Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Mother and Children's Hospital: Belfast Health and Social Care Trust and Department of Health, Social Services and Public Safety

9 March 2016

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

Mother and Children's Hospital: Belfast Health and Social Care Trust and Department of Health, Social Services and Public Safety

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Alex Easton (Deputy Chairperson)
Mrs Pam Cameron
Mrs Jo-Anne Dobson
Mr Kieran McCarthy
Ms Rosaleen McCorley
Mr Michael McGimpsey
Mr Fearghal McKinney
Mr Gary Middleton

Witnesses:

Mr Martin Dillon	Belfast Health and Social Care Trust
Mr Bill Pauley	Department of Health, Social Services and Public Safety

The Chairperson (Ms Maeve McLaughlin): I welcome Mr Bill Pauley, the Department's director of infrastructure and investment, and Mr Martin Dillon, the deputy chief executive of the Belfast Health and Social Care Trust.

Bill, I invite you to make an opening presentation, and then we will open up the meeting to comments and questions.

Mr Bill Pauley (Department of Health, Social Services and Public Safety): I will be very brief, Chair. Thank you for the opportunity. As you said, I am the investment director in the Department, and my role is to cover some of the budgetary issues surrounding the project. Martin is, as you said, the deputy chief in the trust, but he is also the senior responsible officer for the delivery of the project and its governance arrangements.

We provided a short briefing paper, which has hopefully been useful to the Committee. It is a joint effort, and, rather than go through it and read it out, I am happy to move to taking any questions that the Committee may have.

The Chairperson (Ms Maeve McLaughlin): OK. That is music to our ears. Thank you.

I will start. The outline business case for the regional mother and children's hospital was approved in February 2014. Is that right?

Mr Pauley: Yes.

The Chairperson (Ms Maeve McLaughlin): The capital cost was £219 million. What are the revenue consequences? I assume that there are consequences year on year, as there are usually extra revenue costs as projects develop. Do you have oversight of that or a view on that?

Mr Pauley: I have not got oversight of that or a view on the extent at this time. The trust will engage with the board on that as we look at the delivery of services closer to when the building is commissioned. There was some material in the business case. It is traditional to do that. I can update you on those elements.

The Chairperson (Ms Maeve McLaughlin): We know that we are talking about £219 million for capital, but we do not know the revenue.

Mr Martin Dillon (Belfast Health and Social Care Trust): The additional revenue costs associated with the increased footprint have been identified in the outline business case, and we have a letter of commissioner support for that. Those revenue costs relate to the current service models, not to any new or future service models, service developments or enhancements to the service. That would be a whole separate discussion. The increased revenue costs associated with the increased footprint and the size and scale of the new hospital have been captured in the outline business case.

The Chairperson (Ms Maeve McLaughlin): Revenue is based on what we are currently doing, is that correct?

Mr Dillon: The additional revenue costs from additional rates — from things such as heat, light and power — have been identified but not from the new models of care. That will be a separate discussion with the commissioners or under whatever new arrangements follow them.

The Chairperson (Ms Maeve McLaughlin): I assume that that will include extra nurses —

Mr Dillon: Indeed.

The Chairperson (Ms Maeve McLaughlin): — staff and rooms, right through to cleaning staff.

Mr Dillon: Indeed, we are moving from a situation in which we have 31 single rooms to 124 single rooms, each with a pull-down bed for a parent or carer. Clearly, there will be implications for the nursing workforce.

The Chairperson (Ms Maeve McLaughlin): You talk about the new model of care. What stage are we at with those projections?

Mr Dillon: The clinical brief phase of the exercise has been completed. There has been extensive engagement with clinicians over the recent six months. That looked at how we currently do things and how we might do things differently in a new regional children's hospital that will serve the children of Northern Ireland for 50 years to come. We had the benefit of three or four of our consultant paediatricians having recently been in Australia or the USA. They are familiar with new models of care and different ways of doing things. They have begun to factor that thinking into the clinical brief, which, in turn, will influence the clinical design of the building. That particular phase is just under way.

The Chairperson (Ms Maeve McLaughlin): Is there a timescale for completing the clinical brief?

Mr Dillon: The clinical brief is now complete and signed off, after extensive engagement with all the relevant clinicians. They have expressed themselves content with the brief and the design that will flow from it. We have now moved into the detailed design phase of the project, where, almost on a room-by-room basis, we decide where the plugs go and where the bedhead services go. We are now going into that level of detail in that new phase.

The Chairperson (Ms Maeve McLaughlin): Excuse me if I am coming at this from a different angle. You are saying that we have moved on to the more detailed design phase, but we still do not know what the new model of care will cost in revenue terms. I am not sure why that is missing.

Mr Dillon: The clinical brief is finished. We are now on to the design phase. There has been early thinking on the new models of care, and, throughout the process, there will be separate discussions

with either the commissioners or the Department on what the new models of care might mean for future revenue. However, at the moment, the outline business case has the additional revenue consequences associated with the additional footprint and so on of the new hospital.

The Chairperson (Ms Maeve McLaughlin): OK. Those conversations will continue.

Mr Dillon: Indeed.

The Chairperson (Ms Maeve McLaughlin): Do we have a cut-off point for the definitive costing of the new model of care?

Mr Dillon: We will not know that definitively until after we finish the detailed design process, and, even after that, discussions will be ongoing. On the overall timetable for the project, assuming that we get the new building handed over to us in December 2021, there will still be a good six or nine months of intensive commissioning thereafter. You can see that there is plenty of room for the discussions to continue.

The Chairperson (Ms Maeve McLaughlin): Is it envisaged that the new regional facility will be the specialist perinatal care facility that is so desperately needed, or is it something very different?

Mr Dillon: In terms of?

The Chairperson (Ms Maeve McLaughlin): A specialist unit for mother and children.

Mr Dillon: I am not sure that I understand the question, but we hope to have on site this April or May —

The Chairperson (Ms Maeve McLaughlin): Let me put it slightly differently, then. There are increasingly concerns about access to specialist services for women who suffer from prenatal or postnatal depression. That impacts on mental health. There are very stark figures on that, and we do not have a specialist unit anywhere on the island where mother and child can be treated.

Mr Dillon: Indeed. I understand the question now, Chairman.

The Chairperson (Ms Maeve McLaughlin): I am just trying to get to the thinking around this.

Mr Dillon: We hope to have on site this April or May the main contractor for the new acute mental health hospital on the Belfast City Hospital site, which will be an 80-bed facility. The original business case for that development made provision for a phase 2 development, and we have reserved a site that will facilitate a mother and baby unit if that is commissioned in the future. A site is therefore reserved on the Belfast City Hospital site alongside the new acute mental health unit that will be built there.

The Chairperson (Ms Maeve McLaughlin): A site is reserved for that.

Mr Dillon: It is.

The Chairperson (Ms Maeve McLaughlin): What you are talking about here regarding mother and children is very different. I want to be very clear on that, because the Minister, in answer to a question in the Assembly the other day, seemed to be linking the need for perinatal specialist services to the proposed development, but you are indicating that they are separate.

Mr Dillon: What I can say is that, in the original business case for the acute mental health unit, provision was made for a phase 2 development that would incorporate a mother and baby unit, if such a thing were commissioned or specified in the future, and a portion of site has been reserved for such a facility if it is needed in the future.

The Chairperson (Ms Maeve McLaughlin): On the capacity of the mother and children's hospital, the report that we have seen talks about 155 inpatient beds, 48 day-case beds and 10 theatres. How does that compare with current provision?

Mr Dillon: I can give you a sense of the "from" to the "to", Chairman. As you say, we currently have 97 inpatient or day-case beds, and that will grow to 155 in the new facility. Of the 155, 124 will be single rooms with pull-down beds or sleeping accommodation for parents or carers. We currently have three theatres, although we use some adult ENT theatres and theatres in Musgrave Park for paediatric orthopaedics. That will grow to 10 theatres in the new facility. We currently have 12 paediatric ICU beds, and that will grow to 26 in the new facility, including a high-dependency unit.

At the moment, we accommodate about 30,000 emergency department attendances at the current children's hospital. The new hospital will make provision for up to 45,000 attendances a year. We currently accommodate 50,000 outpatient attendances. In the new hospital, we have made provision for 53,000. That also takes account of the fact that some of the outpatient services may in future be provided in community provision or in health and well-being centres. On elective activity, the current hospital deals with children up until their thirteenth birthday. In the new hospital, it will be up until their sixteenth birthday. At the moment, the emergency department deals with children up until their fourteenth birthday, but, in the new hospital, that could be up until their sixteenth birthday. Both have been sized for up to 18-year-olds, should provision need to be made for that in the future.

The Chairperson (Ms Maeve McLaughlin): From 97 inpatient beds to 155 and from three theatres to 10. Did you say 30,000 attendances?

Mr Dillon: There are 30,000 emergency department attendances at present, but there is provision in the new building to accommodate up to 45,000.

The Chairperson (Ms Maeve McLaughlin): Do you envisage, then, that there will be higher levels of bed occupancy or shorter lengths of stay? I am trying to get a sense of how the figures are being projected.

Mr Dillon: The basis for the 155 beds was on current assessment of need, demographic change and future projections. In fact, those figures were driven by the Health and Social Care Board's assessment of future need, given that, when it is built, the hospital will need to serve children for around 50 years to come.

The Chairperson (Ms Maeve McLaughlin): Do you envisage that there will be capacity, or even spare capacity, to allow waiting lists to come down?

Mr Dillon: Certainly, given that the number of theatres will be going up to 10, yes.

The Chairperson (Ms Maeve McLaughlin): Thank you for that.

Mrs Dobson: Thank you for your briefing. It certainly is exciting news for the future of paediatric care in Northern Ireland, especially in conjunction with the new children's unit at Craigavon Area Hospital, which is due to start.

I have considerable experience of the children's hospital, from when my son was five weeks old. I remember trying to sleep on a chair beside his bed. That was my experience along with that of so many other parents. If you are in that situation and have a seriously ill child, this will certainly be very welcome.

What changes are planned or made possible with the linkage with regional children's hospitals? What plans do you have in place to connect with, for example, the new children's hospital in Craigavon?

Mr Dillon: The usual arrangements around the paediatric network will apply. I am not aware of any specific arrangements other than the normal transfer and other arrangements that will apply through the paediatric network.

Mrs Dobson: I take it that you have been in consultation. When your sick child is transferred from a regional hospital down to the Royal, it is very daunting. I am sure that you have consulted. Have you thought through those links and how things will be seamless when a child is moved to the Royal?

Mr Dillon: Indeed. All of that has been thought through in the clinical brief.

Mrs Dobson: Just in the clinical brief. OK.

Mr Dillon: All those factors were taken account of as we went through it, yes.

Mrs Dobson: OK. I know that the Chair has touched on this, but I would like some clarity on the budget allocation of £16 million for the new hospital. How is it expected to be spent? What is the breakdown?

Mr Dillon: Of the £16 million for 2016-17?

Mrs Dobson: Yes, the 2016-17 budget allocation.

Mr Dillon: I do not know whether you have the full breakdown of the £16 million, Bill, but, given that we are now in the design phase, a lot of that will be spent on design fees for the design team and on the enabling works that are currently under way.

Mrs Dobson: Do you have a breakdown of it?

Mr Pauley: Yes, in paragraphs 16 and 17 of our briefing paper. Approximately £10 million of the £16 million is specifically for the regional children's hospital element. There is then approximately £4·5 million to £5 million for enabling works alongside the Royal maternity hospital project. About £1 million will be for the first stages of the energy centre project.

Those projects are all on the same site, obviously. There are linkages between them. At this stage, the money is for the enabling works on the site, and a lot of the underground inducting work that is necessary will relate to both the maternity build project and the children's hospital, which are beside each other on the site. As such, those budgetary elements are making up the £16 million that we plan to spend next year.

Mrs Dobson: OK. I am pleased to see that you have taken best-practice ideas from across the country. You referred to the USA and Australia. Can you give us some examples of the specific new ideas that will be incorporated or are being considered?

Mr Dillon: In addition to what I have already said, the design team, a senior clinician and members of the project team went to America last year and visited children's hospitals in Boston, Chicago, San Francisco and Seattle. Very recently, members of the team went to Liverpool and Glasgow to see new state-of-the-art children's hospitals and to look at the models of care there. We are bringing back whatever learning we can take from those visits.

Mrs Dobson: Is there anything specific from those visits that will be incorporated in our new hospital that you can tell us about?

Mr Dillon: No. I need to come back to you on that, on some of the specific learning.

Mrs Dobson: Chair, it would be useful to find out that best practice. Thank you; this is certainly one that the new Committee will be watching with interest.

Mr McCarthy: I am interested in the outline business case that was approved way back in 2014 at a capital cost of £219 million. By the time 2021 comes along, that will have risen by quite a substantial amount. How satisfied or confident are you that the funding will be available to do the plans that you have set out? I very much welcome what is in front of us, absolutely; but we all know how difficult it is, at the moment, to fund the National Health Service in Northern Ireland. How satisfied are you that this money will be available to help you to fulfil your dream?

Mr Pauley: The Budget 2016 process identified this as one of the Executive's flagship projects. For us, that has two impacts. It ring-fences the amount in any given year for the project and it provides assurance that there is commitment to the delivery of the project at Executive level alongside their other flagship projects. That is very important to us. We look at the size of the sums that we anticipate spending, particularly in 2018-19; we anticipate that, during the main construction phase, sums in the low sixties of millions will be spent on the project per annum. That is a considerable chunk of money. In the Executive's Budget, planning for that level of money is now part of central planning, alongside the other large investment projects that they will be taking forward.

Mr McCarthy: You are confident that —

Mr Pauley: It gives us added assurance that the money will be set aside for this project first, if you like, and with priority, before the other commitments are examined. We look forward to that.

Mr McCarthy: I wish you every success in that. Potentially, will specialist services be provided at this hospital to people beyond the boundaries of Northern Ireland? Will people come from other places to avail of these facilities?

Mr Pauley: There are ongoing discussions about the delivery of some children's cardiac and congenital heart services that would link with this facility, because this will be where some of the clinicians, and so on, will be based. However, in terms of the numbers, the overall size and planning that Martin referred to in detail, most of that has been around our projected needs. Increasingly, however, we discuss areas of joint working, where that can benefit both sides and where people may benefit in both directions.

Mr McCarthy: OK.

Mr Dillon: We will continue to need to look outside Northern Ireland for some highly specialist services. As the Committee knows, children's heart surgery will move to Dublin in the fullness of time, under the all-island congenital heart disease network. Children's catheterisation will be done in Dublin, as it is at the moment; but very strong diagnostic work in relation to children's cardiology will remain in Northern Ireland and full provision has been made for that in the new children's hospital.

Mr McCarthy: Is it a continuation of what is at the Royal Victoria Hospital at the moment regarding cardiac services? Is that what you are saying? Will some of that remain in this new hospital?

Mr Dillon: Paediatric catheterisation has moved to Dublin. Children's surgery is largely being done in England at the moment, either in London or Birmingham. Around the middle of 2017 or early 2018, that will move to Dublin. However, this will leave behind a lot of outpatient work, review work and diagnostic work with children in Belfast, in terms of the all-island network.

Mr McCarthy: Thanks, Chair.

Ms McCorley: Go raibh maith agat, a Chathaoirligh. Thank you very much for the presentation. Can I ask you about the social clauses for the new build? It is mentioned in paragraph 18. It does not really give any detail. It just says:

> *"social clauses including aspects such as: Employer's Social Requirements; New Entrant Trainee Opportunities; Opportunities for skilled/experienced workers."*

It is as sketchy as that. I have information about the new Royal Hospital in Liverpool. That has very detailed information on what the social clauses are going to entail. The new developer is called Carillion, and it will be building on a site that is right beside a very disadvantaged area so, in that respect, it is similar to where the Royal is located. They have agreed 750 jobs during construction, 60% of which must come from the local area and 15% from priority wards in the area. There is a lot more detail, but do you get what I am saying? There are very real commitments. Can you tell me something about the commitments here, beyond the vague references in the presentation?

Mr Pauley: We are fully aware and cognisant of the Executive's policy on social clauses. We take the advice of our Central Procurement Directorate colleagues on that in the different areas of the contract, where we would negotiate elements in relation to social clauses with any potential contractor. What we have listed there are the potential contract terms that we would discuss with people when the main construction contract is to be put in place.

Ms McCorley: Do you mean prior to the appointment of a contractor?

Mr Pauley: Yes. That is to be done as part of the contracting process. Contracts let at the minute are for the smaller, enabling-type stages on the site. It is anticipated that the main contract for the main construction, when the money rises to £60 million per annum, will be let in 2018; and it will be in that

contract that there will be the greatest scope for social clauses and other elements. These are the areas that we hope to discuss with any potential contractor, as to where —

Ms McCorley: Can you give me some sense of what that might include?

Mr Pauley: It might include providing training for new entrants to the labour force, as we have said. There may be skilled or experienced workers from an area who have been laid off recently, or there may be people who are unemployed. We would discuss the range of those areas, training plans for the project and the provision of apprenticeships or other training —

Ms McCorley: Will you be quantifying the level of support you will be seeking?

Mr Pauley: There is a balance between what you actually quantify and whether that will bring an additional cost to the contract, if you specify items as contract terms. And, there are elements of this where we would be discussing with contractors what their policies might be on recruiting, training and developing young people, more experienced people or people with different labour-market attributes, that would make them more or less competitive without some form of support.

Ms McCorley: The detail that is in the Liverpool example is very —

Mr Pauley: Liverpool is at a further stage in the process. They have a contractor with whom they have arrangements in place. They have reached certain agreements with them.

Ms McCorley: These are very high-level commitments. Do you see this contract being compliant in a similar way?

Mr Pauley: It will be compliant with the Executive policy on social clauses.

Ms McCorley: So it is going to be the minimum standard, then.

Mr Pauley: There is a balance to be struck. If we specify in the contract that it is requirement, then it can be taken into account by the contractor in the pricing of the contract, in terms of who they would employ and what they would employ. Contractors must also take account of employment law: who they recruit and how they recruit them. We will be applying the Executive's policy on social clauses fully in the contract to make sure that opportunities exist for those who are disadvantaged in the labour market, either young people or older people, or those with different skills.

Ms McCorley: Would you be able to get us any more information on the types of requirements you would be wanting to see?

Mr Pauley: The list we have given is from the types of contracts that exist and the types of areas in which we look currently when contracting for social clauses.

Ms McCorley: I know what you are saying, but we are on the cusp of a major development in west Belfast and I would like to see some evidence showing that the people who live there will benefit from it. The Liverpool example clearly delivers in a very impressive way for that local area. I would like to see what the Department has in mind when this project is compared to something like that. So, where will this be on your list of priorities when you appoint a contractor? Can you get me some more information on this?

Mr Pauley: We can give you further information on it as the project develops and when we reach the point of having discussions with a contractor. There is a stage at which you might make it a contract condition, or term, at the outset as, in contracting terms, something you want to buy. There is also a stage at which we would examine the policies that all the potential bidders for that contract might be applying to people they would employ and use to help deliver the contract. To the extent that we are allowed to take those factors into consideration when selecting a preferred contractor for this site, we can set out and show what we are allowed to accept as contractual conditions at that point.

Ms McCorley: But, will there be an opportunity for the Committee to have this discussion before the final decision is made as to who will be appointed?

Mr Pauley: We are happy to keep the Committee updated on the progress we are making as regards the process of delivering the project and taking forward the contract.

Ms McCorley: OK.

Mr Pauley: We are fully aware of the policy of social clauses and want to meet the requirements. It is Executive policy that every effort is made so that our major infrastructure projects benefit the locality in which they serve.

Ms McCorley: I can see that there is flexibility in there and that is where the problem lies: It can be about how you might interpret your responsibilities. I would be seeking —

Mr Pauley: The contracting guidance on social clauses is quite complex. At points it can be, as you specified, a condition of something you are buying and therefore would pay for as an attribute of the project. Another issue is whether we would be prepared to pay extra for the premises in relation to them employing more in a particular group of people. We can look at the policies of the companies that are bidding for this contract and what they intend to do as a matter of course or routine and how they would deliver the project, recruit from the local area and provide training and development and other opportunities for their workforce.

Ms McCorley: OK. Thank you. It would be good for the Committee to be kept up to date on any developments.

I wish to ask a question on another subject which relates to my constituency; it is to do with the Glenmona Resource Centre. I know that discussions are ongoing as there is a danger that it might close down. I know that the current management board is withdrawing from it and that there are issues with staff pensions. There are also issues regarding the vulnerable young people who avail of the services there. Can you give me an update on what is happening?

Mr Dillon: The service at Glenmona is a regional service commissioned by the Health and Social Care Board and paid for directly by the Health and Social Care Board on behalf of the trusts. We know that the Health and Social Care Board is in direct discussions with the diocese and the trustees, and we await the outcome of those discussions. I can say, from the Belfast Trust perspective, that we stand ready to do anything that will be asked of us in relation to the future of the service. However, we have to await the outcome of the discussions between the Health and Social Care Board and the trustees. The board is leading on this matter.

The Chairperson (Ms Maeve McLaughlin): Thank you for that. I do not think that any other members have indicated. Going back to the second last point, in relation to social clauses; the Strategic Investment Board (SIB) has a toolkit. In my own city, we went through this debate with things like the Peace Bridge and restoration of the Guildhall. It is about maximising these clauses. I think it would be useful, because we have a capital investment of £219 million, and there is a toolkit that can be applied to that regarding a formula for how many people who are long-time unemployed can be employed. It would be very useful for us to get a sense of that breakdown.

Mr Pauley: We are comfortable about doing that. We are aware of the toolkit and have met SIB colleagues. We have talked to them about developments on the Altnagelvin site in relation to that as well, and how we might apply it. There is a procurement guidance note in place, that is accepted policy, setting out in a little bit more detail some of the balancing issues between when you make it a contractual requirement and the other areas that you can consider as part of the selection processes that are just about the policies of potential contractors themselves and how they approach the issue or intend to approach it.

The Chairperson (Ms Maeve McLaughlin): Again, it would be useful to share that with the Committee as well as we move forward.

Mr Pauley: We are aware of it, we follow it and we apply it.

The Chairperson (Ms Maeve McLaughlin): OK, folks. Thank you very much for your time and detail today.