States of Jersey
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Future Hospital Review Panel

Our Hospital Project

Witness: Deputy Chief Minister

Thursday, 17th June 2021

Panel:

Senator K.L. Moore (Chair)

Connétable M.K. Jackson of St. Brelade (Vice-Chair)

Deputy M.R. Le Hegarat of St. Helier

Connétable A. Jehan of St. John

Deputy D. Johnson of St. Mary

Deputy I. Gardiner of St. Helier

Witnesses:

Senator L.J. Farnham, Deputy Chief Minister

Deputy H.C. Raymond of Trinity, Assistant Minister for Health and Social Services

Mr. A. Scate, Director General, Infrastructure, Housing and Environment

Mr. R. Bannister, Development Director, Our Hospital Project

Ms. H. Cunningham, Group Director, Treasury and Exchequer

Professor A. Handa, Our Hospital Clinical Director

Ms. C. Landon, Director General, Health and Community Services

[15:02]

Senator K.L. Moore (Chair):

Good afternoon and welcome to this public hearing with the Future Hospital Review Panel. I think we are now live. Good afternoon and apologies for the slight delay. We were just waiting for some people to join this hearing with the Future Hospital Review Panel. We will start with the usual introductions for the record, and I also have to explain before I do that all attendees should have their laptops on with their video on but no sound, please. If you could use your microphone, which

is on the desk, turn it on by the black button to the right of the microphone, so that we can hear when you speak. That would be very helpful indeed. Otherwise, as normal as can be rules of engagement in these times and we look forward to hearing your succinct and clear answers this afternoon. As mentioned, introductions. I am Senator Kristina Moore and I am the chair of this panel.

Connétable M.K. Jackson of St. Brelade (Vice Chair):
Constable Mike Jackson, deputy chair of the panel.

Deputy M.R. Le Hegarat of St. Helier:
Deputy Mary Le Hegarat, member of the panel.

Connétable A. Jehan of St. John:
Andy Jehan, Connétable of St. John, member of the panel.

Deputy D. Johnson of St. Mary:
David Johnson, Deputy of St. Mary, member of the panel.

Deputy I. Gardiner of St. Helier:
Deputy Inna Gardiner, member of the panel.

Deputy Chief Minister:
Senator Lyndon Farnham, chair of the Hospital Political Oversight Group.

Assistant Minister for Health and Social Services:
Deputy Hugh Raymond, Assistant Minister for Health and Social Services, and Deputy to Lyndon Farnham.

Director General, Infrastructure, Housing and Environment:
Andy Scate, director general of Infrastructure, Housing and Environment.

Development Director, Our Hospital Project:
Richard Bannister, the development director, Our Hospital Project.

Group Director, Treasury and Exchequer:
Hazel Cunningham, group director, Treasury and Exchequer.

Senator K.L. Moore:

Thank you. We are going to start by running through timelines as they stand currently, so the panel have reviewed the current timelines provided by the project team. The planning application at the moment is scheduled to be made in November of this year and we understand that planning inspectors' work will take about 6 months at a minimum. That means of course that the planning decision for the hospital is likely to fall within the purdah period before the elections, which are now tabled for June of next year. Minister, could you confirm please that that is your understanding of the timeline as it currently stands? If you could mute the devices, please.

Deputy Chief Minister:

Thank you. So 6 months from November takes us into April, so there is a possibility that the planning determination could come at the end of April, May but you are right, it could come later. It could come during the purdah period, it could come into the next Assembly but we very much hope that it will come before that.

Senator K.L. Moore:

Of course 6 months from November is May, so that will definitely be in the purdah period as we believe it, but that is the minimum time that it will take the planning inspection to happen. Were Ministers aware of that timing at the time that the change for the timetable for the election was proposed?

Deputy Chief Minister:

When it became apparent that the planning application was going to be deferred from September to November we then all became aware; I think all States Members were probably aware, that it could fall into election period, yes.

Senator K.L. Moore:

Was that one of the driving forces behind the move to change the election timetable?

Deputy Chief Minister:

No. The proposition to change the election was from the Privileges and Procedures Committee and I do not think they considered the hospital project as part of their process. I am certainly not aware that they did.

Senator K.L. Moore:

Is it the Minister's understanding of the spirit and the wording of the restrictions on decision-making of major projects during the purdah period that it would not be possible for a Minister to sign off such a decision?

Deputy Chief Minister:

That could happen, but there are possibly further discussions to be had about how Government is conducted during that period, whether it be limited powers afforded to existing Ministers or the power transferred to States Members who are not seeking re-election and I think that is something that has to be decided upon or delegation to senior officers of certain functions.

Senator K.L. Moore:

As the Minister responsible for the project, do you think that is acceptable that such a major decision for the Island could be transferred or delegated to either unelected people or outgoing Ministers who will not be held accountable to the public?

Deputy Chief Minister:

In relation to this project, which will be the biggest ever capital project the Island has embarked upon, it would not be appropriate to delegate that outside of the political sphere, so I feel that it would have to either be signed off before the election or in the new Government. I do not think it would really be possible or practicable during the purdah period.

Senator K.L. Moore:

Is it your preference that if it does fall within the purdah period that it should be determined once the election is completed and a new Government are installed?

Deputy Chief Minister:

I think that would be my preference. I think it needs to be signed off, given its size and scale, by the Government, whether it is this Government or the next Government.

Senator K.L. Moore:

Thank you. With all of the elements of the project as they are currently scheduled will the information and the relevant detail that is required for the presentation of the outline business case and the funding proposals be available at the time of the presentation, which I believe is due to be next month?

Deputy Chief Minister:

Yes, in relation to the outline business case the political oversight group considered the final draft yesterday. There are some amendments to be made to that. Once those amendments have been made we will share that with the Scrutiny Panel and then it will go to the Council of Ministers.

Senator K.L. Moore:

Excellent, so it is slightly ahead of schedule at the moment?

Deputy Chief Minister:
Currently.

Senator K.L. Moore:
Great, and does it meet all of the requirements in the amendment that we proposed in terms of the site selection?

Deputy Chief Minister:
I believe it does. It is a long document and we have spent a lot of time on it, but perhaps there is an officer who would like to provide reassurance on that fact?

Development Director, Our Hospital Project:
The simple answer to your question is yes. It takes on board the advice that was given to us by Scrutiny and their advisers around about Christmastime. That has all been incorporated and when you see the document, when we issue it later this week, you will recognise those changes.

Senator K.L. Moore:
Thank you. In this panel's review of the site selection process that was published in November last year a key finding was that there did not appear to be any inclusion for unforeseen setbacks within the process and this could cause the project to go off track, and for costs to spiral, potentially. This is acknowledged in the ministerial response and it is exactly what has happened. We were told initially in R.54 the O.B.C. (outline business case) was due to be published in February of this year. We were then told that it would be presented in March. Now of course it has been delayed to July. Robust scrutiny and challenge is part of our democratic process. The panel would like to know what else has caused the delay in the publication of the O.B.C.

Development Director, Our Hospital Project:
The initial slippage was caused by some setbacks in being able to proceed with the design of the access road up to the top of the hill. That was because we were waiting for the review of an amendment that was put forward. We did not lose all of that time. We progressed as much as we could with solutions but we then had to look at the key things that would give certainty within the outline business case. One of the things was to have taken the design to concept stage, which is also known as R.I.B.A. (Royal Institute of British Architects) 2. The R.I.B.A.2 design was presented over the course of the last 4 weeks and has now concluded in a report that is available and published on the website. That gave us more certainty about the costs associated with the hospital and likely costs associated with the hospital, which gave us a firmer foundation to be able to do the financial

and economic aspects of the O.B.C. That is the primary reason why the O.B.C. has been released now as opposed to any earlier.

Deputy I. Gardiner:

Thank you for your answer. To clarify, the delay was between February and July. We are talking about a 6-month delay. Why has it not been taken into account in the planning that you would need this assessment to make sure that the financial implications will be fully assessed? We are talking about a 6-month delay, not 2 or 3 months.

Development Director, Our Hospital Project:

The timeline you are referring to, the February timeline, was before we had done any work to set out the timeline for the design and therefore it would have been a flawed timeline at that particular time.

Deputy I. Gardiner:

Does it mean that the indication of the timeline during the debate on the proposition in November was not considered?

Development Director, Our Hospital Project:

The request that was made during that proposition and amendment set out a recommendation from Scrutiny advisers that said that you should share the O.B.C. with us so that we could have a look at it before it gets published and in there it stated February. That wasn't a date that was provided by the project.

Senator K.L. Moore:

That was the date provided in R.54 I believe, which was published by the Chief Minister in 2019.

[15:15]

Development Director, Our Hospital Project:

Thank you for that clarification. The document you are referring to is the mandate for the project, which was back in May 2019, apologies. At that time we had no certainty about the detailed timetable for when the design would come forward or when we would have the expertise in place to be able to do it, so that is a refinement based on that. Apologies for the misunderstanding.

Senator K.L. Moore:

Could you give us an idea of the number of people who are working on the team that are building the outline business case?

Development Director, Our Hospital Project:
On the outline business case probably in the order of 5 to 7 people.

The Connétable of St. Brelade:
Regarding reprovisioning of the services to Les Quennevais, in May it was confirmed that the budget for the reprovision of services from Overdale had risen from an estimated £10 million to over £15 million, and I know Richard in previous meetings indicated that was the top of the budgeted envelope. Can you confirm that the current budget for the reprovision of Overdale still remains at £15 million?

Deputy Chief Minister:
Thank you. The current budget is £14.6 million, I believe. That is the figure we will be using currently. Caroline or Richard?

Development Director, Our Hospital Project:
The answer is yes, I can confirm that £15 million is still the capped maximum. We are looking wherever we can to make savings and you may have seen that we are trying to explore whether we can use equipment from decommissioned parts of the Nightingale and other areas to try to create those savings. Please take that as the capped figure rather than the current forecast cost.

The Connétable of St. Brelade:
Thank you. The Overdale decant functional requirements brief states that an additional schedule of accommodation was being developed that provides departmental summaries, which have been produced at a room-by-room level to underpin the functional brief. The schedules provided a net area for each room and gross area for each department. First, has the schedule of accommodation been finalised and when will it be available? Who is best to answer? Perhaps we can come back to Ashok once we get him into the meeting. To develop further on that, is the planning application for the site still scheduled to be made in July and what will that application be for?

Development Director, Our Hospital Project:
The key answer is yes, the application is still intended to be in July. It is going through its review processes at the moment and it will go to our political oversight group in July. Subject to all of that going okay then the submission will be made. The application is for a change of use and it is to change the use of Les Quennevais from a school to the clinical consultation space, et cetera, that is needed for that premises.

The Connétable of St. Brelade:

Given that the normal procedure for a planning application is something in the order of 12 weeks will that time in with the timeline currently in place for the relocation of services? It is the understanding of the panel that the intention had been for the relocation to start in December 2021. Has this changed?

Our Hospital Clinical Director:
Hello, and I am sorry. I could see you but I could not get into the meeting. I do not know if you can hear me now.

Deputy Chief Minister:
Yes, we can, loud and clear.

Our Hospital Clinical Director:
Maybe I could go back to the first question?

The Connétable of St. Brelade:
Yes, indeed. Shall I re-put that question, Ashok, for clarity? The Overdale decant functional brief requirement states that an additional schedule of accommodation was being developed that provides departmental summaries that have been produced at a room-by-room level to underpin the functional brief. The schedules provide a net area for each room and gross area for each department, so we are asking: has the schedule of accommodation been finalised and when will it be available?

Our Hospital Clinical Director:
Yes, it has, and the final set of meetings with the clinical users were held in the last 7 days. We are now, we think, pretty well ready for that part of the planning application and the whole of the clinical-facing areas on the ground floor have been agreed by all the individual departmental leads and staff as well as the H.C.S. (Health and Community Services) executive and the area that we have got the next week to finalise is the non-patient-facing office space or back office spaces and we anticipate that those will be completed in the next 10 days or so.

The Connétable of St. Brelade:
So in reality will that form part of the outline business case for Les Quennevais? Is that correct?

Our Hospital Clinical Director:
Sorry, I did not get that. I lost you again.

The Connétable of St. Brelade:'

Am I right in assuming that will form part of the outline business case for the decant to Les Quennevais?

Our Hospital Clinical Director:
It will do, absolutely, but the Les Quennevais School reprovision is only a small part of the overall outline business case.

The Connétable of St. Brelade:
Going back to the second point, which the Minister has suggested you might be able to address, what is the timeline currently in place for the relocation of services? It is the understanding of the panel that the intention has been for the relocation to start in December 2021. Has there been any change to that and if so why?

Our Hospital Clinical Director:
The 2 planning applications, one for the demolition and one for the reprovision, are going to be submitted by the end of July. We anticipate a planning decision for both in October and the facility will be scheduled to be operational in 2022. Obviously we need a period of time for the rebuild, which we anticipate to commence in January, and it is approximately around a 6-month work around and then around 3 months for transfer of services, so that we would expect the facility to be operational by the autumn of 2022.

The Connétable of St. Brelade:
The project team have stated there is no current intention to maintain healthcare facilities at the Les Quennevais site beyond its use as a decant facility while the new hospital is under construction. Does this remain the case?

Our Hospital Clinical Director:
The majority of services that are going to be relocated to the old Les Quennevais School site are provided for within the functional brief and schedule of accommodation of the new hospital. There are a small number that are not within that. Those are primarily driven by the clinical services telling us that they do not see their future in the new hospital, and those include the Child Development and Therapy Centre, older mental health and psychology outpatient services, to name 2.

The Connétable of St. Brelade:
Do you consider those services could be provided at Les Quennevais in the longer-term?

Our Hospital Clinical Director:

No, I think alternative suitable provision will need to be made. Certainly the ambition from the mental health team is that a significant proportion of the outpatient services will be provided in a more dispersed way in the community and they see the new facility in the hospital being primarily for acute inpatient services and supporting the community-based services. The model for mental health is very much one of community-facing for the vast majority of the services and that is what the commissions in those services have told me.

The Connétable of St. Brelade:
Thank you. The underlying reason for that line of questioning is that there is considerable demand for housing in the area and if housing providers are to be able to take advantage of utilising it.

Our Hospital Clinical Director:
There is certainly no intention for the Les Quennevais School reprovision to be a long-term provision. In fact, as part of the site selection options appraisal, one of the criteria was to try to co-locate as many of the services, if not all, as possible and also for looking to a medium-term provision so that the services would not have to move twice in the time it took to build a new hospital and also that it should not inconvenience patients and Islanders.

The Connétable of St. Brelade:
Regarding the timeline of the development of a travel plan for the facility at Les Quennevais, have the scheduled travel surveys now been conducted? I am not sure who would be the one to answer that.

Our Hospital Clinical Director:
Possibly Richard or Jess. What I can say is that we have got the first tranche of that work around the number of parking spaces made. You will know from previous conversations that we are also in consultation with the bus services to look at what provision can be made. Also there will be provision for sufficient bicycle racks and showering arrangements for members of staff. The staff survey is underway, and we are also looking at other local opportunities for sharing of parking facilities.

The Connétable of St. Brelade:
Could you tell us when the travel plan could be shared or when it might be available?

Our Hospital Clinical Director:
I think the travel plan will be ready in time for the planning application, at the latest by the end of July.

Development Director, Our Hospital Project:

May I just add, it will be brought to the Parish Roads Committee prior to that, so that we have dealt with the consultation and feedback on that plan prior to it being included as the impact assessment with the planning application?

The Connétable of St. Brelade:
Thank you. To finalise on that, in terms of discussions with the bus service, what are the views of the bus services as to how they will provide for that?

Development Director, Our Hospital Project:
Just to let you know that we have had …

Our Hospital Clinical Director:
I am sorry, I am not sure if that was addressed to me.

Development Director, Our Hospital Project:
We have had the conversations with the bus service. They have got an initial solution for us. We need to explore that a little further because it involves putting yellow line restrictions on some of the roads and as soon as we have got that nailed on we will be able to come and present it to the Roads Committee.

The Connétable of St. Brelade:
One thing that concerns me primarily is the need for buses to turn around in the car park and the potential loss of spaces in that car park as a result. Has that been considered?

Development Director, Our Hospital Project:
We are absolutely aware of that and it is being considered currently.

Deputy I. Gardiner:
I would like to ask the Minister for clarification because from my memory, and it may be wrong, the Assembly was told that the relocation for Les Quennevais will happen in December 2021 and it will cost £10 million. Now it is happening in December 2022, a year later, and it will cost approximately £15 million, if the numbers are correct in my head. Would you please explain this?

Deputy Chief Minister:
I am trying to recall, and I simply cannot, the intention for the move to take place in 2021. I am sorry, I might have to defer to Richard to explain, if that was the case, the rationale in terms of the timetable, but I do not recall that timetable but I could be wrong. I am not sure who would want to explain the reasons for the increase in budget.

Development Director, Our Hospital Project:

In terms of timetable, it just comes down to establishing the practicalities of moving all those services from where they are now to where we are proposing to put them. There was some time lost while we were trying to identify solutions for the decant from Overdale. It turned out there was only one credible option, which was Les Quennevais. The work that has gone on since then has been the detailed analysis of how we could accommodate all of the services at Les Quennevais and at the same time as doing that we have been working with the users to make sure that we get the functional brief, et cetera, correct, as Ashok has already explained.

[15:30]

In terms of the financial implications, the cap of £15 million is based on a design, whereas everything that had been done up until that point was based on guesses as to how much it might be. The very initial guesses that were made in terms of the costs were made before we knew that Les Quennevais was the only option available to us. It is just down to better knowledge, not down to loss of control or loss of specification.

Deputy I. Gardiner:

I appreciate that. It is really helpful but it does worry me that the first number was an indication and when they calculated the real number it was increased substantially, and now when we are talking about £800 million the worry is when we calculate the real number what increase we will see.

Senator K.L. Moore:

Before we move off the subject of Les Quennevais it was mentioned that some outpatient services or at least Child Development and Therapy will not be going into the Our Hospital. Could you explain for us please where those services are anticipated to go and how the cost of putting those services wherever they are intended to be delivered will be funded?

Our Hospital Clinical Director:

The reason those services are not being re-provided in the hospital is, as I said, at the express request of those clinical teams. They tell us from talking to their service users, and I think as far as the future of those services in 5 years' time is concerned, that is something that is still being considered by the H.C.S. executive, so the director general may have some information on that.

Director General, Health and Community Services:

The services that are not going to be relocated currently back into the hospital are family services, our pain clinic and the Child Development and Therapy Centre. In combination with these services

we firmly believe that pain can be delivered and perhaps should be delivered in the community with provision within the acute hospital, of course, for people who need to be referred in there. For family services, as has been previously indicated, we do not want to be doing therapeutic interventions on a hospital staircase or in a hospital bed. We would prefer to do it within a patient's own home or a place of care. Although there are patients who do still require therapies in the hospital we will manage facilities within there. The Child Development and Therapy Centre is an ongoing piece of work about how we relocate their services and that is a joint piece of work that is happening.

Senator K.L. Moore:

Could you explain how the provision of those services will be paid for?

Director General, Health and Community Services:

The existing funding envelope will move for those services. We envisage that pain will probably but again I do not want to make a unilateral …

Senator K.L. Moore:

I am just concerned that nobody can hear you. Perhaps you might have your finger held on the button. If you could just let it go then we will be able to hear you.

Director General, Health and Community Services:

Sorry, yes. The current cost, the current financial envelope, for the delivery of those services will follow those services to wherever they go. That is the same for every service that would move out of the hospital. I would envisage that those services, particularly pain, would sit more responsively within a G.P.'s (general practitioner) surgery, because G.P.s know their patients better and are able to be more responsive around their care than what we do in secondary care. But I do not want to presume that because that will be a decision that will be taken by the Partnership Board and we anticipate the first meeting of the Partnership Board will be in August. Informal conversations we have had are that services such as pain, services such as therapies, fit much better within a primary care setting.

Deputy M.R. Le Hegarat:

Therefore if I have to go to a G.P. to have that pain treatment I can assume that I will not get any bill whatsoever? Obviously at the moment if I go to my G.P. I only get the subsidy from Social Security and as we all know that has not been up for a number of years. Can you clarify for us now that if I have to go to a G.P. for any of the services that are currently provided by the hospital I will not be paying?

Director General, Health and Community Services:

Thank you for the opportunity, Deputy Le Hegarat, and I think I have said it in numerous forums, any care that is currently provisioned within the hospital that is free of charge will be free of charge regardless of where that care is provisioned in the future. This is an integrated care solution. It is not revolutionary, it is not new. It is standard practice across most health economies. The money that currently pays for that service now will be transferred. Patients will incur no additional cost when they go to the G.P. for scans, for therapies, for interventions, anything that is currently provided free of charge now will be provided free of charge in the future and ongoing in the future unless the Jersey Assembly make a different decision about the direction of healthcare going forward.

Senator K.L. Moore:
We are going to hand over now to Deputy Johnson with some questions on the provision of private healthcare.

The Deputy of St. Mary:
Good afternoon. In relation to private healthcare targets and for the overall information, can you please detail the best practice model on which the private healthcare facility will be based?

Director General, Health and Community Services:
Again I think that is a model that we are going to work through with partners and with other providers on the Island. I think private healthcare is always contentious. The disadvantage of it is that it can be perceived to reduce access and reduce responsiveness and it can also erode public confidence within the provision and their trust in the provision of healthcare. We now have a patient tracking list, so that first issue has gone. You can go online, you can see your wait. We are also starting to do that around our private patients so we can understand what that disparity is, because we want that disparity to be as small as possible. Previously you could not do that. As of last year all public and private activity within the general hospital across all our estate has been separated so that public practice is not penalised at the expense of private practice. I firmly believe that we have to pursue private practice. It attracts clinicians to the Island, it gives us more variety around recruitment and it does enable more choice. More pertinently it enables us to generate income. Jersey is perfectly positioned for private patients. We have excess beds and low numbers of people in those beds. We have the available capacity to be able to deliver additional services and generate income that we can put back into public services.

The Deputy of St. Mary:
For clarity, I was not challenging the idea of private facilities being made available. I was trying to get a better feel for how it will work. On that point, it is obviously in the gestation period from what you have just said, but how will it operate or how do you envisage it operating alongside the public functions of the hospital.

Director General, Health and Community Services:

Where I have worked with best practice it has worked separately, so you have a separate facility that you are able to manage through job planning, through financial accountability, through good governance, so that you are firmly provisioning public practice and firmly provisioning private practice and never the twain shall meet because you can cause yourself issues around your public accessibility. We want to make it really clean and we want to give parity of weight to public and private patients so that you do not opt for private care because it is quicker; you opt for it because it has got some bells and whistles around it. The quality of care, the outcomes and the access will be the same.

The Deputy of St. Mary:

Again thank you for that. How will the unit be resourced and staffed under your ideas? What impact will this have first of all on the level of revenue?

Director General, Health and Community Services:

I am just speaking from the perspective of H.C.S., so it is very much this will be a conversation that we want to have with partners because we firmly believe that private practice is not just the remit of secondary care. There is a whole wraparound opportunity for patients, so again even private care we want to talk through with the Partnership Board. As you have rightly identified, private practice always no matter how clean you keep it impacts on public practice. It is why you have to manage it. We will staff it in the way that we staff now and we will use the business opportunities that we develop in order to be able to finance it. I think if we can do it properly with the appropriate bed base then it can significantly impact upon our revenue. I think we can offer opportunities to other jurisdictions who do not have the same opportunities that we have around occupancy and capacity in order to generate income for Jersey Care.

The Deputy of St. Mary:

You mentioned earlier on or you used the expression: “Never the twain shall meet” so in staffing terms does that mean that staff on public wards will never deal with private wards and vice versa?

Director General, Health and Community Services:

That is a conversation to have with our staff. I have worked both models, where you have just had privately staffed wards and the nurses do not move around, because it is predominantly the nurses. Generally you find a better model is where nursing staff can work across the piece. The private ward always tends to have a few more bells and whistles and be a pleasant place to work, so I think it is about sharing that opportunity. Also there are learning opportunities. As regards the clinicians, private practice that is well-developed and organised allows you to attract visiting consultants.

Again, procedures that we currently do off-Island and some opportunities around plastics that we can bring visiting consultants into the Island. Absolutely we would want to blur that line because we would want our existing clinicians to learn, so we would hope to have a shared list where if we had a visiting consultant we had a home consultant sharing that list so that you could have a shared learning opportunity.

The Deputy of St. Mary:
So to go back to your reference of never the twain shall meet, they in fact will meet?

Director General. Health and Community Services:
Occasionally, when it benefits patient outcomes absolutely.

The Deputy of St. Mary:
And will benefit the staff, from what you said?

Director General, Health and Community Services:
Again it needs to be a conversation with our staff. Where we were, where the twain will well and truly embed together because we mixed all our activity, it is not good for patients. It is negative for access, it is negative for outcomes. Where we are now is much better. Where we hope to get to is our optimum solution around public and private work.

The Deputy of St. Mary:
Flowing from your replies to that, is it intended that the provision be supplied by a third-party healthcare provider?

Director General, Health and Community Services:
The preference is no. We have the skills on-Island to do that. It is difficult for me to sit here and say in 4 years' time … so we do not support having an external third party controlling our private practice. Why would we do that? We would lose revenue opportunities, but I cannot sit here and say to you that in 4 years' time we might not enter into partnership with another provider that could be a private provider, but that is not the intent. We do not intend to lose control of our private activity. It is a foolish health economy that does that. If we need to engage in partnership working in order to benefit patient outcomes then we will consider that. We would prefer to do that with other public entities.

The Deputy of St. Mary:

Sorry, forgive my ignorance here, but you say engage in partnership. How would that work? If control is going to be maintained by the public health authority how would the involvement of a partner offering private services be enmeshed in that?

Director General, Health and Community Services:
To use radiotherapy, we could enter into an arrangement with Genesis to have a radiotherapy provision. Would we want to do that? We would need to look at other areas that have done that in other jurisdictions and see whether that would be beneficial to Jersey. It could be beneficial, because our volume is low, but if we provision a service across the whole of the Channel Islands it would not necessarily be as beneficial. I can sit here and say no to you, but that is disingenuous. I think it would be an iterative journey around what is available for medical practice and what our patients need. We are very open to delivering as much care as we can on-Island. We recognise we might need partners to do that, we will need partners to do that, we would prefer them to be public partners but if we need them to be private we are open to entering into partnership, but not a partnership that disadvantages our own clinicians and our own provision.

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.

[15:45]

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.

The Deputy of St. Mary:

Thank you for that clarification. It is therefore a saving you are making in a way, the £3 million annually for keeping it on-Island rather than off-Island. That would surely mean that we have got 27 years where we can expect £3 million plus in for future? That is your expectation?

Our Hospital Clinical Director:

Absolutely. It is an investment for the next 30 years but if you build to rent then you expect to make that kind of return as well.

Director General, Health and Community Services:

Our clinicians do a phenomenal job delivering public and private activity. We do not support them enough around their private activity. We do not provision them with the facilities that they would require in order to be able to maximise that revenue. Resultingly, a lot of them utilise different providers, which is not great for them and certainly is not great for us. I think we have an opportunity to really grow our activity but also to maximise our current activity by provisioning the right services for our clinicians in order for them to be able to accelerate their list throughput.

The Deputy of St. Mary:

You have perhaps partially answered this question already, but at the moment private healthcare is integrated into the current general hospital provision. Can you clarify the current position, the extent to how the current position differs from what you envisage in the future?

Director General, Health and Community Services:

We have moved on a lot with private practice, as I have alluded to originally it was mixed, so you had public and private patients on the same list, which is difficult. We no longer have that. We do have a private ward. It is a great facility for what we offer but we could offer more and we could do more and it is within the challenges of our current estate, which I know everyone is fully aware of. But we have completely rationalised how we manage that activity. We have transformed our theatre schedule and we are trying to be as responsive as we can to our clinicians' needs. We have some challenges and we are working through that with our clinicians. The change has been difficult and we perhaps have not managed that as well as what we could have done but we are working that through with our clinicians to ensure that going forward we provide a service that is … as I have said, our Holy Grail is you come in public, you come in private, you wait the same; that is what we are working towards, that is why our waiting lists, which are valid waiting lists, are now on our website.

The Deputy of St. Mary:

Thank you. I apologise to my colleagues for going off-piste now from my panel list but having experienced private care to a certain extent, I am struck by the lack of uniformity in what the private sector offer. I say that in a sense that some insurers will allow X pounds for a procedure, another for Y pounds and certain items like anaesthetists are not even covered or we do not know it until later. That has always seemed to be a failing in the system in the sense that unless there is certainty a private person may well decide to go on the State and cost the Government money, is that in the course of being rationalised in any way?

Director General, Health and Community Services:
Absolutely. I would like to invite you to our task force, that is one of our most wicked issues and that is also to do with our negotiations with the insurers and what a package looks like and how we have standardised packages. We have not been great at managing that. We have not had a private patient manger, so we should not be surprised. The service that we offer to private patients is not what we want it to be or what we envisage it to be. We have got a lot of work to do on that. We have still got a lot of work to do around that.

The Deputy of St. Mary:
Thank you for being so open. Does that involve dialogue with the medical profession generally because I presume they accept positions here on the basis that they will receive so much from the public purse and so much from outside? Do they need to be, I would not dare say reined in, but does some tension need to be made to that aspect as well?

Director General, Health and Community Services:
We are working with our clinicians about how we can best deliver patient care; public and private. I think we are really, really lucky on this Island. I have worked in many, many places and we have clinicians who are utterly focused upon patient outcomes. We are working to help them to ensure that we get the best for our patients, be that public and private. Some of those conversations are going to be challenging but our clinicians are fully engaged in having them with us, as are our insurers.

The Deputy of St. Mary:
Thank you and I wish you well. A couple of minor questions in a way; the project team have outlined that the private ward will provide flexibility and resilience for the new hospital. In order for them and how to gain an understanding of what the O.H. (Our Hospital) team regards as a best practice model, can you explain under what circumstances would the ward be requisitioned for public use, if you envisage that ever?

Director General, Health and Community Services:

We have a lot of bed capacity and we have low occupancy. We are really lucky. I cannot see it being requisitioned as it normally would when you have pressures at your front door because we do not have pressures at our front door. But it would be requisitioned for a pandemic. It would be requisitioned if we needed additional bed capacity to do a waiting list initiative. I cannot see that being an issue. Resilience for us is around a pandemic situation.

The Deputy of St. Mary:

Okay, so in general circumstances you would not see any private facility being called upon to release their beds for public use.

Director General, Health and Community Services:

They need to be really clear, the private facility will not be policing their beds. If public patients need to use private beds, then public patients will use private beds. We ring-fence public activity, not private. We are a healthcare system. If we need to use private beds for public patients we will, regardless of the circumstances but for resilience it is around pandemic. But absolutely we will be in a fortunate position of having capacity in the public wards that is going to be beautiful. The private wards can have bells and whistles, so it is going to have leather instead of fancy material. But if we need to put somebody in there for whatever reason, who is a public patient, absolutely we will.

The Deputy of St. Mary:

Thank you. Moving on, I apologise because I am rather late coming on to this panel but what provision for private healthcare is or will be included in the Jersey Care Model, which I do appreciate is still under development?

Director General, Health and Community Services:

All care that we provision in H.C.S. will be on the table for conversation at the Partnership Board, all care that we provision, including private care. We hope to be able to involve partners in that in our private offer, so that particularly in the third sector we are able to bring partners into that envelope so they too are also able to benefit from revenue-generating opportunities. If you look at other jurisdictions which offer really embracive private care, they utilise their volunteers from third sector within that private unit but it is part of the package and then that money goes back into that sector or organisation. That is our aspiration but, again, that needs to be as part of the conversations with the Partnership Board because the third sector might turn round and go: “On your bike.” We need to have those conversations with them.

The Deputy of St. Mary:

Okay. Thank you again for that. My final question in this general area is apart from private healthcare, and that is almost a saving rather than anything else, what other income streams, if any, have been or are being considered at the new hospital and would form part of the Care Model?

Director General, Health and Community Services:

I do not think that we are actively considering income generation outside of our private work because we would not want to income-generate from our public work. What we want to do is be able to deliver our public work as safely and efficiently as we can. We continue to do that in H.C.S. We have a cost improvement programme in place to deliver £12 million this year. We have already delivered £10 million of that; that is through working differently and more effectively and eliminating waste, of which we have got quite a bit within health. But not impacting upon patient care, indeed enhancing patient care because qualitative care is normally fiscally-efficient care, contrary to most assumptions. Our main focus, in fact our only focus is around generating activity through private patients. There may be other opportunities in the estate that we are being presented with. I have never been fortunate to work in such an estate but at the moment we are not considering those.

The Deputy of St. Mary:

Okay, well that completes my area on private healthcare but I will leave it to others to pursue the Jersey Care Model.

Senator K.L. Moore:

Thank you. Now the Constable of St. John just has a follow-up question.

The Connétable of St. John:

You say you are not looking at other income streams, we heard recently that you are looking at the potential for teaching and education from other areas. Is that not an income stream?

Director General, Health and Community Services:

Apologies, but I am unaware of any work stream that is happening within H.C.S. around teaching and education.

The Connétable of St. John:

You are having a new knowledge centre which could be used for outside people.

Director General, Health and Community Services:

Sorry, yes. Yes, there is an income-generating opportunity there, apologies. Can I ask Ashok, he is our education expert, to perhaps elaborate on that for us?

Our Hospital Clinical Director:

Thank you. Certainly the investment in the Knowledge and Education Centre is in large part aimed at continuing professional development of our own staff. Also, we have a lot of training undertaken on the mainland in the U.K. (United Kingdom) and other parts of Europe and other parts of the world indeed, and lots of efforts have already been made in training Islanders on Island to remain working on Island in healthcare. There is a large part of that development and that does give us a facility which could be very attractive for post-graduate training in courses. We already have undergraduate students from Southampton University and there would be an opportunity to increase that, and that will be revenue-generating. We already have foundation doctors that come to us with their basic salary paid by the Health Education England and there would be an opportunity to increase some more training on Island, which would be a generating of income overall, in that we would get 40 hours a week of doctors' time free of charge, if you like. On top of that, the opportunity to use Jersey as a fantastic destination for people to come and do training courses and then stay on for a holiday or a break as well. Why would you go to London to do a course at the Royal College of Surgeons when you could come to the new hospital in Jersey and then have a few days in Jersey afterwards, enjoying the fine cuisine and Island life? Those are real significant opportunities for income generation, in addition to the ones that the director general has already outlined.

The Connétable of St. John:

Thank you. In terms of income generation, why do we not have a private patient manager at present?

Our Hospital Clinical Director:

Sorry, I missed the end of that question, why do we not have one now?

Director General, Health and Community Services:

It is me, Ashok. That post was given up as part of the cost improvement programme probably 5 or 6 years ago, so that is what we are seeking to rectify.

The Connétable of St. John:

Thank you. The final question on this from me is what work has been done already on partnerships, either private or public, ahead of the outlined business case?

Director General, Health and Community Services:

Sorry, can I clarify, is this around the Care Model or working together within the hospital?

The Connétable of St. John:

It is about the private facility, the private healthcare: what work has been done so far on partnerships with either private or public partners?

Director General, Health and Community Services:

No conversations have been had at all. The work we have been doing internally has been to rationalise the way that we manage public work. We only had effective waiting lists since last year. Now we understand our activity and we are trying to manage it accordingly. We are doing work with our clinicians to rationalise our public and our private offer. Conversations around private work will be happening at the Partnership Board, which we anticipate will have its first meeting in August, providing that recruitment goes well. Because we want to have those partnerships hand in hand with partners around the Island. We have had conversations with some of our insurers, our private insurers, around what are the possibilities in 4 years and of course they are delighted to have the opportunity to be able to provision insured care in a fantastic new facility. But we need to make sure that that conversation ensures that care works for us as well.

Deputy M.R. Le Hegarat:

Thank you. In the absence of the schedule of accommodation, how will it be clear to clinicians and consultants what space the departments and services will have and whether it will be sufficient for their needs?

Deputy Chief Minister:

Ashok, would you take this, please?

[16:00]

Senator K.L. Moore:

Professor Handa, could you hear us? I am afraid we seem to have lost him again. Is there anyone else who is able to answer that question?

Development Director, Our Hospital Project:

Yes, there is a schedule of accommodation which accompanies the 1 to 200-scale plans. There is a schedule of accommodation, there are plans …

Our Hospital Clinical Director:

I am not sure how to answer that because there is a schedule of accommodation, it has been issued some time ago. It has been continuously worked on at the subsequent clinical user groups. When we get to the external design lot, the clinical user groups scheduled for the week of 19th July will have final sign-off on the space overall. The next phase of the design going through to 3 stage will

be a room-by-room look at equipment and size, et cetera. The schedule of accommodation is available or has been available for some time. It is, as always in design processes, a work in progress because it is informed iteratively by continuous user groups as they refine both their models of care but also look at what other facilities are available in other parts of the world. Of course, both this committee and the political oversight committee have repeatedly asked me to go back and check and challenge the commissions to make sure that we are walking that tightrope between making sure we have a facility that is futureproof for the next 30 years and at the same time not overly generous and, hence, wasting taxpayers' and Islanders' money.

Deputy M.R. Le Hegarat:

Okay, thank you. What you are saying is you can confirm that all clinicians and consultants are content with the space and it is sufficient for their needs.

Senator K.L. Moore:

Yes, we seem to have lost him again. Is there somebody who can answer?

Director General, Health and Community Services:

Deputy, there has been, as Ashok has said, ongoing engagement with all of the clinical groups around what their space could look like. Some of those conversations have involved challenge around what perhaps services think they want but what we need in order to be able to deliver good care. But I am confident that all services have been fully communicated with. Our clinicians have been consulted and are content, some of them less so, some of them ecstatically content with the services that we offer. But I am confident that what we are building and scheduling is right for the needs of Jersey. Ashok, I do not know if you wish to elaborate.

Our Hospital Clinical Director:

Yes, sorry, I have been dropping out of signal, my apologies for that. Absolutely, for the Les Quennevais reprovision, absolutely all of the services are extremely pleased with what they are getting. As far as the main hospital is concerned, the vast majority of clinicians, I will say over 95 per cent, are content when we meet them. Of course, the challenges that I talked about are uncomfortable on both sides, both for them and for me, but that is what is in my job description, to make sure that they have adequate provision. But I think I can confidently say that the clinical teams have been engaged, they have constantly had their questions and challenges back to me addressed and we will continue to do that right down to the socket boards and the services within every single room, the last screw and chair and table, et cetera.

Deputy M.R. Le Hegarat:

Perfect, thank you, we will move on. Is an independent health impact assessment being conducted to accompany a planning application?

Senator K.L. Moore:

Does anyone wish to answer that question?

Development Director, Our Hospital Project:

The simple answer to the question is no. There was one done, I think, on the previous project but when we have checked in with advisers this time there is no need to do that, so the answer is no.

Senator K.L. Moore:

Why might that be, please? What are the reasons?

Development Director, Our Hospital Project:

I can't see that over here and unfortunately, I would need to dig out the advice of the advisers.

Deputy M.R. Le Hegarat:

Okay, thank you. Because obviously it is known to be better practice in relation to major projects but obviously we will await your response to that at a later time.

Our Hospital Clinical Director:

Sorry, I am not sure, what do you mean by an independent health impact assessment? Because we have got independent scrutiny not just from yourselves but also from healthcare experts within the team. I think Richard will know that we have got Mott MacDonald and Turner & Townsend challenging both our finances and the provision within that. I do not know whether that is what you meant and we may have misunderstood what you meant by the assessment. There is certainly some independent checking of what we are doing.

Senator K.L. Moore:

Okay. If I can assist there, I think this is really in the realms of planning and the impact that a project, a major project, would have on both the users of the building and also its neighbours. I think, Mr. Scate, you might be able to address that.

Director General, Infrastructure, Housing and Environment:

Thank you, Senator. Yes, we would expect the planning application that is received to include a range of issues within its environmental impact assessments, emerging environmental impacts obviously are associated with people impacts, so in terms of air, air quality, noise, dust, those matters certainly would be elements to either pick up from the environmental impact assessment or

indeed be conditioned or consented as part of any construction environmental management plan. Some of the conditions and controls that are put on development thereafter, so there is a part of the proposal which would need to be assessed coming into the planning stage as to what is the proposal and what impacts it will have on people either using it or certainly living around it. If any impacts are highlighted then they can be mitigated as part of, as I said, an environmental management plan, construction plan and conditions on any consent.

Deputy M.R. Le Hegarat:

Okay, thank you. In the Deputy Chief Minister's response to the panel's letter of 31st March 2021 it was stated that the aim was to find a new location of the hydrotherapy pool and sexual health clinic by May 2021. It is understood that the sexual health clinic will be remaining in its current location. Has an appropriate location now been found for the hydrotherapy pool?

Director General, Health and Community Services:

No, Deputy, we are still working on that.

Deputy M.R. Le Hegarat:

Do we have any indication as to when we will get the information as to where that location will be?

Director General, Health and Community Services:

The manager that I have tasked to work on this has been given a deadline of the end of August to bring back to the team proposals around where we could possibly relocate the pool. I anticipate, assuming those proposals are realistic and achievable, that I will be able to update the panel in September.

Deputy M.R. Le Hegarat:

Okay, thank you. One of the advantages often given for the construction at the Overdale location has been that it was the one-site option. It is now clear that some services at the request on occasion of clinicians and service users will not be contained on the Overdate site. The sexual health clinic is remaining at its current site, the hydrotherapy pool, psychotherapy services, rehabilitative services and ancillary services mentioned in the decant functional brief will also be provided separately from the main site. The panel also understands the intention of the Jersey Care Model is that elements of primary care be devolved from the main site. Excluding the provision intended through G.P. surgeries and community partners, how many sites are being looked at in addition to the main site to be a permanent part of the healthcare estate?

Deputy Chief Minister:

Thank you, Deputy. I think we will go to Ashok on that because that goes back to his previous answer in relation to how the people delivering the services want to operate them moving forward. Ashok.

Our Hospital Clinical Director:

Yes. The only services that are not going to be relocated are the Child Development and Therapy Centre. We have talked about the pain service, there is room for it within the new hospital but it will be a hybrid provision with some in hospital and some in the community. Then the older mental health and psychology services, it may well be that they would prefer a site, again, devolved around the community, either in primary care or community-based care, which is the future of mental health, to have this both devolved and inpatient model. We are not anticipating necessarily needing additional sites for that. Then the one other area that is currently going to be re-provided at the old Les Quennevais School but we are still working with the team on that. Future is not directly healthcare related but it is a facility for the Meals on Wheels that is currently provided at Overdale and will be re-provided at Les Quennevais School. We are not anticipating significant other estate.

Deputy M.R. Le Hegarat:

Okay, thank you. It is mentioned, however, in the bridging Island Plan about health hubs, as I said, it is referenced in the Island Plan. How many health hubs do we anticipate having and where will they be located?

Our Hospital Clinical Director:

I think the director general is best placed to answer that.

Director General, Infrastructure, Housing and Environment:

If it helps, Deputy, I can answer with a planning hat on. I think the Island Plan is trying to reflect potential future requirements and as the conversation at the time … sorry, I think as the Island Plan was being formulated there were some conversations around whether the Island needed other health centres. It is a draft Island Plan, so I am not seeing that as now a geographic or a spatial need in the final Island Plan, so that might be an element that needs to change.

Deputy M.R. Le Hegarat:

Okay. However, in relation to the Jersey Care Model it is being made quite clear that there would be provisions allocated elsewhere. Can we sort of get an indicator of what sort of services will be provided at health hubs and are we going to get any moving forward? I am conscious of what the director general just said in relation to the Island Plan but all the way through the process in relation to the Jersey Care Model we have talked about locations and health hubs. Since we are on this

topic, can we just ask that are we still looking at health hubs in relation to the Jersey Care Model to deliver services and where are those likely to be?

Director General, Health and Community Services:

Apologies, Deputy, and I do not wish to demur with you but we have been very … so in the early days of the Care Model we thought that we would have hubs. Indeed, we thought we would have had one at the General and one in the rest of the Island, one in the north of the Island and we had had conversations about that. We very quickly realised that after we went round the G.P.s in our first summer that we would not need that because we have an awful lot of health facilities on the Island; healthcare centres, G.P. practices, which can act as hubs, in effect, so we do not need to build new hubs or provision any new hubs. I think that just must be something historical from the Island Plan. We have no intention to create health hubs. We have an intention to sit with the Partnership Board and work through where we best provision care. It may be that the decision is, is that diabetes care is provisioned at a surgery, The hub is a surgery in St. Helier and then there is outreach into other practices but that is a conversation that we anticipate having with primary care colleagues around: what is the best fit to deliver good outcomes for our patients?

Deputy M.R. Le Hegarat:

Thank you for that clarification because I think there still seems to be among the public, and certainly by some of us, that that was still on the table. I think it is helpful to have resolved that matter, so we now know that there will not be any new health hubs. What consideration was given to including provision for housing essential health workers on the Overdale site?

Deputy Chief Minister:

Ashok, would you like to start with this? I am not sure if Rob Sainsbury is on the call and working on the accommodation plan. Ashok, are you there?

Our Hospital Clinical Director:

I am sorry, could that question be repeated, please?

[16:15]

Deputy M.R. Le Hegarat:

It certainly can. What consideration was given … hello, can you hear me?

Our Hospital Clinical Director:

Yes, I can hear you.

Deputy M.R. Le Hegarat:

Perfect. Okay, what consideration was given to including provision for housing essential health workers on the Overdale site?

Our Hospital Clinical Director:

The accommodation for healthcare workers has not ever been part of the Our Hospital Project. It is not the part of healthcare that is in the same strain as the healthcare estate and, of course, the primary concern is to make sure that we get the right accommodation and facilities for patients. Of course, a secondary consideration is the well-being of our staff but that is not part of this project. The simple answer is, as far as site selection and the design and schedule of accommodation and functional brief, that has not ever included accommodation for staff, other than on-call emergency staff, which is in schedule and has more than adequate provision.

Director General, Health and Community Services:

We already have significant staff accommodation prominently in St. Helier and we are currently undergoing a refurbishment programme. We have just recently done Hue Court to ensure that accommodation is fit for purpose. One of the challenges we do have, and I think I might have spoken about it in a panel, is around accommodation for families. Some of the conversations we are having is, as you know, we are very fortunate to be bequeathed property by Islanders and some of that property is very expensive to maintain; it is very old and we have difficulties finding tenants for it. We've got our first meeting tomorrow with our property team, and Andy is part of that, in order to discuss how we can best rationalise that property in order to perhaps purchase property that is more family friendly because that is our significant challenge. We want to attract people to the Island who have skillsets that we require and if they bring family with them we do currently find it challenging to accommodate them.

Deputy M.R. Le Hegarat:

Okay, thank you. I will now hand over to Deputy Gardiner.

Deputy I. Gardiner:

I will continue, I will go back to the infrastructure and connection to the Care Model and the hospital. So in the bridging Island Plan it is referenced that the Jersey Care Model has been developed as clinically-led model for how future health and care services are to be delivered across all sectors in the Island. It is used in that document to outline how infrastructure, including provision of new hospital, might change over the duration of the Island Plan. However, the panel have also heard from a director general at the briefing that the technicalities are in embryonic stage. We heard today that it still has not been finalised. It may be G.P. We might not have health hubs. Not sure where

we will find ourselves. So please can you be clear about the stage of development that the Jersey Care Model has reached, especially in relation to the infrastructure requirement where we are now?

Director General, Health and Community Services:

With absolute respect, Deputy, we have been clear and we have probably been clear for the last year, maybe longer, that we are not having health hubs. So I am unsure as to that confusion, although I recognise it being in the Island Plan does not help, so apologies for that. We have been clear in all our panel interviews with the Health and Community Services Panel, in our briefings, that we are not having hubs. We did have a very long conversation about hubs but when we went around the Island and did our Parish visits, loud and clear we were told, we heard from patients, they want care provision closer to home and that care is probably most responsibly delivered by their G.P.s who provision the majority of care on this Island, not H.C.S. So we have been very clear all along, it is clear in our documentation around the Jersey Care Model, it is clear in the documentation and proposal that went to the Assembly, there would not be health hubs. Where we are currently around the Jersey Care Model is we are following the recommendations of our Scrutiny Panel around setting up our governance structure. Our Scrutiny Panel very helpfully looked at the work we had done and recognised gaps we had around our governance. Particularly around putting in place a governance structure that engendered trust in other partners because we are a bit of a monolith in H.C.S. So that is the structure that we are currently putting in place. We anticipate that we will have the first meeting of the Partnership Board, but that is dependent upon recruitment, in August. Then we will start moving significantly around the changes that we want to make to the delivery of care on the Island. It is not appropriate for us to do that now because that would be just H.C.S. driven. A lot of the challenges we face are that a lot of care that has been delivered on the Island has been secondary care driven, not driven by patient need, patient want, patient experience and not driven by working in partnership with colleagues and partners. That is the way that we want to move forward.

Deputy I. Gardiner:

Thank you, I appreciate. So, if I understood correct, it was no engagement yet with G.P. surgeries that they will be able to deliver infrastructure-wise the Jersey Care Model because the Jersey Care Model was not delivered. At the same time, we are moving forward with the application for the new hospital, which will be submitted in November. We are having an application for Les Quennevais that we will spend £15 million for the temporary result, maybe considering can it be used as a place for delivering the Care Model. I do not know. Of the west. I am just raising concerns that if the Jersey Care Model infrastructure-wise getting behind the development around the hospital and other infrastructure facilities. Are you really sure that workstream of your workstream around the Jersey Care Model is not an appropriate juncture with the terms of relation with Our Hospital project?

Director General, Health and Community Services:

Absolutely, Deputy. Can I clarify, I did not say there has been no engagement with primary care. Indeed, I am meeting with primary care tonight and meet with them every month. My officers have regular engagement with primary care and we ...

Deputy I. Gardiner:

Apology, I would like to clarify my question. Have you had a confirmation from the G.P. surgeries they will be able to deliver Jersey Care Model of regarding that they have enough infrastructure for all services that you would like to deliver the community? Do you have this confirmation?

Director General, Health and Community Services:

No, and we have not sought to have that absolute confirmation because that is an unrealistic expectation. What we have committed to is that we will not transfer care out of the hospital into an environment that is not suitable to deliver care. We are a public health provider. Our service is determined by patient experience and patient outcomes. If a service, if a group of G.P.s, or the primary care body, identify a practice that they think has the requisite skills to deliver a service then that is what the Assembly has kindly granted us funding for in order to be able to support that practice to do that. But again that is not my decision. Power has been invested way too long on this Island in the director general of H.C.S. That will be the decision of the Strategic Partnership Board, which our G.P.s will sit on. Indeed, the chair of the P.C.B. (Primary Care Body) is sitting on the interview panel around who will chair that board. We are really keen to work collaboratively with G.P.s. We have visited every practice. We are engaging in conversation with them. You can never communicate enough, I accept that. Absolutely value what G.P.s deliver, they deliver way more care than us, more responsive care than us. We are there for when patients need them at that end of the pathway. We need to invest in the end down here, which is considerably cheaper and results in less cost in secondary care. At the moment it is the other way around. So we are absolutely ready to ongoing dialogue with our G.P.s.

Deputy I. Gardiner:

Thank you for your answer. It is helpful. My emphasis was around the infrastructure and the planning application going forward and the concern would we have enough infrastructure in place to deliver the Care Model. I definitely understand the conversation will be ongoing. The panel has been told, and you mentioned, that under the Jersey Care Model money follow the patients. However, with the closure of the rehabilitation unit and the shorter stay of patients needing care at the General Hospital, families are discovering that they are having to self-fund the longer-term aspects of rehabilitation care. As this unit will not be reinstated in the hospital, and I understand that we probably will not need a rehabilitation unit in the acute hospital, but we still need rehabilitation unit, please explain how it will be intending that this care be funded and where it sits in the Jersey

Care Model? Because currently no neuro physiotherapy that was delivered in Samares Ward is delivered in the community. No visit from the specialist rehabilitation consultant. The physiotherapy one hour but it is not consistent because we do not have enough physiotherapists in the community. So it definitely was a reduction in the services and increase since the ward was closed. So how will it be looking going forward please?

Director General, Health and Community Services:

Deputy, with respect, the rehabilitation unit has not been closed. Samares has been closed. We provide full neuro and stroke rehabilitation within the General Hospital, which I would argue for acute neuro and stroke rehabilitation is the more effective place. There are 12 beds within that hospital, 6 for neuro rehab, 6 for stroke rehab. I confirm those beds are in place within the General Hospital.

Senator K.L. Moore:

The point is that patients are sent home after 6 weeks and their families are telling us that they are facing costs of £70,000 a year privately, to themselves, for providing care that would have previously been offered had the rehabilitation unit at Samares been left open. Their family, not being sent home from the care that they are receiving at the hospital.

Director General, Health and Community Services:

Absolutely, and I think I asked this last time, please let me have the details of those patients. Patients were in Samares, not all patients, but a significant number of patients were in Samares for up to 42 weeks. That is not rehabilitation. That is homing patients, which is again I remind the panel that we have 1,000 beds outside this hospital for elderly care, for nursing home and care homes, for a jurisdiction of this size we have 1,000 beds. Samares was rehabilitating some patients but not all patients. It was creating dependency. Now, if patients are incurring costs as a direct result of service not being provisioned that was previously provisioned at Samares, that is not our intention and that should not be happening. So, again, I ask that you let me have the details of those patients so that I can address that. I am aware of one patient whose relative we are talking with who has written into me and my team. Because the care we have delivered on that occasion is not responsive care and we are seeking to address that. So please let me have the details of that patient. There is no intention to withdraw any kind of care for Islanders. That is not to our benefit. Those patients will re-present at secondary care and cost even more money and, more pertinently, will incur more injury and suffering.

Deputy I. Gardiner:

Can you confirm that neuro physiotherapy that was provided in Samares Ward will be provided in the community? Because currently from our understanding it is not provided in the community.

Director General, Health and Community Services:

Any therapy that was previously provisioned should be being provisioned for patients who require that care, that have had that care prescribed as part of their care package. If that is not happening then again please bring that to my attention and I can investigate that and look into it.

Deputy I. Gardiner:

We will move on, yes, thank you. And what work is being done to ensure comprehensive public understanding of the Jersey Care Model and its realisation of the services that they may have expected to be located at the new hospital?

Director General, Health and Community Services:

Not enough. I have met with somebody today. Because what we have realised is we went around the Island, did the Care Model, then the pandemic came. I have met with somebody today, a communications person, to talk about doing some comms around what the model is and what it is not. Because I am aware that there is confusion out there and people are scared that they are going to have to be pay for services, as the Deputy has quite rightly identified. Or they are scared that services are going to be taken away from them or they are not going to be able to present at E.D. (Emergency Department). So our plan is to launch a communications campaign, probably starting next month. But we are also going to go out around the Island again. So we are going to go and do our presentations at the 12 Parishes over the summer, open presentation for people to come along and ask us questions. The Jersey Care Model is not about engendering more cost. What you get free now you will get free in the future. It is not about destroying primary care. Why would we do that? It is about enhancing primary care. It is about taking power and money away from H.C.S. because too much power and money is invested in secondary care on our Island. But I recognise that we have not been as good as we could have been at communicating that.

[16:30]

I welcome that, you are spot on, we need to do more so that Islanders feel much more engaged in what we are trying to do and much more involved.

Deputy I. Gardiner:

I welcome in the meetings, the Parishes. Just a note, would you present at the Parishes, I think might be helpful, to have a straightforward comparison of the effects on Islanders between the old version of the Jersey Care Model, that it will be straightforward, clear for the Islanders; what was the old model, what will be in the new Jersey Care Model?

Director General, Health and Community Services:

It is like you in the room with me today. What we are going to do is: "This is what is in the hospital now", service by service, specialty by specialty. "This is what is going to be in the new hospital, this is what we anticipate we are going to be talking about at the Partnership Board about coming out into the community." If the whole Island stands up, not even the whole Island, but a significant proportion of patients stand up and go: "We do not want our physiotherapy in our own homes; we much prefer having it in the hospital", then we are not going to say: "You cannot have it in the hospital." Yes, we are going to have that really clear communication in really clear layman's language: "This is what you get now, this is what we are proposing you get with the model."

Senator K.L. Moore:

Now we are going to have some questions about access from the Constable of St. John.

The Connétable of St. John:

Thank you. Access to the new hospital site remains at the forefront of many Islanders' concerns as demonstrated by the vote at the St. Helier Parish Assembly on 9th June to block work until further details were received about the changes. How will the outcome of that Assembly be addressed?

Deputy Chief Minister:

Thank you, Connétable. First of all, I just wanted to use this opportunity to reiterate that, contrary to some of the media reports, the Our Hospital group and the team are listening to the concerns of the parishioners. Many of the concerns raised have gone back to the roads design team with a view to ensure that we are doing everything we can to meet and address some of those concerns. Some it might be possible to and some it might not be deemed possible to. But I am looking at Andy now, if I can, just to give a bit more detail around that.

Director General, Infrastructure, Housing and Environment:

Thanks, Senator. It is important to put in context what the Parish Assembly was there for. We went back to this Parish Assembly following the previous Parish Assembly, which asked for further information around impacts on the road across 4 main areas. So, as the detail is evolving, more detail can be provided. That is now being provided back to anyone looking, either through the Our Hospital website, but also to the Assembly. So it is very clear, it was very clear that there is a section of the community who are not happy with either the location or the access proposals. From my perspective, I do not think that is a surprise. With my experience in planning you sort of please and annoy in equal measure, is a sort of a bit of a phrase, but we see a lot of positives around planning, we see a lot of negatives around planning. So certainly in terms of impacts there will always be some impacts of development and there will always be certain residents who are not happy with what is being proposed or where it is being proposed. So what I hoped to do on the Parish Assembly last week was to let those parishioners know what the purpose of the Assembly was. It was to

inform their own Parish in terms of the position that Parish is taking in response to the project and especially the conversations that we need to have around land acquisition and Parish land. So the Parish are clearly receiving a very clear message from its Parish Assembly as to the position the Parish of St. Helier is being asked to take. From a project perspective, there are lots of other opportunities as well for the public and parishioners of St. Helier to have a say. Indeed, I would urge all Islanders to have a say. This is a proposal for everybody. There is the planning application, which is the pivotal point of public engagement and public examination. So there will be a public inquiry on the planning application. That process has to look at all of the positives, of which there are many, and balance that against some of the development impacts, which there will be some undoubtedly. Because, as I said, all developments have impacts. That is the balance that the inquiry has to take. It is a challenge for the inspector to have. The inspector will have to balance those things on their decision scales, so to speak, and come up with a recommendation as to whether the benefits of the hospital outweigh some of the impacts that are being seen. So it is important to say that everyone's view is valid, it has to come in. I would urge people to focus on planning matters, planning inquiries, obviously that is where there needs to be some focus. But it gave the project team very much clarity last week as to what the parishioners are asking the Parish of St. Helier to do and how they want the Parish of St. Helier to react to us and the project team.

The Connétable of St. John:

Is it not time to reconsider again access from the Inner Road or even, like Fort Regent, access by elevator?

Director General, Infrastructure, Housing and Environment:

The project team and the team we have are looking at access. They are looking at the realistic ways of getting access. The road proposal that we have is the most realistic way of accessing the site. Road infrastructure already exists. The team have looked at, I guess, a variety of things over preceding months around whether it be cable cars or elevators or lifts, those sorts of things. Simply put, we are talking about the movement of a significant amount of people every day into that facility and out of it, whether it be patients, staff, deliveries, and the like, and visitors. So, whatever mode of transport we are looking at, it has to move masses of people on a daily basis. The honest answer is that a road is the only way of doing that. Other forms of solutions, such as lifts and elevators, can move people but they are not as consistent as a road. They have far more moving parts than a road. We just need to make sure the access is one that works under all conditions and can be consistent.

Deputy Chief Minister:

Could I just come back to the Constable's question about reconsidering access from the Inner Road? At the very early stages of the process to decide which was the best way to improve access, careful

consideration was given to a number of schemes going in from the Inner Road, which involved significantly more impact on property, not least the King George Homes. Also, far more environmental impact as the road would have to go up through Val André and there would be a much greater impact on the natural environment. If I remember rightly, the costs were considerably higher, at the estimate of 2 to 3 times higher than the current proposal for the improvements to Westmount Road. So it would be highly unlikely that would be revisited for those reasons.

The Connétable of St. John:

There is potential in my view for pedestrian and cycle access from the Inner Road, which would not impact on the environment greatly.

Deputy Chief Minister:

That is a very fair point and that is something we can consider. I will turn back to Andy and talk about the sustainable transport corridors and what is planned for through the People's Park and the top end of Val André, and if there is any reconsideration of improving the pedestrian/cycle access from the Inner Road.

Director General, Infrastructure, Housing and Environment:

I will start with the road as proposed currently. We are talking about a standard Jersey road-width carriageway, blacktop bit of road. We have vehicles of about 2.35 metres, we have pressure to extend that limit regulation-wise to take bigger vehicles on our roads. We do see some pressures for 2.4 and certainly upwards to 2.5 metres. But if I stick with the 2.35 metres at the moment that is our general standard width. You need a bit of wriggle room on either side of that, so to speak, to give you a bit of comfort, especially travelling around bends. So drivers do stray, they stray close to the white line, they stray sometimes over the white line. But we ideally do not like to stray over the middle of the line. So I think what I would like to stress first of all to the panel is that the road widths that we are talking about are standard and we see them elsewhere in the Island. It is just something sensible for safety purposes. The other point is that it is also sensible to look at a footway next to the road, either for road safety purposes, but people expect to see a footpath alongside of the road. For me, the cycle enhancement is something we need to look at. This road will be a lower gradient to the one that is there now and there will be more people cycling, either proper cycles or e-cycles. We are seeing technology in cycling increasing substantially and even over the last year to 2 years we are seeing far more e-cycles and the ability of e-cycling is increasing. So we have a duty to look at sustainable transport corridors. We have a duty to look at this corridor. But also other areas as well. So I do not think it is an either/or, it is probably both. If we are going to be clear about delivering some of our carbon targets and transport behaviours, which have to change as a result of our net-zero aspirations, I do think we need to see cycling and walking in far greater locations, not just one road. There are always opportunities to improve a lot of infrastructure across the Island. But where

we come from the sustainable transport corridor perspective we have to try to do our best where we can to build these things in. So that enables that future behaviour to change. As Professor Handa has said, this facility is going to be there for some time. It will be there longer than some of us. But the people who come behind us, it has to be sustainable as well, and I cannot predict what those transport behaviours will be like in 20, 30 years' time. But I can look at current trends. Current trends mean we will see far more electrification of our transport fleets and probably far more autonomous vehicles at some point as well. There is a duty on us to make sure that our roads are a standard size so that those technologies can be handled.

The Connétable of St. John:

Thank you. The design appears to advocate moving Westmount Road away from its current position to a position nearer the top of the cliff overlooking the quarry. Have the stability problems been considered?

Deputy Chief Minister:

The short answer to that is yes. It is a critical part of the proposal. As the design of this road but also of the main structures themselves for the facilities increased, the more survey work we have done. We have been delayed on some of the access to survey work but certainly stability of land is one of those issues that certainly we have taken into account as part of the survey work and will flow through to the ...

The Connétable of St. John:

Perhaps the D.G. (Director General) could share some of the early findings.

Director General, Infrastructure, Housing and Environment:

We are confident that the proposals that we have are deliverable in simple terms. All types of development will need stabilising and foundations of some kind. But we have not seen anything at this point that makes us feel that we should not be looking there.

The Connétable of St. John:

Thank you. Would you be able to provide the panel with the reports you have on the problems of stabilising the rock face please?

Director General, Infrastructure, Housing and Environment:

In terms of sharing information, as the information gets to a stage where it is firmed up and it is more final and it is able to be shared, there is not a problem. Invariably, some of those issues are going to need to be shared in any case as part of the planning process.

The Connétable of St. John:

What consideration has been given to the park and ride proposal for the lower park presented by a member of the public as an alternative to building a multistorey carpark on green zone fields?

Deputy Chief Minister:

Can I start with that? So provision has been given and budget allocated to a park and ride scheme, but not as the sole provider of transport to the scheme. As an additional, as a supplementary scheme. The scheme we were shown by a parishioner is a scheme that has considerable planning implications for the whole of the lower park and I am not sure I am qualified or know enough about the scheme to comment on it. But it is perhaps unlikely to provide a realistic alternative to the transport access that we need to sustain the new hospital. If Andy wants to add anything to that then he can.

Director General, Infrastructure, Housing and Environment:

I agree, Senator. We would need to look at the benefit of people still travelling literally to the same geographic location, parking on open space and then being transited to another location literally just vertically above them. I do not think that would be beneficial. That would certainly increase journey times for those people. If they are in their car it is far more sustainable for them to travel to the front door rather than use a much-needed open space at St. Helier to do so because we are desperately short of open space in St. Helier. All the studies show that. So I do not think we would be supportive of seeing open space loss for that purpose.

[16:45]

Deputy M.R. Le Hegarat:

What about the park and ride going from Patriotic Street Car Park?

Director General, Infrastructure, Housing and Environment:

Where we are talking about car parks that already exist and where we are talking about a hoppa bus service, we are talking about trialling that this year, but certainly to plug the hospital site into the bus network from town, that is different. So especially staff, et cetera. It depends who is visiting for what purpose. We need to look at what is the transport solution for the visit required? If you are visiting somebody you may well be able to plan that more effectively than if you are a member of staff, you will want to travel differently possibly. Certainly if you are a more infirm patient you would want to be closer to the facility. So all of those measures are really important to factor into the transport solution. There is not one size fits all. But the majority of people accessing the facility will need to use their private vehicle to do so.

Deputy I. Gardiner:

A very quick question: would the Minister or team meet or planning to meet with the parishioner to understand the details of this proposal before ruling it out that it is not suitable?

Deputy Chief Minister:

In the past I have had a number of meetings with the parishioner about the scheme. I know enough about it to form an opinion. But that is only an opinion as a layperson. He would really need to forward it or start to get more detailed designs and progress along the planning route. But I also understand that he would perhaps need to seek support from the Parish as well in a similar way.

Deputy I. Gardiner:

The main concern is about how we can avoid a multistorey car park at the green space and to see more park and ride and have limited space or smaller space for parking on the site.

Deputy Chief Minister:

I know. I understand. But I am not sure whether a multistorey car park or layered car parking and complete landscaping of the lower park might also be quite a controversial scheme. So a difficult one. But from my perspective I think it would be difficult to get that one moving.

The Deputy of St. Mary:

Just to add on to the question just raised, you mentioned earlier on about car park journeys, people having to park in one place and then get another thing. I mean that in itself does not allow the fact that a large number of people are already in town, either on a working day or live there, and they do not have to do an extra journey. So it is not so much park and ride as it is the ride bit, which there will be a lot of cases where they do not need to ... they are already in situ, as it were, to make the journey and I am sure that has been taken into account.

Director General, Infrastructure, Housing and Environment:

I would advocate that first of all utilise the car parking spaces within town that we already have. We do have capacity in town. Interestingly, as we have come through the last 18 months we are going back to normality but use of public car parking spaces is varying. We are seeing different patterns for that as people work differently. Firstly, I would always urge people to utilise the capacity that we already have. If you are living in town and you want to access, we are look at the potential hoppa bus service or indeed just routing of standard services via the hospital estate. But also I think it goes back to the point I made around the road and the footpath and the cycle path; it will be of a gradient which is far more usable than the current infrastructure. It is, I guess, modal shift on all fronts really. There will be some journeys that people undertake, they can cycle or walk to the hospital on that occasion. Other times they visit they may well not be able to walk or cycle or indeed get the bus.

So I think we have to cover all eventualities, and indeed the weather. One of the conversations we always have around transport policy, and sustainable transport, about getting people to change their behaviours, it also needs to be weather dependent and it needs to be issue dependent. Therefore the mode of transport needs to suit the journey that you are doing. What we want people to do is just be more mindful about: does the mode of my journey today suit what I need? Therefore we have to make sure the hospital is accessible by both public transport, cycling, walking and private vehicles.

The Connétable of St. John:
Can you confirm what stage the transport assessment and associated framework travel plan are at and also whether the highways R.I.B.A. stages are on schedule to be completed at the same time as the main site elements of the application?

Director General, Infrastructure, Housing and Environment:
If I take the travel plan first. There is a lot of survey work going on and there has been recent survey work done, and now we have access to various pieces of land, especially Parish land, to do that purpose. Understanding how the current hospital is working versus what does the current road network look like up there, that is all very live. There is a lot of survey work going on that is feeding into the R.I.B.A.2 stage of design, which we have reached. Invariably that has to continue because a lot of this transport data has to be put into the transport sections of the environmental impact assessment to accompany the planning application later this year. There is - forgive the pun - more to travel on that. There is still a lot of work ongoing in terms of survey and finalising the detailed design. In terms of the other aspects of the travel plan, in terms of how facilities are used and how the occupier, Health and Community Services, will be asked to use the building, those things can be conditioned and required as a result of planning permission. That is for a later stage.

The Connétable of St. John:
The R.I.B.A., is that on schedule?

Director General, Infrastructure, Housing and Environment:
Yes, it is. We are on schedule and we are looking for a planning application later this year because of the timescales that we outlined at the start of the meeting.

The Connétable of St. John:
When will an evidence and detailed traffic plan be publicised?

Director General, Infrastructure, Housing and Environment:

So again, the main body of publication for that will be the planning application. There will be an environmental impact assessment. With that it needs to include ... transport impact is a big issue for any major development. That will be a point where a foot of paper, effectively, metaphorically - hopefully it will be more digital nowadays - it is a very significant piece of evidence that accompanies the planning application. So it is at that stage later this year where a lot of that data becomes available and again the main focus then is that public inquiry where this needs to be examined by obviously professional inspectors coming in. The Highways Authority will be there on one side of the table and obviously the applicant, the hospital team, will be on the other side, and then third parties will also be there. That is the sort of timescale.

The Connétable of St. John:

Final question from me is: the panel have already asked on a number of occasions, and recommended in its report on the access route, that the Council of Ministers give full consideration to pursuing option 6 of its own proposition, the "do nothing" option. As this would reduce construction time, loss of green space, trees, children's play areas, existing parking spaces, historical sites and disruption to existing modes of access, in the light of continual vocal opposition will this option be fully considered?

Deputy Chief Minister:

I will start with that, if I may. I think the short answer to that is no, it cannot be considered. The infrastructure, as it is, is not deemed capable of supporting the resources and the infrastructure that the new hospital would need. What we did undertake to do was to try and find a solution, which was a blend of option 6 and option 7. That is only making changes to the road where we have to. That is the instruction from the oversight group that has gone to the road engineering team from the start. We have said all the way along, only make changes that we absolutely need to provide the right access, the relevant access and, of course, that would also ensure that the planning considerations are more content with what we are doing. If we do not do anything I just do not think we would get a planning approval because the current infrastructure is not up to the job basically.

Senator K.L. Moore:

I think that is quite clear and we will leave it there. We are mindful of the time however we did start a couple of minutes late, so we may - I apologise in advance - go a little over the 5 o'clock marker but we are now into our final section of questions and I shall be as brief as I possibly can, and hopefully the answers will be also. If we look back at the previous hospital project, one of the criticisms that was often levelled at it was the cost of the process. £41 million was spent and the process went through 2 planning applications. We now see with the latest transfer of funds to cover the cost of this project, until the Assembly agrees the funding stream, that this project is now likely to cost £50 million up to September of this year. Of course, as we have reiterated this afternoon,

that will not get it to the point of having a planning application ready. £50 million in addition to the monies that were spent on the previous project. If I can remind you, in R.54 of 2019, a report that was published by the Chief Minister demonstrating his rationale for this new project, he stated: "Wherever possible the work that has already taken place on the hospital project will be reused, reducing immediate future costs without prejudicing a fresh start on a project burdened by a long and complex history." In short, Minister, the question is: are you content with the level of spending and the value for money that this project team has delivered to a point where you will be in September with still no application ready to go in for planning?

Deputy Chief Minister:

Thank you for that question. I am pleased we have an opportunity to clarify that. I think the Ministerial Decision recently signed by the Minister for Treasury and Resources led to some headlines, although they might have been technically accurate they were and have been open to misinterpretation because the scheme is working within a budget. The original budget for the design and delivery work was for £28 million to take us to the planning determination first; from zero to planning determination. That is one stream. In addition to that, a further £70 million is required, and a large majority of that is in relation to the decant and the transfer of the current services at Overdale to Les Quennevais, and £11 million for the land acquisition that is currently taking place. We have asked that takes us to September because September is when we come to the Assembly and we will be asking 2 things. We will be asking for approval for the overall budget of £804.5 million and we will also be bringing a funding proposition, and these funds enable us to get to that stage. So the Minister for Treasury and Resources has reprioritised funding from within her department to meet those needs. If I can hand over to Hazel very quickly just to, if you want a very brief breakdown of the £70 million and the £11 million ... the £11 million is fairly clear but the £70 million I think that would be helpful. But I will reiterate technically correct; the planning process has been delayed because ... and there is no blame apportioned to anyone. It was just a process. The Assembly instructed us to come back with the access route and that took time. So that pushed everything down the road. That soaked up some of the margin we had for delay, so it just tightened things up a bit but the firm commitment is still to deliver the hospital by the end of 2026.

Senator K.L. Moore:

I appreciate that the Treasury team have been extremely patient today but I think really the line of questioning is far simpler than that. I accept the point that you have attributed £11 million to the cost of acquiring land; that is fine. Then there is the £15 million for Les Quennevais. So we can put those aside as physical delivery of care. £50 million take away the £26 million that we have just identified still leaves £24 million spent on the design and process to date, including what we were told was going to be recycled from the previous project. There is still a considerable level of cost, Minister.

Deputy Chief Minister:

Yes, it is, but it is within our original budget and anticipated cost. I think if we get from day zero to planning determination within that budget of £28 million then we have done well. I can defer to Richard who can talk a little bit about ...

Senator K.L. Moore:

Just if I may. If we recall correctly, the Government Plan identified £20 million for this project to this point. So we are over that budget.

Deputy Chief Minister:

£20 million was allocated. I think the current spend is just over £20 million, £21 million at the moment. So then I will let Treasury explain the detail around that.

[17:00]

In response to your question, yes, I do think we have got very good value for money from the current design team and all the work that is going on. This is a huge project and it is eyewatering amounts of money. We are putting the team under, as is the project director, constant pressure to ensure we get the best value all the way through the project.

Group Director, Treasury and Exchequer:

I can certainly talk about the Ministerial Decisions which have added, as you say, to the overall budget. As you rightly say, the Government Plan for 2021 set out £20 million of funding and then subsequently there was a Ministerial Decision which set out a further £11.2 million, and then the most recent Ministerial Decision, which was signed by the Minister for Treasury and Resources at the end of May allowed an additional allocation of the £17.8 million, which has clearly set out the reprovisioning from other projects, which were set out in the Government Plan. But at a project level have agreed or have set forward that those projects are essentially slipping and that money can be released and diverted to the hospital project, so it does not have any significant consequences for those individual projects and that funding will be revisited in 2022. Those projects, where they can deliver, or they can continue to deliver as previously set out for their individual project plans, that money will be refunded to those projects.

Senator K.L. Moore:

Thank you. Contingency is obviously a factor and optimism bias, is the term I think I am looking for. We are seeing of course that there has been considerable construction inflation in the past year or so and it is likely that inflation across the board will increase in the coming years. Therefore, where

are we at, at the moment, in relation to optimism bias and contingencies? Noting of course ... I think that might be Professor Handa, if you could turn off your microphone, it might be helpful. Thank you. Noting of course that the Minister identified that he will be coming to the Assembly asking for the full £804 million of funding so the question being: where are we at in terms of the contingency return and what margin for error is there left in the project?

Deputy Chief Minister:

The updated figures are all articulated in the outline business case that is coming to you shortly. That breaks down the amount of contingency and optimism bias that we have utilised so far, not just in the design cost or the land acquisition or the decant costs but also in the estimations of the future work. So rather than go through all of that now, which I can if you will give me 30 seconds to find it, I propose we send that to you in the outline business case.

Senator K.L. Moore:

Okay. We will give you that this evening and we look forward to receiving the outline business case in the next week or so. That leads us just simply to the final question which was: in the recent briefings where the designs were unveiled it was said in a number of briefings during the introduction when the Professor revisited the reasons for the need for a new hospital, 3 key reasons were outlined, I think, in those arguments. One being that the current site and the current buildings were too small for the needs of the current population; that the experience for both patients and staff was suboptimal; and that the cost, as we know for maintaining the hospital to current expected medical standards, was about £65 million over the 10-year period that we are currently in. Therefore, with that knowledge, and going through the process that you have to date, Minister, and seeing the eyewatering costs, as you have already described this afternoon, are you content that this project is the right project in terms of value for money, both for the current population and also taking into account the legacy for the Island's children, who will bear the cost of borrowing?

Deputy Chief Minister:

I remember a conversation I had with the Constable of St. John when we talked about this. and he confirmed his support but he said: "Not at any cost." I think the political oversight group have made that clear all the way along. We want a very good hospital. We do not want to build an average hospital, one that will do. We want a really good hospital that will stand the test of time for future generations of Islanders. I do firmly believe that the Overdale site is the right location. It is an elevated peaceful location. We are not just building a hospital there. You cannot compare what we have presented now as a hospital campus with the previous proposal in Gloucester Street. What we are building, we have sort of at least 4 hospitals in one. We have a general hospital, acute hospital, an ambulatory hospital, a maternity hospital, we have a mental health facility, we have a learning centre, energy centre, landscaped parks, gardens and recreational areas in one area. So

we have created something completely different, which comes at an increased cost. But as I said before, it is not always about cost, it is about the value. I firmly believe that as an investment we must move and think past the cost. We must look at the cost in the context of the overall health budget, the money we are going to invest in health over the next 30 to 40 to 50 years, which is the projected life of this facility, which will be billions and billions of pounds, against the asset that the public of Jersey will have. In the future we are acquiring land and we are creating a very valuable asset. In the future, the value of that asset can be realised again, future generations of Islanders might well wish to rebuild - I wish them well if they do - to embark on another hospital project in 50 years' time. I am assured and feel comfortable that we will leave behind a very valuable asset for them to deal with as they see fit.

Senator K.L. Moore:

The 50-year lifespan is pretty much a fact of life, I think, in building terms at the moment it seems. However, we are also very aware that we are struggling at the moment to recruit nurses and doctors. There needs to be room in future budgets for public finances to fund staff costs and make sure that Jersey is a place that people want to come and work and deliver care so that we can afford to offer those services to Islanders going forward. The balance has to be struck between those 2 things because the building is all well and good but it needs to have the ability to provide the services within it. Of course, repaying a considerable loan will impact on those public finances and the ability to pay good salaries. Without wanting to give a speech to you at this point, the question is: is your political oversight group content with that balance going forward that it will be affordable and achievable, and that further restraint should not be sought because of course there is a choice? You had a £466 million choice and, to be fair, when States Members rescinded the Gloucester Street site they were told that doing so would achieve and deliver a cheaper alternative. Now we know today that that is very far from being a cheaper alternative what we are looking at, so we look to you as the political leader to explain how you see it.

Deputy Chief Minister:

I am sure I speak for the whole political oversight group, while the location is important, what is more important is what goes on, on the inside of the building, the technology we invest in and the staff we employ in the future. That is paramount and that is leading the project. Professor Handa said on a number of occasions, it is a clinically-led design, we are designing it from the inside out, and while we want to produce something that is aesthetically pleasing and acceptable, I reiterate what goes on on the inside is more important than anything else. Of course technology is moving so fast in the world of medicine we want a facility that is adaptable and that we can incorporate that new technology in the fullness of time in relation to attracting staff. All I know is that from feedback I have received from officers and Professor Handa, that this new hospital campus will be a huge catalyst in bringing new staff and specialists and experts to Jersey. It will be a place where they want to

come and work. I understand, and Caroline can nod her head or shake her head if she disagrees, but potential new staff and clinicians and people thinking about coming to work in Jersey when they have seen the plans for the new hospital they have been very excited about it. I think that is acting as a catalyst to already start attracting staff. I have spoken a bit about the cost and the value but we also have to remember that there is a benefit for locating as much of the health estate on one site as possible and we will be freeing up a lot of valuable assets around the Island, which can be developed quickly, I hope, for much needed housing for Islanders. We are not building in the benefits of releasing other land or the value of that to the cost of the project, which you could argue could be offset against the capital cost. Our Hospital Oversight Group and myself are firmly committed to the project and confident that we are making the right investment for Jersey and we know we have to work hard to win more hearts and minds and we intend to do that in the weeks and months ahead.

The Connétable of St. Brelade:

If I may, as an add-on to the Constable of St. John's questions regarding access, reaffirm my concern regarding the access from the west and you, Minister, might be in a position to experience in the fullness of time. But I am not really asking for answers now but I would just ask you to consider giving more weighting to those who will need to access Overdale from the west because quite frankly it is unsatisfactory at the moment, in the present plans.

Deputy Chief Minister:

I will give you that commitment, Constable, thank you.

Senator K.L. Moore:

With that, I thank you all very much for your attendance and your answers this afternoon. I close the hearing.

[17:12]