:

Will the Committee consider writing to the Finance Minister to inform him of the severe underfunding of the Health Service and request financial assistance? If no member seconds my proposal, it will fall.

The Chairperson:

We will wait until the witnesses have finished giving evidence before considering that proposal. I will not let that one pass.

Thank you very much, Mr Cole and Mr Galway, for your evidence.

Mr Cole:

Thank you again. I am sorry that it was a slightly depressing story.