Outline Business Case and Funding

Future Hospital Review Panel

1st October 2021

S.R. 13/2021

States of Jersey
States Assembly

États de Jersey
Assemblée des États

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1. Chair's Foreword

It is widely agreed by the Future Hospital Review Panel, the States Assembly and islanders that we need a new hospital. However, the Assembly is being asked to support a plan that will inflict harm on the island, if it does not amend this proposal.

Many people have expressed frustration at the time it has taken to propose various plans, with none meeting general approval. But that is no reason to push on regardless of the consequences. Such a major decision must be taken with all of the facts assembled and careful consideration of the impact such a decision will have upon our community and its future. The Assembly has been put in a difficult position. As this report will identify, they are being asked to take a considerable decision without being furnished with the full information that would be expected of a project of such a scale. And not for the first time.

In February 2019, when introducing the debate for the rescindment of Gloucester Street as the preferred site (P.5/2019), Deputy Russell Labey stated: "*Time and time again 'standout' is being confused with feasible and economically preferable. There are more feasible and economically preferable sites and if there were not, I am absolutely certain that Philip Stadden would have approved Gloucester Street*." He went on to claim that "*with a new site, with a build cost that is less, to possibly - with a good wind - recoup some of that £27million*."

The Deputy was right to focus on feasibility and the economy as key matters when drawing up an important public project. Sadly, the decision of that day has not bestowed the island with a solution that is "*economically preferable*." The £27 million referred to, was the amount of public money that was to be written off if the Assembly voted to look for an alternative site for the project. The project being considered by the Assembly in P.80/2021 comes at almost double the cost of the £466 million (including optimism bias, contingency and site-specific costs) option for Gloucester Street, so it will not be recouping any money lost, it has instead caused the Government to propose a high risk, speculative approach as their preferred funding method.

Following the vote in favour of P.5/2019, the Chief Minister published a Report (R.54/2019) outlining his next steps. He committed to financial phasing over a 20-month period to take the project to the Full Business Case stage by February 2021 at a projected cost of £7.5 million. He stated that "*The principles to be applied will be that all the above financial allocations will be ring-fenced and released on request in amounts not exceeding £500,000, so accountability can be achieved and recorded*."

However, two and a half years later the project costs are now in excess of £47 million pounds, a Full Business Case is not complete, nor has a planning application been submitted. The "*fresh and bold approach*" that was promised has resulted in a project that has ballooned to such an extent that the government has had to make budget transfers, such as R.105/2021 of some millions of pounds to keep paying the fees of the team working on the project.

The Future Hospital Review Panel has sought both technical and economic advice. As readers will see in their reports, the research that has been conducted by Currie & Brown finds that there is insufficient evidence to justify the size and scale of the project. And, therefore, the cost.

We have also used the Chartered Institute of Public Finance Accountancy (CIPFA), the same advisors who have worked with former Scrutiny Panels as they have considered funding options

for previous hospital projects. In 2016 the Corporate Services Scrutiny Panel pointed out the "inherent dangers of borrowing large sums of money, exacerbated by the uncertain economic climate". The cost of £804.5 million to be funded by borrowing £756 million, is a plan that CIPFA find to be of a scale that would do damage to the Island's public finances.

So why is the States' Assembly being asked to agree an historic departure from the prudent approach that our Island has been known for? That is simply not clear. The Deputy Chief Minister, as the political leader of the project, assures concerned islanders that he "*very much hopes*" that the project will be delivered under budget. But that is the best guarantee he has.

Performance to date indicates that members should treat these claims with extreme caution. Not only is the Outline Business Case found wanting, this report will remind members of the flaws in both the site selection process and the access route proposals. Proper process has not been followed, on not one, but on three occasions, yet the government has failed to hold those discharged with the task of planning for a new hospital to account. With a project of this scale and risk to the island, it is unacceptable to allow the Assembly to be railroaded in this way. For that reason, the Future Hospital Review Panel is proposing a restrained budget to the Assembly.

It should have been the role of the Our Hospital Political Oversight Group to challenge this project as it ballooned and to ensure that it met its targets within the plan promised in R.54/2019. They will tell the Assembly that members should link arms with them and simply be brave, to focus on the delivery of a building. Any basic search of hospital projects will reveal that only a very small number of hospitals cost their communities the amount that we are being asked to pay. The Queen Elizabeth Hospital in Glasgow for example was completed in 2015 at a cost of £842 million, but it is a "super hospital" with 1,677 acute beds. At the very extreme level, The Royal Adelaide Hospital in Australia was named the third most expensive building in the World, costing $2.1 billion (£1.5 billion) and designed to admit 80,000 patients a year.

There is no doubt that States Members want to do the right thing for the community they serve. It is the view of this Panel that the most prudent path to delivering a hospital and providing the best level of service within it, is through securing an economically preferable budget.

The Panel would like to thank its advisors and officers for the considerable effort they have put into completing this detailed work in a compressed timeframe. It has been particularly difficult for them to do so, as they have faced consistent reluctance on behalf of the government to share the information that they have in their possession in a timely fashion. Such barriers are regrettable and do not honour the spirit of inclusive work with Assembly members, or the principle of accountability.

Senator Kristina Moore

Chair of the Future Hospital Review Panel

2. Executive Summary

In undertaking this review, the Future Hospital Review Panel has sought to examine whether the budget of £804.5 million for a new hospital, as proposed by the Government of Jersey, is appropriate for Jersey and – alongside this question of affordability – whether the scale of the project as currently planned is justified.

To assist in this work, the Panel engaged the services of two expert advisers. The first advisers, Currie & Brown, have undertaken an independent, technical appraisal of the Our Hospital Project Outline Business Case. The Outline Business Case (OBC) is the document prepared by the Government to underpin the budget proposal for the project and the means by which it is intended to fund that budget. The core of their task was to determine whether the OBC was robust and supported the Government's conclusions.

The second adviser body is the Chartered Institute of Public Finance and Accountancy (CIPFA) who were engaged to examine the affordability of the budget level and the economic impact of borrowing using two public bonds of approximately £400 million each. The adviser brought with them a knowledge of Jersey based on previous engagement with Scrutiny during its work on the Medium Term Financial Plan, Government Plan and earlier hospital projects.

The findings of Currie & Brown and CIPFA are integral to this report.

In addition to this expert advice, the Panel received over 130 public submissions to its call for evidence and a detailed submission from the lobby group, Friends of Our Hospital.[1] The Panel is grateful to all those who took the time to respond with their views. The submissions are examined later in this report, however, the overwhelming view of the respondents to the Panel was that £804.5 million is too much. The consistent message that this Panel has received during the course of this review is that Jersey needs a new hospital which is affordable, and which caters for the needs of the community. There also remains a conviction that the voice of the community is not being heard in relation to the hospital project.

The Panel held three public hearings during the course of this review. The Deputy Chief Minister, Senator Lyndon Farnham, was a witness at two of the hearings. The Treasury Minister, Deputy Susie Pinel, and Assistant Treasury Minister, Deputy Lindsay Ash, were also witnesses at hearings. In all cases they were accompanied by members of the Our Hospital Project team and a number of Government and Treasury and Exchequer officers. The Panel is grateful to all of them for their time and their responses.

At the Panel's final Public Hearing on this review, held on Thursday 16th September, Senator Farnham said that he hoped that the whole project could be delivered without utilising all of the £804 million budget and that there was scope to deliver at a lower level:[2]

Deputy Chief Minister:

[1] Our Hospital Project Outline Business Case and Funding Review Submissions
[2] Transcript - Future Hospital Review Panel - Our Hospital Project Outline Business Case and Funding Review - Witness Deputy Chief Minister and Minister for Treasury and Resources - 16 September 2021

> *"I very much hope we can fund the delivery of the whole project without utilising all of that budget. If we are to look at how the budget is made up I believe there is scope to deliver at a lower value."*

In compiling this report and reviewing the evidence it has received, it is the opinion of the Panel that this assurance is not enough of a guarantee that expenditure will be capped in an appropriate manner.

The advice received from CIPFA is that the approach taken by Government in P.80.2021 – Our Hospital – Budget, Financing and Land Assembly[3] commits the States of Jersey to a strategy that may impair future policy option capability and threatens the stability of the current medium and long-term financial strategy. CIPFA found that in terms of proportionality, the scale of the project is extremely big, and its nature and complexity mean that it has the potential for costs to exceed £1 billion.

In light of this scale, it is therefore of concern to the Panel that one of the primary findings made by Currie & Brown is that – in their view and experience – the Outline Business Case does not provide the evidence needed to justify the scale of the project as it is currently outlined. Their report also voices a number of concerns about the departures made from the accepted compliance model for such reports.

These concerns and findings and the views gathered from the public submissions have led the Panel to conclude that the design, scale and scope of the project should be revisited to fit a more restrained budget.

It is acknowledged that the road to reaching P.80.2021 has been a long one and that there is a desire from all corners of the community for a new hospital to be built, including the members of this Panel. However, it is also clear to the Panel that – notwithstanding the amount spent to date – this should not be at any cost. It remains unclear to the Panel why the political direction of this project has allowed for a build of this scale to develop with little evidence as to why that should be the case.

As part of their report for the Panel, CIPFA pose a question which, in turn, the Panel would like to put to its fellow States Members:

> *"Given the sheer scale of the New Hospital related capital expenditure, relative to the size of the public service expenditure and tax raising capability on the island, a legitimate question arises - are the anticipated benefits of this scale of project greater than the funding risks and associated impacts on other parts of public services within Jersey?"*

The Panel believes that Islanders want their political leaders to focus clearly on the level of borrowing and expenditure involved in this project. To this end, the Panel has lodged its amendment, Our Hospital – Budget, Financing and Land Assembly (P.80/2021): second amendment[4], which presents a more restrained budget window within which a good hospital for the Island's future can be developed.

[3] P.80.2021 – Our Hospital – Budget, Financing and Land Assembly
[4] Our Hospital – Budget, Financing and Land Assembly (P.80/2021): second amendment

3. Finding and Recommendations

Key Findings

Key Finding 1

The Government communication and consultation undertaken as part of the Our Hospital Project has done little to reassure Islanders about the cost of the project.

Key Finding 2

Significant delays occurred in the provision of the information requested by the Panel's advisers on the Outline Business Case (despite the assurances of the Our Hospital Political Oversight Group's 'intention to positively and constructively engage with the Scrutiny process') and have caused subsequent delays to the production of the adviser's report and this report.

Key Finding 3

The original date of the debate was moved from 14th September 2021 to 5th October 2021 to allow nine weeks for the Scrutiny Process.

Key Finding 4

The Panel received minutes of meetings of the Our Hospital Political Oversight Group held since April 2021 on 24th September 2021. This contradicts the Our Hospital Political Oversight Group's stated 'intention to positively and constructively engage with the Scrutiny process'.

Key Finding 5

The political timeline imposed on the Our Hospital Project has constrained the work of the Our Hospital Project Team and had a subsequent detrimental impact on the work conducted by Scrutiny. It is noted that this timeline is one year behind the schedule laid out in R.54/2019 New Hospital Project: Next Steps.

Key Finding 6

The Outline Business Case is non-complaint with the UK HM Treasury Green Book Standard.

Key Finding 7

In contradiction to the commitment made in R.54/2019 – New Hospital Project: Next Steps, in relation to the adoption of the Green Book Five Case Model, the five cases all have instances where best practice guidance and the requirements of the standard have not been followed, or lacks detail and evidence. This contributes to an assessment that the Outline Business Case is not robust.

Key Finding 8

Insufficient rationale has been provided for departures from Treasury Green Book principles.

Key Finding 9

Justification for the scale of the project has not been evidenced in the Outline Business Case.

Key Finding 10

The Outline Business Case is not robust enough to support P.80/2021.

Key Finding 11

The Outline Business Case strategic case includes the majority of the core content recommended in the Green Book and Better Business Case guidance, however, it does not adequately articulate the core scope of the project, proposal to develop a new hospital of circa 67,000m^2, a figure which has not yet been finalised, or the minimum service requirements that need to be met. This has led to confusion over the size and scale of the proposed development.

Key Finding 12

The Outline Business Case does not demonstrate alignment between the Our Hospital Project and key strategic programmes, especially the Jersey Care Model, and appears to have been formed in isolation to other Government priorities and strategies.

Key Finding 13

The long list of options does not fully explore all potential options including hospital size, scope and location.

Key Finding 14

The shortlisting of options has not been undertaken in line with Green Book 2020.

Key Finding 15

There is no Business As Usual (BAU) option which is required to provide a true baseline against which to compare options.

Key Finding 16

No facilities management and utilities revenue costs have been included to identify the financial impact of the options compared to the existing arrangements, the Outline Business Case therefore fails to evidence that the proposals provide the best value for money.

Key Finding 17

No facilities management information will be available before the debate of P.80/2021.

Key Finding 18

The Outline Business Case does not include fully evidenced consideration to other potentially viable options nor a Business As Usual comparison, which is unacceptable for a project of this scale.

Key Finding 19

The Outline Business Case does not provide benefit monetisation and therefore fails to provide evidenced value.

Key Finding 20

Although the Economic Case is lacking information and is not HM Treasury Green Book compliant, cost calculations are generally within expected levels and reasonably calculated. However, there are elements that are costed at the higher end or above expected benchmarked pricing.

Key Finding 21

Future revenue costs to the Island of Jersey of the Our Hospital Project proposals have not been calculated, risking additional constraint on public finances.

Key Finding 22

The Commercial Case of the Outline Business Case is not compliant with the Green Book requirements.

Key Finding 23

There is no evidence that the investment to construct, operate, maintain, and staff the private patients wing will provide commercial returns by income from private patients.

Key Finding 24

There is little evidence to indicate a strategy on how benefits, such as job creation, will be achieved.

Key Finding 25

The Management Case of the Outline Business Case is broadly compliant with Green Book requirements, however it is lacking elements to allow for understating of Risk and Change Management.

Key Finding 26

The need to gain States Assembly approval for additional expenditure over and above the £804.5 million budget is unlikely to act as an effective control on costs, especially in the latter stages of the project, as the choice facing Members will be between agreeing or accepting an unfinished project

Key Finding 27

Detailed capital and revenue running costs should have been clearly formulated and stress tested before funding solutions are considered

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Key Finding 28

Bond finance is a sensible approach to this scale of borrowing if there is full confidence in the asset (hospital) specification to service demand and needs and robust cost construction.

Key Finding 29

A reduced budget would allow for an alternative funding solution to be sought.

Recommendations

Recommendation 1

The Deputy Chief Minister, prior to the finalisation of the Full Business Case, should identify elements of the Jersey Care Model that relate to the Our Hospital Project and these should be clearly set out in detail in the form of a clinical strategy. This should articulate how hospital services are expected to change in the future and how service transformation will impact on capacity, clinical adjacencies and hospital design.

Recommendation 2

The Deputy Chief Minister must ensure a robust option appraisal is undertaken and a value for money is evidenced if progressing to Full Business Case. This must include:

- **Consider a full range of options for inclusion in the shortlist to include both location and scope of the proposal to address the priority investment objective.**
- **Include the Business As Usual option in the shortlist.**
- **Include a less ambitious preferred way forward option in the shortlist.**
- **Undertake a full quantified assessment of costs, risks and benefits of the shortlisted options to identify the NPSV (net present social value) of each option, in order to support the identification of the option offering greatest value for money to society.**
- **Costs should include the ongoing running costs of the hospital including staffing and facilities management services.**

Recommendation 3

The Deputy Chief Minister must, prior to the finalisation of the Our Hospital designs, outline predicted revenue costs of the proposed changes in healthcare provision.

Recommendation 4

The Deputy Chief Minister must, prior to final design of the private ward, provide to the Assembly a fully evidenced business case to justify the additional spend and space allocation to private services in the new hospital.

Recommendation 5

The Deputy Chief Minister should publish full details of the change management plans for the transition to the new hospital and provide full detail of the project risk register prior to accepting a Full Business Case.

Recommendation 6

The budget for the Our Hospital Project should be reduced to £550m to include optimism bias, site-specific costs and contingency.

Recommendation 7

The scale of the cost and borrowing should be reduced to limit exposure to financial risk.

Recommendation 8

Overall borrowing for the project should be reduced to £400 million and Treasury should explore other options including the use of the 'windfall' payment of approximately £40 million resulting from JT's sale of its IoT business and other asset disposals opportunities.

Recommendation 9

To preserve the integrity of the Strategic Reserve Fund, a specific Our Hospital Fund should be created to 'improve focus'. Included in this recommendation is that accountability is imposed on the Project Senior Responsible Officer (SRO) for the delivery of the project within the revised approved cost envelope.

4. Introduction

Background

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 for the Island in the future. At various times since that decision, elements of the hospital have been described as dilapidated and in need of either complete refurbishment or rebuild in the next decade.

The Clinical Director of the project recently explained the reasons for needing a new hospital were that the current site was 'tired' and offered a 'sub-optimal experience for staff and patients' he has also maintained that costs to maintain the hospital in a way that meets modern standards continue to escalate and that the facility has 'outgrown' the site.

Following elections in 2018 the Planning Inspector presented the conclusions of a Planning inquiry on the proposals for a redeveloped hospital on the existing site at Gloucester Street expanding onto at least two neighbouring hotels, an additional third party property and using another site nearby which was in the ownership of the States of Jersey[5]. The Minister for the Environment Deputy John Young refused the application on 14 January 2019.[6]

In February 2019 the States Assembly voted to rescind plans to build a new hospital on the existing site.[7] In bringing that proposition Deputy Russell Labey argued:

> *"The project team is producing a hospital design to fit the size of the Gloucester Street site, when what we need is a hospital that meets Jersey's clinical need. The fatal error was choosing the site before addressing the need and producing a proper design brief, the design brief, which still is not in a satisfactory fit-for-purpose state today…. We have to put a stop to it. The site has to change; governance has to change. There will have to be change with the project team, I am afraid. It will take time, but we must strive for a change in public confidence too and we can do it. Some might say you cannot please all the consultants all of the time. Yes, we can. Yes, we will. There has to be a change in attitude and operation at the top level of the civil service, egos to one side. The Assembly must provide them clear political direction, as only a Parliament can do in a democracy, and on this issue, it is the Assembly's way or the high way."* [8]

On 13th May 2019, the Chief Minister presented the report 'New Hospital Project: Next Steps to the States Assembly'.[9] This Report sought to propose a new phased approach to deliver a new hospital as follows:

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[5] Planning Inquiry: Proposed new General Hospital Jersey
[6] New General Hospital: Public Inquiry Decision: PP/2018/0507
[7] P.5/2019 Future Hospital: Rescindment of Gloucester Street as Preferred site
[8] Hansard, Wednesday 13th February 2019, p.7
[9] R.54/2019 'New Hospital Project: Next Steps

- establish the agreed clinical requirements of a new hospital
- use the outcome of this to scope the size and shape of a new hospital to shortlist potential locations
- undertake a thorough process of Island and stakeholder 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.

At the time that R.54/2019 was presented, the aim was set to complete this process within 20 months. Provisional estimates for indicative costs given in R.54/2019 were stated as £7.4 million. The aim was to submit a planning application for an alternative hospital in February 2021. It was also stated in this report that "financial allocations will be ring fenced and released on request, in amounts not exceeding £500,000, so accountability can be achieved and recorded." It was confirmed to the Panel that total spend to date as of 16th September 2021 was £47.6 million, with a forecast of £59.5 million spend by October 2021.[10]

In November 2020, Overdale was approved by the States Assembly as the preferred site for the new hospital.[11] This decision was taken despite the Panel identifying that a number of processes used in the identification of the proposed site did not adhere to best practice.[12] This included the apparent lack of use of SMART objectives or Critical Success Factors in narrowing of sites, as well as the Strategic Outline Case not being finalised at that stage. The Panel subsequently lodged amendments to P.123/2020 Our Hospital Site Selection: Overdale [13] and produced a report [S.R.9/2020]. The Panel will not be revisiting findings and recommendations of that report in detail, however, it is important to highlight that the Panel's amendments to P.123/2020 were adopted by the Assembly. These amendments sought to oblige the Council of Ministers to include certain information in a report prior to debate of the Outline Business Case of the Our Hospital project. The Assembly therefore would expect to have full awareness and receipt of:

a) the performance detail from the demand-modelling with all key demand and capacity assumptions linked to the sizing of the new hospital and how this links to the role and function of health facilities as set out in the Jersey Care Model;
b) a statement by clinical specialty that senior clinical representatives have agreed and signed off their respective departments, both room areas via the Schedule of accommodation, and drawings that match the latest hospital plans;
c) the proposed hospital total area including all main hospital street communication corridors, department circulation and non-roof plant, in order to provide a total inclusive Schedule of Accommodation;
d) the calculations for all project cost including non-works costs, equipment costs, non-medical costs (including the whole life transport solution), inflation, optimism bias, a clear split of all project contingencies, the premium costs for materials and

[10] Transcript - Future Hospital Review Panel - Our Hospital Project Outline Business Case and Funding Review - Witness Deputy Chief Minister and Minister for Treasury and Resources - 16 September 2021, p.45
[11] P.123/2020 Our Hospital Site Selection: Overdale
[12] S.R.9/2020 Report - Review of the Future Hospital Site Selection Process - 13 November 2020
[13] P.123/2020 Amd – Our Hospital Site Selection: Overdale

confirmation that all “current exclusion” are subject to at least the latest provisional sums;

e) an analysis that the aligned programme has taken account of both the programme impact, Covid-19 and Brexit;
f) a full breakdown of the assumptions and amounts for recurring savings supporting the overall affordability of the project for both capital and clinical/support revenue; and
g) forecast Cost at Completion of the following components:

i. Construction of the hospital and ancillary facilities (works costs)
ii. Furniture fixtures and equipment
iii. Decant costs
iv. Delivery Partner contingency
v. Site specific costs
vi. Pre-construction services agreement
vii. Site acquisition costs (+ reprovision of costs if any)
viii. Services and utilities
ix. Optimism bias and client contingency
x. Migration costs (from exiting hospital to new facility)
xi. Pre-operational costs
xii. IT and specialist equipment
xiii. Demolition of existing hospital
xiv. Government of Jersey internal costs
xv. External adviser costs
xvi. Total forecast development budget

It is disappointing that there are gaps in the provision of this information in the Outline Business Case which means that States Members do not have a clear picture of exactly what will be produced for the financial commitment made.

The Council of Ministers brought forward P.167/2020 Our Hospital, Preferred Access Route[14], which showed the final option and included the technical report by the design and delivery partners. This was debated and approved by the States Assembly in early February 2021. The Panel, with the assistance of expert advisors, undertook an options appraisal of the 70+ options identified in the technical report to ensure that the final option was the most appropriate. A report[15] was produced which listed key findings and recommendations, many of these highlighted concerns that the Panel held about a lack of adherence to procedures in the finalisation of the Preferred Access Route.

The preferred site was approved with a budget envelope of £804.5 million. The project is currently aligned with the Royal Institute of British Architects (RIBA), Treasury Green Book Standards and

[14] P.167/2020 Our Hospital, Preferred Access Route
[15] S.R.2/2021 Access Route to Overdale

PRINCE2 and is currently at RIBA Stage 2. The project is operating to a partnering contract between the Government of Jersey and the design and delivery partner. A Strategic Outline Case (SOC) has recently been approved together with a Functional Brief. It is anticipated planning for the site and the access route will be submitted in November 2021 with approval expected within 6 months from submission. Following this approval, the project build will begin.

The Outline Business Case (OBC)[16] was presented to the Assembly on 22nd July 2021 and the Our Hospital – Budget, Financing and Land Assembly proposition[17] was lodged on 3rd August 2021, outlining the funding solution for the project.

Timeline

[16] R.124/2021 Our Hospital Project – Outline Business Case
[17] P.80/2021 Our Hospital – Budget, Financing and Land Assembly

Figure 1: Hospital Timeline

23 Oct 2012	P.82/2012 Health and Social Services: A New Way Forward adopted

1 Dec 2016	P.110/2016 Future Hospital: preferred site adopted
23 May 2017	P.130/2016 Future Hospital Funding Strategy withdrawn
23 Nov 2017	C&AG Report - Decision Making: Selecting a Site for the Future Hospital (March 2012 - February 2016)
13 Dec 2017	P.107/2017 Future Hospital: approval of preferred scheme and funding adopted
13 Feb 2019	P.5/2019 Future Hospital: rescindment of Gloucester Street as preferred site adopted

13 May 2019	R.54/2019 New Hospital Project: Next Steps
11 Sep 2019	R.116/2019 Our Hospital Programme: Update to the States Assembly
12 June 2020	Design and Delivery partner announced
July 2020	Site Shortlisting report
Oct 2020	Site Evaluation Report
Oct 2020	Public Engagement and Communications Strategy
3 Nov 2020	P.114/2020 Jersey Care Model adopted
17 Nov 2020	P.123/2020 Our Hospital Site Selection: Overdale adopted
17 Nov 2020	P.129/2020 Our Hospital Project: acquisition of land for the new hospital at Overdale adopted
22 Nov 2020	Our Hospital Project: Functional Brief Requirements
Dec 2020	Access Options Appraisal document
1 Feb 2021	P.167/2020 Our Hospital: Preferred Access Route adopted
15 March 2021	Overdale Decant Functional Requirements Brief
July 2021	Stage 2 Design Report
22 July 21	R.123/2021 Outline Business Case lodged
3 Aug 2021	P.80/2021 Our Hospital – Budget, Financing and Land Assembly lodged
10 Aug 2021	P.132/2021 Debt Framework lodged
05 Oct 2021	**Debate of P.80/2021**

Panel Overview

The Panel launched the Our Hospital Project Outline Business Case and Funding Review[18] on 23rd July 2021. The review is part of the Panel's ongoing scrutiny of the Our Hospital Project which may also include a review of the planning application associated with the site in the coming months.

This review looks at the Outline Business Case which has been developed by the Our Hospital Project Team to explain the size, scale and cost of the hospital project and also the budget and means of funding that budget.

The Panel's approach to this review has been to look at it in two phases. This was partly for practical reasons necessitated by the different publication times of the documents and partly because it made good sense to examine the Outline Business Case, which necessarily supports the budget conclusions, separately and using expert advisers in each case.

As detailed in the summary, Currie & Brown have brought their expertise to a thorough examination of the Outline Business Case and CIPFA have examined P.80/2021 and the economic and financial impact that proposal will have on the Island's future.

The substantive findings and recommendations made by the Panel are covered in the following sections of the report on the Outline Business Case and on the proposition, however, the Panel has also made some over-arching observations which are outlined in this overview.

Communication and consultation

What is clear to the Panel, as a result of the many submissions that have been made to the Panel and the petitions that have been raised in the wake of the presentation of P.80/2021, is the high level of public emotion that surrounds the project.

However, despite this depth of feeling, the assertions made by Government and the existence of forums for different stakeholder groups, a common theme expressed to the Panel is that the voice of community is not being heard.

The frustration expressed in the following submission is echoed in many others:[19]

> *"It will be argued by Senator Farnham that the community is being kept abreast of developments through the Overdale Neighbourhood Forum which meetings I attend. It has however been my experience that valid community observations/suggestions are noted but nothing else."*

Key Finding 1

The Government communication and consultation undertaken as part of the Our Hospital Project has done little to reassure Islanders about the cost of the project.

[18] Our Hospital Project Outline Business Case and Funding Review
[19] Submission - Our Hospital Project Outline Business Case and Funding Review - P Embery - 2 September 2021 Scrutiny Submissions

It is the Panel's view that the communication and consultation undertaken has done little to reassure Islanders about the cost or the Our Hospital Project as a whole.

Delays and challenges

In a letter[20] sent to the Panel Chair by the Deputy Chief Minister dated 19th August 2021, Senator Farnham set out his assurance on behalf of the Our Hospital Political Oversight Group (OHPOG) that it was the group's 'intention to positively and constructively engage with the Scrutiny process' and, further that 'the POG intends to continue to fully engage with the Future Hospital Review Panel's current review of the Our Hospital Outline Business Case (OBC) and the accompanying proposition to fund the £804 million project'.

It is acknowledged that in response to a request made by the Panel, the OHPOG postponed the original date of the debate from 14th September 2021 to 5th October 2021 to allow nine weeks for the Scrutiny Process[21]. However, the Panel's experience since that date – and the experience of its advisers on the Outline Business Case, is that requests for information have not been replied to in a timely fashion and this has meant that critical pieces of information had not been received until the same week in which the advisers were due to be producing their report.

At the Panel's final Public Hearing of the review on 16th September, the delays were acknowledged by Senator Farnham:

> *"Yes. I have talked to the chair of the panel last week briefly because I was made aware by the team that they were working hard to get all the information as quickly as possible. I think time pressures and the sheer volume of work that has been requested has contributed to that. I apologise if there has been any delay but just to reassure the panel that we will do everything we possibly can to make sure that you receive the requested information in a very timely fashion, bearing in mind that there is a lot of information to collate and send forward."*

Requests for the minutes of OHPOG meetings held since April were made consistently between May and September 2021. Minutes were received for meetings until the end of July 2021 were received on 24th September 2021.

The Panel is of the view that, despite the longevity and many iterations of the hospital project since 2013, the political timeline imposed on the Our Hospital Project has constrained the work of the Our Hospital Project Team and their ability to respond adequately to adviser requests and has had a subsequent detrimental impact on the work conducted by Scrutiny. It is further noted that the project is now one year behind the schedule set out by the Chief Minister in R.54/2019 – New Hospital Project: Next Steps.[22]

[20] Letter to the Panel from the Deputy Chief Minister
[21] Letter - Deputy Chief Minister to FHRP re proposition update - 14 July 2021.pdf
[22] R.54 – New Hospital Project: Next Steps p7

Delays on specific areas, such as the ongoing work on the facilities management costs which will be subject to a separate business case, will be mentioned later in the report.

Although it is not specific to the remit of this report, it is pertinent to the context of this project to highlight some of the timing challenges that continue to face the project, including the timing of the decision on the planning application and its proximity to next year's General Election and the preceding period of 'purdah'.

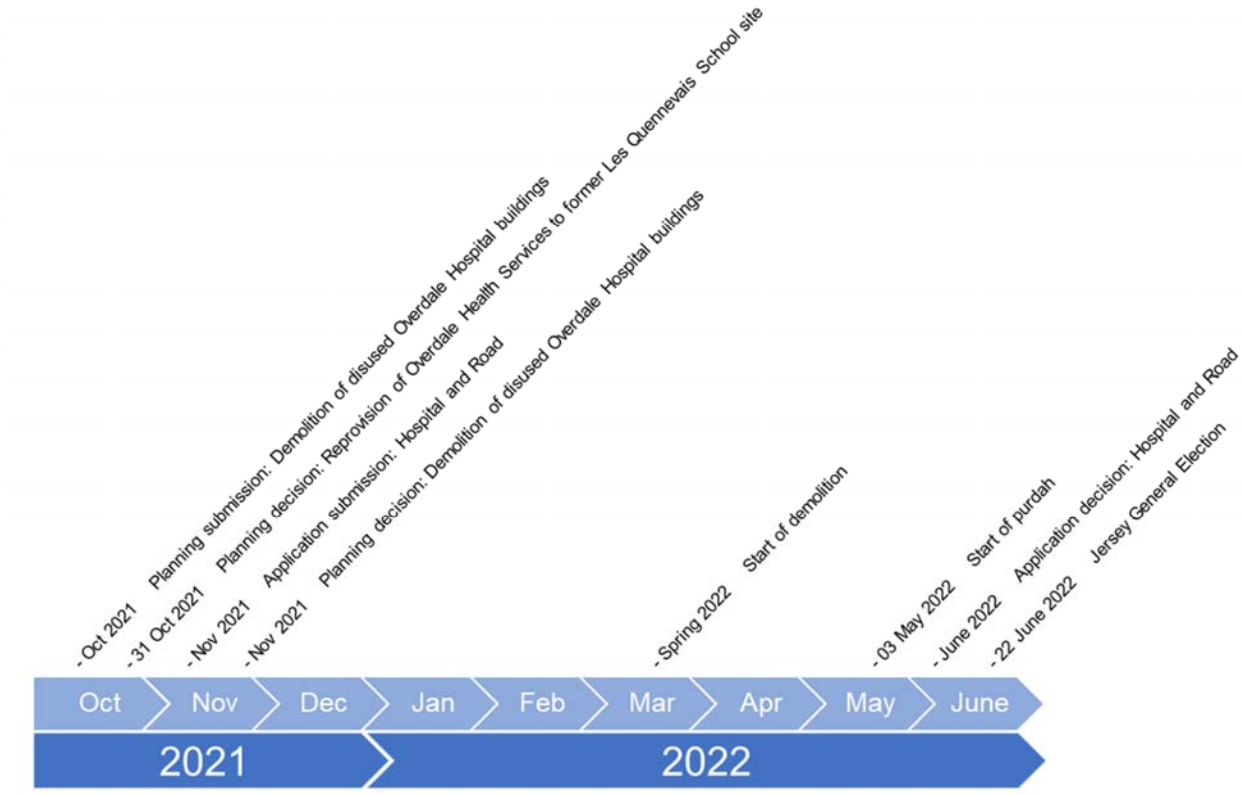

Fig. 2: expected timeline

Key Finding 2

Significant delays occurred in the provision of the information requested by the Panel's advisers on the Outline Business Case (despite the assurances of the Our Hospital Political Oversight Group's 'intention to positively and constructively engage with the Scrutiny process') and have caused subsequent delays to the production of the adviser's report and this report.

Key Finding 3

The original date of the debate was moved from 14th September 2021 to 5th October 2021 to allow nine weeks for the Scrutiny Process.

Key Finding 4

The Panel received minutes of meetings of the Our Hospital Political Oversight Group held since April 2021 on 24th September 2021. This contradicts the Our Hospital Political Oversight Group's stated 'intention to positively and constructively engage with the Scrutiny process'.

Key Finding 5

The political timeline imposed on the Our Hospital Project has constrained the work of the Our Hospital Project Team and had a subsequent detrimental impact on the work conducted by Scrutiny. It is noted that this timeline is one year behind the schedule laid out in R.54/2019 New Hospital Project: Next Steps.

5. R.123/2021 Outline Business Case

This section of the Panel's review introduces the findings of its advisers Currie & Brown. It outlines how they approached their examination of the Outline Business Case (OBC) and brings this examination together with evidence provided to them both in writing and as a result of the Public Hearings held as part of this review.

The terms of reference of the Currie & Brown appointment were to undertake an in-depth appraisal of the Outline Business Case for the Our Hospital Project in a two-phased approach:

1. To review the Outline Business Case and determine whether it meets best practice with regard to the following:
    a. Examination of the structure and ensure this is within the expectations of the five-case model and follows the HM Treasury Green Book Standard.
    b. Analyse each of the five cases and provide detail on the robustness of each to meet the overall objectives of the Our Hospital Project.
    c. Compare each of the five cases within the Outline Business Case to the documents issued previously and make comparisons to show any major changes highlighting risks and/or benefits.
2. To provide detailed analysis on the funding and budget with particular attention to the following:
    a. Review the overall costs and budget and measure against the budget proposal of £804 million to ensure it is sufficient to meet all aspects of the Our Hospital Project.
    b. Analyse any amendments to the budget since the proposal of £804 million in the Strategic Outline Case and highlight any differences in costs.

Compliance with accepted standards

The Green Book

The Green Book is guidance issued by HM Treasury on how to appraise policies, programmes and projects. It also provides guidance on the design and use of monitoring and evaluation before, during and after implementation. Appraisal of alternative policy options is an inseparable part of detailed policy development and design… The Green Book is not a mechanical or deterministic decision-making device. It provides approved thinking models and methods to support the provision of advice to clarify the social – or public – welfare costs, benefits, and trade-offs of alternative implementation options for the delivery of policy objectives.[23]

Five Case Model

HM Treasury highlights the importance of developing business cases using the Five Case Model, allowing decision makers and stakeholders a proven framework for structured 'think'

[23] The Green Book (2020) – www.gov.uk

and assurance that the project is strategically sound, will maximise public value, is commercially viable, is affordable over time and can be delivered successfully.[24]

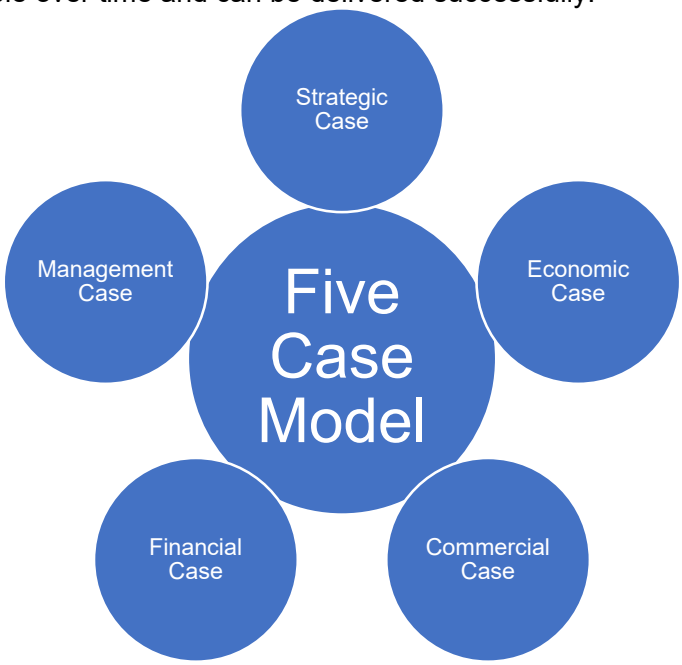

Fig. 3 Five Case model

It is clear that the key finding of Currie & Brown is that the Outline Business Case is non-complaint with the UK HM Treasury Green Book Standard. Their reasoning for this statement is that each of the five cases has instances where best practice guidance and the requirements of the standard have not been followed, or lacks detail and evidence, which contributes to an overall assessment that the business case is not robust.

The report to P.80/2021 states that:

> *"The* Outline Business Case *follows a best practice method that is referred to as The Green Book (after the name of the guidance) or the '5-case model' which cover different aspects of the proposal."*[25]

The Outline Business Case states:

> *"This Outline Business Case has been developed following the principles set out in the UK HM Treasury Green Book 5 Case Business Case Model. The Green Book is internationally recognised as being a gold standard process for developing a business case and is therefore being followed by the Government of Jersey for major Projects and in the development of this project."*[26]

Further, the Chief Minister made the commitment that the Green Book 'five case model' would be adopted in presenting R.54/2019 New Hospital Project: Next Steps to the States Assembly[27].

[24] HM Treasury, 2018, Guide to Developing the Project Business Case
[25] P.80/2021 Our Hospital – Budget, Financing and Land Assembly – p11
[26] P.80/2021 Our Hospital – Budget, Financing and Land Assembly – OBC p9
[27] R.54/2021 New Hospital Project: Next steps – p7

Currie & Brown have raised this concern with officers at the meetings held as a part of this review and have questioned officers and Ministers at two of the three Public Hearings held.

Key Finding 6

The Outline Business Case is non-complaint with the UK HM Treasury Green Book Standard.

Key Finding 7

In contradiction to the commitment made in R.54/2019 – New Hospital Project: Next Steps, in relation to the adoption of the Green Book Five Case Model, the five cases all have instances where best practice guidance and the requirements of the standard have not been followed, or lacks detail and evidence. This contributes to an assessment that the Outline Business Case is not robust.

In answer to queries about the adherence to the Green Book raised at the Public Hearing held on 11th August 2021, the Hospital Project Construction Manager, Gretta Starks, said:

> *"…this is a business case being developed in Jersey and it needs to be appropriate for the context here. So informed by the Green Book, informed by other methodologies that we are using on the project such as Prince2 but also mindful of the context that we are delivering in and particularly in the requirements of the Public Finance Manual."*[28]

Key Finding 8

Insufficient rationale has been provided for departures from Treasury Green Book principles.

The departures made from the Green Book methodology were a recurring theme throughout the requests for information made by Currie & Brown and despite the explanations provided by Ministers, officers, and members of the Our Hospital Project team, they remain of the opinion that insufficient rationale has been provided for the departures made from the principles. The diversions from the methodology will be explored under each of the case specific headings below.

Key Finding 9

Justification for the scale of the project has not been evidenced in the Outline Business Case.

Alongside this conclusion, runs the second crucial observation made by Currie & Brown which is that the justification of the scale of the project has not been evidenced in this document. In their view – and by extension that of the Panel – is that this is a clear deficiency in the document before States Members.

This being the case, it is difficult for the Panel to come to any conclusion other than that it is not robust enough to underpin the budget or the funding solution proposed in P.80/2021.

[28] Transcript - Future Hospital Review Panel Public Hearing with the Deputy Chief Minister - Our Hospital Project Outline Business Case and Funding Review – p4

Key Finding 10

The Outline Business Case is not robust enough to support P.80/2021.

As already outlined earlier in this report, following its detailed scrutiny of the Our Hospital Site Selection: Overdale [P.123./2020], producing a report [S.R.9/2020], this Panel made a number of recommendations which called on the Council of Ministers to ensure that adequate and robust information was provided to States Members prior to debate of the Outline Business Case of the Our Hospital project.

It is particularly concerning that adequate information has not been provided when the Strategic Outline Case indicated an increase in this regard when compared to the existing revenue budget.

Importantly, the Panel believes that the States Assembly will be making a decision on P.80/2021 while not in possession of the all the information it needs about the future costs of the new hospital.

Strategic Case

- *Make the case for change and demonstrate how it provides strategic fit*

The Panel's advisers, Currie & Brown, have determined that the Strategic Case includes the majority of the core content recommended in the Green Book and *Better Business Cases for better outcomes 2018* guidance. In particular, it provides:

- an organisational overview
- a list of relevant strategies
- the spending objectives
- a summary of existing arrangements
- details of the estates element of the 'business needs'
- and the main benefits, constraints and dependencies (risks are described in the Economic Case).

However, they have found that the Strategic Case falls short in terms of demonstrating 'strategic fit' (a key Green Book requirement) and setting out full details of the 'business strategy', the 'potential scope' and the 'service requirements' (*Better Business Cases for better outcomes 2018*, *section 2*). Mainly these issues relate to the evidence, or lack thereof, to support the proposal to develop a new hospital of circa 67,000m^2 and does not explain at an acceptable level of detail the service requirements based on demand and capacity planning – this is the principal flaw in the Strategic Case.

The Panel has heard from evidence from the Our Hospital Clinical Director, among other witnesses, at a number of hearings in relation to the changing square meterage of the project.

At a hearing held on 11 August 2021, Professor Handa, stated that the size of the project will not increase further:

"There is no danger of it increasing any further, it will only be going down. The one bit we will not compromise is clinical safety and patient experience."

At the same hearing, the following clarification was also provided on the size:

"Where we were at S.O.C. stage was 67,000 square metres, as you have mentioned. The O.B.C. position is at 69,000 so we have not got that 10 per cent increase you mentioned. The 69,000 position incorporates a number of the savings that [have been] mentioned before that are being worked through. Just for clarity on the OBC position."

There remains a concern about the confusion and inconsistency between the RIBA Stage 2 report figure of c73,000sqm and the costs included in the OBC in which the position is 69,000sqm. This has led to public confusion over the size and scale of the proposed development. It is accepted that design development will continue however, it is the case that the broad size should remain in line with Outline Business Case stage.

Key Finding 11

The Outline Business Case strategic case includes the majority of the core content recommended in the Green Book and Better Business Case guidance, however, it does not adequately articulate the core scope of the project, proposal to develop a new hospital of circa 67,000m^2, a figure which has not yet been finalised, or the minimum service requirements that need to be met. This has led to confusion over the size and scale of the proposed development.

It has also been identified that, while relevant policies and strategies are documented, the Outline Business Case does not demonstrate alignment between the Our Hospital Project and key strategic programmes, especially the Jersey Care Model. Moreover, it gives the impression that proposals for the new hospital have been developed in isolation from the broader strategic context. With the Panel's adviser stating:

"It is acknowledged that the JCM was developed as a separate programme, but we would expect the OBC to provide greater detail on the clinical strategy for the new hospital, which is derived from the JCM, and to demonstrate how the OHP will contribute to delivering the JCM (i.e. as a key enabler)."

This is reinforced by the absence of an audit trail demonstrating how the outputs from the Jersey Care Model have informed the scope and scale of the new hospital and how the functional content (such as beds, theatres and imaging) for the new hospital have been determined. It is not accepted that the information is included to the necessary level or provides the audit trail that would be expected to demonstrate the scale of the hospital.

It also remains unclear how and where some services will be provided once the lifespan of the Les Quennevais reallocation ends and how they will be accommodated either within the Jersey Care Model. As an example, as this report was being finalised, the Panel visited the recently refurbished Child Development and Therapy Centre, currently housed in the Overdale site. This service will move to Les Quennevais but, as yet, no clear plans are in train for its future accommodation when that site is vacated, nor is there consideration of the costs of such further relocations.

The evidence that would be expected at Outline Business Case stage on the demand and capacity modelling has not been provided which calls into question the extent to which the scope and sizing of the new hospital is robust.

Further, no Workforce Strategy has been produced to support the Outline Business Case. The Panel have been made aware that this would be expected in order to understand the workforce required to support the new model of care and scale of hospital, as well as the recruitment or training plan to achieve this. The revenue consequences on the planned workforce strategy should also be included in order that the true long-term affordability of the proposals can be assessed.

At the Public Hearing held on 11 August 2021, the Associate Director, Improvement Innovation, Health and Community Services, said:

> *"The workforce strategy has started. There is a piece of work being led by our Associate Director for People Services and the timescale for that is to deliver the strategy quarter 2 next year, is my understanding. But that work has started."*

Key Finding 12

The Outline Business Case does not demonstrate alignment between the Our Hospital Project and key strategic programmes, especially the Jersey Care Model, and appears to have been formed in isolation to other Government priorities and strategies.

Recommendation 1

The Deputy Chief Minister, prior to the finalisation of the Full Business Case, should identify elements of the Jersey Care Model that relate to the Our Hospital Project and these should be clearly set out in detail in the form of a clinical strategy. This should articulate how hospital services are expected to change in the future and how service transformation will impact on capacity, clinical adjacencies and hospital design.

However, despite the assurance given on workforce planning – and also in relation to facilities management – it is the Panel's opinion that it is a key deficiency of the document and one which means that it is not possible for the States Assembly to make an informed decision on the full future costs of the new hospital. The detail of the costs which the adviser would have expected to see outlined at this stage are contained in their report.

The Panel is aware that its recommendation for a reduced budget sets a limit within which discussions would need to be had about the expectations of the building and what is required.

As outlined in the Panel's amendment, it is not seeking to be prescriptive about how the budget should be achieved, particularly as it is clear from its recent Public Hearings and from the most recent briefing given by the Our Hospital Team on the design stages, that this remains an evolving project.

Concern has been expressed by individuals throughout this review that, despite the acknowledgement that 'like be compared with like' the Government has not appeared to engage with providing the public with a suitable benchmark comparison to understand the scale of the build proposed. It is accepted that suitable benchmarking has been provided on cost but the scale.

The concern in relation to suitable benchmarking is also a significant part of the submission provided by the Friends of Our New Hospital which is appended to this report.

Economic Case

- *Identify the proposal that delivers best public value to society, including wider social and environmental effects*

The Panel's advisers, Currie & Brown have stated that the Economic Case of the Outline Business Case does not meet Green Book requirements in the following ways:

- The long list of options does not fully explore all potential options including hospital size, scope and location.
- The shortlisting of options has not been undertaken in line with Green Book 2020, with no application of the options framework filter. It should be noted that in its fact-checking of this report that the Government have concluded that all aspects of the options framework filter were considered – although not in the form set out in the Green Book.
- There is no Business As Usual (BAU) option which is required to provide a true baseline against which to compare options
- Inadequate workforce costs or building running costs have been provided to inform the comparison of options
- Benefit quantification of each option has not been undertaken in line with Green Book requirements.
- A Net Present Cost (NPC) has been provided instead of a Net Present Social Value (NPSV) to compare options. No social impact has been quantified (a monetised value).

The Government has stated that the site selection process was set out at Strategic Outline Case stage and that to include other options at the Outline Business Case stage would not be appropriate as it would challenge the States Assembly decision to site the new hospital at Overdale.

Notwithstanding this assertion, a robust OBC would consider other scoping options to make sure that in economic terms the correct option was chosen.

In addition, the Panel believes there has been a lack of consideration given to a dual site option throughout the process.

Although the point is covered in Currie & Brown's report, for clarity on the lack of a business as usual option, the following explanation is provided.

> The longlist includes a Do Nothing option which is not applicable in the 2020 Green Book. Instead, inclusion of a Business as Usual (BAU) option is required as the counterfactual against which to assess other options. HMT Green Book 2020 states at 4.8:
>
> > "Business As Usual (BAU) in Green Book terms is defined as the continuation of current arrangements, as if the proposal under consideration were not to be implemented. This is true even if such a course of action is completely unacceptable. The purpose is to provide a quantitative benchmark, as the "counterfactual" against

which all proposals for change will be compared. BAU does not mean doing nothing, because continuing with current arrangements will have consequences and require action resulting in costs, in practical terms there is therefore no do-nothing option"

In addition, the Green Book (section 3.24) states that:

> "The strategic dimension of the Five Case Model must identify "Business as Usual" (BAU) – that is the result of continuing without implementing the proposal under consideration. This must be a quantified understanding to provide a well understood benchmark, against which proposals for change can be compared. This is true even when to continue with BAU would be unthinkable."

The description of the Do Nothing option in the Our Hospital OBC is to keep the site running without significant investment in infrastructure, and assumes closure of the hospital in 2026. Therefore this description aligns with the BAU definition in the Green Book and is deemed to be the correct counterfactual / baseline comparator option.

Key Finding 13

The Outline Business Case does not demonstrate alignment between the Our Hospital Project and key strategic programmes, especially the Jersey Care Model, and appears to have been formed in isolation to other Government priorities and strategies.

Key Finding 14

The shortlisting of options has not been undertaken in line with Green Book 2020.

Key Finding 15

There is no Business As Usual (BAU) option which is required to provide a true baseline against which to compare options.

The estimated cost for the preferred new build option has generally been based on the design, the scale of which is informed by the schedule of accommodation. The Panel's advisers indicate the justification for the full schedule of accommodation has not been provided, however, it has been determined that the costs presented for the RIBA Stage 2 design are realistic and robust.

Developing the schedule of accommodation has been described on a number of occasions as an 'iterative process' by the Our Hospital Project Clinical Director, Professor Ashok Handa, including as part of his evidence given at the Public Hearing held on 16th September:

> *"We have challenged the clinicians on the numbers of beds, other facilities required, all the way through that process. Those processes each result in an output of change in design and amendment to the schedule of accommodation. The schedule of accommodation is aligned to that. We know that many of the services have changed the service configuration and profile and that has continued to inform that."*[29]

[29] Transcript - Future Hospital Review Panel - Our Hospital Project Outline Business Case and Funding Review - Witness Deputy Chief Minister and Minister for Treasury and Resources - 16 September 2021, p.16

Specifically, no facilities management and utilities revenue costs have been included to identify the financial impact of the options compared to the existing arrangements. It has been stated that the lack of information is due to Facilities Management services being subject to a separate business case.

Key Finding 16

No facilities management and utilities revenue costs have been included to identify the financial impact of the options compared to the existing arrangements, the Outline Business Case therefore fails to evidence that the proposals provide the best value for money.

At the Public Hearing held on 16th September, the Deputy Chief Minister, acknowledged the fact that facilities management information would not be available prior to the debate on the budget and funding of the Our Hospital was 'not ideal' for States Members and alluded to the time pressure on the project:

> *"A facility management business case is currently being developed to consider the future strategy and costs associated with delivering the new facilities. So that is an urgent piece of work in progress. Waiting for this piece of work to complete before presenting the outline business case will introduce significant delay to the project, and that is what we want to avoid. In an ideal world, if we had years and years to build this, we would wait and we would line it up properly but from the very start of the project we said we are going to have to be running some of these exercises in parallel, and that is what we are doing. While I do accept it is not ideal not to have these detailed costs in the outline business case, as we would have hoped to do initially, it is a work in progress and we will provide that as soon as possible. Efficiencies can and will be made to the Our Hospital Project using newer technology. For example, the way we are going to power, for example, the whole campus as opposed to the way we are powering it now. Then all the advantages of improved clinical adjacencies. Like I say, not ideal but it is due to the timeframe we are working, the team are working on this urgently to get that information as soon as possible because it is important information for States Members. I do accept that."*

While the best way of delivering services could be considered by a separate business case the revenue consequences should be included in the Outline Business Case in order that the true long-term affordability of the build proposal can be assessed.

Key Finding 17

No facilities management information will be available before the debate of P.80/2021.

The Panel's adviser has identified that the Critical Success Factors (CSFs) put forward in the Our Hospital Project's Outline Business Case focus on meeting the strategy and business needs and includes affordability. However, they do not cover value for money, supplier capacity and capability or potential achievability. It is highlighted by the Panel's adviser that this could lead to the shortlisting of options which do not have the potential to be value for money, deliverable (achievable) or be attractive and match supplier side capability/capacity. The CSFs therefore fall short of what would be expected.

The Panel has been informed that the long list of six options were detailed in the SOC and represented in the Outline Business Case. This information is consistent with that provided to the

Panel at Public Hearings by the Our Hospital Team. However, the Panel's understanding is that these do not look at the various permutations of the Green Book methodology (e.g. the need to consider Scope, Solution, Delivery, Implementation and Funding of each option). In particular it does not look at options with alternative service scopes, for instance and option with and without the private patient unit.

The Panel believes that it is a key deficiency in the economic case as it does not allow proper consideration to be given to other potentially viable options as they have not been identified.

The Advisers highlight that to be Green Book compliant the shortlists options would include:

- BAU for use as a benchmark.
- Do minimum option (that just meets the business needs)
- Preferred Way Forward (that may or may not be the Do Minimum)
- A more ambitious preferred way forward (this may be more expensive, deliver more value, but at higher costs with increased risks
- A less ambitious preferred way forward – unless the preferred option is a do minimum (this option may take longer, deliver less value but cost less and / or carry less risk)

However as identified in the Outline Business Case, only two options have been fully considered:

1. A Do Minimum option, which has been incorrectly identified as the baseline comparator
2. The preferred option

The Panel's adviser has made the following comment:

> *"Given the scale of the investment being sought, it is not best practice and not acceptable to see just a single alternative option to the baseline in an OBC for a scheme of this scale. This is not something seen in any other business case of this scale from Currie & Brown's collective experience."*

Key Finding 18

The Outline Business Case does not include fully evidenced consideration to other potentially viable options nor a Business As Usual comparison, which is unacceptable for a project of this scale.

The Outline Business Case identifies benefits of the options and has allocated scoring to each item. This does not provide monetised benefit measurement. As such it has been identified by the Panel's advisers that there is no way of being sure that value for money is going to be achieved. When questioning the lack of such quantification it was asserted by the Our Hospital Project team that data maturity in Jersey would not allow this.[30] However, as identified by the Panel's advisers, enough information was available to allow benefit quantification to be completed in the Jersey Care Model business case, which would suggest data is available to have at least quantified key benefits.

The Panel's advisers highlight:

[30] Transcript - Future Hospital Review Panel - Our Hospital Project Outline Business Case and Funding Review - Witness Deputy Chief Minister and Minister for Treasury and Resources - 16 September 2021, p.8

"The response as to why benefits quantification was not undertaken also states "Assessing benefits on a quantitative basis would not have altered the conclusions of the OBC and it is likely that postponing the decision-making process due to the availability of quantitative data would have delayed the overall project timeline. The benefits included in the OBC are considered to provide a firm basis and sufficient confidence for decision makers concerning the case for a new hospital at Overdale." This is entirely subjective and an unsatisfactory response, which undermines the process and approach set out in the Green Book."

Key Finding 19

The Outline Business Case does not provide benefit monetisation and therefore fails to provide evidenced value.

The Panel's advisers have indicated that the costs included within the Outline Business Case are generally within expected levels and reasonably calculated, however there are some issues and points that they have highlighted:

- **Preliminaries** – there is a £33.6 million variance between the DDP and project costs consultant. Whilst recognising that work is ongoing to reduce this difference and come to agreement on an acceptable level this does represent a risk to the agreement of the final target cost within the allowance set out in the Outline Business Case. Any overage to the Outline Business Case preliminaries allowance requiring to be funded from client risk / OB allowances.
- **Design Fees** – are at the higher end of expected costs compared to UK mainland healthcare projects.
- **Overhead and Profit** – 9.5% is higher than expected benchmarks and was accepted as part of the DDP accepted first stage tender. It is highlighted by the adviser that a review of the value of construction works expected at the time of the first stage tender submission to establish if there is any potential to reduce this OHP level to reflect any increase in the estimated works costs may be worthwhile
- **Site Acquisition** - Negotiations are ongoing with landowners and there remains a risk that properties are not secured at estimates included in the Outline Business Case or completed within the timescales necessary to support construction to commence.
- **Revenue costs** – As identified these are not adequately detailed in relation to facilities management and utilities costs

To aid in benchmarking the Panels' adviser have provided the following calculations:

OBC Costs	
Main works costs	£311.7 million
Deduct abnormal cost items	
Extra cost for multi storey car park	(£7.0 million)
Westmount Road	(£19.0 million)
Demolition	(£2.6 million)
Sub-total	**£283.1 million**
Preliminaries	£48.1 million

Contactor contingency	£26.5 million
Sub-total	**£357.7 million**
Overhead & Profit	£34.0 million
Total estimated construction contract	**£391.7 million**
Build cost per m^2	**£5,672 / m^2**

UK Benchmark Projects[31]	
Project 1	£4,854
Project 2	£4,784
Project 3	£4,030
Project 4	£4,626
Project 5	£4,678
Project 6	£5,363
Project 7	£4,252
Project 8	£3,413
Project 9	£4,237
Project 10	£4,723
Project 11	£4,867
Project 12	£5,125
Project 13	£5,763
Median Benchmark Projects	**£4,701**
Jersey Hospital	**£5,672**
% above median benchmark cost	**21%**

However, the adviser has indicated that there are additional elements which may account for the additional costs, identifying that these potentially stand at:

- 15% Jersey factor
- 2-3% onset costs for construction of four separate structures (Main Hospital building, Mental Health, Knowledge Centre and Energy Centre)
- 3-4% due to design issues e.g. complex roof design, ground abnormal items and general pricing uncertainty etc.

The adviser has stated:

> *"At this stage of early cost estimating this margin of cost variance is not unusual and is not significant within the overall scale of the project and can be seen as an opportunity to target cost reductions through the robust target value design approach being implemented by the project team."*

[31] Based on comparable major acute healthcare projects

Key Finding 20

Although the Economic Case is lacking information and is not HM Treasury -Green Book compliant, cost calculations are generally within expected levels and reasonably calculated. However, there are elements that are costed at the higher end or above expected benchmarked pricing.

Recommendation 2

The Deputy Chief Minister must ensure a robust option appraisal is undertaken and a value for money is evidenced if progressing to Full Business Case. This must include:

- **Consider a full range of options for inclusion in the shortlist to include both location and scope of the proposal to address the priority investment objective.**
- **Include the Business As Usual option in the shortlist.**
- **Include a less ambitious preferred way forward option in the shortlist.**
- **Undertake a full quantified assessment of costs, risks and benefits of the shortlisted options to identify the NPSV (net present social value) of each option, in order to support the identification of the option offering greatest value for money to society.**
- **Costs should include the ongoing running costs of the hospital including staffing and facilities management services.**

Financial Case

- *demonstrate the affordability and funding of the preferred option, including the support of stakeholders and customers, as required*

Most of the Finance Case section addresses the funding proposal which is discussed later in this report.

However, the Panel's advisers have indicated that the Outline Business Case includes limited information on the revenue impact of the proposed new build solution. Those revenue impacts included are limited to lifecycle (planned replacement) expenditure and the cost of providing a shuttle bus.

The Panel's advisers have suggested that it would be expected that an Outline Business Case would clearly set out the total revenue burden including, for instance, facilities management and the utilities costs of the proposed solution. It would also be usual for the options considered, to provide a comparison with existing revenue costs in order that long-term affordability and value for money is proven. As the Panel's advisers highlight, the Green Book notes that the five case model should cover "What is the impact of the proposal on the public sector budget in terms of the total cost of both capital and revenue?".

Therefore, as the shift to a new facility is a step change from existing workforce arrangements, the Outline Business Case should also set out the workforce plans and revenue costs for operating the new facility. There is a lack of information provided on this item. In addition to providing cost information to evidence long term affordability, the risk around implementing a workforce plan should also be stated.

When questioning this point the Panel was informed that a separate piece of work was being undertaken to understand these costs, however it has been anecdotally suggested that replacing the aged estate and efficiencies will reduce current costs.[32] As highlighted by Currie & Brown:

> "*Revenue impacts for the preferred option could be significant compared to existing arrangements and the lack of detail does not provide decisions makers with the true picture on the overall cost impacts of the development and should be provided to allow fully informed decision making on the long term revenue impacts of the project."*

Both Currie & Brown and CIPFA have identified that the Outline Business Case is silent on the anticipated running costs of the new hospital and that this lack of information has a negative impact on the credibility and robustness of the approach taken. The Panel also identified that this information should be provided at the time of the presentation of the Outline Business Case in its scrutiny of P.123/2020, and through its amendment.

Key Finding 21

Future revenue costs to the Island of Jersey of the Our Hospital Project proposals have not been calculated, risking additional constraint on public finances.

Recommendation 3

The Deputy Chief Minister must, prior to the finalisation of the Our Hospital designs, outline predicted revenue costs of the proposed changes in healthcare provision.

Commercial Case

- *demonstrate that the preferred option will result in a viable procurement and a well-structured deal between the public sector and its service providers*

The Panel's adviser has identified that the OBC commercial case does not comply as it refers to a procurement strategy set out in the Strategic Outline Case (SOC) which was not followed in full and as described in the SOC commercial case.

It is further highlighted that there is no evidence that a realistic and credible commercial deal can be struck in connection with the stated private patient's strategy and inclusion in the hospital plans of a private patient's area larger than the existing facility. Specifically, there is no evidence that the investment to construct, operate, maintain and staff the private patients wing is supported by income from private patients. It has been ascertained that the number of beds anticipated in the proposed patients ward is based on consideration of the Associate Medical Director, Manager for Surgical Services, Manager for Medicine and Associate medical Director for medicine, with the Our Hospital Clinical Director indicating:

> *"…the short answer to that is it is a legitimate purpose and the reason for that is we know that a very large amount of private practice goes off-Island. Jersey money and patients are having to travel because the hotel services and the facilities are not adequate on-*

[32] Transcript - Future Hospital Review Panel - Our Hospital Project Outline Business Case and Funding Review - Witness Deputy Chief Minister and Minister for Treasury and Resources - 16 September 2021, p.8

Island for the type of facilities that patients would want privately. This is about making a facility available, keeping the Jersey pound and patients on Jersey." [33]

The Panel further notes that figures were provided by Professor Handa, in relation to the case for the private facility during an exchange at a Public Hearing in June, however, it would appear that these figures have not been verified or expanded upon in the Outline Business Case:

The Deputy of St. Mary:

And maybe our own budget, so on that I have a note here that the current expectation is that a private facility will cost £8.8 million, which is expected to be recouped within 3 years, or have a useful life of 30 years. Can you give indication as to how that projection was arrived at?

Director General, Health and Community Services:

I am going to have to turn to Finance to understand that.

Our Hospital Clinical Director:

Maybe I could step in. Those are figures from previous information that I have given to this committee and that £8.7 million is based on the total square metres of the private patient facility and costing as we know one square metre is around £5,500.

The early work on expected income is around £3 million per year of Jersey money goes off-Island into predominantly London but other major academic health centres and some on the south coast. That is where the £3 million comes in and 3 times 3 would give you the £9 million return. The expected lifespan of the new facility is a minimum of 30 years before it needs significant investment, so we are not adding that in, but of course we are expecting to build a hospital that is going to last 50 to 60 years, but you would expect after 30 years to start having significant reinvestment to upgrade and refurbish. That is where those figures come from.[34]

As noted in the economic and financial case sections of this report, there is no cost information for the operating revenue consequences of the facilities management strategy. This is a significant area of non-compliance within the overall business case as decision-makers are not being provided with the estimated true cost of ownership of the asset. Future operating costs having significant implications on recurring revenue costs.

The proposed contract strategy for delivery of the construction works is the adoption of the NEC3 (National Engineering Contract) Option C Target Cost Contract. Whilst updated NEC4 contract conditions are available and are an evolution of NEC3 with improvements, the use of NEC3 is still considered appropriate for this scale of project.

The Panel has noted that the Pre-Construction Services Agreement in place with the appointed DDP includes a mechanism to share the cost risk for delivery of the construction works. With the agreed 'pain share' arrangement, the Government of Jersey would be liable for a share of costs incurred up to 10% above the accepted target cost (or the adjusted target cost to reflect agreed changes during construction). Based on the agreed share percentages the maximum additional

[33] Transcript - Future Hospital Review Panel - Our Hospital Project Outline Business Case and Funding Review - Witness Deputy Chief Minister and Minister for Treasury and Resources - 16 September 2021, p.20
[34] Transcript – Future Hospital Review Panel – Witness, the Deputy Chief Minister – 17th June 2021

liability to the Government of Jersey above the accepted target cost (assuming a target cost of £604 million in line with the estimated construction costs in the Outline Business Case) would be £22.5 million.

The RIBA Stage 2 report has been included with the Outline Business Case. The Panel's adviser has indicated that this report includes significant detail on the architectural development of departmental layouts etc. It includes limited information on the approach to sustainability/net zero carbon and the overall building engineering strategies necessary to ensure compliance with relevant healthcare technical standards.

The Panel's adviser highlights that the Outline Business Case references the benefits criteria for the project and the KPI's that have been agreed within the project team for job creation and new entrants to the construction industry; apprentices; placements; and training opportunities. However, the Panel's adviser indicates that there is a lack of detail of the strategy for achieving these targets.

Key Finding 22

The Commercial Case of the Outline Business Case is not compliant with the Green Book requirements.

Key Finding 23

There is no evidence that the investment to construct, operate, maintain, and staff the private patients wing will provide commercial returns by income from private patients.

Key Finding 24

There is little evidence to indicate a strategy on how benefits, such as job creation, will be achieved.

Recommendation 4

The Deputy Chief Minister must, prior to final design of the private ward, provide to the Assembly a fully evidenced business case to justify the additional spend and space allocation to private services in the new hospital.

Management Case

- *demonstrate that robust arrangements are in place for the delivery, monitoring and evaluation of the scheme, including feedback into the organisation's strategic planning cycle.*

The Panel's adviser has indicated that the management case of the Outline Business Case is generally complaint with Green Book requirements on the general governance and management arrangements.

However, as highlighted in the strategic case analysis of this review, the advisers have indicated that it would benefit from explaining the linkages and interdependencies with the Jersey Care Model and the Digital Strategy.

Furthermore, there is no evidence in the Outline Business Case of the planning discussions and feedback to provide assurance that a planning application is supported by Development Control and the timelines required are achievable.

Key Finding 25

The Management Case of the Outline Business Case is broadly compliant with Green Book requirements, however it is lacking elements to allow for understating of Risk and Change Management.

Recommendation 5

The Deputy Chief Minister should publish full details of the change management plans for the transition to the new hospital and provide full detail of the project risk register prior to accepting a Full Business Case.

The Outline Business Case sets out the arrangement for management of change to the design and construction contract. It includes limited reference to the change management and training and development plans necessary for clinical redesign and facilities management

It has been indicated to the Panel by the advisers that the methods to be adopted for measuring and monitoring benefits realisation benefits register has not been included in the Outline Business Case and that there is little detail on measures that will be implemented to maximise the community benefits and social value.

Although there is a risk management strategy in place, the project risk register has also not been included and key / critical risks have not been highlighted, which limits visibility to decision makers on the risks and mitigation measure in place.

There is also limited information on how the project team are addressing strategies to ensure the transition from construction to occupation is managed and that operational performance is optimised.

6. P.80/2021 Our Hospital – Budget, Financing and Land Assembly

The terms of reference for CIPFA were as follows:

1. Review and analyse the proposed use of a bond and if this is the best value for money for the OH Project and ensure this funding solution is appropriate and proportionate for the project:
    a. To list any other funding options, as appropriate
    b. To review the budget increases and interim funding solution used throughout the project and measure these against best practice
    c. To review the proposed repayment, in particular to analyse if the returns on the Strategic Reserve over the full life of the bonds will be sufficient to meet both the annual financing costs and grow the value of the investments to a sufficient level to meet investor capital repayments, as proposed
    d. To analyse the financial impact on the Island's economy
    e. To analyse the impact that repayments of borrowing of this scale will have on general revenue expenditure, particularly meeting the costs of running a health service, such as maintenance, staff facilities and pay increases

At the heart of the Panel's concerns and therefore the driving force for its amendment to P.80/2021 is that the project did not begin with the premise of affordability.

The Panel cannot find evidence that the Our Hospital Political Oversight Group set out a maximum spending envelope within which the Our Hospital Team were able to develop their plans.

It is acknowledged that the Panel has been made aware on a number of occasions that the intention of this iteration of the hospital project was to be clinically-led. At a number of Public Hearings, the Our Hospital Clinical Director, Professor Ashok Handa, has outlined clinicians have been involved in user groups throughout the process.

> *"As you will know, and we discussed at that meeting, the initial modelling was based on the PwC report. Subsequent to that we have had 5 rounds of clinical user groups. We have challenged the clinicians on the numbers of beds, other facilities required, all the way through that process. Those processes each result in an output of change in design and amendment to the schedule of accommodation. The schedule of accommodation is aligned to that."* [35]

However, while the Panel is firmly supportive that the needs of clinicians and health professionals are crucial to the development of the design and build, those expectations should have been given a financial framework from the outset of the project.

> ***Senator K.L. Moore:***
>
> *I would just like to ask one another question. Firstly, as the politician and political lead on this project it is within your domain to apply restraint to the budget and to cut your cloth*

[35] Transcript - Future Hospital Review Panel - Our Hospital Project Outline Business Case and Funding Review - Witness Deputy Chief Minister and Minister for Treasury and Resources - 16 September 2021, p.16

accordingly if you felt that the £804 million envelope was excessive. Could you explain why you have not done that?

Deputy Chief Minister:

I have not said it is excessive. I said it is a lot of money. It is accepted by the oversight group, on the advice and the work that has been done, and lodged the proposition accordingly. Of course, there were pressures and options to go even further. I mean if you look around the world the way medical science is evolving there are some extremely interesting opportunities, but also very expensive opportunities. I do not recall having used the word "world-class", I think it appears somewhere, we want to build as hospital that is fit for Jersey and is right for Jersey. We do not want to build a hospital that will just deal with something that is particularly average. We want to build a good hospital. [36]

Recommendation 6

The budget for the Our Hospital Project should be reduced to £550m to include optimism bias, site-specific costs and contingency.

In their report for the Panel, CIPFA conclude that, given the evidence at their disposal, P.80/2021 should not be agreed unless:

- There is total transparency around the clinical need that drives the scaling of the specification of the project
- A full and stress-tested Outline Business Case on running costs is delivered.

In CIPFA's view, the absence of an Outline Business Case which sets out the running costs is a serious weakness which potentially undermines the credibility of the Our Hospital Project on cost containment and resource consumption.

> *"Given that the annual actual running cost exposure of the OH based on the current specification is currently unknown and there is a lack of insight into the rationale behind the scaling of the project in terms of area and acute bed numbers, it is difficult to have absolute confidence in the efficacy of the overall cost construction and the effectiveness this asset will provide to the people of Jersey."*

Key Finding 26

The need to gain States Assembly approval for additional expenditure over and above the £804.5 million budget is unlikely to act as an effective control on costs, especially in the latter stages of the project, as the choice facing Members will be between agreeing or accepting an unfinished project

In line with the advice received from CIPFA, the Panel remain unconvinced that the need to revert to the States Assembly for any further budget above the £804 million set by the proposition would result in a realistic check on costs. CIPFA cite the phenomenon of project lock in, as follows:

[36] Transcript - Future Hospital Review Panel - Our Hospital Project Outline Business Case and Funding Review - Witness Deputy Chief Minister and Minister for Treasury and Resources - 16 September 2021, p.4

"We believe that project 'Lock In' may become a key inhibiting behavioural factor due to the nature of this complex project. Project Lock-in is a behavioural dissonance where objectivity in decision making is impaired due to decision makers and advisers being unable, through behavioural influences, to consider all available options including project termination or significant downward recalibration of specification."

The advice received by CIPFA is that the proposition and the approach taken by the Our Hospital Team has risks attached which commit the States of Jersey to a strategy that may impair future policy option capability and threaten the stability of the current medium and long-term financial strategy. In terms of proportionality, their view is that the scale of the project is extremely big, and its nature and complexity mean that it has the potential for costs to exceed £1 billion.

Further, they outline that a revised approach should be considered which would set a lower project cost envelope within which clinicians would need to revise their expectations and the project quantum costs be recalibrated. "*For example, matching clinical need to a level of affordability that can comfortably be accommodated within the overall medium term financial strategy for the States of Jersey."*

The Panel has concluded that, in the current financial circumstances and to reduce exposure to unknown future financial risk, an affordable and appropriate figure for Jersey's new hospital is £550 million. For clarity, this figure would include optimism bias, client contingency and site-specific costs.

This amended budget is recommended as a pragmatic approach to providing the States Assembly with a choice other than acceptance of the £804 million budget or rejection of the current project.

As a consequence of the lowered budget, the borrowing on bond finance should also be reduced. It is noted – and of concern to the Panel having become aware of this point during the finalisation of this report – that the States Assembly are not being asked to approve the borrowing instrument but that the Government's preferred option of bond finance is laid out in P.80/2021 alongside comparison options.

Recommendation 7

The scale of the cost and borrowing should be reduced to limit exposure to financial risk.

It is the Panel's view recommendation that the budget is revisited to:

- scale back the project cost and borrowing exposure so that the risks are reduced
- ensure that affordability is considered at every level of the project
- allow more time for a measured and transparent approach to running costs to be achieved, by reducing the specification.

Key Finding 27

Detailed capital and revenue running costs should have been clearly formulated and stress tested before funding solutions are considered

Key Finding 28

Bond finance is a sensible approach to this scale of borrowing if there is full confidence in the asset (hospital) specification to service demand and needs and robust cost construction.

However, in summary and as detailed in the Panel's amendment to P.80/2021, CIPFA has concluded that detailed capital and revenue running costs should be clearly formulated and stress tested before funding solutions are considered. While CIPFA agree that bond finance is a sensible approach to this scale of borrowing, they are also clear that this needs to have a backdrop of full confidence of the asset (hospital) specification to service demand and needs and robust cost construction. This lack of information undermines the proposed budget and, by extension, the means of funding it.

The Panel also notes the view of its adviser that the States of Jersey has a consistent record of capital programme slippage so borrowing in advance of need attracts unnecessary risks as well as costs. It is acknowledged that there is also a view that there are risks associated with not borrowing in advance of need in relation to financing costs and the expense of mitigations. The Panel believes that a fully considered and balanced approach is essential to robust and informed decision making.

The evidence provided from Treasury officials during Public Hearings is that the method of borrowing allows Jersey to take advantage of historically low interests at this point in time. They have also been clear that they have moved away from the 'blended' financial solution outlined in previous iterations of the hospital project because the financial climate and global circumstances are now very different.

The Director, Treasury and Investment Management provided the following explanation of the risk modelling:

> **"***Yes. I think there are 2 risks here. There is the short-term risk that once we have raised the debt there is, potentially, a market downturn before we have spent all the money on the hospital project. But we are applying a specifically defensive strategy to that portion of the monies to ensure that the capital element is protected as much as possible. Then you have got the long-term risks that I think you have just alluded to, is that the investment returns do not achieve the excellent returns that we have received in the past.*
>
> *What we asked our advisers to do was to model that scenario and they believe that even in what you would call a stress scenario where the investment returns are lower than forecast, there is a probability of at least 75 per cent of not only repaying the debt but of the Strategic Reserve growing to a level of 30 per cent of Q.V.A. (quarterly variable allowance) or G.D.P., which is something that the Fiscal Policy Panel are quite keen on us to achieve over time; that is by 2050. If you look at 2060 they believe there is an 87 per cent probability of achieving both of those scenarios. I think it is also fair to say that we do not just invest these monies and leave them there. The Minister has an independent Treasury Advisory Panel which is reviewing performance quarterly and that on a multi-annual basis we stress-test the portfolio for shock events to understand how it might react*

and not only that we would change the investment strategy to react to those events and to ensure that we do achieve the objectives that we want to."[37]

However, it is the Panel's view, in line with opinion provided by its advisers, there are financial risks posed by the project. These risks, as outlined by CIPFA and contained in the Panel's amendment to P.80/2021, are:

- **Lower than expected investment performance.** That the rate of investment return is lower than anticipated and threaten the delivery of required level of performance.
- **Opportunity Loss**. There are opportunities that will be foregone in tying up this level of investment. Any asset sale alternative assumptions should be happening as a matter of course to fund the public service investment. Expected organic growth within the Strategic Reserve Fund will be displaced by the requirement to lock in to financing the Our Hospital project. The view has been expressed to the Panel that the investment portfolio is not being tied up in the way suggested. Further, that Strategic Reserve is still available for its primary purpose but politicians would, if they decided to utilise it in the future, need to consider the implications - based on thorough advice on the Fund's value. CIPFA's view, however, is that the primary purpose has been altered due to the modification of "the objectives of the Strategic Reserve to finance and manage the servicing and repayment of debt and the directly associated costs of doing so." (P.80/2021 Page 5 Para 1.3). Their understanding remains that investment returns will be directed for a specific purpose outwith the original purpose of this reserve.
- **Reduced capacity for future borrowing.** There is potential that the headroom for borrowing would reduce and a potential credit rating notch downgrade creates the potential for future borrowing to be more expensive.
- **The changed nature of the Strategic Reserve Fund.** The change proposed see the fund change from one which exists to assist in the event of threats to being a means for funding external borrowing. P.80/2021 specifically allows the Strategic Reserve fund policy to be amended so as to allow the Fund to be used to support the delivery of Our Hospital.
- **Lack of cost control.** There are many global examples of project overrun on major infrastructure projects.
- **Lack of effective States Assembly control.** Potential lack of effectiveness of Assembly decision control on costs due to nature of the project. Although the Panel acknowledge that any costs above an approved budget envelope would need to be approved by the States, the current scale means that the Assembly would be faced with the enviable task of choosing between an increase beyond £804.5 million or an unfinished hospital. In other words, the project is too big to be allowed to fail.
- **The scale of future impact.** In the event of the non-delivery of investment returns and overage in project costs, tax and spend decisions for the public services on the island in the years ahead could be impacted. It could create the potential for tax increases, for

[37] Transcript - Outline Business Case and Funding Review - Assistant Minister for Treasury and Resources - 8 September 2021, p.23

example. The scale of project costs is currently higher than an annual personal income tax yield, corporate tax yield and GST put together.

- **Global uncertainty.** The approach taken (as outlined below) enhances the acceptance that expenditure will be financed by bond finance and that external debt is a positive strategy. In a settled world where arbitrage may work this would make sense but there are growing material global uncertainties emerging. The States has agreed to a new debt issuance strategy. It is expected that there will be up to five bond issuances over the next four years, raising up to £1.7bn. All proceeds will be paid into the Strategic Reserve Fund.Principal and coupon payments are expected to be met from the Strategic Reserve Fund.
- **Precedent.** Although the Government of Jersey has used external, specifically bond, financing in the past to aid its Social Housing programme, doing so to fund the Our Hospital Project reinforces a behaviour of borrowing in advance of need without having complete oversight of the overall project cost or running costs of the asset being created. As stated earlier, CIPFA's view is that the lack of sight on running costs is a serious omission which undermines the credibility of the Our Hospital Project at this point in time. In the terms used by the Panel's advisers: "Bond finance is not free money' irrespective of financial leverage/arbitrage."

Key Finding 29

A reduced budget would allow for an alternative funding solution to be sought.

The Panel's finding in this regard is that, with a reduced budget, an alternative solution could be found which reduces the reliance on borrowing and by extension on bond financing.

Recommendation 8

Overall borrowing for the project should be reduced to £400 million and Treasury should explore other options including the use of the 'windfall' payment of approximately £40 million resulting from JT's sale of its IoT business and other asset disposals opportunities.

It is the Panel's recommendation that overall borrowing for the project be reduced to £400 million and that the Treasury explore other options including the use of the 'windfall' payment of approximately £40 million resulting from JT's sale of its IoT business and the possible disposal of other assets. The Panel is also of the opinion that further special dividends should be explored with JT in relation to the sale of the IoT business.

Advisers have indicated that the foregone reduction on expected investment returns to the Strategic Reserve Fund of £2.1 billion would arise on a £1.2 billion investment over 40 years. Simplistically, should a significant sum of bond finance be committed – say £800 million, this example gives an indication of the level of investment returns given up or foregone from normal reserve growth, to repay the debt and coupon costs over the period – as an example – £1.4 billion of foregone utility.

CIPFA have reported on their view of the changed use of the Strategic Reserve Fund and the precedent set that future capital spend – beyond the Our Hospital project – could be financed

using bond finance. This is a course which the Panel believes would create a mindset which accepts external debt as the best strategy at a time of increased global uncertainty.

Recommendation 9

To preserve the integrity of the Strategic Reserve Fund, a specific Our Hospital Fund be created to 'improve focus'. Included in this recommendation is that accountability is imposed on the Project Senior Responsible Officer (SRO) for the delivery of the project within the revised approved cost envelope.

Their conclusion is that to preserve the nature of that fund, a specific Our Hospital Fund be created to 'improve focus'. Included in this recommendation is that accountability is imposed on the Project Senior Responsible Officer (SRO) for the delivery of the project within the revised approved cost envelope.

> *"It is submitted that the establishment of a specific OH reserve using a recalibrated 'affordable project cost envelope' and an accountability requirement embedded in Jersey Finance Law, should deliver the necessary conditions to enforce further grip and accountability on the project that could mitigate any unforeseen cost pressures. Should a more aggressive investment strategy be still deemed to be necessary, such higher risks could be contained within the specific OH reserve rather than being expanded and applied to the residual amount within the Strategic Reserve Fund. Should the revised cash envelope be determined, as an example, at approximately £550 million, the SRF could still have in excess of approximately £550 million at the outset and the integrity of the purpose of the SRF preserved."*

7. Public and Third Sector Submissions

The Panel issued a public call for evidence on 4th August 2021 which ran until the 3rd September 2021 and in excess of 130 submissions were received.[38] These submissions have been uploaded to the scrutiny website, in an anonymised format unless individuals indicated that they were happy for their comments to be accredited. The Panel wishes to thank everyone who responded but is unfortunately unable to refer to every submission within its report.

The Panel also directly contacted the third sector/key stakeholder to gauge their views. A detailed submission was provided by the Friends of Our New Hospital.

The Panel asked to receive views on whether:

- The proposed budget of £804.5 million is appropriate for Jersey and for this project
- £756 million of that budget should be borrowed by using public bonds
- Borrowing of this scale should be used to finance a new hospital
- The investment returns of the Strategic Reserve should be used to pay debt financing costs, management and administration costs
- The proposition adequately addresses the economic risks or benefits
- The conclusions of the Outline Business Case are reasonable
- The Outline Business Case provides sufficient evidence to support the scale of the proposed project
- It is sensible to use the Strategic Reserve [Rainy Day Fund] to manage debt and funding of the Our Hospital Project

As well as additionally asking members of the public:

- What key issues you think States Members should consider when they debate the funding proposal?
- What further information, if any, you need about the proposed funding for the Our Hospital Project?

[38] Call for Evidence - Our Hospital Project Outline Business Case and Funding Review - 04 August 2021

It is acknowledged that many of the submissions expressed opinions which fell outside the parameters of the review, as seen in Fig 4. However, they are indicative of the level of feeling that people have about the site and the project, over and above the question of cost. As stated above, it would also indicate that the messages that Government wished to project through its communication channels has not been wholly successful or given people the assurance that their voices have been heard. It is the Panel's belief, through its review of these submissions, that this is especially true of the residents in the immediate area.

Fig.4 Full word cloud[39]

When analysing public submissions for those items relevant to this review it is clear to the Panel that the majority of comments on the Our Hospital Project are unsupportive. A large proportion (86 of 134) expressed the view that the £804.5 million budget for the project was either outrageous, inappropriate or unacceptable.

The second most numerous submissions (46 of 134 submissions) were those expressing concern about the size of, and financial burden created by, the proposed funding solution.

[39] A word cloud is a visual representation of larger written submissions, the larger the text the more commented upon that factor.

Further comments expressed the view that there was no need for a 'world class' hospital, instead a functional design was required (38 of 134). Many highlighted that hospitals had been built within lower budgets elsewhere in the world (36 of 134) and there were calls for a pause of the Our Hospital Project or an outright rejection of P.80/2021 (33 of 134).

Fig.5 Reduced word cloud

The full submissions can be viewed here.

A selection of those related to the 5 top comments areas are:

Project cost

"The proposed budget of £804.5 million is totally inappropriate for Jersey and this project is simply not sustainable for future generations to pay back in taxes. I am 25 years old and I am so very concerned about how this cost is going to burden my generation that are already facing the heavy financial burden of paying for a one bedroom flat in town, let alone any sort of family home that they can grow into with a future family. Please do not let us face this added burden when I know that so many of my friends are not returning to the Island given the already high costs of living here." [40]

"The money that has been spent so far is outrageous and what it's going to cost!! The people who are planning this should take a step back and think how they would spend their own money!" [41]

"When the original cost of £400M was suggested there was a sharp intake of breath by many people. Recently The States voted through a budget of £800M + I wonder what the final figure might be?" [42]

[40] Submission - Our Hospital Outline Business Case and Funding Review - Anon 41 - 31 August 2021
[41] Submission - Our Hospital Outline Business Case and Funding Review - Anon 7 - 31 July 2021
[42] Submission - Our Hospital Project Outline Business Case and Funding Review - B de la Haye (2) - 31 August 2021

"I strongly disagree with the massive costs involved both already spent and the amount being proposed for the building of the new hospital." [43]

Funding Solution

"As one of the younger generation of islanders I am, to say the least, terrified of what impact this will have on the cost of living. Ultimately we are seeing unprecedented spending by this government, compounded by the still rising costs not only to the government but also the local economy/community of COVID-19. They simply should not be allowed to take out a disproportionate loan over such a lengthy term." [44]

"The Strategic Reserve Fund should not be used in the way proposed. This is a Smart Alick trick to make the real cost of the New Hospital disappear and remove all impact on the present generation. It will prevent the Fund being used in the future, if there is an emergency, as the borrowing can only be repaid if the Fund is intact and growing."[45]

"Any assumption of returns that covers 40 years is unreliable and it is irresponsible for the government to propose that past performance on the rainy day fund 'guarantee' future performance. The world economy is changing very quickly these days (Brexit, COVID etc) and we cannot assume that Jersey 'finance industry will continue to provide all the tax revenue and positive economic impact as before." [46]

Hospital design

"No common sense has been applied to this project and it is high time that Members began to use common sense when considering what is proposed and ensure that we have a sensibly priced but adequate hospital for the needs of a small island, not a world class one more befitting a huge city with surrounding, dependent populations." [47]

"Firstly, the powers that be keep talking about 'A World Class Hospital'. We are a small Island. We do not need a World Class Hospital, but just a well staffed functioning General Hospital. Leave the 'World Class' to the Centres of excellence, the teaching hospitals like the London teaching hospital that I trained in. These hospitals are in areas of huge populations and do pioneering work and attract the best medical staff from all over the world." [48]

"The huge atrium and unnecessarily flamboyant design should be reconsidered and redesigned and a simpler building should be provided." [49]

[43] Submission - Our Hospital Outline Business Case and Funding Review - Anon 46 - 31 August 2021
[44] Submission - Our Hospital Outline Business Case and Funding Review - Anon 8 - 5 August 2021
[45] Submission - Our Hospital Project Outline Business Case and Funding Review - Levitt - 20 August 2021
[46] Submission - Our Hospital Project Outline Business Case and Funding Review - E Icardi - 31 August 2021
[47] Submission - Our Hospital Project Outline Business Case and Funding Review - G Le Rossignol - 31 August 2021
[48] Submission - Our Hospital Project Outline Business Case and Funding Review - A Morgan - 31 August 2021
[49] Submission - Our Hospital Project Outline Business Case and Funding Review - J Pinel - 06 September 2021

Comparison to other construction

"Look at UK new builds and ask yourselves why the estimates to build our new hospital are more than double those of larger hospitals recently built elsewhere." [50]

"From Statista: "London is the region with the highest building costs for all three types of hospital recorded here"

A General Hospital built in London in 2018 was the most expensive hospital built in the UK between 2016 and 2018, but it cost just £3,780 per square meter. (https://www.statista.com/statistics/601817/hospital-building-cost-uk-2016/)

At say £4,000 per square meter in 2021, we could build a hospital of over 200,000 square

meters for £805.5m. My view is that the planned hospital and its equipment is either massively spec'd over the island's needs for the next 50+ years, or the architects, builders and equipment suppliers are making a massive profit, chances are it's a bit of both." [51]

Pausing the project

"An immediate halt needs to be called to the proposed borrowing and the current planned construction. Apart from the fact that this is nearly three times the cost of similar hospital constructions in the UK and EU, the future prosperity of this island is not assured and borrowing at this level could be crippling to the people of Jersey.

Those in power should look at what the island can actually afford and have a hospital designed within this cost. At present they are telling themselves they can have, and deserve, a Ferrari when all they can afford is a Mini." [52]

"It is not too late to stop the project. I think the whole project should be re assessed by the new government elected next year and put on hold until then." [53]

"I think out of control is a very reasonable term, how you get this back on any form of sensible course I have no idea, but you have my support. As I said at the beginning I'm just not an expert, but this Hospital looks like it will be the piece de resistance of a very failing States assembly, and this failure will impact all of us and our families for many years to come." [54]

Additional quotes that the Panel wishes to highlight:

"This is turning into an even bigger fiasco than the last attempt when we were told 'lessons had been learnt." [55]

[50] Submission - Our Hospital Project Outline Business Case and Funding Review - Perchard - 7 August 2021
[51] Submission - Our Hospital Project Outline Business Case and Funding Review - Scarott - 12 August 2021
[52] Submission - Our Hospital Project Outline Business Case and Funding Review - Johnson - 10 August 2021
[53] Submission - Our Hospital Project Outline Business Case and Funding Review - Corrigan - 16 August 2021
[54] Submission - Our Hospital Project Outline Business Case and Funding Review - T Forder - 03 September 2021
[55] Submission - Our Hospital Project Outline Business Case and Funding Review - G Aubert - 31 August 2021

"The decision to force through the Assembly a vote of approval for the Overdale site in the absence of any details of the construction road, the loss of open fields, the destruction of homes, the demolition of Plemont ward, the removal of the Crematorium, the purchase of the Jersey New Waterworks Company headquarters (for demolition) and the callous eradication of the Bowls Club is deeply and profoundly morally corrupt."* [56]

"My sole issue is the upset that this is causing families regarding the disruption of the crematorium. For a host of reasons, my mum (as do I) take great comfort in being able to visit my dad at the crematorium. Whilst the crematorium is in need of development, the setting brings peace to love ones who have already suffered significantly. Any interference of the crematorium is totally unnecessary and should be managed with the upmost of respect to all those who have loved ones resting there. The loss of the view and overriding setting would be unforgivable." [57]

*"We have endured twelve months of hell not knowing what impact this project will ultimately have on our property. I say this because when Overdale was chosen as the preferred site it was indicated that three properties** within the immediate vicinity of my property were to be acquired by the Government and authority was given by the States Assembly to proceed with compulsory purchases if negotiated acquisitions could not be achieved. Subsequent to such approval it has transpired that as many as 14 homes/properties will be acquired and destroyed to accommodate the building of the Super Highway and hospital. A completely different picture to that originally sold to the States Assembly."* [58]

*It has been noted by the Government of Jersey that future plans for the Crematorium are not part of the Our Hospital Project

** It has been noted by the Government of Jersey that more than three properties were included in P.129/2020 – Our Hospital Project: Acquisition of Land at Overdale

[56] Submission - Our Hospital Project Outline Business Case and Funding Review - A Le Quesne - 31 August 2021
[57] Submission - Our Hospital Outline Business Case and Funding Review - Anon 25 - 28 August 2021
[58] Submission - Our Hospital Project Outline Business Case and Funding Review - P Embery - 2 September 2021

8. Panel Conclusion

The Panel's conclusion to this report is based on the same principles and views outlined for States Members in its amendment to P.80/2021:

1. The Outline Business Case is not robust.
2. The scale of the project before the States Assembly has not been justified.
3. As a result, the budget of £804 million has not been justified.
4. The scale of the project introduces an inappropriate level of risk to the Island's financial and economic future.
5. The level of borrowing should be set at a lower level and tempered with alternative means of funding.

There is a significant groundswell of public opinion that the scale and size of this project needs to be curbed and that those with the political ownership of Our Hospital focus clearly on the level of borrowing and expenditure involved.

It is clear that the majority of members of the public who responded to this review and have voiced their concerns to States Members, to the media and on social media want their political leaders to think again before committing Jersey to a hospital budget of £804.5 million.

Appendix 1: Panel Membership and Terms of Reference

Panel Membership

Senator Kristina Moore
(Chair)

Connétable Mike Jackson
(Vice-Chair)

Deputy Inna Gardiner

Deputy David Johnson

Deputy Mary Le Hegarat

Connétable Andy Jehan

Senator Sarah Ferguson

Appendix 2: Terms of Reference

To undertake an in-depth appraisal of the Outline Business Case (OBC) and the accompanying proposition for funding the Our Hospital Project in a two-phased approach

1. To review the Outline Business Case and determine whether it meets best practice with particular regard to the following:
    a. Examination of the structure and ensure this is within the expectations of the five-case model and follows the HM Treasury Green Book Standard.
    b. Analyse each of the five cases and provide detail on the robustness of each to meet the overall objectives of the OH Project.
    c. Compare each of the five cases within the OBC to the documents issued previously and make comparisons to show any major changes highlighting risks and/or benefits.

2. To provide detailed analysis on the funding and budget with particular attention to the following:
    a. Review the overall costs and budget and measure against the budget proposal of £804 million to ensure it is sufficient to meet all aspects of the Our Hospital Project.
    b. Analyse any amendments to the budget since the proposal of £804 million in P.123/2020 and highlight any differences in costs.

3. Review and analyse the proposed use of a bond and if this is the best value for money for the OH Project and ensure this funding solution is appropriate and proportionate for the project:
    a. To list any other funding options, as appropriate
    b. To review the budget increases and interim funding solution used throughout the project and measure these against best practice
    c. To review the proposed repayment, in particular to analyse if the returns on the Strategic Reserve over the full life of the bonds will be sufficient to meet both the annual financing costs and grow the value of the investments to a sufficient level to meet investor capital repayments, as proposed
    d. To analyse the financial impact on the Island's economy

e. To analyse the impact that repayments of borrowing of this scale will have on general revenue expenditure, particularly meeting the costs of running a health service, such as maintenance, staff facilities and pay increases.

Appendix 3: Evidence considered

Currie & Brown Report



Government of Jersey

Our Hospital Project - OBC Scrutiny Panel Report

Ref: 4104109

01 October 2021

Currie & Brown

Revision control

Rev	Date	Description of revision	Prepared by
1.0	01/10/21	Final report	Douglas Ross Helen Pickering Martin Clark

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Currie & Brown

Contents

Executive Summary

The Outline Business Case (OBC) for the Our Hospital Project (OHP) is considered to be non-complaint with the UK HM Treasury Green Book Standard.

Each of the five cases has instances where best practice guidance and the requirements of the standard have not been followed, or has none or limited detail and evidence, which contributes to an overall assessment that the business case is not robust.

Strategic Case

The Strategic Case section of the OHP OBC includes the majority of the content recommended in the Green Book and Better Business Case: for better outcomes guidance (Guide to Developing the Project Business Case). In particular, it provides: an organisational overview; a list of relevant strategies; the spending objectives; a summary of existing arrangements; details of the estates element of the 'business needs'; and the main benefits, constraints and dependencies (risks are described in the Economic Case).

However, the Strategic Case falls short in terms of demonstrating 'strategic fit' (a key Green Book requirement) and setting out full details of the 'business strategy', the 'potential scope' and the 'service requirements' (Better Business Case, section 2).

Whilst relevant policies and strategies are documented the OBC does not demonstrate alignment between the OHP and key strategic programmes, especially the Jersey Care Model, and it gives the impression that proposals for the new hospital have been developed in isolation from the broader strategic context. References are made to the Functional Brief for the new hospital being "informed" but not "driven" by the Jersey Care Model, which raises concerns about the extent to which strategic alignment has been achieved. This is reinforced by the absence of an audit trail demonstrating how the outputs from the Jersey Care Model have informed the scope and scale of the new hospital and how the functional content (beds, theatres, imaging, etc) for the hospital have been determined.

The evidence that would be expected at OBC stage on the demand and capacity modelling has not been provided which calls into question the extent to which the sizing of the new hospital is robust.

There is no Workforce Strategy that has been produced to support the OBC. It would be expected to see this to understand the workforce required to support the new model of care and scale of hospital, as well as the recruitment or training plan to achieve this. The revenue consequences on the planned workforce strategy should also be included in order that the true long term affordability of the proposals can be assessed.

Economic Case

The Economic Case does not meet the Green Book requirements in the following key areas:

- The long list of options does not fully explore all potential options including hospital size, scope and location.
- The shortlisting of options has not been undertaken in line with Green Book 2020, with no application of the options framework filter.
- There is no 'Business As Usual' (BAU) option which is required to provide a true baseline against which to compare options
- No workforce costs or building running costs have been provided to inform the comparison of options
- Benefit quantification of each option has not been undertaken in line with Green Book requirements.
- A Net Present Cost (NPC) has been provided instead of a Net Present Social Value (NPSV) to compare options. No social impact has been quantified.

The estimated cost for the preferred new build option has generally been based on the design, the scale of which is informed by the schedule of accommodation. Whilst the justification for the full schedule of accommodation has yet to be provided, the costs presented for the RIBA Stage 2 design are realistic and robust.

No facilities management (FM) and utilities revenue costs have been included to identify the financial impact of the options compared to the existing arrangements. It has been stated that the lack of information is due to FM services being subject to a separate business case. Whilst the optimum route for delivery of the services could be considered by the separate business case, the revenue consequences should be included in the OBC in order that the true long -term affordability of the build proposal can be assessed.

Financial Case

Most of the Finance Case section addresses the funding proposal which is outwith the scope of this Report.

The OBC includes limited information on the revenue impact of the proposed new build solution. Revenue impacts are limited to lifecycle (planned replacement) expenditure and the cost of providing a shuttle bus.

It would be expected that an OBC would clearly set out the total revenue burden including facilities management, utilities costs etc of the proposed solution and for the options considered, providing a comparison with existing revenue costs (Business As Usual) in order that long term affordability and value for money could be proven.

As the shift to a new facility is a step change from existing workforce arrangements, the OBC should also set out the workforce plans and revenue costs for operating the new facility. No information is provided on this item. In addition to providing cost information to evidence long term affordability, the risk around implementing a workforce plan should also be stated.

Commercial Case

The commercial case refers to a procurement strategy set out in the Strategic Outline Case (SOC) which was not fully followed as described in the SOC commercial case.

There is no evidence that a realistic and credible commercial deal can be struck is in connection with the stated private patients strategy and inclusion in the hospital plans of a private patients area larger than the existing facility. There is no evidence that the investment to construct, operate, maintain, and staff the private patients wing is supported by income from private patients.

As noted for economic and financial case section there is no cost information for the operating revenue consequences of the FM strategy and utilities. This is a significant area of non-compliance within the overall business case as decisions makers are not being provided with the estimated true cost of ownership of the asset. Future operating costs having significant implications on recurring revenue costs.

The proposed contract strategy for delivery of the construction works is the adoption of the NEC3 Option C Target Cost Contract. Whilst updated NEC4 contract conditions are available and are an evolution of NEC3 with improvements, the use of NEC3 is still considered appropriate for this scale of project.

The RIBA Stage 2 report has been included with the OBC. The report includes significant detail on the architectural development of departmental layouts etc. It includes limited information on the approach to sustainability / net zero carbon and the overall building engineering strategies necessary to ensure compliance with relevant healthcare technical standards.

The OBC references the benefits criteria for the project and what KPI's have been agreed within the project team for job creation and new entrants to the construction industry; apprentices; placements; and training opportunities. There is a limited detail of the actual strategy for achieving these targets.

Management Case

The management case is generally complaint with Green Book requirements on the general governance and management arrangements.

It would benefit from explaining the linkages and interdependencies with the Jersey Care Model and Digital Strategy.

Whilst the planning approval process is stated There is no physical evidence in the OBC of the planning discussions and feedback to provide assurance that a planning application is supported by Development Control and the timelines required are achievable.

The OBC sets out the arrangement for management of change to the design and construction contract. It does not include any reference to the change management and training and development plans necessary for clinical redesign and facilities management

The methods to be adopted for measuring and monitoring benefits realisation benefits register has not been included.

There is limited detail on measures that will be implemented to maximise the community benefits and social value.

The project risk register has not been included and key / critical risks shave not been highlighted to provide visibility to decision makers on the risks and mitigation measure in place.

There is a limited information on how the project team are addressing soft landings to ensure the transition from construction to occupation is managed and that operational performance is optimised.

1. Introduction

1.1 Scope of report

Currie & Brown were appointed by the Government of Jersey to support the Scrutiny Panel undertake a review of the Outline Business Case submitted by the Our Hospital Project Team for approval.

The terms of reference of the Currie & Brown appointment were to undertake an in-depth appraisal of the Outline Business Case (OBC) for the Our Hospital Project in a two-phased approach:-

1. To review the Outline Business Case and determine whether it meets best practice with regard to the following:
    a. Examination of the structure and ensure this is within the expectations of the five-case model and follows the HM Treasury Green Book Standard.
    b. Analyse each of the five cases and provide detail on the robustness of each to meet the overall objectives of the OH Project.
    c. Compare each of the five cases within the OBC to the documents issued previously and make comparisons to show any major changes highlighting risks and/or benefits.
2. To provide detailed analysis on the funding and budget with particular attention to the following:
    a. Review the overall costs and budget and measure against the budget proposal of £804 million to ensure it is sufficient to meet all aspects of the Our Hospital Project.
    b. Analyse any amendments to the budget since the proposal of £804 million in the Strategic Outline Case and highlight any differences in costs.

Excluded from the Currie & Brown review was the following which was to be undertaken by a another consultant separately appointed by the Government of Jersey Scrutiny Panel:-

3. Review and analyse the proposed use of a bond and if this is the best value for money for the OH Project and ensure this funding solution is appropriate and proportionate for the project:
    a) To list any other funding options, as appropriate
    b) To review the budget increases and interim funding solution used throughout the project and measure these against best practice
    c) To review the proposed repayment, in particular to analyse if the returns on the Strategic Reserve over the full life of the bonds will be sufficient to meet both the annual financing costs and grow the value of the investments to a sufficient level to meet investor capital repayments, as proposed
    d) To analyse the financial impact on the Island's economy
    e) To analyse the impact that repayments of borrowing of this scale will have on general revenue expenditure, particularly meeting the costs of running a health service, such as maintenance, staff facilities and pay increases

1.2 Best practice guidance

The following best practice guidance documents have been considered in the review of the Our Hospital Project OBC:

- *HM Treasury Green Book 2020* – Central Government Guidance on Appraisal and Evaluation.
- *HM Treasury Guide to developing the Project Business Case: Better Business Cases for better outcomes 2018*. Referred to as "BBC guidance" in this report, it is referenced in the HMT Green Book 2020.
- *NHS Improvement Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts 2016.* This contains a detailed checklist of requirements for a SOC, OBC and FBC specific to healthcare and is the latest published checklist.
- *Department of Health & Social Care (DHSC) Comprehensive Investment Appraisal (CIA) Model User Guide 2019*. This was published as the tool replacing the Generic Economic Model (GEM) which is a requirement of the NHSI Guidance. It is used to calculate the Net Present Social Value (NPSV) as required by the HMT Green Book 2020

1.3 Information provided

Appendix A contains the schedule of information requests.

1.4 Information missing

The following information has not been made available, which we would expect to be in place at OBC stage:

- Workforce costs of shortlisted options
- Facilities Management costs of shortlisted options
- Utilities costs of shortlisted options
- Benefit quantification

1.5 Meetings held

The following meetings were held with the project team to explore specific areas of the OBC. These were:

- 5th August – Initial briefing by OHP Project Team and advisors
- 10th August – Economic Case discussion with Project Team and business case advisors, EY.
- 6th September – Capital costings discussion with cost advisors, Turner & Townsend.
- 7th September – Demand and Capacity Modelling meeting with OHP Project team and clinical advisors, MJ Medical.

2. The Strategic Case

2.1 Compliance statement

The Strategic Case should provide the rationale for the project, by making the case for change and demonstrating how the project provides 'strategic fit'. It should describe the outcomes that are expected and show how they fit with "wider government policies and objectives" (Green Book, section 3.23). The case for change should be based on agreed SMART (Specific, Measurable, Achievable, Relevant and Time-constrained) objectives, a clear description of the 'Business as Usual' position and a robust gap analysis to determine the 'business needs'. These 'business needs' should be "supported by service demand and capacity planning" (BBC, chapter 2).

The OBC for the Our Hospital Project (OHP) includes the core content for a Strategic Case recommended in the Green Book and the BBC guidance, in that it sets out the strategic context and the case for change, including the spending/investment objectives.

However, the Strategic Case (and the associated 'Functional Brief' section of the Economic Case) does not adequately articulate the core scope of the project or the minimum service requirements that need to be met. As explained below, the OBC does not provide the evidence to support the proposal to develop a new hospital of circa 67,000m^2 and does not explain at an acceptable level of detail the service requirements based on demand and capacity planning – this is the principal flaw in the Strategic Case.

Overall, the Strategic Case is compliant with Green Book in terms of the content it covers, but it does not contain the level of detail or supporting evidence that would be expected in an OBC for a major infrastructure scheme, particularly in relation to the clinical, digital, workforce and estates strategies and the demand and capacity modelling to underpin the scale and cost of the new hospital facilities. In that respect we do not regard the Strategic Case as robust.

2.2 Key findings

The key findings outlined below are based on a review of the OHP Strategic Case (and the 'Functional Brief' section of the Economic Case which contains information usually presented in the Strategic Case) against the recommended content/level of detail set out in both the Green Book/Better Business Cases guidance and in NHS checklists, as indicators of business case best practice for a major healthcare project.

2.2.1 Strategic context

The BBC guidance notes the need to outline the relationship between the proposed programme and other programmes and projects within the organisation's strategic portfolio, including relevant milestones and timescales on the critical path for delivery. An OBC should also demonstrate alignment between the project and relevant external strategies and policies.

Section 1.5 of the OBC includes details of three other strategies being developed which are linked to the Our Hospital Project but are outside the scope of the OBC (i.e. the Jersey Care Model, Digital Strategy and Facilities Management Strategy). A review of relevant policies is also provided in section 3.2, but there is no information on the specific impact of these policies on the OHP or how the OHP will contribute to delivering the national policy agenda.

There is limited clarity throughout the OBC on the relationship between the OHP OBC and the JCM. It is acknowledged that the JCM was developed as a separate programme, but it would be expected that the OBC to provide greater detail on the clinical strategy for the new hospital, which is derived from the JCM, and to demonstrate how the OHP will contribute to delivering the JCM (i.e. as a key enabler). The JCM documents address the future role of the hospital in the wider healthcare system and outline at high-level the services to be provided but the OBC does not demonstrate clearly how the proposed capital investment specifically enables delivery of the JCM, which would be expected in an OBC.

It is noted in section 3.2.10 of the OBC that the outputs of the demand and capacity modelling exercise undertaken for the JCM were used to inform the Functional Brief for the new hospital, but this has not been evidenced in the OBC or any supporting documentation received (see also section 2.78 below). The Functional Brief document does not contain any details of the capacity to be included in the new hospital, nor is this information available in the JCM documents.

2.2.2 Investment Objectives

The OBC includes five Investment Objectives for the OHP that have been developed (at SOC stage) and refined by a number of key stakeholders, in line with the Green Book/BBC guidance. Whilst the investment objectives were updated from SOC stage to be made SMART, there are no objective metrics to measure whether or not objectives have been achieved and a limited clarity on how some of the assessment criteria, e.g. 'timely accessible services', will actually be measured.

2.2.3 Business needs/case for change

The case for change is based on the condition, functional suitability and configuration of the existing estate and the lack of resilience. Supporting information is provided in the form of a summary of the key findings of the six-facet survey undertaken in 2019 (it would have been expected the six-facet survey to have been provided in full as an appendix to the OBC, given its significance).

The needs relating to the estate are articulated in detail, although it would have been helpful for more evidence to be provided, particularly in relation to the statements about bed capacity. The 'case for change' section of the OBC would also benefit from greater consideration of the needs relating to all the investment objectives, as advised in the BBC guidance.

2.2.4 Benefits

The expected benefits of the OHP are set out in section 3.7 of the OBC. Categorisation of the benefits and the relationships with the investment objectives, as recommended in the Green Book, is provided in the Economic Case (section 4.10).

2.2.5 Risks

The main risks to the programme/project would typically be summarised in the Strategic Case, in line with the BBC guidance, however this is the not the case in the OBC. Details of the main risks identified are given in the Economic Case (section 4.11).

The NHS England and NHS Improvement checklist supporting Green Book guidance notes the need for the strategic case to summarise the main risks of the proposed investment project. Section 4.11 Risk appraisal includes details of the main risks and management of risk however there is no summary / reference to risk in the strategic case.

2.2.6 Constraint and dependencies

Some of the constraints described fit the criteria in the BBC guidance, but others do not appear to represent clear external conditions or parameters.

The dependencies listed are in line with the BBC guidance, but the key programme dependencies referenced in section 1.5 of the OBC (the Jersey Care Model, the Digital Strategy and the Facilities Management Strategy) are not listed. This is a significant omission given the impact of these three strategic programmes on the scale, scope, design and costs of the new hospital.

2.2.7 Clinical strategy

The Green Book and the BBC guidance stipulates the need for a business case for a public infrastructure scheme to demonstrate the 'strategic fit' of the project. In the context of a healthcare capital scheme, this would be achieving through explaining how the proposed estate

solution aligns with the underpinning clinical strategy/model of care. In the case of the OHOP OBC, this alignment has not been evidenced.

The OBC includes a sub-section on the Jersey Care Model, but this focuses more on process than outcomes and does not explain how the JCM has impacted on the OHP. Additional information on the JCM is provided in the Functional Brief, which does give some detail on patient pathways and clinical adjacencies, but lacks information on service models, activity and capacity, and alignment with the JCM. As noted, the Functional Brief does not include any details of the activity volumes to be delivered in the new hospital or the physical capacity to be provided.

The OBC states that the Functional Brief for the new hospital aims to be fit for any likely model of care – whilst future flexibility and adaptability are essential characteristics of hospital design, equally the design should reflect and respond to an underpinning clinical strategy. The JCM is described as being outside the scope of the OBC which is confusing as an approach. We would expect any healthcare capital scheme to be treated as an enabler for clinical service delivery but the service drivers on the proposals for the new hospital are not articulated well in the OBC. We are surprised that that appears not to be the case for a healthcare development of this scale.

2.2.8 Demand and capacity

As explained above, the Green Book guidance is clear that the rationale for a capital scheme as set out in the Strategic Case should include the service requirements, which should in turn be based on demand and capacity planning. This is not the case in the OHP OBC.

There are references to demand and capacity planning in the OBC, particularly in the Functional Brief section of the Economic Case, but there are no details of the inputs to or outputs from the model that has presumably been used to determine the functional content (and associated space requirements) of the new hospital. We would have expected the OBC (and appendices) to include, as a minimum, the following information:

- Baseline hospital activity for all specialties and modalities
- Demographic change projections
- Service transformations (e.g. admission reductions)
- Projected future hospital activity for all specialties and modalities
- Throughput assumptions
- Occupancy assumptions
- Modelled capacity requirements

This information should have been included in the OBC for inpatient beds, daycase beds, critical care beds, birthing rooms, theatres, imaging and outpatients but it is not presented in the document (nor is it included in the Functional Brief, despite statements made by members of the OHP team). Despite numerous requests, this information has not been provided by the OHP team during the course of our review. We were advised that the required information is presented in the published Jersey Care Model documentation, but this is not the case. Contradictory statements have been made by the OHP team and their advisors on issues such as the bed occupancy rates that were applied to determine the required capacity of the new hospital.

The JCM states an expectation that the future bed capacity of the new hospital should be in the range of 150 – 210 beds but the Deputy Chief Minister's written response to the Chair of the Panel (dated 27th August 2021) states that the new hospital is planned to include 294 beds. Presumably further demand and capacity modelling work has been undertaken since the JCM was developed or the figures in the JCM document don't include all the bed categories in the new hospital, but this audit trail has not been provided.

The absence of any detail on the demand and capacity modelling for the new hospital is a major concern and calls into question the need for facilities of the scale proposed in the OBC. There is insufficient evidence in the OBC and supporting documents of the need for a hospital of circa 67,000m^2 as proposed.

2.2.9 Digital strategy

We would expect the OBC to include a coherent digital strategy for the new hospital project, but this is not the case. The OBC refers to the 'GoJ digital solution' and the 'wider digital strategy' that has been developed by HCS, but this is stated as being outside the scope of the OBC, despite it being reflected in the Functional Brief.

Again, this approach is confusing and potentially misleading as it is not clear whether the capacity and size of the healthcare facilities reflect the digital solutions that could be implemented or whether all costs have been accounted for. There is a section on 'digital transformation' in the Strategic Case, but this does provide any evidence or assurance that the plans and designs for the new hospital fully take account of the opportunities offered by emerging digital technology. This is a major weakness in the OBC.

2.2.10 Workforce strategy

The OBC should include a Workforce Strategy that is aligned to the clinical strategy, the demand and capacity model, the digital strategy and the revenue cost assumptions, but this is not the case. There is a brief reference to the workforce in section 6.9 of the Commercial Case, but this relates only to terms and conditions.

The lack of a workforce strategy for the OHP is a major concern in terms of the robustness of the OBC in general and the financial assumptions in particular, as we have explained elsewhere in this report.

2.2.11 Estates strategy

The proposals for the new hospital should be set in the context of a wider estates strategy for healthcare facilities in Jersey, but this is not evidenced in the OBC. There is some consideration in the Commercial Case of the potential configuration of the estate following the development of the new hospital, but this is not presented in the form of a coherent, well thought out estates strategy, which we would expect to be included in an OBC.

In addition, an estates strategy for healthcare facilities in Jersey should include details of facilities Management strategies, operational estates management and sustainability plans but these are either presented as outside the scope of the OBC or lacking in detail, neither of which should be considered acceptable for a circa £800m capital investment.

2.3 Conclusions and recommendations

The Strategic Case section of the OHP OBC includes the majority of the content recommended in the Green Book and BBC guidance. In particular, it provides: an organisational overview; a list of relevant strategies; the spending objectives; a summary of existing arrangements; details of the estates element of the 'business needs'; and the main benefits, constraints and dependencies (risks are described in the Economic Case).

However, the Strategic Case falls short in terms of demonstrating 'strategic fit' (a key Green Book requirement) and setting out full details of the 'business strategy', the 'potential scope' and the 'service requirements' (BBC, section 2).

Whilst relevant policies and strategies are documented the OBC does not demonstrate alignment between the OHP and key strategic programmes, especially the Jersey Care Model, and it gives the impression that proposals for the new hospital have been developed in isolation from the broader strategic context. This is reinforced by the absence of an audit trail demonstrating how

the outputs from the Jersey Care Model have informed the scope and scale of the new hospital and how the functional content (beds, theatres, imaging, etc) for the hospital have been determined.

Information on the demand and capacity modelling, which should have been appended to the OBC, has been repeatedly requested throughout our review but our Requests for Information, the Panels' questions in the two public hearings (and related correspondence), and discussions held with members of the OHP team and their advisors (PWC and MJM) have not elicited adequate responses and we have not been provided with the evidence that would be expected at OBC stage. No explanation has been given as to why the detailed demand and capacity modelling outputs have not been provided, which calls into question the extent to which the sizing of the new hospital is robust.

In relation to the Strategic Case, we make the following recommendations

1) The elements of the Jersey Care Model that relate to the OHP should be clearly set out in detail in the form of a **clinical strategy**. This should articulate how hospital services are expected to change in the future and how service transformation will impact on capacity, clinical adjacencies and hospital design.

2) The OBC should include full details of how the functional content of the new hospital has bene determined through **demand and capacity modelling**. The model should include baseline activity, population projections, future demand, performance improvements (e.g. length of stay reductions), throughput assumptions (e.g. occupancy rates) and operational adjustments (e.g. resus rooms).

3) The **digital strategy** for the project should be clearly set out, with full details of the new technologies/systems to be incorporated in the new hospital and an assessment of the impact of the digital strategy on the service model/clinical strategy, capacity model, workforce strategy and hospital design. Alignment with the wider HCS Digital Strategy should be demonstrated.

4) A **workforce strategy** for the project should be produced. The strategy should explain how the Jersey Care Model, the Digital Strategy and the demand and capacity model projections will impact on future workforce requirements and how the workforce strategy impacts on the hospital design. Changes to workforce requirements should be reflected in the revenue costs incorporated into both the economic appraisal and the affordability assessment.

5) An **estates strategy** for HCS properties should be provided. The estates strategy should expand on the baseline estates information included in the OBC and explain how the estate in its entirety will be developed to respond to the clinical strategy (i.e. the Jersey Care Model), the Digital Strategy, the FM Strategy and sustainability plans. The estates strategy should set out the proposed future use of all properties post-implementation of the OHP and detail planned asset disposal.

6) The **investment objectives** should be updated to include meaningful objective measures, linked to the benefits realisation plan.

3. The Economic Case

3.1 Compliance statement

The economic dimension is the analytical heart of a business case where detailed option development and selection through use of appraisal should take place. The economic dimension of the business case is driven by the SMART objectives and delivery of the business needs that are identified in the strategic case.

The Green Book notes that the five case model should cover "What is the net value to society (the social value) of the intervention compared to continuing with Business As Usual? What are the risks and their costs, and how are they best managed? Which option reflects the optimal net value to society?"

The Outline Business Case (OBC) does not include the required Business As Usual (BAU) costs. It has been explained in the OBC that a baseline comparator utilised for comparison is in fact a modernisation and upgrade of existing facilities to meet modern standards. Without the inclusion of BAU cost the OBC is non complaint against Green Book principles.

Section 1.4 of the OBC clearly states that "the OBC is the second stage of the Green Book process with its primary purpose to assessed shortlisted options in more detail and select a preferred option whilst gaining clarity around the affordability of the scheme". Only two options are included, a baseline comparator and the new build option. No other options have been noted as being considered, and there is no evidence of options being considered in connection with affordability of the overall scheme.

The OBC states that it has been produced in line with HMT Green Book 2020, however there are key areas within the Economic Case that do not meet these requirements. To summarise, these are:

- The long list of options does not fully explore all potential options including hospital size, scope and location.
- The shortlisting of options has not been undertaken in line with Green Book 2020, with no application of the options framework filter.
- There is no 'Business As Usual' (BAU) option which is required to provide a true baseline against which to compare options
- No workforce costs or building running costs have been provided to inform the comparison of options
- Benefit quantification of each option has not been undertaken in line with Green Book requirements.
- An NPC has been provided instead of a Net Present Social Value (NPSV) to compare options. No social impact has been quantified.

As part of the scrutiny process, the Our Hospital Project team have acknowledged areas of non-compliance. Rationale provided relates to Jersey specific needs, particularly around the site selection process. However, this is not made transparent in the OBC and is therefore misleading by stating that the economic case is in line with Green Book methodology. .

3.2 Key Findings

3.2.1 Critical Success Factors (CSFs)

CSFs are included within the economic case as follows:

1. Does the option support the safe delivery of high-quality, efficient and effective care in the

future?

2. Can the option be delivered by the required operational date of 2026?
3. Does the option accommodate a mix of co-located clinical and supporting facilities, including mental health facilities?
4. Is the option flexible enough to support the delivery of healthcare in the future?
5. Does the option offer the prospect of continuing to provide safe and effective care during the delivery of the new hospital?
6. Is the option likely to be affordable from both a revenue and capital perspective?
7. Does the option allow sufficient space for future expansion if required?

The Green Book 2020 sets out that Critical Success Factors would include:

- Strategic fit and meets business needs
- Potential Value for Money
- Supplier capacity and capability
- Potential affordability
- Potential achievability

The CSFs put forward in the OHP OBC focus on meeting the strategy and business needs and includes affordability. The CSFs do not cover value for money, supplier capacity and capability or potential achievability. This could lead to the shortlisting of options which do not have the potential to be value for money, deliverable (achievable) or be attractive and match supplier side capability/capacity. The CSFs therefore fall short of what would be expected.

The required operational date of 2026 in CSF 2 is not evidenced in the OBC, except to say "*4.4 - the condition of the physical infrastructure of the buildings would make it unsafe to continue to provide healthcare services from the facility and it will not be possible to continue to deliver services beyond 2026*" and "*4.7.1.2 - The existing Jersey General Hospital (JGH) is close to the end of its life as a functioning facility and will no longer be able to function beyond 2026 without significant investment*". These statements would need to be further substantiated in order to place this timescale as critical to success.

3.2.2 Longlist of options

The long list of six options were detailed in the SOC and are re-presented in the OBC. These options include Do Nothing, Do Minimum, various levels of refurbishment of the existing site and a new build (site agnostic).

At longlist stage, the Green Book methodology is to consider a broad range of option choices covering:

1. Scope - coverage of the service to be delivered
2. Solution - how this may be done
3. Delivery - who is best placed to do this
4. Implementation - when and in what form can it be implemented
5. Funding - what this will cost and how it shall be paid for

The OHP long list of options does not look at the various permutations of the above, in particular it does not look at options with alternative service scopes e.g. with or without the private patient

unit. This is a key deficiency in the economic case as it does not allow due consideration to be given to other potentially viable options as they have not been identified.

Counterfactual / baseline comparator option

The longlist includes a Do Nothing option which is not applicable in the 2020 Green Book. Instead, inclusion of a Business as Usual (BAU) option is required as the counterfactual against which to assess other options. HMT Green Book 2020 states at 4.8:

> "*Business As Usual (BAU) in Green Book terms is defined as the continuation of current arrangements, as if the proposal under consideration were not to be implemented. This is true even if such a course of action is completely unacceptable. The purpose is to provide a quantitative benchmark, as the "counterfactual" against which all proposals for change will be compared. BAU does not mean doing nothing, because continuing with current arrangements will have consequences and require action resulting in costs, in practical terms there is therefore no do-nothing option"*

In addition, the Green Book (section 3.24) states that:

> *"The strategic dimension of the Five Case Model must identify "Business as Usual" (BAU) – that is the result of continuing without implementing the proposal under consideration. This must be a quantified understanding to provide a well understood benchmark, against which proposals for change can be compared. This is true even when to continue with BAU would be unthinkable."*

The description of the Do Nothing option in the OHP OBC is to keep the site running without significant investment in infrastructure, and assumes closure of the hospital in 2026. Therefore, this description aligns with the BAU definition in the Green Book and is deemed to be the correct counterfactual / baseline comparator option.

Site selection

It is acknowledged that a separate site selection process was undertaken in early 2021 during the OBC process to confirm the preferred site. The methodology used included a review against two key criteria relating to size of site and timescale (site was required to be available for construction by 2022 to achieve completion in 2026) to reduce the options from 82 to 17.

The Citizens Panel Assessment Criteria was then used to reduce the options from 17 to 5 and a key finding as part of the review was that the criteria did not use weighting and could be considered subjective and open to interpretation.

The process undertaken from 5 shortlisted sites to achieve the preferred site, Overdale, involved further hurdle criteria relating to perception of achievability such as planning permission, and a judgement of the final two sites by the Our Hospital Political Oversight Group and the Council of Ministers. The methodology associated with this is part of a separate scrutiny report with a key finding being *Key Finding 14 - The site selection process had many areas lacking objectivity and was not balanced.*

It would be standard at OBC stage to include various site options for a new build in the long list rather than being 'site agnostic' as it is difficult to assess the option without knowing where it will be located. It would have been expected at OBC stage for the longlist to have been updated from SOC stage to include the shortlisted site options for the new build. The demonstration of Overdale as the preferred site could then have been fully set out in terms of Value for Money through the Green Book process of selection against CSFs and undergoing an economic appraisal considering relative costs, benefits and risks. Instead, the process undertaken is to select Overdale on qualitative criteria and not consider any other site in economic terms.

3.2.3 Shortlisting process

The Green Book 'Options Framework Filter' should be used to shortlist the long list of options by RAG rating them against the CSFs. Whilst the OHP OBC rates the long list of options against the CSFs, there are two flaws in the process:

1. CSF6, relating to affordability, was excluded from the RAG rating exercise *"as the GoJ Treasury was still exploring options around the financing of the proposed scheme. Affordability would therefore be assessed in the OBC Financial Case once the options have been shortlisted and costed in more detail".* As set out in the options framework filter process and generation of the longlist, the options should have been defined sufficiently at this stage to include funding and enable as assessment of potential affordability. The consequence of this is that unaffordable options could be shortlisted.
2. The Green Book requires that the BAU option is carried forward to the shortlist, even if such a course of action is completely unacceptable. However, the OHP OBC does not shortlist the BAU option for this very reason, meaning that the shortlist does not contain a true counterfactual position.

3.2.4 Shortlisted options

The Green Book requires the following options to be shortlisted:

- BAU for use as a benchmark counterfactual.
- Do minimum option (that just meets the business needs required by the SMART objectives)
- Preferred Way Forward (that may or may not be the Do Minimum)
- A more ambitious preferred way forward (this may be more expensive, deliver more value, but at higher costs with increased risks
- A less ambitious preferred way forward – unless the preferred option is a do minimum (this option may take longer, deliver less value but cost less and / or carry less risk)

Only two options have been shortlisted in the OHP OBC:

1. A Do Minimum option, which has been incorrectly identified as the baseline comparator
2. The preferred option

Therefore, the shortlisted options are non-compliant and do not enable a robust value for money assessment of sufficient option choices against a proper counterfactual. Given the scale of the investment being sought, it is not best practice and not acceptable to see just a single alternative option to the baseline in an OBC for a scheme of this scale. .

3.2.5 Evaluation of shortlist

The Green Book is clear in it's methodology of determining the option offering most value for money (VfM) by comparing each shortlisted options costs, risks and benefits. These are to be monetised for each option over the life of the asset, and a Net Present Social Value (NPSV) generated. The OHP OBC produces a Net Present Cost (NPC) rather than a NPSV, meaning that only costs have been quantified and social value impact has been excluded from the calculations. An economic model template produced by advisors Ernst & Young has been utilised to calculate the NPC.

3.2.6 Costs

Capital and lifecycle costs, as well as shuttle bus costs have been produced. Commentary on these has been provided in section 3.3. There are no costs provided in relation to:

- Workforce costs
- FM costs
- Utilities costs
- Land sale income

These are substantial costs over the life of the asset and the differential between the options should be part of the VfM assessment at OBC stage to inform the selection of the preferred option, a critical decision-making point in the development process.

3.2.7 Risks

Capital contingency and optimism bias has been included within the capital costs of both options.

Ongoing operational risks associated with the options have not been assessed or quantified. This would be expected at OBC stage to understand the relative merits of each option in terms of the residual risk that remains following intervention.

A true baseline comparator in the HMT Green Book is the BAU option, described above. By assessing the ongoing operational risk of the BAU option, alongside the other options, would be essential in the demonstrating VfM of the intervention.

Although a BAU has not been included, it would be expected that the baseline comparator option would leave increased operational risks than a full new build at Overdale, however this has not been analysed or demonstrated in the calculations.

3.2.8 Benefit quantification

The Green Book requires quantification of all benefits associated with each option including cash releasing, non-cash releasing, societal and unmonetizable. This would provide a holistic view of the benefits to the public sector of a significant investment.

Benefits of the options have been identified and 'scored' rather than quantified and monetised. Scoring of benefits is a subjective view of comparing options, rather than assessing the real economic and societal benefits to the public sector. This means that there is no way of being sure that value for money is going to be achieved.

Cash releasing benefits such as the disposal of vacated sites are also not included.

Clarifications sought during the review do not provide evidence and therefore confidence that the preferred option can demonstrate greater benefit to society than the costs associated with the investment. It is stated that data in Jersey is not available to undertake the quantification, however data was available to allow benefit quantification to be completed in the Jersey Care Model business case. This suggests data is available to have at least quantified key benefits.

The response as to why benefits quantification was not undertaken also states "*Assessing benefits on a quantitative basis would not have altered the conclusions of the OBC and it is likely that postponing the decision-making process due to the availability of quantitative data would have delayed the overall project timeline. The benefits included in the OBC are considered to provide a firm basis and sufficient confidence for decision makers concerning the case for a new hospital at Overdale*". This is entirely subjective and an unsatisfactory response, which undermines the process and approach set out in the Green Book.

3.2.9 Preferred option selection

The OBC concludes the preferred option is the Overdale new build option by comparing the "NPC per benefit point" i.e. the relative costs and benefits of the two shortlisted option. Noting the omissions in these calculations, this is not a reliable assessment. The qualitative scoring

approach used to be the standard methodology but was replaced several years ago, as it lacked robustness.

3.3 Capital Costs Key Findings

The Outline Business Case (OBC) includes capital cost estimates for a baseline comparator options and the new build option.

3.3.1 Baseline comparator option

The baseline comparator is not the required BAU option, but an option to modernise and upgrade of existing facilities to meet modern standards.

The baseline comparator costs have been stated as £940.2 million and the backup information to support calculation of this estimate has been provided for review. Whilst limited information is available on scope and content of this option, the costs included would appear to be generally robust.

The base build costs have been developed utilising average costs per m2 for either refurbishment or new build areas. This form of high level costing is acceptable for the limited level of information that has been produced for the baseline comparator.

Contractor risk has been included at 10%, which is higher than included for the new build option and reflects the level of construction risk associated with a refurbishment and new build development across existing sites.

Professional fees and equipment allowances have been included at reasonable levels for the level of work anticipated to develop this option.

A client risk allowance of £73 million has been included which is a similar level as the new build option. It would have been expected that the client risk associated with a more complex refurbishment and new build option may have been higher as more likelihood that scope would change as the brief developed and risks associated with working in existing buildings operational sites is greater.

The optimism bias (OB) allowance is 19.5% compared to 6.5% for the new build option. A higher OB would be expected due to the increased level of uncertainty with the baseline comparator option as it has not been developed to same level of detail as the new build – no clear brief, working within existing sites etc. The higher OB in part offsets the concerns of the lower level of client risk.

3.3.2 New build option

The baseline comparator costs have been stated as £804.5 million and the backup information to support calculation of this estimate has been provided for review.

Main Works

The main works costs is stated as £311.7 million. This is fully supported by elemental cost plans and is based on an overall building area (all new build facilities) of 69,048m^2.

The area utilised is less than the 73,330m^2 area stated in the RIBA Stage 2 design report. Clarification was sought on this difference and it was confirmed that area reductions have been proposed across the following:-

- Requirement for Automated Guidance Vehicles omitted – the Design and Delivery Partner to consider flexibility for future introduction in flexibility review
- Emergency Department: Could be reduced by 1x resus and 2x majors
- Urgent Treatment Centre: Could be reduced from 11 to 6 minors' cubicles

- Theatres: Move of Interventional Radiology Suite to Radiology and conversion of 2 Minor Operations Suites (MOPS) into 1 theatre – MOPSs to relocate from Outpatient Department to Theatre floor which will assist with staffing concerns/utilisation
- Intensive Treatment Unit: Reduction in bed base from 12 to 10 with x 4 en-suite (2 x isolation) and 2 x 2 bed bays
- Renal: Reduction in 2 side rooms
- Oncology: Reduction in 3 chairs
- Pharmacy: Reduction in fluid store from 6 to 2 weeks on site – team to continue to review area
- Medical Day Unit: Merge with Ambulatory Emergency Care (removal of 8 trollies and increased beds)
- Pharmacy fluid store (weeks 3-6): To go to purposely adapted stores at Five Oaks
- Private Patients Outpatient Department: Efficiency challenge to Outpatient Department
- Wards reconfigured to 30 bedded wards with efficiencies in circulating areas

It is recognised that fine tuning of area briefing, and design will continue as engagement with clinical users' groups progresses through RIBA Stage 3 design. It would have been expected that the omission of the requirement for AGV's would be supported by a cost benefit analysis, as this decision could have consequences on the facilities management long term operating costs.

The main works costs of £311.7 million have been determined by elemental costs plans prepared by the DDP team and validated by the project cost consultant. The project cost consultant has undertaken benchmark analysis of the construction costs and are satisfied it represent reasonable value in the current market

From review of the individual elemental costs plans provided there are no significant cost issues identified.

Preliminaries

A £53.4 million allowance for preliminaries costs (e.g site management, site facilities, logistics etc) has been included. This allowance is based on an assessment by the project cost consultant, as the costs submitted by the DDP at £87 million were considered to be unrealistic.

The preliminaries cost included equates to 17% of the main works costs and the project cost consultant has benchmarked their assessment with other comparable projects. This evidences that the allowance included is at the higher end of expectation compared to similar projects, which would be expected to account for the Jersey location factor.

The benchmarking undertaken aligns to our own sperate analysis on expected preliminaries cost levels.

This £33.6 million variance between the DDP and project cost consultant is however concerning, and whilst recognising that work is ongoing to reduce this difference and come to agreement on an acceptable level this does represent a risk to the agreement of the final target cost within the allowance set out in the OBC. Any overage to the OBC preliminaries allowance will require to be funded from client risk / OB allowances.

Design Fees

A £33.6 million allowance for design services provided by the DDP team has been included in the OBC. This equates to 10.77% and is based on first stage tender returns and adjustments to reflect changes since initial stage contract award.

This level of fees is at the higher end of expected costs compared to UK mainland healthcare projects, but is reflective of market tested competition and the Jersey location factor

Inflation

The £34.6 million allowance for inflation has been calculated utilising BCIS indices with a Jersey factor applied. This equates to 8.6% (of main works, fees, and preliminaries). Whilst the logic of applying BCIS is correct, the allowance equating to only 2.15% p.a (crude calculation 8.6% / 4 years) may be low based on current market and the external influences of material cost increase above inflation, labour issues and potential increase in healthcare projects in the UK (HIP1 schemes).

The actual inflation allowance included in the target cost will be determined at the time of agreement and will be reflective of the feedback from the market testing process and what level of inflation risk both sub-contractors and the DPP are willing to accept. Any overage to the allowance in the OBC figures will require to be funded from client risk / OB allowances.

Equipment

The £56.3 million allowance included has been based on an equipment schedule provided by MJ Medical. This allowance is in line with expected benchmarks for the size of the facility.

As the Equipment Committee is formed during RIBA Stage 3 design, they should have responsibility for managing the equipment within this allocated budget and be challenged to maximise transfers for the existing facility to minimise costs where possible.

Contractor contingency

A quantified risk register is available to support the DDP risk contingency allowance included within the OBC costs. Some areas of risk may be duplicated with the client risk register, but at this stage of the project a risk allowance for design and construction equating to 6% (of £604 million) is a reasonable assessment.

Pre Construction Service Agreement Costs

The £34.2 million allowance included is based on original tendered values and agreed post contract award adjustments.

Overhead and Profit (OHP)

The £44.7 million allowance is based on the fully tendered and market tested rate of 9.5% applicable to all DDP costs.

Whilst this level of OHP is higher than expected benchmarks, the 9.5% was submitted by the DDP as part of their accepted first stage tender submission and fixed as part of that process. It may be worth a review of the value of construction works expected at the time of the first stage tender submission to establish if there is any potential to reduce this OHP level to reflect any increase in the estimated works costs.

Reprovision of Service from Overdale

A £14.6 million cost allowance has been included for the temporary facility to provide relocated services at Les Quennevais School site. The allowance has been proposed by the DDP and reviewed by the project cost consultant

Decant and migration

An allowance of £0.60 million has been included for decant and migration costs associated with relocation from existing facilities to the new building. This is based on advice from the project cost consultant. This allowance may be considered to be light recognising potential Island constraints,

but in overall scale of the project a small change will not have significant consequences on overall project costs level.

The decant and migration strategy will require to be worked up into a fully costed workable plan recognising the constraints of Island resources.

It has been clarified that the OBC costs do not include any costs associated with decommissioning or demolition of the existing facilities.

Optimism Bias

The calculation sheets for the 6.5% allowance have been provided and the logic is as expected. The OB allowance equates to £38.1 million

The output may be lower than compared to other schemes, but comparison can be difficult as the calculations on each project reflect the level of maturity of the scheme at the point the OB is calculated.

The OB should also be considered in the context of the sperate client risk contingency allowance.

Client Contingency

A quantified risk register is available to support the £73.1 million client risk allowance included within the OBC costs. Most of the identified risks relate to delays to the project programme and as such as each risk is considered individually rather than as concurrent events, which is more likely, risk allowances may be considered to have been duplicated and over inflated. However, at this stage of the project a risk allowance for client changes, client delays etc equating to 12% (of £619 million) is a reasonable assessment.

Government of Jersey (GoJ) Costs

These costs are split £10.5 million for internal GoJ team costs and £29.0 million for external advisor costs.

The estimated GoJ internal team costs are based on resources assessed as required and costed by GoJ finance team and are generally comparable to other similar projects. The external advisor costs are based on based on tendered allowances.

Site Acquisition

The total cost of site acquisition is noted as £34.3 million. The adequacy of this budget allowance has not been separately verified.

Negotiations are ongoing with landowners. There remains a risk that properties are not secured at estimates included in the OBC and completed within the timescales necessary to support construction to commence.

Construction Cost Benchmarking

In order to validate the robustness and adequacy of the construction cost forecast, which accounts for 64% of the overall OBC cost allowance, we have prepared the undernoted benchmarking analysis based on healthcare projects of similar scale and complexity.

OBC Costs	
Main works costs	£311.7 million
Deduct abnormal cost items	
Extra cost for multi storey car park	(£7.0 million)
Westmount Road	(£19.0 million)
Demolition	(£2.6 million)
Sub-total	**£283.1 million**

Preliminaries	£48.1 million
Contactor contingency	£26.5 million
Sub-total	**£357.7 million**
Overhead & Profit	£34.0 million
Total estimated construction contract	**£391.7 million**
Build cost per m^2	**£5,672 / m^2**

Currie & Brown UK Benchmark Details	
Project 1	£4,854
Project 2	£4,784
Project 3	£4,030
Project 4	£4,626
Project 5	£4,678
Project 6	£5,363
Project 7	£4,252
Project 8	£3,413
Project 9	£4,237
Project 10	£4,723
Project 11	£4,867
Project 12	£5,125
Project 13	£5,763
Median Benchmark Projects	**£4,701**
Jersey Hospital	**£5,672**
% above median benchmark cost	**21%**

It is anticipated that for projects of this scale the Jersey location factor would equate to around 15% above UK levels.

With the hospital project generally comprising four distinct blocks – main hospital, energy centre, knowledge centre and mental health unit influencing the overall costs - the separate buildings would be more expensive than a single building. As such it would be expected that the build cost would sit above the median level.

From review of the individual building cost estimates, the oncost for four separate structures is assessed to be around 2-3%.

Based on location and sperate building structures it is anticipated that a cost estimate of around 17-18% above median benchmark levels would be reasonable.

The additional 3-4% assessed to be included in the OBC cost estimates above reasonable benchmarks could relate to design issues e.g. complex roof design, ground abnormal items and general pricing uncertainty etc and equates to £10 - £13 million.

At this stage of early cost estimating this margin of cost variance is not unusual and is not significant within the overall scale of the project and can be seen as an opportunity to target cost reductions through the robust target value design approach being implemented by the project team.

Lifecycle Expenditure

Lifecycle costs for the baseline comparator option equate to £62/m2 per annum. Whilst at higher end of expectations, it is difficult to fully assess due to the limited information for this option. For the purposes of theoretical comparison, as it has not been utilised for informed decision making, the figure used is reasonably robust.

Lifecycle costs for the new build option equate to £56/m2 per annum. Adjusting for the Jersey

factor this forecast is within expected benchmarks for life cycle cost for new acute healthcare facilities.

Revenue costs

No revenue costs have been included for the baseline comparator.

No revenue costs, other than for a Shuttle Bus, have been included for the preferred option.

Revenue costs for facilities management and utilities should have been included in the OBC to provide an understanding of the true cost of ownership and whether the proposed options are affordable in the long term.

It has been stated in the OBC that that the facilities management would be subject to a separate business case, which if it considers the best approach for delivery of the services is an acceptable approach. However, the estimated costs within which the services will be delivered should be included in the OBC.

The separation of revenue maintenance and running costs into a separate business case not only contributes to a non-complaint business case, it also raises concerns that the design and specification of the project to date has progressed without full regard of these costs issues and decisions that could contribute to reduced running costs may not have been considered and opportunities missed.

There appears to be an underlining assumption that the new facility, despite it being bigger and having more single bedrooms etc, will be either less or the same cost to maintain as the facilities it is replacing. The Strategic Outline Case indicated an additional annual revenue cost of £7.2 million.

The revenue costs should also consider and highlight the potential double running costs as the new facility is completed and handed over to GoJ for clinical commissioning and transfer, whilst at the same time the existing facilities remain operational.

3.4 Conclusions and recommendations

The Economic Case is not compliant with the best practice guidance and uses alternative and subjective methodology to select a preferred option for taking forward to FBC stage.

The robustness of the alternative methodology applied to identify the option delivering greatest value for money has been considered. Our conclusion is that there is insufficient evidence to give confidence that the proposed preferred option is the option delivering greatest value for money in economic terms. The fundamental reasons for this are:

- Having only two shortlisted options does not constitute a sufficient shortlist in an OBC. Properly evaluating the costs, risks and benefits of alternative options should have been included, rather than presenting just one option to compare with the “baseline comparator” option.
- Regardless of the tool used to assess the overall value for money, all costs should have been considered in full so as to make a comparison between options. The absence of key and significant costs such as workforce and building running costs renders any value for money assessment flawed.

The estimated cost for the preferred new build option has generally been based on the design, the scale of which is informed by the schedule of accommodation. Whilst the justification for the full schedule of accommodation has yet to be provided, the costs presented for the RIBA Stage 2 design are realistic and robust.

No facilities management and utilities revenue costs have been included to identify the financial impact of the options compared to the existing arrangements.

Recommendations

The key recommendations to ensure a robust option appraisal is undertaken and a value for money option selected to progress to FBC are:

1. Consider a full range of options for inclusion in the shortlist to consider both location and scope of the proposal to address the priority investment objective.
2. Include the Business As Usual option in the shortlist.
3. Undertake a full quantified assessment of costs, risks and benefits of the shortlisted options to identify the NPSV of each option, in order to support the identification of the option offering greatest value for money to society.
4. Costs should include the ongoing running costs of the hospital including staffing and FM services.

4. The Financial Case

4.1 Compliance statement

The financial dimension is concerned with the net cost to the public sector of the adoption of a proposal, taking into account all financial costs and benefits that result. It covers affordability, whereas the economic dimension assesses whether the proposal delivers the best social value. The financial dimension is exclusively concerned with the financial impact on the public sector.

The Green Book notes that the five case model should cover “What is the impact of the proposal on the public sector budget in terms of the total cost of both capital and revenue?”.

The OBC includes limited information on the revenue impact of the proposed new build solution. Revenue impacts are limited to lifecycle (planned replacement) expenditure and the cost of providing a shuttle bus.

It would be expected that an OBC would clearly set out the total revenue burden including facilities management, utilities costs etc of the proposed solution and for the options considered, providing a comparison with existing revenue costs (Business As Usual) in order that long term affordability and value for money could be proven.

As the shift to a new facility is a step change from existing workforce arrangements, the OBC should also set out the workforce plans and revenue costs for operating the new facility. No information is provided on this item. In addition to providing cost information to evidence long term affordability, the risk around implementing a workforce plan should also be stated.

4.2 Key findings

A review of the proposed funding solution for the project is not part of this report

The commentary on capital costs has been included in Section 3.3 of this report.

The commentary on revenue lifecycle cost included has been included in Section 3.3 of this report.

There is no information provided to enable comments on revenue costs for facilities management, utilities, and workforce**.**

4.3 Conclusions and recommendations

Revenue impacts for the preferred option could be significant compared to existing arrangements and the limited detail does not provide decisions makers with the true picture on the overall cost impacts of the development and should be provided to allow fully informed decision making on the long term revenue impacts of the project.

5. The Commercial Case

5.1 Compliance statement

The commercial dimension concerns the commercial strategy and arrangements relating to services and assets that are required by the proposal and to the design of the procurement tender.

The Green Book notes that the five case model should cover "*Can a realistic and credible commercial deal be struck? Who will manage which risks?"*

The commercial dimension feeds information on costs, risk management and timing back into the economic and financial dimensions as the procurement process proceeds. This is part of the iterative process of developing a proposal into a mature business case.

The commercial case notes that a separate business case is being prepared in connection with the facilities management strategy for the new facility. No cost information for the operating revenue consequences of the FM strategy is included either in the commercial case or financial case. This is a significant area of non-compliance within the overall business case as decisions makers are not being provided with the estimated true cost of ownership of the asset. Future operating costs having significant implications on recurring revenue costs.

A further area of non compliance where there is no evidence that a realistic and credible commercial deal can be struck is in connection with the stated private patients strategy and inclusion in the hospital plans of an private patients area larger than the existing facility. There is no evidence that the investment to construct, operate, maintain, and staff the private patients wing is supported by income from private patients.

5.2 Detailed analysis

5.2.1 Procurement

The procurement strategy, approach, and route to agreement of the strategy has been set out as required. This should be a statement of fact as the first stage procurement activities to select the DDP have been completed.

The adopted two stage design and build procurement strategy was agreed at a workshop in November 2019.

The first stage tender implemented in early 2020 was, according to the SOC information to include Overheads and Profit, Preliminaries, Risk and Pre Construction Services.

The second stage tender would be an open book market testing exercise, where tenders are obtained from the supply chain based on the RIBA Stage 3 design. This second stage leading to an agreed target cost for inclusion in the Full Business Case (FBC) and accepted as the DDP contract target cost for delivery of the works within.

It is understood that preliminaries information was not requested as part of the first stage. Firm values were obtained in competition for pre-construction services (e.g design services), and overhead and profit percentages.

Whilst recognising that design and site information was not available at the time of the first stage tender in order that preliminaries costs could be fully established, some form of commercial framework could have been put in place to drive a structure for securing future cost certainty within the preliminaries cost component.

This limitation on cost certainty or a commercial framework for agreement of preliminaries costs has exposed the project to a risk that preliminaries costs will escalate beyond that stated in the OBC costs and the potential that the project team and DDP are unable to agree acceptable preliminaries levels.

There is currently a difference of approx. £34 million between the DDP assessed preliminaries cost and those assessed by the project cost consultant and included in the OBC cost.

It is recognised that this is an initial position from the DDP, and that work is ongoing to narrow the gap and move closer towards the OBC cost.

This limitation on cost certainty for preliminaries is however no different from the risk of not being able to agree the full works costs that will be subject to a second stage marketing testing process as the team progressively build up the target cost ready for inclusion in the FBC.

The core issue is that the approved procurement strategy has not being implemented as described in the SOC with no preliminaries information was obtained as part of the first stage tender process.

A Pre Construction Services Agreement is in place with the appointed DDP and this is an appropriate arrangement for the type of contract strategy adopted. As this contract was signed on 23rd July 2020 and included the works necessary to support the OBC the terms of this contract have not been reviewed.

The proposed contract strategy for delivery of the construction works is the adoption of the NEC3 Option C Target Cost Contract. Whilst updated NEC4 contract conditions are available and are an evolution of NEC3 with improvements, the use of NEC3 is still considered appropriate for this scale of project.

The NEC3 Option C contract is a target cost contract with the DDP paid actual costs incurred up to the value of the agreed target cost (or the adjusted target cost to reflect agreed changes during construction).

The contract includes a mechanism to share the cost risk for delivery of the construction works with any saving up to 10% below the target cost shared between the Government of Jersey and the DPP.

In line with a collaborative sharing of risk, the contract also has a mechanism for the sharing of cost overruns above the agreed target cost between the Government of Jersey and the DPP. This is an acceptable arrangement and is common on major capital projects as it provides a commercial framework to avoid over inflated target costs (e.g target costs loaded with unacceptable levels of risk which could lead to a gain share when risks items do not occur).

With the agreed pain share arrangement, the Government of Jersey would be liable for a share of costs incurred up to 10% above the accepted target cost (or the adjusted target cost to reflect agreed changes during construction).

Based on the agreed share percentages the maximum additional liability to the Government of Jersey above the accepted target cost (assuming a target cost of £604 million in line with the estimated construction costs in the OBC) would be £22.5 million.

The pain share would require to be funded from client risk allowance (currently £73 million as set out in the OBC). Approximately 30% of the current client risk allowance included in the OBC would be required to fund the pain share if it was 100% incurred.

The second stage tender process to market test the various work packages that will be utilised to build up the target cost is due to commence in September 2021 based on the current RIBA Stage 2 design and the emerging RIBA Stage 3 design and be completed by February 2022.

There are no fundamental concerns with this approach, as a true target cost should be an "*estimate of the forecast outturn cost assuming an average level of risk*" rather than fully complete design and tender strategy to develop a target cost.

However, there is a concern that based on the level of design maturity, particularly building engineering services, and the limited timescale to conclude by February 2022, that the target may include higher levels of risk, or indeed it may not be clear on what is included in each work

package.

This risk is mitigated by the project cost consultant and technical advisor undertaking rigorous and comprehensive due diligence on design information available for obtaining tenders and utilised for development of the target cost.

The target cost to be agreed with the DDP will include allowances for the risks accepted by the DPP and which they are responsible for managing delivery within the accepted target cost.

A quantified risk register is available to support the DDP risk allowance included within the OBC costs. Some areas of risk may be duplicated with the client risk register, but at this stage of the project a risk allowance for design and construction equating to 6% (of £604 million) is a reasonable assessment.

The DDP risk register will ultimately allocate the risks held by the DDP and included as part of the target cost to deliver the construction works. This should be continually under review in the lead up to the target cost agreement, with a focus on ensuring no duplication between baseline pricing within the tendered work packages and the risk register. This will be a critical activity for the project cost consultant.

5.2.2 Vacant / Surplus Sites

The available surplus sites following transfer to the new hospital have been identified.

Forecast capital receipts from disposal of surplus assets have been stated as outwith the scope of the OBC. This is not unusual as actual capital receipts could be variable in both timing and value.

With the overall affordability challenges of the project, it may be a useful exercise to assess the potential value of capital receipts and timing and model a scenario of the impact on borrowing requirements of any capital receipts.

5.2.3 Land transactions

There is a plan in place for land acquisitions, with some sites already acquired.

The total cost of site acquisition is noted as £34.3 million. The adequacy of this budget allowance has not been separately verified.

Negotiations are ongoing with landowners. There remains a risk that properties are not secured at estimates included in the OBC and completed within the timescales necessary to support construction to commence.

Compulsory Purchases Orders are noted as potentially being required which increases the acquisition timescale risk.

5.2.4 Private patient's strategy

Included in the hospital plans is a private patient's area larger than the existing facility.

There is limited evidence included in the OBC that the investment to construct, operate, maintain, and staff the private patients wing is supported by income from private patients.

The OBC notes that private healthcare in Jersey currently generates £10 million net income annually, however justification based on net present costs should be included to confirm that the initial capital expenditure and annual operating costs can be fully supported by income achievable.

It has been noted that the private patients wing provides surge capacity to deal with hospital pressures such as future pandemics, however as identified in Section 2.2 the overall size and capacity of the hospital has yet to be fully explained and as such surge capacity may already be factored into non private patients bed numbers.

5.2.5 Technical design and build information

The design process is being delivered in line with the RIBA Plan of Works which is an acceptable framework for design development and milestone approvals.

The RIBA Stage 2 (Concept Design) Report has been included with the OBC.

The report includes significant detail on the architectural development of departmental layouts etc.

It includes limited information on the approach to sustainability / net zero carbon and the overall building engineering strategies necessary to ensure compliance with relevant healthcare technical standards.

There is evidence of healthcare planner input and senior clinical sign off of the design. Minutes of the Our Hospital Project - Clinical and Operational Client Group meeting from 17th May 2021 have been provide which state "*COCG AGREED that the design report summarised the progress that has been made this stage and that the design should now move forward to the next design stage*".

This meeting was in advance of the RIBA Stage 2 Report dated July 2021 and as such it is unclear what design was approved.

As noted in Section 2.2 of this Report that whilst sign off has been achieved the required size of the hospital has not been fully evidenced.

Evidence of 1:200 drawing sign off / approval status by clinical / departmental / infection prevention and control user groups etc was requested but not provided. It is expected that this would be in the form of physically signed drawings noted with an approval status A to D (A: approved, B: approved with comments: C: comments and resubmit with amendments, D: rejected).

It is noted that the RIBA Stage 2 design is subject to ongoing review and challenge to capture changing clinical requirements and efficiencies in departmental planning. This design will be developed for submission of the planning application

The comments on the RIBA Stage 2 report from the project appointed technical advisor have been provided and this provides reassurance that some level of scrutiny of the DDP proposals has been undertaken. These comments have identified matters that require to be addressed as part of the RIBA Stage 3 design.

The majority of the 319 page RIBA Stage 2 design report relates to architectural design, with only one page allocated to mechanical, electrical and public health (MEP) systems, and one page referencing sustainability.

With MEP systems of critical importance in hospital facilities – compliance with relevant standards, maintaining patient safety etc – and whilst it is normal that the MEP design lags behind architecture, we would have expected to see more information on MEP strategies within the RIBA Stage 2 design report.

It is understood that Jersey do not have separate Heath Technical Memoranda for setting design standards, but it is noted in the OHP Employers Requirements documents that UK Heath Technical Memoranda and Health Building Notes will be followed. It would be useful to have a compliance schedule included as part of the MEP information to evidence each of the systems has been considered and where compliance with HTM's is achieved or deviated from.

Simple questions that could have been addressed include, rate of air changes to single bedrooms and how this is being achieved, natural or mechanical ventilation? How is resilience being achieved in mains utilities?

With net zero carbon an increasing priority and the Government of Jersey having a goal for carbon neutrality by 2030, and indeed the project benefits criteria Nr 33 being the creation of low

carbon generating facilities, there is a limited information on what the plans are for the new hospital to contribute to this goal.

Strategies for reduction in embodied carbon and operational carbon should be clearly set out. Decisions on architectural layout and materials, structural form and MEP systems all have an impact and opportunities may be lost if strategies are not set out now.

5.2.6 Risk registers

A quantified risk register is available to support the DDP risk allowance included within the OBC costs. Some areas of risk may be duplicated with the client risk register, but at this stage of the project a risk allowance for design and construction equating to 6% (of £604 million) is a reasonable assessment.

The DDP risk register will ultimately allocate the risks held by the DDP and included as part of the target cost to deliver the construction works. This should be continually under review in the lead up to the target cost agreement, with a focus on ensuring no duplication between baseline pricing within the tendered work packages and the risk register. This will be a critical activity for the project cost consultant.

A quantified risk register is available to support the client risk allowance included within the OBC costs. Most of the identified risks relate to delays to the project programme and each risk is considered individually rather than as concurrent events, which is more likely, as such risk allowances may be considered to have been duplicated and over inflated. However, at this stage of the project a risk allowance for client changes, client delays etc equating to 12% (of £619 million) is a reasonable assessment.

Examples of client risk items are delays and design changes in connection with planning application, increase cost for land assembly, economic and external factors, client brief changes, delays to project programme up to full business case.

5.2.7 Planning Application

This is covered within the management case.

5.2.8 Social Value

This section of the OBC references the benefits criteria for the project set out in Section 4.10.5 of the OBC. KPI’s have been agreed within the project team for job creation and new entrants to the construction industry; apprentices; placements; and training opportunities

The OBC would benefit from the social value strategy for the project being included as an appendix clearly setting out the strategy for achieving the set KPI’s. This project is a once in a lifetime opportunity to generate real additional social and providing information on the strategy for achievement will provide reassurance to decision makers that KPI’s will be achieved, or improved on, rather than stating aspirational targets.

5.2.9 Equipping Strategy

It is noted that an equipping strategy is in place, but the Equipping Committee that will be responsible for implementation of the strategy has yet to be formed.

It would have been expected that group for responsibility for equipping would have been in place during the OBC and taken ownership of the equipment list and pricing

The equipment list has been compiled by MJ Medical who are part of the DDP team, and priced by the DDP and reviewed by the project cost consultant

5.2.10 Facilities Management Strategy

It is noted that a separate business case is being prepared in connection with the facilities

management strategy for the new facility. The separate business case can consider the optimal delivery strategy for FM services.

This is an acceptable approach as hospitals are highly complex buildings with specialist plant and equipment requiring long term maintenance and establishing the correct solution will provide long term benefit.

Whilst the delivery strategy can be part of a sperate business case cost information for the operating revenue consequences of the FM strategy should have been included in the OBC.

As future operating costs have significant implications on recurring revenue costs decisions makers are not being provided with the estimated true cost of ownership of the asset to validate long term affordability.

5.3 Conclusions and recommendations

Preliminaries cost information at the time of Design and Delivery Partner (DDP) tender, which was set out in the SOC as being an element of the approved tender strategy, was not provided as part of the bidding activities.

This limitation on cost certainty or a commercial framework for agreement of preliminaries costs has exposed the project to a risk that preliminaries costs will escalate beyond that stated in the Outline Business Case (OBC) costs and the potential that the project team and DDP are unable to agree acceptable preliminaries levels. The project team should provide regular updates on how agreement of preliminaries costs are progressing.

This limitation on cost certainty is however no different from the risk of not being able to agree the full works costs that will be subject to a second stage marketing testing process as the team progressively build up the target cost ready for inclusion in the Full Business Case. The core issue is that the approved procurement strategy has not being implemented as described in the SOC.

The proposed contract strategy for delivery of the construction works is the adoption of the NEC3 Option C Target Cost Contract. Whilst updated NEC4 contract conditions are available and are an evolution of NEC3 with improvements, the use of NEC3 is still considered appropriate for this scale of project.

The NEC3 Option C contract is a target cost contract with the DDP paid actual costs incurred up to the value of the agreed target cost (or adjusted target cost to reflect agreed changes during construction). The contract includes a mechanism to share the cost risk for delivery of the construction works (pain / gain share), which is common on major projects.

Quantified risk registers have been prepared for both the DDP risk and the client risks evidencing the £35.8 million and £73.1 million included in the OBC cost breakdown. The client risk register includes an allowance for potential funding of a share of overage (pain share) to the agreed target cost. The required level of risk allowance to fund any share of cost overrun should not be overlooked.

The surplus sites available on opening of the new hospital and transfer of services have been identified. The use / disposal plan etc in connection with the surplus sites is out of the scope of the OBC, this is not usual.

There is a plan in place for land acquisitions, with some sites already acquired. Negotiations are ongoing with landowners. There remains a risk that properties can be secured at estimates included in the OBC and completed within the timescales necessary to support construction to commence. Compulsory Purchases Orders are noted as potentially being required which increases the acquisition timescale risk.

There is limited evidence to support the stated private patient's strategy. Evidence should be

included in the OBC on the operating revenue and income streams for the private patient's facility which supports the investment to construct a +2000m^2 (approx. +£10 million) high specification facility. This will identify any difference from current operating revenue costs and provide an estimate of the true cost of ownership of the new facility.

Whilst noting that the strategy for delivery of facilities management services is subject of a separate business case which will define the optimum best value route for service delivery, there are no cost estimates for these services provided in the OBC.

Decision Makers are being asked to approve capital investment / borrowing requirements with no information on the recurring revenue costs to maintain and operate the facility.

There is evidence of healthcare planner input and clinical sign off of the current RIBA Stage 2 design. It is noted that the RIBA Stage 2 design is subject to ongoing review and challenge to capture changing clinical requirements and efficiencies in departmental planning. This design will be developed for submission of the planning application. As noted in Section 2.2 of this Report that whilst sign off has been achieved the required size of the hospital has not been fully evidenced.

The RIBA Stage 2 report has been included with the OBC. The report includes significant detail on the architectural development of departmental layouts etc. It includes limited information on the approach to sustainability / net zero carbon and the overall building engineering strategies necessary to ensure compliance with relevant healthcare technical standards.

Strategies for reduction in embodied carbon and operational carbon should be expanded and clearly set out what technologies and solutions are being implemented to support achievement of the Jersey 2030 goals.

The OBC would benefit from the social value strategy for the project being included as an appendix clearly setting out the strategy for achieving the set KPI's. This project is a once in a lifetime opportunity to generate real additional social and providing information on the strategy for delivery of the KPI's will provide reassurance to decision makers that KPI's will be achieved, or improved on, rather than be aspirational targets.

6. The Management Case

6.1 Compliance statement

The management dimension is concerned with planning the practical arrangements for implementation. It demonstrates that a preferred option can be delivered successfully. It includes the provision and management of the resources required for delivery of the proposal and arrangements for managing budgets. It identifies the organisation responsible for implementation, when agreed milestones will be achieved and when the proposal will be completed.

The management dimension should also include: the risk register and plans for risk management; the benefit register; the arrangements for monitoring and evaluation during and after implementation and any collection of data prior to implementation, including the provision of resources and who will be responsible.

The Green Book notes that the five case model should cover *"Are there realistic and robust delivery plans? How can the proposal be delivered?"*

The management case is generally complaint with Green Book requirements on the general governance and management arrangements.

It would benefit from explaining the linkages and interdependencies with the Jersey Care Model and Digital Strategy.

Brief CV biographies should be included for the key project team members for the GoJ and external advisor teams to evidence that they have skills and experience required to aid successful delivery of the proposal and arrangements for managing budgets.

There is no evidence in the OBC of the planning discussions and feedback to provide assurance that a planning application is supported by Development Control and the timelines required are achievable.

The OBC sets out the arrangement for management of change to the design and construction contract. It does not include any reference to the change management and training and development plans necessary for clinical redesign and facilities management

The methods to be adopted for measuring and monitoring benefits realisation benefits register has not been included.

There is little detail on measures that will be implemented to maximise the community benefits and social value

The project risk register has not been included and key / critical risks shave not been highlighted to provide visibility to decision makers on the risks and mitigation measure in place.

There is limited information on how the project team are addressing soft landings. The term 'soft landings' refers to a strategy adopted to ensure the transition from construction to occupation is managed and that operational performance is optimised

6.2 Key findings

6.2.1 Governance / Management Arrangements

The various levels of governance and management groups are set out in the Our Hospital Project Manual included as an appendix in the OBC, with terms of references and membership of each group explained

There is no reference to Gateway Reviews as part of the project governance process.

The Gate Review process set out by UK Government gives independent guidance to Senior

Responsible Owners (SROs), programme and project teams and to the departments who commission their work, on how best to ensure that their programmes and projects are successful. This process is anchored to the Five Case Business Case Model and looks to examine programmes and projects at key decision points in their lifecycle to provide assurance that they can progress successfully to the next stage.

The use of the gate process should be considered, as it will aid scrutiny of the project moving forward providing that structured independent review as the project moves through each gateway.

From review of the senior GoJ governance groups the membership is fully GoJ officers and appears not to include any independent members. Where a major project is being undertaken, particularly by an authority not experienced of delivering such a scale of project, it may benefit the ongoing governance and scrutiny if an independent expert with experience of delivering major projects is added to a senior group to aid the challenge and decision making.

6.2.2 Project Team

Brief CV biographies should be included for the key project team members for the GoJ and external advisor teams to evidence that they have skills and experience required to aid successful delivery of the proposal and arrangements for managing budgets.

The OBC would benefit for the GoJ project team structure being included in an organigram and linkage to the panel of external advisors. This will allow identification of any roles yet to be filled and an explanation of the strategy and timeline to fill these posts.

6.2.3 Programme

There are clear hold points linked to the design development process and the business case process.

The key deliverables expected to provide assurance that the project remains on track at each of these milestones could be set out e.g. will the technical advisor provide a key stage assurance review of the whole project, and in particular the MEP systems, as part of the FBC process.

A project programme is in place for the next stage development works and the following key activities are highlighted:-

Programme Item	Commentary
Market Testing (bidding & selection of work package contractors) for main packages seems to be based on Stage 3A design to give a Target Cost by 8 Feb 22	This is ambitious considering the RIBA Stage 2 design is not yet frozen, with clinical briefing not 100% signed off
RIBA 3B design complete 7 Feb 22 with Report complete 7 Mar 22	The design is complete almost to same day the target Cost is submitted, which could result in the target being based on design assumptions and is risk loaded as full information is not available
Project Cost Plan updated by 11 Feb 22	Interim cost updates should be provided during Stage 3B to verify costs are being managed within any OBC approved envelope
Cost information for FBC by 12 Apr 22	FBC cost information being presented is not the finalised target cost, risk that target costs escalates

Negotiation / Finalisation target cost 28 April 22	

6.2.4 Planning Application Process

The process for a single planning application has been stated and the benefits of this revised approach form the original process involving two submission.

It is noted that formal pre-planning advice was due to be provided by the GoJ Development Control in June. There is no documentary evidence in the OBC of the planning discussions and feedback to provide assurance that a planning application is supported by Development Control and the timelines required are achievable.

6.2.5 Change Management

The OBC sets out the arrangement for management of change to the design and construction contract. It does not include any reference to the change management necessary for clinical redesign in order that the strategy for migration to the new ways of working are tested and implemented prior to moving.

This is linked to the financial case where there is no consideration of the impact on workforce revenue costs. There should be a workforce strategy that seeks to address the current workforce challenges across the various hospital sites and a project specific plan that takes account of the impact of service redesign opportunities to be achieved as part of the new hospital and co-location of services.

The OBC should also include the strategy for change management in connection with facilities management as there is a transition from older buildings to a modern larger facility.

It is noted that this is subject to a separate business case the timing of which is unclear. This delay in consideration of the FM strategy in tandem to design development creates a risk of lost opportunities in connection with an effective soft landings strategy.

6.2.6 Stakeholder Engagement and Communications Plan

There is reference to the OHP Public Engagement and Communications Strategy and the core elements are set out in the OBC.

6.2.7 Training and Development Plans

The successful delivery of a new service model for the new hospital is reliant not only on the new building, but staff who are capable and trained in the new ways of working. This will be a significant undertaking that cannot solely rely on on-the-job training, dedicated time will need to be planned and budgeted for in the months and years in advance and after the new facility opens

There is no reference training and development plans the primary aim of which should be to:-

- Support staff to be ready to work in different ways that align with the new clinical model ahead of opening.
- Support the Deployment of Redesigned Services, both as test-of-change and full implementation.
- Support safe commissioning and operation of the new facilities
- Set out the time commitment required by the Board to ensure appropriate training of staff ahead of the new hospital opening.

6.2.8 Benefits management

Whilst the rationale for replacing the hospital, which is beyond its serviceable life may seem

obvious, the rationale for an investment also needs to reflect the wider clinical and non-clinical benefits. This will provide the evidence base that the project is worthwhile and that a successful outcome is achievable. The benefits to be achieved are discussed in the Strategic Case and have resulted in the creation of a Benefits Register

The benefits register has been included in the OBC as an appendix. It is however lacking the method on which it will be measured and monitored.

It is crucial that the benefits monitoring is considered continuously at all stages of the project, and the Senior Officer Steering Group will regularly review the Benefits Realisation Plan for progress and ensure alignment with overall project strategy.

6.2.9 Local Community Benefits

There is little detail on measures that will be implemented to maximise the community benefits and social value.

The OBC would benefit from the social value strategy for the project being included as an appendix clearly setting out the strategy for achieving the KPI's stated in the commercial case. This project is a once in a lifetime opportunity to generate real additional social and providing information on the strategy for delivery of the KPI's will provide reassurance to decision makers that KPI's will be achieved, or improved on, rather than be aspirational targets.

6.2.10 Risk Management

There is a risk management strategy in place. The risk register has not been included with the OBC.

The key / critical risks should be called out in the OBC text for visibility to decision makers on the risks and mitigation measure in place.

6.2.11 Commissioning

The importance of the commissioning process cannot be under-estimated, as failure to adequately consider this process is likely to cause increases to project costs and failure to deliver agreed service benefits and project outcomes.

There is no reference to a commissioning plan and how this will be developed. Refer to section 6.2.12 for further information.

6.2.12 Soft Landings

There is limited of information on how the project team are addressing soft landings. The term 'soft landings' refers to a strategy adopted to ensure the transition from construction to occupation is managed and that operational performance is optimised.

There has been broad consensus that buildings in operation do not perform as well as they could. There is often a significant gap between predicted and achieved performance that results in part from short-comings in briefing, design and construction and in part from poor operation. This problem arises by the almost complete separation of construction and operation.

This transition needs to be considered throughout the development of a project, not just at the point of handover. Ideally the client should commit to adopting a soft landings strategy in the very early stages so that an appropriate budget can be allocated, and appointment agreements and briefing documents can include relevant requirements. This should include agreement to provide the information required for commissioning, training, facilities management, and so on, and requirements for Building Information Modelling (BIM).

With the facilities managements services being subjected to a separate business case and lack of information on facilities management costs in the OBC there is a concern that this important

activity is not having the attention necessary to aid overall design, build and operate success.

6.2.13 Contract Management Plan

A Pre Construction Services Agreement is in place with the appointed DDP and this is an appropriate arrangement for the type of contract strategy adopted. As this contract was signed on 23rd July 2020 and included the works necessary to support the OBC the terms of this contract have not been reviewed.

The proposed contract strategy for delivery of the construction works is the adoption of the NEC3 Option C Target Cost Contract. Whilst updated NEC4 contract conditions are available and are an evolution of NEC3 with improvements, the use of NEC3 is still considered appropriate for this scale of project.

To aid the administration and management of the NEC contract the contract administration software CEMAR has been selected for use on the project. This is an industry recognised solution and acceptable, and critical, for successful management of this large scale contract.

6.3 Conclusions and recommendations

The management case is generally complaint with Green Book requirements on the general governance and management arrangements. It would benefit from explaining the linkages and interdependencies with the Jersey Care Model and Digital Strategy.

A brief description of the project team roles has been included, however brief CV biographies should be included for the key project team members for the GoJ and external advisor teams to evidence that they have skills and experience required to aid successful delivery of the proposal and arrangements for managing budgets.

There is no documentary evidence in the OBC of the planning discussions and feedback to provide assurance that a planning application is supported by Development Control and the timelines required are achievable. It would be helpful to include written evidence of engagement with the planning authorities (letter of support etc) in order that the risk can be understood.

The OBC sets out the arrangement for management of change to the design and construction contract. It does not include any reference to the change management and training and development plans necessary for clinical redesign and facilities management. With such a major undertaking as a new hospital the management of change should be planned early in the development lifecycle.

With investment decisions based on benefits, it is essential that robust monitoring is in place to validate the achievement of benefits or identify necessary corrective actions during the project development to maintain achievement of the stated benefits. The OBC should state the planned monitoring to be undertaken

The OBC is light on plans to be implemented to maximise social value. It may be that a separate social value plan is in place, but this should be summarised, or included as an Appendix, clearly setting out the plans to be implemented as to who the targets will be achieved.

The key / critical risks should be provided to highlighted to provide visibility to decision makers on the risks and mitigation measure in place. The risk register should be included as an Appendix

To ensure the transition from construction to occupation is managed and that operational performance is optimised a “soft landings” strategy should be implemented and described in the OBC.

Appendices

Appendix A - Schedule of information requests

Request for Information Schedule
Jersey Hospital Project

RFI Number	Date Raised	Description	Requested by	Response Required by	Response	Response Date	Status	Comments
1	26/07/2021	Documentation requested to allow review to commence:- 1. Approved Strategic Outline Case and associated appendices 2. Any Scrutiny Reports papers associated with the Strategic Outline Case 3. Outline Business Case and associated appendices 4. RIBA Stage 2 (Concept Design) Report 5. The Our Hospital Functional Brief (version 6.1) as referred to in the OBC, or later version if revised 6. The Our Hospital Employer's Requirements 7. Detailed calculations for figures supporting the Baseline Comparator Capital Costs and New Build Costs, including Works, professional fees, non works, equipment, contractor contingency, optimism boas, inflation, GoJ Team cost, client contingency	Douglas Ross	28/07/2021	All information received	10/08/2021	**Closed**	Response date is date of last information receipt
2	26/07/2021	From review of the initial draft OBC it lacks information on the future revenue consequences of the new hospital. There are no facilities management operational costs provided, and there is no information on workforce / plan costs. Section 5.2.3 of the Draft OBC states these costs will be developed and advised in the FBC. In accordance with Green Book guidance revenue impacts should be assessed and included in OBC for baseline, options considered as part of options appraisal and preferred option. This information is requited in order that full impact of decision to approve the OBC is understood. Recognise that this will be subject to ongoing review and update for FBC. The draft OBC references workforce efficiences may be achieved from the move from existing estate to new hospital, but also refences potential impacts of single rooms. This significant unknown could have major revenue effects and wider workforce plan risks which should be highlighted in the OBC.	Douglas Ross	06/08/2021			**Overdue**	At the Advisors briefing held by the OHP project Team it was indicated that revenue costs for FM and Workforce have not been determined and are not available.
3	26/07/2021	The OBC appendices noted below are "embedded" documents within the pdf copy of the OBC and we are unable to open these directly from the OBC main file. Can these be issued separately:- Appendix D - OHP New Risk Template Appendix E - Benefits Register Template Appendix F - OHP Project Manual Appendix G - OHP Concept Report Summary	Douglas Ross	28/07/2021		28/07/2021	**Closed**	

4	06/08/2021	Please provide the demand and capacity model (including comparison bewteen existing and future capacity) that underpins the clincal model and schedule of accommodation.	Douglas Ross	10/08/2021	The demand and capacity model, including comparison between existing and future capacity, underpinning the clinical model and schedule of accommodation can be found in the OBC in the following references: OBC Page 18, Section 2, sub-paragraph 2.2.5. Functional Brief OBC Page 41, Section 3, sub-paragraph 3.2.10 Proposed Future Model of Care OBC Page 70, Section 4, sub-paragraph 4.6.2.1 Demand and Capacity Modelling OBC Page 18, Section 2, sub-paragraph 2.2.5. Functional Brief refers, and extract is below: “A discrete event simulation model was developed that estimated the flows of demand through the new hospital, taking account of peaks/troughs in demand during the course of the year. The model utilised data from the calendar year 2019 as its baseline position, including information on demand for the Emergency Department, inpatient beds, day case trolleys, theatres and outpatient clinics. There were also a number of areas that were additionally built into the modelling such as demand for critical care, chemotherapy chairs, etc. All of the modelling was split by elective and emergency pathways and was further subdivided into medical and surgical specialties to take account of the very different pathways for each of these types of care. OBC Page 41, Section 3, sub-paragraph 3.2.10 Proposed Future Model of Care refers and extract is below: The model was initially run through to 2036 on a 'do nothing' basis. In doing this, it made use of Statistics Jersey's +1,000 net migration population projections to estimate an age-adjusted growth for services over this period. Following this, a series of interventions as identified through the Jersey Care Model programme were applied to create the 'do something' case. A summary of the Do Nothing / Do Something Cases is: 1. Do Nothing: healthcare services continue in line with the existing operating model. 2. Do Something: based upon the adoption and implementation of a healthcare transformation programme such as the Jersey Care Model and involving Jersey specific pathway and process improvements to bring healthcare in line with best practice standards e.g.: • length of stay reductions • introduction of admission avoidance schemes • enhanced intermediate care offer • increased day surgery rates • adoption of emerging healthcare improvement opportunities (e.g. digital advances) The Do Something model was approved on the basis that transformation and modernisation is custom practice globally across health care systems. The programme in Jersey will be supported through the delivery of the Jersey Care Model and other schemes that develop in line with wider health economy and Government of Jersey quality and service improvement programmes. The JCM was reviewed and stress tested by PwC (Price Waterhouse Coopers) (completed May 2020). The outcome of the review was considered by the HCS team and further refined to take into account the impact of the COVID-19 pandemic. Outputs have been presented to the Council of Ministers and it has subsequently been approved following debate in States Assembly in Q4 2020. The revised model	11/08/2021	**Closed**	Response provided is unsatisfactory. Refer RFI Nr 11 for follow up question.

					has also been independently reviewed and tested by the Health Scrutiny Committee, supported by their advisors. OBC Page 70, Section 4, sub-paragraph 4.6.2.1 Demand and Capacity Modelling refers and extract is below: The outputs of the demand and capacity modelling were used to inform the discussions on the Draft Functional Brief for the new hospital, where additional operational adjustments were made (i.e. to take account of the fact that operationally three Resus bays will be required in the Emergency Department even though the daily demand for these bays would not directly support this). The following statement is noted in the Functional Brief: “The outcome of the JCM review has provided recommendations for the future direction of integrated care in Jersey, additional system changes that may be required and implementation considerations. The resulting demand and capacity modelling has informed, but not driven, the development of this Functional Brief for the Our Hospital project.” “The starting point for the ‘Functional Content’ has been created based on the results of a HCS review and stress test of the JCM undertaken from October 2019 to June 2020, and the subsequent secondary care demand and capacity model. The output of the review has been augmented through a series of interactive clinical workshop sessions with the Health and Community Services leadership and the Our Hospital clinical leadership teams.” In addition to this, the Functional Brief considered the diversity of the local population and the increasing elderly population. The following is also noted: “The Functional Area Assessment (“FAE”) is developed around the modelling output following the review of the JCM and moderated further with the hospital leadership and clinical teams, based on the future healthcare needs of the population of Jersey in 2036. Although a transformation model such as the JCM has informed this Functional Brief, both the FAE and the future flexible design of the Our Hospital project mean that independent of the JCM, the hospital will be fit for any model of care designed in line with best clinical and operational practice for the population of Jersey for the next 30-40 years.”			
5	06/08/2021	Please provide the room by room Schedule of Acommodation with a briefed versus drawn comparison. Where there is derogation from Health Building Notes etc utilised for setting the brief plase provide reasons for the derogation. Please provide in both pdf and Excel file formats.	Douglas Ross	10/08/2021	The schedule of accommodation can be found in the RIBA 2 report on pages 67-68 under section 6 clinical planning strategy. The editable version will be forwarded on once received by the DDP which has been requested. See RIBA2 Design Assumptions and Derogations Register.pdf for the schedule of assumptions and derogations applied to this stage of design. The editable version will be forwarded once received by the DDP which has been requested.	27/08/2021	**Closed**	Part response, no room by room SoA provided, no area derogations schedule provided, technical derogations schedule provided
6	06/08/2021	Please provide 1:200 departmental drawings and evidence of sign off / approval status by clinical / departmental / infection prevention and control etc user groups. Please provide in pdf and dwg file formats.	Douglas Ross	10/08/2021	Please provide evidence of sign off / approval status by clinical / departmental / infection prevention and control etc user groups. COCG discussed the design report during COCG meeting of 17 May 2021 and recorded on meeting minutes (20210517 COCG Minutes v.0.1) item 2 “COCG AGREED that the design report summarised the progress that has been made this stage, and that the design should now move forward to the next design stage.” Please provide the 1:200 departmental drawings. The 1:200 departmental drawings are a	13/08/2021	**Closed**	Drawings not provided as requested, follow up RFI raised along with supplementary

					continuation of the 1:500 key clinical flow diagrams found in the RIBA 2 report on pages 79 onwards under Section 6 Clinical Planning Strategy. The 1:200 layouts were developed and signed off during the Clinical User Group meetings, the meetings created a schedule of requests and actions that were developed and answered during this engagement process.			information request.
7	09/08/2021	The Ministerial Reponse to the Future Hopsital Review Panel review of the site selection process noted "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" (Recommendation Nr 28). Please provide a copy of the Technical Advisors Report on the RIBA Stage 2 Design Report, or if no report is available please provide evidence of the Techncal Advisors scrutiny and challenge on the design process and acceptance that it meets the Funcational Brief and Employers Requirements.	Douglas Ross	11/08/2021	The Design and Delivery Partner is responsible for design and has appointed a team of expert designers, experienced in hospitals of this scale, to design the hospital. As part of the design process they are required to review the design against the Government of Jersey Employer's Requirements, and to confirm how compliance with them has been achieved. This is set out in their RIBA2 report. In addition, the Government of Jersey have directly appointed a technical advisor team who support the Government of Jersey in review of design proposals. This technical advisory team, led by Mott MacDonald, supported the GoJ in review of the RIBA2 design information. The approach that the team took is set out below, and Mott MacDonald are available to brief Scrutiny Panel advisors on the review process they carried out if this is helpful. Following receipt of Volume 1 of the RIBA Stage 2 report from the Design and Delivery Partner (DDP) on Tuesday 11 May 2021 at 21:55, Mott MacDonald carried out a review, in line with their appointment as an Intelligent Client. Subsequent to this they held two workshop sessions with the DDP on the 18th and 20th of May 2021 when the DDP presented their proposals for discussion. Formal issue of the RIBA Stage 2 report by the DDP took place on Mon 14 June 2021 at 08:19. The scope of the review undertaken was to identify areas of clarification / ask probative questions of the RIBA 2 in line with an 'Intelligent Client' role. Commentary and observations were made by Mott MacDonald (and their specialist subconsultants, HKS (architecture) and ETL (healthcare planning). Observations were made under the following categories: 1. Technical, 2. Future Flexibility / Adaptability, and 3. Opportunities to Maximise Social Outcomes, Each comment / observation was assessed as follows: • Minor issues for noting • Issues that can be addressed / concluded in Stage 3 • Issues that require to be addressed as early as is practicable in Stage 3 This included consideration of the Employers Requirements (supplementing the review of the ERs that had been done at bid stage). Whilst a small number of items were identified as needing to be addressed as early as is practicable in Stage 3, there were no items that had been identified during the review that were believed to require conclusion prior to RIBA 3 commencement. The comments were discussed to the DDP to allow 'counter comment', resulting in an agreed way to proceed and close during the RIBA Stage 3 process.	27/08/2021	**Closed**	Part answered, TA Report not provided as requested

8	11/08/2021	The Ministerial Response to the Future Hospital Review Panel review of the site selection process noted "The design is also predicated on a 75% occupancy level". Can it be confirmed that the design is still based on 75% occupancy? In addition at the Scrutiny Panel Advisors briefing by the OHP team 5th August it was stated that the Private Hospital wing is also considered as part of expansion plans to address short term surge capacity, is this correct? If the 75% still applies can it be confirmed if this across all departments or only relates to specific departments e.g out of 128 generic inpatient beds, demand until 2036 only predicts only 96 will be utilised, of the 8 theatres, only 6 are required through to 2036? The NHS England New Hospital Programme is based on 85-95% occupancy levels (down from pre pandemic planning assumptions of 90-95% utilisation). What is driving modelling on 75% occupancy?	Douglas Ross	13/08/2021	1. The Ministerial Response to the Future Hospital Review Panel review of the site selection process noted "The design is also predicated on a 75% occupancy level". Can it be confirmed that the design is still based on 75% occupancy? Yes 2. In addition at the Scrutiny Panel Advisors briefing by the OHP team 5th August it was stated that the Private Hospital wing is also considered as part of expansion plans to address short term surge capacity, is this correct? Yes. 3. If the 75% still applies can it be confirmed if this across all departments or only relates to specific departments e.g out of 128 generic inpatient beds, demand until 2036 only predicts only 96 will be utilised, of the 8 theatres, only 6 are required through to 2036? The outputs of the demand and capacity modelling, including assumptions on occupancy levels, were used to inform the discussions on the Functional Brief for the new hospital. 75% is assessed to be an average occupancy level, and therefore we would expect normal variance to mean that, at times, a greater degree of capacity will be needed. 4. The NHS England New Hospital Programme is based on 85-95% occupancy levels (down from pre pandemic planning assumptions of 90-95% utilisation). What is driving modelling on 75% occupancy? As an Island, Jersey does not have the option to divert patients to another nearby hospital, as is the case in the NHS. Therefore, some additional capacity needs to be built into design to accommodate variance in occupancy during periods of nomral or extraordinary pressure on health and care services, which also allows for future capacity based on epxected changes in demographics beyond 2036. Aside from this, evidence suggests that when occupancy levels rise above 85%, there is a link with increases in waiting times in ED, increases in hospital acquired infections and poorer patient experience.	16/08/2021	**Closed**	
9	11/08/2021	The OHP: OBC New Build Cost Plan Summary dated 15/06/21 provided to the Scrutiny Panel Advisor Team 10/08/21 highlights that the OBC costs are based on a Gross Floor Area adjusted for "Opportunities for reduced GIA arising from clinical brief review exercise at end of Stage 2" which equates to a 4,282m2 reduction to the GFA stated in the RIBA Stage 2 Design Report. Please provide a schedule evidencing where this reduction has been achieved across the departments. What is the status of this area reduction, has it been agreed and signed off by clinical user group teams?	Douglas Ross	13/08/2021	Where areas may be reduced in size, these have been discussed and accepted by clinical user groups and the Health and Community Services Executive team. The Design and Delivery Partner has continued to explore the opportunities identified to develop an updated Schedule of Accommodation in collaboration with the Clinical Director. The design evolution is ongoing and final approval for any changes in floor area will be sought from the Clinical and Operational Client Group. The opportunities for area reduction as identified at the end of the Royal institute of British Architects (RIBA) Stage 2 are set out in the list below. • Requirement for Automated Guidance Vehicles omitted – the Design and Delivery Partner to consider flexibility for future introduction in flexibility review • Emergency Department: Could be reduced by 1x resus and 2x majors • Urgent Treatment Centre: Could be reduced from 11 to 6 minors' cubicles • Theatres: Move of Interventional Radiology Suite to Radiology and conversion of 2 Minor Operations Suites (MOPS) into 1 theatre – MOPSs to relocate from Outpatient Department to Theatre floor which will assist with staffing concerns/utilisation • Intensive Treatment Unit: Reduction in bed base from 12 to 10 with x 4 en-suite (2 x isolation) and 2 x 2 bed bays • Renal: Reduction in 2 side rooms • Oncology: Reduction in 3 chairs	27/08/2021	**Closed**	

					• Pharmacy: Reduction in fluid store from 6 to 2 weeks on site – team to continue to review area • Medical Day Unit: Merge with Ambulatory Emergency Care (removal of 8 trollies and increased beds) • Pharmacy fluid store (weeks 3-6): To go to purposely adapted stores at Five Oaks • Private Patients Outpatient Department: Efficiency challenge to Outpatient Department • Wards reconfigured to 30 bedded wards with efficiencies in circulating areas as well as more efficient staffing ratios			
10	11/08/2021	The area of the existing hospital is stated in the SOC as 40,032m2, with the preferred option being stated as 73,330m2 in the RIBA Design Report (69,048m2 stated in OHP: OBC New Build Cost Plan Summary). Whilst recognising healthcare technical standards drive an increased area, can you provide a "bridge" diagram to explain the step change in area e.g single beds adding Xm2, new standards adding Xm2, expansion capacity addition Xm2. Whilst appreciating this will be approximate it will explain to lay members the reasoning for such a movement in area from the existing non-compliant facility.	Douglas Ross	13/08/2021	We do not currently have a bridging diagram but have commenced producing one to aid your review. The attached Excel shows the indicative sizing for the new hospital which references the following area estimations from Section 4.6.1 of the OBC: o Current Jersey General Hospital size (40,032m2) o Jersey General Hospital uplifted to current standards (55,482m2) o New hospital without the HCS efficiency work being achieved (uplifting for future demand) (79,618m2) o New hospital with the HCS efficiency work being achieved (66,947m2) An additional column has been added which will be populated to show the proposed bridge in order to explain the additional movements in area to 69,048m2 in the OHP: OBC New Build Cost Plan Summary and 73,330m2 in the RIBA Design Report. This will be provided as soon as it is complete.	27/08/2021	**Closed**	Bridge diagram awaited
11	13/08/2021	In RFI Nr 4 we asked to see the demand and capacity model and requested a comparison between existing capacity and future capacity. The response we received points us to three sections of the OBC: OBC Page 18, Section 2, sub-paragraph 2.2.5. Functional Brief This section includes a description of the process for producing the Functional Brief and notes that "the outputs of the demand and capacity modelling were used to inform the discussions on the Functional Brief for the new hospital". This section of the OBC does not include details of the outputs of the demand and capacity modelling exercise, i.e. bed numbers, theatre numbers, etc. OBC Page 41, Section 3, sub-paragraph 3.2.10 Proposed Future Model of Care This section describes how the Jersey Care Model was tested by PWC and how a 'do something' case was created. It explains that PWC undertook modelling to determine future capacity requirements based on demographic modelling and assumptions relating to operational improvements. This section of the OBC does not include details of the outputs of the demand and capacity modelling exercise, i.e. bed numbers, theatre numbers, etc. OBC Page 70, Section 4, sub-paragraph 4.6.2.1 Demand and Capacity Modelling This section also outlines how the demand and capacity modelling was undertaken and how the functional content for the new hospital was determined. It repeats some of the material included in sub-paragraph 3.2.10. Again, this section of the OBC does not include details of the outputs of the demand and capacity	Douglas Ross	16/08/2021	Appended to this response is a PowerPoint presentation which was provided with regard to the Our Hospital demand and capacity model at the time of the development of the Functional Brief in May 2020. Also appended in Excel format are the 2036 Do Nothing, 2026 Do Something and 2036 Do Something outputs as discussed at that same time. Please note that as the model is stochastic, no two runs of it are precisely the same - this is the reason that some of the figures are slightly different between the two files appended, albeit the key totals (i.e. numbers of inpatient beds) are within 1 or 2 beds across the different runs. As has been previously explained, the outputs of the demand and capacity modelling (received summer 2020) were used to inform the development of the Draft Functional Brief for the new hospital. Through detailed discussions in the Clinical, Strategic User Groups (which have taken place over the last year) the model has been refined and has evolved through the incorporation of throughput adjustments and operational model changes required post pandemic i.e. Emergency Department operational flow model for minors, requirement for three resus bays.	27/08/2021	**Closed**	

		modelling exercise, i.e. bed numbers, theatre numbers, etc. We repeat our request for information – can we please have the outputs of the demand and capacity modelling exercise undertaken for the Functional Brief, along with a comparison of the planned future hospital capacity and the existing hospital capacity. This is required to validate the robustness of the OBC and supporting design and costs.						
12		Please provide the detailed elemental cost breakdown that supports the elemental summary breakdowns previously provided. Please provide the detailed breakdown sheets referenced in the preliminaries summary sheet previously provided that supports the adjustments made to the DDP costs. The DDP priced risk register provided amounts to £22,657,637, yet the amount included in the OBC summary equates to £36,366,710. From review of the inflation sheet this difference relates to "Design Contingency". Can a breakdown of the design contingency allowance be provided? Can the BCIS data used to populate the inflation sheet be provided, as we are unable to reconcile some of index information with the published BCIS data. Can you conform that the inflation calculations are based on end index values and not the mid point Quarter information? Can you confirm that the inflation calculations are wholly based on UK driven indices and there has not been any adjustment for specific Jersey factors? If there has been an adjustment please confirm what these are? Can you confirm what the £2,519,695 of DPP compensation events awaiting OBC ratification relate to. Are there any further compensation events due to the DPP required to deliver the FBC and construction target price? The Optimism Bias calculation notes it is based on £619.4m less £32.7m PCSA costs. The PCSA costs noted as included in the £619.4m breakdown amounts to £34.2m, why the difference? Please provide the calculations to support the costs included in the Client Risk Register.	Douglas Ross	17/08/2021	1	25/08/2021	**Closed**	

13		Further to the response to RFI Nr 6, please provide copies of the Minutes of Meeting Clinical & Operational Client Group "20210517 COCG Minutes v.0.1" as referenced in the response. The response to RFI Nr 6 also notes that "The 1:200 layouts were developed and signed off during the Clinical User Group meetings, the meetings created a schedule of requests and actions that were developed and answered during this engagement process.". In the absence of the detailed sign off information requested, please provide the schedule of actions and status of the requests. This is required to understand the robustness of the design sign off, and understand risk of potential for change during FBC stage. Furtther to the reponse to RFI Nr 6 we are aware the RIBA stage 2 Report has drawings, but we have requested full scale drawings as the images in the RIBA Stage 2 report are not to scale and lack detail.	Douglas Ross	17/08/2021	2	16/08/2021	**Closed**	
14	16/08/2021	The Functional Brief stated that the use of Automated Guided Vehicles would be investigated and incorporated as part of the FM and hospital design solutions, and the RIBA stage 2 Report references the design can facilitate AGV's. We noted from the equipment cost schedule provided that £372,750 has been omitted for provision of AGVs. Can you clarify the status of AGVs within the design and FM solution for the Project? What cost benefit analysis has been undertaken to prove value for money of including AGV's within the design or excluding their use from the FM strategy?	Douglas Ross	17/08/2021	AGVs were investigated during RIBA2and at the point the RIBA2 Report was finalised the design facilitated the use of AGVs. However, the analysis undertaken confirmed that it was challenging to evidence the benefit of incorporating them into Our Hospital, due in part to some of the project specific features of Our Hospital, and so the current assumption and FM approach assume that AGVs would not be provided on day one. The opportunity to futureproof the design so they could be introduced at a later stage is being considered.	27/08/2021	**Closed**	References analysis, but not provided
15	17/08/2021	DDP Risk ID23 - This risk reltes to delay impacted by late completion of the early works and DDP Risk ID 43 relates services relation delaying the project. Are these items not client risk and duplication of Client Risk ID OBC15? DDP Risk ID53 - there is a risk that the site contains contaminated ground. Can you clarify the status of site investogation works and any initial findings?	Douglas Ross	18/08/2021	Risk ID23 & 43. These costs cover the DDP's risks associated with delivering the works. The client risks include the impact of extended delays to the overall programme of works beyond these periods together with the effects on other project costs. Risk ID53. The site investigation works have been progressing as access to the various plots become available. Information on the site investigation works to date is identified in the RIBA 2 report. Please note that the pricing of all risks will be revised and refined as the project moves forward and mitigation measures are progressed.	27/08/2021	**losed**	

16	17/08/2021	Client Risk OBC1 relates to potential delays from land assembly. The pack of cost information previously provided notes the budget for land assembly, can this budget list be updated to confirm purchase status, noting outstanding purchases in order that level of risk can be considered. Client Risks OBC1, 2, 3, 5, 7, 8, 12, 15, 16, 18 all relate to potential delays to the programme and total £50,478,405 app 70% of overall client risk allowance. It would appear that the impact of each risk relating to programme has been considered individually. Would a combined assessment of overall programme delay not provide a more accurate assessment of cost risk related to potential delays, rather than a risk allowance which equates to app. 8% of expected target price (£604m). Client risk OBC14 references GoJ liable for 5% of cost once cost more that 10% of AFL. Can you clarify this statement as we cannot align it to the pain / gain model stated in the OBC which has GoJ liable for 50% of cost of the first 5% of cost overrun and then a further 20% of 5-10% overrun. Client Risk OBC18 includes a significant allowance for contractor and supply chain insolvency. What security package has been agreed with the DDP partner to mitigate this risk - performance bond, parent company guarantee etc? What security package is proposed for supply chain works - performance bonds etc. Has a cost benefit analysis been done on use of Subguard insurance or similar to mitigate cost risk arising from supply chain default?	Douglas Ross	18/08/2021	As at 4 August 2021 the spend of land assembly was £16.38m. There is also an additional £3.45m of land assembly where Heads of Terms have been completed. There are a wide number of factors that have been considered in relation to potential programme delay, particularly at this early stage of the project. The overlap between specific risks have been considered in the evaluation of client risk and please note that these values also include aspects of cost increases to the value of the construction works and other GoJ costs. OBC 14. Please note the distinctions between the PCSA pain/gain, AFL and main contract pain-gain arrangements. OBC18 - Supply chain insolvency risks are being reviewed and considered in more detail with the DDP as the project procurement packaging strategy is refined. A PCG is to be provided for the DDP and cost/benefit analyses will be reviewed for bonding and other potential security arrangements, with consideration of GoJ guidance.	27/08/2021	**Closed**	
17	17/08/2021	Can you provide a copy of the master development programme clearly setting out tasks and timescales to complete the design and agreement of the target price, the FBC preparation and submission period, construction period, and migration / decant to new facility.	Douglas Ross	18/08/2021		01/09/2021	**Closed**	Follow up RFI raised as information provided lacks detail on activities to evidence FBC is deliverable by dates stated
18	24/08/2021	Further to the response to RFI 8 on occupancy levels the logic for 75% occupancy in emergency beds, maternity, critical care is understood. Are general inpatient beds, theatres, imaging, outpatients etc all modelled o the same 75% occupancy modelling? This can be clarified through issue of the demand cand capacity modelling and the planned meeting to review.	Douglas Ross	25/08/2021	As has been explained the outputs of the demand and capacity modelling, including assumptions on occupancy levels, were used to inform the discussions on the Functional Brief for the new hospital, with an average occupancy level of 75%. The demand and capacity modelling has been shared in response to RFI11 and this and the offered meeting to review should hopefully enable the advisors to understanding the occupancy assumptions that have been made.	27/08/2021	**Closed**	

19	31/08/2021	Further to the response to RFI 5 the room by room SoA requested has not been provided as requested. We are aware the RIBA Stage 2 Design Report included the departmental comparison (albeit the RIBA Stage 2 version on Page 67 contained errors as Outpatients, Renal and Private Patients information is missing), but have specifically requested the supporting Room by Room analysis, and also notes of any are derogations from the HBN standards being followed. Please provide the information originally requested.	Douglas Ross	01/09/2021	The attached Schedule of Accommodation was produced at the same time as the Functional Brief and was used to informed the RIBA Stage 2 design work and OBC (File name: MJM_JerseyOurHosp_201127_SOA_v6.0). It is considered to be an appropriate basis for Outline Business Case stage, however, the functional brief and schedule of accommodation are iterative documents, that have evolved since this information was approved by the Clinical and Operational Client Group in late 2020. Changes since this time have been as a result of ongoing consultation and challenge of designs by clinicians led by the Clinical Director and public, POG and Scrutiny feedback on RIBA2 designs. A final schedule of accommodation will not be available until it is approved by the Clinical and Operational Client Group in Q3 2021. On this basis, it woud not be appropraite to share updated versions of the documents until they have been fully considered and approved by the client. We would ask that the attached information be used for the purposes of the Panel's review but not made public, as this could provide misleading informaiton to the public that the schedule of accommodation has been finalised. Once approved, the final schedule of accomodation will be shared with the Panel. With regards to derogations, the client's requirements for the project include compliance with HBN/HTM including space standards mentioned in these guidance documents, and any deviations from this will have to be identified and agreed with the client team. The derogations identified to date have already been provided in response to RFI5.	08/09/2021	**Closed**	
20	31/08/2021	Further to the response to RFI 5 we confirm it notes the process followed for the TA review but the specific outputs or recommendations report requested has not been provided. Please provide the TA Report and the responses / actions required to the points raised.	Douglas Ross	01/09/2021	See attached (OHP-DDP-XX-XX-LG-W-000200_CLIENT COMMENTS AND ROKFCC RESPONSES TO RIBA2_V3.pdf) for the TA commentary for RIBA2 and the DDP responses to each item.	10/09/2021	**Closed**	
21	31/08/2021	Further to the response to RFI 5 and issue of departmental SoA the Private Patients Wing, Renal and Outpatients are not listed in the SoA information provided. The total of the main building departments listed in the SoA is 38,854m2, not 47,651m2 as stated Based on review of data on Page 60 of the RIBA Stage 2 Report the missing departments appear to be included in the total of 47,651m2 and be the reasons for the variance. Can a corrected SoA be issued to clear up this error in information issued. Please ensure that the full room by room SoA previously requested when issued includes all areas of the hospital.	Douglas Ross	01/09/2021	An updated SoA(210824 RIBA2 Design Report Public V1 SOA (003) For Issue.pdf) is attached which shows the departments as requested.	13/09/2021	**Closed**	

22	03/09/2021	Question 18 Response The response to 18 doesn't answer the question. The question is not about building options, it is asking why different options for service scope, capacity and scale of the hospital weren't considered. There is no evidence in the SOC or OBC that alternative scenarios to the single functional brief were considered and no explanation as to why that wasn't done. No response has been given to the question as to why the Green Book options framework filter wasn't adopted (this is not mentioned as a 'variation' from the Green Book in the response to question 17).	Douglas Ross	06/09/2021	Although some elements of the options framework filter do not appear in the OBC as the advisers may be accustomed to, in some circumstances decisions that would form part of the options framework filter have been taken early outside of the OBC process, which are appropriate to the Jersey context and to allow the project to progress at pace. For example, if decisions on the hospital site and the development of the functional brief were left until a later point in OBC development, there would be an increased associated risk of abortive costs if preferred options were not approved. In addition, the project has always been led by the clinical needs of Jersey, and therefore the development of the functional brief for the Our Hospital Project started before the commencement of the Business Case process - and was already quite well developed at the outset of the SOC in early 2020. This initial functional brief for the proposed new hospital was developed by Jersey clinicians based on the health needs of the Jersey population. Ahead of the development of the second iteration of the SOC in summer 2020, further refinement of the functional brief was undertaken. This considered a number of specific options to include within the new hospital development. Each of these options was considered from a clinical benefit and cost perspective. The outputs of this process were included in the new hospital option in the SOC (Second Iteration) and were also used to support the Site Selection Process. Following the conclusion of the Site Selection and the selection of Overdale of the preferred site, detailed design work commenced which culminated in the RIBA Stage 2 Report which was referenced in the OBC. The rationale for concluding functional brief options ahead of the OBC was to ensure that the States of Jersey had a clear understanding of the new build option to ensure that the site selection process was robust and definitive. Following the confirmation of Overdale as the Preferred site in November 2020 by the States Assembly, detailed design work then commenced on that new build option which informed the RIBA 2 report which is referenced in the OBC.	07/09/2021	**Closed**	
23	03/09/2021	Question 20 Response The demand and capacity modelling presentation we were sent on 27th August includes a series of assumptions regarding reductions in outpatient attendances, reductions in length of stay, etc. This suggests that there is data available to enable quantification of at least some of the benefits that would be achieved in the new hospital. The response to this question appears to miss the point – the OH team has previously stated that lack of data was the reason for not quantifying benefits whereas the response correctly notes that the availability of data would not in itself lead to benefits being identified, so data doesn't appear to be the issue. The question remains – what is the justification for not quantifying benefits in the OBC?	Douglas Ross	06/09/2021	The availability and quality of data remains an area for improvement that is being addressed both within Health and Community Services and across the Government of Jersey. As the Panel's advisers note, some data was available as part of the demand and capacity modelling for the Jersey Care Model, however, there would have been a need for sizeable work to convert this information into quantitative benefits that are specific to Our Hospital. Therefore, due to general data availability issues and capacity of information analysts within Health and Community Services – owing to their ongoing redeployment to the Covid-19 public health response – the timelines for the availability of data and the production of the OBC did not coincide. Assessing benefits on a qualitative basis would not have altered the conclusions of the OBC and it is likely that postponing the decision-making process due to the availability of quantitative data would have delayed the overall project timeline. The benefits included in the OBC are considered to provide a firm basis and sufficient confidence for decision makers concerning the case for a new hospital at Overdale.	08/09/2021	**Closed**	

24	03/09/2021	At our meeting with the project team on 10th August about the economic case, it was requested that we were sent the detail that sits behind the NPC calculations. We were advised these only included capital costs, lifecycle costs and the shuttle bus costs, but we never received the suporting calculations requested. Could this be provided.	Douglas Ross	06/09/2021	Please find the NPC model attached. Please note the following when reviewing: - Sensitivities: The version of the Model we have shared is set to the Base Case Scenario ("Scenario 1"). In the event that you want to change to one of the Sensitivity Scenarios, it is necessary to change cell D11 on tab "Control". If you experience any difficulties, we can show you this on a call. - Tab "O_Tables": There is an manual adjustment (highlighted in yellow) in cells D37 and D46. This is to split inflation in the Baseline Comparator Option as the data provided by the cost Consultant didn't exactly match the way model worked. - General Point: There are some minor rounding differences between the Model and OBC document which were driven by converting whole numbers into £'m. - Tab "O_Tables": Please note we have also noted a minor sum-up error in the OBC Document (Table 20) which should read £235.8m (as presented in the model) but currently reads £232.8m. In both Model and OBC the annual breakdown of these numbers is correct and it is that breakdown which is used in NPC calculations. Table 20 is also an example of rounding differences when whole numbers are converted into £'m.	08/09/2021	**Closed**	
25	03/09/2021	Question 2 Reponse Part of the response to the area reduction question noted that "Wards reconfigured to 30 bedded wards with efficiencies in circulating areas as well as more efficient staffing ratios". This would infer that some element of workforce modelling has been undertaken. Yet one of the major issues with the OBC already raised was lack of costed workforce plan with response from the OHP project team that this was not available. Can the work to date on workforce modelling be provided.	Douglas Ross	06/09/2021	The workforce plan is still underway. The response about nursing ratios for a 30 bedded ward as opposed to a 26 bedded ward refer to the Jersey policy of a Nurse staffing ratio for in-patients of 1 to 6. Hence a 30 bedded ward fits a 1 to 6 ratio and a 26 bedded ward will either get underprovision (Unsafe) or overprovision. It did not mean that the full workforce plan is complete.	10/09/2021	**Closed**	
26	03/09/2021	Question 3 Response The lack of Soft Facilities Management, Hard Facilities Management and utilities costs being included in the OBC has been again been supported by the statement that "a separate Facilities Management Business Case is currently being developed to consider options for the future delivery of these services". The optimum route for delivery of these service may be subject to a seperate business case, but without an estimate of these costs being included in the OBC and NPC calculations the OBC is not compliant with Green Book and does not present the Government of Jersey with the full picture around the recurring revenue costs. The new hospital is approx. 72% larger than the existing facilities being replaced. The SOC made the commitment to include these costs, and the OBC pushes transparency on theses costs further down the line into FBC. There is sufficient expertise within the OHP Cost Advisor, Technical Advisor and DDP teams to provide an estimate of what these costs are in order to provide a comparison between existing baseline costs across multiple site and the new facility to highlight the difference. With the Government of Jersey debating funding for the project which relies on increased borrowings and revenue costs to support this borrowing, the full revenue cost impact of the hospital	Douglas Ross	06/09/2021	It is misleading to state that the new hospital is 72% larger than the current as this increase only applies to the movement in the current Jersey General Hospital to the new proposed hospital at Overdale. It does not take into account that a number of HCS facilities elsewhere on the Island will cease to deliver healthcare services post the opening of the new hospital with those services being relocated into the new hospital building. For example, the existing FM budget covers the current Overdale Hospital, St Saviours, elements of the Five Oaks site and a number of smaller properties. The Government of Jersey has commissioned and is currently undertaking a detailed piece of work to consider how Facilities Management Services will be delivered post the opening of the new hospital. This business case is considering a number of options and is aiming to deliver the required FM services in a more efficient manner, which will be partially facilitated by consolidating multiple sites into a single site. There is an existing budget for the delivery of FM services at the existing HCS Estate (including Jersey General Hospital) and one of the Critical Success Factors for the FM Business Case is that that budget will not be exceeded and potentially be reduced. We note your suggestion that a high-level piece of work is undertaken at this stage ahead of the FM Business Case being developed. The GoJ has considered this and whilst it recognises it would provide additional information in the Our Hospital OBC, there is also a risk that it will be relatively quickly superseded by a more detailed piece of work and therefore present a an ultimately incorrect FM cost variance (be it positive or negative at this stage). As such, the GoJ remains	10/09/2021	**Closed**	

		should be presented in the OBC Please provide these and include in an updated NPC calculation.			comfortable that the current approach of assuming no material change in the current FM budget is reasonable whilst awaiting the completion of the FM Business Case work.			
27	03/09/2021	Question 7 Response The response notes that the "costs for decommissioning and demolition of the existing facilities at Overdale are included in the OBC figures". Can it be confirmed that no costs have therefore been included for the decommissiong or demlition of the existing Jersey General Hopital and mental healh facilities once services have transferred to the new facility?	Douglas Ross	06/09/2021	Costs are included in the OBC for decommissioning and demolition of the Overdale site. Costs for decommissioning and demolition of other hospital buildings that will be relocated to Our Hospital are not included in OBC figures. The future uses of sites left vacant following the commission of Our Hospital have not yet been determined and therefore the need for any demolitions (and associated costs if required) has not been confirmed. One reason for this is that whilst the sites may be in current clinical use, they could be suitable for a variety of other uses such as housing, education, amenity space or key worker accommodation, for example. In addition, the timing and process of identifying assets for other uses or disposals may be quite different to the project build. There is also a range of requirements emerging in the Island Plan, which may inform any future use of vacated sites. For example, it doesn't make sense to dispose of a former clinical site which would then require the Government to acquire a new site to provide, say, a new primary school. These strategic matters are not within the scope of the Our Hospital project and will be addressed by the Government of Jersey in due course, as part of its Estates Management Strategy and Corporate Asset Management approach in consultation with the operational departments.	08/09/2021	**Closed**	
28	03/09/2021	The response to RFI Nr 17 includes a high level summary master development programme. What was requested was a programme clearly setting out tasks and timescales to complete the design and agreement of the target price, the FBC preparation and submission period, construction period, and migration / decant to new facility. For absolute clarity, this is a fully integrated and detailed bar chart programme showing all the activities, critical path interdependencies, client sign off to achieve completion of the design to achieve planning milestone, the design activities, procurement actions (showing all work packages) and costing activities to arrive at an agreed target price to be included in the FBC, the construction sequencing based on the OBC design and decant timescales. The DDP and Project Manager should have this level of detail to provide a mechanism for evidencing dates are achievable and managing progress,	Douglas Ross	06/09/2021	The programme for the pre-construction services agreement is attached. Please note that this programme remains under continuous review and iteration, which is normal for any large scale project. In relation to the construction programme, there remains many elements of dependencies in relation to the programme for the construction period, including the conclusion of RIBA Stage 3 design, planning decision, supply chain and materials availability, which means that the construction programme is still under development. However, the current information available suggests that the overall construction programme can be achieved by 2026.	08/09/2021	**Closed**	

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CIPFA Report

CIPFA performance in public services

States of Jersey
States Assembly

États de Jersey
Assemblée des États

Financing Our Hospital Project

September 2021

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Introduction

In September 2021, the States of Jersey commissioned CIPFA Business - Finance Advisory (the commercial arm of the Chartered Institute of Public Finance and Accountancy) to support the work of the Future Hospital Review Panel in the Review of the Future Hospital Funding Strategy Proposition (P80/2021) in the context of the Outline Business Case [R.124/2021].

Context

We were asked to review the proposed Future Funding Strategy which was lodged by the Council of Ministers on 3 August 2021 (P.80 2021), the main feature of which is for the States approval of borrowing up to £756 million to finance the Our Hospital Project (OH), primarily through the utilisation of Bond issuance. In addition to 'Financing our Hospital' we understand that there is a drive to put in place a more expansive debt strategy that not only deals with the financing of a new hospital but other capital expenditure projects. Re-purposing the nature of the Strategic Reserve Fund (SRF) is also a requirement embedded within this strategy:

"Financing the hospital through borrowing – in the context of the Council of Ministers' policy on financing and the Minister for Treasury and Resources' wider Debt Strategy – and modifying the objectives of the Strategic Reserve to finance and manage the servicing and repayment of debt and the directly associated costs of doing so."[1]

We understand that there is an expectation that there will be five bond issuances raising some £1.7 billion over a five-year period to fund the bulk of Capital expenditure (two £400 million bond issuances tracked to repayment in 35 and 40 years-time). Critical to this approach is the use of the Strategic Reserve Fund (SRF) as the platform to pay both Bond debt repayment and coupon costs through arbitrage on investment returns. Such returns will accrue from investing the balance on the Strategic Reserve Fund, leveraging an expected arbitrage between investment returns estimated to yield an annual minimum of 4.6% (based on RPI at 2.6% +2% growth). Annual coupon costs of 2.0% are envisaged so a positive performance on investment returns is critical although it is noted that a "2.5%

[1] P.80/2021 Page 5 Para 1.3

coupon applied over a 35/40-year bond life is a conservative estimate."[2]. There are two main performance objectives set from investment returns:

- Full repayment of debt repayment and coupon costs
- Maintaining as a tracker measure, the Strategic Reserve at a level equivalent to 30% of the economic Gross Value Added (GVA)

In relation to this assessment, we were asked to form a view and advise on the following areas:

- Borrowing approach – Bond Finance
- Borrowing modelling assumptions
- Opportunity cost
- Project cost estimates and containment
- Financial Resilience

Borrowing approach – Bond Finance

The recommended approach using Bond Finance against alternative funding sources outlined within the proposition is considered to be appropriate. In context, we would consider Bond Finance to be the most appropriate funding solution and the approach used by Treasury advisors to determine the best funding solution, is considered to be robust. We would agree that Bond issuance provides the optimal approach against other forms of borrowing in that it provides certainty over a longer-term exposure to borrowing costs that will allow for some agility around the formulation of other future funding strategies.

Borrowing modelling assumptions

Core to the modelling assumptions is a revised, more aggressive approach to investing the level of funds required to repay the £756 million project costs of OH from an overall cost exposure of £804.5 million. It is assumed that the 'more aggressive approach' is being taken to maximise the probability of achieving the twin objectives of debt/coupon repayment and 30% GVA tracking. A more aggressive approach implies a strategy that could attract higher risk. We understand that even with a more aggressive approach to investments, a probability of only 50% exists that both objectives will be achieved by 2040 and

[2] P.80/2021 Page 29 Para 10.19

this is further imperiled when a 2% stress level is applied within the early years. Overall, we are further advised that there is a probability in excess of 60% of both objectives being achieved at a point in time within 2060. Whilst historical performance has significantly outperformed these expectations, we are encouraged with the positive level of objectivity applied within the modelling assumptions in that the potential for investment returns to fail to perform is acknowledged. However, notwithstanding this level of objectivity, we are not convinced that a differential strategy is appropriate as it imports a higher risk approach. The current investment strategy appears to be effective in managing some £2.750 billion of reserves that are outside the Strategic Reserve Fund. The more aggressive approach appears to be made (contrived) to fit a model that delivers rates of return modelled at some 4.6%. This modelled target is selected to allow the two disparate objectives of Debt repayment/coupon cost (2%) and 30% GVA tracking to be achieved. This adoption is not considered to be a prudent approach, particularly starting in a point in time where world markets are riddled with significant uncertainty, albeit some markets are performing well against expectations. The suggested approach brings forward a behaviour of borrowing in advance of need without knowing the overall project cost or running costs of the asset being created. The lack of an outline business case (OBC) on running costs is the most serious failure and undermines the credibility of the formulation of the OH project at this crucial decision point in time.

Opportunity cost and headroom

The opportunity cost of accommodating the anticipated capital cost of the New Hospital within the existing financial strategy needs to be recognised as being high, in proportion to Jersey's overall public service expenditure and income model. By committing to this level of capital spend, being directly financed from investment returns from the Strategic Reserve, it must be recognized that this approach will inevitably reduce future opportunities to grow the Strategic Reserve Fund and provide options for other project options or as an alternative 'hedge' against further unforeseen major challenges. It is estimated that the opportunity foregone would equate to at least £1.4 billion of lost investment returns to finance the OH project in addition to significantly reducing headroom for further potential external financing should an unforeseen event requires significant funding. Additionally, this level of borrowing will inevitably reduce headroom for future borrowing at the same level cost. It is also possible, but not absolute, that Jersey

will attract a marginal downgrade in credit rating by a notch and this may lead to higher borrowing costs in the future.

Given the sheer scale of the New Hospital related capital expenditure relative to the size of the public service expenditure and tax raising capability on the island, a legitimate question requires to be considered - are the anticipated benefits of this scale of project greater than the funding risks and associated impacts on other parts of public services within Jersey?

Project cost estimates and containment

Whilst our scope precluded any meaningful analysis of estimated project costs, the containment of overall project costs will be crucial as the size, complexity, and specialist nature of this type of project has the propensity for cost control to be problematic. There has been a growing global trend of major infrastructure projects significantly overspending on approved budgets[3]. We are not fully convinced that the level of optimism bias contingency at £38.1 million or 4.7% of overall project costs of £804.5 million (for the unforeseen negative impacts on cost) is realistic although we do concede. That said, the Client Contingency provision of some £73.1 million provides some element of buffer, albeit Client Contingency is generally built on 'known' risks rather than the 'unknown' risk provision of Optimism Bias. It should be noted that the HM Treasury Green book provides an upper bound limit for optimism bias on non-standard projects at 51% which is more than double the standard upper bound limit of 24%. Given that the annual actual running cost exposure of the OH based on the current specification is currently unknown and there is also a lack of insight into the rationale behind the scaling of the project in terms of area and acute bed numbers, it is difficult to have absolute confidence in the efficacy of the overall cost construction and the effectiveness of the delivery of positive outcomes this asset is designed to provide.

A recent UK example of the complexity associated with a large Hospital Project is illustrated through the completion of the Queen Elizabeth Hospital in Glasgow at a cost of approximately £842 million. Construction started in 2011 and the Hospital opened in 2015 with a capacity of some 1,677 acute beds. It is recognised that this 'super hospital' project was a significant challenge for the NHS client

[3] Megaprojects and Risk an anatomy of ambition and
Decision-making on Mega-Projects - Bent Flyvbjerg – Professor of Major Programme Management at Oxford University's Saïd Business School

(NHS Greater Glasgow and Clyde) and that repair and performance issues resulted in legal action being initiated against parties involved in the construction and initial operational running due to unforeseen consequences of the design and build components and the consequential impact on the resourcing and management of the facility. Assumptions around making existing operating budgets 'fit' into an unknown running cost envelope for a new hospital are extremely naïve and at worst reckless. The approach advocated within the proposition brings forward a behaviour of borrowing in advance of need without knowing the overall project cost or running costs of the asset being created. **It would be our considered view that the absence of an outline business case (OBC) on running costs for the OH project is the most serious weakness and potentially undermines the overall credibility of the formulation of the OH project on cost containment and resource consumption.**

We are not convinced that a proposed check/pause on cost overrun by imposing a requirement for Assembly approval to be obtained before further costs are incurred will act as an effective control over unregulated costs - particularly in the latter stages of the project. We believe that project 'Lock In' may become a key inhibiting behavioural factor due to the nature of this complex project[4] including scale and complexity. Project Lock-in is a behavioural dissonance where objectivity in decision making is impaired due to decision makers and advisers being unable, through behavioural influences, to consider all available options including project termination or significant downward recalibration of specification.

Financial resilience

Given the sheer scale of the New Hospital related capital expenditure relative to the size of the public service expenditure and tax raising on the island, potential non-delivery of investment returns and overage in project costs may disproportionately impact tax and spend decisions for the public services on the island in the years ahead – potential for tax increases. Indeed, the scale of project costs is higher than Jersey's annual personal income tax yield, corporate tax yield and GST put together.

[4] Mega-Projects' Cost Performance and Lock-In: Problems and Solutions - Hugo Priemus and Bert van Wee, eds., International Handbook on Mega-Projects, Cheltenham, UK and Northampton, MA: Edward Elgar, 2013

In the course of our review, we were advised that, as a backstop, assets owned by the States of Jersey could be sold to bridge any gap on the ability to make Bond and associated Coupon repayment. Asset sale alternatives to failed investment returns are in themselves opportunities lost, as capital receipts arising should be treated as expected in the normal course of the effective utilisation of assets, recycling asset sales and opportunities to further fund the public service investment. Expected organic growth within the Strategic Reserve Fund would be displaced by the requirement to 'lock in' investment returns to financing the OH project. We have also been advised that there is an expectation that most future capital spend over and above the OH project capital expenditure will be financed by Bond finance and this approach delivers an acceptance of future Bond financing being the 'go-to' solution. This could set a worrying precedent that underlines an acceptance that locking into external debt is the most optimal strategy. In more settled economic times, where arbitrage may work, this would objectively make sense but there are material uncertainties now emerging in the recovery from the global Covid-19 pandemic that should provide cause for considered reflection.

Summary

Such is the scale of the OH project that failure to deliver investment performance and/or a significant overspend on the project, (a combination of both) may have a measurable impact on the overall revenue tax and spend model for the Island and has the potential to impair fiscal stability. The downsides associated with the magnitude of expenditure associated with the OH project are potentially problematic. At this level of investment, significant opportunities will be foregone, in proportionality terms and there may be a 'gearing' effect (restriction) on the impact of further investment. Overall opportunity cost will restrict further capabilities and borrowing headroom may be reduced. Within a worst-case scenario this may lead to more expensive future borrowing options being the norm.

Whilst the current modelling for the OH is deemed by Treasury advisers to be 'affordable', the approach taken by the OH Team has risks attached which commits the States of Jersey to a strategy that may impair future policy option capability and potentially impacts upon the stability of the current medium- and longer-term financial strategy. In proportionality terms, the sheer scale of the project is extremely high and by its nature/complexity, has the potential for costs to exceed

the current estimated cost envelope of £804.5 million. With no current intelligence on asset running costs this substantially weakens the actual credibility and robustness of the approach taken to date.

Notwithstanding these negative comments, Bond financing is still considered to be the optimal solution if this level of borrowing is deemed to be required rather than the previous recommended blended approach. This is due to market changes since such an approach was recommended in a previous iteration of this project in 2017. Overall, the formulation of Treasury Management strategy is considered to be sound, but the approach applied within the OH project is disconnected. The detailed capital and revenue running costs should be clearly formulated and stress tested BEFORE funding solutions are considered. Bond finance is not 'free money' irrespective of financial leverage/arbitrage. It is, however, an inherently sensible approach providing there is full confidence around the asset specification as driven by valid expected service demand needs and robust cost construction estimates. Given the current evidence at our disposal on the OH project, it would be our considered view that the proposition should NOT be agreed unless assurance can be obtained that:

- There is total transparency around the clinical need that drives the scaling of the specification for the OH project to the current level

- The proposals under consideration deliver a full and stress tested/transparent OBC on running costs – this is fundamental to a rounded view being obtained on the efficacy of the overall project – a full financial analysis of capital and revenue running costs for the proposed OH project is needed before a considered decision can be taken

Revised approach

Notwithstanding the above two requirements, at the highest level, a more pragmatic general approach could include setting an acceptable level of affordability and putting in place conditions that would minimise any unregulated cost pressures. On affordability testing, the determination of a cost envelope that is deemed to be 'affordable', thus reducing financial leverage risks, would set realistic parameters around the overall project specification. Crudely, this would be setting a lower project cost envelope that the clinicians would need to revise

expectations around and project quantum costs recalibrated. For example, the objective of matching clinical need to a level of affordability that can comfortably be accommodated within the overall medium term financial strategy for the States of Jersey.

It would make sense to preserve the nature/essence of the Strategic Reserve Fund and create a specific Our Hospital Reserve Fund to delineate and improve focus. We understand that this approach would need to be reinforced by a specific amendment to Jersey Finance Law. Jersey Finance Law could also be amended to impose an accountability duty imposed on the Project Senior Responsible Officer (SRO) for the delivery of the project within any revised approved cost envelope. It is submitted that the establishment of a specific OH reserve using a recalibrated 'affordable project cost envelope' and an accountability requirement embedded in Jersey Finance Law, should deliver the necessary conditions to enforce further grip and accountability on the project that could mitigate any unforeseen cost pressures. Should a more aggressive investment strategy be still deemed to be necessary, such higher risks could be contained within the specific OH reserve rather than being expanded and applied to the residual amount within the Strategic Reserve Fund. Should the revised cash envelope be determined, as an example, at approximately £550 million, the SRF could still have in excess of approximately £550 million at the outset and the integrity of the purpose of the SRF preserved. We would submit that our suggested approach:

- Scales back on the original the project cost and borrowing exposure to a revised overall cost envelope that is deemed to be 'affordable' – risks are downsized
- Preserves the original nature of the SRF
- Provides more precision and focus on cost containment as the 'affordable project cash envelope could be enshrined in law within a OH specific reserve and an accountable single SRO highlighted
- Provides more assurance within final decision making as returning to a lower level of specification should allow time for a measured and transparent approach to running costs to be synchronised

In response to any plans to accommodate Bond finance to fund most or all of future capital spend, we would advise caution. The States of Jersey has a consistent record of capital programme slippage so borrowing in advance of need attracts unnecessary risks as well as costs. A fully considered and balanced approach is essential to robust and informed decision making.

Finally, we would wish to take this opportunity to record our sincere gratitude to Members of the States Assembly, Management and Staff at the States of Jersey for the provision of extremely valuable support in the course of our work.

Written submissions

Written submissions were uploaded to the Scrutiny website and can be accessed here.

Public Hearings

The Panel held three public hearings:

11 August 2021 – Witness: Deputy Chief Minister

8 September 2021 – Witness: Assistant Minister for Treasury and Resources

16 September 2021 – Witnesses: Deputy Chief Minister and Minister for Treasury and Resources

The Hearings were recorded and transcribed, these are available from the States Assembly website:

www.statesassembly.gov.je

Appendix 4: Cost of Review

Public Hearings - £450

Social media advertising - £20

Expert Advisors - £76,575

States Members briefing - £300

Total = £77,345