Review of the Future Hospital Site Selection Process

Future Hospital Review Panel

13th November 2020

S.R.9/2020

States of Jersey
States Assembly

États de Jersey
Assemblée des États

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1. Executive Summary

The process for selecting a new hospital site began with site elimination based on size. Fifty-five potential sites were rejected where 9 of the 55 met the minimum size set within the site selection criteria. It is unclear why these sites were deselected during the first round of elimination. The People's Park site, which made the final 2 shortlist, should not have been selected beyond the initial site selection process as it would have been considered below the size requirement within the site selection criteria.

Following this process, a Citizens' Panel consisting of 17 unnamed islanders was established and with the assistance of an independent unnamed facilitator; 24 item selection criteria were created to reduce a list of 17 sites to 5.

The Citizens Panel did not appear to use SMART objectives or Critical Success Factors (**CSFs**), as advised in the HM Treasury Green Book. The methodology adopted was a '*Yes, No, Maybe*' 'Matrix' using Red Amber Green (**RAG**) ratings. The Our Hospital (**OH**) Project Team has confirmed that the 24 criteria were applied in a sequential fashion and not weighted. Supportive documentation was not provided to advise how the chosen criteria were 'priority sequenced'. As SMART targets were not identified this could result in the outcomes being considered subjective.

The Scrutiny Review Panel has concerns around the 40–50 year life cycle of the hospital plan. There is no clearly defined, projected timeline and there appears to be an absence of hospital specific analysis documentation. A single document is required to detail how a plan has been incorporated for expansion to suit a demographic 40-50 years for the future. Also, how this will suit the future needs of the hospital specifically utilising the adjacent site.

The Government of Jersey (**GoJ**) development and approval of the Strategic Outline Case (**SOC**) is due to be published in November 2020 which will be after the States Assembly debate the selection of the preferred site. This is considered unusual.

£44.5m has already been spent as of April 2019 which likely has increased significantly due to the recent work carried out by the OH Team and the Delivery Partner (Contractor).

The contract proposed between the GoJ and the Delivery Partner is a target cost contract with financial risks being shared between the GoJ and the Delivery Partner in an agreed proportion.

The construction cost of the hospital in isolation is currently set at £412.2m. Based upon the understanding that the eventual size of the hospital will be approximately 70,000m2 this is a cost of £5,888 per m2. This represents an expected benchmark cost for this type of hospital, excluding

premiums for building in Jersey versus the UK. Having said that, there is an additional £254 million for non-site-specific costs which bring the overall cost to circa £800 million.

There is no finalised schedule on which all capital cost and program is predicated upon. Before any assurances about maximum costs can be understood, this is required to enable it to be used as an audit tool and baseline for the project as it develops.

The GoJ has an appropriate level of contingency for this project. The level of contingency held by the Delivery Partner is considered likely insufficient given the complexity of the scheme.

Once the initial design of the hospital is established, a detailed cost review should be undertaken in to ensure GoJ are receiving value for money. In addition, when the Delivery Partner cost plan is agreed, a review should be carried out to assess the process of approval of changes within the contract.

2. Key Findings

Key Finding 1

There do not appear to be SMART objectives to link what previous information was used to the current project. Without this information, it is challenging to make objective decisions to measure what, if any, costs have been reduced and what information was actually used.

Key Finding 2

There does not appear to be any inclusion for unforeseen setbacks within the process. This could cause the project to go off track and cause costs to spiral.

Key Finding 3

The Panel has concerns around the 40–50-year life cycle with no clearly defined, projected timeline and the absence of hospital specific analysis documentation. The OH Project Team has defined two areas of expansion:

- 15% additional area within the ground floor, providing flexibility for the foreseeable future until 2036. Effectively a 10-year post project completion allowance.
- Provision of an adjacent site as set out in the site selection criteria for future expansion. This has been proposed to allow expansion of all areas of the proposed hospital for a period of 40-50 years. Without focus on new models of care and transfer of activity from hospital to community, the hospital (and the site) will come under pressure within about 12 years.

Key Finding 4

The Panel understands a topographical survey report was carried out for the 5 sites on the shortlist later in the selection process and questions if this should have been applied to the 17 sites prior to meeting the crucial stage of the Citizen's Panel criteria.

Key Finding 5

South Hill was eliminated at stage 1 due to being unable to meet either of the options due to size. The site was in fact large enough to accommodate both options and if the set criteria had been applied, it should not have been eliminated at this stage.

Key Finding 6

Based on the set criteria, People's Park, should not have been considered due to being insufficient in size. The Panel is of the opinion that, should the criteria have been applied, the site would have been eliminated at stage 1 due to being unable to meet either of the options.

Key Finding 7

The advisors have raised 9 sites that were eliminated at the initial stage for being unable to meet either of the options regarding size. It is clear, however, that based on size, all of these 9 sites meet the criteria and could accommodate either option.

Key Finding 8

The risks associated with the Compulsory Purchase Order (CPO) surrounding Overdale have not yet been confirmed. It may be likely the process to obtain the required land and properties for the hospital project would not necessarily take any less time to acquire than some of the sites that were discounted at the timetable criteria stage.

Key Finding 9

The RAG matrix could be considered confusing in using the results with green and red signifying a result of both yes/no.

Key Finding 10

The facilitator for the group is not named and therefore the Panel, or its advisors are unable to comment on whether the facilitator had suitable experience and knowledge in working with the group to develop Critical Success Factors (CSFs) as advised in the HM Treasury Green Book.

Key Finding 11

The criteria did not use weighting and could be considered subjective and open to interpretation.

Key Finding 12

It does not appear the Site Selection Panel had access to technical advisors prior to the selection process. The Panel is of the opinion that should technical advice been obtained prior to this process, the site at Five Oaks would not have met the criteria based on its location lending it to having access problems with the approach road and would have been eliminated at an earlier stage.

Key Finding 13

There were no operational clinical staff or end users on the Site Selection Panel, who would have had a more detailed understanding of the potential location, particularly regarding the patient population and services to be delivered.

Key Finding 14

The site selection process had many areas lacking objectivity and was not balanced. Sites were excluded whilst others remained in the process when the criteria was not met.

Key Finding 15

The decision as to what homeowners were directly affected by the Overdale site was subjective and did not take into account the full impact of the highways. It appeared that homeowners not directly affected by the site had not been communicated with initially and only those with properties that would require CPO had been contacted.

Key Finding 16

Health and Community Care, Primary Care and the Voluntary Sector had not been engaged with according to the list provided by the OH Project Team.

Key Finding 17

The Panel is alarmed at the lack of engagement with healthcare providers from the OH Project Team.

Key Finding 18

Although it has been discussed that mental health facilities will be an integral part of the new hospital build; it is unclear if this will be in the main building or adjacent premises.

Key Finding 19

The lines of accountability should be defined regarding responsibility for the Strategic Outline Case (SOC).

Key Finding 20

The Panel is concerned the key message and deliverables of the Jersey Care Model (JCM) may have been compromised due to the haste in finding a suitable site for the hospital.

Key Finding 21

If the care in the community concept within the JCM is not implemented as envisaged, the hospital site will come under pressure within approximately 12 years.

Key Finding 22

There has been a lack of clarity as to how the JCM will directly impact the development of the future hospital, which has resulted in a lot confusion amongst States Members and members of the public.

Key Finding 23

The level of contingency held by the delivery partner (Contractor) of £14.7m, represents 3.5% of £412.2m (being the construction cost of the hospital) and is considered likely insufficient given the complexity of the scheme.

Key Finding 24

Within the documents disclosed it is undefined whether there is an additional cost or premium being allowed for building in Jersey compared with the UK.

Key Finding 25

In the absence of a defined SOC it is considered “somewhat optimistic” to deliver the new hospital within the proposed budget at this stage of the project.

Key Finding 26

NEC3 Option C is a target cost contract with activity schedule where the out-turn financial risks are shared between the client and the contractor in an agreed proportion. The client being GoJ.

Key Finding 27

To enable good management of the project and for it to be delivered on time and within the proposed budget, it is imperative that key personnel involved in the project should have knowledge of the NEC3 contract suites, not just the delivery partner.

Key Finding 28

It is considered best practice for the SOC to be produced and approved at a much earlier stage in the project and there is a risk that should the SOC not be approved when presented, decisions made on site selection could unravel.

3. Recommendations

Recommendation 1

The Council of Ministers should ensure the OH Project Team provide the Panel with a list which clearly defines which previous information was used and how it informed the site selection decision making criteria. This should be provided within 3 months from the presentation of this Report.

Recommendation 2

The Council of Ministers should provide the calculations for all project cost including; non-works costs, equipment costs, non-medical costs (including the whole life transport solution), VAT, inflation, optimism bias, a clear split of all project contingencies, the premium costs for materials and confirmation that all "current exclusion" are subject to at least the latest provisional sums. This should be provided prior to lodging any proposition seeking the Assembly's approval of the Outline Business Case.

Recommendation 3

The Council of Ministers should ensure the OH Project Team provide a document detailing how the plan has been incorporated for expansion to suit a demographic 40-50 years for the future. In addition, how this will suit the future needs of the hospital specifically utilising the adjacent site. This should be provided without delay.

Recommendation 4

The Council of Ministers should ensure the OH Project Team undertake to provide a hospital-based analysis single document specific to the project in order to test resilience of the planning assumptions. This should be presented to the Panel without delay.

Recommendation 5

The Council of Ministers should undertake post Covid pandemic planning and establish impact on sizing and configuration of the hospital without delay.

Recommendation 6

The Council of Ministers should ensure the OH Project Team provide the Panel with reasoning as to why topographical surveys were only carried out on the 5 site shortlist. This should be provided without delay.

Recommendation 7

The Council of Ministers should ensure the OH Project Team provide the Panel with further details of how the "maybe" criteria was applied and why it was not defined within the site selection documents. This should be provided without delay.

Recommendation 8

The Council of Ministers should ensure the OH Project Team provide the Panel with reasoning behind why the risks associated with the CPO around Overdale were not taken into consideration as a risk when applying the criteria at Step 3 – 'Clinical criteria for site assessment' – timetable. This should be provided without delay.

Recommendation 9

The Council of Ministers should ensure the OH Project Team provide, in absolute confidence to the Panel, the experience of the facilitator advising the Citizen's Panel in order for the Panel's advisors to make an informed decision as to understanding the knowledge the facilitator had in developing CSF's in line with Green Book standards.

Recommendation 10

The Council of Ministers should ensure the OH Project Team provide the Panel with valid reasons as to why the site selection criteria was not always applied. This should be provided without delay.

Recommendation 11

The Council of Ministers should ensure the OH Project Team implement an open and transparent communication and engagement process with the residents affected by the Overdale site without delay and a communication strategy supplied to the States Assembly. More work should be undertaken via social media on an ad hoc basis and monthly updates in a newsletter/email to encourage full participation. This should begin immediately.

Recommendation 12

The Council of Ministers should ensure the OH Project Team engage with the third sector and public health providers without delay.

Recommendation 13

The Council of Ministers should ensure the OH Project Team undertake wider engagement with the public and clinicians to share the current picture, and regular dialogue should be carried out. This should be carried out immediately.

Recommendation 14

The Council of Ministers should ensure the OH Project Team improve the level of engagement with the public and healthcare providers to share the current position, plus establish regular ongoing communication channels. This should happen immediately.

Recommendation 15

The Council of Ministers, together with the OH Project Team, should ensure a small and appropriate group (to include relevant stakeholders) is charged to consider the feasibility and functionality of the proposed mental health facility. This will include whether it can be integrated into the singular building or more likely that it is a standalone facility either on the proposed site or at an alternative location. This should be fully costed and transparent and provided to the Panel within 3 months of presentation of this Report.

Recommendation 16

The Council of Ministers should ensure the OH Project Team have a clear approvals process with agreed and/or delegated authority for each group. This should be set out in relation to approvals to prove due process has been followed and best practice is met. In addition, a single set of performance standards should be established and agreed and should be implemented without delay.

Recommendation 17

The Council of Ministers should ensure the OH Project Team peer review all plans and designs with workforce requirements established. This should be undertaken prior to the agreement of costs.

Recommendation 18

The Council of Ministers should ensure the OH Project Team undertake and provide a full review of the performance standards to include the 2036 capacity. This would include ongoing monitoring of the JCM care in the community concept and targets and should be implemented without delay.

Recommendation 19

The Council of Ministers should ensure the OH Project Team provide the Panel with the project schedules and the block plans using @1:200 scale drawings. These should be created and approved ahead of budget sign off to enable resolution of any outstanding issues.

Recommendation 20

The Council of Ministers must ensure and evidence that the contingency level for the delivery partner (Contractor) has been increased to the considered normal, appropriate level of approximately 10%, which represents £41.22m. This should be put in place without delay.

Recommendation 21

The Council of Ministers should ensure the OH Project Team provide documentation detailing how an additional cost or premium is being allowed. This should be provided without delay.

Recommendation 22

The Council of Ministers, together with the OH Project Team, must ensure any Guaranteed Maximum Price (GMP) should not be applied until there is alignment between the clinical 2036 strategy*, the technical specifications (that match the Schedule of Accommodation (SOA) as drawn), the cost plan (including any Jersey island premium), project non works and mapping to the construction programme. Only then can there be a cost of reasonable certainty that can be used as an audit tool and baseline for the project as it develops. This should be undertaken without delay.

**The planning upon defining the new "our hospital" model has worked to ensure that the States of Jersey model of care and clinical strategy is right sized for demographic and non- demographic forecasts and aligned to clinical spatial areas up to the year 2036.*

Recommendation 23

The Council of Ministers, together with the OH Project Team should ensure the capital costs include, not only major medical equipment that is detailed and specific, but also building services, IT and digital platforms. This should be undertaken without delay.

Recommendation 24

The Council of Ministers, together with the OH Project Team should undertake, once the initial design of the hospital is established, a detailed cost review in order that GoJ are satisfied they are receiving value for money. This should be undertaken once the initial design process has been signed off.

Recommendation 25

The Council of Ministers, together with the OH Project Team, should ensure a system of regular reviews at project milestones is implemented to check the project is on track and progressing

within the set budgets. This should be shared with the States Assembly by the Council of Ministers prior to each project milestone.

Recommendation 26

The Council of Ministers should ensure the OH Project Team understand key risks and costed and detailed mitigation plans put in place. This should be implemented without delay.

Recommendation 27

The Council of Ministers should instruct the OH Project Team to implement the relevant training for Senior Officer Steering Group (SOSG) and members of the Our Hospital team to ensure they are familiarised in the operation and use of the NEC3 suite of contracts without delay.

Recommendation 28

The Council of Ministers, together with the OH Project Team, should engage a suite of client-side independent technical advisors that should be contracted to hold the Design and Delivery Partner to account and ensure the needs of the GoJ are being met. This should be undertaken as soon as practical.

Recommendation 29

The Council of Ministers should ensure the OH Project Team provide the Panel with a Risk Register which is developed fully and maintained including full potential costs of risks and their mitigation. This should be provided without delay.

Recommendation 30

The Council of Ministers should ensure the OH Project Team implement a clear approvals process with defined levels of delegated authority published. This should be implemented immediately.

4. Introduction

The Future Hospital Review Panel is undertaking a review of the next steps towards the build of a new hospital, as set out in a report published by the Chief Minister in May 2019 - R54/2019 'New Hospital Project: Next Steps'. The Panel launched its review on 29th September 2020 focusing on the decision-making process in determining the final site recommendation and whether the process was fair and transparent.

Review Panels are set up with the agreement of the Chairmen's Committee to review particular proposals, issues or projects. They are made up of States Members who are not Ministers or Assistant Ministers.

Background and Context

On 15th January 2019, Proposition P.5/2019 Future Hospital: rescindment of Gloucester Street as preferred site was lodged by Deputy Russell Labey. The Proposition asked the States Assembly to rescind its decision to build on the current hospital site and to reconsider alternative sites. The Proposition was debated on 13th February 2019 and was adopted by the States: 39 pour, 7 contre and 2 abstentions.

On 13th May 2019, the Chief Minister presented a report to the States R.54/2019 'New Hospital Project: Next Steps' (**R.54/2019**). R.54/2019 proposed a new, phased approach to the development of a new hospital. Firstly, it proposed to establish the agreed clinical requirements of the new hospital and secondly, to use the outcome of this to scope the size and shape of a new hospital to inform the shortlisting of potential locations.

The Government of Jersey (**GoJ**) announced a shortlist of 5 sites in July 2020 having gone through a sequential test and a prioritised series of criteria. In October of this year, a single site was announced as Overdale and on Tuesday 6th October 2020, P.123/2020 'Our Hospital Site Selection – Overdale', (**P.123**) was lodged au Greffe by the Council of Ministers. The Proposition is due to be debated by the States Assembly on 17th November 2020.

The Panel's Review

The Report firstly provides the background on the previous hospital project and the need for a new hospital leading up to the lodging by the Chief Minister of R.54/2019. The Report then examines what exactly is being proposed and makes reference to R.54/2019 and R.116/2019

Our Hospital Programme: Update to the States Assembly (**R.116/2019**). The next chapter considers how previous information was used to inform the decisions undertaken and the timescale for the project. It then goes into the methodology and site selection process highlighting key areas of concern for the Panel. Public engagement follows together with excerpts from public written submissions. The Report goes into the area of the new hospital project and the Jersey Care Model (**JCM**) detailing how these are integrated. The following chapter on costs highlights the set budget for the current project and compares it with the project undertaken previously. The Report concludes with governance covering the Business Case and Functional Brief and goes on to detail the Panel's next steps.

Methodology

Since launching its review at the end of September, the Panel has gathered evidence in several ways including:

- public hearings with the Deputy Chief Minister;
- written views from relevant stakeholders (all submissions were published on the States Assembly website);
- private briefings from relevant Ministers and officers;
- documentation provided to the Panel, upon request, by Ministers and Government officers in relation to the proposition;
- documentation in the public domain.

Transcripts for the public hearings can be accessed via the States Assembly website.

Appointment of Advisors

Following a full tender process, the Panel engaged K2/Archus as advisors to provide expert technical assistance during the review.

They were engaged to:

- Undertake a technical analysis of the Future Hospital Preferred Site Option and of any supporting documentation provided to the Panel by the Health and Community Services;

- Provide technically informed analysis/interpretation, of relevant submissions received by the Panel from key stakeholders or other interested parties;
- Assist the Panel in preparing for Public Hearings by providing specialist advice on areas of questioning;
- Complete a final report in October for the Panel's consideration.

Abbreviations Key	
GOJ	Government of Jersey
JCM	Jersey Care Model
SOC	Strategic Outline Case
MOG	Ministerial Oversight Group
POG	Political Oversight Group
SOSG	Senior Officer Steering Group
HCS	Health & Community Services
CPO	Compulsory Purchase Order
RAG	Red, Amber, Green
CSFs	Critical Success Factors
FNHC	Family Nursing & Home Care
OBC	Outline Business Case
GMP	Guaranteed Maximum Price
GIFA	Gross Internal Floor Area
TSSU	Theatre Sterile Supply Unit
DGH	District General Hospital
SPG	Supplementary Planning Guidance

5. The Need for a New Hospital

Background on previous hospital project

In 2011 the existing General Hospital located in Gloucester Street, St Helier, was considered to be insufficient to meet the needs of health care services of the Island in the future. Certain elements of the hospital were considered dilapidated and it was found that the hospital would require complete refurbishment or rebuild in the next decade.

The Government of Jersey (**GoJ**) appointed a number of external professionals to undertake;

a) a review into how existing health services were provided and the steps required to ensure Jersey could offer quality care;

b) a Pre-Feasibility Spatial Assessment and Strategic Outline Case (**SOC**) which also formed the initial evaluation of site options;

c) design of the proposed hospital to submit to the Planning Department.[1]

In June 2013, the outcome of a Ministerial Oversight Group (**MOG**) considered that a phased redevelopment and expansion of the existing Jersey General Hospital in Gloucester Street was the preferred solution. However, in 2019, following 2 rejected planning applications and a proposition (P.5/2019) to rescind the decision to build the new hospital on the current site, the States decided the project needed a new direction. An amendment to P.5/2019 was brought which effectively stated that should the States undertake a further site selection process in the future, it should be done in a fair and transparent way. This amendment was adopted by the States Assembly.

The Panel's advisors, K2/Archus have made the following comments to illustrate what, in their experience, the risks and benefits would be with utilising the Gloucester Street site based on the updated clinical requirements for the new hospital: -

- Firstly the ability to recreate a modern health campus to the proposed SOJ brief for 2036 and beyond (70,000sqm²) means substantial change in existing site layout on a congested existing site, with little room to easily expand and meet the clinical and environmental standards would be extremely difficult.

[1] Future Hospital Feasibility Study: Strategic Brief

- Secondly, the costs and speed of building additional facilities, refurbishing existing facilities becomes both slow to develop and high risk to meet cost parameters.
- Finally, for buildability contractors also need adequate space to develop and decant on a busy hospital site. In our experience with the amount of building work required versus the return on investment and matching the clinical brief, this site was understandably excluded from the shortlist.[2]

The original process took over 8 years with a considerable financial commitment in excess of £40 million. This is discussed later in this Report under the *"Costs"* section. A vast amount of documentation and supporting evidence exists which determine the conclusions about the overall need and physical area for the new hospital at that stage.

What is being proposed - Main Proposals of the Our Hospital Project

R.54/2019 'New Hospital Project: Next Steps' to the States Assembly

On 13th May 2019, the Chief Minister presented R.54/2019. This report outlined a new phased approach to deliver a new hospital as follows: -

- firstly, establish the agreed clinical requirements of the new hospital;
- secondly, use the outcome of this to scope the size and shape of a new hospital to inform the shortlisting of potential locations;
- thirdly, involve a thorough process of Island and stakeholder communication and engagement on those locations, alongside technical and financial assessments of deliverability, in order to identify a preferred site for the Government and States Assembly to consider and approve.

There were 4 key areas of difference listed within the report from the previous approach to the project and are documented below.

1. We (*the Government of Jersey*) are being more inclusive in involving and engaging States Members, staff, stakeholders and Islanders in the process, including through the use of Citizen Panels, and through working closely with Scrutiny.

[2] K2/Archus Report – November 2020

2. We are taking the opportunity to review the model of health care delivery, under the leadership of the Minister of Health and Community Services, to ensure that the current clinical requirements take account of changes since they were originally scoped in 2012.

3. We will bring in a construction and development partner earlier in the process, to help drive down costs.

4. We are building on all the experience of what went before, to ensure that we learn from it, embracing the best of what was achieved before and avoiding repeating past mistakes.[3]

R.54/2019 states the new project would draw on relevant information that was gathered for the previous hospital project, supplemented by new insights and requirements arising from the development of the Jersey Care Model (JCM) since the previous work was carried out. This is discussed further in this Report under the section "*How was previous information used to inform decisions for this process".*

The report from the Chief Minister also explained how the political oversight of the project would be initiated. It discussed the need for a Political Oversight Group (POG) and the necessity of engagement with clinicians to establish the requirements that would be considered essential in developing a new hospital. It was also stated as part of this early phase, to procure appropriate specialist skills to support the project to include:

- Project Director
- Health Planner/Clinical Lead
- Clinical Design Team
- Specialist legal/Procurement Advice
- Communications and Engagement Lead
- Financial and Economic Appraisal Advice
- Site Assessment Advisers.

There was also a drive for more engagement as it was recognised this may not have been carried out appropriately on the previous hospital project. *"...There wasn't enough engagement last time round. Engagement wasn't conducted properly, and required staff to be revisited with the final plan..."*[4]

[3] R.54/2019 – New Hospital Project: Next Steps
[4] R.54/2019 - New Hospital Project: Next Steps

Additional proposals included:

- Engagement with children who are regular users of the Hospital;
- The ability to engage with staff anonymously;
- Engagement with possible contractors, including UK, French and Polish;
- Regular engagement with politicians;
    - Regular briefings with a monthly e-mail update the minimum level of contact which would reduce once building has begun;
- Engagement to enable staff and the Public to know the progress being made and the decisions being taken on a regular basis.

It was recognised there was a need to carry the Public along with the project throughout the build. *"...Can't just drive project through without engagement..."*[5]

It should be noted that R.54/2019 also stated the need to understand the limits of engagement and whilst clinicians should be involved, "*they would be experts in their subject but not in building (comparison to asking teachers about building a school). However, involvement with clinicians should mean spending time in Departments to gain a full understanding of needs."*[6]

R.116/2019 – Our Hospital Programme, update to the States Assembly

On 11th September 2019, the Minister for Economic Development, Tourism, Sport and Culture (Deputy Chief Minister and political lead of the 'Our Hospital' project) presented R.116/2019 – 'Our Hospital Programme, Update to the States Assembly'. The purpose of this report was to set out the progress that had been made in relation to the 'Our Hospital' Project over the 4 months since the presentation of the Chief Minister's report (R,54/2019). The Deputy Chief Minister advised:

> *It shows that the project has established appropriate governance at both a political and officer level; that it has secured approval for the initial funding needed to get the project started; that the process for recruiting and procuring the team has been approved and is underway; and that the work has been carried out to develop an updated Jersey Care Model, which is due*

[5] R.54/2019 - New Hospital Project: Next Steps
[6] R.54/2019 - New Hospital Project: Next Steps

to be considered by Ministers in October following more than 40 engagement events with clinical and health staff, the wider health community and the voluntary sector.[7]

The report also stated that the Government was *"mindful of criticisms by the Comptroller and Auditor General over governance and decision-making in the early stages of the previous Future Hospital Project, the first few weeks of the new project focused on establishing appropriate governance and ensuring that all involved understood their accountabilities and responsibilities."*

The report went on to describe the details of the various groups to be involved in the 'Our Hospital' process. These groups included the Political Oversight Group (POG), Senior Officer Steering Group (SOSG), Clinical Group and Delivery Group. These groups are discussed in more detail later on in this report under the section "Ministerial Accountability".

[7] R.116/2019 – Our Hospital Project, Update to the States Assembly

6. How was previous information used to inform decisions for this process?

Within R.54/2019, the Chief Minister proposed *"…the new project will draw on any relevant information that was gathered for the previous project, supplemented by new insights and requirements arising from the further development of Jersey's health care model since the previous work was carried out. Furthermore, wherever possible, the work that has already taken place on the Hospital project will be re-used, reducing immediate future costs, without prejudicing a fresh start on a project burdened by its long and complex history…"*[8]

The total amount of funds spent on the original hospital project, as at April 2019, totaled £44,461,500.

The Panel was keen to understand what, and how, previous information had been used to inform the decision-making process of the new hospital project. The Panel received the following response via email:

> *…we do not have a central log of the use of previous work, which would be a time-consuming process given the web of work being undertaken in different workstreams. However, work undertaken by the 'Future Hospital Project' is regularly referred to and used as the project progresses. As you note, there are references to the reuse of work throughout project documentation including but not limited to:*
>
> - *Work of Gleeds*
> - *Work of WS Atkins*
> - *Development of the site selection process*
> - *Previous site selection long list*
> - *MJM Health Planner work*
> - *Consideration of the Planning Inspector's report from the previous Public Inquiry*
> - *Previous site technical assessments*
> - *Hospital Policy Development Board Report*
>
> *There will also be further opportunities to reuse work undertaken as part of the Future Hospital Project in design phases, for both clinical and non-clinical areas. Of course, the Our Hospital Project will make good use of this valuable resource, however, we are not yet at this*

[8] R.54/2019 – Our Hospital Project: Next Steps

stage in the project. So, there is a substantial amount of previous work which we are unable to use at present, but will once the project moves past the site selection stage…"[9]

Key Finding 1

There do not appear to be SMART objectives to link the previous information used to the current project. Without this information, it is challenging to make objective decisions to measure what, if any, costs have been reduced and what information was actually used.

Recommendation 1

The Council of Ministers should ensure the OH Project Team provide the Panel with a list clearly detailing which previous information was used and how it informed the site selection decision making criteria. This should be provided within 3 months from presentation of this Report.

[9] Email from OH Team to Scrutiny – 29th October 2020

7. Timeframe

Proposed Timeline for pre-building

In early 2020, POG were provided with information[10] from the 'Our Hospital' Project team that outlined:

- The increasing costs of the planned backlog maintenance programme for the current hospital estate at Gloucester Street;
- The statutory, clinical and operational safety challenges associated with a deteriorating estate.

On this basis, it was agreed that the new site should be operational by the end of 2026, which was noted as a tipping point *when costs to keep the existing facilities operational would rise significantly.*[11]

A key part of the site elimination criteria was whether or not sites could be made available and would be ready for 2026. This is discussed in more detail under the section *"Site Selection Criteria"*. Within R.54/2019, the initial timeframe is stated as follows:

> *It is estimated that it will take at least 20 months to secure an agreed outline design, cost plan and delivery plan for a preferred option, along with a business case and a draft planning submission that links to the new Island Plan. However, the next nine months will be critical in assembling the new team, putting in place the key governance arrangements, establishing effective engagement with politicians, hospital staff, stakeholders and Islanders and agreeing the shortlist of credible sites for detailed assessment, in order to prepare an Outline Business Case by early 2020*" The report goes on to say that whilst the proposed timeline is ambitious, it is firmly believed that if everyone supported the process, and there were no further delays, it would be possible to deliver the new hospital within 20 months. *It requires us collectively to agree that this is a priority, and to work together; but if we do, we can still deliver a completed Hospital in a similar timescale to that of the previous scheme.*[12]

[10] No clear description of the analysis and research of this information is provided within this Report
[11] Our Hospital Site Shortlisting Report July 2020
[12] R.54/2019 - New Hospital Project: Next Steps

In a written question to the Deputy Chief Minister, the Panel asked whether the 2026 deadline for delivering the new hospital was achievable. The Panel was advised that *"…based on the information available at this early stage of the project and pre-design, and the advice of the Delivery Partner, it is achievable..."*[13] The response went on to say that although the timetable being worked to was realistic, it did not include allowances for unforeseen setbacks which would require the exploration of *"the use of phasing and phased planning, modern methods of construction including off-island fabrication and, as a last resort, parallel commissioning activity."*[14]

Key Finding 2

There does not appear to be any inclusion for unforeseen setbacks within the process. This could cause the project to go off track and cause costs to spiral.

Recommendation 2

The Council of Ministers should provide the calculations for all project cost including; non-works costs, equipment costs, non-medical costs (including the whole life transport solution), VAT, inflation, optimism bias, a clear split of all project contingencies, the premium costs for materials and confirmation that all "current exclusion" are subject to at least the latest provisional sums. This should be provided prior to lodging any proposition seeking the Assembly's approval of the Outline Business Case.

Potential Future Expansion

In 2013, the original data for spatial requirements carried out by WS Atkins was projected from 2010 to 2040 - a 30-year future plan. The Panel raised this projection with the Deputy Chief Minister at its public hearing in October and asked what the current projected plan was. The Panel was informed: -

> **Clinical Director, Our Hospital:**
> *…The projection for this is what we would need for 2036. The current timeline for the hospital, as you know, is to be built by December 2025 but commissioned by 2026, and then we will look 10 years ahead of that…*[15]

[13] Letter to Review Panel from Deputy Chief Minister – 23rd October 2020
[14] Letter to Review Panel from Deputy Chief Minister – 23rd October 2020
[15] Public Hearing with Deputy Chief Minister – 13th October 2020

The Panel is aware there is flexibility for expansion within the proposed plans. However, in a written question to the Deputy Chief Minister, the Panel asked for more specifics on what the current projection would be and how long before the new hospital could no longer accommodate the needs of the Island. The Panel received the following response:

> *…The needs of the island, as far as can reasonably be foreseen, will be met until at least 2036 with a further expansion ground floor area of 15% and flexibility in design to allow for changes in the delivery of health care beyond that. Although the possibility of expansion has been built into plans, this does not necessarily mean there will be a need to expand. Best practice health and care models may continue to evolve based on more community and closer-to-home care. It is therefore important that the site is flexible and has the option for expansion. Thus, it is expected that the preferred site put forward by the Council of Ministers will be able to accommodate the needs of the Island for at least 40-50 years…*[16]

As far as the Panel is aware, there is no one single document which provides analysis specific to the Our Hospital project projection and planning assumptions. Whilst the Panel understand the hospital is one part of a wider health system, it raised with its advisors the future flexibility allowed within the proposed hospital build. It was advised that *"there was a strong link in early documents but this became more tenuous in later documents which were very hospital specific. Although 15% flexibility is built in, population growth on the Island is forecast at 1% per annum so this flexibility wipes out after 15 years (less allowing for compound growth). So unless there is a focus on new models of care and transfer of activity from hospital to community the hospital (and the site) will come under pressure within about 12 years."*

The advisors have also stated *"It would be correct to have a hospital-based analysis specific to the project in order to test resilience of the planning assumptions. However, the hospital is one part of a wider health system and some care (diagnostics and consultations) can be transferred to community/primary care settings."*[17]

Key Finding 3

The Panel has concerns around the 40 – 50-year life cycle with no clearly defined, projected timeline and the absence of hospital specific analysis documentation. The OH Project Team has defined two areas of expansion:

[16] Letter to Review Panel from Deputy Chief Minister – 23rd October 2020
[17] Email from K2/Archus – November 2020

- 15% additional area within the ground floor, providing flexibility for the foreseeable future until 2036. Effectively a 10-year post project completion allowance.
- Provision of an adjacent site as set out in the site selection criteria for future expansion. This has been proposed to allow expansion of all areas of the proposed Hospital for a period of 40-50 years. Without focus on new models of care and transfer of activity from hospital to community the hospital (and the site) will come under pressure within about 12 years.

Recommendation 3

The Council of Ministers should ensure the OH Project Team provide a document detailing how the plan has been incorporated for expansion to suit a demographic 40-50 years for the future. In addition, how this will suit the future needs of the Hospital specifically utilising the adjacent site without delay.

Recommendation 4

The Council of Ministers should ensure the OH Project Team undertake to provide a hospital-based analysis single document specific to the project in order to test resilience of the planning assumptions. This should be presented to the Panel without delay.

Recommendation 5

The Council of Ministers should undertake post Covid pandemic planning and establish impact on sizing and configuration of the hospital without delay.

8. Site Selection Process

Methodology and Site Selection Criteria

Step 1 - Call for Sites

In December 2019, to ensure that all possible locations for Jersey's new hospital were considered, Islanders were invited to suggest sites where they thought the building could be located. This resulted in a total of 82 distinct sites as potential locations for the Hospital.[18]

Step 2 - Clinical Criteria for Site Assessment

Site area Health and Community Services (**HCS**) colleagues and the 'Our Hospital' project's Clinical Director reviewed the necessary clinical adjacencies and floor areas required for each clinical service to be delivered in the new hospital, as part of the development of the draft functional brief. The work was informed by best practice in hospitals in other jurisdictions and established the clinical services that would need to be located on the ground floor of any hospital to best deliver clinical care.[19] It was concluded in order to meet the clinical requirements on the ground floor, 2 options would be proposed.

The 2 Options

Option 1 - main site ground floor arrangement that would be supported by separate site facility alongside the main building, housing appropriate clinical and support services with. This ancillary site would be directly adjacent or up to 50m away and would provide non-clinical essential support services.

- Essential ground floor hospital area requirement (including external circulation areas) = 23,243m2
- Adjacent site = 8,504m2 • Car parking – 800 spaces over 2 x floors = 9,219m2 or existing parking capacity

Option 2 – main site, including basement that could support the functioning of the hospital. This allows the total ground floor area to be marginally smaller than Option 1 and enables essential support services to be co-located within the new hospital building without the need to increase the building's height to incorporate an interstitial service floor. Option 2 retains the need for a

[18] Our Hospital Site Shortlisting Report July 2020
[19] Our Hospital Site Shortlisting Report July 2020

separate facility alongside or close to the main building, but this site could be further away – clinicians are agreed that some services could be up to 15 minutes' walk from the main building.

- Essential ground floor hospital area requirement (including external circulation areas) = 22,890m2 • Nearby site = 3,590m2
- Car parking – 800 spaces over 2 x floors = 9,219m2 or existing parking capacity

Table 1 below, Future Hospital Size Requirements, specifies the differing areas in m2 of the existing hospital, WS Atkins Spatial Assessment which was carried out in 2013 and the States of Jersey Current Criteria, Options 1 & 2.

Table 1

Future Hospital Size Requirements					
11/11/2020	**All Floors (m2)**	**Ground Floor m2**	**Site Area m2**	**Adjacent Site (m2)**	**Parking (m2)**
Existing hospital	38,630	<10,000	21,320	-	Patriotic St
WS Atkins Spatial Assessment 2010-2040	63,644	18,281	21,320	-	Patriotic St
States Current Criteria					
Option 1 (without basement)	69,004***	21,192	23,243*	8,504	9,219
Option 2 (with basement)	69,004***	17,703	22,890**	3,590	9,219

* Approximately 9% increase to original site area
** Approximately 7% increase to original site area
*** Approximately 8.5% increase to original site area

Site Selection Document

In July 2020, the "Our Hospital Site Shortlisting Report" was produced to *"…outline the approved methodology to establish a long list of potential sites for a new hospital for Jersey and identify a shortlist of sites. The steps that have been taken to agree criteria that would be applied to this long list of sites, including clinical and community involvement…"*[20] The Document includes a number of Appendices which are reviewed in this document and explained in more detail under the "*Site Selection Criteria"* subheading.

The Appendices

- 2.1b Appendix I - List of sites
    - Listed the 82 initial sites

[20] Our Hospital Site Shortlisting Report July 2020

- 2.1b Appendix II - notes on each site (FINAL)
    - This is an assessment of the 82 suggested sites against the footprint requirements of the new hospital (using the 2 options) and the existing uses on the site that would need to be relocated to create a development site
- 2.1b Appendix III - Outcome Matrix (FINAL)
    - Assessment of sites large enough for Option 1 or Option 2 and potentially available in timeline
- 2.1b Appendix IV Citizens' Panel agreed criteria (FINAL)
    - List of 24 criteria questions as approved by the Citizens Panel

This document illustrated the 24 criteria questions used by the Citizens Panel to establish and identify a shortlist of sites. This process resulted in the 5 site shortlist. Topographical surveys were carried out on all sites included on the 5 site shortlist.

Key Finding 4

The Panel understands a topographical survey report was carried out for the 5 sites on the shortlist later in the selection process and questions if this should have been applied to the 17 sites prior to meeting the crucial stage of the Citizen's Panel criteria.

Recommendation 6

The Council of Ministers to ensure the OH Project Team provide the Panel with reasoning as to why topographical surveys were only carried out on the 5 site shortlist. This should be provided without delay.

Citizens Panel

On 11th November 2019, the Government of Jersey invited Islanders to give their views as part of the process of delivering a new hospital for Jersey. The 'Our Hospital' project announced it was setting up a Citizens' Panel as part of its engagement process, to help provide a representative voice from a wide cross-section of the community. The role of the Citizen's Panel was to make sure that the views of Islanders were taken into account by the project when considering where the new hospital might be built. The Panel would be asked to reach a consensus view on the criteria that the 'Our Hospital' Project Team would then use to determine where the new hospital

could be built. It is worth noting that the Citizen's Panel was not asked, at any point throughout the process, to give its view about where the location of the hospital should be.[21] On 9th March 2020, a statement was made by the Deputy Chief Minister on the "Our Hospital Project" and stated the Citizen's Panel (made up of 17 islanders) had met 3 times and were working on the criteria and the sequence of questions.

The Citizen's Panel had Terms of Reference and were accountable to the 'Our Hospital' Team. The Terms of Reference included: Purpose, Objective, Responsibilities, Scope, Meeting Frequency and Confidentiality. It was agreed that the members of the Citizen's Panel would remain anonymous. The Terms of Reference can be found on the Government of Jersey website.

Following the initial deselection stages applied in 1 and 2, a criteria of 24 questions was created by the Citizen's Panel. This criteria was applied by the Site Selection Panel to the remaining 17 sites which reduced the shortlist to 5. This is discussed in more detail in the next section of this Report titled *"Site Selection Criteria".*

The Review Panel met, via Microsoft Teams, with 4 members of the Citizen's Panel on 30th September 2020. The meeting was held in confidence and gave the Review Panel the opportunity to ask the Citizen's Panel questions about the overall process and where, if any, areas they thought could be improved. The Citizen's Panel fed back that overall, they found that the process was well organised, independent, professional and focused on problem solving. The members also explained that they were comfortable in just setting the criteria and were not involved in any way in the selection process. The members went on to say they did not feel there was enough engagement with the Public as to the role of the Citizen's Panel and explained that one of the reasons for them choosing to remain anonymous was to avoid any public discontent resulting in a blame situation against the members.

The Site Selection Criteria

Once the call for sites had been finalised, the selection criteria was applied to the 82 sites in the following order:

- exclusion based on size (being unable to meet option 1 or 2);
- timetable – hospital to be operational by 2026 therefore sites had to be available for construction by 2022;
- criteria by the Citizens Panel (sequential test criteria consisting of 24 questions).

Exclusion of Sites from 82 to 39

[21] Our Hospital Announcement – 11th October 2019

The application of the minimum site size requirements as stated in option 1 and 2 reduced the list of sites under consideration from 82 to 39. It should be noted the current hospital site on Gloucester Street was on this list, even though the States Assembly voted in 2019 to rescind the decision to build on this site.

Throughout its review, the Panel has gained an understanding into how the site selection criteria was set to determine how the sites would be eliminated at each stage of the process. The Panel is therefore concerned around 2 sites in particular, namely South Hill and Peoples Park, which do not appear to have met the set criteria. This is discussed below: -

South Hill

The site at South Hill has an overall ground floor area of 30,910m2 and is listed within the Site Selection Document Appendix II as having an adjacent site. As mentioned previously in this Report, there were 2 options being proposed, each with a minimum floor area plus parking.

Option 1

- Essential ground floor hospital area requirement (including external circulation areas) = 23,243m2
- Adjacent site = 8,504m2 • Car parking – 800 spaces over 2 x floors = 9,219m2 or existing parking capacity

Option 2

- Essential ground floor hospital area requirement (including external circulation areas) = 22,890m2 • Nearby site = 3,590m2
- Car parking – 800 spaces over 2 x floors = 9,219m2 or existing parking capacity

According to the Site Selection Shortlist Report, *Appendix II, Notes on the Outcome of Consideration*, South Hill was excluded based on size in the initial first stage criteria due to *not being large enough to accommodate either option*[22]*.* However, South Hill, with an area of 30,910m2 is large enough and therefore should have met this criteria. When the Panel queried this in a letter to the Deputy Chief Minister, it was advised that the reason for South Hill not meeting the criteria was based upon the uneven nature and steep gradients of the site. It was also stated "*the site could not reasonably create the flat area required".*[23] The Panel was further advised that the site *"…would prove impractical to create sufficient level land within the timetable and in*

[22] Appendix 2 – Notes on each site
[23] Letter from Deputy Chief Minister to Review Panel – 20th October 2020

summary, South Hill was removed at stage 3 of the site selection process – consideration of whether sites could be deliverable by 2026…"[24]

The Panel questions why the site was eliminated at Stage 1 due to not being large enough to accommodate either option, when it did in fact meet this criteria and why, within the letter to the Panel dated 20th October 2020, it is stated that South Hill was removed at a later stage due to *being undeliverable by 2026*.

At its hearing with the Deputy Chief Minister on 13th October 2020, the Panel explored this area further.

> ***Deputy M.H. Le Hegarat:***
>
> *Okay, so therefore based on that why was South Hill eliminated due to not meeting the size criteria for either option when in fact it is more than large enough to accommodate?*
>
> ***Development Director, Our Hospital:***
>
> *There is obviously a difference in figures; I need to see the figures you are referring to there. When South Hill was considered there was the footprint of the site itself but when the detail of topography was looked at it became clear that quite a large amount of that topography was taken up by steep hills and various different things, which meant that the developable area of the site is not the same as the redline boundary of the site. But what figures you are looking at there, I am not sure.* [25]

Key Finding 5

South Hill was eliminated at stage 1 due to being unable to meet either of the options due to size. The site was in fact large enough to accommodate both options and if the set criteria had been applied, it should not have been eliminated at this stage.

Peoples Park

The site at People's Park, with a ground area of 22,784m2, made the final 2 of the shortlist despite the fact that the ground area is not large enough to accommodate either of the 2 options. When the Panel questioned its observation with the 'Our Hospital' Project Team it was advised:

[24] Letter from Deputy Chief Minister to Review Panel – 20th October 2020
[25] Public Hearing with Deputy Chief Minister – 13th October 2020

…People's Park is slightly below the required area to accommodate a version of the hospital but it was considered that some flexibility in design could probably achieve a workable scheme. Any such scheme would include a provision for future growth and as such People's Park did not fail the criteria rather it became a 'maybe'…[26]

The 'maybe' assessment, referred to in the response to the Panel, is briefly noted within the Site Shortlisting Report, which states:

A concept was developed and approved of a sequential test for site shortlisting, which would screen out less suitable sites from a long list of sites on a pass/fail basis according to a prioritised series of criteria that would be developed by a Citizens' Panel. It was agreed that the sequential test criteria would be framed in question-form and scored in line with HM Treasury Green Book Guidance, which provides for the following assessments-

- *Yes (site passes the question/criterion/test)*
- *No (site fails the question/criterion/test, and does not pass to the next question for appraisal)*
- *Maybe (site passes the question/criterion/test with a compromise or mitigation) …*[27]

The Panel does not understand how People's Park managed to pass the first stage of the criteria when the criteria clearly states that sites would be excluded based on size if they were unable to meet option 1 or 2. There is no reference as far as the Panel can see within the documentation that lists Peoples Park as a "maybe".

The concept as described above states the "maybe" process happens at the Citizen's Panel stage (stage 3) (which is when the sites were reduced from 17 to 5) based on meeting the sequential test. The definition of "maybe", although described, is not defined in any great detail and could be applied to any site.

Key Finding 6

Based on the set criteria, People's Park, should not have been considered due to being insufficient in size. The Panel is of the opinion that should the criteria have been applied, the site would have been eliminated at stage 1 due to being unable to meet either of the options.

[26] Email from OH Team to Scrutiny Officer – 29th October 2020
[27] Our Hospital Site Shortlist Report July 2020

Recommendation 7

The Council of Ministers should ensure the OH Hospital Project Team provide the Panel with further details of how the "maybe" criteria could be applied and why it was not defined within the site selection documents. This should be provided without delay.

The advisors to the Panel have also raised concerns around the initial elimination process and have highlighted 9 sites which have been deselected whilst appearing to meet the size criteria, including:

		Main Site Area m^2	Adjacent Site Area m^2	Nearby Site?	Commentary
1	B&Q plus Powerhouse	26,161	0		The site is not large enough to accommodate any Option
8	Field North of Union Inn	23,228	0		The site is not large enough to accommodate any Option
17	Government House	44,270	0		The developable area is limited and could not accommodate any Option
23b	Fields behind Millbrook Playing Fields	23,136	0	Yes	The site is not large enough to accommodate any Option
54	West Park	29,787	0	Yes	The site is not large enough to accommodate any Option

61	Field 1219, La Grande Route de Mont a L'Abbe	25,490	0		The site is not large enough to accommodate any Option
63	Field adjacent to St Saviours Church	23,870	0		The site is not large enough to accommodate any Option
69	Former Jersey College for Girls	27,957	0		The site is not large enough to accommodate any Option
82	South Hill	30,910	0	Yes	The site is not large enough to accommodate any Option
					28

***...55** potential sites were rejected purely due to size. As noted above, however, **9** of the 55 appear to meet the minimum size criteria. It is not clear, therefore, why the sites in the table above have been deselected purely on the grounds of site area during the first round of reviews...*[29]

Key Finding 7

The advisors have raised 9 sites that were eliminated at the initial stage for being unable to meet either of the options regarding size. It is clear however that based on size, all of these 9 sites meet the criteria and could accommodate either option.

The advisors went on to discuss briefly how a further **20** potential sites were rejected in the next elimination stage (Step 3 - Clinical criteria for site assessment – timetable) due to there being existing uses on the site which would need to be relocated. It was then assumed that having to do this would result in the programme not being met and the deadline of 2026 for the hospital to be operational would not be met. *"...In this instance it is fair to say that some sites with existing*

[28] K2/Archus Report – November 2020
[29] K2/Archus Report – November 2020

occupants could potentially have been considered in the long list and the assumption that the majority of sites could not is subjective. In addition, the Overdale site considered in the short list does have some land acquisition requirements, both for the main site and the highway works. The time it would take to obtain these elements of land would not necessarily take any less time to acquire than some of the sites that have previously been discounted..."[30]

Key Finding 8

The risks associated with the Compulsory Purchase Order (CPO) surrounding Overdale have not yet been confirmed. It may be likely the process to obtain the required land and properties for the hospital project would not necessarily take any less time than to acquire some of the sites that were discounted at the timetable criteria stage. (Step 3 - Clinical criteria for site assessment – timetable)

Recommendation 8

The Council of Ministers to ensure the OH Project Team provide the Panel with reasoning behind why the risks associated with the CPO around Overdale were not taken into consideration as a risk when applying the criteria at Step 3 - Clinical criteria for site assessment – timetable. This should be provided without delay.

Exclusion of Sites from 39 to 17

The next stage of the test was designed to eliminate those sites that could not be delivered by 2026. Factors that were considered as part of the deliverability criterion were:

- Ownership
- Availability of developable land

Exclusion of Sites from 17 to 5

The criteria for considering sites at the next stage required the involvement of the Citizen's Panel Assessment Criteria. Details of the Citizen's Panel and its role within the project is discussed earlier in this Report. The Citizens Panel were supported by an independent facilitator from the

[30] K2/Archus Report – November 2020

UK and met independently of the 'Our Hospital' Project Team. A sequential test criteria of 24 questions was composed by the Citizen's Panel which was then applied to the remaining 17 sites. These criteria were reached with the Citizen's Panel working together with the independent facilitator. According to the 'Our Hospital Site Shortlist Report':

> "*After some familiarisation sessions, the Citizens' Panel worked together with the facilitator to establish the criteria they thought were important in determining the site for the Hospital. In a session after the workshop their criteria were crystalized into a priority sequenced list and approved by the Citizens' Panel.*[31]

The results of the test criteria were then applied to a matrix which used a Red, Amber, Green format (**RAG**). Traditionally, red would be classed as no and green yes, however, within this matrix, green is also used for no and red is also used for yes. It is not easy to ascertain which site is favourable and in addition, there is no overall total of which site scores highest based on the positives. As a visual aid to the reader, it could be safely assumed the more green the better suited the site, however, this is not the case within this matrix. The results of this part of the selection criteria reduced the sites from 17 to 5.

It should be noted that the original site selection process undertaken by WS Atkins, utilised a point based hierarchical system using a methodology based on current UK NHS space and design standards.

Key Finding 9

The RAG matrix could be considered confusing in using the results with green and red signifying a result of both yes/no.

Key Finding 10

The facilitator for the group is not named and therefore the Panel, or its advisors are unable to comment on whether the facilitator had suitable experience and knowledge in working with the group to develop Critical Success Factors (CSFs) as advised in the HM Treasury Green Book.

[31] Our Hospital Site Shortlisting Report July 2020

Recommendation 9

The Council of Ministers to ensure the OH Project Team provide in absolute confidence to the Panel the experience of the facilitator in order for the Panel's advisors to make an informed decision as to understanding the knowledge the facilitator had in developing CSF's in line with Green Book standards.

Critical Success Factors

The advisors to the Panel have pointed out that "Critical Success Factors (**CSFs**) are a small number of criteria used at the long list stage to make strategic choices about options. The purpose of a CSF is to support an assessment of how well an option is likely to succeed across the five dimensions of a business case and deliver SMART objectives. The selection criteria should be developed around key CSFs, such as:

- Strategic Fit/Meeting Business Needs
- Value for Money
- Affordability
- Achievability

There is no mention of CSFs in any of the documentation received. In addition, where it is stated that the Site Selection Panel adopted a form of the HM Treasury's Green Book methodology of '***Yes, No, Maybe***', when the potential site failed the question/criterion/test and '*should not pass to the next question for appraisal*' it appears from the outcome matrix that later criteria were then considered even after a '***No***' result had been recorded."[32] This is discussed further in the advisor's report which is appended to this document.

The advisors also raised concerns around the fact that the criteria had been set using a sequencing system as opposed to weighting and stated *"...The lack of weightings meant that the Red Amber Green (RAG) ratings could be interpreted differently according to technical understanding, site knowledge and perception..."*[33] A weighted process would take into consideration the varying degrees of importance of the criteria questions with some points scoring higher than others.

[32] K2/Archus Report – November 2020
[33] K2/Archus Report – November 2020

The advisors went on to make the point that the 24 questions which formed the criteria are largely subjective, making the marking open to challenge and debate. "*...Notwithstanding this, the sequential fashion in which the criteria were applied has driven the outcome. In reality two factors i.e. (1) sites large enough and (2) potentially deliverable within the desired timeframe have been used as pass/fail criteria, resulting in the list of 17 sites. The other 22 criteria were therefore rendered not relevant..."*[34]

At its public hearing with the Deputy Chief Minister in October, the Panel raised the issue of the criteria questions, that formed the RAG matrix, having not been weighted. The Panel received the following response:

> ***Development Director, Our Hospital:***
>
> *"…weighting wise; we tried to avoid weightings because previous versions of the project had struggled with weightings being applied. So, in terms of site selection, we definitely took advice from the clinicians on the priorities that we should use in terms of the sequence of questioning, and then with the citizens' panel criteria for the sites we used again a sequence that they felt was appropriate..."*[35]

The Panel went on to ask the Deputy Chief Minister in a written question what the struggles were in using a weighting process and the key difference between weighting and sequencing. The Panel was informed that the way the site selection process was undertaken for the previous iteration of the hospital project (Future Hospital Project) was challenged by the Hospital Policy Development Board in its report published in November 2018. Among these challenges, the weightings associated with them were criticised for being too light or too heavy. The Deputy Chief Minister advised:

> *Weightings are of course a matter of opinion – in seeking objectivity there is a risk of subjectivity. Unless trial calculations are made covering all possible eventualities, opinion may change and require weightings to be updated as the implications of each eventuality becomes known, which can compromise the process as a whole. In order to avoid this situation, the project team instead developed a sequential test for site selection that was approved by the Our Hospital Political Oversight Group.*[36]

Key Finding 11

The criteria did not use weighting and could be considered subjective and open to interpretation.

[34] K2/Archus Report – November 2020
[35] Public Hearing with Deputy Chief Minister – 13th October 2020
[36] Letter from Deputy Chief Minister to Review Panel – 23rd October 2020

It was explained to the Panel that the concept of the sequential test would screen out less suitable sites from a long list on a pass/fail basis according to a prioritised series of criteria as was set out in the Site Shortlisting Report. It was also explained that as part of the project is being clinically led, the criteria provided by the clinicians and health care professionals were addressed first.

Exclusion of Sites from 5 to 2

On 4th September 2020, it was announced by the Government of Jersey that the 'Our Hospital' site shortlist had been reduced from 5 to 2. The announcement stated the 5 sites had been assessed using criteria formed by working with the 'Our Hospital' Citizen's Panel, medical professionals and from the feedback received during island wide public consultation. The announcement also stated that assessments undertaken in reducing the sites looked at the clinical suitability, location, environmental, economic and social impact. The process for deselecting the sites from 5 to 2 involved the findings of the site acquisition report and the preliminary assessments carried out by the Design and Delivery Partner.

Hurdle 1

The 5 sites were examined and then 3 deselected as they were believed not to be able to meet the timeline and other technical factors especially their ability to meet planning policy (Island Plan). The three sites deselected were:

- Millbrook – Complex multiple acquisition and the potential for compulsory purchase, together with departure from current planning policy are cited as key reasons for deselection of Millbrook.
- St Andrews Park – Ruled out due to the requirement of a special law to develop the site. It is stated the timescale could therefore not be met. Loss of amenity and access and highways are also key factors leading to its deselection.
- Five Oaks – The site is under multiple ownership and would require 'significant' land acquisition to facilitate the highways improvements required. Visual impact is also noted as an adverse factor for this site, leading to its deselection. Given these factors it is surprising that this site was not deselected at an earlier stage.

The Site Selection Panel were supported by technical advisors covering:

- Jersey Government Highways and Infrastructure
- Jersey Government Town Planning
- Hospital planning, architecture, and design

Key Finding 12

It does not appear the Site Selection Panel had access to technical advisors prior to the selection process defined above at Hurdle 1. The Panel is of the opinion that should technical advice been obtained prior to this process, the site at Five Oaks would not have met the criteria based on its location lending it to having access problems with the approach road and would have been eliminated at an earlier stage.

Key Finding 13

There were no operational clinical staff or end users on the Site Selection Panel, who would have had a more detailed understanding of the potential location, particularly regarding the patient population and services to be delivered.

The Final Site

Hurdle 2

The remaining 2 sites were assessed against the full list of criteria which was applied by the Site Selection Panel. The Delivery Partner illustrated the results using a 'swingometer' to assess the relative merits of Overdale vs Peoples Park. The analysis undertaken by the Delivery Partner was presented graphically. The Panel's advisors have stated *"...this analysis does not conclude that there is an absolute winner but shows both sites have relative merits and disbenefits that require careful consideration..."* [37] . The advisors went on to state the factors used for reducing the sites from 5 to 2 also appeared to effect the 2 final remaining sites. It is unclear how these sites were not deselected at Hurdle 1 as they too were *unlikely to meet the timeline and other technical factors*.[38]

- Overdale – this site is under multiple ownership, does not accord with the current Island Plan in its entirety, requires significant highways improvements, effects heritage assets and will impact the Jersey skyline.
- Peoples Park – this site will result in loss of amenity which does not accord with the current Island Plan in its entirety; is smaller than ideal but otherwise would appear to meet the requirements of Hurdle 1. People's Park has an area / size below the minimum required.

[37] K2/Archus Report – November 2020
[38] Our Hospital Site Shortlisting Report July 2020

On Tuesday 6th October 2020 it was announced the final preferred site, subject to States approval was Overdale and P.123/2020 'Our Hospital Site Selection – Overdale', (**P.123/2020**) was lodged au Greffe by the Council of Ministers.

The Deputy Chief Minister presented a Statement to the States Assembly which outlined the reasons for Overdale as the preferred site summarising the process: -

> *…A thorough site selection process was developed and applied to the most comprehensive long list of potential sites. This long list of sites has then been evaluated according to a set of extensive criteria developed and agreed by clinicians, health care professionals, a Citizens' Panel of Islanders and technical advisers. As such, this process ultimately resulted in a final shortlist of two sites: Overdale and People's Park. Taking that into account, together with all of the clinical, locational, environmental, design, economic, financial and social impacts of the new hospital on the final two sites, the Our Hospital Political Oversight Group and the Council of Ministers have determined to recommend to The States that Overdale is approved as the preferred site for Jersey's new hospital and accordingly, a Proposition is being lodged today to reflect that decision...*[39]

The statement also confirmed that the final site of the new hospital was due to be debated by the States Assembly on 17th November 2020.

The Panel's advisors have commented on the decision to choose Overdale as the preferred site as not being fully explained or justified. They state *"...of course, the GoJ could justify Overdale as being the best site for the project but may not easily be able to explain and justify how they were able to reach their decision using their own criterion which is generally not measurable..."* [40] The advisors have also stated the reasons for selecting Overdale over Peoples Park requires explanation and justification, f the decision is to be fully understood and supported.

Within P.123/2020, it is stated:

- *There must be no further delay.*
- *Taking into account all of the clinical, locational, environmental and economic and social impacts of the new hospital on our final two sites, the Our Hospital Political Oversight Group and the Council of Ministers were in no doubt that Overdale was the best option and would deliver an exemplary hospital, future-proofed for future generation of islanders.*

[39] P.123/2020 - Our Hospital Site Selection – Overdale
[40] K2/Archus Report – November 2020

Key Finding 14

The site selection process had many areas lacking objectivity and was not balanced.

Sites were excluded whilst others remained in the process when the criteria was not met.

Recommendation 10

The Council of Ministers to ensure the OH Project Team provide the Panel with valid reasons as to why the site selection criteria was not always applied. This to be provided without delay.

9. Stakeholder Engagement

Engagement with the Public

The Panel held a call for evidence targeting members of the public and stakeholders within the healthcare and third sector divisions. The Panel received various written submissions from the public which are available to view on the States Assembly website. An overview of these submissions is detailed below:

> *I work at Overdale and have done for many years. During periods of poor weather clinics have been cancelled as patient transport/staff have been unable to safely get up the hill, from any road. Due to the additional time taken to get to the site I suspect that more appointments will be cancelled or missed and a demand for more out of hours clinic appointments as people will not be able to access the site quickly in their lunch hour or throughout the day for appointments…*[41] *(anonymous)*

> *I reside at Castle View, a development of 5 houses on Westmount Road. At no point have I been contacted or even considered in this process. I have particular concerns in that my neighbours at Castle View will effectively lose their homes and have to relocate elsewhere within the Island. I have concerns that the value of my property will be severely impacted should the plans be approved...*[42] *(anonymous)*

> *I live in close proximity to Overdale, just off Tower Road at the beginning of Richelieu Park, within 100 metres of the proposed site so the building work and the noise associated with it will seriously impact on our lives as will the future operation of the hospital. Living near Overdale it is blindingly obvious that it is not a suitable site. To place a hospital at the top of an incredibly steep hill is just crazy. I am reasonable fit and yet I still find it a challenge to walk up from town. Westmount and Tower Road are always the first roads to shut in wintery conditions and in the last significant snow to hit Jersey, Tower Road and Westmount were closed for a couple of days. I was horrified to hear the plans to rebuild Westmount Road. I can imagine how the home owners felt to hear the news that their houses are vanishing and the impact it would have on others nearby. The hill itself is has a long history of landslides and instability so will probably end up costing far more than predicted. It has already been acknowledged that it will be challenging and complex…*[43]

[41] Written Submission from Member of the Public 1 – 3 October 2020
[42] Written Submission from Member of the Public 6 - 14 October 2020
[43] Written Submission from Member of the Public - Pippa Dale - 15 October 2020

Why is saving the King George cottages more important than saving Hillcrest homes? We live and work in St Helier, pay taxes and support the local economy in many ways. We deserve to be represented too…[44]

…our houses were being considered in connection with the possible location of the hospital. Whilst possibly a separate issue, my wife and I had our property on the market and had received 2 separate offers to buy. Following some legal advice, we were advised the letter received had to be disclosed to any potential purchasers, which of course we did. Following this, both purchasers stated they were withdrawing their offers until such time as there was certainty as to where the hospital site was to be located. Therefore we have currently lost out on the sale of our property, an issue we will take legal advice on depending on the outcome of this and future decisions. We, as the owners of [redacted], individually emailed Phil Dawes of D2 Real Estate confirming our position that we would be willing to sell to the States. We understood that having the States purchase our properties, it would be one less boundary issue to worry about and the houses could be used in the interim to house workers associated with the construction of the hospital. It now transpires, that shortly after the letters were issued, someone within the States has changed the position and stated that our properties are no longer required…[45] *(anonymous)*

What has seemingly been missed is that the acquisition and subsequent clearing of this land is not as straight forward as simply negotiating with the owners of those three properties. For context, Hillcrest and Castle View essentially form a small estate of 10 private houses, all of which share a single entrance onto Westmount Road. The entrance road, together with several common areas (including a percentage for art fixture beside the entrance), along with essential utilities (including a private sewer system) are in common ownership and there are number of rights enjoyed by all residents of the combined estate over that area. The proposition includes the acquisition of these commonly owned areas, including the sole entranceway to the estate. Therefore negotiation / engagement needs to be made with all 10 of the owners of Hillcrest and Castle View…[46] *(anonymous)*

This is an important issue, as it is a requirement of the Outline Planning Guidance issued by the Planning Minister on 20th May 2020 that there should be evidence of consultation with the public. To date (20 October 2020) there has been nothing that is recognisable as public

[44] Written Submission from Member of the Public – Tamara Vanmeggelen – 9th October 2020
[45] Written Submission from Member of the Public 8th – 14th October 2020
[46] Written Submission from Member of the Public 9th – 12th October 2020

consultation. There was promise of an OH website in January 2020 at a meeting between the Friends of Our New Hospital, the States CEO, DGHCS and the OH Project team, but despite frequent enquiries to ask when it might be published there is no sign of it. However, we are now told that it will go live to coincide with the release of the Functional Assessment on 17th November 2020, which coincides with the States debate on the choice of Overdale as the location of the OH, lodged as P123/2020 on 6th October 2020. In our view the level of engagement regarding the OH project with key stakeholders and the public has been wholly inadequate. Only the States Members can assess the level of engagement they experienced but looking from the outside it would appear they have been kept in the dark along with the public...[47]

The written submissions caused the Panel some concern and they raised the Public's concern with the Deputy Chief Minister to ascertain if negotiation and engagement would be needed from all 10 owners of Hillcrest and Castle View and not just those with homes required under CPO.

Question
As the proposition includes the acquisition of commonly owned areas, including the sole entranceway to the estate, can you confirm you do not need the approval of all owners of the estate/s and not just those required under CPO?

Answer
Yes, this is correct.[48]

The Panel will continue to monitor the possibility of Compulsory Purchase arrangements between the GoJ and the effected residents at Overdale and will recommend the Deputy Chief Minister updates the Assembly regularly.

Key Finding 15

The decision as to what homeowners were directly affected by the Overdale site was subjective and did not take into account the full impact of the highways. It appeared that homeowners not directly affected by the site had not been communicated with initially and only those with properties that would require CPO had been contacted.

[47] Written Submission – Friends of Our New Hospital – 20th October 2020
[48] Letter from Deputy Chief Minister to Review Panel – 23rd October 2020

Recommendation 11

An open and transparent communication and engagement process is carried out with the residents affected by the Overdale site without delay and a communication strategy supplied to the States Assembly. More work should be undertaken via social media on an ad hoc basis and monthly updates in a newsletter/email to encourage full participation. This should begin immediately.

OH Project Team Engagement Process

At its hearing with the Deputy Chief Minister on 13th October, the Panel asked what level of public engagement had been undertaken, or was due to be undertaken. In particular, with those residents who would be directly impacted by the hospital being located at the Overdale site. The Panel was informed that now that the final site had been announced, *"…we are starting to make contact with the broader stakeholders…"*[49]

Within R.54/2019, it is stated that engagement with children who are regular users of the Hospital should take place. At its hearing with the Deputy Chief Minister on 13th October, the Panel asked how this was progressing.

It was explained that whilst there was the social values strategy in place, the strategy document had not yet been shared with POG and, therefore, the level of detail contained could not be discussed at this time. However, the Deputy Chief Minister reassured the Panel that *"…we are rolling out with the education institutions, at all age levels and qualification levels, general qualifications related to the construction industry that we can roll out…"*[50]

In written correspondence to the Deputy Chief Minister on 15th October, the Panel asked to be provided with a timetable of when the 'Our Hospital' Team intended to carry out consultation with members of the public who would be directly impacted by the build at Overdale together with details of which residents they planned to meet.

In a response to the Panel, the Deputy Chief Minister explained they could not provide this information, as it would identify the personal details of individuals. The response went on to say*:*

[49] Public Hearing with Deputy Chief Minister – 13th October 2020
[50] Public Hearing with Deputy Chief Minister – 13th October 2020

...In addition, now that the preferred site has been formally lodged with the States and made public, all the owners and tenants of property adjacent to the Overdale site, who could be impacted by the construction of the new hospital, have been contacted so that any questions and concerns can be addressed. The project will continue to engage with both landowners and neighbours of the proposed preferred site...[51]

The response also explained that any owners of property or land that could directly be affected by Overdale had been in discussions with a property agent from the 'Our Hospital' Project Team since July when the five shortlisted sites had been announced.

On 20th October 2020, following oral questions in the States Assembly, the Deputy Chief Minister circulated a copy of a letter which had been sent to the residents and neighbours of Overdale from the 'Our Hospital' Design & Delivery Partners. The letter contained "…*useful information regarding ongoing engagement with residents in the vicinity of Overdale."*[52]

The letter was to give assurance that the approach to neighbourhood engagement was taken very seriously by the Design and Delivery Partners and that the next phase of community engagement would begin. This would include contacting homeowners, landlords and tenants who lived adjacent to the proposed site. The letter also stated that regular neighbourhood meetings would take place around project progress and timelines, details about construction activity, defined hours of work together with providing hotline telephone numbers and contact details.

At the time of writing this report, the Panel is not aware how much of this engagement had been carried out and is therefore unable to comment further. The Panel will, however, continue to monitor this situation and will recommend the Deputy Chief Minister provides regular updates to the States Assembly on the engagement the Design & Delivery Partners are undertaking.
The Panel requested a list of stakeholders with whom the 'Our Hospital' Team had confirmed engagement with. The confirmed list is below:

- All HCS Staff
- COCG
- Senior Clinicians
- HCS Executive
- Medical Staff Committee
- Citizens Panel

[51] Letter from Deputy Chief Minister to Review Panel – 23rd October 2020
[52] Email to States Members from Deputy Chief Minister – 20th October 2020

- States Members
- Council of ministers
- Connétables
- Future Hospital Review Panel
- SOSG
- POG
- Landowners/Neighbouring Properties
- Media
- General Public
- Friends of our Hospital
- Scrutiny Advisors

Prior to receiving this confirmed list, the Panel had received a more detailed and lengthier list of potential stakeholders the 'Our Hospital' Team was planning to target. This included Health and Community Care, Primary Care and the Voluntary Sector. The Panel is therefore disappointed to find that neither of these 3 key stakeholder areas appear to have been targeted prior to the final site being announced.

Key Finding 16

Health and Community Care, Primary Care and the Voluntary Sector had not been engaged with according to the list provided by the OH Project Team.

Recommendation 12

The Council of Ministers should ensure the OH Project Team engage with the third sector and public health providers without delay.

The advisors also had concern around the level of public engagement and the need to build public confidence. They write within their report that *further public engagement ensuring openness and transparency would have helped*. Whilst ongoing Covid restrictions may have hindered public engagement to some degree, digital public engagements, presentations of the 5 sites discussing the evaluation process and dialogue around the next steps may have helped. The advisors also state *"...given the importance of audit and public involvement, it is disappointing that some form of public site opinion electronically via social media and email could have been built into the results as we have seen elsewhere which builds public confidence..."*[53]

[53] K2/Archus Report – November 2020

The advisors have stated *"…whilst different numbers pertain in the PWC report and more recent notes for the project team of some 200 staff have been involved, a number of the meetings have been unusually small according to records for a project of this size…"* [54]

Recommendation 13

The Council of Ministers should ensure the OH Project Team undertake wider engagement with the public and clinicians to share the current picture, and regular dialogue should be carried out. This should be carried out immediately.

Third Sector/Healthcare Provider Engagement

As part of its own call for evidence, the Panel targeted the third sector and healthcare providers one of which was Family Nursing and Home Care (**FNHC**). The Panel provided a list of questions, one of which was "*Were you consulted in regard to the proposals contained within the Site Selection Document and, if so, at what stages*?"

The response from FNHC was they were unable to answer any of the questions within the Panel's call for evidence as they had not been part of the discussion. FNHC went on to say *"…In terms of community services, I can confirm that our organisation is ready to expand and develop the delivery of community services and is working with HCS on the Jersey Care model. Equally FNHC would support the development of a new hospital, the services within it and any development of services within the community. This process could have been improved by engaging with community stakeholders such as FNHC who are key in the delivery of services in the community and interface daily with hospital services…"*[55]

The Panel also received a response from Diabetes Jersey who also stated they were not involved in any consultation and when asked if the engagement process met their expectations to which they replied:

> *"Since there was no engagement, there were no expectations"*

The Panel also asked what they (healthcare providers/third sector) would change in the engagement process if they could, to which Diabetes Jersey replied:

[54] K2/Archus Report – November 2020
[55] Written Response from Bronwyn Whittaker, CEO, Family Nursing and Home Care – 20th October 2020

The decision on the new hospital's location should remain a political one, but as soon as the States Assembly decides, HCS and the planners should consult with the appropriate elements of the third sector to work in partnership for the benefit of all those for whom the facility is being provided[56]

Key Finding 17

The Panel is alarmed at the lack of engagement with healthcare providers from the OH Project Team.

Recommendation 14

The Council of Ministers should ensure the OH Project Team improve the level of engagement with the public and healthcare providers to share the current position, plus establish regular ongoing communication channels. This should happen immediately.

Mental Health Integration

The Panel questioned if a mental health facility, integrated within the environment of a busy, rapid hospital setting could be unsettling for some mental health patients and a more therapeutic environment should be applied.

The Deputy Chief Minister responded to explain the hospital would be designed to receive any acute patient, whether their ailment is of physical or mental health. *This is to ensure parity of care and access for patients with a physical or mental health presentation. It has not been concluded that the mental health facility will be in the same building. Nor has it been concluded that it will be in an adjacent building, rather it will be located on the proposed site.* [57]

Key Finding 18

Although it has been discussed that mental health facilities will be an integral part of the new hospital build; it is unclear if this will be in the main building or adjacent premises.

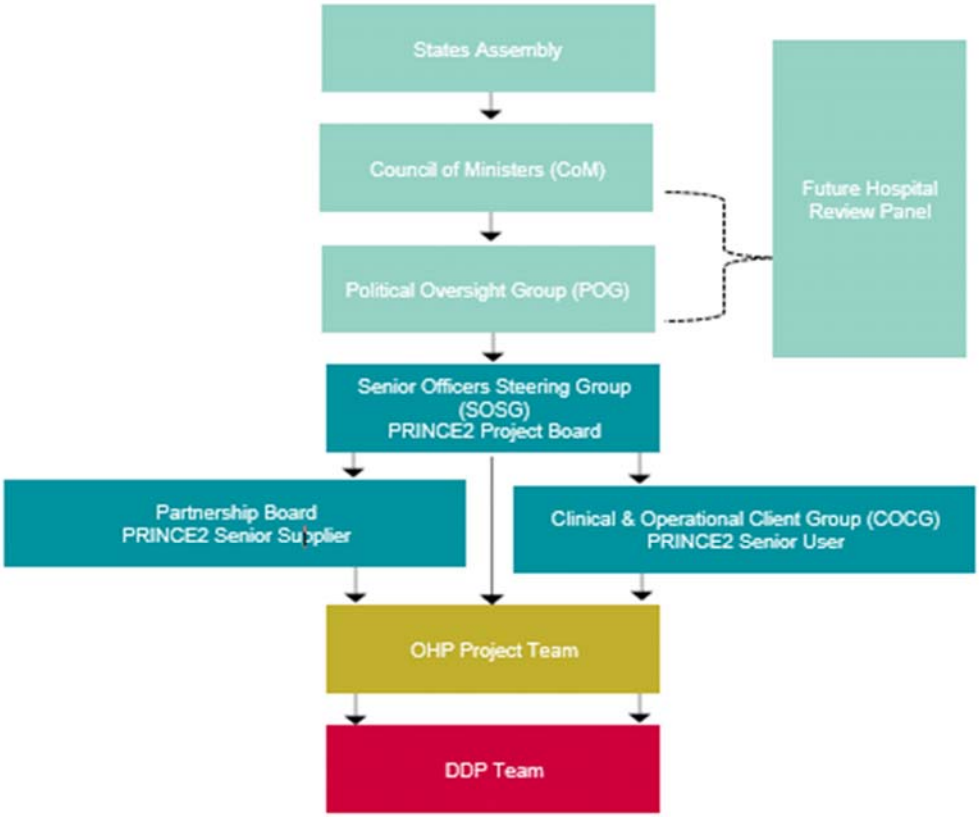
[56] Written Submission from Diabetes Jersey – 23rd October 2020
[57] Letter from Deputy Chief Minister to Review Panel – 23rd October 2020

Recommendation 15

The Council of Ministers, together with the OH Project Team, should ensure a small and appropriate group to include relevant stakeholders should be charged to consider the feasibility and functionality of the proposed mental health facility. This will include whether it can be integrated into the singular building or more likely that it is a standalone facility either on the proposed site or at an alternative location. This should be fully costed and transparent and provided to the Panel within 3 months of presentation of this Report.

10. Ministerial Lines of Accountability

The 'Our Hospital' project has various groups and teams involved. Throughout the Review process, the Panel has questioned the clarity around the lines of accountability. During its hearing with the Deputy Chief Minister on 13th October 2020, the Chair of the Panel questioned the role of POG and its responsibility in the decision making. The Chair was advised by the Chief Executive that the political oversight group makes, on behalf of the Council of Ministers (COM), the operational decisions in relation to the development of the specifications.[58]



The Organisation chart[59] above shows the lines of accountability for each of the groups involved in the project. It should be noted the information in this section is taken from the OH Project Manual which was shared with Scrutiny on 2nd October 2020. The Panel has been made aware the document is a work in progress.

[58] Public Hearing with Deputy Chief Minister – 13th October 2020
[59] OH Project Manual – Work in Progress

Political Oversight Group

The Political Oversight Group (POG) has been established for the 'Our Hospital' Project. The POG provides independent scrutiny and oversight to the delivery of a new hospital as well as making decisions and taking recommendations to COM, who they take direction from. They also lead on Communications outside the project team.[60]

The Political Oversight Group was established in May 2019 and comprises 8 members:

- Senator Lyndon Farnham (Chair) – Deputy Chief Minister and Minister for Economic Development, Tourism, Sport and Culture
- Deputy Hugh Raymond (Deputy Chair) – Assistant Minister for Health and Community Services
- Senator John Le Fondré – Chief Minister
- Deputy Richard Renouf – Minister for Health and Community Services
- Deputy Kevin Lewis – Minister for Infrastructure
- Deputy Lindsay Ash – Assistant Minister for Treasury and Resources
- Deputy Rowland Huelin – St. Peter
- Connétable Philip Le Sueur – Trinity
- *Assistant chief Minister, Connétable Christopher Taylor, also attends the Political Oversight Group as a substitute for the Chief Minister**

Also attending the group by standing invitation are the following officers:

- Charlie Parker – Chief Executive Officer
- Caroline Landon – Director General for Health and Community Services
- *John Rogers*** – Director General for Growth, Housing and Environment
- Richard Bannister – Interim Project Director
- *Andy Scate*** – Group Director for Regulation (*now Acting Director General*)
- *Stephen Hardwick**** – Director of Communications
- Mike Thomas – Director of Risk and Audit

[60] OH Project Manual – Work in Progress

* Does not attend as a substitute. Has attended on 28th August 2019, 3rd October 2019, and 31st October 2019. Does not receive invitations, papers or have any other involvement in the project. (fact checking from Department)

** John Rogers left his position as Director General of Growth, Housing and Environment in March 2020. He has had no involvement with the project since he left his role. Andy Scate has provided continuity, as he is acting Director General

*** Stephen Hardwick left the Government of Jersey in February 2020

Senior Officer Steering Group

The Senior Officer Steering Group (SOSG) acts as the PRINCE2 project board to oversee and direct project delivery. It makes decisions within its authority levels on the approach to be taken to deliver the project. It ensures coordination of the project into other government programmes and departments. It is accountable for the success of the 'Our Hospital' project.[61]

The Senior Officer Steering Group was also established in May 2019 and meets at least monthly, two weeks prior to Political Oversight Group meetings. Membership comprises of:

- Charlie Parker (Chair) – Chief Executive Officer
- Caroline Landon – Director General for Health and Community Services
- *John Rogers*** – Director General for Growth, Housing and Environment
- Richard Bell – Treasurer
- *Andy Scate*** – Acting Director General, Infrastructure, Housing and Environment Department
- *Stephen Hardwick**** – Director of Communications
- Mike Thomas – Director of Risk and Audit
- Steve Mair – Group Director - Performance, Accounting and Reporting
- The Interim Project Director also attends the Senior Officer Steering Group

The Clinical and Operational Client Group acts as the PRINCE2 Senior User, responsible for specifying the clinical and operational requirements for a new hospital for Jersey. It provides a project-level connection to the wider health initiatives via reporting channels to HCS.

This group is chaired by the Director General for Health and Community Services, meets monthly, and has a broad-based, clinically-led membership. Membership comprises of:

- Director General, Health and Community Services
- Chief Nurse
- Group Managing Director, Health and Community Services
- Group Medical Director
- Group Director Commercial Services
- Interim HR Director
- Chief Pharmacist

[61] OH Project Manual – Work in Progress
** - please see reference above
*** - please see reference above

- Head of Mental Health and Associate Medical Director
- Chief Clinical Information Officer
- Associate Managing Director, Modernisation
- Associate Managing Director, Care Groups
- Clinical Director, Our Hospital Project (reporting role only)
- Our Hospital Project Director (reporting role only)
- Consultant Gastroenterologist and Hepatologist
- Consultant General and Colorectal Surgeon
- Head of Finance Business Partnering, Our Hospital
- Policy Principal, Employment and Social Security
- Acting Associate Director Health Modernisation
- Interim Director of Health Modernisation
- Associate Chief for Allied Health Professions and Wellbeing
- Head of Communications for HCS

The Partnership Board Prince 2 Senior Supplier

At the time of drafting this Report, the Partnership Board members was being established.

The advisors had made the assumption that the SOC would be approved by the Senior Officer Steering Group (SOSG). Should this be the case, the advisors were keen to stress the importance of the approvals process regarding the SOC and went on to state that due process needed to ensure transparency and appropriate sequencing of approvals to meet best practice.

Key Finding 19

The lines of accountability should be defined regarding responsibility for the SOC.

Recommendation 16

The Council of Ministers should ensure the OH Project Team have a clear approvals process with agreed and/or delegated authority for each group. This should be set out in relation to approvals to prove due process has been followed and best practice is met. In addition, a single set of performance standards is established and agreed which should be implemented without delay.

11. Relationship of the Future Hospital and the Jersey Care Model

In October 2020, the Health and Social Services Scrutiny Panel presented its Report on the Jersey Care Model to the States Assembly (S.R.5/2010). It is important to note the key areas as to how the JCM and the hospital project will integrate.

While not specifically part of the 'Our Hospital' project, in R.54/2019, the Chief Minister advised that its development was a critical re-condition as it would determine the patient needs for a new Hospital, and therefore the size and shape of the Hospital to be developed. Primarily, the JCM refers to the secondary care model as unsustainable and over reliant on beds, both in and out of hospital.

Within R.116/2019, it is stated the project brief (for the hospital) will be developed, based on the Jersey Care Model being developed by Health and Community Services, including:

- establishing project objectives and measures of success
- drawing up a shortlist of sites for detailed evaluation, based on Planning Guidance that has been requested from the Minister for the Environment
- develop a strategic outline case for the new Hospital

The Jersey Care Model Briefing Paper, R.137/2019 was presented to the States on 31st October 2019 and within it, it was recognised that the future secondary care system should continue to provide many of the existing functions, it also identified key differences to what is now envisaged in respect of the hospital setting, compared to the previous Outline Business Case (**OBC**) for the Future Hospital. Fundamentally, HCS believed at the time that the new hospital should be smaller in scale than originally proposed. It is believed that by improving length of stay, focusing more on ambulatory services and by utilising out of hospital services as an alternative to bed-based care, the bed base could remain a similar level to the current state and therefore circa 80 beds less than the previous OBC (280 beds were proposed in the previous OBC). In addition to this change, R.137/2019 highlighted further key differences to the previous future hospital plan which included:

- Services such as Physiotherapy, Podiatry, Long Term Condition Management and those outlined in Appendix G [of the JCM Briefing Paper] can be partially or fully provided in an alternative care setting outside the hospital including home focussed community care.

- The Outpatient service is proposed to operate in a different way by adopting virtual Hubs for specialist advice and guidance and continuity in care that connects the entirety of the health and care system. The new approach for planned care management and in particular chronic disease management would see the previous 'Westaway Court' concept removed from future plans.
- Capacity in the future building should be modular in nature so that clinical environments can be adapted to reflect demographic pressure areas such as gastroenterology, renal or cancer services for example where increased capacity may be needed.
- The new facility should be co-located with a small inpatient mental health unit (Campus model) so that services can be closer integrated. This will ensure clinical and non-clinical support services are concentrated in one campus rather than spread across the Island as they are currently.
- The new facility needs greater ambition for digital optimisation than the previous scheme, which is again anticipated to impact on the physical scale and requirements of the Hospital.
- The new facility needs to operate with confidence that out of hospital primary, community, social and intermediate care services are managing increased activity, therefore protecting the Acute Hospital capacity for true hospital-based care need.[1]

In the Site Shortlisting Report that was presented by the 'Our Hospital' Team in July 2020, it was advised that an impact assessment of the five proposed sites would be undertaken from a clinical perspective and that the exercise would allow the clinicians to ensure the proposals are clinically led, ensuring the optimum delivery of the brief and alignment to the JCM.

In contrast to what was advised back in 2019 within R.116/2019, the message more recently has been that the Jersey Care Model will *inform* how the future hospital will function, rather than the size and shape of the hospital, but will not *define* the clinical and non-clinical design requirements.

At a briefing in August this year, the Health and Social Security Panel was advised by the Group Managing Director of Health and Community services that the Future Hospital would not be informed by the needs of the Jersey Care Model, as work from the JCM would be delivered in the community before the future hospital was completed. Rather, the Future Hospital specification would be determined by the Our Hospital Project Group through its clinical process. It was further

advised that the JCM would have an impact on how patients use and move through the hospital, which could lead to redistributed pathways and lead to various new outpatient settings, rather than informing the specification and clinical adjacencies of the new hospital.

The 'Our Hospital Site Selection: Overdale' Proposition and Report (P.123/2020) states:

> *...whilst the proposed JCM will inform the development of the functional brief for Our Hospital, it will not define the clinical and non-clinical design requirements…*

Key Finding 20

The Panel is concerned the key message and deliverables of the JCM may have been compromised due to the haste in finding a suitable site for the hospital.

P.123/2020 also confirms that due to constantly evolving models of health and care delivery and the needs of Islanders as treatments and technologies continue to progress, the new hospital will be designed in a flexible way to enable clinical and non-clinical areas to be adaptable with the ability to change in layout and use.

Whilst the JCM Briefing Paper suggested that the future hospital should be smaller in size than originally proposed, it is now anticipated that the future hospital will, in fact, be larger than was considered under the 'Future Hospital' Project. The spatial assessment reports carried out in 2013 concluded the hospital should be 63,644m2 with a footprint of 21,320m2. The new size has been estimated at 69,004m2 with a footprint of 22,243 with basement and 23,243 without. These sizes form the basis of the 2 different options being proposed for the new site.

The Review Panel was under the impression the larger hospital site would be needed due to most of the necessary clinical services to be delivered in the new hospital building being on the ground floor. As previously discussed in this Report, this was a requirement by the hospital clinicians with HCS Colleagues and the 'Our Hospital' clinical director using best practice in other jurisdictions. It was established that the appropriate clinical services would be best delivered on the ground floor. We have also been advised that due to an uncertain future (in light of recent pandemics), the new hospital needs to be flexible to deal with anything that arises and also needs to be future proofed for the next 30-35 years.

Whilst the Hospital Review Panel understands that the hospital is one part of a wider health system, it raised with its advisors if the flexibility allowed within the proposed hospital build would

be able to meet the needs of the JCM. It was advised that "*there was a strong link in early documents but this became more tenuous in later documents which were very hospital specific. Although 15% flexibility is built in, population growth on the Island is forecast at 1% per annum so this flexibility wipes out after 15 years (less allowing for compound growth). So unless there is a focus on new models of care and transfer of activity from hospital to community the hospital (and the site) will come under pressure within about 12 years*."[62]

Key Finding 21

If the care in the community concept within the JCM is not implemented as envisaged, the hospital site will come under pressure within approximately 12 years.

Key Finding 22

There has been a lack of clarity as to how the Jersey Care Model will directly impact the development of the future hospital, which has resulted in a lot confusion amongst States Members and members of the public.

Recommendation 17

The Council of Ministers should ensure the OH Project Team peer review all plans and designs with workforce requirements established. This should be undertaken prior to the agreement of costs.

Recommendation 18

The Council of Ministers should ensure the OH Project Team undertake and provide a full review of the performance standards to include the 2036 capacity. This would include ongoing monitoring of the JCM care in the community concept and targets and should be implemented without delay.

[62] Email from K2/Archus – November 2020

Recommendation 19

The Council of Ministers should ensure the OH Project Team provide the Panel with the project schedules and the block plans using @1:200 scale drawings. These should be created and approved ahead of budget sign off to enable resolution of any outstanding issues.

12. Costs

Projected Costs for Current Project

As mentioned previously in this Report, considerable costs were incurred during the previous future hospital project. These were in excess of £40 million and are explained in the table below. [63]

Costs of the Future Hospital project to April 2019

Summary	Cumulative spend to April 2019	% of total cost	Additional information
	£	%	
Pre-feasibility and feasibility work (2012–13)	576,525	1	
Internal client costs	2,664,713	6	Internal recharging of staff
External advisers	22,085,736	50	Gleeds UK (£14.4 million), Hacquoil & Cook Jsy (£3.2 million), Camerons Jsy (£2.4 million); J3 Jsy (£2.1 million)
Stakeholder engagement	207,991	0	
Property	383,483	1	
Offsite preliminary works	6,079,908	14	Includes work at Overdale
Site acquisition	868,292	2	
Relocation works	8,310,039	19	Includes catering move and Parade offices
Planning fees	639,164	1	
J3 costs	2,645,648	6	J3 is the consortium of Sir Robert McAlpine, F.E.S. and Garenne
Total expenditure to April 2019	**44,461,500**	**100%**	

Period	£	%	
Total spend to May 2018	28,895,809	65	Spend started in 2012, in earnest from 2014–15
Spend June to December 2018	12,315,798	28	
Spend January to April 2019	3,249,894	7	
Total expenditure to April 2019	**44,461,500**	**100%**	

(Ledgers have yet to close for April 2019 so there may be further costs in April.)

The projected costs for the new hospital site at Overdale have been proposed at £550m. There are additional site-specific and non-site-specific costs estimated to be £254m, therefore, the total cost being proposed is in excess of £800 million.

"...The Government of Jersey has negotiated a maximum build cost of £550m for Overdale..."[64]
These costs do not include non-site-specific costs which are anticipated for decant, demolition,

[63] R.54/2019 – Our Hospital Project: Next Steps – Appendix 4
[64] P.123/2020 - Our Hospital Site Selection - Overdale

project development, advice and management for works to decommission the current general hospital.

Table from P.123/2020 [65]

Design and Delivery Partner (DDP) Costs	**Overdale**	**Peoples Park**	**Comparator**
	£'m	**£'m**	**£'m**
Construction of the Hospital	412.2	397.7	14.5
Furniture Fixtures & Equipment plus Decant Fees	55.3	55.3	-
Delivery Partner Contingency	14.7	14.7	-
Site-specific Costs	38.7	26.8	11.9
Pre-Construction Services Agreement	29.2	29.2	-
Total Costs – Delivery Partner	**550.0**	**523.7**	**26.3***

*total is correct for rounding

> *…The total of these additional site-specific and non-site-specific costs are estimated to be £254m for Overdale and £220m for People's Park. This breakdown of anticipated cost is set out below in Table 2. It should be noted that the costs outlined below may be partially offset by operational savings realised (to be determined -TBD) – these savings will be assessed as part of the Outline Business Case…*[66]

The advisors have informed the Panel that in addition to the Delivery Partner costs, this sum of £254.5m which has been identified for GoJ direct costs, including land acquisition, internal costs and optimism bias/client contingency amounts to approximately 30% of the design & delivery partner costs, which is the level expected at this stage of the project.

Contingencies

The Panel has learnt from its advisors that the inclusion of suitable levels of optimism bias and project contingencies within the client budgets appear appropriate for this stage of the project.

[65] P.123/2020 - Our Hospital Site Selection - Overdale
[66] P.123/2020 - Our Hospital Site Selection - Overdale

There is however, a small level of contingency (£14.7m (3.5%)) held within the delivery partner costs and given the complexity of the scheme this is considered to be insufficient. The advisors have state they would expect a contractor contingency of approximately 10% to be included for budgeting purposes.

Key Finding 23

The level of contingency held by the delivery partner (Contractor) of £14.7m, represents 3.5% of £412.2m (being the construction cost of the hospital) is considered likely insufficient given the complexity of the scheme.

Recommendation 20

The Council of Ministers must ensure and evidence that the contingency level for the delivery partner (Contractor) has been increased to the considered normal appropriate level of approximately 10%, which represents £41.22m. This should be put in place without delay.

Previous Project vs New Project

Throughout the Review, the Panel has questioned the costs of the previous future hospital project which was a complete demolition and new build in phases with additional acquired and GoJ sites.[67] The previous project was projected to cost £466 million and as previously mentioned, the current project has a projection in excess of £800 million. The Chair of the Review Panel raised this at the recent hearing with the Deputy Chief Minister and it was explained that like for like comparisons could not be made regarding both projects. The previous project was due to be two sites and the current project is proposed as one site with additional services such as mental health being integrated into the development. The Panel was also made aware that the previous project did not allow for the expansion that was being proposed in the current project. The Chief Executive advised:

> ***Chief Executive:***
> *The estimated costs are more than that that were proposed and we can show that and come back to you on that. But what I was trying to point out is that the current proposed cost estimate is not a like-for-like comparison with the previous cost estimate for Gloucester Street and that is just fact. The £456 million would not have been the final bill for the completion of*

[67] Factual checking comments from Department

the health service as we are proposing at Overdale with a single-site solution, it would have been considerably more. [68]

The Panel's advisors have raised the issue of costs within the table in P.123/2020 which shows a cost of £412.2m for the construction of the hospital itself. The advisors explained that *"...based upon our understanding that the eventual size of the hospital will be approximately 70,000m^2 this results in a cost per m2 of £5,888. We would expect the benchmark cost for this type of hospital to be in the range £5,500 to £6,500 m2. This excludes any premium for building on Jersey versus the mainland..."*

Key Finding 24

Within the documents disclosed it is undefined whether there is an additional cost or premium being allowed for building in Jersey compared with the UK.

Recommendation 21

The Council of Ministers should ensure the OH Project Team provide a documentation detailing how an additional cost or premium is being allowed. This should be provided without delay.

Recommendation 22

The Council of Ministers, together with the OH Project Team, must ensure any Guaranteed Maximum Price (GMP) should not be applied until there is alignment between the clinical 2036 strategy*, the technical specifications (that match the Schedule of Accommodation (SOA) as drawn), the cost plan (including any Jersey island premium), project non works and mapping to the construction programme. Only then can there be a cost of reasonable certainty that can be used as an audit tool and baseline for the project as it develops. This should be undertaken without delay.

**The planning upon defining the new "our hospital" model has worked to ensure that the States of Jersey model of care and clinical strategy is right sized for demographic and non- demographic forecasts and aligned to clinical spatial areas up to the year 2036.*

Within P.123/2020, paragraph 6.2 states '*The Government of Jersey has negotiated a maximum build cost of £550m for Overdale*'. The advisors have concerns around this figure stating *"...it is difficult to understand how such an emphatic statement can be made at this stage. The sum of*

[68] Public Hearing with Deputy Chief Minister 13th October 2020

£550m relates to the 'affordability limit' to be agreed as part of the pre-construction appointment with the Delivery Partner (FCC/ROK). This in turn will relate to the information upon which this figure is based. With relatively little information upon the design of the hospital, site surveys and information, enabling works requirements and scope of highways works there is significant risk that the final sum paid to the Delivery Partner will exceed the figure stated..."[69]

The advisors go on to say *"...To effectively guarantee the costs to deliver the new hospital at this stage of the project would appear to be somewhat optimistic..."* [70]

This statement has been further qualified below:

> *The question relates to us stating negotiated build cost of £550m in proposition. Their statement is correct that we cannot guarantee a cost of £550m at this stage, we have an affordability limit in the PCSA which is a target not to exceed figure that partners are working towards. We do also have a realistic level of optimism bias and client contingency for any changes that we wish to make that are different to the employers requirements. The DP should live within the £550 to deliver the employers requirements. That is why the £550m is challenging and we are very unlikely to deliver below this without compromising the hospital*[71]

Key Finding 25

In the absence of a defined SOC it is considered "somewhat optimistic" to deliver the new hospital within the proposed budget at this stage of the project.

Recommendation 23

The Council of Ministers, together with the OH Project Team should ensure the capital costs include, not only major medical equipment that is detailed and specific, but also building services, IT and digital platforms. This should be undertaken without delay.

Recommendation 24

The Council of Ministers, together with the OH Project Team, should once the initial design of the hospital is established a detailed cost review should be undertaken in order that GoJ are happy they are receiving value for money. This should be undertaken once the initial design process has been signed off.

[69] K2/Archus Report – November 2020
[70] K2/Archus Report – November 2020
[71] Factual checking comments from Department

Recommendation 25

The Council of Ministers, together with the OH Project Team, should ensure a system of regular reviews at project milestones to check the project is on track and progressing within the set budgets should be implemented. This should be shared with the States Assembly by the Council of Ministers prior to each project milestone.

Recommendation 26

The Council of Ministers should ensure the OH Project Team Key understand key risks and costed and detailed mitigation plans put in place. This should be implemented without delay.

Contract

The Panel is aware the use of the NEC suite of contracts is being used for the delivery of the project. The advisors have confirmed this suite of contracts would be recommended for major public projects as it promotes strong project management and risk management as well as a collaborative approach between the parties. Whilst the advisors support the use of this contract, it should be noted that the main construction contract is intended to be an NEC3 (Option C) which shares the risk of cost increases between the Employer and the Contractor. As such the Employer (GoJ) should be aware that there is no guarantee that the project will be delivered on or below the currently forecast figure. However, the delivery partner is incentivised to bring the project in on time and on budget.

Key Finding 26

NEC3 Option C is a target cost contract with activity schedule where the out-turn financial risks are shared between the client and the contractor in an agreed proportion.

The advisors have also made the point that in order for the NEC3 contract approach to work correctly and successfully, all key participants should be familiar and trained in the thinking behind the use of the contract. This would include the project manager plus the delivery partners key personnel. The advisors have recommended that the SOSG and Our Hospital team are also familiarised in the operation and use of this contract type. In addition, they also state "*we also have a view that in pursuing the selection of Mace and FCC that the Our Hospital Project Team*

do not have access to a 'client side' suite of Technical Advisors that can hold the contractors to account and ensure that the client's needs (through the Employer's Requirements) are met. We believe this is a deficiency in the structure that has been adopted and should be rectified."[72]

Key Finding 27

To enable good management of the project and for it to be delivered on time and within the proposed budget, it is imperative that key personnel involved in the project should have knowledge of the NEC3 contract suites, not just the delivery partner.

Recommendation 27

The Council of Ministers should instruct the OH Project Team to implement the relevant training for SOSG and members of the Our Hospital team to ensure they are familiarised in the operation and use of the NEC3 suite of contracts without delay.

Recommendation 28

The Council of Ministers, together with the OH Project Team, should engage a suite of client-side technical advisors that should be contracted to hold the Design and Delivery Partner to account and ensure the needs of the GoJ are being met. This should be undertaken as soon as practical.

Recommendation 29

The Council of Ministers should ensure the OH Project Team provide the Panel with a Risk Register which is developed fully and maintained including full potential costs of risks and their mitigation. This should be provided without delay.

[72] K2/Archus Report – November 2020

13. Business Case and Functional Brief

Best Practice for Public Sector Infrastructure Projects

The benchmark best practice for major infrastructure projects funded through government and public sector is the UK Treasury published guidance under the 'Green Book' or 'Appraisal and Evaluation in Central Government'. The advisors have undertaken this review in line with this guidance and have reviewed the governance, process and decisions/approvals which has been benchmarked against best practice. The advisors have given background on how this process should evolve:

- The Green Book sets out the evolution and development of the Business Case through three key stages which are documented; these being, The Strategic Outline Case (SOC), The Outline Business Case (OBC) and The Full Business Case (FBC). Each of these cases are, in turn, organised into five separate cases; The Strategic Case, The Economic Case, The Management Case, The Financial Case and the Commercial Case. Each of these 'cases' are developed in greater detail as the Business Case progresses with a different level of emphasis at each stage. It is also required to undertake an appraisal of alternative options (the option appraisal) to meet the strategy within the SOC.

The advisors point out the any key decisions that will inform the outcome of any option appraisal should be made or recommended prior to the completion of the SOC however, what is unusual with the 'Our Hospital' project process is that the SOC has not yet been produced.

It would be considered normal for the SOC to be produced and approved at a much earlier stage in the project and to contain the following:

- Strategic Context
- Health Service Need
- Shortlist of Options
- Costs & Affordability
- Timetable & Deliverability

The HM Treasury approval process for programmes and projects (Nov '16) suggests that the SOC should identify a long list of options that will be considered.

Following the sequence of events, the 'Our Hospital' Team have taken, should the SOC not be approved when presented, decisions made on site selection could unravel. *"...Although we*

believe this risk to be small the fact that it exists and the approving bodies of the SOC to some extent have 'their hands tied', means that best practice has not been followed rigorously and the sequencing of events has introduced risk..."[73]

It would appear that at the time the SOC is published:

1. A preferred site will be chosen and therefore a range of alternative options will not be provided
2. A set of Employers Requirements will have been developed
3. A Delivery Partner and procurement approach selected

The Panel's advisors were informed by the 'Our Hospital' Project Team that an early draft of the SOC was produced in April '20 and issued to POG. The completed SOC, which is due to be presented after the debate in November, has not been made available to the advisors. Whilst a draft of the SOC had been made available as recently as 6th November, this was on a confidential basis and therefore the Panel is unable to refer to it within this Report.

It was considered by the Panel the area around the business case needs to be read in more granular detail and is discussed further in the K2/Archus Report which is attached to the Report as Appendix 2.

Key Finding 28

It is considered best practice for the SOC to be produced and approved at a much earlier stage in the project and there is a risk that should the SOC not be approved when presented, decisions made on site selection could unravel.

Recommendation 30

The Council of Ministers should ensure the OH Project Team implement a clear approvals process with defined levels of delegated authority published. This should be implemented immediately.

Procurement

As part of the process in assisting the Panel, the advisors met with Head of Procurement and the Category Manager of Commercial Services within the GoJ to understand the process for the

[73] K2/Archus Report – November 2020

procurement of the PMO (project management office) supplier. The advisors state *"...the process would appear to have been carried out in a fully compliant fashion, leading to the appointment of MACE. The only matter that gives rise to concern is that one of the four interview panel is an ex-director of MACE. We understand that the individual (Richard Bannister) has signed a declaration of non-conflict and that the panel members were all in agreement with the choice made. The procurement of the Delivery Partner resulted in the appointment of FCC, a Spanish contractor. The process undertaken appears robust and in accordance with good practice. The contracting strategy chosen is to appoint the delivery partner under a preconstruction services agreement (PCSA). The PCSA is an appointment to plan, design and procure the works required to deliver the new hospital..."*[74]

[74] K2/Archus Report – November 2020

14. Next Steps

As part of the ongoing work into the new hospital, the Panel may consider undertaking a review into the financial implications of the project. The proposition for the financials is due to be lodged in May 2021 and will require comprehensive scrutiny.

The Panel will also follow closely the possibility of Compulsory Purchase Orders as proposed in P.129/2020 Our Hospital Project: Acquisition of Land at Overdale.

The Panel's advisors, K2/Archus have provided the following information for the Panel's review for forward consideration.

> ***OUR HOSPITAL PROJECT JERSEY ISSUES FOR FORWARD CONSIDERATION BY THE SCRUTINY COMMITTEE***
>
> *The Scrutiny Panel established by the States of Jersey Government to review the proposals and delivery of the island's Our Hospital project has commissioned K2 Consultancy and Archus as external advisors. As advisors to the Panel we have produced a detailed report on the processes and key decisions on the project so far and provided guidance on where these processes could have been improved when compared to best practice. As reflected in our Terms of Reference this is very much a 'backward look' at what has gone on and what could have been done better. However, we believe that there is also benefit in taking a 'forward look' and providing the Panel with guidance and pointers where ongoing scrutiny of the project should be directed to ensure that the project meets its stated objectives within both the required cost and programme constraints. In setting out these pointers we have structured this brief paper under the following sections:*
>
> - *Planning issues*
> - *Cost and Programme issues*
> - *Specification issues*
> - *Ensuring good Governance Planning Issues*
>
> *Our Report sets out the planning issues and risks currently presented by the project given the selection of Overdale as the preferred site. Issues going forward that the Panel should consider include:*
>
> - *Even if the determination of full planning is achieved by the six months projected timescale it does run the risk of challenge.*

- *The Committee can reasonably request what mitigation will be put in place if the decision is challenged.*
- *This is also the case if supporting decisions on compulsory purchase are challenged including from neighbours as well as owners of land/property to be purchased.*
- *The above risks could lead to the call for a full Public Enquiry which will be both time and resource hungry. We are aware that the planning process for the new hospital will involve a public enquiry. After the enquiry is concluded and the Minister makes their determination, (assuming an approval) then there is a residual risk that the decision could be challenged and taken to the Royal Court on a point of law. This will result in a significant delay. A separate check will need to be made to establish if during the CPO process a public enquiry might also occur and impact the programme. This will require specialist legal advice and not part of the expert advisors remit.*[75]

It is therefore considered that the Scrutiny Panel should request a detailed risk identification and mitigation strategy around the Planning issue alone. The risks should be quantified in terms of additional cost and programme delay to the project and to establish what impact that this will have on any commercial agreement with the Delivery Partner. Mitigations should be clearly laid out and reviewed to ensure accountability and resources to focus on a mitigation actions are identified. Cost and Programme Issues Our Report sets out our views on the appointment of Project Managers Mace and Delivery Partner FCC. Through the process there has been much mention of an agreed contract sum of £550 million with a project risk sum of £254 million. However, as our Report points out this contract sum is based on known information at a point in time when project detail is quite low. The risk of cost inflation on the project is high as the detail improves. Therefore, issues to consider going forward include:

- *For the Panel to request regular (quarterly) notifications that the contract sum remains within the £550 million and the quantification of additional project and site related costs and risks remain below £254 million.*
- *If either of the sums are exceeded when reported to the Panel then the Panel can reasonably request a detailed reasoning behind the inflation and what steps will*

[75] Advice provided by K2/Archus received from MS Planning in Jersey

be taken to manage/mitigate the risks that have emerged and bring the forecast final cost back within the approved budget.

The Panel should also seek assurance that the proposed contract sum is inclusive of all Project costs. This should allow for non-works costs, equipment costs (via a bill of quantities), VAT, inflation, optimism bias, a clear split of all project contingencies (for transparency to be split between client contingency and contractor contingency) any island premium for materials and that all "current exclusions" are subject to at least latest provisional sums and are itemised.

- *The Panel can also request assurance that mitigating actions are put in place with clear lines of accountability and responsibility should cost or programme increase.*

This will link to having full access to the Project Risk Register which is a recommendation of our Report. Specification Issues It is our view that a significant risk to managing the cost of the Project and maintaining an affordability cap is the risk of 'specification drift' and 'scope creep'. This is where, as the project develops, requests for additional services or space is made which then leads to increased capital costs. We therefore believe it is reasonable for the Panel to have continued oversight and scrutiny of the key demand assumptions and how they relate to the planned area of the new-build hospital. This will include:

- *The performance detail from the demand modelling for transparency with all key assumptions and facilities inclusions to meet the model of care*
- *That there is a clear statement that all appropriate clinical representatives have signed off departmental 1:200 drawings and that these are consistent with and linked to the Schedule of Accommodation (SoA) and the SoA remains updated to reconcile with latest as drawn areas.*
- *The SoA should include the totality of the hospital and measured inclusive of all plant and communications.*

Where there is a link to absorbing increased capital costs through proposed revenue savings the Panel should seek assurance that there is a full breakdown of the assumptions and amounts for recurring savings that support the overall affordability of the project. Ensuring Good Governance An area of concern set out in our Report is that the route chosen to appoint a 'Delivery Partner' and Project Manager has meant that there is no Technical Advisory team in place appointed by the client that has a duty of care to the client and ensures that the Contractor and Project manager are held accountable for their deliverables against clear specifications. We believe that the Panel should seek

assurances that under the proposed structure there will be regular and visible reporting by the contractor and the project manager on ongoing performance of the Project. HM Treasury recommend the introduction of 'Independent Project Assurance' (IPA). To that end we recommend that a structure of regular reviews by an independent panel is undertaken (progressively and at key Gateways ie OBC Production, FBC Production, Pre-Construction and at periodically through construction) are put in place. These Project and Gateway Reviews can be structured to scrutinise each of the key headings above i.e.:

- *Planning Risk*
- *Cost and Programme Risk*
- *Specification Risk*

This would provide an ongoing and valuable role of the Panel to make sure the objectives and planned cost of the project are met.

Appendix 1: Panel Membership and Terms of Reference

Panel Membership

Senator Kristina Moore (Chair)

Connétable Mike Jackson (Vice-Chair)

Deputy Mary Le Hegarat

Deputy Rob Ward

Deputy Kirsten Morel

Deputy Inna Gardiner

Senator Sarah Ferguson officially stepped down as Chair of the Public Accounts Committee (PAC) on 20th October and Deputy Inna Gardiner was appointed as the new Chair on the same day. Subsequently, Deputy Gardiner became a member of this Panel. We thank Senator Ferguson for all her hard work during her time on the Review Panel.

Terms of Reference

1. To review the decision-making process that was undertaken in determining the final site recommendation, with particular regard to the following:

    a. Fairness
    b. Transparency
    c. Appropriateness
    d. Overall cost, affordability and value for money

2. To assess the methodology and the set criteria used throughout the site selection process and its suitability.

3. To determine the lines of Ministerial accountability in the decision-making process and its effectiveness.

4. To examine the timeframe in which the decision-making process took place.

5. To determine the extent to which previous work, which was produced under the Future Hospital Project, was considered.

6. To assess the level of engagement that was undertaken with States Members, key stakeholders and members of the public.

7. To assess how the development of the Jersey Care Model and its proposals impacted on the decision-making process.

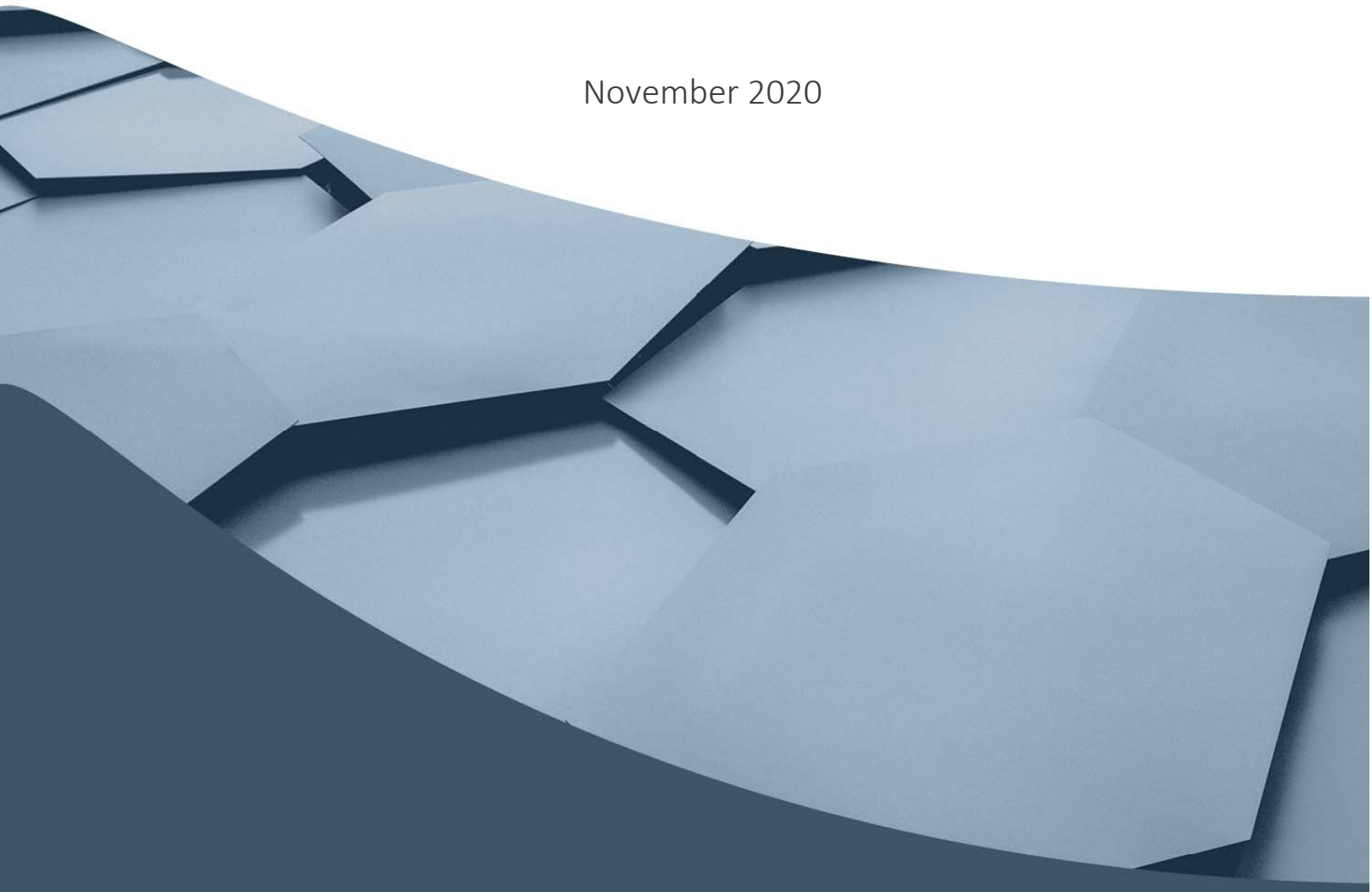
Appendix 2: Advisor’s Report

Review of Future Hospital Site Recommendation: Preferred Option

Our Hospital | Project

Government of JERSEY

November 2020



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Document control

Report title	Review of Future Hospital Site Recommendation: Preferred Option For the States of Jersey Hospital Review Panel
File ref	G:\Southwest\Clients\Jersey\Master GoJ Future Hospital Scrutiny Panel External Advisors Report 2020-11-04.docx
Prepared by	John Setra – Managing Director, K2 Group Richard Darch – Chief Executive, Archus Conor Ellis – Head of Health Strategy & Planning, Archus
Date	4 November 2020

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1 Executive Summary

Our Review has found a Project that has presented a series of challenges to many parties and stakeholders over several years. It is our view that those parties involved in developing the model of care, site selection, the capital program and revenue costings have done so in good faith. However, the gestation of the project has meant that, with the stop start nature and changes in emphasis from a series of different stakeholders, clinical changes and design briefs has meant, any audit was bound to uncover contradictory inputs and risks in the process to deliver the Our Hospital Project .

There is clearly considerable work expounded in the States of Jersey model of care. Broadly our review shows that the future policy, direction, flexibility and sustainability are in line with international best practice. That said, significant work is needed to move from a concept design into a functioning hospital.

We find that there has been considerable investment in clinical managerial and technical teams in supporting the work on the States of Jersey model of care and the functional brief. We would note that the number of engagement exercises, given the time scale and importance, is just about in line with what we typically expect. However, there is no clear functional model in a single document that sets out exactly the performance standards, the clinical and nonclinical specifications and the finalised schedule of accommodation upon which all capital cost and program is predicated upon. Whilst the Our Hospital team have been working on the Employers Requirement, it was not available to the independent review despite requests. Further work has been ongoing on block and scale plans for comparison purposes that would benefit from a review, again this has not been made available to us. The work that has been undertaken is evidenced by, for example, the integration of the mental health facility into a hospital campus or what a stand-alone unit may look like and how it functions. We see the need to understand how a single unit including mental health, could operate safely, providing holistic care, discreetly, for the active management of that care group and its staff. This needs to be proven.

We found that during the site selection process long lists were systematically looked at in line with the Green Book from HM Treasury. The team note that SMART targets were not identified, which may result in the outcomes being considered subjective. There is clearly contention around a handful of sites that were eliminated early in the process and this demonstrates the difficulty of using criteria which are not measurable. The lack of weightings meant that the Red Amber Green (RAG) ratings could be interpreted differently according to technical understanding, site knowledge and perception. The Site Selection Panel adopted a form of the HM Treasury's Green Book methodology of '***Yes, No, Maybe***', when the potential site failed the question/criterion/test and '*should not pass to the next question for appraisal*', and it appears from the outcome matrix that later criteria were then considered even after a '***No***' result had been recorded.

Notwithstanding this, we observe that the application of key criteria has consistently prioritized deliverability by 2026 as the overarching priority. Other factors appear secondary and not of equal weighting. The drive to achieve an operational hospital by 2026 also appears to have impacted the process and resulted in the decision to run a number of activities in parallel that would normally occur sequentially in such a major project. Notably the development and approval of the Strategic Outline Case (SOC). This is due to occur after the selection of the preferred site and therefore out of sequence.

The independent panel believe there is significant risk around delivering either of the two finalised options: in our opinion there was insufficient due diligence undertaken in a rigorous manner to facilitate proper

systematic evaluation - two examples are cited to underpin this assessment. An earlier document for MJ Medical was based on a minimum site footprint for the ground floor, which is referenced as criteria in some of the site selection processes for rejection of some sites. In recent correspondence it has become clear that delivering the solution on the People's Park (one of the two shortlisted options), for example would not have been able to meet this requirement. Secondly, there are elements around compulsory purchase orders around the timing of delivering site access that would mean the overall capital and project timing could not be guaranteed.

The management of the process for the appointment of both Mace and FCC as the 'delivery partner' we find to have been carried out appropriately and to good procurement standards. We would note that the timing of the selection of a contractor (FCC) seems premature when compared against the progress of the SOC but we accept their input will be helpful to undertake technical assessments related to the process of site selection. We note several significant risks remain at large with the preferred site. This includes the time and impact associated with compulsory purchase, the design of the facilities, the highway works and site engineering challenges. The inclusion of suitable levels of optimism bias and project contingencies within the client budgets appear appropriate for this stage of the project. There is only, however, a small level of contingency (£14.7m (3.5%)) held within the delivery partner costs; given the complexity of the scheme we believe this to be a very low sum. We would expect a contractor contingency of approximately 10% to be included for budgeting purposes.

NEC 3 is proposed as the form of contract with the Delivery Partner. Whilst acceptable, this form of contract does have some clauses that have been updated in the NEC 4 version. We have provided GoJ a list of Clauses that we have agreed with NHS colleagues in England that should be subject to careful scrutiny. It should be noted, the GMP element is in effect a target cost. It will be a cost target at the time it is made and relies upon the level of detail and specification available at the time. All projects make changes. In the case of GoJ, any GMP should not be applied until there is alignment between the clinical 2036 strategy, the technical specifications (that match the SOA as drawn) the cost plan (including any Jersey island premium) project non works and mapping to the construction programme. Only then can there be a cost of reasonable certainty that can be used as an audit tool and baseline for the project as it develops.

We also have a view that in pursuing the selection of Mace and FCC that the Our Hospital Project Team do not have access to a 'client side' suite of Technical Advisors that can hold the contractors to account and ensure that the client's needs (through the Employer's Requirements) are met. We believe this is a deficiency in the structure that has been adopted and should be rectified. This would also ensure that the States of Jersey have access to an informed resource who are also able to undertake Gateway Reviews at key milestones of the Project.

In considering the governance there were issues in the tracking of project team members, terms of reference not always aligned to previous documentation and in some cases a lack of reporting. This would include the lack of formal minutes and regular reports of a detailed nature through to committees of the States of Jersey. Again, this is not to undermine the reports written but detailing and describing major complex events and process in summary documents can overstate or overlook material risk factors which, for good practice, should be recorded fully. We do not feel that transparency has been in any way deliberately opaque, however, the process has been hindered by a lack of criteria with clear guidance to avoid the site selection process looking loosely defined or subjective, which could appear the case.

The advisory team accept the findings of the site selection process which did not shortlist the Gloucester Street site. It has not been part of our review work, but we make 3 comments. Firstly the ability to recreate a modern health campus to the proposed GoJ brief for 2036 and beyond (70,000sqm²) means substantial change in existing site layout on a congested existing site, with little room to easily expand and meet the clinical and environmental standards would be extremely difficult. Secondly, the costs and speed of building additional facilities, refurbishing existing facilities becomes both slow to develop and high risk to meet cost parameters. Finally, for buildability contractors also need adequate space to develop and decant on a busy hospital site. In our experience with the amount of building work required versus the return on investment and matching the clinical brief, this site was understandably excluded from the shortlist.

In the final section of this report we offer good practice and next steps that, in our view, should be undertaken over the coming months to ensure the Sates of Jersey Our Hospital plans are delivered accordingly. From the evidence provided we accept that no one site will achieve total consensus or generate full support of the public, politicians and stakeholders. Whilst the site selection process could be criticized in several areas, to reopen the process will cause significant delay and further cost.

We also aware of the need to spend public money wisely and obtain value for money. We are highly conscious of the substantial costs incurred already and the time spent to date in attempting to deliver this project. As at April 2019 a total of £44.5m had been spent which will have now been increased significantly due to the recent work carried out by the OH Team and the Delivery Partner. This should not, however, mean that the review panel can sign off this process without identifying the need, on behalf of the scrutiny committee, for further work. We believe that there is a need for further due diligence around the long term fit of the proposed design solution that reviews the proposed link between projected activity to the clinical model, workforce, and space requirements to a drawn Gross Internal Floor Area (GIFA). The as-drawn area can then be reviewed alongside the chosen contractor to understand the programme and cost implications. This would provide the Scrutiny Panel with clear evidence of the deliverability of the proposed Programme and Cost (capital and revenue) with a greater degree of assurance than we believe is available currently.

2 Background

In May 2019 the Chief Minister announced proposals to the States Assembly for establishing a new programme for delivering a new Hospital for Jersey. He proposed a three phased approach for the '*Our Hospital*' Project which:

1	2	3
establish the agreed clinical requirements of the new Hospital	use the outcome of this to scope the size and shape of a new Hospital to inform the shortlisting of potential locations	involve a thorough process of Island and stakeholder communication and engagement on those locations, alongside technical and financial assessments of deliverability, in order to identify a preferred site for the Government and States Assembly to consider and approve.

The preferred site has continued to be the subject of political and public debate since 2012. In its role of providing ongoing scrutiny on behalf of the citizens of Jersey the Scrutiny Panel commissioned external advisors to review the process adopted so far in reaching the current proposals for the delivery of the Our Hospital project.

The K2 and Archus appointment was confirmed, and the information review commenced on 23rdSeptember 2020. The K2/Archus team was led by:

- John Setra – Managing Director, K2 Group;
- Richard Darch – Chief Executive, Archus;
- Conor Ellis – Head of Health Strategy & Planning, Archus.

As external advisors we had organised a wide range of meetings with stakeholders of the Project. We were also provided with an extensive amount of reading material and a Microsoft Teams channel was set up to share confidential files and information (See Appendix 1). A series of meetings and Panel sessions to ask questions, observe, and gather information have been held with:

a. Future Hospital Scrutiny Review Panel;
b. Technical Briefing 2 – Re Final Site (OH Project Team);
c. Political Oversight Group;
d. Clinical Director;
e. Interim Project Director;
f. HCS & Senior Responsible Officer;
g. GoJ Finance Team;
h. Delivery Partner (FCC/Rok);
i. Public Hearing – Deputy Chief Minister;
j. Procurement – Delivery Partner (FCC/Rok);
k. Procurement – PMO (Mace).

The team also provided a draft list of questions for the Scrutiny Review Panel (Public Hearing). Initial feedback and several briefings with the Future Hospital Scrutiny Review Panel including

- Letter to Deputy Chief Minister – follow up questions;
- Initial Thoughts & Findings.

The report is structured according to the main areas the team was asked to comment upon.

3 Functional Brief

3.1 Development of the Functional Brief

The development of the latest version of the Functional Brief goes back to 2012 when the Health and Community Services ('HCS') engaged with the Island's health community in developing the 'Jersey Care Model'. This model set out the planning for primary, community and hospital care and was the vision for the future configuration of services and location of those services, whether at home, in community facilities or in hospital. It therefore became the foundation for establishing what services should be provided from the new hospital. Since 2012 the HCS has examined and recorded what has changed and updated the model to take account of developments in clinical and healthcare practice and technology, tailored to the Island context.

The development of the Jersey Care Model was a critical pre-condition, because it will determine the patient needs for a new Hospital, and therefore the size and shape of the Hospital to be developed.

The most recent draft functional brief for the Our Hospital project was developed in April 2020, in partnership with HCS, clinicians and health professionals. It was based on:

- The vision of the Jersey Care Model ('JCM');
- Demand and capacity modelling by PwC, taking into consideration demographic modelling and service transformation opportunities outlined in the JCM;
- PWC were asked to consider the overall Jersey Healthcare model and ensure the workforce ramifications, IT and transformation aspects alongside next steps by care pathway;
- High-level modelling assumptions developed by:
    - MJ Medical Health Planners;
    - HCS Executive Team;
    - Clinical Director for the Our Hospital project, who provided independent challenge based on expert knowledge of hospital estates in other jurisdictions.

We note the process of linking the JCM to the development of block plans has evolved over time ahead of the detail that would normally be required to have reached a preferred option.

3.2 Clinical and economic benefits

The initial functional brief highlighted several clinical and economic benefits, including opportunities to:

- Bring clinical services onto one site, or a main site and a nearby, smaller ancillary site;
- Improve wellbeing amenities for patients and HCS staff;
- Support the transformation of health and care services in line with the vision of the JCM;
- Rationalise HCS estates and make efficiencies in terms of land use for health and care delivery:
    - The current General Hospital covers an area of c38,630m2 of space over a number of floors;

- A 'lift and shift' new build, designed to the necessary specifications of the current delivery model. incorporating current services only, is estimated to cover an area of c55,500m2 i.e.The hospital team could have had an option to simply replicate the hospital as it stands but on a new site, the lift and shift option using present standards would have been expected to be in the region of 55,000sqm2 allowing for recent guidance;
- The proposal for 'Our Hospital', taking account of proposed requirements of the Jersey Care Model, would cover an area of c69,000m2. (The proposal for 'Our Hospital' allows HCS to vacate an additional c34,000m2 of space across several sites.

3.3 Scenario Modelling and Options Appraisal

Two scenarios were developed:

Option One

Design a new hospital based upon the current approach to delivering care in Jersey, modernising to meet contemporary guidelines for clinical areas, with an increased bed base due to demographic changes and projected disease profiles.

MJ Medical Health Planners, HCS representatives and the project's Clinical Director established that the minimum ground floor footprint areas of the new hospital for Option One would be 40,966m2 consisting of:

- Main site ground floor arrangement that would be supported by a separate site facility alongside the main building, housing appropriate clinical and support services. This ancillary site would be directly adjacent or up to 50m away
- Essential ground floor hospital area requirement (including external circulation areas) of 23,243m2.
- Adjacent site of 8,504m2
- Car parking – 800 spaces over 2 x floors equating to 9,219m2 (or utilise existing car parking capacity)

Option Two

Design a new hospital based upon the proposed Jersey Care Model, to develop community and ambulatory care settings, reducing the need for a significant increase in the acute inpatient setting

A minimum ground floor footprint area of 35,699m^2 for Option Two was established, comprising:

- Main site, including basement that could support the operation of the hospital. This allows the total ground floor area to be marginally smaller than Option One and enables essential support services to be co-located within the new hospital building without the need to increase the building's height to incorporate an additional service floor. This option retains the need for a separate facility alongside or close to the main building, but this site could be further away – clinicians agreed that some services, including estates, staff wellbeing centre and administration could be up to 15 minutes' walk from the main building.
- Essential ground floor hospital area requirement (including external circulation areas) of 22,890m2
- Adjacent site of 3,590m2
- Car parking – 800 spaces over 2 x floors equating to 9,219m2 (or utilise existing car parking capacity).

3.4 Impact on site selection

The work to establish a minimum floor/site area was undertaken for the purposes of site shortlisting and does not represent a brief for the final design. A final design brief will be developed for the preferred site, once identified and approved.

The minimum ground floor footprint of both Options One and Two was applied to each of the sites on the long list of potential sites at c23000m².

3.5 The updated Functional Brief

Jersey Care Model and Fit

The Jersey Care Model (JCM) has evolved over several years. There are three critical elements to the evolution of the model to where it is today; these being: the PWC study, the EY option appraisal and the MJ Medical 'Kit of Parts'.

PWC Report

We find the PWC report on the JCM comprehensive and in line with the types of inputs typically provided for new hospital projects.

The scenario presented looks at a plan from 2021 to 2025 and up to 2036; it demonstrates significant change up to 2036. This change may reflect where the JCM currently is, however because by 2036 the population of Jersey is anticipated to increase by 19%, inflation is at 3% per annum and an age demand increase of 31% there is a clear need for reform and change.

Table 5 from the PWC Report presents the assumed impact on hospital activity in each care area that the JCM would have. The shifts are rather radical, particularly in ED where the reduction in attendances is greater than that which is typically delivered in the short to medium term. The shift from ED to UCC (Urgent Care Centre) and Primary Care is an internationally accepted process, however the speed and scale of the transition in Jersey would be challenging.

The JCM is predicated on a UCC being developed off site; whilst this is normal practice, given the size of the island, the workforce, costs and viability associated with establishing a UCC off the main hospital site will need close scrutiny, unless the location of the UCC is sufficiently far from the existing acute hospital to be of value.

Table 5: Assumed impact on hospital activity on care areas

Area	Assumed impact on hospital activity
ED	Reduce total ED attendances by 10%
ED	Reduce ED attendances age 65+ by 18%
ED	65% of remaining ED attendances go to the UCC, taken from non-urgent and standard activity
Inpatient	Reduce hospital admission rates by 17%
Inpatient	Reduce length of stay for stranded patients by up to 25 beds
Inpatient	Reduce mental health bed days by 27%
Outpatient	Move Trauma & Orthopaedics (23%), ENT (12%), Ophthalmology (7%), Community Dental Services (90%), Gastroenterology (20%), Podiatry (50%) out of hospital
Outpatient	Move Dermatology (12%), Cardiology (32%), Neurology (30%), General Medicine (35%), Respiratory Medicine (50%) follow-ups out of hospital
Social care	Move residential care placements by 70% and nursing care placements by 46%

There is a clear caveat noted on the extent to which the UCC location and workforce will impact the decision to locate the UCC outside the main hospital campus.

The JCM report highlights the impact on the following care divisions: Mental Health Support Services, Intermediate Care, Primary Care, Women and Children's, unscheduled care and adult social care. However, there was very little detail relating to the impact on the Women's service as the Women and Children's section only included Acute Paediatrics and Community Care.

The PWC report finds that "overall the model is in line with group practice for integrated care" (p 26) and we would conclude accordingly.

A series of workforce reviews provide good explanations for how the workforce will be managed under the JCM. However, further refinement of workforce requirements is necessary to underpin the savings suggested by the JCM. We presume this has already been checked.

The digital enablers and the use of Kaiser Permanente's (US Health System) risk stratification of social prescribing, of crisis prevention, of Primary Care Intervention and the links to Social Care are all established practice.

EY Options Appraisal

The JCM was subject to an Ernst & Young (EY) Options Appraisal Summary of several functional areas which commented on the projected benefits and risks of co-locating services onto one site.

Currently, there is limited uptake of private patient services on the island, as there is no difference between the private patient service and the normal service. 30% of Islanders have private health insurance but most of them receive their private healthcare off the island, for example, in Southampton. HCS are developing a private patients' strategy for the island as it is considered that improvements within the private patient services, for example higher specification rooms with an ensuite and better nursing to patient ratios, coupled with more effective marketing, would encourage patients to seek private healthcare on the island. Private patients are expected to generate a revenue but quantifying this requires further work.

The existing Mental Health facilities are in a poor condition and are causing operational difficulties. The Mental health facilities need to be redesigned, so that the current and future Mental Health needs of the population are met. The JCM proposes that the Mental Health facilities are re-located to the OH Hospital from St. Saviour's Estate. The size of the Mental Health facility will be reduced from 12,980m2 to 11,836m2. Reduced building running costs will provide future revenue savings which could be reinvested into Community Mental Health Services. Consolidating existing areas will also provide capital from the vacated building. There will be no service delivery savings. The JCM recommends that the Mental Health Unit be closely integrated with the main hospital. However, if the Mental Health facility is on the main Hospital campus but is not within the main hospital building, there will be additional costs associated with staff and patient facilities, unless the Mental Health facility is sufficiently close to the main hospital.

The Engineering and Estates require an area of 1,557m2, up from 691m2. This increase is large and is needed so as to meet the current building standards. This larger area will have both increased building running and financial costs, these could be partly offset by efficiencies from co-location, such as cross-skilling of teams. Additionally, capital receipts could be generated if all services are re-located to the new hospital site.

The Equipment Library and EBME (Electrical & Biomedical) Workshop requires 799m2; a comparison cannot be made between the current size as it was not provided. Co-locating the equipment library from three separate sites to one site will lead to reduced transport time, fewer duplicate purchases and cross-skilling of teams.

The Theatre Sterile Supply Unit (TSSU) area required could decrease from 3,739m2 to 1,029m2. Currently TSSU is at Five Oaks and includes laundry and central stores. If TSSU was relocated there could be a potential £1.5 million capital receipt from the estimated land value, helping to reduce the overall capital spent. Additional efficiencies from relocation would be a reduction in travel time and storage space required.

Currently, patients requiring radiotherapy for cancer treatment must travel to another acute Trusts in the UK to receive it. This is not ideal. However, off-island tertiary care may lead to better health outcomes which needs to be considered. The Cancer Strategy is being developed to understand whether it is viable to bring more cancer services to Jersey. The expected size of the Cancer Centre OH is 4,094m2 this would lead to significant capital and building running costs that would be difficult to recover through service savings. Economies of scale would be challenging as the population in Jersey is small and it is likely that expensive equipment would be under-utilised. However, there is a future financial risk with the current service, as UK providers (such as Southampton) may increase tariffs for Jersey. Whether this financial risk would mitigate the cost of the cancer service on Jersey would require further research.

The Knowledge and Training Centre area will increase from 1,293m2 to 2,714m2, this area is much larger than the standard area required in both small and medium DGHs for an Education and Research Centre (954m2). Currently, Wessex Deanery sends approximately 40 Junior Drs to Jersey, these Drs require a Knowledge and Training Centre for ongoing professional development. These Drs are needed to prevent substantial understaffing leading to significant clinical risk. The Knowledge and Training Centre must be close, if not on, the main hospital site to ensure utilisation.

The catering department requires an area of 1,000m2, the current size is unknown and so a direct comparison cannot be made. This is much greater than the area required in a standard SOA for a small District General Hospital (DGH) (539m2) and medium DGH (734m2). The catering facility is 18 months into a new refurbishment, a minimum of 7 years is required before the hospital is operational. Once the hospital is being built, it is likely that a break cause can be invoked on the lease. However, if this is not possible and the contract cannot be terminated early, there is a risk that £313k would have to be paid annually for the St. Peter's facility. There could be additional revenue from the private inpatient service via a "chef-on-demand" service but this would require more financial analysis and is unlikely to provide significant income.

Our Hospital Kit of Parts MJ Medical (July 2020)

We understand the narrative offered for the components designated 'essential' on the main hospital site. However, the interpretation of the rationale for the c23,300m2 area required for the ground floor accommodation is slightly surprising. All Hospital's require the following areas (these tend to be on the ground floor if possible):

- An entrance area, however, the proposed size of the area is extremely large given the volumes predicted;
- An Emergency Department;
- Several diagnostic facilities, including imaging, with office space often above the ground floor;
- A pharmacy, with office space often above the ground floor;
- A mortuary and post-mortem area;

- A TSSU.

The proposed ground floor area on the main site includes 2403m2 to allow for 15% future growth capacity and 2764m2 for the courtyard lightwells. This is not the typical methodology. Furthermore, there is additional areas for ambulance/blue light drop-off, parking, PTS drop-off/pick up and the main entrance/visitor drop off. This additional space increases the total ground floor area required from 16,024m2 to 23,243m2. Whilst this matrix was mandatory, one wonders whether the site selection process may have been helped by a less prescriptive smaller scale ground floor requirement by splitting some departments, which is commonplace.

There is a ground floor requirement for physiological monitoring, the entire acute floor, Orthopaedic outpatients and the Mental Health Facility. This requirement may have narrowed the options available for Jersey Health and Social Care for site selection. It is not best practice to have an integrated Mental health facility, and whilst the official position is that the location is still being considered, the integration onto the main hospital as shown as a proposed design solution on block plans is not evidence based. Providing a separate facility is likely to challenge the brief with support accommodation being needed over that of a hospital, nevertheless it is the right direction to plan for.

Whilst this is a matter of clinical judgement, we note that the fresh cook kitchens/stores are estimated at 1,000m. We presume this is now subject to detailed work. We note that only the adjacent building and ground floor has been supplied and not the upper floors, this is unusual and a single set of SOA for the entire building as drawn should be available to the Scrutiny Committee for transparency.

The MJM paper reviewed also provides a narrative on the support services, engineering states and knowledge centre. It gives two options; first is 13,587m2 and the second is 12,807m2. This is generous, both in comparison with other areas within the hospital estate and compared with our experience of other new hospitals we have planned in the last 12-18 months. This may well have been rationalised over the past few months, but we remain unsighted.

It is stated that the car park needs to be ideally within 50m of the hospital; however, this is extremely ambitious and a one minute travelling distance will only work for a small part of the site, the key is good public transport access, good drop off, accessible space in close proximity to the main entrance and cycle/pedestrian routeways, safety being built in from the start.

Site Performance Standards and Function Brief

The response received on Wednesday 28th October 2020, to our previous request for access to the performance standards of the hospital indicated that there is not one single document for this but there is a collection of documents.

In correspondence received from the Chief Ministers Department the development of the Functional Brief is based on the following:

- Previous work by the Future Hospital project;
- Sense checking from HCS Executive meetings and their operational data;
- Meetings with all AMD's (Senior Clinical Leaders with Operational Responsibility for the clinical services) and their relevant managers;
- JCM strategic documents;

- Stress testing of JCM assumptions undertaken externally by PWC and then supported by this external review;
- Oversight by COCG (a different set of Senior Clinicians and Managers in HCS);
- 43 Clinical user group meetings (involving over 200 staff) to critique and challenge the Draft Functional brief looking at the assumptions and predicting the future Healthcare and operational needs;
- External Review by the Clinical Director benchmarking against other international healthcare models.

This however should have been turned into a series of clinical and non-clinical specifications which should then link to clinical adjacencies and dovetail to form a matching Schedule of Accommodation (SoA). This work may be underway, but we are currently unsighted on this, nevertheless it would represent best practice.

3.6 Summary

Findings

We find the PWC report on the JCM comprehensive and in line with what we would expect from a project of this scale. We agree with the movement of clinical care from ED into UCC and Primary Care; however, we have concerns about the speed and scale of this shift. We broadly agree with the EY appraisal and recognise some of the points raised require further investigation. The Kit of Parts Report explains the rationale behind the c23,000m2 for the ground floor of the hospital, however we question the methodology of the selection of that scale, given the sub 70,000 sqm² overall size of footprint required

However, further challenges remain such as, clarifying the design deliverables and the clinical strategy. Additionally, there has been no access for the advisory team to performance standards which we would typically expect to review. Our position remains that we would suggest a matter of urgency a review to bring together a single performance standard and set of assumptions; all of which could alter the technical requirements.

The assumptions should be reviewed independently to ensure they are

- Up to date with similar performance of small/medium DGHs
- Include post covid/pandemic planning
- Include latest activity 2020/21 and suggested demographic and non-demographic changes aligned to the 2036 baseline suggested by the Project team.

Despite requesting the GIFA for the block drawings that we have seen in the Scrutiny sessions, the project team felt it was inappropriate to share it with the review team ahead of the Employers Requirements being released in November. Specifically, the response from the Project team is noted: “The current GFAs don’t match the MJM minimum areas used for site selection because they were minimums, and the new ones are actuals”. We have concerns about this policy as it would indicate that there might well now be a risk of a higher area total over the MJ schedule. This could cause capital, revenue and programme increases. Without access to the design team’s drawing models there is no way of scrutinising this aspect, so it must sit as a notified project risk under design team optimism bias.

We find it is possible that the performance standards, block plans and current as drawn GIFA may not align. This needs a full review. We further would suggest that the Mental Health unit is not suitably located inside the main hospital unless it can be attached to it as a discrete and separately identifiable unit. However, this is hard to deliver in a design of something of this scale.

Recommendations and Next Steps

We recommend that an independent party is given access to the performance standards of the current hospital in order to validate those parameters and to ensure they link to a full drawn SOA. If needed this should be updated, ahead of any decision being taken on the final site selection decision to ensure proper transparency of process. This would remove the risk of scope change or any capital and revenue gap that could lead to revision at a later stage, if for instance the areas have increased, the Scrutiny team would want to understand the timescale and project cost implications.

We agree with the action points from the PWC model of care report. Many of these would also be prudent to agree on the operating model, ensuring it accords with the plans of the project team and are sustainable in terms of proposed staffing and the long-term revenue costs. It would be helpful to have working meetings with the clinical fraternity to assure strategic alignment.

Our position remains that we would suggest as a matter of urgency, that there is a review which brings together a single performance standard set of assumptions that aligns the functional brief with clinical and non-clinical policies, which in turn accord with both the drawn SOA and the cost and programme.

4 Engagement process

4.1 Public and Citizens' Panel

Function of Citizens' Panel

After some familiarisation sessions the Citizens' Panel worked with a facilitator, to establish the criteria they thought were important in determining the site for the Hospital. The Citizens' Panel was supported by colleagues from Health & Community Services to ensure that the process of developing the criteria was primarily based on clinical requirements. In a session following the workshop, the criteria were prioritised, and subsequently approved by the Citizens' Panel.

The Site Selection Panel later ratified these criteria which were used to reduce the long list from 17 sites to five. The Site Selection Panel consisted of:

- Director General, Health & Community Services;
- Clinical Director, Our Hospital project;
- Interim Project Director, Our Hospital Project;
- Chief of Staff;
- Director of Natural Environment.

We have been advised that the Site Selection Panel was also supported by technical advisors from:

- Jersey Government Highways & Infrastructure;
- Jersey Government Town Planning;
- Hospital Planning, Architecture and Design.

Attendances, notes of meetings or specific advice given has not been provided so we are unable to comment as to the effectiveness and impact of the support provided

The criteria that were deemed more important by the Citizens' Panel were applied first, with subsequent criteria applied in accordance with the prioritised sequence agreed by the Citizens' Panel. It should be noted that the Site Selection Panel considered some criteria to be less definitive, for example whether the site was a greenfield or brownfield development.

Observations - Our Hospital Citizen's Panel – Selection Methodology Statement, December 2019

From the outset, the original outline of the Citizens' Panel selection method was established to ensure a viable process. Applications were open for 3 weeks and 43,000 responses were received by the social media campaign. Originally, it was envisaged that there would be 4-5 sessions over a 4-8 week period. The selection process would include population stratification in line with the island's gender and age demographics. Further measures were applied, such as no sitting politicians, no criminal convictions and no existing health and social care staff, to ensure consistency and to avoid pre-existing prejudicial viewpoints.

As described above, the Citizens' Panel was established with a suitable methodology and terms of Reference were developed for this group. There were only 17 members of the Citizens' Panel and there has been no record provided (for confidentiality) specifying the membership details of the Citizens' Panel. Therefore, it cannot be confirmed that the Citizens' Panel was truly representative of the island but is presumed to be so.

The facilitator for the group is not named and therefore we are unable to comment on whether they had suitable experience and knowledge to develop Critical Success Factors (CSFs), as advised in the HM Treasury Green book. It was stated by the project team that he was highly experienced, and certainly users stated in feedback sessions the process and facilitation had worked well.

CSFs are a number of criteria used at the long list stage to make strategic choices about options. They should support an assessment of how well an option is likely to succeed across the five dimensions of a business case and deliver SMART objectives. The selection criteria should be developed around key CSFs, such as:

There is not one mention of CSFs in any of the documentation received. In addition, where it is stated that the Site Selection Panel adopted a form of the HM Treasury's Green Book methodology of 'Yes, No, Maybe', when the potential site failed the question/criterion/test and 'should not pass to the next question for appraisal' it appears from the outcome matrix that later criteria were then considered even after a 'No' result had been recorded.

We have been advised and the Department has confirmed in a public forum that the criteria were applied in a sequential fashion and not weighted. Supportive documentation was not provided to advise how the chosen criteria were 'priority sequenced'.

Furthermore there were no operational clinical staff or end users on the site selection panel, or indeed on the Citizens' Panel who would have had a more detailed understanding of the potential location, particularly regarding the patient population and services to be delivered. It is also not specified what detail the Site Selection Panel had for each of the sites. Supporting minutes of the appraisal session should be read in conjunction with the final outcome matrix to provide assurance that a logical and robust assessment took place. This would highlight the consistency of decision making and identify whether there were any strong objections to the final decision by members of the Site Selection Panel.

The 5 sites shortlisted at the end of this appraisal were the same 5 locations that did not have any negatively persuasive comments, about the site being difficult and in an unsustainable location, when the original list was refined into the long list. This would suggest that the Site Selection Panel possibly already had appraised several sites, which by then limited the scope of the Citizens' Panel.

4.2 Public Engagement

The announcement of the 5 shortlisted sites on 13th July 2020 naturally created a significant public reaction and generated discussion across the Island. Following the announcement, the public were given a leaflet directing them towards the official GoJ 'Our Hospital' website. On this website was a Feedback Survey to allow the public to identify criteria that they consider important for the preferred site. Over 600 islanders participated in this Feedback survey, the results of which would suggest that the opinion of the respondents corresponds to the recommendations of the report for the desirable criteria for preferred site. We believe a full assessment of the written comments of respondents still needs to be conducted.

The public engagement strategy going forward into the second stage of the Site evaluation period is being developed with the 'Our Hospital' team.

It is likely that further Public information, ensuring openness and transparency would have helped. Due to ongoing COVID restrictions this could have been in the form of a digital public exhibition; presenting retrospectively the 5 sites, the evaluation process, key characteristics/criteria and the next steps. Given the importance of audit and public involvement, it is disappointing that some form of public site opinion electronically via social media and email could have been built into the results as we have seen elsewhere which builds public confidence.

4.3 Clinician Engagement

The interim report stated that a detailed clinical engagement programme commenced after the short listing. The following groups met for two Clinical rounds and two Site Brief rounds in August 2020:

- Emergency Department including UTC
- Acute Floor
- Diagnostic Facilities for Radiology & Physiological Monitoring
- Pathology
- Mortuary & PM
- Pharmacy
- Theatre Suite
- Critical Care (ITU & HDU)
- Ward Central Core
- Inpatient Beds
- Private Unit (OPD/Theatres/Beds/Lounge)
- Outpatients Public Entrance
- Outpatients Unit – Orthopaedics
- Outpatients Unit
- Renal
- Maternity
- Medical Oncology Chemotherapy Treatment
- Women & Children's Entrance
- Women's Unit – Obstetric & Gynae Outpatients
- Women's Unit – Obstetric & Gynae Inpatients
- Newborn Unit
- Paediatric Inpatients
- Paediatric Outpatients
- Mental Health Centre
- FM Support – non clinical
- Engineering & Estates
- Equipment Library & EBME Workshop
- TSSU
- Catering
- Public Entrance
- Cancer Centre
- Staff Wellbeing Centre
- Knowledge & Training Centre
- Administration & Office Accommodation

A 'Healthcare Survey' of opinion was undertaken, which investigated which criteria were desirable at the preferred site. Although the sample size of clinical and professional respondents was relatively small, the results would suggest that the sites less favoured by the clinicians and professionals who responded to the survey correlate with the recommendations of the report. A full assessment of written comments still needs to be conducted.

4.4 Summary

Observations

Overall, the Site Evaluation report includes all necessary details that would be expected at this level. Specialist advice was sought regarding Land Acquisition, economic appraisal etc. and both clinical and non-clinical stakeholders were engaged in the process on both a clinical and site/location perspective. K2/Archus would like to see how this has been developed to produce the final report stating the preferred opinion, and involving more in public opinion surveys, post full due diligence on all 5 sites, given the importance of not only getting the right site result, but involving the ultimate stakeholders.

The report identifies issues around existing occupants, additional works to provide necessary access and so on, as well as planning and construction delivery issues, which are likely to increase both the cost and programme. It can therefore be deemed that the exercise to reduce the original site based on programme alone could be seen as flawed.

Recommendations

We suggest that a wider engagement is initiated with the public and clinicians to share the current picture, plus regular dialogue. Whilst the PWC report mentions one set of numbers, more recent project team notes state that some 200 staff have been involved so far, however a number of the meetings record unusually small attendances for a project of this size. This suggests a potential issue of some reticence of involvement. It is considered that more work could be undertaken via social media on an ad hoc basis and monthly updates in a newsletter/email to encourage full participation.

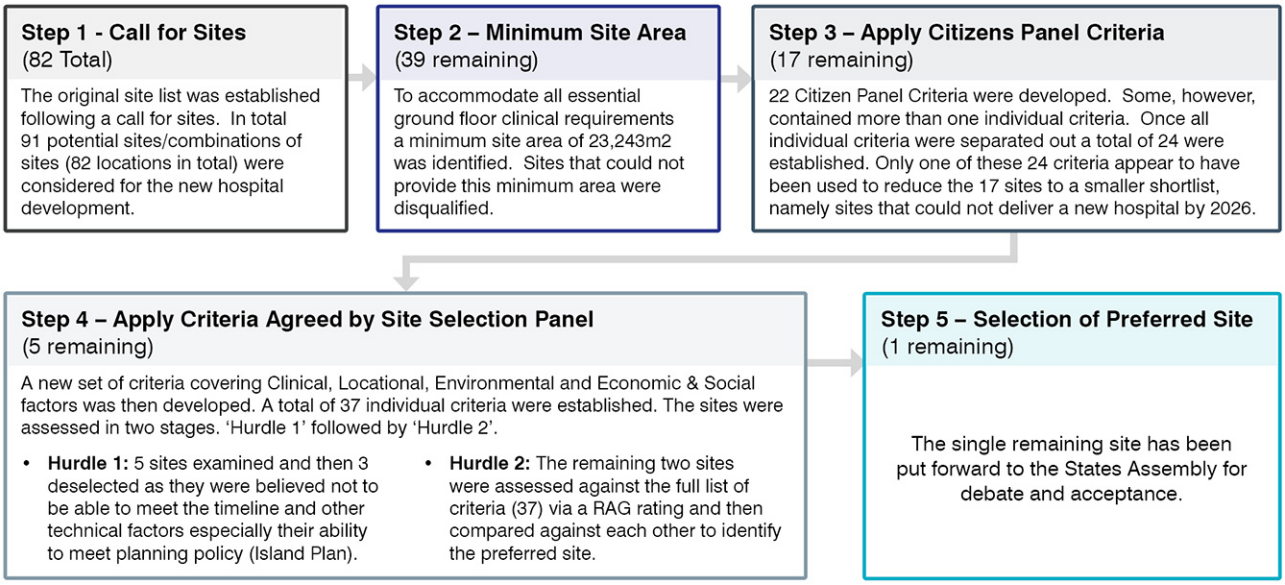
It would be useful to validate the clinical workforce by specialty to ensure that the new build will have sufficient staffing. If it is likely there will not be enough staff, then it would be necessary to ensure a full review of the workforce and recruitment plan. The PWC report captures many of the workforce assumptions and required items for completion.

5 Site Selection

5.1 Methodology

From our review of the available documentation we understand the following methodology was applied at various stages, resulting in the identification of the preferred site.

Figure 1 - Site selection process



Following step 1 a long list of sites was developed and reviewed:

Table 1 - Original List of Sites showing those rejected on basis of size and/or programme/harm

Key

	Rejected Criteria 2 – site area			*Rejected Criteria 3 - Programme*
	Rejected – Unsustainable/Harmful			*Shortlisted*

Ref	Site
1	B&Q Plus Powerhouse
2	Bagot Road Field
3	CineWorld & Aqua Splash
4	CLM plus Lempierre Court
5	Commercial Buildings
6	D'Hautree
7	FB Fields
8	Fields North of Union Inn
9	Field opposite St Saviour's School

Ref	Site
41	Randells & Parade Gardens
42	Remaining IFC Site
43a	Fire Station & Old Police HQ & Nr 46 & Rouge Bouillon
43b	Fire Station & Old Police HQ
44	Scare Coeur Building Site
45	Springfield Stadium
46	St Clements Golf Club
47	St John's Manor
48a	St Saviour's Hospital

Ref	Site
10	Fields at Junction La Rue de la Retraite & Le Boulivot de Bas
11	Fields opposite Rondels Farm Shop
12	Former B&Q site
13	Former Pontins site
14	Fort Regent & South Hill
15	Fort Regent
16a	General Hospital
16b	General Hospital plus Cyril Le Marquand
16c	General Hospital plus properties on Kensington Place plus Westaway Court
17	Government House
18	Greenfields – Five Oaks
19a	Jardins de la Mer Car Park
19b	La Fregate plus Jardins de la Mer Car Park & CineWorld
20	La Collette
21	La Fregate Reclamation
22	La Motte Street
23a	Millbrook Playing Fields
23b	Fields behind Millbrook Playing Fields
23c	Fields behind & Millbrook Playing Fields
24	New North Quay & Old Harbour
25	Normans Site – Five Oaks
26	Normans Site & JT & JEP & Health & Fields – Five Oaks
27	Old Harbour Reclamation
28	Old JEP plus Health Sites – Five Oaks
29	Old JEP plus Le Geyt Centre & Health sites – Five Oaks
30	Old JEP site – Five Oaks
31	Old Les Quennevais School
32	Overdale plus fields 1550 & 1551
33	Overdale plus West Park
34	Overdale plus Westmount Escarpment
35a	Overdale
35b	Overdale including George V Cottages
36	Parade Gardens plus General Hospital
37a	Parade Gardens
37b	Parade Gardens plus Westaway Court & Maison Le Pape
38	Parish of St Helier Parks Department
39	People's Park
40	Pier Road Car Park

Ref	Site
48b	St Saviour's Hospital plus Clinique Pinel
48c	St Saviour's Hospital plus Clinique Pinel & Rosewood
49	Swimming Pool plus Glacis Field
50	Tamba Park
51	The Limes
52	Warwick Farm
53	West Hill
54	West Park
55	Overdale Hospital including Crematorium
56	Field H1550 Westmount
57	Field H1551 Westmount
58	Bellozanne Valley
59	Dual Site – General Hospital plus Overdale
60	Elizabeth Harbour
61	Fields 1219, La Grande Route de Mont a L'abbe
62	Field behind B&Q
63	Field adjacent to St Saviour's Church
64	Fields off Highview Lane
65	Fields off La Grande Route de St Jean
66	Fields South of Airport
67	Fields to North of Five Oaks
68	Former Ann Street Brewery
69	Former Jersey College for Girls
70	Grainville Playing Field
71	Grainville School
72	Jersey Gas Site Tunnell Street
73	Le Masurier's Land Bath Street
74	Longueville Nurseries
75	Samares Nurseries
76	Snow Hill Car Park
77	St Andrew's Park
78	Summerland plus Ambulance
79	Waterfront – Zephyrus & Les Jardins de ka Mer
80	Westaway Court
81	Westmount Quaarry
82	South Hill

Observations

Step 2 - Minimum Site Area

The Our Hospital Shortlisting Report, July 2020 identifies the requirement for any shortlisted site to be able to provide a minimum ground floor area for the new hospital of:

- Option 1 – 23,243 m^2
- Option 2 – 22,890 m^2 (main site, incl basement)

Within the report several sites appearing to meet these criteria have been deselected, including:

Table 2 - Deslected sites

ref		Main Site Area m^2	Adjacent Area m^2	Nearby Site?	Commentary on site
1	B&Q plus Powerhouse	26,161	0		Not large enough to accommodate any Option
8	Field North of Union Inn	23,228	0		Not large enough to accommodate any Option
17	Government House	44,270	0		The developable area is limited and could not accommodate any option
23b	Fields behind Millbrook Playing Fields	23,136	0	Yes	Not large enough to accommodate any Option
54	West Park	29,787	0	Yes	Not large enough to accommodate any Option
61	Field 1219, La Grande Route de Mont a L'Abbe	25,490	0		Not large enough to accommodate any Option
63	Field adjacent to St Saviours Church	23,870	0		Not large enough to accommodate any Option
69	Former Jersey College for Girls	27,957	0		Not large enough to accommodate any Option
82	South Hill	30,910	0	Yes	Not large enough to accommodate any Option

55 potential sites were rejected purely due to size. As noted above, however, 9 of the 55 appear to meet the minimum size criteria. It is not clear, therefore, why the sites in the table above have been deselected purely on the grounds of site area during the first round of reviews.

A further 20 potential sites were rejected due to the knowledge that there were existing users on the site which would need to be relocated. It was then assumed that having to do this would result in the programme not being met. In this instance it is fair to say that some sites with existing occupants could potentially have been considered in the long list and the assumption that the majority of sites could not is subjective. In addition, the Overdale site considered in the short list does have some land acquisition requirements, both for the main site and the highway works. The time it would take to obtain these elements of land would not necessarily take any less time to acquire than some of the sites that have previously been discounted.

After sites discounted on the grounds of area and programme were discounted. 17 sites remained.

Step 3 – Apply Citizens' Panel Criteria (17 Remaining)

24 criteria were established following the involvement of the Citizens' Panel. It has been stated that these criteria were applied 'sequentially'. This implies that the criteria were prioritised in some fashion to decide the order in which the criteria were applied. In addition, it has been stated that 'the process was primarily based on clinical requirements'1. Clinical requirements appear to refer to the deliverability of the new hospital by 2026 and is therefore programme related. Two principal factors were identified. These were 'Ownership' & 'Availability of Developable Land'. How each of these criteria were applied equally and consistently across the list of sites, resulting in the 17 remaining is unclear.

Whilst it is positive that a Citizens' Panel was assembled it does not appear that the factors, they identified have been applied in site selection. Instead, the priority to deliver the new hospital within a relatively short timescale appears to be the single and deciding factor.

It is interesting to note that in the table contained within the 'OH Site Shortlisting Report July 2020 – Appendix 2' a number of sites (identified in yellow – table 1) were annotated with the comment '***considered by the Site Selection Panel but in a difficult and unsustainable location. The impact of the building on the character of the area would be harmful***'. The same comment was applied to St Saviour's Hospital site (48a) with the suffix '*and there would be a loss of a significant heritage asset*'. We cannot find evidence of or been advised how this selection criteria was developed or how it was applied. Following the assessment of the 17 sites considered 5 sites remained, namely:

- 23c - Fields behind & Millbrook Playing Fields;
- 32 - Overdale plus Fields 1550 & 1551[1];
- 39 - People's Park;
- 67 - Fields to the North of Five Oaks;
- 77 - St Andrew's Park;

If we use the stated criterion within Step 2 and Step 3; Sites 39 and 67 should not have been selected to the shortlist of 17 or 5. Site 39 People's Park has an area / size below the minimum required. Site 67 Fields to the North of Five Oaks has known issues with access / approach roads that should have been considered a reason not to be selected.

Step 4 – Apply Criteria Agreed by Site Selection Panel (5 Remaining)

The sites were assessed in two stages. 'Hurdle 1' followed by 'Hurdle 2'.

Hurdle 1 – 5 sites examined and then 3 deselected as they were believed not to be able to meet the timeline and other technical factors especially their ability to meet planning policy (Island Plan). The three sites deselected were:

- Millbrook – Complex multiple acquisition and the potential for compulsory purchase, together with departure from current planning policy are cited as key reasons for deselection of Millbrook.
- St Andrews Park – Ruled out due to the requirement of a special law to develop the site. It is stated the timescale could therefore not be met. Loss of amenity and access and highways are also key factors leading to its deselection.
- Five Oaks – The site is under multiple ownership and would require 'significant' land acquisition to facilitate the highways improvements required. Visual impact is also noted as an adverse factor for this

[1] P.123 Our Hospital Site Selection: Overdale – Lodged au Greffe 06 October 2020

site, leading to its deselection. Given these factors it is surprising that this site was not deselected at an earlier stage.

The factors for deselecting these sites also appear to affect the two remaining sites, namely:

- Overdale – this site is under multiple ownership, does not accord with the current Island Plan, requires significant highways improvements, effects heritage assets and will impact the Jersey skyline.
- People's Park – this site will result in loss of amenity; it is smaller than ideal but otherwise would appear to meet the requirements of Hurdle 1.

Given the analysis above, it is not clear how the three sites were removed at Hurdle 1 were selected. It would appear that some of the factors for deselecting also apply to the remaining sites.

Hurdle 2 – The remaining two sites were assessed against the full list of criteria (37). The Delivery Partner illustrated the results using a 'swingometer' to assess the relative merits of Overdale v People's Park. This takes the analysis undertaken by the Delivery Partner and presents it graphically.

This analysis does not conclude that there is an absolute winner but shows both sites have relative merits and disbenefits that require careful consideration.

Step 5 – Selection of Preferred Site (1 Remaining)

P.123 Our Hospital Site Selection: Overdale – Lodged au Greffe on 6th October 2020 by the Council of Ministers concluded:

> *9.2 There must be no further delay.*
>
> *9.5 Taking in to account all of the clinical, locational, environmental and economic and social impacts of the new hospital on our final two sites, the Our Hospital Political Oversight Group and the Council of Ministers were in no doubt that Overdale was the best option and would deliver an exemplary hospital, future-proofed for future generation of islanders.*

The decision to choose Overdale as the preferred site has not been fully explained or justified. Of course, the GoJ could justify Overdale as being the best site for the project but may not easily be able to explain and justify how they were able to reach their decision using their own criterion which is generally not measurable. The reasons for selecting Overdale over People's Park requires explanation and justification if the decision is to be fully understood and supported.

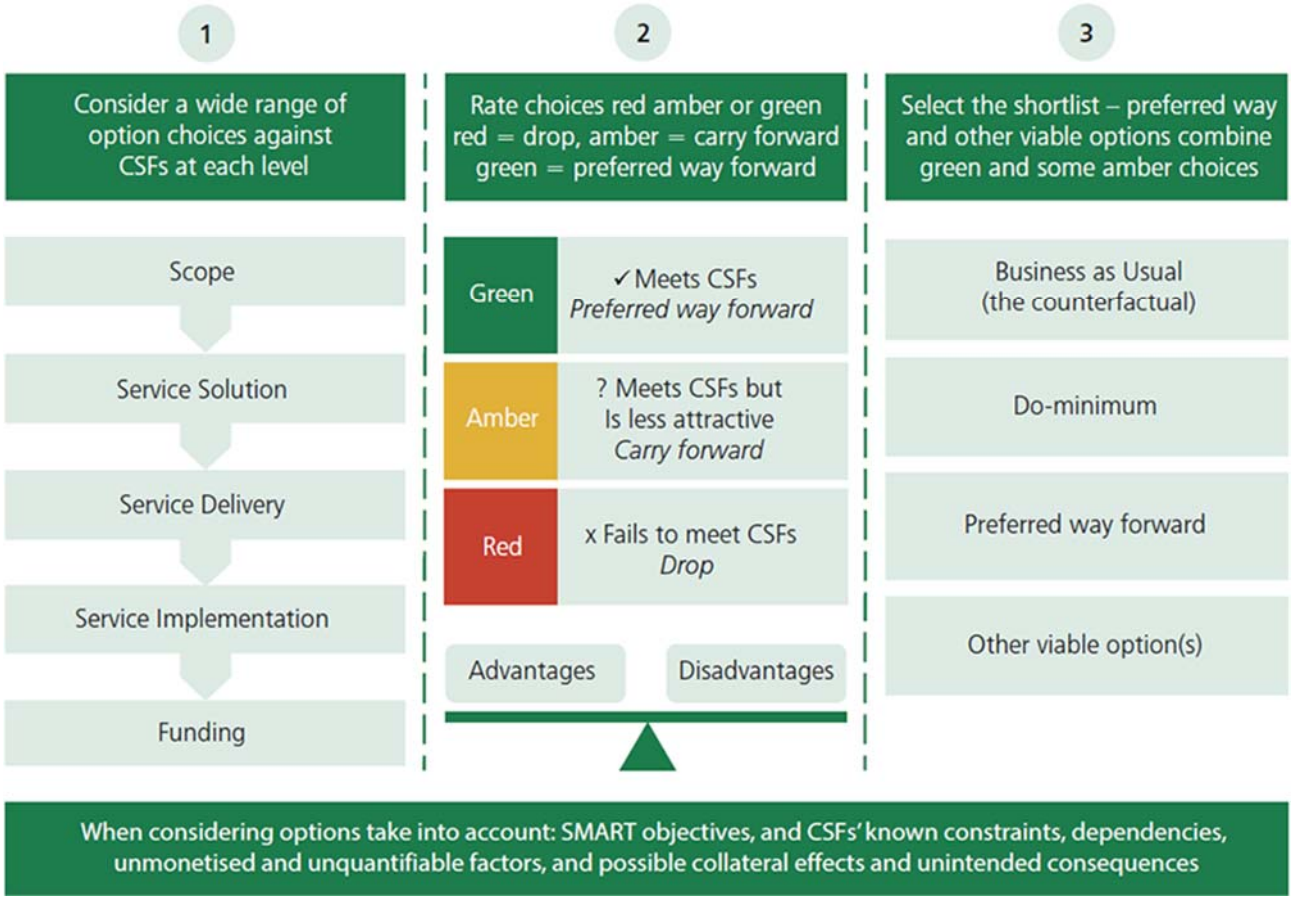
General Observations & Comments

In accordance with the HM Treasury Green Book, when a long list has been generated and assessed, a small number of viable options known as the short-list can be identified. Within each category (e.g. scope), a number of alternative options should be considered and challenged according to how well they meet the Critical Success Factors (CSFs). This can be done by considering their strengths, weaknesses, opportunities, and threats (SWOT). The CSF's are used to develop the key assessment criteria against which each option is assessed. The assessment criteria should incorporate 'SMART' objectives to avoid subjective assessments being made which are then open to challenge. SMART objectives are:

Specific	Measurable	Achievable	Realistic	Timebound

The Citizens' Panel Criteria are largely subjective, making the marking open to challenge and debate. Notwithstanding this, the sequential fashion in which the criteria were applied has driven the outcome. In reality two factors i.e. (1) sites large enough and (2) potentially deliverable within the desired timeframe have been used as pass/fail criteria, resulting in the list of 17 sites. The other 22 criteria were therefore rendered not relevant.

Figure 2 - Citizens' Panel Criteria - Site selection process



Overall the Site Evaluation report (October 2020) includes all necessary detail as would be expected at this level. Specialist advice was sought with regard to Land Acquisition, economic appraisal etc. and clinical and non-clinical stakeholders were engaged in the process on both a clinical and site/location perspective.

The report does, on a more detailed review of each site, identify issues around existing occupants, additional works to provide necessary access etc., planning and construction delivery issues which are likely to increase both cost and programme. We note, therefore, that some of the original factors used to discount sites appear to be factors present in the five sites shortlisted e.g. parts of the Overdale site are in multiple ownership and therefore the land acquisition process may not be straightforward, open to challenge and therefore not meet the desired timescales.

The assessment criteria used at the site evaluation stage (5 sites) developed from the Citizens' Panel criteria were 'developed' and used as part of the Hurdle 1 & Hurdle 2 criteria for final site selection. These criteria were grouped in to four categories, namely:

1. Clinical	2. Locational	3. Environmental	4. Economic & Social

Of the criteria produced by the Citizens' Panel the following number of elements were taken through to the selection criteria used by the project team:

1. Clinical	2. Locational	3. Environmental	4. Economic & Social
6 out of 7	4 out of 9	6 out of 6	1 out of 1

Less of the original locational criteria were used. Those not used included:

- (12) Is the site directly below the flightpath to the airport?
- (13) Is the site in the built-up area?
- (14) Is the site on brownfield land?
- (15) Is the site a green field site?
- (16) Can the site be accessed from various directions?

Table 2 (Assessment Criteria) within the OH Site Evaluation Report contains 8No. Economic & Social criteria. It would be common practice to expect overall cost and affordability to be one of those criteria. It is not identified as part of the selection and therefore does not appear to have been assessed at this stage. This appears unusual if the HM Treasury Green Book was indeed followed.

5.2 Planning Risk Review

K2/Archus engaged MS Planning to review the planning matters associated with the proposed site selection. Their report and findings are contained in Appendix 3.

MS Planning advised that the current Island Plan will take precedency in decision making should an application come forward. Any application will be subject to a 'public interest test' where there would need to be sufficient justification to depart from the plan. It is noted that all sites suitable for a new hospital come with challenges and impacts that will cause harm and that a plan to build a major hospital is unlikely to fit neatly with current policy.

The review stated that the previous application for a hospital took 9 months to decide and that the time allowed within the current programme of 6 months is the absolute minimum that could be expected. There is therefore some risk around this timeframe.

The Supplementary Planning Guidance (SPG) draft issued in May 2020, seeks to make allowance for a new hospital either via identifying a new site or enabling a new proposal to be tested, thus easing the way for a positive decision. Due to the current timing of issue, it will not, however, have statutory weighting before the Our Hospital application comes forward. It will, nonetheless, be of material consideration when considering the application. It will identify that healthcare needs can be introduced as a factor for consideration. It will make provision for need for critical public and community infrastructure to carry sufficient weighting.

The planning issues that will need to be considered by an independent inspector and by the Minister ahead of any decision will include:

- Impact on protected open spaces;
- Impact on green zone & green backdrop;
- Highways matters;
- Impact of listed buildings;
- Visual impact.

Even with the publication of the SPG the above issues exist and will need to be considered. We are aware that early applications for demolition and highway works are due to come forward ahead of the application for the new hospital site. These applications may be viewed as prejudging the main hospital application site and could therefore receive some difficulty in being dealt with, given the current process.

The risks based upon the current strategy, given the Island plan is not due to be updated until 2022, are multiple and include:

- A 3rd party appeal system exists in Jersey i.e. someone within 50m of the site can appeal which if occurs can lead to a court hearing;
- A ministerial decision is challengeable in court.

The planning process will include a public enquiry via an independent inspector and then it is likely that the Minister for the Environment will be called to make the final determination. We understand that the Minister is discussing establishing a panel to share the decision-making responsibility. To allow this, planning law will need to be redrafted and passed.

6 Governance and Project Management

6.1 Applying Best Practice

Our Focus on Governance

Our focus on reviewing the Governance arrangements put in place for the project and how the structures have been deployed to make and ratify key decisions and approvals has concentrated on whether:

- Have the governance structures and decision making followed due process?
- Does that due process reflect best practice in terms of public sector investment in major infrastructure projects?

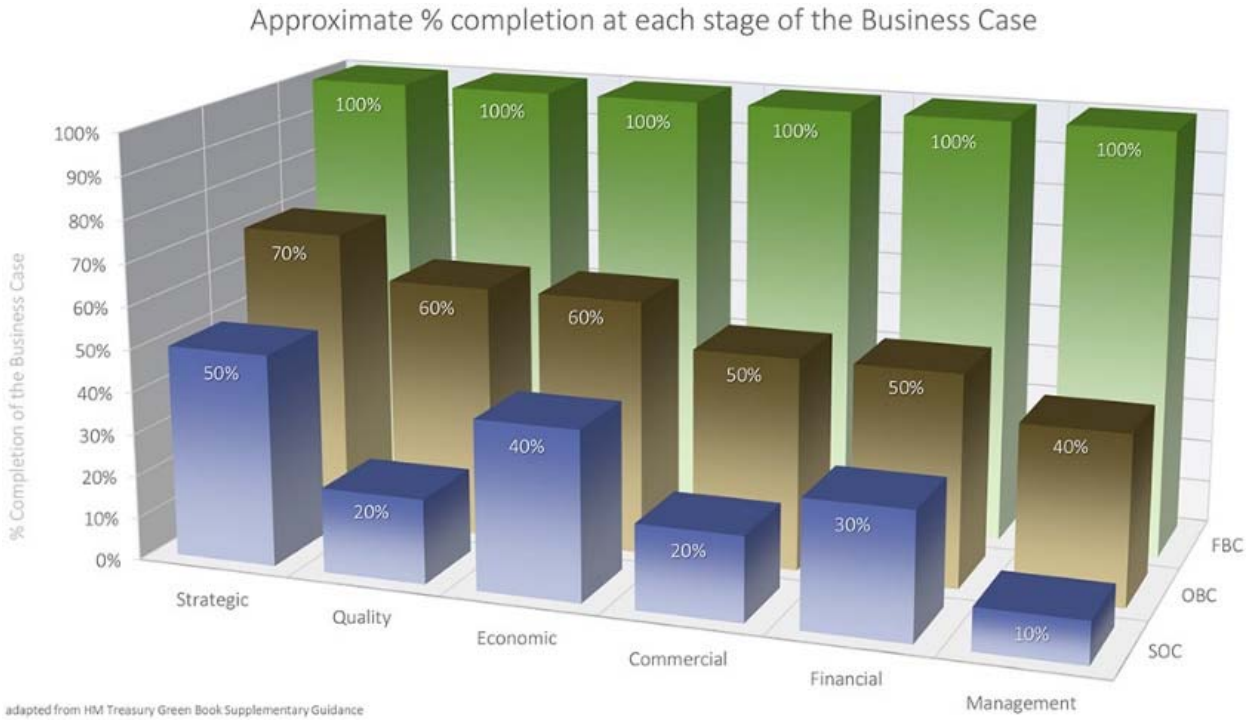
Through this approach it is considered that the Scrutiny Panel can reach an informed view on whether the key decisions reached to progress the Project are defensible and auditable and will continue to stand up to scrutiny as the project progresses.

Best Practice for Public Sector Infrastructure Projects

The benchmark best practice for major infrastructure projects funded through government and public sector is the UK Treasury published guidance under the 'Green Book' or 'Appraisal and Evaluation in Central Government'. The Ministry for Treasury and Resources of the Jersey Government has adopted the Green Book guidance to inform major investment decisions on the Island including to inform investment decisions taken by the Investment Appraisal Board (IAB). Given this adoption we have reviewed the governance, process and decisions/approvals against this benchmark best practice.

The Green Book sets out the evolution and development of the Business Case through three key stages which are documented; these being, The Strategic Outline Case, The Outline Business Case and The Full Business Case. Each of these cases are, in turn, organised into five separate cases; The Strategic Case, The Economic Case, The Management Case, The Financial Case and the Commercial Case. Each of these 'cases' are developed in greater detail as the Business Case progresses with a different level of emphasis at each stage. This can best be demonstrated in the graphic below:

Figure 3 – Section percentage completion by business case stage



This shows the emphasis for the Strategic Outline Case (SOC), at the front, is on making the Strategic and Economic Case.

It is also required to undertake an appraisal of alternative options (the option appraisal) to meet the strategy within the SOC. What is unusual with the Our Hospital project process is that key decisions that will inform the outcome of any option appraisal have been made and/or recommended prior to the completion of the SOC. Whereas it is normally the SOC which should identify the chosen option with all supporting decisions required to then be issued for approval.

It is recognised that the Our Hospital project has a long history and the decision around the siting of the hospital is the most contentious issue for the project. We believe that the process for site selection (as described above) has been undertaken in good faith in order to settle the siting issue once and for all. Also, the process has been undertaken in order to inform the SOC and ensure that a viable and supportable chosen option emerges. However, this process and sequence of events has run the risk of a SOC being issued for approval and if not approved, for whatever reason, then decisions on site selection are unravelled and there is a need to revisit the siting issue. Although we believe this risk to be small the fact that it exists and the approving bodies of the SOC to some extent have 'their hands tied', means that best practice has not been followed rigorously and the sequencing of events has introduced risk.

Due Process

The Approvals Structure for key decisions and documents relating to the Our Hospital Project is set out under 5.2 below. This sets out the role of each key group established as part of the Governance structure for the Project. However, it is unclear through this structure where responsibility for the ultimate approval of the SOC resides.

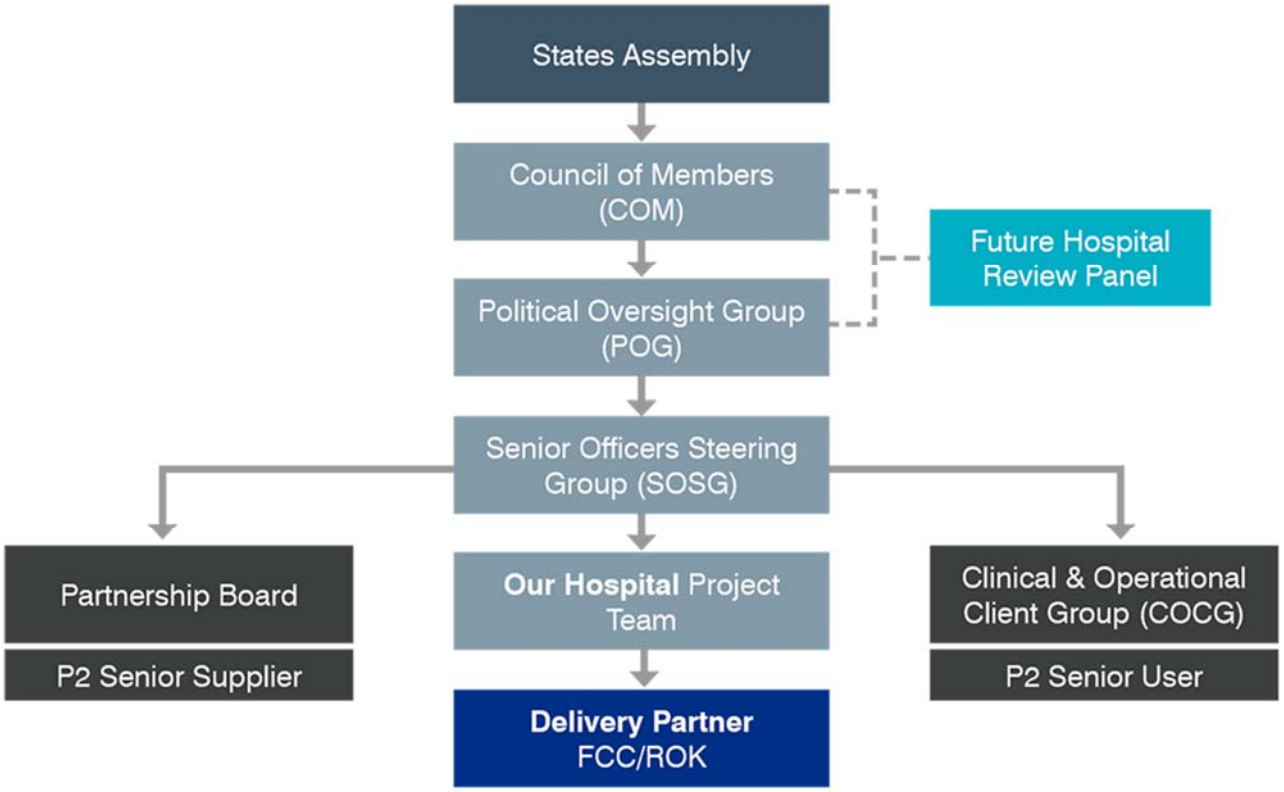
It is our assumption that the SOC will be approved by the Senior Officer Steering Group (SOSG). The decisions and key parameters that then arise from this approval i.e. Site Selection, Capital Budget and Programme are, where appropriate, raised with the Political Oversight Group (POG) for approval. This would represent Due Process and ensure that there is transparency and appropriate sequencing of approvals. However, we are unclear whether our assumption is correct and this needs to be tested.

We therefore Recommend that a clear Approvals Process with Agreed and/or Delegated Authority for each group is set out as well as the Terms of Reference for these groups in relation to Approvals. This would evidence that Due Process has been followed and that this process can map across to best practice as set out in the guidance for publicly funded major infrastructure projects.

6.2 Governance Structure

The overall structure within which the Our Hospital project sits is understood to be as shown below.

Figure 4 - Project Governance Structure



A project manual has been developed by Mace, acting in their role as PMO which describes how the project will be managed – 'Our Hospital Project V2.3 (work in progress draft) September 2020'.

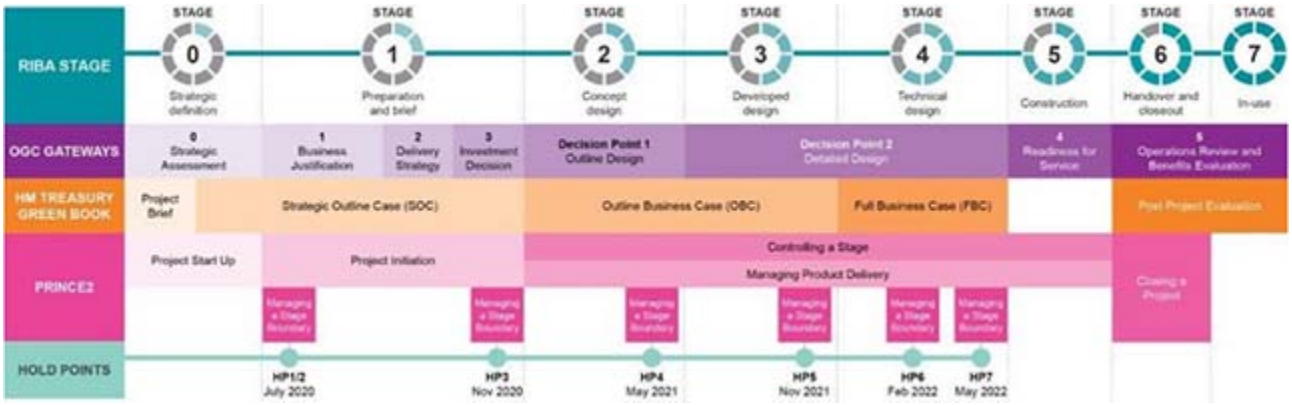
The manual identifies that the project will be managed and governed in accordance with:

- PRINCE 2;
- Government of Jersey Public Finance Manual;
- UK Treasury Green Book;
- NEC3 Contract (Agreement between Design & Delivery Partner and GoJ).

The NEC4 Contract is now the current form but NEC3 has been used more widely and is more familiar to the market, which is why it has been chosen according to the OH Project Team. We would accept this rationale.

6.3 Programme and Methodology

Figure 5 - RIBA stages business case process



The diagram above illustrates the proposed programme & methodology to be employed by the project team (see OH Project Manual v2.3 p60). It identifies a series of 'Hold Points' or 'Gateways' which is good practice when undertaking a major project. The manual states that at Hold Point 3 the Strategic Outline Case (SOC) and Employers Requirements will be confirmed alongside the announcement of the preferred site.

Figure 6 - business case stages

SOC	OBC	FBC
The concept stage; ascertains strategic fit; makes the case for change; determines short list of potential affordable options; conveys management capacity and capability to deliver	Detailed appraisal of options; determines best value for money solution; prepares for procurement; confirms funding and affordability; proidves detailed management plan for delivery	The final, technical document; outcome of procurement process; final check on affordability and VfM; contract details, comprehensive delivery plan and benefits realisation

It would be considered normal for the SOC to be produced and approved at a much earlier stage in the project and to contain the following:

- Strategic Context;
- Health Service Need;
- Shortlist of Options;
- Costs & Affordability;
- Timetable & Deliverability.

The HM Treasury approval process for programmes and projects (Nov '16) suggests that the SOC should identify a long list of options that will be considered.

It would appear that at the time the SOC is published:

- A preferred site will be chosen and therefore a range of alternative options will not be provided;
- A set of Employers Requirements will have been developed;
- A Delivery Partner and procurement approach selected.

Each of the above actions would normally happen after the SOC is published and approved. We have been advised, however, that an early draft of the SOC was produced in April '20 and issued to POG. This document has not been made available to K2/Archus.

Recommendations

1. It is recommended that a process of Independent project Assurance (IPA) is put in place as advised by HM Treasury and that detailed reviews are undertaken at each gateway to check adherence to the agreed plan and approvals.

2. The SOC is reviewed and meets the requirements of 5 case model which is generally accepted as the standard for development of business cases.

6.4 Risks and Risk Management

K2/Archus have been provided with a "Risk Register" dated September 2020, containing 14 *open* items. This may simply be a high-level Risk Register, but it appears limited in the risks identified and captured. Key risks that need to be further explored and addressed include:

- Client change;
- Adequacy and accuracy of overall development budget;
- Adequacy of project contingencies;
- Effectiveness of governance arrangements;
- Loss of key personnel;
- Technical matters;
- Failure to agree terms with Delivery Partner;
- Increases in scope;
- Workforce;
- Sustainability;
- Clinical engagement;
- Public engagement.

Design and delivery of a major new hospital including the likely enabling, highways and off-site works carries with it significant risks. The assessment and impact of the risks involved appear to be underplayed to a degree. Should the project not proceed as envisaged and the scope of the project increase or delays be encountered then this could give rise to significant cost increases.

Within the Deputy Chief Ministers response to the Future Hospital Review Panel (23 October '20) the response states ' The Employers Requirements Document, incorporating the Functional Brief, requires the designers to consider a hospital that can provide flexibility to accommodate any modern health care model…'. This requirement is wide and unspecific which may result in a failure to meet the client's expectation or a significant cost to ensure all eventualities are covered.

We maintain that the appointment of a Contractor pre-SOC is highly unusual given the risk that if the SOC is not approved then significant sums will have been expended. However, if we accept that parallel activities (rather than sequential) are necessary on this project given the site selection process then the appointment at this stage could be seen as a way of generating a level of cost certainty to the planning and approvals processes. Whilst slightly out of sequence from a governance point of view, the advantage should be taken of the appointment to have a detailed cost plan (which can form an auditable baseline) soon after the approval of the SOC.

Observations

Design and delivery of a major new hospital including the likely enabling, highways and off-site works carries with it significant risks. The assessment and impact of the risks involved appear to be underplayed to a degree. Should the project not proceed as envisaged and the scope of the project increase or delays be encountered then this could give rise to significant cost increases.

Within the Deputy Chief Ministers response to the Future Hospital Review Panel (23 October '20) the response states ' The Employers Requirements Document, incorporating the Functional Brief, requires the designers to consider a hospital that can provide flexibility to accommodate any modern health care model…'. This requirement is wide and unspecific which may result in a failure to meet the client's expectation or a significant cost to ensure all eventualities are covered.

Whilst slightly out of sequence from a governance point of view i.e. before the SOC is approved the early involvement of a Delivery Partner is seen as a positive action, albeit it will be some time before accurate construction costs are established.

Recommendation

A costed risk register is developed and monitored. Regular independent review and challenge, together with sensitivity analysis which examines best, worst, and most likely outcomes. The project manual proposes using Trend Management to provide an early warning system. The principle is accepted and welcomed but no detail has been provided. The project team should be requested to further develop and implement such a system without delay.

6.5 Financial and Commercial issues

The project must comply with all aspects of the Jersey Public Finance Manual.

Our understanding is that the total development budget for the preferred site at Overdale is currently estimated at £804.5m. This consists of £550m as the costs for the Design and Delivery Partner plus £254.5m other costs, including land acquisition and client contingency. We have not been shown any affordability calculations that confirm that this sum is affordable and how it will be financed.

Cost and affordability normally feature significantly in any options appraisal. It is noticeable that cost has not featured and that funding approval of the chosen scheme will be via a separate finance paper to be published next year, according to the advice received from Steven Mair (Group Director, Performance Accounting and Reporting).

Procurement & Contract Management

As part of our review K2/Archus met with James Cowley (Head of Procurement) and Daniel De La Cour (Commercial Services) to understand the process for the procurement of the PMO (project management office) supplier. From what we have learned, the process would appear to have been carried out in a fully compliant fashion, leading to the appointment of MACE. The only matter that gives rise to concern is that one of the four interview panel is an ex-director of MACE. We understand that the individual (Richard Bannister) has signed a declaration of non-conflict and that the panel members were all in agreement with the choice made.

The procurement of the Delivery Partner resulted in the appointment of FCC, a Spanish contractor. The process undertaken appears robust and in accordance with good practice. The contracting strategy chosen is to appoint the delivery partner under a preconstruction services agreement (PCSA). The PCSA is an appointment to plan, design and procure the works required to deliver the new hospital.

We have undertaken a review of the PCSA which includes comments and observations on the proposed contract (see Appendix 4). The version that we have been issued identifies the requirement to develop a

'Project Cost Plan Identifying the Affordability Limit - Schedule 8'

For clarity, the Project Cost Plan is to be prepared and presented by the Consultant during the performance of this agreement. The Affordability Limit will be derived from this document following a joint review between the parties and following the release of the Schedule of Accommodation and any other document the Consultant reasonably requires.

This suggests an 'Affordability Limit' should be identified and agreed as part of the PCSA. We have been advised that this has been set at £550m.

The value of this appointment is approximately £30m. The PCSA is intended to lead to a position at which the delivery partner can be contracted to build the new hospital via an NEC3 form of contract (option C) target price. The intended form of contract also contains a pain/gainshare arrangement.

The NEC Option C is a target cost contract with activity schedule where the out-turn financial risks are shared between the client and the contractor in an agreed proportion.

Target cost contracts can be beneficial where the scope of work is not fully defined or where the risks anticipated are greater than usual.

The option C contract allows the financial risks to be shared between the parties (employer and the Contractor) which motivates the contractor to deliver the works in the most cost-efficient way.

NEC 3 Contract issues

From a previous recent project we have put together some key points that can arise for consideration on the NEC3 contract and amending existing clause terms.

- Clarity as to the concept of GMP – public sector bodies should avoid the terminology of GMP and stick with a 'Target Cost' contract
- Unless absolutely necessary, it is more sensible to avoid insisting on a capped cashflow as this can prevent the Contractor from achieving programme betterment and drives wrong behaviours
- Public sector bodies need to seriously consider whether upon reaching the agreed contract sum, the project from a financial perspective struggles to survive or whether there should be the introduction of a robust mechanism for introducing a pain/gain share which sets out to drive gain for both parties and not to be seen as favouring only the client. This again will be instrumental in driving the right behaviours

- The introduction of making an assessment of the Contractor's share throughout the duration of the construction, rather than at the end, otherwise, it can expose the client to overpayment and having to claw back monies which could prove problematic

- Introduction of Priority of documents

- Contractor's design to exercise reasonable skill expected of a professional exercising the same duties

- Clarity around critical path on programme and a clear time bar for acceptance by the Public sectors PM

- Submission of application for Payment as a absolute requirement for payment

- Introduction of BIM

- Provision of IPR

- Introduction of Disallowed Costs for defective works during the works

- Alignment of Activity Schedule, Cashflow and Programme – this needs to be closely linked with Project Controls and earned value

- Provision for undertaking of final assessment

- Acceptance of defect and for PM to make his own assessment (currently not included within the NEC3)

- Introduction of Force Majeure event inclusive of Covid-19 and Brexit (currently NEC3 only has a simple prevention clause which will need expanding)

- Clear definition of what risks we expect the Contractor to take on Covid-19 and in relation to Brexit (both have created significant uncertainty and not all events will be captured under the realms of a change in law)

- Provision of linking accepted programmes with entitled payments. Currently, NEC3 loses its teeth after the first programme for acceptance where the contract provides for withholding 25% of the value of works undertaken, but thereafter there is no link with financial entitlement

- Clarification of compensation event for weather and agreed definition (to include wind measurement – particularly important where many activities are crane dependent)

- Provision of PCG and Performance Bond – We do not know the SOJ agreement with FCC. However, if possible a Performance Bond would be useful although this many not be achievable. In the current uncertain market, a 10% performance bond may be very important , this occurs in many countries globally as a client retained amount.

- Current key issues around Environmental, Sustainability, Social Values will need to be built into the contract

- Detailed definition of Completion and any performance compliance requirements

Observations

The use of the NEC suite of contracts is recommended for the delivery of major public projects. It promotes strong project management and risk management as well as a collaborative approach between the parties. We support its use in the context of this project. It should be noted, however, that the main construction contract is intended to be an NEC3 (Option C) which shares the risk of cost increases between the Employer and the Contractor. As such the Employer (GoJ) should be aware that there is no guarantee that the project will be delivered on or below the currently forecast figure.

Recommendations

For the NEC3 contract approach to work correctly and successfully it is important that all of the key project participants are familiar and trained in the thinking behind and use of the contract. It will be important for the 'project manager' (named in the contract) plus all of the delivery partners key personnel to be familiar with the procedures required by the contract, including early warning meetings, compensation events etc. It will also be paramount that upon entering into the construction contract the information ('works information') which will be relied upon is as thorough and accurate as it can possibly be. A significant amount of change during the project is likely to result in delays and increases in costs, which must be avoided if the project is to remain on track. We recommend that the SOSG and Our Hospital team are also familiarised in the operation and use of this contract type.

6.6 Cost

According to the tables contained within the Our Hospital Site Selection paper lodged au Greffe on 6th October 2020 paragraph 6.2 states 'The Government of Jersey has negotiated a maximum build cost of £550m for Overdale'. It is difficult to understand how such an emphatic statement can be made at this stage. The sum of £550m relates to the 'affordability limit' to be agreed as part of the pre-construction appointment with the Delivery Partner (FCC/ROK). This in turn will relate to the information upon which this figure is based. With relatively little information upon the design of the hospital, site surveys and information, enabling works requirements and scope of highways works there is significant risk that the final sum paid to the Delivery Partner will exceed the figure stated.

The costs within the table in the proposition (Table 1) identify a cost of £412.2m for the construction of the hospital itself. Based upon our understanding that the eventual size of the hospital will be approximately 70,000m2 this results in a cost per m2 of £5,888. We would expect the benchmark cost for this type of hospital to be in the range £5,500 to £6,500 m2. This excludes any premium for building on Jersey versus the mainland.

In addition to the Delivery Partner costs, a sum of £254.5m has been identified for GoJ direct costs, including land acquisition, internal costs and optimism bias/client contingency. The sum for optimism bias/client contingency amounts to approximately 30% of the design & delivery partner costs, which is the level expected at this stage of the project.

The cost to build the new hospital at Overdale is approximately £60m higher than an equivalent hospital at People's Park. This comparison includes an allowance of £23.1m for the reprovision of the park. Should this

sum be excluded from the costs associated with People's Park then the cost to deliver a new hospital on the People's Park site would be over £80m lower.

Observations

To effectively guarantee the costs to deliver the new hospital at this stage of the project would appear to be somewhat optimistic. The overall budget (£804.5m), however, would appear to be sufficient for a project of this size and the contingency allowance is appropriate. Our key concern would be to ensure that the scope and design of the hospital does not grow so the current allowances are exceeded. In addition, client change will require careful management and approval and might if not kept in check also lead to cost overruns. The OH Project Team have explained to K2/Archus that they will employ a 'cost led' design approach to remain within budget. We would support this approach noting that the client and key stakeholders will need to understand and support this approach also.

Any premium for delivering construction on Jersey has not been made explicit. This factor requires further investigation.

Recommendations

Once the initial design of the hospital is established a detailed cost review should be undertaken in order that GoJ are happy they are receiving value for money. This should be followed by regular reviews at project milestones to check the project is on track and progressing within the budgets set. Key risks need to be understood and costed and detailed mitigation plans put in place.

The process for approval of change will need to be rigorously and robustly implemented and monitored.

6.7 Roles & Responsibilities

The membership, function and roles of individuals within each of the groups is detailed below.

Political Oversight Group (POG)

A Political Oversight Group (POG) was formally established and comprised the following eight members:

Table 3 - Political Oversight Group (POG) Core Membership

Name	Role
Senator Lyndon Farnham (Chair)	Deputy Chief Minister & Minister for Economic Development, Tourism, Sport & Culture
Deputy Hugh Raymond (Deputy Chair)	Assistant Minister for Health & Community Services
Senator John Le Fondre	Chief Minister
Deputy Richard Renouf	Minister for Health & Community Services
Deputy Kevin Lewis	Minister for Infrastructure
Deputy Lindsay Ash	Assistant Minister for Treasury & Resources
Deputy Rowland Huelin	St Peter
Connetable Philip Le Sueur	Trinity
Connetable Christopher Taylor	Attends as a substitute for the Chief Minister

Also attending POG by standing invitation were the following:

Table 4 - Additional POG Attendees by Invitation

Name	Role
Charlie Parker	Chief Executive Officer
Caroline Landon	Director General for Health & Community Services
John Rogers	Director General for Growth, Housing and Environment
Richard Bannister	Interim Project Director
Andy Scale	Group Director for Regulation
Stephen Hardwick	Director of Communications
Mike Thomas	Director of Risk & Audit

The roles and responsibilities of POG were as follows:

- Consideration of monthly progress updates;
- Agreed Terms of Reference and project governance for:
  - Political Oversight Group – providing political oversight;
  - Senior Officer Steering Group – directs and manages operational issues;
  - Clinical Group – developed the health brief;
  - Delivery Group(s) – focused on legal, procurement & delivery matters;
  - Citizen's Panel – engages stakeholders to build consensus;
- Allocated the following oversight responsibilities to:
  - Communications - Senator Farnham & Deputy Raymond;
  - Day to Day Political Coordinator & Spokesperson in liaising with Scrutiny & States Members – Deputy Raymond;
  - Clinical Model – Deputy Renouf & Deputy Raymond;
  - Site Scoping & Selection – Deputy Lewis, Connetable Le Sueur & Deputy Raymond;
  - Finance – Deputy Ash & Chief Minister;
  - Community Engagement – Deputy Huelin;
  - Construction Programme & Procurement Process – Deputy Lewis, Connetable Le Sueur & Deputy Raymond;
- Considered the approach to key project risks, interdependencies and risk management;
- Approved the approach to project funding and the formal application for the first tranche of funding to be submitted to the Minister for Treasury and Resources;
- Approved the approach to assembling the project team through a combination of secondment, recruitment and procurement arrangements;
- Approved the outline approach to communications and engagement;
- Approved the approach to engaging positively and proactively with Scrutiny and the States Assembly;

- Approved the outline proposals for establishing and running a Citizens' Panel;
- Approved the approach to procurement matters;
- Received updates on the development of the Jersey Care Model, which will provide the framework within which the new Hospital will need to be designed;
- Approved the project timetable, and the major 'gates' at which key decisions are needed to progress the programme, based on H.M. Treasury's Green Book five-case model.

Senior Officer Steering Group (SOSG)

The Senior Officer Steering Group (SOSG) met monthly, two weeks prior to the POG meetings. Membership comprised:

Table 5 - Senior Officer Steering Group (SOSG) Core Membership

Name	Role
Charlie Parker (Chair)	Chief Executive Officer
Caroline Landon	Director General for Health & Community Services
John Rogers	Director General for Growth, Housing and Environment
Richard Bell	Treasurer
Andy Scate	Group Director for Regulation
Stephen Hardwick	Director of Communications
Mike Thomas	Director of Risk & Audit
Steve Mair	Group Director – Performance, Accounting & Reporting
Maria Benbow	Commercial Director
TBC	Interim Project Director

SOSG reviewed the project's operational issues and discussed and approved papers that were tabled for POG consideration.

Clinical and Operational Client Group (COCG)

The Clinical Group was responsible for developing the clinical brief, and establishing patient needs for the new Hospital. It was chaired by the Director General for Health and Community Services, met monthly, and has the following membership:

- Chief Nurse;
- Group Managing Director, Health & Community Services;
- Group Medical Director, Health & Community Services;
- Head of Estates, Health & Community Services;
- Project Management Office Director;
- Development Director (PRINCE 2 Project Manager);
- Design & Delivery Partner Director;
- Health Modernisation Director;
- Head of Business Partnering, Our Hospital Project;
- Clinical Director, Our Hospital Project.

Delivery Group

The Delivery Group was the Project Team senior meeting, chaired by the Interim Project Director, and it met weekly. It was responsible for the day-to-day activities of the project and for ensuring that actions were completed to timetable.

6.8 Stakeholder Engagement

Jersey Care Model

Health and Community Services ('*HCS*') engaged with the Island's health community in developing the Jersey Care Model. The last review of Jersey's primary, secondary and tertiary care was completed in 2012. HCS examined what has changed in the intervening years and updated the model to take account of developments in clinical and healthcare practice and technology, tailored to our Island context.

The development of the Jersey Care Model was a critical pre-condition, because it will determine the patient needs for a new Hospital, and therefore the size and shape of the Hospital to be developed.

During July, August and September 2019, the Department's officials and clinical leads have held more than 40 engagement sessions with the following audiences, setting out the components of the Jersey Care Model, explaining what is different from the current model, and seeking their views and support. Sessions were held with the following groups:

Health & Community Services	Primary Care
• Associate Medical Directors • Consultants • Registered Managers • Senior Sisters • Soft facilities staff • All HCS staff (6 open sessions)	• GPs (9 sessions targeted at each large GP surgery) • GP Surgeries • Community Pharmacists • Dentists • Optometrists
Voluntary Sector	
• Jersey Hospice Care • Family Nursing and Home Care • Silkworth Trust • Cheshire Homes • Diabetes Jersey • Call and Check • Jersey Alzheimer's Association • Mind • Jersey Hospice Care • Good Companions • Communicare • Refuge • Age Concern	• Citizens' Advice Bureau • Shelter • Mental Health Cluster • Jersey Sport • Independent Advocacy Service • LV Homecare • Les Amis • Tutela • Autism Jersey • CAG • Gentle care • Headway • Care Federation

• Co-op	• Mencap

Citizen's Panel

Following the publication of the Jersey Care Model, the Citizens' Panel was established to seek Islander views about what they regard as important, step-up community engagement and communications about how the new Hospital will fit within the new model.

Following an Island wide invitation for applications, a Citizens' Panel was formed using an anonymised selection process involving those applicants who met the selection criteria. It was overseen by former Social Security Minister Francis Le Gresley and care was taken to ensure that the panel was reflective of the make-up of the Island's population, as per advice received from Statistics Jersey.

During February and March 2020, the Our Hospital Citizens' Panel convened on four occasions to support the Our Hospital project by formulating the criteria that they considered should form the basis of a sequential test, which would help narrow down the long list of sites – which had been nominated by the public – to a short list.

Supported by an independent facilitator from the UK, the Our Hospital Citizens' Panel met independently of the Our Hospital Project Team and used their original Terms of Reference as a starting point for discussions alongside the draft Our Hospital Supplementary Planning Guidance Advice Note, which was published in February 2020 by the Minister for the Environment. Whilst the Draft SPG was not adopted policy at the time, it was reasonable to consider the suggested advice as a template for the issues around the Our Hospital project.

After some familiarisation sessions, the Citizens' Panel worked together with the facilitator to establish the criteria they thought were important in determining the site for the Hospital. In a session after the workshop their criteria were crystalized into a priority sequenced list and approved by the Citizens' Panel.

A shortlisting panel was convened to ratify the initial assessments conducted in steps 1-3 and apply the selection criteria developed and agreed by the Citizens' Panel in step 4. The Panel consisted of:

- Director General, Health and Community Services
- Clinical Director, Our Hospital project
- Our Hospital Interim Project Director
- Chief of Staff
- Director of Natural Environment

The Panel were supported by technical advisors covering:

- Jersey Government Highways and Infrastructure
- Jersey Government Town Planning
- Hospital planning, architecture, and design

The Site Selection Panel considered the assessment of sites that could accommodate the minimum size for a hospital ground floor, that was undertaken by expert MJ Medical Health Planners and had been endorsed by HCS Associate Medical Directors. The Site Selection Panel ratified the initial assessment of sites.

The Site Selection Panel considered the assessment of ownership and availability of sites regarding deliverability by 2026. It is important to note that the availability of sites and whether it enables the project timeline was also a criterion agreed by the Citizens' Panel. The Site Selection Panel agreed a reduced list of sites that could not be delivered by 2026, which were discounted from the long list.

The Site Selection Panel then considered the remaining 17 sites and tested each against the sequential test criteria that had been developed and agreed by the Citizens' Panel. Those criteria that were deemed more important by the Citizens' Panel were applied first, with subsequent criteria applied in accordance with the critical sequence agreed by the Citizens' Panel. It should be noted that the Site Selection Panel considered some criteria to be less definitive. For example, the Citizens' Panel criteria asked if the site was a greenfield or brownfield development in that sequence. The Panel agreed that the former should not rule out consideration of the latter. The Site Selection Panel considered that these criteria should be fully explored as part of the technical assessment process, along with the criterion 'potential impact on heritage assets'. The appraisal of sites was undertaken as follows:

- Any site that did not meet the criteria (HM Treasury – NO). For the purposes of the shortlisting matrix, these determinations were highlighted in red.
- Any site that did (HM Treasury - YES) or could possibly (HM Treasury - MAYBE) meet the criteria moved to the next test. For the purposes of the shortlisting matrix, these determinations were highlighted in green or amber respectively.

Observations

How the group went about the development of the site selection criteria was not recorded. We have been advised that the group worked to achieve complete agreement across the group to the criteria used.

7 Conclusion and Recommendations

7.1 Conclusions

The site selection process could be criticised for not meeting best practice, due to the following:

- Site selection criteria were largely subjective and not measurable;
- Some sites were deselected for unknown reasons (i.e. sites removed even though they met the minimum requirement for site area);
- Some sites were rejected from the original list as they didn't appear to be practical from a programme point of view. Other sites, which had similar problems were left on the long list – criteria do not appear to have been applied rigidly and consistently;
- Site Selection Panel did not include any clinical and non-clinical operational leads/end users;
- Site Selection Panel did not follow their own methodology e.g., once a site has failed one of the criteria to not apply the next;
- Outcomes were recorded only – no minutes of discussions have been made available.

To reduce the long list to a short list a Citizens' Panel was assembled to produce a list of criteria. The results of this exercise produced criteria that, in the main, were not measurable and could not be classed as SMART, which would meet best practice. Only two of the criteria appear to have been applied to deliver the shortlist, namely:

1. Minimum size of site;
2. Deliverable by 2026.

Overall, the site selection process contains areas for improvement and could be open to challenge.

There is significant work required to move from site selection to a detail brief. There needs to be alignment of performance standards discussed with an expert clinical group within the hospital and wider health stakeholders with social care for sustainability and overall strategic fit. The link between the emerging JCM and new hospital design needs to be established as it will affect design and scope of the new hospital. This is outstanding. An early understanding of clinical operational workforce or digital requirements will be beneficial as we know it will be significantly more expensive to retrofit once full design planning and construction are ongoing. Areas of design and scope to be developed include the level of provision for private patients, which remains to be proved. The decision to incorporate a mental health unit on the same site also needs to be established and proven.

Various levels of engagement during the process to date have occurred. Meetings between the OH team and clinicians have been carried out which, we have been advised, have informed the design. A series of meetings with some of the 'secondary' bodies that will have an interface with the new hospital are, however, outstanding. Public engagement via the Citizens' Panel has been positive. Ongoing public engagement together with explanations for decision making will be important moving forward if decisions are to be widely understood and supported.

A total development budget of £804.5m has been proposed. This figure is not based upon sufficient levels of detail to make it robust and deliver confidence that it will not change. Design is at a pre-concept phase, the cost of land acquisition remains at large and many technical challenges remain. A fixed price will not be agreed with the Design and Delivery Partner, rather a 'target price' agreed. It has been advised that an 'affordability limit' of £550m has been agreed with the Delivery Partner. This requires further understanding as to how this figure has been arrived at. It will now require a process of 'cost led' design to be carried out. The timescale identified for the project is extremely challenging and therefore slippage will also lead to pressure on the cost of the project should the programme extend. As the project proceeds there is a significant risk that the outturn cost of the project exceeds the total budget identified unless strict management and governance procedures are put in place.

The procurement process for the PMO (MACE) and the Delivery Partner (FCC/ROK) appears satisfactory and in accordance with good practice. The early involvement of a Delivery Partner during the design and pre-construction stages is viewed as positive. The choice of contract type (NEC3) is appropriate for a major public project and supported, albeit the client should understand the level of risk that they are accepting.

The desire to deliver a new hospital by 2026 appears to be overriding due process on occasions and driving actions. This includes the decision to select a preferred site ahead of the Strategic Outline Case (SOC) being published and approved. Whilst delivery to programme is important it should not mean that due process is not followed.

7.2 Recommendations

The team recommends the following

1) Undertake a review of the performance standards including 2036 capacity;
2) Undertake post Covid pandemic planning and establish impact on sizing and configuration of the hospital;
3) Ensure that the schedule accommodation is up to date and is linked to the block plans and `1: 200 drawings. This to be undertaken ahead of budget sign off to enable resolution of any outstanding issues;
4) Ensure the capital costs include, not only major medical equipment that is detailed and specific, but also IT and digital platforms;
5) Charge a small and appropriate group to consider the feasibility and functionality of the proposed mental health facility. This will include whether it can be integrated into the singular building or more likely that it is a standalone facility either on the proposed site or at an alternative location. This should be fully costed and transparent;
6) All plans and designs to be peer reviewed & workforce requirements established;
7) Ensure the level of space allocated to cancer care, knowledge and training centre, entrance area, support services, engineering and estates are reviewed;
8) Ensure a single set of performance standards is established and agreed;
9) Action an improvement in the level of engagement with the public to share the current position, plus establish regular ongoing communication channels;

10) Ensure that the decision to select Overdale as the preferred site is properly detailed and explained;

11) The approvals process is clarified with clear levels of delegated authority published;

12) Ensure that a Risk Register is developed fully and maintained including full potential costs of risks and their mitigation;

13) Undertake NEC3 training for all key project participants including client representatives;

14) Ensure a value for money review is carried out once the Delivery Partner cost plan is produced;

15) Initiate an IPA process (independent Project Assurance) for the project moving forward as recommended by HM Treasury.

8 Post Review Commentary

8.1 Missing Information

The following information, which may provide assurance that the most effective evaluation was undertaken, was not provided to Archus for their review:

- Membership of Citizen's Panel;
- Who were the technical advisors to the Citizens' and Site Selection Panels and what was their experience?
- Minutes from Citizens' Panel Meetings showing how criteria was 'priority sequenced';
- Minutes from Site Selection Panel Appraisal of Long List – showing evidence of discussions held with regard to final ratings;
- Membership of Clinical Group;
- Membership of Delivery Group;
- Membership of Project Team;
- Final Site Selection Report;
- Results of Healthcare Survey;
- Results of Public Feedback Survey.

8.2 Functional Brief

It is accepted that the project is at an early strategic stage. It would be beneficial if the GoJ Scrutiny Panel received a single report bringing together all aspects of the functional brief. This is in our opinion one of the key findings to ensure an inclusive clinical activity, performance assumptions, operational policy requirements, clinical adjacency matrix and matching Schedules of Accommodation strategy for the entire facility in a single document.

- The performance detail from the demand modelling needs to be specialty specific, so that all key elements are visible for transparency and to ensure they meet the SOJ model of care
- That there is a clear statement that all clinical specialty representation have signed off departments at 1:200 drawing level, that those match the technical requirements and the linked schedule of accommodation.
- The finalised SOA includes the totality of the hospital and measured inclusive of all plant and communications and matches the final as drawn version.
- That the functional brief includes for covid and pandemic planning(allowances for flexibility, extra circulation as appropriate, infection control and storage of PPE etc) Particular attention in flows needs to be applied to isolation facilities in Emergency departments, waiting areas, ICU, Theatres and ensure department flows have sufficient back of house methods for access/egress that minimise contamination .

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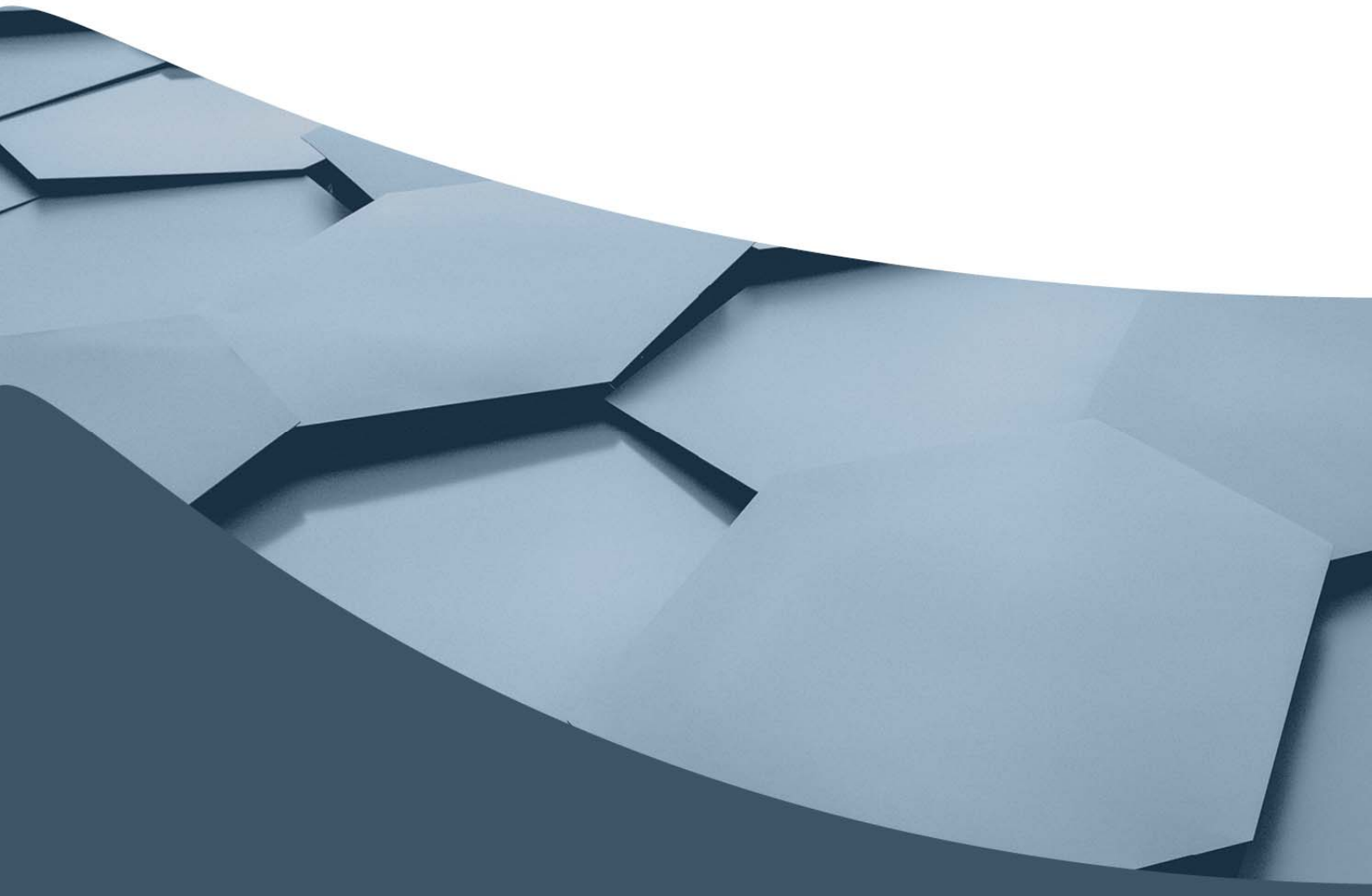
Appendices



Appendix 1 – Documents reviewed

- P.5 2019 Amendment by Deputy Morel
- p.123-2020 - Our Hospital Site Selection - Overdale
- Planning Inspectors Report - 2018
- Appendix_Three_-_Supplementary_Planning_Guidance_–_Advice_Note_-_Our_H
- p.5-2019 consolidated version - Rescindment of Gloucester Street
- 2020.10.20 Response re South Hill
- 2020.10.20 Letter re Documentation
- 2020.10.23 to OH Scrutiny Follow up questions
- 2020.10.19 - Follow up Questions from Advisors following Hearing - responses
- 2020.10.23 - Risk Register
- C&AG Report-Decision-Making-Future-Hospital-Site-Selection-23.11.2017
- OHP DP Tender Report v6.6 inc Appendices
- 2.1a Appendix 3 MJM Kit of Parts_v1.1 (1)
- 2.1a Appendix 2 MJM Draft Functional Requirements Brief v1.0(2)
- 2.1a Functional Brief and Options Appraisal (1)
- 2.1a Appendix 3 MJM Kit of Parts_v1.1
- 2.1a Appendix 2 MJM Draft Functional Requirements Brief v1.0(1)
- 2.1a Functional Brief and Options Appraisal
- 2.1a Appendix 4 MJM Suggested Employers Requirements Skeleton v1.0 (1)
- 2.1a Appendix 4 MJM Suggested Employers Requirements Skeleton v1.0
- 2.1a Appendix 1 EY Options Appraisal Summary (1)
- 2.1a Appendix 1 EY Options Appraisal Summary
- P.129-2020
- 2020.10.13 -DRAFT Question Plan
- SPG Advice Note - Our Hospital
- Land Acquisition - Overdale Report 061020
- Final Site Selection Proposition Lodged 061020
- JCM Review Paper_20200528_Final_Draft_incl Addendum
- 2.3 Finance Paper Final (short form)
- 200929 - OHP - Project Manual v2.3 WIP DRAFT FOR ISSUE
- 20200903 Scrutiny Presentation Shorter Shortlist
- 2.1b Appendix IV Citizens' Panel agreed criteria (FINAL)
- r.54-2019 Our Hospital Programme Update to States Assembly Sept 2019

- .DS_Store
- 2020.10.05 - Jean Lelliott
- Independent Assessment of Site Selection Weighted Analysis 170920 -
- New Hospital Site Selection Assessment Report (2)
- New Hospital Site Selection Assessment Report (2)
- Panel assessment Copy of Site Selection Weighted Analysis 170920

- 2.2 Finance Briefing Paper 20200408
- 20200710 Scrutiny Site Briefing - FINAL (1)
- Appendix 6.3 Drainage Considerations
- Appendix 6.1 Site Acquisition Feasibility Report
- Appendix 6.4 Site Economic Assessment
- Functional Brief and Options Appraisal
- Timeline - Previous committments
- Relevent Media Articles and FOIs
- Site Selection Report - Appendix I - List of sites
- Site Selection Report
- Site Selection Report - Appendix II - notes on each site (FINAL)
- R Our Hospital Citizens Panel selection methodology CW
- Site Selection Report - Appendix III - Outcome Matrix (FINAL)
- OHP_Jersey_Interim site evaluation_V8
- Our Hospital - Stakeholders
- 2020.09.22 - Citizens Panel Question Areas
- r.116-2019 - Our Hospital Project - Next Steps
- 20191111 Our Hospital Citizens' Panel TOR
- ID Our Hospital Kit of Parts report 20200722 CB
- ID Our Hospital Site Shortlisting Report 20200825

- 1.12 - W.S. Atkins - SoJ Healthcare Planning Methodology
- 1.14 - W.S. Atkins Hosp Pre-Feasibility Spatial Assessment Project May 2013
- 1.17a - W.S. Atkins Refined Concept Addendum Appendices 2013
- Appendix 2 - Verification of previous site deselection
- Timeline 2011 - 2019

- OHP Contract PEP Comment Tracker 2020 07 20
- Our Hospital PCSA 200720
- pdfsam_visual_05GaZ
- Schedule 09 - Notional PWDD Calculation
- Schedule 09 - OHP-ITT Clarification Stage_Agenda E FCC ROK (Bidder 2)
- Schedule 09 - Our Hospital - Z Clauses and Schedules 021219 (2)
- Schedule 09 - Our Hospital Main Contract Option C 021219
- Schedule 09 - ROK FCC_JV_Covering Letter 20.05.20
- Schedule 09 - ROK FCC_JV_Covering Letter 26.05.20
- Schedule 09 - Schedule of Cost Components
- Schedule 9 - Jersey OHP - Delivery Partner Procurement - Declaration Statements_SIGNED
- Schedule 10 - Appendix 1 - The Employer's Requirements
- Schedule 10 - Appendix 3 - Staff Allocation for Pre-Construction Services ROK FCC JV
- Schedule 10 - Appendix 4 - Schedule of Surveys
- Schedule 10 - Appendix 5 - On-going monitoring of financial standing
- Schedule 12 - OHP Stage 1A Activity Schedule FINAL
- Schedule 12 - OHP Stage 1B Activity Schedule FINAL
- Schedule 13 - Staff Rates and Expenses

Appendix 2 – Our Hospital: Planning Risk Review – Briefing Note And Commentary

1. This Note has been produced for K2 Consultancy in support of their engagement with the States of Jersey Hospital Review Panel.

2. MSPlanning have been asked to provide commentary and advice in connection with the proposed approach by the Our Hospital team relating to planning matters. Specifically, we have been asked to set out the risks associated with the planning process.

3. I have been provided with a selection of documentation, comprising:

- Reports on Shortlisting and Plan for Detailed Site Appraisal Process (with appendices) 6 July 2020;
- Our Hospital Supplementary Planning Guidance: Advice Notes;
- Chief Minister's Report to States Assembly R.54/2019 being the Hospital Project Program Updates, 13 May 2019;
- Planning Inspectors Report for the PP/2018/0507 planning application;
- Interim site evaluation report, with Appendices, 15 August 2020;
- Citizens' Panel Question Areas, 22 September 2020;
- Scrutiny Site Briefing presentation of 10 July 2020;

4. I can confirm that all these documents have been read and understood. In providing feedback, I have tried to take the documents in chronological order.

5. The Inspectors Report for the PP/2018/0507 application set out that:
"the legal framework for considering any planning application in Jersey is set by the Planning and Building (Jersey) Law 2002 (as amended). The Law adopts a "plan-led" system whereby the Island Plan, produced in an open and participative process and thereafter adopted, takes primacy in decision-making. There is a general presumption that development which is in accordance with the Island Plan will be permitted and development that is inconsistent with the plan will normally be refused. A decision maker does have the discretion to depart from the provisions of the Island Plan if there is "sufficient justification ".

6. The Inspector noted that the current plan is the 2011 Island Plan (Revised 2014) which does not make any specific provision, or site allocation, for a new General Hospital.

7. The Inspector accepted that there are well evidenced difficulties arising from the existing General Hospital estate and that the "need" for a new hospital in some form, as part of a new model of care, is well evidenced and undisputed. He considered that *"this is a material and weighty planning consideration ".*

8. The Inspector noted that there would be tangible negative impacts in relation to townscape in

particular streets, some of those impacts will be "*dramatic and adverse*". He also noted that the design "*pushes somewhat beyond the urban design comfort zone*" and considered that the proposal breached several design policies from the Island Plan, and these breaches would normally lead to a refusal of planning permission.

9. He also noted that the proposal would introduce very large and tall buildings into the immediate setting of an extremely fine and significant listed building and cause harm to the setting of other listed buildings in the wider vicinity. Notwithstanding other positive heritage aspects of the scheme, he considered "*each of the instances of identified harm represents a breach of policy"* which weigh against the proposal.

10. He also found that there will be a significant loss of sunlight and overshadowing of a number of residential properties and that these impacts would be unreasonable, again breaching Island Plan policies, and weighing against the proposal.

11. In balancing the factors in favour of the proposal - including the spatial and locational factors supporting a sustainable and accessible location, plus the comprehensive redevelopment removing a collection of unattractive buildings to be replaced with an integrated set of new buildings and attractive areas of public realm - the Inspector concluded that:
"the adverse effects and impacts are significant and demonstrable and all matters that are fundamental to the Island Plan, and indeed the Law. Put simply, the Plan says that developments that have the adverse effects I have identified will not be permitted. As a result, a logical plan-led conclusion guides the decision-maker to refuse planning permission, due to the significant planning harm that will be caused."

12. The Inspector then turned to the issue of whether there is sufficient justification to depart from the provisions of the Island Plan, as the Law allows. He noted that what constitutes sufficient justification for overriding the plans provisions is not defined, but "*there can be little doubt that providing a much-needed new hospital to serve Jersey's population could provide such a "public interest" justification."*

13. The Inspector then concluded that the plan-led recommendation is that the application should be refused for the reasons he identified, however he invited the Minister to consider whether there is sufficient justification for accepting the significant planning harm, identifying that *"this would be a political assessment and decision."*

14. In refusing the planning application, by reference to Ministerial Decision MD–PE–2019–0004 (see Appendix A) the Minister took Officer advice that there was a well evidenced and undisputed need for a new hospital, which is in the Island interest. The Minister is recorded as noting that this need, combined with the many other planning benefits of the development, was considered by Officers to be sufficient to outweigh the negative planning impacts of the proposal and leads to a decision to approve the outline application. However, the Minister considered that on the basis of the planning harm identified by the Inspector he was *"unable to conclude that there existed an overriding public interest benefits which provided sufficient*

justification for making a decision which is inconsistent with the Island Plan."

15. The Minister also noted the Inspectors view that "*There is no stand-out alternative site option that would be clearly superior in planning terms*" the Ministerial Decision indeed records that *"each alternative sites identified would come with a range of different adverse environmental effects and consequences."*

16. It is therefore safe to say but even at this early stage in this Review, it is apparent that the planning professionals (including the independent Inspector) and the Minister were aware that any alternative sites will come with particular planning challenges.

17. It is worthwhile identifying that this planning application was refused on 14 January 2019, having been received as valid on the 16 April 2018. This Application went to the public inquiry process in September 2018 and the Inspector's Report was issued on the 10 December 2018.

18. The timeline therefore shows a nine-month period, from submission to determination comprising:

- 5 months from submission to the public inquiry
- 3 months for the Inspectors reports to be produced, and
- 1 month for consideration by the Minister.

19. It should be noted that this was the second application for a new hospital on the Gloucester Street site and the earlier PP/2017/0990 application had a determination timeline of six months (from submission in mid-July 2017 to the refusal on 9 January 2018. This comprised:

- Four months from submission to the public inquiry
- Two months for the Inspectors report to be produced, and
- One week for consideration by the Minister.

20. From consideration of the timelines relating to other public inquiries in recent years, the periods for assessment and determination have not been below six months (see Appendix B).

21. This reflects that the process of a public inquiry is logistically complex and resource hungry. It is also fixed to a timetable which is set out by the Planning and Building (Public Inquiries) (Jersey) Order 2008. Although there is some flexibility it realistically requires a timetable of an absolute minimum of nine weeks from the announcement of the inquiry, to the inquiry taking place. This is subject to lead-in times for the validation of an application (anything from one week to 6 weeks) and the complications of securing an Inspector from the UK, including coordinating their diary, and avoiding public holidays etc.

22. It is also likely that the Minister would be conscious that the public inquiry had been called because "*the application is likely to have a significant effect on the interests of the whole or substantial part of the population of Jersey*" (as per Article 12 of the Planning Law) and that

having called an inquiry on this basis the timetable should legitimately allow for the population of Jersey to have sufficient time to properly input in the process.

23. Once the inquiry has concluded there is no timetable for the Inspector to produce his report, and when the report is submitted to the Minister there is no timetable for the Minister to then make their determination.

24. As has been seen with two public inquiries heard in the autumn of 2020, external factors can also influence the timetable, and the coronavirus "lockdown" meant that independent Inspectors could not travel from the UK, and although virtual hearings were considered the need to undertake a site visit meant that this was not a practical alternative.

25. For programming purposes, a six-month process from the submission of the application to its Ministerial determination is the minimum that should be realistically expected.

26. The Chief Minister's Report to the States R.54/2019 sets the context for the "next steps" following the refusal of the second Gloucester Street application, and the decision of the States Assembly to rescind the designation of this location as the preferred site.

27. With reference to the planning considerations, this R.54 report sets out that:
"in conjunction with the Minister for the Environment, we will establish a proper "public interest test" which insures that appropriate weight is given to this sometimes competing interest and expectation involved in determining the site selection and planning matters."

28. Also, this R.54 report sets out that:
"we will also ensure that the Government updates the planning framework in an appropriate and timely manner, so that the new Island Plan (unlike the current Plan) specifically allows for the designation of a new hospital. This will be subject to consultation, scrutiny and consideration by the States Assembly. "

29. R.54 also included summaries of discussions that the Chief Minister had had with States Members, and these discussions included that: the public interest test needed to have an appropriate weighting; there should be ways to work round the Island Plan; and, whether the magnitude of the decision should be carried by the single person as Minister for the Environment alone.

30. In February 2020 Supplementary Planning Guidance (SPG) in the form of an advice note titled "Our Hospital " was issued in a draft form. This SPG was adopted by the Minister in May 2020 and will be a material consideration in the determination of any planning application.

31. The catalyst for this SPG is a request from Senator Farnham, as Chair of the Our Hospital Political Oversight Group, to the Minister of the Environment to request planning guidance to support the hospital application (and process).

32. This request echoed many of the topics which the Chief Minister referenced in R.54 in his notes about discussions with other Members (as noted earlier) and sought guidance on two matters being:

- First, the planning process you would expect to be followed in the site selection process; and
- Second, the issues that you would expect to be covered when putting together the planning application, and the issues that will need to be answered for the planning determination.

33. The SPG, in my view is a fairly dry document which sets out a summary of the key planning policy considerations which are already within the Island Plan, layered with the usual Ministerial requirements for a valid application.

34. It does, however, touch on two key issues which were not explicitly requested in the letter from Senator Farnham being the "public interest test" and the context of the new Island Plan. These issues are discussed in turn below.

35. With reference to the "public interest test" (which has become the term used for considering whether there is sufficient justification to depart from the Island Plan – as per the provisions of Article 19 of the Planning Law) the SPG says that it is not possible to list all the matters which might constitute a wider public interest benefit on a proposal which has not yet been submitted and on a site which has yet to be selected.

36. However, some commentary is then included, with the SPG noting that:
"*failing to address, or delaying, the evidenced need for a new general hospital will have profound and negative consequences, which will increase in scale and severity over time. Whilst not a planning issue, this is clearly a concern to the Island and thus a matter of public interest."*

37. In my reading, the SPG is leaning towards a position whereby the healthcare needs of the Island can be introduced into the decision-making process, alongside the planning needs as articulated by the Island Plan policy framework.
38. Whilst touching on the issue of the public interest test, the SPG does not explicitly set out that the Minister will take healthcare needs into account, neither is it explicit that significant weight will be apportioned to these pressing health care needs as part of a wider balance with whatever planning issues are identified in the assessment of the application.

39. I think it is also notable that the SPG does identify that a new hospital of the scale required is unlikely to fit neatly with the Island Plan policy context and that some tension with the policies and some adverse environmental and other effects are very likely. The SPG also sets out that "*we have not identified a perfect site for the new hospital. Instead feasible site options have been identified that could deliver the hospital project, with each presenting different environmental effects and consequences*."

40. I consider this to be somewhat underselling the scale of the challenges which may lie ahead. The development of a hospital of around 70,000 m² is highly unlikely to be delivered in Jersey without some "planning harm" being identified, some of this harm may well be significant, and beyond a "policy tension". Such a conclusion aligns with the feedback from the independent Inspector for the previous applications and may set expectations at a more realistic level.

41. I consider the SPG has shortcomings that means it isn't as useful to the Minister, and the application team, as it could be (and indeed as they may need it to be in the final determination).

42. On the second topic emerging in the SPG, but not identified explicitly in the letter from Senator Farnham, the guidance identifies that the Island Plan is currently being reviewed, and that it will make provision for a new hospital " *either by way of allocating a specific site or including a policy which enables a new proposal to be tested* " depending on the progress of the Our Hospital project relative to the Island Plan. The SPG identifies that the context for decision-making in a new Island Plan is in all likelihood going to be "*more straightforward*" but there will still be planning and other issues that need to be addressed.

43. As with the issue of the public interest test, the SPG falls somewhat short of explaining how the emerging Island Plan review will provide a more straightforward decision-making process. It is impossible to consider a situation emerging where key issues such as the need for high quality designed appropriate to its context, the protection of the amenities of neighbours, and the preservation of the special interest of listed structures (being the reasons for the previous refusals) are edited-down as planning issues to any significant degree. In all probability these will be important tests carried forward from the current Island Plan into the new Island Plan.

44. The review of the Island Plan has been somewhat disrupted by the coronavirus pandemic, coupled with the uncertainty of Brexit, and as such the new Island Plan will cover a shorter three-year period, from 2022 to 2024, before a longer term, 10 year plan will be put into place. The "Preferred Strategy Report" has just been issued, (as endorsed by the Council of Ministers) and this establishes that the draft Island Plan is scheduled for publication for 12 weeks consultation in March 2021 with approval by the States Assembly (following an independent inspection) anticipated for early in 2022.

45. The Preferred Strategy Report identifies that the plan will be to make provision for the redevelopment of critical public and community infrastructure. This will "*include provision for a new hospital…. "*. However, this falls somewhat short of saying that a site-specific designation will be made.
a. Even if a site-specific designation is made, the timeline for the adoption of the Island Plan is early 2022, meaning that it is likely to have statutory weight in the public inquiry for the Our Hospital application, but it could be some limited weight and therefore have a bit of relevance. Indeed, the timeline for the Our Hospital application means that the independent

inspection of the new Island Plan is likely to occur around the same time as the public inquiry for the hospital.

46. Moving to site selection, it is apparent from the 10 July 2020 Scrutiny Briefing Paper and the report on Shortlisting (etc) of 6 July 2020, that the site selection process was based several logical sequential filtering steps, being:

- a public 'Call for Sites';
- clinical requirements for both hospital content and adjacencies, which set a minimum ground floor area;
- the issues of timetable based on the 2026 'deadline' set by the financial and logistical issues associated with maintaining the current hospital estate;
- criteria developed by a Citizens' Panel to identify important issues;
- a detailed appraisal against the Citizens' Panel criteria, by the Site Selection Panel.

47. The Report and the Scrutiny briefing paper both clearly conclude *"no ideal site – each site has unique opportunities and challenges."*

48. The planning policy risks are identified, at broad level (as a scheme is not available to produce a detailed review) within the interim site evaluation report, and it is quite clear (at section 5.2) that:
"Insofar as the five shortlisted sites are concerned, none benefit from unqualified policy support from the Island Plan."

49. Indeed, the Interim Site Evaluation Report does identify that the shortlisted sites will have planning issues to deal with which were not relevant to the two previous applications including (variously) elements of Protected Open Space, Green Zone and Green Backdrop Zone. There are also different technical policies to navigate, including complex highways matters.

50. I'm aware that there has been some discussion that it may be necessary to progress applications for enabling works ahead of the primary hospital proposals. It is my view these will be difficult to justify given that they somewhat pre-judge that the hospital application will be delivered and be successful, although they may be justifiable on the basis of wider public gains irrespective of the Our Hospital context.

51. It is perhaps worthwhile at this juncture to note that a third-party appeal system exists in Jersey, whereby if someone has an interest in land within 50 m of an application site and has made a representation at the application stage, then they can appeal against a decision made by the Department or the Planning Committee.

52. Enabling applications would be at risk of planning appeal by a third party which could add four months to their determination (and a significant degree of uncertainty) and would involve an independent Inspector coming from the UK to hear the case and write a recommendation to the Minister (who makes the final decision).

53. As the Minister has already indicated that the application for the hospital itself would be called-in for his consideration after a public inquiry, it is not believed that such a primary determination is challengeable by way of a third-party appeal, as the Minister would have made the first decision, and it cannot be escalated to anyone further for a second determination. It would remain however that a Ministerial determination after a public inquiry is challengeable in Court – in a manner similar to a judicial review in the UK.

54. It is clear to me that the project team are aware that "*all sites would need mitigation against planning policy when considered against the plan as a whole*." What we don't know at this stage is the magnitude of those risks, which cannot be properly quantified without a specific scheme being available, at least in a sketch form. In my view, it is highly likely that the policy hurdles will be of an equivalent magnitude to those which were appraised by the independent Inspector in his December 2018 report, although the issues themselves may be different.

55. The timetable for the new Island Plan does enable site-specific designations to be incorporated into the new policy framework however this is unlikely to have gained statutory weight by the time of the public inquiry to consider the hospital application. A new Island Plan may have some weight although I can foresee a situation where, at best, a site-specific designation is not completely permissive but sets, for example, a criteria-based framework against which an assessment would need to be made. That framework already exists in the broader policy set out within the current Island Plan and SPG, although having it pulledthrough to a specific element of the new Island Plan (even if not yet adopted) may advance the application slightly.

56. Although there is no legal formal concept of "precedent" in a planning sense, as no two applications are ever identical with contextual circumstances, it is relevant that the Minister has, in his January 2019 determination, felt unable to accept the case that the need for a hospital represents the public interest test / sufficient justification necessary to make a determination which will result in identified planning harm occurring.

57. It is my view that the conclusions of an Inspector in relation to the Our Hospital application will also identify planning harm, which may also be of a significant magnitude. The Minister will therefore be tasked with making a determination which, to a greater or lesser extent reflects the same circumstances that he found himself in back in early 2019.

58. The content of the Our Hospital SPG does not provide him with a different determination framework to that which was around in 2019, and as such he will – to use the terminology from the previous planning Inspector – be faced with making his own political assessment of the public interest.

59. This is probably why the Minister has been discussing establishing a panel to make the decision, with him sitting alongside the Chairman of the Planning Committee and the Assistant Minister. It is unclear at this stage whether such an approach is politically acceptable, and (in any event) it would mean that the relevant provisions of the Planning and

Building (Jersey) Law 2002 would need to be re-drafted. It may, however, enable a different determination to be made, with a broader political consensus as to the public interest test.
60. It is therefore my conclusion that the process is fraught with risks (primarily timetable) and that the determination will involve planning-harm being identified, which does not accord with the policy framework of the Island Plan (either current or emerging new) and that the Minister (sitting alone, or with a Panel) will be making a determination on still-undefined public interest test, which is inherently political.

John Nicholson BA(Hons) BPl MRTPI
Chartered Town Planner
For MSPlanning Limited.

Appendix A - Ministerial Decision MD-PE-2019-0004 (to refuse PP/2018/0507)

Minister for the Environment

Ministerial Decision

Decision Reference: MD-PE-2019-0004			
Decision Summary Title:	Public Inquiry Decision PP/2018/0507 – New General Hospital	**Date of Decision Summary:**	14th January 2019
Decision Summary Author:	Director of Development Control, Regulation, Growth, Housing and Environment	**Decision Summary: Public or Exempt?**	Public
Type of Report: Oral or Written?	Written	**Person Giving Oral Report:**	N/A
Written Report Title:	Report to the Minister for the Environment	**Date of Written Report:**	10th December 2018
Written Report Author:	Mr Philip Staddon – BSc, Dip, MBA, MRTPI	**Written Report: Public or Exempt?**	Public
Subject: Decision following a Public Inquiry under Article 12 of the Planning and Building (Jersey) Law 2002 (as amended) on Outline Planning application PP/2018/0507 at the General Hospital, Kensington Place & Westaway Court, Savile Street, St. Helier, Jersey.			
Decision(s): The Minister refused to grant planning permission under Articles 12 and 19 of the Planning and Building (Jersey) Law 2002 (as amended), in respect of the following development: OUTLINE APPLICATION: Demolish Stafford Hotel, Revere Hotel, 33-40 and 44 Kensington Place, including Sutherland Court, and parts of General Hospital; Peter Crill House, Gwyneth Huelin Wing, link block, lab block, engineering block and chimney, 1960's and 1980's block on the Parade, temporary theatre block and Westaway Court. Phased construction of new hospital buildings at the General Hospital site and at Westaway Court, refurbishment of the Granite Block for continued nonclinical hospital use, improvements			

and construction of one half-deck of parking to Patriotic Street Car Park, and all associated landscaping and public realm, highways and access, plant and infrastructure works. Fixed Matters: Means of Access. Reserved Matters (by parameter plans): Scale and Mass, Siting, Landscaping and Appearance and Materials. EIS submitted. 3D model available. AMENDED PLANS
Reason(s) for Decision: The Minister agreed with the Inspector's recommended reasons for refusal and refused the planning application. The Inspector's recommendation in his report dated 10th December 2018 is: That, unless the Minister considers that there is a public interest benefit that provides a sufficient justification for making a decision which is inconsistent with the Island Plan, planning permission should be REFUSED for the following reasons: Reason 1 (Heritage): The proposed main hospital development, by virtue of its siting, size and mass, would not preserve or enhance the settings of numerous heritage assets. It would cause serious harm to the immediate setting of the nineteenth century Grade 1 Listed Building within the site, which would be overwhelmed and dominated by the imposition of large, tall and imposing modern buildings in its immediate setting. The settings of Listed buildings on Kensington Place and Edward Place would also suffer serious harm from the proximity and imposing presence of the new blocks. The proposal would also harm the settings of Listed buildings and places in the wider locality, most notably the many Listed buildings along Peirson Road, Victoria Park, People's Park and Westmount Gardens and Lower Park. As a result, the proposal conflicts with Policy HE1 of the Island Plan and with the strategic high priority given to the protection of Jersey's historic environment set out in Policy SP4. Reason 2 (Residential amenity): The proposed main hospital development would, by virtue of its siting, size and mass, lead to unreasonable harm to the residential amenities and living conditions of neighbouring residential properties. In particular, a significant number of residential properties on Kensington Place, Newgate Street and Patriotic Street will suffer notable reductions in daylight and, in some cases, these effects will be exceptionally severe. There will also be a significant loss of sunlight to properties on the north-west side of Kensington Place. As such, the proposal is contrary to Policies GD1(3) and GD3 of the Island Plan 2011 (revised 2014) which seek to protect reasonable expectations of amenity and mediate the Plan's support for higher density development. Reason 3 (Design, townscape and visual impacts): The proposal, by virtue of its likely size, height and mass as set out in the submitted parameters, would result in a building that would be too large for this restricted site. In addition to significant heritage and amenity harm (Reasons 1 and 2), the proposal would also result in localised adverse townscape and visual amenity impacts, most notably in Kensington Place, Newgate Street, Patriotic Street and when viewed from approaches from the northwest, from where the building would appear imposing and out of scale. This conflicts with the Island Plan's strategic Policy SP7 (Better by design) and with Policies GD7 (Design quality), BE5 (Tall buildings) and GD5 (Skyline, views and vistas). The Minister noted the Inspector's invitation to consider whether there is sufficient justification, in the public interest, for accepting the significant planning harm and conflicts with the Island Plan, to grant Outline planning permission. The Minister received and considered officer advice, consistent with that provided to the Applicant and to the Public Inquiry. He agreed with officers, who considered that there is a well-evidenced and undisputed need for a new hospital, which is in the Island's interest. The Minister noted that officers considered that this need, combined with the many other Planning benefits of the development, would be sufficient to outweigh the negative Planning impacts of the proposal and lead to a decision to approve the Outline application. However, the Minister was clear that the Inspector had weighed up the negative and positive aspects of the proposal in coming to his recommendation, and the Inspector stated that to make a decision in the public interest, which is inconsistent with the Island Plan, would be a political one. The Minister considered that the serious impacts of the proposed development on the residential amenity of its neighbours, the general townscape and on heritage assets were unacceptable, particularly as the Inspector indicated that alternative sites were available. For this application, the Minister was unable to conclude that there existed an

overriding public interest benefit which provides sufficient justification for making a decision which is inconsistent with the Island Plan. Additionally, the Minister considered that there was no reliable evidence of the length of delay involved, were the States of Jersey to consider alternative options. The Minister accepted the Inspector's conclusion that the Gloucester Street site remains a sustainable location for a new hospital in broad spatial terms and also accepts that it remains the States of Jersey's preferred site. It would continue the delivery of medical services in an established central and highly accessible location. The Minister agreed with the Inspector's conclusion that the impacts of this current application, set out in the reasons for refusal, are a product of "the site being not quite large enough to comfortably accommodate the proposed scheme". That does not preclude a different application from overcoming these issues in this location. The Minister recognises this decision may lead to more work in order to resolve these issues. The Minister also noted the Inspector's view that, "there is no stand out alternative site option that would be clearly superior in Planning terms". Each alternative site identified would come with a range of different adverse environmental effects and consequences. Finally, the Minister recorded his thanks to the Inspector for a robust and thorough report, and also to the Applicant's project team, which had worked hard within a remarkably short timescale "to produce a calmer, more sophisticated and refined proposal". Nonetheless, for the reasons identified, the Minister refused this current Outline planning application.	
Resource Implications: Unknown at present.	
Action required: Inform interested parties, press and public of the decision	
Signature: Deputy John Young	Position: Minister for the Environment
Date Signed:	Date of Decision: 14th January 2019

Appendix B - Summary of timeline for all previous applications called to public inquiry.

SITE	REF	REGISTERED	DETERMINED	MONTHS
Broadlands	P/2019/1042	Aug 19	Not yet	14+
Field 622	P/2010/1717	Nov 10	Aug 13	33
J525	P/2019/1183	Sept 19	Not yet	13+
Hospital 2017	PP/2017/0990	July 17	Jan 18	6
Hospital 2018	PP/2018/0507	April 18	Jan 19	9
St Peter housing	PP/2017/1444	Oct 17	April 18	6
Grantez	P/2015/1860	Dec 15	July 16	7
Les Q School	P/2016/0870	July 16	Feb 17	7
Plemont	P/2011/1673	Dec 11	Sept 14	33
Tamba	P/2017/1023	July 17	July 18	12

Appendix 3 - Summary of NEC 3 Contract issues

From a previous recent project, we have put together some key points that can arise for consideration on the NEC3 contract and amending existing clause terms.

- Clarity as to the concept of GMP – public sector bodies should avoid the terminology of GMP and stick with a 'Target Cost' contract
- Unless absolutely necessary, it is more sensible to avoid insisting on a capped cashflow as this can prevent the Contractor from achieving programme betterment and drives wrong behaviours
- Public sector bodies need to seriously consider whether upon reaching the agreed contract sum, the project from a financial perspective struggles to survive or whether there should be the introduction of a robust mechanism for introducing a pain/gain share which sets out to drive gain for both parties and not to be seen as favouring only the client. This again will be instrumental in driving the right behaviours
- The introduction of making an assessment of the Contractor's share throughout the duration of the construction, rather than at the end, otherwise, it can expose the client to overpayment and having to claw back monies which could prove problematic
- Introduction of Priority of documents
- Contractor's design to exercise reasonable skill expected of a professional exercising the same duties
- Clarity around critical path on programme and a clear time bar for acceptance by the Public sectors PM
- Submission of application for Payment as a absolute requirement for payment
- Introduction of BIM
- Provision of IPR
- Introduction of Disallowed Costs for defective works during the works
- Alignment of Activity Schedule, Cashflow and Programme – this needs to be closely linked with Project Controls and earned value
- Provision for undertaking of final assessment
- Acceptance of defect and for PM to make his own assessment (currently not included within the NEC3)
- Introduction of Force Majeure event inclusive of Covid-19 and Brexit (currently NEC3 only has a simple prevention clause which will need expanding)
- Clear definition of what risks we expect the Contractor to take on Covid-19 and in relation to Brexit (both have created significant uncertainty and not all events will be captured under the realms of a change in law)
- Provision of linking accepted programmes with entitled payments. Currently, NEC3 loses its teeth after the first programme for acceptance where the contract provides for withholding 25% of the value of works undertaken, but thereafter there is no link with financial entitlement
- Clarification of compensation event for weather and agreed definition (to include wind measurement – particularly important where many activities are crane dependent)
- Provision of PCG and Performance Bond – We do not know the SOJ agreement with FCC. However, if possible a Performance Bond would be useful although this many not be achievable. In the current uncertain market, a 10% performance bond may be very important, this occurs in many countries globally as a client retained amount.
- Current key issues around Environmental, Sustainability, Social Values will need to be built into the contract
- Detailed definition of Completion and any performance compliance requirements

Appendix 4 - NEC 3 Contract Review

THIS PRE-CONSTRUCTION SERVICES AGREEMENT

Parties

(1) The Minister for Infrastructure "*Employer*"

(2) ROK Group Holdings Limited "*Consultant*"

BACKGROUND

A. The *Employer* wishes to undertake the design, development, construction and completion of the Our Hospital, hospital project (the "***Project****")* on the *Site.*

B. The *Employer* wishes to engage the *Consultant* to without limitation Provide the Services to design the Project, advise on the buildability of the Project and manage all interested stakeholders.

C. Following completion of the Services the Employer may wish to instruct the Consultant to carry out and complete the design, construction and completion of the Project on the terms provided for pursuant to the Works Contract.

The Consultant will Provide the Services in accordance with this Pre-Construction Services Agreement and the *conditions of contract.*

The *conditions of contract* are the core clauses and the clauses for the NEC3 Professional Services Contract incorporating:

Option A (Priced Contract with Activity Schedule) in respect of the Stage 1A (Feasibility) as set out in Schedule 10; and

Option C: (Target Contract) in respect of the Stage 1B (Balance of services) set out in Schedule 10 (Third edition, 2013)

Pre-Construction Services Agreement

The documents forming this Pre-Construction Services Agreement include:

Schedule 1 – Option Z – Additional Conditions of Contract
Schedule 2 – Option X – Additional Options
Schedule 3 – Contract Data
Schedule 4 – Third Party Agreements
Schedule 5 – Sub-Consultant Collateral warranty agreement
Schedule 6 – Sub-Contractor Collateral Warranty agreement
Schedule 7 - Notice to Proceed
Schedule 8 – Project Cost Plan
Schedule 9 – Works Contract and Works Contract Conditions
Schedule 10 – Scope
Schedule 11 – Programme (First Accepted Programme)
Schedule 12 - Activity Schedule
Schedule 13 – Staff Rates and Expenses.

- **Affordability Limit**

The Consultant shall design the Works within the 'Affordability limit' identified in the Project Cost Plan. This shall include but will not be limited to:

- All design work including investigations/surveys/research as necessary to inform the design;
- Activities in connection with this Pre-Construction Services Agreement;
- Construction and the on-going design of the intended Project;
- Additional Services
- Additional Infrastructure – Transport Links
- Group 1,2,3 and 4 medical/specialist equipment;
- Preliminaries, overheads and profit/fees (pre and post Contract);
- Risk;
- Contingencies and
- Anticipated Inflation.

The 'Affordability limit' is the maximum forecast amount in the development of the Prices and which sum shall be Agreed between the parties before or on August, 31st 2020.

Is there not an Affordability Limit set out from the very outset? Schedule 8 suggests this is identified during the PCSA?

- **COVID-19**

If following the date of this contract, any States of Jersey departments and/or Ministers or other Parochial or Island Authority or the Government of the United Kingdom take any action or impose any greater restrictions in connection with COVID-19 than have been imposed prior to the date of this Pre-Construction Services Agreement, and such actions or restrictions prevent either Party from complying with its material obligations under this contract, then the Parties shall in good faith discuss and use reasonable endeavours to agree a means of working to ensure such obligations are met. For avoidance of doubt, the incapacity to perform due to those actions or greater restrictions will not be considered a Breach of the Contract by any of the Parties.

No comment, the intention here is clear

OPTION Z: ADDITIONAL CONDITIONS OF CONTRACT
Schedule 1

No comments

OPTION X: ADDITIONAL OPTIONS
Schedule 2

No comments

CONTRACT DATA PART ONE – DATA PROVIDED BY THE *EMPLOYER*
Schedule 3

Share Range	Share Percentage
Gain	**Gain**
95% to 100% of the Target Cost	50% Contractor / 50% Employer
90% to 95% of the Target Cost	25% Contractor / 75% Employer
Below 90% of the Target Cost	100% Employer
Pain	**Pain**
100% to 105% of the Target Cost	50% Contractor / 50% Employer
105% to 110% of the Target Cost	75% Contractor / 25% Employer
Above 110% of the Target Cost	100% Contractor

110% of the Target Cost is the sum above which the Contractor takes the whole risk of cost escalation.

Suggest the EmployerConsultant set out some worked examples of the above pain / gain share scenarios to ensure they are fully understood

CONTRACT DATA PART TWO – DATA PROVIDED BY THE *CONSULTANT*

Schedule 3

Statements given in all contracts

1. **If Option A or C is used**
   - The Activity Schedules are as set out in Schedule 12.
   - The tendered total of the Prices is £29,206,605, being
     - Stage 1A, Option A …….. £4,411,844
     - Stage 1B, Option C …….. £24, 797,761 **does not align with activity schedule**

Third Party Agreements
Schedule 4 – **no comment – third party agreements not used**

SUB-CONSULTANT COLLATERAL WARRANTY AGREEMENT
Schedule 5 – **Liability only 10 years?**
PI is back to back with main contact

SUB-CONTRACTOR COLLATERAL WARRANTY AGREEMENT
Schedule 6 – **no comment**

NOTICE TO PROCEED
Schedule 7 – **no comment**

PROJECT COST PLAN IDENTIFYING THE AFFORDABILITY LIMIT
Schedule 8

For clarity the Project Cost Plan is to be prepared and presented by the Consultant during the performance of this agreement. The Affordability Limit will be derived from this document following a joint review between the parties and following the release of the Schedule of Accommodation and any other document the Consultant reasonably requires.

Should an Affordability Limit not be agreed in advance and then later refined after feasibility?

WORKS CONTRACT AND WORKS CONTRACT CONDITIONS
Schedule 9

- NEC3 Engineering and Construction Contract (April 2013) Option C (the 'NEC3 Contract');
  ok

- Schedule of Additional Conditions of Contract amending the NEC3 Engineering and Construction Contract (April 2013) (the 'Additional Conditions'); and
  ok

- The NEC3 Contract and the Additional Conditions are subject to:

  - be agreed between the Parties.
    This should these not all be agreed, the terms of the works contract should be agreed before entering into the PCSA

- the agreed points set out in Agenda E of the ITT Clarification Stage dated 15.05.2020 which clarifies and records responses to previous questions and responses; and

  ok

- the covering letter dated 20 May 2020 as supplemented and amended by the further covering letter dated 26 May 2020.

  ok

SCOPE

Schedule 10

The following are the Services referred to in Contract Data Part 1:

The initial objective of the Services will be to secure a fixed price lump sum price to provide feasibility studies on multiple sites with options in size and form showing floor plans, elevations, cross sections, adjacencies, pre-planning consultation, materials study, structural engineering thoughts/proposals, service strategies/engineering, sustainability, cost estimate, risk and opportunities register. **Should there not be an agreed format of the cost plan, risk and opportunities register**

Upon completion of these studies, the sites will be selected by the Employer after consultation with the Consultant and other interested stakeholders.

The Consultant may then be requested to continue with the primary objective of the Services identified herein under the NEC3 Option C form of Contract. This two-staged approach provides the client with certainty in the feasibility stage for a known cost allowing for a brief pause in the need for site selection. for Works to maximise cost certainty for the Employer prior to commencement of the construction of the Works. This must be in conjunction with the finalisation and presentation of the contractor's proposals and the completed Works Contract.

The Services described below are indicative of the minimum level of service expected as part of this Agreement:-

Pre-Construction Services

Summary

1. Stage 1A: Undertake feasibility studies on multiple sites to be identified by the Employer;

2. Stage 1B: Complete the Services identified below to design, develop, construct and complete the ‘Our Hospital’ project;

3. Stage 1A and 1B: Provide all services and information as is necessary to meet the deliverables and timescales identified within the Accepted Programme to achieve the commencement of construction mid-2022.

Health & Safety

4. Undertaken sufficient due diligence to ensure all persons employed by the Consultant have the necessary competence to undertake the tasks they have been appointed to do under this appointment;

5. Provide a Health and Safety Project Co-ordinator (HSPC) for the purposes of fulfilling the obligations and duties as defined by the Management in Construction (Jersey) Regulations 2016

   This term is inconsistent with that used by the consultant, may be worth clarifying

6. Provide evidence to the Employer that Regulation 10 of the Management in Construction (Jersey) Regulations 2016 has been and shall continue to be complied with.

   is this on the activity schedule? Same comment applies for many of the following items

   a copy of the activity schedule (not in pdf) and the programme would be use ful to review all of these. If not suggest someone else checks this.

7. Advise the client of their duties under the Health and Safety at Work (Jersey) Law 1989, CDM (Jersey) 2016 Regulations, Health and Safety (Management in Construction) (Jersey) Regulations 2016 and all other statute, guidance, regulations etc. Ensure all designers comply their duties in respect of the aforementioned and the 9 principles of prevention

8. Consult with the Health & Safety Inspectorate, if required or when necessary to do so.

Design / Buildability

9. The Employer will provide suitably sized accommodation for the pre-construction activities of the PCSA project team – exact location to be confirmed by the Employer. The Consultant should allow for the fitting out of the building to a CAT B standard to suit the requirements of the Employer's team (The Employer will provide their own equipment, the Consultant should make due allowance for their own). Assume the number of operatives using the office will be circa 15 with a separate meeting room for 8-10 persons and hot desking capability. Full connectivity to wi-fi, display equipment for 'live' BIM model and desktop for 2D drawings (Consultant to supply this equipment).

10. To undertake feasibility studies on multiple sites such that the Employer can make a fully informed decision on the 'preferred' site or sites. These feasibility studies should include assessments of key infrastructure requirements, intrusive ground condition surveys, provision of block plans and 3D images for presentation purposes, consultation with stakeholders both clinical and non-clinical, health and environmental impact assessments, considered legal/land issues, an assessment against planning policies, risks and opportunities. A draft programme including design, enabling, construction

and an indicative cost estimate. The presentation of these findings will conclude this aspect of the appointment.

See comment elsewhere on feasibility surveys

11. Following site(s) selection proceed with all other duties listed herein.

12. Actively lead, co-ordinate and take full responsibility for the entire design and the design process to ensure satisfactory progression of the same for the completion of RIBA Stage 4 in accordance with the Accepted programme. Subject to satisfactory completion of RIBA Stage 4 and adequate market testing, this Service may lead to the Notice to Proceed. The Consultant is responsible for the sequential approval of the design throughout the period of the PCSA.

Adequate market testing?

13. Compliance with the published Health Technical Memoranda (HTMs) and Health Building Notes (HBN's) is not required 'per se' but the Employer expects design solutions that are appropriate for the project and the Island. The Consultant will be expected to develop the design standards with clinical and non-clinical stakeholders through the period of the PCSA. The HTM's and HBN's may however offer a sensible template for guidance.

14. Prepare, provide and update a 'Design Responsibility Matrix' to define the roles and responsibilities of the Consultant design team ensuring gaps between interfaces, errors or deficiencies in design and absence of production information does not occur.

15. Establish and proactively engage with all stakeholders to ensure full understanding of the 'Jersey Care Model', the draft functional brief and operational policies (expected end of June 2020) and schedules of accommodation (expected end of June 2020).

16. Actively take part in 'Visioning' workshops (2Nr) and a 'building blocks for clinicians' workshop (1Nr) in April/May 2020. The conclusion of which will finalise the 'brief'.

17. Hold, chair and minute design team meetings, workshops, engagement sessions, briefings and present proposals at appropriate intervals to the Employer team and within the timescales shown on the Accepted Programme. Invite the Employer's team to all design team meetings. Using the appropriate media, demonstrate design proposals via a BIM 3D model. This is to ensure the Employer is kept fully and visually informed throughout the design process.

18. Attend Steering Group, Project Board Meetings, provide comprehensive overview of the deliverables, risks and information required by the Employer. Attendance may also be required on the 'Citizen's panel' to provide overview of the design, site and local considerations.

19. Continue with the above to complete the RIBA Stage 2 (as per RIBA Plan of Work 2013) design including 1:500 site plan, 1:200's for the OBC stage submission in accordance with the Accepted programme and to begin the process of setting the Target Cost agreement. Prepare OBC report and submit to Employer. It should be noted by the Consultant that the OBC and FBC stage submittals are comparable to the P22 Framework deliverables.

20. Provide 1:500 site plan and massing proposals before the end of July 2020; 1:200 plans, sections, elevations and landscaping to commence from July 2020. MJ Medical who will provide the SoA, functional brief and operational policies would like the opportunity to review these proposals. It is expected the delivery partner will engage with MJ Medical, develop the design and obtain approval form the end users.

21. Continue with the design to complete the RIBA Stage 3 (as per RIBA Plan of Work 2013) design ,MNBV/including NBS specifications to facilitate 'soft testing' of the market for key packages in accordance with the Accepted programme and to set the Target Cost.

22. RIBA Stage 3 for the purpose of this project shall include but is not limited to completed structural design, external envelope, fire strategy plans, reflected ceiling plans, developed finishes schedules, partition types and NBS specifications.

23. Provide an 'ICT responsibility matrix' which clearly identifies all hardware and software needs, infrastructure, cabling, leads, distribution diagrams, wireless provisions, loose peripherals, access, licences etc. It should specify, supplier, funder, installer, test and integration into external systems.

24. Consult with the planning authority to obtain the planning permit, attend hearings as necessary and liaise with all other stakeholders in respect of the planning application and prepare all submittals as required by the Government of Jersey, this will include but not limited to, scale and massing, sitting, means of access, external appearance and materials, landscaping, contaminated land assessment (if appropriate), surface water management, biodiversity impact statement, noise survey data, waste management plan, design and access statement and EIA. You are referred to the Jersey Planning portal identified below:
https://www.gov.je/SiteCollectionDocuments/Planning%20and%20building/F-P1-NonHouseholderApplicationForm2019.pdf

25. Discharge planning conditions and 'reserved matters' including those which relate to pre-commencement of the works. Tabulate, monitor and progress with the Employer to achieve the planned Commencement date and the planned Completion date.

26. Continue with the design to complete the RIBA Stage 4 design (as per RIBA Plan of Work 2013) including NBS specifications for the FBC stage submission in accordance with the Accepted programme and in preparation for the subcontract tender enquiry process. Acquire technical or specialist design from the supply chain where necessary and incorporate as required. Prepare FBC report and submit to Employer.

27. Schedule regular user group meetings to review and revise where necessary all finishes, layouts, specifications, infection control, access, security and MEP installations.

28. Produce fully co-ordinated room loaded layouts, data sheets and equipment groupings for all rooms within the Project.

29. Provide and maintain a detailed design Risk Register for the project from the commencement of the PCSA. Update the register (min. once every 4 weeks) to show clear actions/timings to eliminate or mitigate these risks in full consultation with the Employer.

30. Investigate the location of all known and potentially unknown underground services using desktop studies and site based exploratory works as necessary to prove existence, locations, depths, capacity, structures, condition and connectivity. Revise design as required as a result of any discovery to avoid uneconomic cost or risk.

31. Provide Information Management software (4Projects/Viewpoint/BIW) license to be used by the Consultant and Employer teams. It is to be administered by the Consultant for the duration of the PCSA.

32. Appoint a Soft Landings Champion to follow Soft Landings Principles and work with both Client and IPT Soft Landings Champions.

33. Respond to all reports and recommendations from the Employer and if appropriate external stakeholders, ie. building control, fire service/engineer

34. Allow to hold meetings as required with Hospital personal to identify the specialist equipment requirements (i.e. MRI equipment and specialist turnkey packages etc.). Advise on best procurement options, minimisation of cost and de-risk hospital liability.

35. Undertake investigation works to identify bonded warehouse / storage facility requirements to provide continuity of construction where bad weather or other such events prevent the supply of materials to the Island. Ensure storage is suitably sized and located to mitigate the risk of delays to the construction period.

36. Ensure design incorporates readily available materials, sized to commonly available component sizes, provide information and guidance on waste and recycling management procedures and techniques during the design process, such that on-site wastage is kept to an absolute minimum.

37. Develop specific technical proposals for maximising productivity on a project of this type and scale, which are set against benchmarked schemes.

38. Produce a design which is both sustainable and follows best practice for environmental performance through specification and construction. The method of environmental assessment is not yet determined, this may be BREEAM, LEED or another. Provide all resources and continually advise on progress and if required, in respect of the credits sought to achieve the measured criteria.

39. Prepare BREEAM credit evidence for RIBA Stage 3 and 4 designs in time for timely submissions to the BRE and for OBC and FBC stage submittals.

40. Advise on potential impact of the Works upon neighbouring occupiers (if any) and users of nearby highways and planning the execution of the Works in such a way as to minimise disruption and prevent nuisance.

41. Co-ordinate the mechanical and electrical design information and assist in the production of fully coordinated drawings with regard to consistency, safety and builders' work. Formulate a cost-effective procurement route for the builders' work element. Clearly identify the extent that each particular work package shall be responsible for, to facilitate efficient work package procurement.

Building Information Modelling

42. Appoint a BIM Information Manager to assist the Employer during the entire period of the PCSA to develop the Employer Information Requirements (EIRs) and to manage the BIM process.

43. Create an informative BIM Execution Plan to PAS 1192-2 that fulfils the business need, identifies material, functional and performance requirements in respect of the individual departments, building components and maintenance. Submit within 4 weeks of the completion of OBC stage.

44. Ensure that the Works adopt the principles and meets the requirements of Level 2 BIM. The objectives being to satisfy the data and information requirements and to ensure the Works generate comprehensive and useable asset databases, and generate assets that meet operational performance requirements;

45. The final details for deliverables to achieve Level 2 BIM are to be included in the BIM execution plan (BEP) to be agreed between the parties. The BEP should be updated pre and post Contract.

46. A BIM execution plan (BEP) should be developed by the “Project Team” as the design stages progress to communicate proposals and approach, in response to the EIR COBie schema should be implemented as the core information exchange format sufficient to comply with the asset management standards.

47. Regularly provide and update a fully collaborative 3D model on a common data environment (CDE). It should be accessible by the Consultant team and Employer. Ensure the model is created upon a single software source and is ‘federated’ to provide clash detection capability and design co-ordination.

48. Liaise with any equipment procurement specialist engaged by the Employer and integrate any proposals from such specialist into the procurement plan.

Cost

49. Agree design deliverables with Consultant design partners. Provide an Activity Schedule for all engaged designers and submit to the Employer within one month of PCSA appointment. The activities described within the AS’s should broadly align with the scope and expected deliverables of this appointment.

50. Update and revise Activity Schedules as necessary to reflect progress of design and status of deliverables. Present monthly for interim assessments.

51. Monitor progress of the design and performance of design team against submitted Activity Schedules throughout the PCSA period. Report to the Employer's consultant team any deviation from the expected deliverables to meet the OBC, FBC stage submissions and proposed Notice to Proceed.

52. The Consultant will be expected to demonstrate 100% market testing of the supply chain and to the latest design information produced.

53. Collaborate, prepare and regularly update the Project Cost Plan (minimum fortnightly), attend monthly cost/commercial meetings with the Employer's PM and QS. Identify key design, programme and cost risks with mitigation proposals.

In what format?

54. Ensure the design team are fully aware of the elemental cost limits for the Project. Organise and facilitate a cost-design review workshops, focusing on efficient construction, avoidance of complex interfaces and the identification of major savings to the Project Cost Plan. Recommend economics in cost and time that may be available.

55. The Project Cost Plan shall be presented in an agreed and consistent format to avoid any ambiguity or confusion and reflect to market research and design development. A fully updated cost plan aligned with the design are to be provided prior to the closure of both the OBC and the FBC stage submissions, and upon the conclusion of each RIBA stage.

This should be agreed in advance, or at least the basic principles and level of information

Market testing of early cost plans and bechmarking requirements

56. Provide a comprehensive review of the Project Cost Plan before the submission of the planning application is made to validate the affordability of the proposals.

57. Obtain budget costs for all Group 1 and Group 2 equipment including all building materials not incorporated into L/P&M supply chain partners.

Group 3&4?

58. Identify to the Project Manager areas of potential increase or savings against the Project Cost Plan co-ordinate the interface between cost information and recommend appropriate action to the Project Team.

59. Participate in the change control system as agreed in conjunction with the Employer to ensure the proper control of all proposed changes. Advise on whether any proposed change is likely to affect the programme and provide advice on time, cost and quality for all proposed changes.

60. Undertake when reasonably requested by the Employer a Monte Carlo simulation analysis of the risk register for the Works to assess those risks, the likelihood of them arising, the cost consequences of such risks and any mitigation strategies. **Identify key stages when this is expected?**

61. Prepare, provide and maintain a detailed Risk Register for the project and from the commencement of the PCSA. Update the register (min. once every 4 weeks) to show clear actions/timings to eliminate, mitigate or manage the risks in full consultation with the Employer.
Format?

62. Produce an 'elemental' life cycle cost analysis report (2 credits) based on conceptual design proposals; GA's/elevations/site plan/functional areas, energy estimates (RIBA Stage 2) for OBC stage submission. Update the LCC for FBC stage submission.
Is the LCC consultant on the staff rates and resources schedule

63. In addition to the above, produce a 'component' level LCC option appraisal before the end of RIBA Stage 4 and in readiness for the completion of the FBC stage submission.
ditto

64. Present value engineering options for consideration by the Employer throughout all stages of design. All proposals should be fully evaluated by the Consultant's design team and any savings in cost or efficiency in construction, maintenance or repair be fully described.

65. Working with the design team constantly review each element of the Project Cost Plan, take a proactive approach when elemental totals are exceeded to bring back into line. Provide feedback to the design team regularly to avoid wasted design effort.

66. Provide a cashflow forecast of expenditure throughout the PCSA period and into the construction phase, update progressively with the programme and market testing data.

67. Undertake value engineering as necessary to achieve the Target Cost.

Procurement

Work Package Structure

68. Prepare and produce a Procurement Strategy which defines the pathway for developing a Contract Price, it should describe and table the procurement process, your intentions to engage with subcontractors, suppliers and the Employer's Consultant team. Each package is to be reviewed for scope, attendances, adjustments, design and risk on an open book basis prior to the agreement of the proposed Contract Price

69. Prepare, provide and update a detailed Procurement programme which identifies design completion dates, enquiry preparation and invitations, joint evaluation periods with Employer's Consultant team, subcontract execution, order placement (earliest/latest dates and lead-times), hold points, quality assurance procedures, commencement and completion dates.

70. Prepare, provide and update a Procurement Schedule which lists each of the trade packages and identifies critical information such as package content, period for subcontract design, shop drawings, off-site fabrication, latest order dates, commencement on site etc. Obtain a minimum of 3 tenders per subcontract package.

71. Develop the Project Cost Plan into clear 'Work Packages' for the purposes of tendering the Works. Agree the format and content in collaboration with the Employer's consultant team.

72. Expand the Project Cost Plan by measuring the 'Work Packages' using the BIM model. Adopt the New Rules of Measurement 2 (NRM2) for the purposes of tendering the packages. Provide to the Employer's Consultant team take-off's for the verification of measured quantities in sufficient time to allow checking of the same before market testing.

Has this been agreed with the consultant, is there an agreed preference for work package measurement?

Where is this on the Activity Schedule, can only see a Draft BQ in our cursory review?

73. Identify to the Employer's Consultant team the design interfaces between packages, how this design intends to be measured and procured. Reaffirm the scope of works within each package to avoid double measurement.

74. Advise on and prepare Information release schedules consistent with the programmes for the subcontract and specialist sub-contractor packages. Report to the Project Manager any slippage against the release dates and make practical recommendations for the steps necessary to recover such slippage.

75. Provide a list of potential tenderers for each package to the Employer and his Consultants for review and comment. Ensure early dialogue takes place to indicate willingness to offer tender return. Review any potential additional tenderers put forward by the Employer and agree the final lists.

76. In consultation with the Employer's team prepare 'draft' tender enquiry packs for each 'Works Package' based upon the above measurement principle, or if more appropriate based upon a schedule of works, specification and drawings. Incorporate all relevant information from the main Contract and issue to the Employer's team for review and agreement prior to market release. Deposit final copies in agreed the Information Management software (4Projects/Viewpoint/BIW).

77. Comprehensively review all drawings, schedules and specifications prepared by the Consultants design team and take responsibility for the completeness and adequacy of the same for the purpose of seeking robust and comprehensive sub-contract tenders which are capable of being priced with

sufficient detail including checking to eradicate any discrepancies or divergences between the documents.

78. Provide to the Employer and his representative a copy of the proposed Sub-Contract conditions for review and incorporating any reasonable amendments the Employer or his representatives may request. Generally, all Sub-Contracts should be in the form of the NEC3 Subcontract (ECS) or the NEC3 Short Subcontract (ECSS) which embodies the mechanics of the head Contract and the spirit of the NEC.

79. Prepare and include within each Work Package an 'Attendance Schedule' exclusive of those attendances provided by the Principal Contractor and for the benefit of all trades, ie. cranes, scaffolding (internal/external), forklifts, hoists, loading bays, skips, welfare etc. Identify all subcontractor preliminary requirements in respect of supervision, plant and equipment.

80. Identify any orders which could be placed early that would provide programme or cost benefits. Submit to the Employer for consideration.

81. Disclose all subcontract risk allowances and include value and description/nature of risk within the project Risk Register and which must be disclosed prior to the presentation of the Contract Price.

Statement on MCD's – should be passed to employer

82. For the purposes of obtaining a robust Contract Price, prepare a marked up scaffolding plan including a scope schedule that defines both location of structures and hire periods aligned with the Accepted Programme. A percentage of the Contract Price will not be an acceptable tender return nor will it demonstrate Vfm.

83. All subcontract tender packs shall be issued and tenders returned concurrently to both the Consultant and the Employer's Consultant team using a common portal (to be determined by mutual agreement). Any subsequent amendment or exchange to complete/query a tender return from a proposed supply chain partner must be shared with the Employer's Consultant team. On receipt of returned tenders, such tenders to be opened at a tender opening meeting with the Project Manager and return values etc. formally notified and signed by each party present.

84. Tabulate and jointly review all subcontract tender returns on a package by package basis. Highlight potential irregularities, abnormal rates and apply star rates where necessary and agreed. Ensure scope of works has been fully priced and cognisance taken of the identified interfaces.

85. Negotiate and secure any proposed adjustments to warranties, insurances, subcontract conditions and the like. Tabulate these amendments within the package reviews. This process must be undertaken in an open manner and in consultation with the Employers consultant team. Any proposed amendment is to be agreed with the Employer's Consultant team prior to its acceptance.

86. Arrange post tender interviews that may be required in order to clarify aspects of the subcontract tender returns and advise the Employer's Consultant team.

87. Prepare a tender evaluation report for each trade package and issue to the Employer for review. Discuss and agree content of the same to continue the development of the Contract Sum.

88. Identify to the Employer any particular need for placing the long lead-in items to meet the agreed programme.

89. With the Employer's Consultant team discuss the project requirements in respect of planned and preventative maintenance (ie. the scheduled servicing of boilers) and other forms of maintenance/servicing to avoid invalidating warranties/guarantees. By agreement, incorporate these into the subcontract packages as required.

90. Include the principles of the government soft landings (GSL) approach within each subcontract enquiry.

Programme

91. Adhere the requirements of the NEC Option A and Option C Contract referred to within.

92. Provide, update and report progress against the Accepted Programme in sufficient detail to manage the pre-construction period and to indicate the critical path sequence.

93. Prepare, provide and update as required a pre-construction design and procurement programme showing the process of design completion, measurement, tender pack consultation, release to market, return, review and agreement. This programme should identify all 'Works Packages'.

94. Prepare and provide short term programmes which demonstrate progress against the Accepted programme, advise if necessary how best to mitigate any programme delay and de-risk hospital liability.

95. Produce a detailed commissioning strategy and programme to ensure all stakeholders are engaged and consulted on the methodology proposed prior to the agreement of the Accepted programme. Submit within 4 weeks in preparation for the completion of FBC.

General

96. Manage the project in accordance with the NEC3 Option A (feasibility stage) and Option C Contract by reference to the terms and conditions herein;

97. To agree the project smart KPI's with the Employer, monitor and regularly report each month. Take action to remedy where performance fails to meet acceptable levels.

98. Attend, chair, participate and minute all meetings. Circulate minutes promptly to entire project team. Deposit copies of all minutes in agreed the Information Management software (4Projects/Viewpoint/BIW).

99. Develop, agree and regularly update the Project Execution Plan which defines as a minimum; the structure of teams, roles and responsibilities, parameters of the project, the objectives, scope, reporting processes, risk management, environmental, health & safety approaches, design intent & co-ordination, document and quality control. Submit for the OBC and FBC stage submissions.

100. Provide, develop and implement a Quality Management Plan that details the activities, standards and tools used to achieve quality in the delivery of the PCSA and in the construction phase. Submit the QMP and develop for both the closure of the OBC and FBC submission stages.

101. Undertake a HAZOP study on proposed design led by independent facilitator and make changes to the design where unacceptable risks have been identified.

102. Provide a copy of the site logistics plans together with methodology for movement of materials, storage, site facilities, security, site hoarding/fencing, craneage, waste disposal, scaffolding, horizontal and vertical lifting, excavation and fire control, accommodation and welfare provisions. Progressively develop and submit for the OBC and FBC submission stages.

103. Liaise, review and confirm client liaison requirements for fit-out, handover procedure and defects rectification procedure with the Project Manager.

104. Obtain, where relevant, all required over-sailing licences or party wall agreement from adjoining owners.

105. Review all major plant installations and plant rooms for location and size with the Employer.

106. Progressively develop the Construction Phase Health and Safety Plan as required under the Construction Regulations and to the satisfaction of the Consultant's design team. Submit for the OBC and FBC submission stages.

107. Progressively develop the Construction Environmental Management Plan (CEMP) throughout the OBC and FBC stages submit for each business case. Complete the CEMP, submit for planning and discharge condition prior to commencement of the Works on site.

108. Progressively develop for each stage submission and as required for planning a Construction Transport Management Plan (CTMP) to minimise interference between public and site traffic, reducing/planning deliveries to avoid peak traffic flows, show route maps, identification of limitations/restrictions of the island roadways, identify signage, parking, storage and loading.

109. Attend design/technical, progress, cost/commercial, stakeholder (internal and external) and all other meetings as necessary to maintain the Accepted programme and to achieve the deliverables for the OBC and FBC stage submission sign off.

110. Assist the project team in the obtaining of all statutory authorities and all other related consents necessary for the execution of the intended building contract.

111. Agree in conjunction with the Employer a Contract Price (providing all supporting information) and provide a fully detailed Activity Schedule and Contract Sum Analysis.

112. Identify to the Employer any items / actions / activity required in order to achieve the primary objective of the pre-construction phase as defined with the Employer's Brief.

113. Develop the Contractor's strategy to manage the process of fitting-out of the Hospital in conjunction with the Employer.

114. Prepare and submit all necessary local, statutory authority, landlord and other third-party negotiations, applications, licences, orders, consents, agreements and approvals for working methods, site access/egress and establishment, craneage, temporary services and terminations/diversions and temporary works.

115. Prior to the commencement of any works on site prepare a photographic 'Schedule of Conditions' (dilapidation survey) for any pavements, roads, services, neighbouring properties and common areas within the vicinity of the site and submit to the Project Manager for approval.

116. Participate in any benchmarking processes as required by the Employer.

117. Provide samples for Employer's team to review to ensure acceptance of proposals prior to the computation of the Contract Price.

118. Develop the Facilities Management strategy with the Employer throughout the period of the PSCA, engaging with clinical and non-clinical stakeholders.

Soft Landings

119. Implement the principles of Soft Landings (SL) without absolute adherence to either Building Services Research or Information Association (BSRIA) or Government Soft Landings (GSL) methodologies. This 'principles-only' approach offers flexibility to ensure the developing SL strategy can be appropriate to and best supports the requirements of the Project (consistent with the BIM Employer's Information Requirements.

120. Appoint a Soft Landings Champion to lead and develop the strategy and scope via workshops to formulate agreed deliverables and outputs. Best practice should be followed to guarantee soft landings is considered in design, in delivery and in end of project training, ultimately ensuring seamless transition to handover and operation. Plan to undertake Post Occupancy Evaluation enabling the resolution of issues past initial aftercare.

121. The Project soft landings strategy should identify specific targets for measurement - hard measures such as Energy, Water, and Carbon consumption are linked to environmental credits; soft measures will link to social and economic performance targets – and will be developed by the Consultant during the course of the PCSA with input from the Employer as required. These targets will be integrated as part of the wider sustainability function and a requirement to consider the environment. This will ensure that through the application of soft landings broad principles, specific BREEAM environmental credits and softer measure targets are delivered.

122. There is a requirement for the appointed Consultant to appoint a soft landings Champion (not an assessor), who will interface with Champion from the Employer team.

Annexed to and forming part of this Schedule 10 is the CD marked 'This is the CD referred to in Schedule 10 of the Pre-Construction Services Agreement between The Minister for Infrastructure and the Minister for Health and Social Services of the Government of Jersey and ROK Group Holdings Limited and FCC Construccion S.A' containing:

- Appendix 1 – The Employer's Requirements; no comments
- Appendix 2 – The Consultant's PEP with residual action list;
- Appendix 3 – Staff Allocation for Pre-Construction Services;
  The majority of the deliverables appear to be assigned to an owner and corresponds to the list above. The remaining deliverables should be assigned an owner.
- Appendix 4 – Schedule of Surveys; and
-

  Stage 1a surveys = £278,090 – where are these items on the Stage 1a activity schedule?

  Are these fees for all feasibility options?

  Stage 1b surveys = £595,035.71 - this seems to correspond with the stage 1b activity schedule, although where are the items noted as "Incl" within the Activity Schedule?

- Appendix 5 – On-going monitoring of financial standing.
  No comments

PROGRAMME

Schedule 11

Not provided

ACTIVITY SCHEDULE

Schedule 12	-	Activity Schedule 1A	=	£4,411,843
	-	Activity Schedule 1B	=	£24,794,764
	Total		**=**	**£24,206,604**

We have not arithmetically checked the activity schedule

See comments on surveys above re how the Appendix 4 corresponds with this schedule?

Consider stating OH&P %'s and calculation for clarity

STAFF RATES & EXPENSES

Schedule 13 - all appear reasonable

What is the Priced Work Done To Date calculation??

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