Northern Ireland
Assembly

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Investment Strategy for Northern Ireland

11 January 2012

NORTHERN IRELAND ASSEMBLY

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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 Mark Durkan
Mr Samuel Gardiner
Ms Pam Lewis
Mr John McCallister
Mr Kieran McCarthy

Witnesses:
Mr John Cole) Department of Health, Social Services and Public Safety
Dr Bernie Stuart)

The Chairperson:

We have an evidence session with Mr John Cole, under-secretary for the Department's health estates investment group, and Mr Bernie Stuart, director of the investment directorate. I will try to keep the session to 30 minutes — 40 minutes max — in order to leave plenty of time for the community pharmacy session. John will do a presentation. Bernie, I have just noticed that you are not a "Mr". It says "Mr" on my sheet, and I cannot see beyond that. Sorry about that, Bernie.

You are both very welcome to the Committee. Fire away, John.

Mr John Cole (Department of Health, Social Services and Public Safety):
First of all, I apologise for my voice. I am suffering a little from something that my son brought home — and it was not a woman. *[Laughter.]*

I welcome this opportunity to brief members of the Committee on the third iteration of the investment strategy for Northern Ireland (ISNI). As part of the Budget 2010 process, the Department of Health, Social Services and Public Safety (DHSSPS) submitted capital bids to the Department of Finance and Personnel (DFP) for a total of £1·8 billion to cover the next four years of capital need. That was based on the Department's formal assessment of the highest priorities for capital investment, following detailed consultation with the policy branches of the Department, the Health and Social Care Board, the five healthcare trusts, the Northern Ireland Ambulance Service and the Fire and Rescue Service. We have assessed the total capital requirement to upgrade the estate to modern-day standards to be approximately £5 billion. As you might expect, we made a strong case for increased investment in health infrastructure, citing the significant deterioration of the condition and functionality of the estate and comparing our levels of investment with those in the rest of the UK.

Historically, the planning and development of the majority of the acute and community facilities in Northern Ireland commenced in the early 1960s, following the establishment of the NHS in 1948. Many of our other buildings, particularly those used for mental health, predate that by a long way, yet they remain in service. By the end of the current ISNI period, most of our facilities will be in excess of 50 years old: a fact reflected not only in the deterioration of the fabric of the buildings but, more importantly, in their ability to facilitate modern standards of care, new methods of practice, new technologies and the increase in demand for service.

Decades of underinvestment in the health infrastructure of the health and social care estate have meant that we have been unable to replace facilities that were due for replacement. Instead, we have had to resort to putting many of our capital resources into carrying out interim repairs to a lot of our buildings rather than replacing them with the appropriate facilities. Many of our buildings have effectively reached the end of their useful life. There is a practical limit to how

effective such interim measures can be. The percentage of available funding that will need to be directed at those measures will increase the longer we do not have the necessary funding to replace major facilities, such as, for example, the children's hospital.

Mental health and learning disability is an area that has faced a cut in its programme as a result of having low levels of investment and having to direct that money into the acute sector. Many of the mental health facilities are in very old buildings, providing highly institutional and sterile environments, and do not reflect modern-day care and the standards that we should be giving to people in line with current departmental policies.

The cuts to the money that we expected from ISNI II have also meant that we have been unable to sustain the investment in the primary and community care infrastructure programme that was started some years ago and that was strongly supported in the recommendations of the recent health and social care review. As a result of the wider economic climate, you will be aware that major cuts were imposed by Treasury on the overall capital allocations to Northern Ireland. The outcome of the UK spending review and the deterioration of the amount of money that could be achieved from the sale of property means that much less money is now available in the capital programmes, and that is reflected in the Executive's budget and the ISNI update.

Our Department was not party to developing the methodology or deciding the relative prioritisation of projects included in the proposed ISNI document. Despite the case we made, the percentage of capital investment for health has been reduced from 22·7% to 17·5% in the current ISNI programme. So, health is a lower priority now than it was in the previous ISNI document. We received an allocation of £856 million over the Budget period, which is much less than we need, approximately £500 million less than the previous ISNI said we would receive and almost £1 billion less than the bid that we made for this period. As a result, we have had to seriously curtail much of what we could achieve in the current Budget period.

ISNI III provides an indication of £1·47 billion over the five years from 2015 to 2020, which amounts to approximately £300 million a year, as opposed to the £200 million a year provided in the current Budget period. While this is clearly a significant amount in any analysis, it is, unfortunately, insufficient to counteract the years of gross underfunding. As recently as 2001-02,

our annual capital allocation was significantly lower than £100 million in present day values and had been at levels equal or lower to that for the previous decade.

Of the £856 million allocated over the current Budget period, £262 million was already committed to projects that had been let, such as the new £270 million hospital at Enniskillen and the £188 million critical care and maternity hospital at the Royal Victoria Hospital. A further £340 million of that money is required to meet fixed annual costs across the total estate, to be used for essential maintenance; replacement of medical laboratory imaging and decontamination equipment; investment in ICT at a strategic and operational level; drug stockpiles, including drugs for pandemic flu; and the replacement of the ambulance, fire and health and social care fleet. The fixed costs amount to approximately £100 million a year.

When those two significant cost commitments are made, it means that only £200 million has been available during the current Budget period for newbuild or major refurbishment projects across all needs and all trusts. On the positive side, over the coming months, it is likely that DHSSPS will benefit from the allocation of some of the additional £134 million announced in the Executive as part of the Chancellor's autumn statement. There is also potential for additional funds from the earmarked A5 carriageway, although I am not sure that that is certain as yet by any means.

Our own investment decisions have to date largely been driven by the following factors: seeking to deliver departmental policy; making services accessible and giving equality of access; making sure we have the right capacity of services; making sure that services are safe and resilient, particularly in the older estates; meeting the needs of developments in practice and technology; and making sure that we are using the estate in the most efficient way.

You will be aware that the recently completed review of health and social care in Northern Ireland identified the need for a reconfiguration of services, with primary and community care playing a much greater role, a reduction in our dependency on hospital treatments, and some rationalisation of the services provided in existing hospitals. While there is not as yet a more detailed plan outlining the practical implications of that, it is inevitable that a significant capital investment will be required to allow for the associated changes. It will also be necessary to invest

significantly in primary and community care in line with the direction of travel, and we are currently considering the use of private sector funding to support the unavailability of public capital in that area.

In light of both the possibility of additional capital, an amount that is as yet unknown, and the as yet undefined capital implications of the health review, the current capital programme for the expenditure of the money that we have for new projects — approximately £200 million — must be considered to be fluid to some degree until greater certainty emerges on what money we will have, when it will be available and any reprioritisation of investment as a result of the implementation of recommendations in the review. The third iteration of ISNI was presented to the Assembly on 17 November and is currently out for consultation, with responses due by 22 February 2012.

The current level of capital, about £200 million per annum, has been relatively constant since there was a step increase about five years ago. While not sufficient to meet our needs, that still represents a very significant and sustained investment in the DHSSPS estate. Over the past few years, that investment has allowed us to make considerable improvements. Examples of what has been achieved include the new south ward block at Altnagelvin Area Hospital, a new critical care block and maternity block at the Ulster Hospital, the new Downe Hospital, new wards at Antrim Area Hospital and a new neurology ward at Musgrave Park Hospital. In relation to mental health, the investment has led to new psychiatric units at Craigavon Area Hospital and Gransha Hospital, and in the area of learning disability it has led to new day centres in Newry and Lisburn. In relation to primary and community care, the investment has led to major new centres in west Belfast and on the Shankill Road and new children's homes in Omagh and Newry. Additionally, we have invested significantly in ICT and in the replacement of the Ambulance Service and the Fire and Rescue Service fleets.

Major projects that we intend to commence during the current Budget period include the new radiotherapy unit at Altnagelvin Area Hospital; the new Omagh hospital; the next major phases of the Ulster Hospital replacement; new theatres at Craigavon Area Hospital; a new A&E department and wards at Antrim Area Hospital, the work on which has already commenced; a new mental health facility for Belfast, as referred to earlier; and health and care centres at

Ballymena, Banbridge and Lisburn.

Over the past five years, our Department has been the best performing Department in spending its full capital allocation per year; we just have not had the allocations we need. One of our highest priorities for some time has been the replacement of the children's hospital, yet the funding for that will not be available until the next Budget period unless we get a special allocation for this much needed regional facility.

In addition to the above projects, our key areas of focus in relation to the development of the estate over the next number of years will be a reconfiguration of the estate to meet the new emerging models of care, including a focus on primary and community care; dealing with the ongoing risks of an ageing estate to protect the delivery of core services; and major investment in enabling ICT.

I hope that gives you an adequate overview of our current position. Dr Stuart and I are happy to take any questions.

The Chairperson:
Thanks a million, John. With regard to the risks of managing the estate, we are all aware of the likes of Belvoir Park Hospital, which sits on the outskirts of Belfast, and the issues that there were last year around security on that site. There are quite a few hospital buildings that are at best an eyesore and at worst a danger to the people who live around them.

You said earlier that the only way that we will be able to develop the estate in the future will be by looking at some kind of private partnership arrangements. I was at the Belfast Metropolitan College this morning with the Employment and Learning Committee, and the chief executive and principal were telling us that, as part of the development of that building, there are contractual obligations around the car park for many years to come, and they have no say in the tariffs. You could see the frustration very early on at the Met not getting any money from the car park because it is all tied up. I want to strike a note of caution, because people are in business to make money. We do not want them to make money on the back of sick and vulnerable people. If that is the route that the Department is going down, that will happen. Do you have some thoughts on where

that is likely to go and what pitfalls you are looking out for?

Mr Cole:

We are very much aware of the pitfalls that you refer to. There have been a number of recent reports on private finance initiatives (PFI), which I am sure you have seen. There is a major review of PFI going on at the moment in London.

The issue of car park charging is not one that we think we will run into again. There was a problem similar to the one you mentioned, although there were controls over the tariffs, with the Royal Victoria Hospital project some years ago. That is coming to an end relatively soon. With the Enniskillen hospital, we will get the money from the car park income. I think that is the case, but I will confirm it later.

We do not envisage a significant programme of major PFI; it is more likely that we would use a third-party development arrangement for the delivery of some of the smaller primary and community care facilities. We are exploring those issues because the Minister has asked us to look at that. There are a number of issues to consider. We would have to demonstrate that it was value for money and each proposal would have to go through the full business case process. We are looking at those issues to ensure that we can do that. The third-party development model has been used quite widely in other parts of the United Kingdom. It is less onerous than the PFI model in relation to the length of contract and the nature of the process, but it is one that we are exploring.

We need to invest more if we are to get rationalisation of services and a push towards preventative care and better management of chronic disease in the community. We will have to invest more in primary and community facilities. Currently, our budget shows that we do not have money to do that other than at a relatively slow rate. The Minister would like to accelerate that, and he has asked us to explore those options. The use of PFI might be a consideration, although only a consideration, for the children's hospital. We are starting a business case to look at the provision of a children's hospital, having already allocated capital for the women's element. That was previously to have been a combined hospital. However, that is proceeding. We are now looking at how we can advance the children's hospital. It is one thing that the

Minister would very much like to do.

We will look at PFI for that if there is not enough capital, because the timescale for that £150 million investment is still way out there. We have only allowed a small amount in year 4 of the current programme to start it off, if we are trying to go on capital. That is assuming that the next Budget will allow us the £150 million to deliver it. There are still risks around the delivery, even though that hospital has been talked about for a long time. A debate in the Assembly calling for it to be made a high priority was supported by all parties, yet the funding has never been made available to allow us to do it.

The Chairperson:

I remember attending briefing sessions here years and years ago about the children's hospital. The management of the obsolete parts of the estate and the upkeep of those buildings is bound to cost a fortune. How much effort has been put into finding buyers for some of the sites that are no longer required?

Mr Cole:

You may not have information on it, but the Health Department is probably taking the lead in having the best information database for managing its estate. We have asset disposal plans for every trust. We have analysed every building that we can seek to get out of, and some of our capital is being used on that basis. We spent £7·2 million last year to get recurring savings of £2·8 million from parts of the estate by getting out of older buildings, getting out of leases and reducing costs through that process. One of our major aims at the moment is to try to use capital as far as possible to reduce revenue expenditure so we can put revenue into front line services rather than into maintaining buildings of this type. We have a very significant rationalisation programme under way and already have a series of projects in place through which to sell properties. The problem at the moment is that in selling them, we are certainly not going to get anything like the money we could have got some years ago.

Dr Bernie Stuart (Department of Health, Social Services and Public Safety):

We have applied for planning permission for some of our sites. I think we were the first Department to do so. For example, we have outline planning permission to assist in the sale of

Belvoir Park Hospital, Bayview in Bangor and Downe Hospital, so that is a method of progressing the sale. We also have a fund of money that we are using to reduce the running costs of what we have left by, for example, putting in more efficient boilers, gas systems and combined heat and power boilers to existing sites in order to reduce the running costs. The management of the estate covers both getting rid of the obsolete bits and tightening up the space. We have introduced new space standards for offices for the estate so that people are going to tighten up on what we have and release more space. That is ongoing, as it the attempt to reduce the running costs.

The Chairperson:

Hopefully you are also using renewable energy as part of that.

Mr Cole:

Yes, absolutely.

The Chairperson:

I know it is a very big thing in the Enniskillen hospital, but we would like that across the board in all government buildings.

Mr McCarthy:

Thank you very much for your presentation; it was very interesting. I am struck by point 22 in your submission, which mentions the hoped-for additional funding. You mention the A5 road scheme: I must say, there are a lot of fingers in that pie.

The Chairperson:

Including the A5 road scheme, Kieran.

Mr McCarthy:

"Including the A5 road scheme", she says. The Compton review is very much focused on community care and so on. Are you saying that proposal c, which is to expand and accelerate current plans for the primary and community care programme, is dependent on your getting the extra funding from the A5 or wherever? That would be a worry for us all.

Mr Cole:

No, that is not what I am saying. The Department will get a share of the £134 million. We may get nothing from the roads money. If more money comes to us, we would try to advance some of the primary and community care schemes because they are smaller and we could get them up and running more quickly. If we do not get it, our only option is to go down the third-party development route, where developers build the facilities and we rent them. That is the option that we are looking at in the event that we do not get sufficient capital to do it ourselves.

Dr Stuart:

That is in addition to the ones that we have in the existing scheme, which are in the paper. Some are already in it. We would do more. The Compton review points us in the direction of doing more.

Mr Cole:

At one stage, £1·1 billion was identified against the primary and community care infrastructure programme. We spent only one twentieth of that. The money is not available because it was cut out from the various ISNI allocations. We have not been given the funding to do it.

Mr McCarthy:

Are you telling us that the community and primary care that is envisaged in the Compton report is not in jeopardy because of what may or may not happen to the funding?

Mr Cole:

It is still in jeopardy, but we are looking at alternatives to see whether we can use private capital through the third-party development model as opposed to the PFI model to build some of the facilities. It is an ongoing exercise. We have to demonstrate that it represents value for money and that DFP support will be there for the process. We are in the middle of that process at the moment; we are carrying it out on the Minister's behalf.

Mr McCarthy:

I notice that you may well complete the Ulster Hospital site in one phase rather than two.

Mr Cole:

Yes.

Mr McCarthy:

Again, that is dependent on the A5 cash or whatever.

Mr Cole:

Yes. We do not have the money to do it, other than what you see in our budget.

Mr Wells:

I may be wandering into other people's constituencies, but, obviously, the new Erne Hospital is a huge chunk of your capital budget. It is for that reason that I am going west of the Bann, as it were. I was thinking that, when you had 1·2 million hectares at your disposal —

The Chairperson:

That is the typo.

Mr Cole:

That is a country, I think, Jim.

Mr Wells:

Yes, I spotted that. Even at £1,000 an acre, you would have been home and dry on that one. Unfortunately, it is not to be. The Erne Hospital looks like a fantastic project. I have been past it a couple of times. As I said to some members this morning, it is 'Star Trek' meets A&E; it is an absolutely extraordinary building. It is beautifully designed. I am sure that the Fermanagh people cannot wait until it is opened. It is a £269 million or £270 million project, which has major implications for the entire budget because of its size. I am a wee bit confused.

Mr Cole:

We are paying only £100 million of it in capital.

Mr Wells:

I was going to ask about that. Who is paying the other part?

Mr Cole:

PFI.

Mr Wells:

So, £169 million of that is from PFI?

Mr Cole:

That is borrowed from the private sector. We pay it in a unitary charge of about £12 million a year back to the developer.

Mr Wells:

Over 25 years?

Mr Cole:

Over 30 years.

Dr Stuart:

There is the £100 million bullet payment, and £130 million is paid for through the PFI. The remainder was the enabling works, which was paid for already by the capital. Only roughly £130 million of that is on the capital balance sheet.

Mr Cole:

When we started on PFI, the yearly repayment would have been very large if the developer had borrowed the full £230 million. Therefore, we decided to put £100 million of capital into it to reduce the unitary payments so as to make the demand on revenue less over those years.

Mr Wells:

And you are putting that entire £100 million into 2012-13?

Mr Cole:

It is paid on the day on which the hospital is completed.

Mr Wells:

That is this June.

Dr Stuart:

Yes.

Mr Wells:

So, somebody will be delivering a cheque of £100 million to a lucky developer in Fermanagh on that day. Obviously, that has a profound impact on the capital that is available for that year if you are paying off £100 million —

Mr Cole:

We got the profile from DFP so that we are able to do that.

Dr Stuart:

The profile was a higher amount across the Budget period. DFP allowed us that extra £100 million.

Mr Cole:

We knew that it was coming up. It is the way that it was planned, Jim. You do not pay out on PFI until the building is finished; that is the incentive to the developer to finish on time.

Mr Wells:

It is a wonderful project that I am sure is hugely welcomed by the community. Given your present difficulties, surely the only way to solve your problems is to go down that route more often.

Mr Cole:

It is. However, any revenue payments that we make come off service delivery. Therefore, the

more that we put into revenue as opposed to capital payments, the more patient services are affected. That is where we may be pushed if we have to do capital investment to facilitate change.

Mr McCallister:

Is your £12 million a year repayment coming from revenue not capital?

Mr Cole:

Yes. That comes off the revenue budget, so it is not available to do other things.

Mr McCallister:

For 30 years?

Mr Cole:

Yes, 30 years. That includes not just the capital repayment but the cost of the unitary charge for the maintenance of the building over that period, the cyclical replacement of equipment and so on. It is not just for the capital repayment.

Dr Stuart:

In order to use that route, we have to demonstrate that it is better value for money over the economic life of the building. Recently, you will have seen that Treasury papers indicate concern about that, and Treasury is looking at whether that is going to be possible in the future. Were we to think about doing another PFI project, we would have to be absolutely certain that it demonstrates value for money. That would have to be demonstrated though a business case that looks at all the current conditions.

Mr Cole:

At present, it costs the private sector twice as much as government to borrow money. That is why there is a question about the value for money aspect of it.

Mr Wells:

I was a bit surprised at some of the capital budget expenditure that you have to incur. For

instance, why is £26 million being set aside for pandemic flu serum?

Mr Cole:

It is not just for pandemic flu serum; it is for a stockpile of drugs that the Department is required to take as part of the UK arrangements. Northern Ireland, Wales, Scotland and England pay a proportional share of the cost of back-up supplies of drugs under arrangements such as those for pandemic flu.

Mr Wells:

I understand that, but why is it coming out of your pot of capital money?

Mr Cole:

Because it is called capital. Once you stockpile it, it is defined in accountancy terms as capital. If, at the end of the year, it is sitting on your shelves, it is counted as capital and it comes off our capital budget. I agree with you, Jim: people think that this is all for buildings. It is not, and that is the point that I am trying to make. When we get this money, people ask why we cannot spend all of that money. Much of it is tied up in ICT contracts and all sorts of other things.

Dr Stuart:

We have no control over that amount: it is a UK-wide contract and it is a pro rata share, so we have to pay what we are told to.

Mr Wells:

I do not know whether you heard the Chairman refer earlier to a letter stating that swine flu has not arrived in Northern Ireland this year, thank goodness. Had you set aside a large block of money to buy further stock and, if so, is that now available for a couple of extra clinics?

Dr Stuart:

No. It is an ongoing, UK-wide contract and there is a set amount paid each year. Irrespective of whether or not flu happens, the drugs have to be replaced.

Mr Cole:

Different drugs must be bought, depending on what the UK contract requires.

Mr Wells:

So there is no windfall there.

Dr Stuart:

No. Such drugs may have a three-year life span, and they will all have to be replaced.

Mr Cole:

We have been paying approximately that amount of money for many years, Jim.

Mr Wells:

To follow up on what Kieran said about the A5: one or two other Departments are watching carefully to see whether they can get their claws on any money that would become available as a result of the A5 project being suspended. I know that the Chairman will not be happy to hear it, but were the project be dumped completely, £400 million would be freed. If distributed pro rata, our Department's share of that would be £160 million capital, because we are —

Mr Cole:

Do you mean in relation to the Department's budget?

Mr Wells:

Yes. We have about 40% of the Budget, so, if it was shared out, it would be about 40% —

Dr Stuart:

That does not follow at all.

Mr Wells:

I know that it does not, but it shows roughly the magnitude of the amount of money that may potentially become available. That would go a long way towards meeting some of the needs that you identified.

Mr Cole:

I can say only that yes, it would and we could certainly use it very effectively. The lead-in period for major hospital schemes means that, by the time we had a business case approved, planning permission agreed and procurement under way, we may well be through the first year. I think that this money — Michelle would know better than I do — will be available next year and the following year rather than later. That is one of the issues with the ISNI proposals: the profile that it gives us for expenditure does not allow for the sustained expenditure that is required by a major hospital, such as the children's hospital.

Mr Wells:

Yes, but, for instance, you have Banbridge clinic and its £15·2 million. That £160 million from the A5 would build 10 clinics.

Mr Cole:

It could do, yes.

Mr Wells:

They could be turned around reasonably rapidly.

Mr Cole:

Probably in three years.

Mr Wells:

I want to know what is going on behind the scenes. Is hard bargaining going on by our Department to try to get its —

Mr Cole:

No; it is not our role, as a Department, to do that.

Mr Wells:

Who is bidding on behalf of the Health Department to get some of that money, were it to become

available?

Dr Stuart:

We understand that discussions are taking place in the Department of Finance and Personnel about what is possible, based on the input to the Budget. As John said, we made a bid before the Budget process started, so the Department of Finance and Personnel has all of that information, knows the unmet demand and will be advising the Executive.

Mr Cole:

We also responded as to how we could spend that money if we were to get some of it, but we are not part of the planning process in respect of how it is allocated. That is a central process with the Executive.

The Chairperson:

It will be an Executive decision, and we do not have a lot of spade-ready projects in addition to what is in this paper. A presentation similar to John and Bernie's could have been given by officials from any Department in the estate; I know that the Department of Education would have a lot of say if a big chunk of money went to health without education getting its share out of it first, because of the position that it is in.

Mr Gardiner:

Thank you for your presentation. You referred to the state of the accommodation in which mentally ill patients are being housed. That is very disappointing and annoying for me. You mentioned Holywell and Knockbracken; are there any others throughout the health service?

Mr Cole:

Yes; maybe that was not clear.

Mr Gardiner:

You glossed over it a bit.

Mr Cole:

We only gave you examples. There is a major development going on at Craigavon psychiatric unit. An extension is being built that will allow people from St Luke's Hospital to be placed in that. That is going through the business case process at the moment.

Mr Gardiner:

When is it starting?

Mr Cole:

I think it is mentioned in the table.

Dr Stuart:

We will not have the start date until the business case has been cleared.

Mr Cole:

We will spend £7 million on it during the current Budget period, so that would be quite a bit of it.

Mr Gardiner:

Is that in the next year?

Mr Cole:

It is in the next two to three years.

Mr Gardiner:

What other areas are there?

Mr Cole:

There is a brand new facility being built at Gransha. We are building Old See House in Belfast, which is an outreach facility, where we try to avoid people being admitted to acute inpatient psychiatric units and deal with them more in the community, which is very much the way of thinking.

Mr Gardiner:

So what you are telling me is that there is funding.

Mr Cole:

They are on the list here. It is the Belfast mental health inpatient unit.

Mr Gardiner:

You just have to get on with it.

Mr Cole:

There is some funding, but not enough to do the major replacements of Holywell and Antrim.

Mr Gardiner:

Have you put your bid in?

Mr Cole:

The bid was £1·8 billion and we got £800 million.

Mr Gardiner:

We have to keep the pressure on if you are interested in that side of it.

Mr Cole:

That is why we are looking for the support of the Committee.

Mr Gardiner:

You will get that support. We are human beings like everybody else, and we want those people looked after. We want the accommodation raised to a standard that is second to none, because, at the end of the day, those people are human beings, and, sadly, they have a mental illness. Personally, I support you 100%.

The Chairperson:

It is a theme that comes up frequently at this Committee. Mental illness and learning disability

are high on the Committee's priority list. Therefore, you will get support for any of the projects that you are bringing forward.

Mr Cole:

It has been a bit of a Cinderella service in the past, and we have not really invested appropriately, but, recently, we have done.

Mr Gardiner:

It is action that is needed.

Mr Cole:

That is what we are working on.

The Chairperson:

John and Bernie, thanks a million for that. This is something that we all want to watch very carefully. As time progresses, and if money becomes available, we would like to have a say in helping to decide how it is spent. Certainly Sam's line of questioning is shared by all members of the Committee. Thanks very much. Happy new year.