States of Jersey
States Assembly

États de Jersey
Assemblée des États

Health, Social Security and Housing Scrutiny Panel

The Redesign of Health and Social Services

Presented to the States on 5th September 2014

S.R.10/2014

Contents

1. Executive Summary

This report stems from a previous review undertaken by the Panel in 2012 into the Health White Paper: Caring for each other, Caring for ourselves. The Department's White Paper was the starting point for a total redesign of Health and Social Services in Jersey. Following its publication, the Council of Ministers lodged P.82/2012 "Health and Social Services: A New Way Forward", which was approved by the States Assembly in October 2012.

In the main, the Council of Ministers were tasked to bring forward for approval proposals for a new hospital, develop a new model of primary care and a sustainable funding mechanism for health and social care by September 2014.

The Panel started its review in 2013 and aimed to consider the proposals for the future hospital project including the creation of a dual site hospital with single bedded rooms. It also aimed to identify key developments and progress since P.82/2012 was approved, and determine to what extent the Full Business Cases for new community services had fulfilled the original objectives set out within the proposition. Other factors included in the Panel's Terms of Reference which have been examined are the basic assumptions and estimates of future requirements for the hospital, on-island and off-island provision, communication with key stakeholders and funding.

The Panel made a commitment in its Health White Paper report that it would continue to meet with the Minister for Health and Social Services, and to follow the progression of the process. The Panel endorsed the Department's vision for change which aimed to produce better outcomes for Islanders, improve the efficiency and effectiveness of resource use, respond appropriately to demographic changes and relieve pressures on current services at risk of becoming over extended. However, the Panel also emphasised the importance of whole systems planning and concluded that hospital services and services outside of the hospital are part of a continuum of care which should be planned as a whole system. The level and range of services in one part are seen to be dependent on the level and range of services in another if needs are to be met without gaps or breaks in timing. Furthermore, any tendency to plan hospital and other services separately should be resisted if the *right* services are to be available in the *right* places at the *right* time.

Sustainability and viability of hospital services within an integrated health and social care model was the overarching objective set out within P.82/2012. This objective reflects that people at all levels in the health service recognise that they operate within a system with multiple interdependencies. Achieving this objective requires an integrated approach to planning and the need to develop services across the whole remit of health and social care. This has not always been apparent within the redesign process, and the Panel stress that where one sector develops without cognisance of the others the results can be very damaging. The lack of a whole system approach is highlighted by the absence of a new model of primary care, which should have been completed before the end of September 2014. The amount of progress made with this important piece of work is concerning to the Panel, particularly when the Minister for Health and Social Services recognised that it was essential the funding mechanisms for primary care link with the sustainable funding streams for the whole of health and social care. The Panel is unclear what impact the delay in completing the new model of primary care will have on the sustainable funding mechanism for health and social care, which the Minister for Treasury and Resources plans to publish as part of the Long-Term Revenue Plan.

The Panel's overall view is that the process followed for redesigning health and social services is very fragmented. There is no new model of primary care and no acute services strategy, which is a tool to identify and manage a number of key issues when planning acute services. The Panel remain unconvinced that the size and scale of the hospital can be decided until there is a clear direction on what services are going to be provided in hospital. This is particularly concerning when the Health White Paper approved by the States embraced a whole system approach to the delivery of health care. Furthermore, the Panel has found little evidence that the development of health care has been taken forward in a consistent way across the whole system.

The Health White Paper made reference to eight enablers in order for the redesign programme to be successful. One of these was data and informatics to provide co-ordinated management information, including data sharing across organisational boundaries. The Panel has found that the historical lack of investment in IT across the system has resulted in some paper-based systems still being used. The Health and Social Services Department admits that this is inefficient and hinders data sharing and yet there seems to be a lack of urgency to address this important issue. This is of major concern as using traditional paper-based processes to manually enter patient information into patient records is known to be less reliable than automated entry.

The Department's Informatics Strategy indicates a need for a further £12 million funding over the period of the next Medium Term Financial Plan. Although an initial phase of the Informatics Strategy is currently underway, it is disappointing that little progress has been made in bringing technologies up to modern day standards, particularly when the need for improved information systems was identified as far back as the 1990s. The development and implementation of new IT systems or applications that link hospital services with those in the community is absolutely paramount if Jersey's redesign of health and social care is to be successful.

In relation to out-of-hospital services, the Panel found that community services appear to be being implemented as individual projects rather than as part of an integrated approach to providing a whole systems approach to health and social care. Whilst the new community midwifery service is an example of a well implemented individual project, intermediate care has been the opposite. The evaluation of the service was critical of progress since 2012 and raised questions about value for money of the current model and approach.

In order to achieve whole system planning, stakeholder engagement is crucial. The Voluntary and Community Sector in particular will play an important role if more care in the community is provided. The Panel has found that since mid-2013, there appears to be greater communication and more successful engagement between the Health and Social Services Department and Voluntary and Community Sector. Many concerns were raised by some organisations, but the Health Department seem to have taken the concerns on board and modified its engagement strategy to meet the Jersey situation. This has formed the basis for some real partnerships going forward.

The ability to deliver a new model of primary care requires meaningful engagement with all primary care providers. One of the Panel's previous recommendations was for GPs and other primary care practitioners to be actively engaged in the ongoing development of primary care services based on a holistic approach to care and multidisciplinary working. During the period of this review the Panel was disappointed to learn that the relationship between GPs and the Health department became fractious, which resulted in a need for mediation in early 2014. It seems that this has improved the

communication between the two parties, but poor communication in the past has delayed progress in the development of the new primary care model and it is still unclear when an agreement will be reached on a way forward.

As the transformation programme progresses, it is equally important that changes are clinically-led. From the evidence sessions, the Panel note that some clinical engagement had been undertaken, particularly since the appointment of the Clinical Lead of the Future Hospital Project, who is leading on the Acute Services Strategy. The Panel was told on many occasions that the proposals for the dual site hospital had been discussed with clinicians, but the evidence suggests that it was not until June – August 2013 when the dual site concept was suggested. W.S. Atkins, who undertook the pre-feasibility work for the hospital, stated they were frustrated that they were not afforded the opportunity to participate in any meaningful clinical team engagement during their study. This is disappointing particularly when one of the priorities given to W.S. Atkins was to identify an appropriate site on which acute healthcare services could be delivered.

There has been considerable work on the development of plans for new hospital facilities and a multitude of documents have been produced with various options included at different stages. Throughout the review, the Panel have found that it was difficult to follow exactly what had changed through the process, and what the basis for the current decision is.

W.S. Atkins provided cost estimates for 5 site options which had been gradually reduced down from a long-list of 25 potential sites. The 5 options included 3 existing hospital site variants and 2 site variants at the Waterfront. One of the reasons for the Ministerial Oversight Group rejecting the split site on the Waterfront site was the separation of the two sites by the main road which would present significant obstruction to providing the necessary clinical and operations links between the sites. With this in mind, the Panel do not understand why similar concerns have not been given the same prominence when considering the proposal to operate a dual site hospital, from the current hospital site and Overdale, which involves a substantially greater degree of physical separation.

Although both Waterfront options had attractions in terms of potential benefits, costs and ease of construction, the Ministerial Oversight Group decided that any Waterfront option would be out of keeping with the existing Esplanade Quarter Masterplan and would require considerable lost opportunity costs to replace or compensate for the loss of existing uses. Furthermore, the options were considered likely to have a detrimental impact on the development of the Jersey International Finance Centre which is expected to generate an income stream considered essential for the development of a new hospital.

With regards to the decision making process for the future hospital, the Panel concluded that the proposal to go ahead with the existing hospital site in preference to any of the Waterfront options or the Warwick Farm site was not based on estimates of costs as the Waterfront was potentially a cheaper option, but on other considerations the value of which could not be included as a financial figure. The Panel also note that even though a number of other factors seem to have come into play in determining that a greenfield or vacant site would not be chosen, it would have proven best in terms of less risk, more benefits and a lower overall cost.

Originally the preferred option of constructing a new hospital on the existing hospital site was costed by W.S. Atkins who identified a total construction and land cost of approximately £462 million, however the Ministerial Oversight Group subsequently identified a maximum sustainable

total capital funding package of £250 million spread over 10 years coupled with a 10 year programme of investment for the maintenance of existing hospital buildings.

Following the decision to limit the budget to £250 million, the Ministerial Oversight Group appointed a design champion in July 2013. The Panel was surprised to learn that such an important post was not advertised and that the normal process for engaging consultants was not followed. Although the timescale was tight, others, including W.S. Atkins, were not given an opportunity to apply for the post. Furthermore, W.S. Atkins were not aware that an appointment was being made to conduct work of direct relevance to their own pre-existing and continuing appointment.

The Ministerial Oversight Group proposed the funding strategy in June 2013 and requested W.S. Atkins to develop a refined proposal based on their previous pre-feasibility study but within the identified funding available (£297m). An addendum to W.S. Atkins' study was issued in October 2013, which incorporated the dual site concept.

During the Panel's review, a question arose as to who first identified the dual site solution. There appears to be different views on this depending on who is asked. Having looked at the relevant minutes over this period and taking into account a draft report and proposition (dated May 2013) supporting the redevelopment of the existing hospital site, which made no mention of the dual site proposal, it seems most likely that the dual site option was not on the table until it was introduced by the design champion in July-August 2013.

The Panel's view of the dual site proposal is that it differs completely to what was previously approved in P.82/2012. P.82/2012 explicitly commits Ministers to bring forward investment plans for hospital services and detailed plans for a new hospital (either on a new site or rebuilt and refurbished hospital on the current site). The Panel believe that it is stretching the language to describe the dual site approach as a new hospital on a new site or a rebuilt and refurbished hospital on the current one. Rather it is for partial new build and refurbishment on the current site and 100% new build on a second site.

The Panel is of the view that any proposal for a new hospital including the dual site option must be considered and approved by the States. Within P.82/2012 and the 2014 Budget, the States were never asked, or agreed that there should be a dual site hospital and the Panel conclude that no formal decision has been taken on this issue.

The Panel's overall view of the process for the future hospital is that it is flawed. There are many features of the process that are of concern. W.S. Atkins felt that at times they were set unrealistically short timescales for the delivery of information or reports. They also felt that they did not engage fully with key members of the Project Board and as a consequence found it difficult to ensure the Board fully understood the challenges of proceeding down a particular route or direction of travel. The process followed to determine a preferred option for the hospital site was long and drawn out.

Furthermore, W.S. Atkins in producing the pre-feasibility study was not limited by a budget. Whilst this may be appropriate in the initial stages, it should become clear very early on what the budget envelope is likely to be so that appropriate value is obtained from consultant time and expertise.

The Ministerial Oversight Group recently commissioned a Peer Review Panel (PRP) to consider and comment on the proposals to deliver aspects of the reform programme. The PRP's report highlighted a number of issues relating to the redesign process. Some of these include a "data lite" position with the absence of robust data and information in a number of areas, a point emphasised by this Panel within its review of the Health White Paper. The PRP also recommended that the provision of a new hospital is pursued as quickly as possible and the implications of the two site approach are assessed in terms of risk and mitigations are identified and applied. The Panel supports the overall conclusion of the PRP's report which reads: "*This is a significant moment for Jersey. Getting this system reform right makes a big statement to the people of Jersey and those outside the jurisdiction*".

2. Key Findings and Recommendations

Key Findings

Please note: Each Key Finding is accompanied by a reference to that part of the report where further explanation and justification may be found.

The Panel's Key Findings are presented in five sections, *General, Whole System Planning*, *Community Services, Future Hospital and Funding*. They have been grouped for ease of reading and are not necessarily presented in the same order throughout the report.

General

1. The Peer Review commissioned by the Ministerial Oversight Group made 11 recommendations in total, many of which mirror the Scrutiny Panel's findings and recommendations contained in its "Health White Paper" report (S.R.7/2012) [section 6].

2. The Peer Review commissioned by the Ministerial Oversight Group, were not provided with W.S. Atkins full report, its addendum or the additional studies undertaken by W.S. Atkins. The review seemed to focus on earlier work undertaken by KMPG in 2011 [section 6].

3. The original intention was to provide mental health facilities at the Overdale Hospital site. The dual site hospital proposal has impacted on this vision, and an alternative facility will need to be identified as part of the Mental Health Review [section 7].

Whole System Planning

4. The Council of Ministers agreed that proposals for the new model of primary care should be delivered by the end of September 2014 in order to align them with the related proposals for sustainable funding of health and social services. However the Panel has found that the new model of primary care will not be delivered by the end of September 2014 and a new date for completed has been proposed for April 2015 [section 6].

5. The development of the primary care service model has experienced some significant difficulties and yet the configuration and delivery of hospital services has a significant dependency on the nature and implementation of that model [section 7].

6. Achieving the Health White Paper's objectives requires an integrated approach to planning and developing services across the whole system of health and social care. The Panel has found little evidence that a whole system approach has been undertaken. This is concerning to the Panel because if one work-stream is developed without cognisance of the other, the successful delivery of the redesign programme is put at risk [section 7].

   <u>Information Services</u>

7. The Panel's previous review of the Health White Paper found in 2012 that the current I.T. system was not integrated between primary and secondary care and was a problem which

required urgent resolution. The Panel has found that this issue is still outstanding [section 6].

8. Informatics and technology are essential to deliver and monitor the service changes and transformation described in the Health White Paper. The Minister for Health and Social Services acknowledged the lack of historical data and made a commitment in 2012 that work would be undertaken to address this issue. The Panel has found that little progress has been made in this area, which is disappointing particularly when the need for improved information systems was identified as far back as the 1990s [section 7].

9. One of the overall conclusions contained in the Comptroller and Auditor General's report "Use of Management Information in the Health and Social Services Department – Operating Theatres" was that improvements to management information should be seen as a priority. The Panel wholeheartedly agrees and expects the Health Minister will take heed of the C&AG's report and its recommendations and conclusions [section 7].

Recruitment and Retention

10. The Commissioning team acknowledged that there is a limited pool of health staff available on the Island which will have an impact on service development and delivery [section 7].

Communication and Engagement

11. Since 2012, there has been an improvement in the level of communication between the Health Department and members of the Voluntary and Community Sector [section 8].

12. Recent mediation in 2014 has improved the relationship between the Health Department and General Practitioners. However, poor communication during 2012/2013 has caused a delay in the development of a new model of primary care [section 8].

13. One of the priorities given to W.S. Atkins was to identify an appropriate site on which acute healthcare services could be delivered. However, their evidence to the Panel stated that they found it frustrating that they were not afforded the opportunity to participate in meaningful clinical team engagement [section 8].

Community Services

14. The timeline for completion of the Full Business Cases to introduce more community services, originally due to commence in January 2013, was ambitious and due to a number of factors the timeline changed considerably [section 6].

15. The impact of delaying the implementation of community-based care strategies will have a significant effect on determining the size of the hospital [section 9].

16. Following the implementation of the Community Midwife Service most views from GP surgeries were positive about the new system of providing an island-wide antenatal care service in accessible non-hospital settings [section 9].

17. Even though the Specialist Fostering service was brought forward to 2013, no specialist foster carers have been appointed to date [section 9].

18. There is a lack of available health visitors on the Island to undertake training for the Sustained Home Visiting Programme and therefore it has been necessary to recruit from the UK. Family Nursing & Homecare are still in the process of recruiting, and they are therefore unable to implement fully the Sustained Home Visiting Programme [section 9].

19. It is unclear to what extent the White Paper development in out-of-hospital care has been taken forward successfully. The one review undertaken by the Health Department - of the intermediate care pilot - is highly critical in that it indicates a lack of readiness to initiate the service as well as a failure to put in place systems to monitor adequately the use of these resources [section 9].

Future Hospital

20. Proposition P.82/2012 “Health and Social Services: A New Way Forward” required the Council of Ministers to bring forward proposals for investment in hospital services and detailed plans for a new hospital (either on a new site or rebuild on the current site) by the end of 2014. This included full details of all manpower and resource implications necessary to implement such plans [section 10].

21. The Ministerial Oversight Group considered a Communication Plan for public consultation. Its aim was to confirm the preferred site through a States decision to enable detailed feasibility work to follow and design for a new hospital to be developed and procured. However the Panel has concluded that no States decision has been taken on this issue despite being the original intention of the Ministerial Oversight Group [section 8].

22. Although the Department has undertaken some form of consultation on the future hospital, the Panel would have expected to have seen greater and more meaningful public consultation, together with a more detailed analysis of the results [section 8].

23. Concerns have been highlighted by the general public and States of Jersey employees about the dual site proposal in relation to operating from two sites, efficiency and transport. The Panel has seen no evidence that these concerns have been addressed [section 8].

24. One of the reasons for rejecting the Zephyrus site (Waterfront) was the separation of the sites by the main road which would present significant obstruction to providing the necessary clinical and operational links between the sites. This is inconsistent with the later proposal by the Ministerial Oversight Group to operate a dual site hospital from the current hospital site and Overdale, which involves a substantially greater degree of physical separation [section 10].

25. At a Ministerial Oversight Group Sub-Group meeting in February 2013, the Chief Executive of the States expressed a view that unless the cost of the scheme could be reduced down to the levels identified in R.125/2012 (between £389m - £431m), it would be necessary for the project to consider what clinical compromises were necessary to achieve a total project cost of below £400 million [section 10].

26. Although the Waterfront options had attractions in terms of potential benefits, costs and ease of construction, the Ministerial Oversight Group Sub-Group agreed that any Waterfront option would be out of keeping with the existing Esplanade Quarter Masterplan and would require considerable lost opportunity costs to replace or compensate for the loss of existing uses. Furthermore, the options developed were considered likely to have a detrimental impact on the development of the Jersey International Finance Centre which would form an income stream considered essential for the development of the new hospital [section 10].

27. A wide range of sites were considered by W.S. Atkins between May 2012 and June 2013 including greenfield sites, and many of these were worked up into relatively detailed costings. The preferred option that emerged was to rebuild on the existing General Hospital site. However the introduction of a reduced budget envelope necessitated a reconsideration of this choice [section 10].

28. Although the preferred site option developed by W.S Atkins identified a total new construction and land cost of approximately £462 million, the Ministerial Oversight Group subsequently determined a maximum sustainable total capital funding package of £250 million (excluding contingency) [section 10].

29. The design champion identified that a single investment in the General Hospital site would not maximise the benefit of the available investment and would result in a more lengthy and complicated construction programme causing significant disruption and inconvenience to patients. The Panel has found no evidence of his analysis on public record to enable an assessment of the factors taken into account or the robustness of judgements derived from it [section 10].

30. W.S. Atkins felt that at times they were set unrealistically short timescales for the delivery of information or reports. They also felt that they were not able to engage fully with key members of the Project Board and as a consequence it was difficult to ensure that they fully understood the challenges of proceeding down a particular route or direction of travel [section 10].

31. It was not until May 2013 that W.S. Atkins were informed of the available budget for the future hospital project. While it may be appropriate that in the initial stages the contractor is not limited by budget, it should become clear very early on what the budget envelope is likely to be so that appropriate value is obtained from consultant time and expertise [section 10].

32. A greenfield site for a new hospital would have been the best option in terms of less risk, more benefits and a lower overall cost [section 10].

33. The process followed to appoint the design champion was flawed. Others were not given the opportunity to apply for the post and W.S Atkins were unaware that an appointment was being made to conduct work of direct relevance to their own pre-existing and continuing appointment [section 10].

34. Although the dual site offers a potential solution for a reduced budget, the current proposal means that 44% of the existing hospital will be new build, 30% will be refurbishment and the remainder will be existing use. This will inevitably result in a need for further capital investment in the future [section 10].

35. The result of W.S. Atkins pre-feasibility study dated May 2013 was that a phased development of the existing hospital site offered the best location for key investment in future hospital capacity following which a draft Report and Proposition was prepared detailing the outcome of the pre-feasibility study. The Panel note that this did not mention Overdale hospital or the dual site concept [section 10].

36. There are conflicting views on who identified the dual site solution. On the balance of the evidence, it seems most likely that the dual site solution had not been identified as an option until it was introduced by the design champion in July/August 2013 [section 10].

37. During the development of the future hospital, options have been continually developing. As assumptions change the basis for comparisons also change and it is therefore necessary to present clearly what is included in the various options. This has not always been apparent in the documentation provided to the Panel and it is therefore questionable whether all option have been compared on a like for like basis [section 10].

38. The proposed dual site option is not included in previous options produced by W.S. Atkins and which reflected the original brief, which in turn reflected the intention of P.82/2012. The impact on patient care of this decision to go with a lesser mix of new and refurbishment has not been made clear and is not in the spirit of the decision to provide new modern hospital facilities in Jersey [section 10].

39. Although estimated revenue figures will be refined alongside the detailed feasibility work, the additional cost of operating on a dual site is estimated by the Treasury Department to be an annual recurrent cost of £1.7 million in 2019 when the Overdale site is planned to be opened. The Panel has found that as the dual site concept was identified at a late stage, a high level analysis of the estimated revenue consequences had not been undertaken when all other options were being considered [section 10].

40. There is a lack of clarity around the decision-making process in determining the size of the budget and why a 100% new build hospital was unaffordable [section 10].

41. The Panel conclude that although mention was made of the dual site proposal in the 2014 Budget report, no formal decision has been taken on this issue as it was not included in the proposition [section 10].

42. The purchase of the two hotels in Kensington Place would make a sensible strategic investment for the States of Jersey as well as providing space to facilitate the development of the existing site [section 10].

43. Due to the limited budget proposed by the Ministerial Oversight Group, W.S. Atkins explained that a target figure of a 15% reduction of room sizes below the UK NHS spatial guidance has been adopted [section 10].

44. The 1960s building situated at the current hospital site has been excluded from the planning as it is not fit for clinical use. Therefore, at the end of the hospital project, the 1960s building will still stand but it is not clear what purpose it will serve in the future, or whether optimum value from the current site is being achieved [section 10].

45. Although the plan is for the Overdale site to be completed by 2019, the overall hospital project will be completed by December 2024. The cost of the project so far totals £574,534 [section 10].

46. There appears to be a lack of progress in strategic planning for acute services and services provided on-island/off-island since 2012. The acute services strategy is not complete and as with the absence of a primary care strategy, has created major difficulties for the Panel in reaching a conclusion about the robustness of the plans for the role, range and scale of future hospital services [section 10].

47. One of the reasons for the dual site concept was because of the potential disruption redevelopment of the current hospital site would cause for staff and patients. The Panel accepts that construction by its very nature does cause disturbance, but there are ways to minimise this both for patients and staff. Lessons and experience from other hospital redevelopments which have managed their levels of disturbance well could have been explored further rather than opting for redevelopment and new build over two sites [section 10].

Funding

48. The Minister for Treasury and Resources stated that the central assumption for growth in the Strategic Reserve is based upon investment returns averaging 5 per cent over the next 10 years. The Minister also stated that with such an investment return, the hospital funding of £297 million can be fully met and the Strategic Reserve would rise to a value of £810 million. It is unclear what the plan will be if the fund does not return the anticipated sum of money when it comes to funding the capital projects [section 10].

49. The Minister for Treasury and Resources made a commitment within the Budgets 2014 and 2015 that the hospital project will be fully paid for by the time it is completed and there will be no cost to the taxpayer and no debt for future generations [section 10].

50. The Long-Term Revenue Plan is being developed by the Treasury and Resources Department. This aims to provide a higher level of funding certainty and will enable long-term sustainable financial planning by the Health Department. It is understood that the sustainable funding mechanism for health and social care will be achieved via the Long-Term Revenue Plan by the end of September 2014 as agreed in P.82/2012 [section 11].

51. The Long-Term Revenue Plan will confirm the level of investment in health and social services into the future. The Panel was informed that it will not propose a separate health fund in addition to the existing Health Investment Fund and Long-Term Care Plan. The Treasury Department explained health services are a public good and as such must be rationed to prevent an unsustainable impact on the wider Jersey economy [section 11].

52. The Minister for Health and Social Services recognised the requirement that the funding mechanisms for primary care link with the sustainable funding streams for the whole of health and social care and that proposition bii and biii in P.82/2012 link together. It is therefore unclear what impact the delay in completing the new model of primary care will have on the sustainable funding mechanism for health and social care [section 11].

53. The work being undertaken to develop a new model of primary care and sustainable funding mechanism for health and social care is likely to impact on the Health Insurance Fund held within the Social Security Department. It is expected that an increase in contributions will be required from individuals in the future [section 11].

54. The Long-Term Capital Plan, published as an appendix to the Medium Term Financial Plan 2013 – 2015 and developed by the Treasury and Resources Department, estimates that £332 million would be required in 2016 for the hospital but this figure did not reflect additional costs of construction in Jersey compared to the UK. The budget figure was to be developed once there was greater certainty arising from the feasibility work [section 11].

55. Within the 2015 Budget it is proposed that contributions to the Long-Term Care Fund in 2014 and 2015 are deferred in order to balance the Consolidated Fund [section 11].

Recommendations

1. The Peer Review Panel's report on the reform of health and social services should be published by the Ministerial Oversight Group along with a formal response to its 11 recommendations before the Budget 2015 debate.

2. Detailed proposals to develop and fund a fully integrated I.T. system should be included in the Medium Term Financial Plan 2016 – 2019.

3. The Treasury and Health Ministers should respond to the specific aspects of the C&AG report: "Use of Management Information in the Health and Social Services Department – Operating Theatres" within the next three months and publish their conclusions about the implications of its findings for the work conducted to date on the planning and development of hospital and out-of-hospital services.

4. Together with the Council of Ministers, the Minster for Health and Social Services must ensure that the new population policy to be agreed by the States in 2015 is taken into consideration when determining the size and scale of the future hospital.

5. The financial and other consequences of the dual site option for the delivery of mental health services and associated facilities must be identified and understood prior to any decision involving the future of acute hospital services and where they are located.

6. Regardless of any future decision to use the Overdale site for hospital services, an appropriate site for mental health services should be identified as part of the Department's review of mental health which will be produced in March 2015.

7. An action plan to ensure the delivery of all eight key enablers should be produced along with appropriate time scales and presented to the States within the next twelve months.

8. Proposals for the new model of primary care should be finalised and agreed by the States at least two months before the Medium Term Financial Plan 2016 – 2019 is debated.

9. Work undertaken by the design champion should be independently reviewed by a fully qualified cost adviser to ensure that the overall cost of the dual site option can be compared with other options considered by W.S. Atkins on a level playing field basis. The result of this work should be published and reported to the States within a six month period.

10. Further work should be undertaken to determine what impact the proposed dual site option based on budget of £297 million will have on patient care in both the medium and longer term and a detailed explanation should be provided to the States on why a 100% new build hospital is unaffordable. This should be completed before seeking a formal decision on the site of the future hospital.

11. The Treasury Minister should provide a detailed plan setting out what actions would be taken if the Strategic Reserve does not return the anticipated return expected from investments within the next six months.

12. The Council of Ministers should lodge a proposition prior to the lodging of the Medium Term Financial Plan 2016 - 2019 to ask the States Assembly to decide on the site for the future hospital in order for a formal decision to be made on this issue.

13. A ten year timeframe to develop a new hospital is unacceptable and Council of Ministers should review both the timescale and the overall budget envelope to ensure that any new hospital will meet the future needs of the Island. This should be completed within the next twelve months.

14. The Panel recommends that percentage for art (based on 0.75%) for the total construction cost of a development should not be allocated for the future hospital project.

15. In parallel with the work being undertaken to develop a new model of primary care and a sustainable funding mechanism for health and Social care, the Social Security Minister should present to the States the long term contribution proposals to support the existing Health Insurance and Social Security Funds.

3. Chairman's Foreword

Since the approval of P.82/2012 "Health and Social Services: A New Way Forward" the Panel has undertaken an extensive review of the proposals including new community services, the future hospital project, a new model of primary care and the sustainable funding mechanism for health and social care. The main aim of the Panel's review was to ensure that the proposals contained within P.82/2012 deliver the anticipated improvements at an affordable cost and at the high standard Islanders should expect.

Evidence suggests that our Island's aging population is growing – by 2040 we will see the number of those aged over 65 increase from 14,797 to 28,882. At the same time, the population of working age adults is projected to decline by 9% (57,762 in 2010 to 52,263 in 2040). This demographic change will create a huge surge in the demand for health and social care. The existing health and social services on the Island are already close to full capacity and to accommodate this increase in demand, we, the States of Jersey, need to take action.

If the proposals contained in P.82/2012 are delivered successfully, we are heading in the right direction to accommodate this increase in demand. It is imperative that the Council of Ministers fulfil the commitments made by the States during the debate on P.82/2012. This review has highlighted some significant issues in the delivery of those commitments.

The new model of primary care will not be delivered by the agreed timescale. The States can now expect to consider a strategy, with funding options, in April 2015. The delay was due to a number of factors including a communication breakdown between the Health Department and General Practitioners. We acknowledge that a mediation session which took place earlier this year has improved the relationship and things are now moving forward. We are unclear what impact the delay has caused, as there has been much emphasis on the new model of primary care linking together with the sustainable funding mechanism for health and social care. We have been told that the sustainable funding mechanism will be achieved through the completion of the Long-Term Revenue Plan by the end of September 2014.

Our concluding thought on this matter is that there can only really be certainty over the size and cost of the hospital once both of these pieces of work have been completed together. This has led to one of our main findings that a whole system approach is not being undertaken, and yet is paramount to the successful delivery of the redesign. Another example of this is the Acute Services Strategy, which is only now being developed. We are concerned that hospital development plans are continuing to be taken forward within a context of what may be significant uncertainty about the mix and scale of acute services. We have continuously asked ourselves: how can the size and scale of the hospital be realistically decided until there is clear direction on what services are going to be provided in hospital?

In relation to out-of-hospital services, we have found that some of the new services provided within the community have been implemented successfully, such as the new Community Midwifery Service. Other services such as Specialist Fostering and the Sustained Home Visiting Service, however, have faced some difficulties with recruitment and have not been implemented fully.

With all of the change happening around primary and secondary care, it is absolutely paramount that our information systems are the best they can possibly be. We are disappointed that little

progress has been made in this area, particularly when the need for improved information systems were identified in the 1990s.

In relation to the future hospital, we have reviewed how this decision was reached and conclude that a strong emphasis in reaching the decision was put on the overall budget envelope. We remain unclear how the budget of £250 million was reached and why it took so long to determine a maximum amount. The effect of a reduced budget means that a 100% new build hospital will not be provided and a dual site hospital has been hailed the preferred option. We believe this option will require further additional costs in the future.

We do support the redevelopment of the Overdale site, but believe it should be used to provide improved mental health facilities, as this was the original intention before the dual site option was identified. We are of the opinion that acute services should, if at all possible, be retained on one site and remain unconvinced that a dual site is the right way forward for Jersey's acute care.

In that regard, we have also concluded that no formal decision has been taken on the future hospital and recommend the Council of Ministers to lodge a proposition prior to the next Medium Term Financial Plan so that a formal States decision can be taken.

We do accept that change does not happen overnight, but these matters are essential if the redesign programme is to be a success. We feel that a 10 year timeframe to develop a new hospital is unacceptable, especially when money is being spent now on a continuing programme of refurbishment in order to bring the hospital standards to an acceptable level.

We would like to acknowledge the contribution made by officers within the Health Department and other key stakeholders in assisting us with our review. We are also grateful to our advisors for the support and advice they have given us.

Finally, I would also like to record my heartfelt thanks to our Scrutiny Officer and my fellow Panel Members for their dedication and hard work in producing this report.

Deputy Jackie Hilton
Vice-Chairman, Health, Social Security and Housing Scrutiny Panel

4. Terms of Reference

The following Terms of Reference were agreed for the review:

1. To consider the proposals of the Minister for Health and Social Services in relation to the future hospital project in particular –

    a. The creation of a 2-site hospital with some services based at a second location
    b. Separation of emergency and inpatient overnight-care from outpatient daycare
    c. Single bed wards
    d. The implications for cost and quality of each of the above
    e. How implementation risks will be identified and managed

2. To determine whether the basic assumptions and estimates of future requirements for the hospital are well founded in relation to predicted utilisation levels, demographic projections and the Minister's preferred models of care

3. To assess the current contributions of on-island and off-island provision and the extent to which the existing analyses and proposals explain and substantiate changes in the balance and nature of their respective roles

4. To identify the key developments and progress since P.82/2012 – A New Way Forward for Health and Social Services – approved by the States in October 2012 and in particular to determine to what extent the Full Business Cases have fulfilled the original objectives as set out in P.82/2012

5. To assess to what extent key stakeholders, in particular General Practitioners and the Voluntary and Community sector, have been included in the development of the Full Business Cases and the proposals for hospital services

6. To establish what funding and other resources will be required to support the revenue as well as the capital costs of services to be provided inside and outside the hospital.

5. Panel Membership

The Health, Social Security and Housing Panel comprised the following Members:

Deputy Kristina Moore, Chairman

Deputy Jacqueline Hilton, Vice-Chairman

Deputy James Reed

Senator Ferguson, Co-opted Member

This review was led by Deputy Jackie Hilton, the Vice-Chairman of the Panel due to Deputy Kristina Moore being on long term leave due to illness.

Expert Advisors

The Panel has engaged Mr Seán Boyle and Mr Gerald Wistow as its expert advisors. The Panel was very pleased to be working with both Mr Boyle and Mr Wistow again, as they had assisted the Panel with its previous review into the Health White Paper.

Mr Seán Boyle

Seán Boyle is a health planning and policy consultant with experience of working at senior level with public and private sector managers, civil servants and politicians (both local and national), and a detailed knowledge of the public policy environment in the UK. He is also a Senior Research Fellow in Health and Social Care at the London School of Economics. His clients have included the Department of Health, the Scottish Parliament, the House of Commons Health Committee, the King's Fund, the Department for Work and Pensions, Chichester District Council, and the Criminal Justice Performance Directorate of the Home Office.

Professor Gerald Wistow

Gerald Wistow is Visiting Professor in Social Policy at the London School of Economics. He has previously been co-director of the Centre for Social Policy Research at Loughborough University, Professor of Health and Social Care and Director of the Nuffield Institute for Health at Leeds University and Chair of Hartlepool Primary Care Trust. He is currently a specialist advisor to the House of Commons Health Committee in the UK. He has published extensively on a wide range of health and social care issues.

Glossary

FBC –	Full Business Case
OBC –	Outline Business Case
MOG –	Ministerial Oversight Group
HASSMAP –	Health and Social Services Ministerial Advisory Panel
PRP –	Peer Review Panel
ICR –	Integrated Care Records
C&AG –	Comptroller and Auditor General
JPH –	Jersey Property Holdings
PCB –	Primary Care Body
MTFP –	Medium Term Financial Plan
LTCP –	Long-Term Capital Plan
LTRP –	Long-Term Revenue Plan
JAA –	Jersey Alzheimer's Association
IAPT –	Improving Access to Psychological Therapies
COPD –	Chronic Obstructive Pulmonary Disease
FN&HC –	Family Nursing & Home Care
JOD –	Jersey Online Directory

6. Introduction

A proposition (P.82/2012) which proposed a radical redesign of health and social services was approved by the States in 2012. Since then, the Health and Social Services Department ("the Health Department") has been working up plans to implement new services within the community (out-of-hospital services) and for a new hospital. The Panel agreed to undertake a review of these plans and their initial implementation as a natural progression from its previous review of the Health White Paper (S.R.7/2012).

This report is intended to update States Members and the public on progress to date in the implementation of this significant service redesign programme which will take ten years to deliver. The report's findings are based on the information the Panel has collected during 2012, 2013 and 2014.

The proposed redesign of Health and Social Services: an overview

The Health Department published a Green Paper in 2011 which asked for the views of Islanders on three scenarios for future health and social care services. The Green Paper was preceded by a KPMG report which reviewed how services were provided and what steps would be required to ensure that Jersey could offer good quality care into the future. The results of the Green Paper were analysed and developed into a White Paper: "Caring for each other, Caring for ourselves".

In order to plan and deliver the redesign of health and social services, the Health White Paper identified eight enablers[1]:

1. Workforce
2. Estates and Facilities
3. Primary Care
4. Technology
5. Data and Informatics
6. Commissioning
7. Funding
8. Legislation and Policy

These enablers were identified as being essential to the successful delivery of the programme. They are discussed in further detail later in the report. The White Paper was put out for public consultation and the final Report and Proposition (P.82/2012) was lodged in September 2012. The Proposition was accepted by the States Assembly on 23rd October 2012 and required the Council of Ministers to co-ordinate the necessary steps to bring forward for approval:

- "Proposals for the priorities for investment in hospital services and detailed plans for a new hospital (either on a new site or a rebuilt and refurbished hospital on the current site), including full details of all manpower and resource implication necessary to begin implementation of the proposals by the end of 2014";

[1] Health White Paper "Caring for each other, Caring for ourselves, page 27

- "Proposals to develop a new model of Primary Care (including General Medical Practitioners, Dentists, high street Optometrists and Pharmacists), by the end of 2014"; (amended during the States Debate to end of September 2014)
- "Proposals for a sustainable funding mechanism for health and social care, before the end of September 2014"

The Case for Change: Health White Paper

According to the study by KPMG, between 2010 and 2040 there will be a 95% increase in the over 65 population (14,797 to 28,882), with a 35% increase by 2020[2] (14,797 to 19,982). P.82/2012 explained that this growth would create a significant increase in demand for health and social care services. Although current services were performing generally well, they were close to capacity and would not be able to accommodate the predicted increase in demand.

Many health and social care staff are approaching retirement age which make current services vulnerable. Of these, some are "generalists" who can treat a wide range of conditions. However as there is a higher degree of specialisation in professional training now, meaning the existing consultant staff cannot be replaced on a like for like basis[3]. P.82/2012 also explained that recruitment of skilled staff is increasingly difficult given Jersey's high cost of living and the competitive remuneration packages for similar staff in other countries[4].

These are important drivers of redesign for health and social care. In summary, a new model of health and social care was identified as being necessary in response to expected increases in demand so that the skills of local staff can be used to the maximum and new roles created which will attract additional staff to work in Jersey[5]. The overarching objective of this model is for sustainable and viable hospital services operating as part of an integrated health and social care system.

Health White Paper Review: A New Health Service for Jersey: the way forward (S.R.7/2012)

The Panel presented its report on the Health White Paper in October 2012. It included a review of the Green and White Papers together with an analysis of the proposition (P.82/2012) which sought approval from the States Assembly for the redesign programme.

The Panel concluded that the proposition[6] should be welcomed in general terms, and emphasised that its scope and scale would necessitate a challenging process of whole systems planning to synchronise the introduction of many new services, some of which were reliant on the recruitment of specialised staff. In particular, the Panel recognised the importance of carefully phasing the development of services in the community with any change in the role and volume of hospital

[2] Health and Social Services Department, Green Paper: Caring for each other, Caring for ourselves, page 3
[3] P.82/2012 Health and Social Services: A New Way Forward, page 8
[4] P.82/2012 Health and Social Services: A New Way Forward, page 8
[5] P.82/2012 Health and Social Services: A New Way Forward, page 8
[6] P.82/2012 Health and Social Services: A New Way Forward for Health and Social Services

services. The Panel also recognised existence of immediate pressures caused by the condition of existing hospital estate which could not wait 10 years.

The Panel endorsed the Department's vision for change which aimed to produce better outcomes for Islanders; improve the efficiency and effectiveness of resource use, respond appropriately to demographic change and relieve pressures on current services at risk of becoming over extended. However, it did question whether the proposals contained in the proposition would deliver the anticipated improvements in health and social services at an affordable cost and with the degree of effectiveness Islanders are right to expect.

In order for the redesign to be a success, the Panel also emphasised the importance of the relationship with the Voluntary and Community sector. It noted that, at times, better communication with voluntary and community organisations would have been advantageous. This finding was of particular significance because the Panel recognised the delivery of the new service model would depend on close collaboration not only within the publicly funded health and social care system, but also between it and the non-statutory sector.

Collaborative working was noted as a priority area specifically relating to the new funding model of primary care and communication with GPs. It was particularly important that this work was developed with full GP involvement and support. The Panel felt that this issue was of such significant importance that it lodged an amendment to P.82/2012 to bring forward proposals to develop a new model of primary care by the end of 2013, rather than 2014. The Council of Ministers welcomed the high priority the Panel placed on primary care but was unable to accept the amendment due to the complexity of the primary care development work. However, it did agree that proposals for the new model of primary care should be delivered by the end of September 2014 in order to align them with the related proposals for sustainable funding of Health and Social Services.

KEY FINDING: The Council of Ministers agreed that proposals for the new model of primary care should be delivered by the end of September 2014 in order to align them with the related proposals for sustainable funding of health and social services. However the Panel has found that the new model of primary care will not be delivered by the end of September 2014 and a new date for completed has been proposed for April 2015.

The Panel also concluded that informatics would play a major role in the success of new service models. The drive to develop community services would be reliant on good quality I.T. systems which ensured the highest standards of patient data handling especially if patient information is to be available to multidisciplinary teams. At the time of its review, the Panel found that the current I.T. system was not integrated between primary and secondary care and was a problem which required urgent resolution.

KEY FINDING: The Panel's review of the Health White Paper found in 2012 that the current I.T. system was not integrated between primary and secondary care and was a problem which required urgent resolution. The Panel has found that this issue is still outstanding.

The Minister's Response

In her response to the Panel's report, the Minister agreed that the amount of change was unprecedented, and emphasised that the associated challenges should not be underestimated. The detailed plans for service changes to community services would be prepared through the development of Full Business Cases (FBCs). This process would engage a wide range of stakeholders including clinical and professional staff, the Voluntary and Community sector and GPs. The Minister also recognised that these individuals and organisations had a good understanding not only of Islanders' health and social care needs but also the effective delivery of services to meet such needs. Their input would be critical to ensuring that the plans were achievable, and had broad ownership.

The Minister also advised that implementation plans would be kept under review and, if necessary, would change over time. The FBCs would contain detailed service specifications setting out what services were required, and the metrics and measures used to monitor delivery and timescales for implementation. The Minister acknowledged the lack of historical data and she advised that work would be undertaken to provide more robust routine monitoring data. This is discussed in further detail later on in the report.

Review of the Redesign of Health and Social Services

Following States approval of P.82/2012 the Department has been preparing detailed business cases for the development of key services, some of which were to be implemented during 2013. The Panel started its review into community services via the FBCs in November 2012, shortly after receiving a timeline from the Health Department. The timeline for completion of the FBCs by the end of January 2013 was ambitious and, unfortunately, due to a number of factors the timeline changed considerably.

KEY FINDING: The timeline for completion of the Full Business Cases to introduce more community services, originally due to commence in January 2013, was ambitious and due to a number of factors the timeline changed considerably.

During 2012 and 2013, the Panel's work has included several meetings with the Minister for Health and Social Services and her Officers to understand the process and revised timeline. Regular updates have been received from the Department as requested by the Panel, and the progress of the FBCs has been scrutinised during quarterly hearings with the Minister.

The Panel's original intention was to review only the FBCs and focus its attention on out-of-hospital (community) services. However the Panel agreed at the end of 2013 to add the future hospital project to its review[7]. The main driver for this decision was the degree of interdependence between community and hospital services. Undertaking two reviews would not only have been more time-consuming but also separating the two topics would have been difficult to manage.

Following its decision to merge the two reviews, the Panel revised its Scoping Document to include the hospital and approved a new set of Terms of Reference which are detailed at the front of this report. The Panel's work has included collating all of the information received during 2012 –

[7] It was at this stage Senator S.C. Ferguson was co-opted onto the Panel

2014 and holding a series of meetings and Public Hearings with Ministers and relevant stakeholders. The Panel also corresponded with W.S. Atkins who were the leading consultant in the work undertaken on the pre-feasibility study for the future hospital. The correspondence can be found in appendix one of this report.

Peer Review of Reform of Health and Social Services

The Ministerial Oversight Group recently commissioned a Peer Review Panel (PRP) to consider and comment on proposals to deliver aspects of the reform programme for the provision of health and social care services in Jersey by 2021. The Panel's Membership was as follows:

- Sir David Henshaw
- Dr Patrick Geoghegan
- Mr Andrew Williamson
- Dr Clare Gerada
- Professor John Appleby

The Chairman of the PRP, Sir David Henshaw, met with the Scrutiny Panel on 30th July 2014. He explained that the review was "short and sharp", and was based on written material supplied by the States of Jersey. They met with key senior departmental officers of Health and Social Services, Treasury, Property Holdings and Social Security over three days but did not have discussions with carers, users or health professionals. The Chairman explained that the Terms of Reference for the review, which can be viewed in full in appendix two, were initiated by the Ministerial Oversight Group.

The Terms of Reference included examining the KPMG modelling work, making comments on the progress of the plans as described in P.82/2012 particularly in the context of the overall States of Jersey Reform programme, and considering the short term and longer term approach and options for sustainable funding of health and social services.

The Scrutiny Panel note that although the PRP's conclusions are at a high level, they do highlight a number of areas where more detailed consideration is required. The recommendations are as follows:

1. *That the States continue with a new model of health and social care. The original KPMG analysis that produced these options was robust and the consultation taken since has confirmed that there is widespread support for pursuing this new model.*

2. *That the programme for improving the quantity and quality of relevant data and information is pursued as vigorously as possible. Knowing what is being delivered and its quality and outcomes will be of enormous help in delivering the reforms.*

3. *That the mixed economy model of provision is the best building block for system reform. The perverse incentives currently operating must be tackled as they present real barriers to system reform.*

4. *That the management capacity driving system reform should be considered and supplemented where necessary by encouraging greater involvement from*

clinicians, interim or external support. Resourcing this work properly must be a priority.

5. *That the focus on integration and system reform be continued and deepened using GPs as a mainstay in the system. We also urge consideration of how other aspects of primary care e.g. pharmacy should be integrated in the new approach. We understand the project scope addresses this issue.*

6. *That the provision of a new hospital is pursued as quickly as possible and the implications of the two site approach be assessed in terms of risk and mitigations identified and applied.*

7. *That the governance arrangements for the integrated system be re-examined. We believe the current work is being well led, but there will be a requirement in the future for the leadership of the system to be more inclusive of clinicians in primary and secondary care and other representatives from within the system. This has to be a group which is accountable and has the authority and power to resolve problems for the benefit of patients. We are not recommending building any sort of replica of the system in the UK but rather ensuring accountability for those that are leading the system.*

8. *That work on building a sustainable set of funding mechanisms be accelerated and in particular that, unless already produced, the estimate for the funding gap should be subject to some sensitivity testing with respect to assumptions made on the cost or 'need' side.*

9. *That the productivity assumptions be included in KPMG's sensitivity analyses. Any mitigation of rising costs must include a review of potential productivity in the system. We understand that productivity has been addressed in the latest piece of work by W S Atkins but have not had sight of this report. We believe that productivity is a critical issue.*

10. *That if the proposal for increased charges - the reintroduction of charges for prescriptions and the new charge for A&E services proceed then provision is made to monitor their impact. In particular, their impact on prescribing and GP visits in total and across demographic groups.*

11. *That if the social insurance fund idea is pursued, then thought needs to be given to its governance arrangements (including independent audit arrangements) and its accountability to those who contribute to the fund through their taxes and levies and to all who use the health and social care services the 2040 Fund pays for.*

The Scrutiny Panel has made the following observations based on the report and its meeting with Sir David Henshaw.

Although the PRP was provided with a vast amount of written material, it was not provided with W.S. Atkins full report, its addendum or the additional studies undertaken by W.S. Atkins throughout the pre-feasibility study. The PRP's focus seemed to be on the original KPMG review

published in 2011, and the Scrutiny Panel question how relevant this work now is particularly when an updated set of population figures are now available.

The PRP's report recognises that there is an absence of robust data and information in a number of areas, reflecting a "data lite" position. Furthermore, the absence of this material has prevented a deep understanding of the delivery and quality of the present service and the future health needs of the population. The report also makes reference to the commitment by the Health Department that the "data lite" position will be rectified. The Scrutiny Panel note that the same concerns were raised during its review of the Health White Paper in 2012, and it is disappointing that more progress has not been made in this area.

The PRP concludes that although the development of a plan for a new model of health and social care in Jersey has taken some time, system integration is the right approach. Furthermore, there are major challenges to face in delivering the changes and close attention must be given to de-risking as much as possible in the approach. The Scrutiny Panel supports the PRP's overall conclusions particularly the last statement which reads "*This is a significant moment for Jersey. Getting this system reform right makes a big statement to the people of Jersey and those outside the jurisdiction*".

KEY FINDING: The Peer Review commissioned by the Ministerial Oversight Group made 11 recommendations in total, many of which mirror the Scrutiny Panel's findings and recommendations contained in its "Health White Paper" report (S.R.7/2012).

KEY FINDING: The Peer Review commissioned by the Ministerial Oversight Group, were not provided with W.S. Atkins full report, its addendum or the additional studies undertaken by W.S. Atkins. The review seemed to focus on earlier work undertaken by KMPG in 2011.

RECOMMENDATION: The Peer Review Panel's report on the reform of health and social services should be published by the Ministerial Oversight Group along with a formal response to its 11 recommendations before the Budget 2014 debate.

7. Whole Systems Strategic Planning

In its previous review of the Health White Paper the Panel concluded that hospital services and services outside of hospital are part of a continuum of care which should be planned as a whole system. This means the level and range of services in one part of the system are seen to be dependent on the level and range of services in another if needs are to be met without gaps or discontinuities of timing. Any tendency to plan hospital and other services separately should be resisted if the 'right' services are to be available in the 'right' places at the 'right' time[8].

Whole Systems Approaches

P.82/2012 explained that sustainability and viability of hospital services within an integrated health and social care model is the overarching objective and the outcome to be achieved. This applies to both hospital services and the health and social care system as a whole[9].

This overarching objective reflects the fact that people at all levels in the health service, from policy makers to frontline staff, recognise that they operate within a system with multiple inter-dependencies. Seeing themselves as part of a whole system enables people and organisations to understand the consequences that their own choice processes and work patterns have for others in the system, enabling the system to act strategically and adapt more intelligently. This approach is now generally accepted and has led to efforts to break down the barriers between different organisations that deliver care.

Achieving the White Paper's objectives requires an integrated approach to planning and developing services across the whole system of health and social care, including acute hospital services, mental health services, out-of-hospital services in community settings, GP-provided primary care, pharmacy provision, optometry, dentistry, social care and care for children. Actions in one sector often have knock-on effects in another. Where one sector develops without cognisance of the others the results can be disjointed.

Key Enablers

In order to plan and deliver the redesign of health and social services, the Health White Paper identified a number of "enablers". These were identified as "cross cutting" work-streams, as they impact on each of the service development plans. The 8 key enablers[10] are outlined below:

1. **Workforce** – a plan to provide the required workforce to support individualised care, independence and maximise the health and wellbeing of Islanders.
2. **Estates and Facilities** – an estates and facilities plan that ensures services are delivered from buildings that are fit for purpose and compliant with required standards.
3. **Primary Care** – a sustainable primary care sector with GPs and others supported to provide and co-ordinate services for Islanders.

[8] S.R.7/2012: Health White Paper review, page 26
[9] P.82/2012 Health and Social Care: A New Way Forward, page 59
[10] Health White Paper "Caring for each other, Caring for ourselves, page 27

4. **Technology** – to provide the technological platform, communications devices, telehealth and telecare, and fund the IT infrastructure, to include computerised patient records.
5. **Data and Informatics** – provide co-ordinated management information, including data sharing across organisational boundaries
6. **Commissioning** – ensure the needs of Islanders are identified, consulting with service users, carers, families and communities. Make evidence-based decisions regarding health and social services and support the Voluntary and Community Sector.
7. **Funding** – to identify funding requirements in accordance with Treasury timescales and decisions.
8. **Legislation and Policy** – to co-ordinate the drafting of legislation in line with States planned timescales.

The eight key enablers are important to consider when reviewing the redesign programme because they were identified as being essential to the successful delivery of the programme. The Panel comments on or makes reference to each of the key enablers throughout the report.

Information Services

This section relates to key enablers 4 (technology) and 5 (data and informatics). P.82/2012 explained that in order to enable strategic change, a number of system-wide needs have been considered including IT support and management capacity to implement change. It is clear that these 'enablers', along with the changes identified in P.82/2012, will be required in order for future services in Jersey to be safe, sustainable and affordable[11].

The Health White Paper also explained the requirement for improved IT services in order to deliver the redesign of Health and Social Services successfully[12]. The Panel identified in its previous review the need for IT systems to be developed to integrate with primary care and make the exchange of data to improve patient care more efficient. At a Public Hearing with the Primary Care Body, its Chairman explained: *"The difficulty is, again going back to silo working, the hospital system has developed in a silo compared with the community system and it is not only the local factors that have determined that, unfortunately. That is what has happened in the U.K. as well. We hope to be able to work as integrated models are rolled out in the U.K. and elsewhere, in conjunction with the I.T. developers in the U.K., to move things towards this model whereby the important data is there for patients when it is needed*[13]."

The Department has made significant investment over recent times but this has seemed to focus solely on the replacement of hospital information systems. The additional funding required was not included within the first phase of the White Paper which is 2013 to 2015 and is planned for the second period of the White Paper developments.

Informatics and technology are essential to deliver the service changes and transformation described in the White Paper. One element of this was the development of an overarching Informatics Strategy. The historical lack of investment in IT across the system has resulted in some

[11] P.82/2012 Health and Social Services: A New Way Forward, page 4
[12] Health White Paper "Caring for each other, Caring for ourselves, page 27
[13] Public Hearing with the Primary Care Body, 14th April 2014, page 24

paper-based systems still being used. The Department admits that this is inefficient and hinders data sharing, but went on to say that the Informatics Strategy will change this once it has been implemented[14].

The Public Accounts Committee recently published its report into Integrated Care Records (ICR) which was an earlier phase of work of the Informatics Strategy. The PAC report concluded that the ICR programme did not achieve the principal objective set in the period 2004 – 2006 of a fully integrated electronic health and social care records system. As of July 2014, the Health Department remain some way short of achieving its goal as paper records are still circulating widely within Health and Social Services and records are still being updated manually.

The Panel held a Public Hearing with the clinical lead in IT, Dr Graham Prince who prior to the publication of the White Paper had been working to push forward informatics within health and social services since 2006 with the ICR programme. In relation to IT systems and the dual site hospital he said: "*Having a dual-site hospital just makes the case for having an electronic system much more robust because obviously you do not want to be moving excessive numbers of paper notes up and down the hill. If our pharmacy is going to be up the hill or down the hill, there is going to have to be movement of things from wherever it is to wherever the patients need to pick it up from[15]*".

Using traditional paper-based processes to enter patient information manually into patient records is known to be less reliable than automated entry and is a cause of major concern particularly in relation to dual site working. Paper based systems allow greater opportunity for human error and the process is bound to be more time consuming for doctors and nurses having to take time away from patients to enter data, recall records or write prescriptions manually.

The Informatics Strategy indicates a need for a further £12 million funding over the period of the next Medium Term Financial Plan. This allocation would be additional to the monies already allocated for the new hospital. An initial phase of the Informatics Strategy is currently underway, though the bulk of the anticipated spend is dependent on securing the £12 million funding. It is understood that provisional funding requests to support the Informatics Strategy have already been submitted to the Treasury and Resources Department[16].

The Health Department has recently appointed a Business Support Group Manager who works in the Information Services Department and two other posts are currently in the recruitment stage – a Head of Informatics and Programme Manager[17].

The clinical lead in IT explained that the Health Department originally wanted to introduce informatics into the community system as part of the ICR programme. However in 2009 there were insufficient funds to complete every element of the ICR programme. As a result, informatics in the community was de-scoped from the programme. Yet a big part of the redesign programme is to introduce more community services to relieve pressure on the hospital and this depends on the timely and accurate flow of information between different parts of the system:

[14] Appendix 2 of response to Panel letter to the Minister for Health and Social Services dated 13th January 2014
[15] Public Hearing with Clinical IT Lead, 14th April 2014, page 9
[16] P.A.C. 2/2014
[17] Public Hearing with the Minister for Health and Social Services, 16th June 2014, page 13

Clinical Lead in I.T

"*So if you are going to have a truly excellent communications system all areas of health care have to communicate with all areas of health care. If you like, that would be community, it would be mental health, it would be the hospital, it would be general practice, and all of those areas need to communicate efficiently with each other and to share information with each other*[18]*."*

It is disappointing that little progress has been made, particularly when the need for improved information systems was identified as far back as the 1990s. The development and implementation of new IT systems or applications that link hospital services with those in the community is absolutely paramount if Jersey's redesign of health and social care is to be successful.

KEY FINDING: Informatics and technology are essential to deliver and monitor the service changes and transformation described in the Health White Paper. The Minister for Health and Social Services acknowledged the lack of historical data and made a commitment in 2012 that work would be undertaken to address this issue. The Panel has found that little progress has been made in this area, which is disappointing particularly when the need for improved information systems was identified as far back as the 1990s.

RECOMMENDATION: Detailed proposals to develop and fund a fully integrated I.T system should be included in the Medium Term Financial Plan 2016 – 2019.

The Comptroller & Auditor General's Report

The Comptroller & Auditor General (C&AG) recently published a report titled "Use of Management Information in the Health and Social Services Department – Operating Theatres". The C&AG's review focussed on the use of management information in acute hospital performance in relation to the use of operating theatres. It is noted that the revenue budget for operating theatres makes up 10% of the hospital's budget[19].

The Panel has extracted below the main conclusions from the C&AG's report which are pertinent to its review:

Access to relevant and high quality management information allows organisation to make strategic and operational decisions efficiently and effectively[20].

Information for decision-making is most useful when derived from high quality data. Where data is of a low quality there is an increased risk that decisions are made which do not promote organisational objectives. There is also a risk that information derived from the data is ignored in decision-making[21]*.*

[18] Public Hearing with Clinical IT Lead, 14th April 2014, page 5
[19] Jersey Audit Office, Comptroller & Auditor General Report: Use of Management information in the Health and Social Services Department – Operating Theatres, July 2014, page 3
[20] Jersey Audit Office, Comptroller & Auditor General Report: Use of Management information in the Health and Social Services Department – Operating Theatres, July 2014, page 2
[21] Jersey Audit Office, Comptroller & Auditor General Report: Use of Management information in the Health and Social Services Department – Operating Theatres, July 2014, page 6

In June 2012 a new Patient Administration System, TRAKcare was implemented across the hospital. There are significant weaknesses in the arrangement for securing data quality for theatre utilisation in TRAKcare and as a result TRAKcare is providing inadequate management information about operating theatre utilisation to support decision-making[22].

Increases to operating theatre capacity are planned; two semi-permanent operating theatres are to be built, enabling one of the existing theatres to be dedicated to maternity; and the draft Medium-Term Financial Plan for 2016 – 2019 includes consideration of a move towards a 12 hour surgery day. A six-day working week for operating theatres is also under discussion. But making informed decisions on the requirements for and use of operating theatre capacity requires good quality information on operating theatre utilisation that is not currently available[23].

Operating theatres are an expensive resource and evidence-based decision-making requires identification of relevant information needs, as well as improvement in the arrangements for securing data quality and effective use of the resulting management information[24].

One of the C&AG's overall conclusions was that improvements to management information should be seen as a priority. The Panel wholeheartedly agrees and expects the Health Minister will take heed of the C&AG's report and its recommendations and conclusions.

It is also a matter of concern to the Panel that the deficiencies identified by the C&AG's report may cast doubt on the quality of the information available for and utilised in modelling and costing the scale and configuration of plans for future hospital services. The Panel is driven by its understanding of the C&AG report to conclude that similar weaknesses may have been present more widely in the planning processes for the redesign programmes reviewed in this present report.

KEY FINDING: One of the overall conclusions contained in the Comptroller and Auditor General's report "Use of Management Information in the Health and Social Services Department – Operating Theatres" was that improvements to management information should be seen as a priority. The Panel wholeheartedly agrees and expects the Health Minister will take heed of the C&AG's report and its recommendations and conclusions.

RECOMMENDATION: The Treasury and Health Ministers should respond to the specific aspects of the C&AG report: "Use of Management Information in the Health and Social Services Department – Operating Theatres" within the next three months and publish their conclusions about the implications of its findings for the work conducted to date on the planning and development of hospital and out-of-hospital services.

[22] Jersey Audit Office, Comptroller & Auditor General Report: Use of Management information in the Health and Social Services Department – Operating Theatres, July 2014, pages 6/7
[23] Jersey Audit Office, Comptroller & Auditor General Report: Use of Management information in the Health and Social Services Department – Operating Theatres, July 2014, page 11
[24] Jersey Audit Office, Comptroller & Auditor General Report: Use of Management information in the Health and Social Services Department – Operating Theatres, July 2014, page 13

Workforce Planning

This section relates to key enabler 1 (workforce). The Panel's previous report into the Health White Paper identified challenges in terms of recruitment and retention, particularly in certain staffing groups. The White Paper proposed an expansion to some services and it was unclear at the time whether additional requirements for staffing could be met given recruitment was already a challenge. It is understood that a three phased approach will be adopted because of the significant workforce challenges in attracting people to the posts and getting services set up and well established. This is still an issue and the Chief Executive of Health explained:

> **Chief Executive of Health**
> "*I think one of the most challenging aspects we have of where we are at currently in this journey we are on for the 10-year transition is doing the workforce planning because it does need specific skills and we are struggling to find those skills at the moment. So we are having to get on with identifying the types of staff that we need, but we do need to inject some specific resource quite quickly now to help us with that"*[25].

In relation to out-of-hospital (intermediate) care the evaluation report drafted by the Commissioning team highlighted the importance of recruiting staff with the appropriate skill set. It acknowledged that there is a limited pool of health staff available on the Island and this has an impact on service development and delivery. It was noted that workforce planning needs to be mindful of the whole system impact and should focus on increasing overall capacity and capability of the workforce as a whole rather than shifting skills from one part of the system to the detriment of another[26].

KEY FINDING: The Commissioning team acknowledged that there is a limited pool of health staff available on the Island which will have an impact on service development and delivery.

The Panel are aware that recruitment and retention is still a real concern, particularly now that services are starting to be rolled out across the island. The Health Department has made some progress since the Health White Paper, in July 2011 an amendment to the primary legislation (Medicines (Amendment No. 3) (Jersey) Law 2011), was adopted by the States Assembly, enabling the Minister to specify a wider range of practitioners that may prescribe medicinal products. Training for this started in 2013, with the introduction of an annual on-island training programme at degree and masters level[27].

> **Chief Nurse:**
> *"We have got a whole range of measures in place which include the changes that we have made to our on-Island pre-nurse training. So again, that is the work we have done with Education, Sport and Culture in relation to increasing the number of places that we have year on year for local Islanders, which fits with the Island strategy as well. At the moment ... we started our first cohort last September with 15 but we can trade that up and down. There is a critical mass issue in terms of the volume that you can train at any one time, because obviously you have to have an appropriate ratio of registered nurses to students. In addition to that we are increasing the amount of time that we are able to take students*

[25] Public Hearing with the Minister for Health and Social Services, 16th June 2014, page 23
[26] Commissioning Intentions Out-of Hospital Services, March 2014, page 8
[27] Commissioning Intentions Out-of Hospital Services, March 2014, page 8

in, so previously it was anything between 2 and 3 years. We are now taking them on an annual basis and we have just recently announced that we will also be training ... offering local Islanders the opportunity to train as midwives, mental health nurses and paediatric nurses. That is with a model that we have developed with the University of Chester, through our links there. We are also able to offer a whole range of opportunities for nurses already registered in Jersey to retain them on the Island so that they get the opportunity that their colleagues may get elsewhere. That is a whole range of qualifications up to Masters level provision, which again is in line with academic access that nurses have elsewhere. We have also been working with Highlands in terms of the work that they do around the BTech (Bachelor of Technology)"[28].

The other issue regarding recruitment and retention is attracting nurses to Jersey with the cost of living being so high. This was identified in the Panel's previous report as a factor placing doubt around the feasibility of the plans for staffing the new services. At the time the Panel questioned whether the introduction of new services should be phased more gradually over a longer timescale. Although the Minister accepted the Panel's recommendation, she said that there should be no requirement to phase in new service plans over a longer timescale solely because of recruitment challenges if the Department continues to work with the States Employment Board, Treasury and nurse representatives[29].

The Panel wanted to assess how much progress had been made in this area, and it was identified by the Chief Nurse as still an area of concern: *"Then the other side, as you mentioned, attracting nurses to Jersey and cost of living and everything else. We are hopeful that the work through the workforce modernisation project and the reform of the way our nurses' job descriptions are developed, the way that nurses are expected to work in Jersey is matched to their salary and that is commensurate with the work that we have been doing in relation to equal jobs of equal pay over the last 12 months"*[30].

The Chief Nurse also told the Panel that she had been involved in the recruitment of a specialist nurse post and found a good candidate but unfortunately the candidate withdrew as they considered it a significant step moving to the Island: *"It goes back to the same issue around housing. The cost of housing is quite startling for people*[31]*".*

The Chief Nurse explained that work had been undertaken jointly with the Housing Department and Jersey Property Holdings to look at the accommodation stock and housing policies with a view to developing a workforce gateway: *"That work is progressing slowly but it is progressing. I would not say we are in a position at this moment in time where I could say, hand on heart, we are there yet. But it is a very encouraging positive conversation"*[32].

The Panel is concerned about how easy it will be to implement the investments in services to deliver the redesign programme. It is clear there are still difficulties in recruitment and this may prove to be an obstacle as more services are rolled out across the Island.

[28] Public Hearing with the Chief Nurse, 11th April 2014, page 3
[29] Ministerial Response to S.R.7/2012, Health White Paper Review
[30] Public Hearing with the Chief Nurse, 11th April 2014, page 4
[31] Public Hearing with the Chief Nurse, 11th April 2014, page 6
[32] Public Hearing with the Chief Nurse, 11th April 2014, page 7

Population Assumptions

The pre-feasibility study completed by W.S. Atkins refers to the population assumptions on which future service activity requirements were estimated. It is noted that the pre-feasibility model initially incorporated the +150 Heads of Household assumption (as used in the KPMG model and the equating to +325 people) and included the latest demographic and migration assumptions produced by the Statistics Department in September 2012[33].

The Treasury Department advised the Panel that the States Statistics Unit had produced more recent population assumptions in September 2013 which were released after the refined concept had been developed and therefore these updated assumptions will form the basis of the feasibility study[34].

It is important to note that the States Assembly approved an interim population policy (P.10/2014) for the next two years - a planning assumption for net migration of +325 people per year to cover the period 2014 – 2015. The Chief Minister advised States Members that a future policy for population could not be set in the absence of a comprehensive planning process given the wide effect migration has on the Island's economy, infrastructure and environment. As a result, it will now be the responsibility of the next Assembly to set a future policy for population as part of its long term planning[35].

It is important that any future population policy is taken into consideration when providing for a new hospital and additional services in the community. The Panel are concerned that the population policy to be agreed by the next States Assembly will take place at the same time work is being undertaken on the feasibility study due to completed in 2015.

RECOMMENDATION: Together with the Council of Ministers, the Minster for Health and Social Services must ensure that the new population policy to be agreed by the States in 2015 is taken into consideration when determining the size and scale of the future hospital.

Acute Services Strategy

The White Paper embraced a whole system approach to the delivery of health care. However the Panel has found little evidence that the development of health and social care is yet being successfully planned and integrated across the whole system. For example, it is only now that a comprehensive acute service strategy is being developed even though a decision already appears to have been taken on both the size and location of the acute hospital facilities. In addition the development of the new model of primary care has experienced some significant difficulties. Yet, the configuration and delivery of hospital services has a significant dependency on the nature and implementation of that model.

It is still early to assess what the impact of out-of-hospital development will be but there is some evidence within the MCAP[36] audit to suggest it may have considerably greater influence on the

[33] W.S. Atkins - Hospital Pre-Feasibility Spatial Assessment Project, May 2013
[34] Treasury and Resources Summary – annex 5 – Submitted to Panel April 2014
[35] Corporate Services Scrutiny Panel S.R.2/2014 "Review of the Interim Population Policy"
[36] MCAP (Making Care Appropriate to Patients) is an audit tool designed to identify opportunities for the delivery of care in settings outside the acute hospital.

reduction of demand for acute services. The MCAP audit sought to facilitate improvement of care quality and reduction in delivery costs by identifying patients in hospital beds whose care could be delivered in an alternative setting. The report highlights that there may be significant scope to reduce bed days and admissions: 54% of admission and continuing stay days could have been avoided with appropriate home services or GP follow-up[37] vs. 42% in the prior MCAP study. However, any increase in home services or follow-ups via GPs must be developed with GP support, and with the provision of appropriate funding.

The Panel asked the Treasury Department whether it would have been preferable to undertake and complete the Acute Service Strategy before proposing the refined dual site concept, as there are factors such as the MCAP audit which may necessitate changes in the design. The Department accepted that in an ideal world an Acute Service Strategy would have been long established, but also said that the condition of the hospital and the challenges identified in P.82/2012 meant that it was important to progress the development of the Acute Services Strategy and future hospital development in tandem[38].

The Panel then asked what would happen if the continuing development of the hospital strategy suggested the budget was too small. The Treasury Department acknowledged that challenges may arise during the Acute Services Strategy development. However, they did not expect that these will require a change to the budget outlined in the Addendum to the Strategic Outline Case[39].

The Panel find it difficult to understand how such an assurance can be provided in the absence of a developed Acute Services Strategy. It is concerned that hospital development plans are apparently continuing to be taken forward within a context of what may be significant uncertainty about the mix and scale of acute services that should and can be undertaken cost effectively and safely on the Island.

At a Public Hearing with the Minister for Health and Social Services, the Panel was advised that the first draft of the Strategy would be completed in June 2014. It will then go through consultation with the clinicians and health advisors from the Kings Fund, recently appointed as part of the feasibility study, will also review the Strategy. When asked when the Strategy would be completed the Department advised that it would be ready for Outline Business Case in January 2015[40].

The Panel has yet to consider the draft Strategy and is therefore not able to determine whether the timeline will be met. The Acute Services Strategy should have been completed before the work on the hospital pre-feasibility study was started. The Panel considers that the size and scale of the hospital cannot realistically be decided until there is clear direction on what services are going to be provided in hospital.

KEY FINDING: The development of the primary care service model has experienced some significant difficulties and yet the configuration and delivery of hospital services has a significant dependency on the nature and implementation of that model.

[37] MCAP Audit Report – States of Jersey Department of Health and Social Services, Service Study Outcomes – May 2013
[38] Treasury and Resources Summary – submitted to the Panel April 2014
[39] Treasury and Resources Summary – submitted to the Panel April 2014
[40] Public Hearing with the Minister for Health and Social Services, 16th June 2014, pages 19/20

Interim financial arrangements for meeting immediate pressures

It was explained within P.82/2012 that the changes to health and social services required an increase in funding, by 2015, of over £11m per annum as identified in the Medium Term Financial Plan (MTFP). This was in addition to the additional £14m per annum growth monies (also identified within the MTFP[41]). In the following planning periods (2016 – 2021) further business cases, including detailed plans and costings, will be developed as part of future MTFPs[42]. It is also acknowledged that significant additional investment beyond 2016 will be required to implement the work streams described in P.82/2012.

The current Medium Term Financial Plan sets out the capital programme for each of the years 2013 – 2015 and the debate on the MTFP approved the capital programme, in total, for each of these years. To comply with the Public Finances (Jersey) Law 2005, the States approved a detailed list of capital projects for 2014. Below is the list of capital projects for 2014 relating to health and social services:

- **Future Hospital (Phase 1) (Design Development, Preliminary Works and Transitions Capacity Requirements) (£10,200,000 for 2014)** - This funding provides for preliminary activities that are required to enable the phased main works programme to be undertaken.

- **Main Theatres Project (£1,837,000 for 2014)** – This funding is the final tranche for a project to deliver improved theatre facilities for the hospital.

- **Future Hospital – Planning (£500,000 for 2014)** – This funding will provide for costs associated with the professional support necessary to develop the project master-plan and progress the feasibility study for consideration by States Members in autumn 2015.

- **Integrated Assessment and Intermediate Care (£500,000 for 2014)** – This project proposes the establishment of an integrated assessment and intermediate care centre which will serve as the base for integrated adult community services for the adult population.

- **Refurbishment of Sandybrook (£1,700,000 for 2014)** – Sandybrook is a 28 bed facility adjacent to the Sandybrook day centre. It was built in 1999 and had not been refurbished since. Sandybrook provides nursing care for older people who have been assessed as needing continuing care to meet higher levels of care needs. The environment is outdated and not suited to the current highly dependent residents.

As set out within the recently published 2015 Budget below is the list of capital projects for 2015 relating to health and social services:

- **Future Hospital – Feasibility Study and Initial Phases – Design and Planning (£22,700 for 2015)** – This funding provides for the development of the feasibility study outline and Full Business Cases for the Future Hospital project to set out the proposed

[41] P.82/2012 Health and Social Services: A New Way Forward for Health and Social Services, page 86
[42] P.82/2012 Health and Social Services: A New Way Forward for Health and Social Services, page 65

overall feasibility concept for the new build and refurbished Future Hospital capacity as set out in P.82/2012.

- **Replacement of MRI Scanner (£2,277,000 for 2015)** - The Health Department currently owns and operates an MRI scanner, which was commissioned in December 2007. The MRI scanner is in constant use and the unit operates Monday to Saturday, however, in 2014 it has also operated on most Sundays to meet increased demand. The MRI scanner needs replacing in 2015 and the replacement costs include the purchase and commissioning of a new machine as well as the necessary building costs associated with installation.

- **Replacement of RIS/PACS (£1,567,000 for 2015)** - Replacement of the Picture Archiving Communication System (PACS) and the Radiology Information System (RIS). PACS and RIS are the names given to a number of computer based systems designed to run the Radiology Department and distribute reports and images to all relevant clinicians both inside and outside the hospital. The scope also covers updating a range of hardware including the main server infrastructure and visual display equipment for viewing the images and reports.

- **Limes Upgrade (£1,662,000 for 2015)** - The Limes is a care home built in the 1980s to a very high standard but not refurbished since.

Mental Health Services

The Panel has been advised that the Health Department is currently undertaking a review of mental health services. Within the Terms of Reference for this review, it is explained that an overarching Mental Health Strategy is required in order to guide the future development of services, with a full review of existing services. According to the Department, a strategy will be produced in March 2015.

The Department intend to take a system-wide approach to the review which will incorporate the acute hospital, primary care, Voluntary and Community Sector provision and interactions with other States Departments where appropriate for example housing and education[43].

Within the Medium Term Financial Plan, £350,000 was identified for a Mental Health Facility Feasibility Study to be undertaken. The MTFP explained that the facilities at St Saviour's Hospital are reaching the end of their economic life and will shortly not be fit for purpose in respect of the ability to supply the desired service provision[44]. It is noted that these figures were subject to change depending on the work undertaken by the Treasury Department.

Although the MTFP suggested that a new mental health facility may be situated at Overdale Hospital the Panel has since been told that this is unlikely if the dual site proposal goes ahead. It is unclear whether another alternative site has been identified, however the Chief Executive of Health explained that Clinique Pinel has been upgraded which would give at least another 10

[43] Health and Social Services Department, Terms of Reference, Mental health Strategy and Service Review
[44] Medium Term Financial Plan 2013 – 2015, page 144

years' worth of life. The Department are also exploring whether it can accelerate a plan for Orchard House which needs to be rebuilt[45].

The financial and other consequences of the dual site option for the delivery of mental health services should be identified and understood in any decision involving the future of acute hospital services. The Panel is concerned whether the latter could lead to less affordable, good quality options for mental health modernisation.

KEY FINDING: The original intention was to provide mental health facilities at the Overdale Hospital site. The dual site hospital proposal has impacted on this vision, and an alternative facility will need to be identified as part of the Mental Health Review.

RECOMMENDATION: The financial and other consequences of the dual site option for the delivery of mental health services and associated facilities must be identified and understood prior to any decision involving the future of acute hospital services and where they are located.

RECOMMENDATION: Regardless of any future decision to use the Overdale site for hospital services, an appropriate site for mental health services should be identified as part of the Department's review of mental health which will be produced in March 2015.

Concluding remarks on whole systems approach

The Health White Paper embraced a whole system approach to the delivery of health care, and the eight enablers are considered essential to the successful delivery of the programme. The Panel has found little evidence that a whole system approach has been undertaken. As this section of the Panel report explains, little progress has been made within information services, the acute services strategy is still being developed, and there are still concerns around recruitment and retention.

KEY FINDING: Achieving the Health White Paper's objectives requires an integrated approach to planning and developing services across the whole system of health and social care. The Panel has found little evidence that a whole system approach has been undertaken. This is concerning to the Panel because if one work-stream is developed without cognisance of the other, the successful delivery of the redesign programme is put at risk.

RECOMMENDATION: An action plan to ensure the delivery of all eight key service enablers should be produced, along with appropriate timescales, and presented to the States within the next twelve months.

[45] Public Hearing with the Minister for Health and Social Services, 16th June 2014, page 56

8. Stakeholder Engagement

Engaging with the Public

The Panel notes the "Future Hospital" website (www.gov.je/futurehospital) includes a video developed to explain the future hospital proposals, an animation of the future hospital design concept, and details of the benefits planned for the "Future Hospital Project".

It is understood that the Ministerial Oversight Group initially considered a Communications Plan which identified that the Ministerial Oversight Group and Sub-Group wished to undertake a public consultation on a preferred site in order to gather views on the site's suitability compared to the alternatives. The aim was to confirm the preferred site through a States decision to enable detailed feasibility work to follow and a design for a new hospital to be developed and procured[46].

Some form of public consultation took place as the Panel were provided with a summary of the records taken of questions raised at the "Future Hospital" public communication events. Five of these were held in October and November 2013 and included single bedded en-suite wards, dual site working and provision of radiotherapy on-Island[47]. Unfortunately the records provided to the Panel did not go into any great detail about the concerns or support from the public.

KEY FINDING: The Ministerial Oversight Group considered a Communication Plan for public consultation. Its aim was to confirm the preferred site through a States decision to enable detailed feasibility work to follow and design for a new hospital to be developed and procured. However the Panel has concluded that no States decision has been undertaken on this issue despite being the original intention of the Ministerial Oversight Group.

KEY FINDING: Although the Department has undertaken some form of consultation on the future hospital, the Panel would have expected to have seen greater and more meaningful public consultation, together with a more detailed analysis of the results.

The Panel's Public Consultation

The Panel itself carried out its own public consultation seeking views on the dual site hospital. The number of responses received was disappointing but of those who did respond a few reoccurring themes emerged:

- With the hospital covering two sites greater expense will be incurred with the duplication of laboratory and pharmacy facilities
- A hospital in one location would be more efficient. As many services as possible should be retained on the current hospital site for reasons of patient safety and efficiency
- Overdale could act as a "Cottage type" hospital for those less critically ill, but still needing hospitalisation or rehabilitation. Patients could be moved to Overdale once they are on the road to recovery

[46] Communications Plan, page 1
[47] Treasury and Resources summary – annex 5, received April 2014

- Non availability of consultants in the main hospital
- Transport to Overdale –
    - The Overdale site, although magnificent in its location, could present real problems with transport
    - Overdale situated on a high plateau which could not be reached on foot very easily
    - All roads to Overdale are narrow and do not allow for speedy access
    - Shuttle buses between Overdale and Hospital could prove inconvenient, slow and costly
    - How often will buses run to accommodate patients
    - How much extra time will be spent getting to work if staff are coming from the East or West of the Island and using the bus service
    - Waste of consultant and other medical personnel's clinical time in having to travel between two sites
    - There needs to be adequate car parking spaces

The Panel also contacted the Jersey Civil Service Association[48] so that views on the future hospital could be gathered from States employees. The key points raised were:

1. In relation to the proposed satellite hospital at Overdale there was much concern about access to the premises and additional traffic in the area.
2. The proximity of the crematorium already causes problems when there is a service which results in parking and traffic problems. There was a suggestion about the possibility of re-locating the crematorium or purchasing a neighbouring field for overspill parking.
3. There was concern about patient transport issues and worry about how disabled patients would get to and from Overdale. The hill up to Overdale is steep and challenging for a fit person. Will suitable public transport be available? Currently all buses go pass the general hospital.
4. How will staffing of two sites be resolved? There are already nursing shortages and staffing two site will increase the demands.
5. Staff time spent moving between two sites will reduce the effectiveness of employees. In addition, the need to travel from one site to another may lead to adverse medical outcomes.
6. Expensive equipment will need to be duplicated and serviced. There might also be the need to have a duplication of services for example Radiology, Pharmacy and Pathology.
7. How would Out Of Hours arrangements be handled – where would the limited number of people work?
8. Pathology samples would need to be transported between sites. This increases the worry about some going missing. This could be particularly difficult during Out of Hours service.

[48] Written Submission from the Jersey Civil Service Association, received 5th June 2014

9. Could have impact on blood donors – large number currently donate during working hours. This could change if they had to go to Overdale.
10. There are concerns about the processing of blood if the main laboratory is at Overdale but the Out of Hours is at a different site. The concerns also include the location of the blood bank and where cross matching would take place.
11. What would happen in major incidents – where would the key staff be?
12. The location of pharmacy could also introduce inefficiencies – there could be long delays if drugs had to be transported. This might result in beds becoming more clogged with those awaiting discharge.
13. The current plan is for Pathology to be located at the Overdale site, yet all of the acute services, which require a prompt Pathology service, are to be located in the main hospital. The Pathology laboratories should be located on the main site - a twin lab system will be more expensive.

KEY FINDING: Concerns have been highlighted by the general public and States of Jersey employees about the dual site proposal in relation to operating from two sites, efficiency and transport. The Panel has seen no evidence that these concerns have been addressed.

Communication with the Voluntary and Community Sector

The Panel's previous review of the White Paper (S.R.7/2012) identified an important role for the Voluntary and Community Sector if more care in the community is to be provided. Evidence received during the Panel's previous review highlighted a degree of enthusiasm for the proposals but also tinged with an element of caution. Some organisations expressed the desire to be treated as equals and enter into medium to long term Service Level Agreements. The Panel also observed that, at times, there was scope for greater communication between the Health Department and the Voluntary and Community sector.

In order for the Panel to understand in detail what efforts were being made by the Health Department to engage with other local providers in the delivery of improved community services, a survey was developed for all members of the Voluntary and Community Sector. The survey was sent to 111 representatives in total on 13th December 2012.

Although the level of responses was low, some interesting findings emerged. In the earlier responses received through the survey, respondents were commenting on how the process was moving too fast, and some felt that they were not being listened to:

> *Unduly time-consuming and complex process (14th January 2013)*
>
> *Didn't feel my input was taken on board and listened to (15th January 2013)*
>
> *The options put forward at the very first meeting were never up for change, the charities views were not listened to. (14th January 2013)*
>
> *They need to listen equally to all services and be open to different viewpoints. I found the process extremely frustrating and a waste of my time as any comments were not taken on board. We had no voice. (14th January 2013)*

Some later comments were more positive, however, which may suggest that the Health Department took on board the concerns raised earlier on in the process:

> *This is a moving feast because as the process has progressed the opportunity and mechanism for true engagement has been modified to meet the real Jersey situation. Thus many of the original concerns have been dissipated and providing HSS and their officers are as good as their word we now have the basis for a real partnership going forward…(5th May 2013)*
>
> *…It is a very time consuming process but the CVS cannot afford to sit back and then complain after the event. (3rd May 2013)*
>
> *We have come a long way from where we started with this process and the proof of success or otherwise will now all be in the delivery and in the forging of true two-way partnerships between the Department and VCS organisations. Proportionality, realism and flexibility is key to the building of successful arrangements as we move forward together. (5th May 2013)*

KEY FINDING: Since 2012, there has been an improvement in the level of communication between the Health Department and members of the Voluntary and Community Sector.

Engaging with Primary Care

This section relates to key enabler 3 (primary care). The Panel recognised the importance of engaging with all primary care providers within its previous review of the Health White Paper. One of its recommendations was that GPs and other primary care practitioners are actively engaged in the ongoing development of primary care services based on a holistic approach to care and multidisciplinary working.

The Panel held a Public Hearing with the Chairman and a member of the Primary Care Body during its review. It is clear that earlier on in the White Paper process GPs felt they were not being listened to and the communication process lacked a multi-disciplinary approach: "*I think from the point of view of significant events during the White Paper process, eventually we have got to a point where I think the people who are heading it up are starting to listen to us, are starting to understand the wider impact of the services that they have and the fact that one cannot just roll out these services in silos and that the impact may be sometimes unintended consequences on different parts of the service needs to be thought about*[49]."

The Panel note that the relationship between GPs and the Health Department became fractious, particularly when a new model of primary care was being developed resulting in the GP's going to mediation in early 2014. Although there would seem to be some improvement in the relationship, the Minister for Health was asked to explain what happened at a Public Hearing: "*There was some consultation last year, which did not quite get off the ground, so we have all, everyone together, sat back around the table at the end of last year, I think it was, and worked a way forward of everyone now engaged and going to take that next step forward of looking at the primary care with*

[49] Public Hearing with the Primary Care Body, 14th April 2014, page 5

[the Deputy Director of Commissioning] leading it and getting expert advice, whatever, as needed, as we go through[50]."

During the Public Hearing with the Primary Care Body, the Panel asked what would be a successful outcome of the mediation: "*A really good piece of work on sustainable primary care, which we are all very comfortable with and all feel part of and delivers what we need it to deliver to the Island. That to me is the ultimate objective of having put everyone in the same room for 2 or 3 days to talk it through, because that to me, we can all agree to behave properly and treat each other with respect and to communicate properly but the real test is getting a robust project out of the whole thing at the end because that is what we need. We need the 3 groups of individuals to work together[51]."*

It seems that communication between the two parties has improved significantly with the help of mediation: *"…..the governance over the process feels more comfortable and we feel more equal partners in the process[52]".* However, the evidence would suggest that poor communication in the past has resulted in a lack of whole system working which has ultimately delayed progress in the development of the new primary care model. It is still unclear when an agreement will be reached on the way forward. This is discussed further on in the report.

KEY FINDING: Recent mediation in 2014 has improved the relationship between the Health Department and General Practitioners. However, poor communication during 2012/2013 has caused a delay in progress to develop a new model of primary care.

Engaging with Hospital Clinicians

P.82/2012 emphasised that the new model of health and social care is a whole system transformation programme and its scale is unprecedented. The new system must be sequenced into a manageable series of projects, and the programme professionally managed. Furthermore, oversight at Ministerial and Corporate Director level is essential, and roles and responsibilities must be clear and the changes must be clinically-led[53].

From the evidence sessions, some clinical engagement has been undertaken and in particular since the appointment of the Clinical Lead of the "Future Hospital Project". The Panel was told on numerous occasions that the proposals and the operations of a dual site hospital had been discussed with clinicians, but this was not until June – August 2013 when the dual site concept had been identified.

W.S Atkins also recognised the importance of undertaking significant consultation with the clinical and medical directors and senior nurse to ensure that the proposed model will operate safely and sustainably[54]. In a recent letter to the Panel, W.S. Atkins explained their frustrations at not being afforded the opportunity to participate in any clinical team engagement during the study: W.S. Atkins said*: "We had recommended and sought clinical engagement from the outset. Indeed, it*

[50] Public Hearing with the Minister for Health and Social Services, 16th June 2014, page 4
[51] Public Hearing with the Primary Care Body, 14th April 2014, page 9
[52] Public Hearing with the Primary Care Body, 14th April 2014, page 7
[53] P.82/2012: Health and Social Care: A new way forward, page 80
[54] Hospital Pre-Feasibility Spatial Assessment Project: Jersey General Hospital Refined Concept: Addendum, 3rd October 2013 page 17

featured in our initial interview presentation and was something we commended on numerous subsequent occasions. It was a process with which we were very familiar from other projects with which we had been involved. When evaluating the various site options, clinical engagement was not so important but, as the study progressed we highlighted in each of the SOC's we submitted, that we considered clinical engagement was essential to ensure that the Hospital Management Team were properly considering their proposed models of care and were securing the 'buy-in' of the clinical leadership. We did find it frustrating that we were not afforded the opportunity to participate in any clinical team engagement during our commission. The priority of our commission was to identify an appropriate site on which acute healthcare services could be delivered[55]*."*

KEY FINDING: One of the priorities given to W.S. Atkins was to identify an appropriate site on which acute healthcare services could be delivered. However, their evidence to the Panel stated that they found it frustrating that they were not afforded the opportunity to participate in meaningful clinical team engagement.

[55] Correspondence from W.S. Atkins, received 3rd July 2014 [full version may be found in Appendix 1]

9. Delivery of Services in the Community

According to P.82/2012 the hospital is central to a sustainable system of health and social care. Modern hospital services and facilities including a "new" hospital are vital, but the need to build primary care and expand community services to offer alternatives, relieve pressure on the hospital and create a sustainable system is also important[56].

The impact of not implementing community-based care strategies has a significant effect on the hospital size. If the community strategies approved within P.82/2012 were not to be introduced, the increase in the hospital area requirement for a new hospital would rise by approximately 9,000m^2, based on UK standards, and incur an additional capital cost of approximately £60 million[57].

Timeline of key milestones

Event	Date	Summary
KPMG	Completed in May 2011	As a result of KPMG's work, three strategic scenarios were identified which summarised options for the future of health and social care in Jersey.
Green Paper: Caring for each other, Caring for ourselves	Published in May 2011	Following the KPMG report, the Department published a Green Paper which asked for views on health and social services and identified support for scenario three "A new model for health and social care" as the preferred option.
White Paper: Caring for each other, Caring for ourselves	Published in May 2012	Following the Green Paper consultation, the Department developed detailed plans for the next 10 years. The White Paper outlined these plans and sought further feedback from the public.
Panel's Report on Health White Paper: S.R.7/2012	15th October 2012	The Panel concluded that the proposition should be welcomed in general terms, and emphasised that its scope and scale would necessitate a challenging process of synchronising the introduction of many new services, some of which were reliant on the recruitment of specialised staff. In particular, the Panel recognised the importance of carefully phasing the development of services in the community with any change in the role and volume of hospital services. The Panel made 21 recommendations in total. The Minister accepted 12, noted 8 and rejected
Ministerial Response to Panel's report: S.R.7/2012	13th February 2013	

[56] P.82/2012 Health and Social Services: A New Way Forward, page 59
[57] Hospital Pre-Feasibility Spatial Assessment Project: Jersey General Hospital Refined Concept: Addendum, 3rd October 2013 page 14

		1 of the recommendations.
P.82/2012 Health and Social Care: A New Way Forward	Lodged on 11th September 2012 Approved by the States Assembly 23rd October 2012	The States approved a radical change to the way Health and Social Services are delivered in Jersey, with an increasing emphasis of health being delivered in community settings with associated benefits for patients and enabling hospital services to focus on the increasing demand posed by demography and an ageing society[58]
Task and Finish Groups working on detailed service specifications and metrics for the new community based services	November 2012 – December 2012	Full Business Cases and service specifications were being discussed with key stakeholders in workshops organised by the Health Department
Tendering sessions	January 2013	The Health Department organised three sessions on the tendering process
Drop-in sessions	February 2013	The Health Department held several drop-in sessions during February 2013. This was for people to talk about challenges and priorities for the services being progressed.
Development of 26 service specifications	October 2012 – January 2013	26 service specifications were developed for the new services identified in the Health White Paper. By January 2013, 12 of these were ready for final review and 14 were being finalised for review in May and June 2013.
Department undertook "listening exercise"	February 2013 – March 2013	The Department completed a 'listening' exercise, after some stakeholders were worried that the process was moving too fast. Some felt that the Department needed to review the emerging detail of the plans that had been developed in October 2012 – January 2013.
Seven services were labelled "green" and the Minister's independence advisory Panel (HASSMAP) and the Minister decided which of these would be tendered or not	March 2013	The seven green services were: Specialist fostering (expression of interest for training element) Short breaks (children) (tendered) Family Care Co-Ordination (not tendered) Community midwifery (not tendered) Parenting Support programme (tendered)

[58] Future Hospital Feasibility Study: Strategic Brief

		Pulmonary rehabilitation (not tendered) Carers Support Services (tendered)
Adverts for "green" services being tendered place in JEP	April 2013	The Department hold a bidders briefing session on 29th April
Development of services labelled "amber"	April 2013 – June 2013	The Department reviewed the "amber" specifications in liaison with a small group of doctors, nurses, other professions and voluntary and community representatives.
Corporate Directors approved 4 pilot projects	July 2012 – January 2014	In July 2012, Corporate Directors approved four pilot projects which went live between September 2013 – January 2014: Short breaks for children (to go live September 2013) Dementia respite (to go live August 2013) End of life (to go live August 2013) Intermediate care[59] (pilot began in January 2013 for 12 month and went live as a mainstream activity from January 2014)
A new model of primary care	2012/2013/2014	On 26 February 2014 the Ministerial Oversight Group Primary Care sub-group approved the Department's proposal that the sustainable Primary Care work should be led on-island, in partnership, drawing on external expertise when required - and the majority of the work will be co-produced, i.e. through working together on-island. This was noted by the full Ministerial Oversight Group on 14 March 2014.

In October 2012, following approval of P.82/2012, the Steering Group, Working Group, Ministerial Oversight Group and a set of task and finish groups started to co-ordinate the work necessary to shape service developments.

The four areas below were known as service workstreams and each one was developed into an FBC accompanied by service specifications. The FBCs include metric and performance measure and implementation plans. By December 2012 some workshops had been held for each of the FBCs:

1. Refocusing Children's Services: Early Intervention
2. Adult Mental Health: Jersey Talking Therapies
3. Healthy Lifestyles: Alcohol

[59] The original pilot for intermediate care was launched in 2012 which had some impact on reducing demand but the short term nature of the resourcing did not allow the whole system to be implemented, therefore Corporate Directors approved additional pilot money for intermediate care (from 1st July 2013).

4. Adults & Older Adults: End of Life Care, Dementia, Chronic Obstructive Pulmonary Disease, Intermediate Care

The service specifications were drafted by the Commissioners and circulated to a range of stakeholders. The Commissioners role is to ensure that the health and social care needs of Islanders are understood and services are available to meet these needs[60]. Commissioning was identified as key enabler 6 which aims to ensure the needs of Islanders are identified and service users, carers, families and communities are consulted. Commissioners are to make evidence-based decisions regarding health and social services as well as supporting the Voluntary and Community Sector.

Some of the new services were due to commence in 2013 but unfortunately the Department's timescale had to be revised for two reasons; firstly, two workshops to discuss the specifications had to be rearranged due to the outbreak of Norovirus in December 2012. Secondly, some of the service areas proved to be more complex than others, and required more ongoing discussion[61].

The service specifications had originally been split into two categories: simple and complex. By working with key stakeholders such as GPs progress was then classified as red, amber or green. By March 2013, seven green specifications were confirmed and were reviewed by the Minister and her independent advisory Panel (Health and Social Services Ministerial Advisory Panel – HASSMAP)[62]. Although the documents were considered to be at implementation stage via the green labelling, this report considers below which services are now fully operational.

In March 2013 the specifications which were labelled amber were being reviewed and the Department was working with doctors, nurses, other professionals, and voluntary and community representatives with a view to finalising the documents by early June[63].

In September 2013, the Health Department explained that detailed work was continuing for the most complex services including intermediate care and long-term conditions. It was also explained that pilots were being conducted for intermediate care as well as children's respite, dementia respite and end of life care.

KEY FINDING: The impact of delaying the community-based care strategies will have a significant effect on determining the size of the hospital.

Funding Out-of-Hospital Services

Funding relates to key enabler 7 which is to identify funding requirements in accordance with Treasury timescales and decisions. The Panel examines funding issues in greater detail further on in the report. The funding proposals for the work-streams in each priority area of service change identified in the White Paper were incorporated into the Medium Term Financial Plan for Phase 1

[60] P.82/2012 Health and Social Services: A New Way Forward page 37
[61] Response to questions raised by the Health, Social Security and Housing Panel, received from Health Department, January 2013
[62] Fortnightly Update email from Director of System Redesign and Delivery, March 2013
[63] Fortnightly Update email from Director of System Redesign and Delivery, March 2013

(2013 to 2015) and these bids for growth were debated alongside the wider, States of Jersey, funding bids[64].

The following table was provided by the Treasury Department:

Reform Health and Social Services	Department	2013 £'000	2014 £'000	2015 £'000
Adult Mental Health (starting with IAPT)	HSS	340	740	1,130
Children's Services (starting with Early Intervention)	HSS	620	740	860
Cross Cutting Infrastructure	HSS	590	670	710
End of Life Care	HSS	400	810	830
Healthy Lifestyles (starting with Alcohol)	HSS	300	440	530
Intermediate Care	HSS	1330	2,340	2,890
Long-Term Conditions (starting with COPD)	HSS	700	1,340	1,630
Older Person's Mental Health (starting with Dementia)	HSS	740	1,810	2,440
Phasing of White Paper Implementation	HSS	(502)		
Non-White Paper elements:				
Vehicle Replacement	HSS	90	200	300
Health Maintenance (JPH)	TSY	630	700	700
HR HSS – 2 additional posts arising from Verita Report	CMD	180	200	200
Total		5,418	9,990	12,220

Further significant investment will be required from 2016 – 2021 to implement the work streams described in P.82/2012 which was estimated as part of the development of the Green and White Papers. Further business cases including detailed plans and costings will be developed as part of the future States Medium Term Financial Pans[65].

The Panel asked the Treasury Minister[66] to provide information on how much of the White Paper has been spent to date, and a breakdown of how much money has been spent to date on each work-stream. The Panel also requested the future planned spend in each area.

[64] Medium Term Financial Plan 2013 – 2015, page 68
[65] P.82/2012 Health and Social Services: A New Way Forward for Health and Social Services, page 86
[66] Information received via letter dated 1st May 2014

Current Spend

The Treasury explained that of the £5.418 million additional growth funding allocated to reform health and social services in 2013 in the Medium Term Financial Plan, £3.950 million has been spent. A further £1.189 million was spent in quarter 1 of 2014.

Funding has been used to create the commissioning team to support the design, commissioning and implementation of the new services. The funding has also been used to support workforce planning, recruitment costs for new staff and IT informatics development. These were identified in the MTFP as the cross cutting infrastructure work streams and the total spend was estimated to be £710,000 by 2015 (funded from Growth Allocation 2013 – 2015)[67].

Future Spend

The implementation plans for each work stream will lead to full implementation of planned services over the next few years which will be managed in a phased approach. The table below was provided by the Treasury Department and sets out the projected recurrent spend for each area which has been reprioritised from the MTFP allocations:

MTFP Work-stream	Updated Work-streams	Forecast 2015 spend	Original MTFP Budget	Difference
Adult Mental Health (starting with IAPT)	Jersey Talking Therapies	1,130,000	1,130,000	
Children's Services (starting with Early Intervention)	Community midwifery Family Care co-ordinator Short breaks respite Specialist Fostering Nurse Home Visiting Parent engagement and support	1,130,000	860,000	450,000
Cross Cutting Infrastructure	Workforce Informatics Commissioning	710,000	710,000	
End of Life Care	Palliative Care	830,000	830,000	
Healthy Lifestyles (starting with Alcohol)	Alcohol Liaison, detox and relapse prevention	530,000	530,000	
Intermediate Care	Community Intermediate Care Service (pilot) Out of Hospital services	2,900,000	2,890,000	10,000
Long-Term Conditions (starting with COPD)	Pulmonary rehabilitations	1,270,000	1,630,000	(360,000)

[67] Medium Term Financial Plan 2013 – 2015, page 74

	Smoking cessation Respiratory services priority investment Cardiac services Diabetes services			
Older Person's Mental Health (starting with Dementia)	Memory Assessment and Early diagnosis Mental Health Liaison Older Adults Community Mental Health Team Carers support	2,340,000	2,440,000	(100,000)
Non-White Paper costs				
Vehicle Replacement		300,000	300,000	
H&SS Total		11,320,000	11,320,000	
Health Maintenance (JPH)		700,000	700,000	
HR HSS – 2 additional posts arising from Verita Report		200,000	200,000	
H&SS Total		12,220,000	12,220,000	

The differences:

The differences from the outline set out in the MTFP are as follows:

- Increased spend on children's services – investment in specialist fostering and short breaks respite services has been accelerated to meet the additional pressing needs in the children's service.
- Reduction in costs for the Community Resource Centre – as part of the Older Adults work stream funding was earmarked to set up a Resource Centre. This will be set up in partnership with the Voluntary and Community Sector but at less cost than originally anticipated. The funding released has been reprioritised to support the children's service investments.
- The proposed expert patient programme has been re-phased and the funding for this has been reallocated from Long-Term Conditions to the children's services. In addition some of the funding has been reallocated to out-of-hospital services as these will incorporate Long-Term Conditions management.

The Tendering Process

The Health Department developed a tendering process to support the delivery of the new model of health and social care and service developments. Tendering for health and social services was explained as the process for deciding which organisations would provide services in the future[68].

[68] "Tendering for Health and Social Services" paper received from the Health and Social Services Department

Each new service would be tendered, unless one or more of the following criteria applied[69]:

- Only one organisation was capable of providing the service
- Only one organisation expressed an interest
- Services were required immediately, and there was insufficient time to follow a tendering process
- The transaction cost of tendering was higher than the benefit that would have been achieved (for example, low financial value services). There might have been circumstances where a low value service would be tendered if a large number of organisations were interested and capable of providing the service
- Tendering would fragment services and increase clinical risk
- The service was unproven, contentious and required piloting
- There was a risk of adverse economic impact to Jersey (this would most likely impact on decision to tender outside of Jersey)

The White Paper Steering Group approved the above criteria by which the decision on whether to tender or not would be made. The Group comprised Health Directors, Medical Directors, Chief Nurse, GPs and the Chief Executive of the Voluntary and Community Partnership. The Group was led by the Chief Officer of Health[70].

Each service specification would be agreed by a Senior Responsible Officer before being submitted to the Chief Officer and the Director of System Redesign and Delivery for review. A Tender Panel comprising the Lead Commissioner, Director of System Redesign and Delivery, Procurement Advisor and Finance Representative would also review each specification against the agreed criteria detailed above. The Tender Panel would prepare a schedule recommending whether services should be tendered (and if so whether they should be restricted to Jersey or available to off-island bidders), whether services should be piloted or whether services should not be tendered[71].

Each service specification would be confirmed by the Steering Group who would also decide if the service was appropriate for tendering using the agreed criteria. A recommendation would be submitted to the Health and Social Services Ministerial Advisory Panel (HASSMAP). The HASSMAP recommendations would be sent to the Minister for her consideration and final approval[72].

In March 2013, HASSMAP recommended which services would be provided by existing services and which would be tendered[73]. This included:

1.	Specialist Fostering	Expression of interest for the training element
2.	Short Breaks (Children)	Tendered
3.	Family Care Co-ordination	Not tendered
4.	Community Midwifery	Not tendered
5.	Parenting Support Programme	Tendered

[69] "Tendering for Health and Social Services" paper received from the Health and Social Services Department
[70] "Tendering for Health and Social Services" paper received from the Health and Social Services Department
[71] "Tendering for Health and Social Services" paper received from the Health and Social Services Department
[72] "Tendering for Health and Social Services" paper received from the Health and Social Services Department
[73] Fortnightly Update email from Director of System Redesign and Delivery, March 2013

6. Pulmonary rehabilitation — Not tendered
7. Carers Support Services — Tendered

During the beginning of the tendering process, some stakeholders raised concerns with the Health Department which included uncertainty about what services might be tendered and how decisions would be made.

In order to support stakeholders throughout the process, the Department offered three 2-hour sessions on tendering – one on a Saturday, one in the week and an evening session to try an accommodate people's availability[74]. The Department also arranged a series of "drop-in" sessions so that stakeholders could have the opportunity to speak to the people facilitating the changes. These were held on a number of occasions during February 2013 and ran into the evening.

Out-of-Hospital Services

As the new out-of-hospital services are still being developed, the Panel wanted to receive views from those who had been involved in the services already implemented. Therefore, the Panel wrote to several stakeholders asking for their views on how successful the new services had been and for an overall view on their impact.

Community Midwifery Service

In August 2013 the new Community Midwifery service was rolled out Island-wide. Each large GP practice would have a named midwife, and expectant mothers would be offered the option of receiving their antenatal care within their GP practice. This followed a pilot at the Cleveland Clinic, which received positive feedback from the ladies being cared for[75].

The Panel wrote to all GP practices in Jersey following the implementation of the Community Midwife Service. Overall, views were positive about the new system of providing an island-wide antenatal care service in accessible non-hospital settings. It was noted that the GP and midwife have been able to have a closer working relationship due to easier and more frequent contact, thus promoting improved multi-disciplinary working.

Some negative views were expressed including that there was no recompense for the cost of the room and appropriate facilities for the midwives to practice at the GP surgeries. Furthermore, some GPs are providing their care at a reduced rate. For example, some surgeries have agreed to see their patients for no charge for any conditions during a pregnancy and in some cases this can be quite often[76].

One doctor's surgery explained that they were not aware of any correspondence from the Health Department relating to Community Midwifery Services within their practice, but nonetheless they do continue to offer antenatal care services[77].

[74] Fortnightly Update email from Director of System Redesign and Delivery, December 2012
[75] Fortnightly Update email from Director of System Redesign and Delivery, July 2013
[76] Written Submission, received 27th April 2014
[77] Written Submission, received 19th May 2014

KEY FINDING: Following the implementation of the Community Midwife Service most views from GP surgeries were positive about the new system of providing an island-wide antenatal care service in accessible non-hospital settings.

Specialist Fostering

The timescale for Specialist Fostering was brought forward to 2013 which includes foster carers supported (both through training and funding) to care for children with more complex needs[78]. The Fostering and Adoption Service explained that the specialist fostering service needs to continue and the early indicators are that it is having a positive affect overall on the fostering service[79]. The Panel held a Public Hearing with the Commissioners involved in the service and asked how much progress has been made:

> ***Deputy J.A. Hilton:***
> *Yes, and a spend to the end of the first quarter of 2014 of £91,392. So, can you just explain to us where you are with specialist fostering? How much have you managed to roll out of that service?*
>
> ***Mr. A. Heaven:***
> *Okay. So, the specialist fostering was a service pack that was agreed - one of the earliest service packs that were agreed and signed off - and delivering that service are our own Children's Services. They have been involved in working up the policy framework to allow the enablement and training of our own fostering workforce. Originally the specialist fostering was costed on a ... literally by making them part of our own staff, so hence there was a bigger cost. Whereas, the model where we ended up was that they would have a contract for service essentially, and we would train them up according to the National Standards for specialist foster carers[80].*

It was disappointing to learn later on in the Hearing that there were no specialist foster carers working in the system:

> **Deputy J.A. Hilton:**
> *But you have not got any specialist foster carers?*
>
> **Mr. A. Heaven:**
> *Correct. It is a flat structure at the moment and it does not matter what needs that child has[81].*

The Fostering and Adoption Service explained that, although the progress may appear slow, it is crucial that foster carers have the right skills to look after vulnerable children[82]. The Director of System Redesign and Delivery said: *"Those existing foster carers will put themselves forward for the additional training and skills that they will need to be those specialist foster carers. Now that*

[78] Fortnightly Update email from Director of System Redesign and Delivery, September 2013
[79] Written Submission from Fostering and Adoption Services, received 30th May 2014
[80] Public Hearing with the Commissioners, 12th May 2014, page 30
[81] Public Hearing with the Commissioners, 12th May 2014, page 33
[82] Written Submission from Fostering and Adoption Services, received 30th May 2014

we have got the investment there that can recompense them for those additional skills, it is a much more attractive option for people"[83].

KEY FINDING: Even though the Specialist Fostering service was brought forward to 2013, no specialist foster carers have been appointed to date.

Sustained Home Visiting Programme

The Sustained Home Visiting Programme was identified by a multi-agency group as a model of early intervention aimed at offering a structure of home based support to families at risk of requiring crisis intervention. The implementation plan for the service specification was completed by FN&HC in November 2013. In January 2014 the plan was signed off by the Ministerial Oversight Group, Steering Group and Finance Department and following the Minister's final approval FN&HC were asked to implement the programme.

Although training programmes have been completed by six existing staff, FN&HC advised that the success of the programme relies on recruiting skilled staff to deliver the intensive structure of home visits to selected families. Unfortunately there are no Health visitors available on the Island and therefore it has been necessary to recruit from the UK. As FN&HC are still in the process of recruiting, they are therefore unable to fully implement the programme[84].

Opportunistic Screening and Brief Intervention was due to be tendered in 2013 and the Department advised that it would be looking for one GP practice and one pharmacy, to run a pilot for 12 months, starting in 2014[85]. It was also noted that piloting of funding GP appointments would commence from January 2014 for a year. This would be focused initially on children who would be receiving the Sustained Home Visiting service, due to the complexity of their needs.[86]

It was also explained that the Department was part-funding a Co-ordinator, who would work at the Samares Child and Family Centre. This would be a joint project with the Education, Sport and Culture Department, and would provide activities focused on promoting and protecting children and family health, working with Health Visitors, Voluntary and Community Sector organisations and Early Years Education Services such as Parenting.

KEY FINDING: There is a lack of available health visitors on the Island to undertake training for the Sustained Home Visiting Programme and therefore it has been necessary to recruit from the UK. Family Nursing & Homecare are still in the process of recruiting, and they are therefore unable to implement fully the Sustained Home Visiting Programme.

Carers Support Service

The Citizen's Advice Bureau made a written submission to the Panel explaining the new Carers Support Service. The aim of the service is to identify "hidden Carers" and to make better quality information and access to care service available to all. The Jersey online Directory (JOD) provides "three click" access for anyone who wants specific information on care needs, whether they are

[83] Public Hearing with the Commissioners, 12th May 2014, page 36
[84] Written Submission from Family Nursing and Home Care, received 29th May 2014
[85] Fortnightly Update email from Director of System Redesign and Delivery, September 2013
[86] Fortnightly Update email from Director of System Redesign and Delivery, September 2013

health professionals, carers, family or individuals with care needs themselves. The website went live at the beginning of January 2014. CAB explained that taking on the Carers Support service and the work surrounding the launch of JOD was a huge piece of work. Now the service is up and running, the impact on staff and volunteers, although heavy, has been manageable. CAB's concluding remarks were that it had good practical support from the Commissioning Team at the Health Department and strong moral support from the Voluntary and Community Sector, other charities and members of the Carers Support Group[87].

Alcohol Pathway

A leadership team was formed in order to ensure that delivery of the service specification within the alcohol pathway is delivered in an efficient and transparent way. The Panel commented during its previous review of the Health White Paper that there had been a breakdown of communication between the Health Department and Silkworth Lodge, a drug and alcohol charity. In a recent written submission to the Panel, Silkworth Lodge explained that communication has improved 100% with key people all being aware simultaneously of important changes, as well as collaboratively agreeing and identifying gaps in the service. Silkworth Lodge went on to say that as the Alcohol Pathway evolves there is no doubt that this will have a significant impact on the length of stay and repeat admission in the General Hospital[88]. The Panel note that, as the Alcohol Pathway develops, future evaluation will be required in order to obtain sufficient evidence to support this claim.

Intermediate Care

Family Nursing and Home Care (FN&HC) explained that the intermediate care pilot had evolved since the beginning of the project in November 2012. They explained that the development and redesign of intermediate care services was a complex undertaking and after a period of time the large multi-agency working groups were disbanded in favour of individual meetings between the Commissioning Team and individual agencies. FN&HC said that although further meetings did occur, these were whole staff meetings that mainly focussed on information sharing rather than discussions on reflecting on the success of the project.

Furthermore, FN&HC explained that the intermediate care pilot had been successful in supporting patients who had been discharged from hospital for the first six weeks post hospital discharge. The pilot enabled patients to have a period of up to six weeks free care either at home or in a care setting[89]. FN&HC advised that they had not been involved in the evaluation of the project, nor had seen the completed evaluation.

It is understood that the Commissioning Team at the Health Department have established a strategic partnership of the key organisations who are providing out-of hospital (intermediate) care. This includes the Primary Care Body, FN&HC and the Voluntary and Community Sector: "*Together we are going to agree what are the things that we are going to measure that will help us all to know whether what we are doing is value for money in the future*"[90].

[87] Written Submission from the Citizen's Advice Bureau, received 23rd April 2014
[88] Written Submission from Silkworth Lodge, received 30th May 2014
[89] Written Submission from Family Nursing and Home Care, received 29th May 2014
[90] Public Hearing with the Minister for Health and Social Services, 16th June 2014, page 8

The Panel discuss the evaluation process regarding out-of-hospital (intermediate) care services further on in this report.

Older Adult Mental Health Services

The Jersey Alzheimer's Association (JAA) provided the Panel with a written submission regarding the new Older Adult Mental Health services. Unfortunately the JAA were unable to provide evidence on the success of the service because none had been implemented. The JAA explained that it had been involved in meetings to implement three mental health services specifications and that an implementation plan would be signed in December 2013. Those attending the meetings were advised that the Plan would be distributed for comment prior to it being signed off, but this did not happen. JAA were given a copy of the Implementation Plan in March 2014 but were asked not to distribute it as it had not been signed off. JAA advised that although they were very supportive of the aims of the Implementation Plan and were pleased that the Health Department were taking the time to involve and utilise their expertise, they are concerned that the timescales may be too ambitious and given previous delays, may not be met[91].

The Panel were told during a Public Hearing with the Commissioners that older adult mental health services are currently in implementation stage: *"So we have then got what is wrapped up as part of a broad range of services around older adults, community mental health services. For that we have developed and we are now in implementation of 3 elements to that, one of which is the mental health liaison service. The second is the community mental health team and the third is the memory assessment and early diagnosis services. All of those investments have been signed off and we are in the implementation at the moment*[92]."

It is disappointing that one of the key organisations in the delivery of older adult mental health services is concerned about the timescales given previous delays. The Commissioning Team told the Panel that the delivery of some services are more complex than others because they may deal with services which have not previously existed, and important partnerships are needed to be in place to ensure they are going to be successful: "*it does vary depending on the complexity of the service and indeed the complexity of some of the relationships that are required to deliver it*".[93]

Jersey Talking Therapies

A joint project between the Health Department, GPs and MIND Jersey will ultimately provide a range of psychological therapies for Islanders which is known as Jersey Talking Therapies. This service will be delivered in GP surgeries (or a central town hub,) and is now scheduled to launch in autumn 2014.

Jersey Talking Therapies is for adults and covers mental health issues such as anxiety or depression, obsessive compulsive disorder, phobias, panic and post-traumatic stress disorder. MIND Jersey's Executive Director said: "*The public can access a course of computerised cognitive behaviour therapy directly via the MIND Jersey website and also book themselves onto a range of*

[91] Written Submission from Jersey Alzheimer's Association, received 13th May 2014
[92] Public Hearing with the Commissioners, 12th May 2014, page 7
[93] Public Hearing with the Commissioners, 12th May 2014, page 14

different psycho-educational workshops, which are designed to help people manage their mood and stress levels and improve their assertion skills[94]".

Evaluation: Community Intermediate Care Pilot

It is unclear how far the development in out-of-hospital care has been taken forward successfully. While there has been some anecdotal evidence of things working well, it is difficult to see developments as positive overall. The report on Community Intermediate Care Services was critical of progress since 2012. To quote the report:

> "*There is insufficient outcome data to determine the effectiveness of inputs. Less than half of the patients (43%), had an outcome scoring, but for those who did the results were positive. Further consideration needs to be given to the appropriate use in future to determine achievement of outcomes. [….] the provision of a range of services that may not all be intermediate care or reablement and in some cases may be duplicating mainstream provision, which raises questions about value for money of the current model and approach. This will need to be carefully worked through as the out-of-hospital system develops to ensure that intermediate care is ring-fenced*[95]."

A budget of £810,000 was allocated to Intermediate Care in January 2013 to cover the period January to September (£90,000/month) and a further £300,000 was allocated in July 2013 to cover the period of October to December (£100,000/month). An additional £2,800 was allocated to establish an office base. The budget for 2013 was therefore £1,112,800 and the actual spend was £1,202,607 which is an over spend of nearly £90,000 (about 8% of the total budget)[96].

Moreover, the report questioned how much of this budget was spent on the task in hand: to develop a new intermediate care service in Jersey.

> *"The data analysis suggests a significant amount of staff time may be diverted to supporting functions other than intermediate care. There is insufficient data to comprehensively determine the average length of stay per episode of patient care for the provision of direct reablement or short term placements by the team. This will need to be remedied in future to ensure the aims of the investment are delivered.*
>
> *The data describing service inputs is limited with unknown inputs for over 1/3 of all cases. The bulk of the budget spent on care provision was for care home beds and domiciliary care packages to facilitate hospital discharge. It is arguable that unless there is evidence of new reablement approaches in the delivery of these services from the Independent sector then this is a duplication of mainstream services and in effect about 50% of the funding has provided mainstream services although quicker and in a more joined up way[97]."*

It is accepted that the work on Intermediate Care services was a pilot project and its aims were to test out ideas about new ways of working in order to reduce lengths of stay and admissions to the

[94] Health and Social Services Department News Release – 26th June 2014
[95] Community Intermediate Care Services Evaluation report, February 2014
[96] Evaluation report on Community Intermediate Care Services
[97] Community Intermediate Care Services Evaluation report, February 2014

hospital when it is clinically appropriate[98]. The Deputy Director of Commissioning explained: *"….the wealth of information from the pilot, it has really helped us to know what are the things that we have to focus on from day one as we move forward and rollout the whole system. So the pilot was a small part of the eventual out-of-hospital system and the learning from that has been invaluable in helping us to design something that will take us to where we need to go perhaps much quicker than we might otherwise have done*[99]".

The Health Department acknowledged that one of the big system issues is a lack of objective data that helps to measure outcomes. The Health Department explained that a new data set has been created which all providers are contributing to. This work has been influenced by GPs and *"….is helping us to get a list of what we think the sensible measures are that will help us as a system to know whether or not we are making a difference to the whole system by the things that we are doing in the community*[100]*"*.

Lack of sufficient data was an issue raised in the Panel's previous report in 2012 and it is concerning that two years on, the lack of data is still an issue. The Panel asked when reliable data and analytic capabilities would be readily available and the Health Department advised that in 2015 it would have robust data collection systems[101].

KEY FINDING: It is unclear to what extent the White Paper development in out-of-hospital care has been taken forward successfully. The one review undertaken by the Health Department - of the intermediate care pilot - is highly critical in that it indicates a lack of readiness to initiate the service as well as a failure to put in place systems to monitor adequately the use of these resources.

A New Model of Primary Care

Primary Care comprises GPs and practice staff, Dentists, Pharmacists and high street Optometrists. It is acknowledged that Primary Care should be the first port of call for a patient, apart from in an emergency. Currently, patients can choose their own GP, but have to pay a charge which is usually around £35.00. Dentists and Optometrists also operate on a fee-for-service basis[102].

P.82/2012 explains that if Primary Care continues to be delivered by a "medically-led" model, the opportunity to enhance and expand the Primary Care team will be lost, with co-payments continuing to deter some patients from accessing their GP or Dentist. Furthermore, access to Dentistry and Optometry, particularly for those on low incomes, will be limited and Pharmacists may be under-utilised in terms of their skills and range of services[103].

The Panel received a report titled: *Sustainable Primary Care for Jersey: The Next Steps*. The Department informed the Panel that the report was the Terms of Reference and Scoping Document for the work which was intended to result in a proposed new model of sustainable

[98] Public Hearing with the Minister for Health and Social Services, 16th June 2014, page 8
[99] Public Hearing with the Minister for Health and Social Services, 16th June 2014, page 8
[100] Public Hearing with the Minister for Health and Social Services, 16th June 2014, page 10
[101] Public Hearing with the Minister for Health and Social Services, 16th June 2014, page 10
[102] P.82/2012 Health and Social Services: A New Way Forward, page 16
[103] P.82/2012 Health and Social Services: A New Way Forward, page 23

primary care by the end of 2014. The intention was to secure a partner to work with the Department, Social Security and Primary Care practitioners.[104]

The Department, Social Security and primary care practitioners were progressing with a procurement exercise in order to select a partner to work with the Department on developing options for a model of sustainable primary care, and to meet the requirements of the scope.[105]

A Tender Evaluation Panel was established for the procurement exercise but it was unable to reach a consensus, and after a discussion had taken place by the Ministerial Oversight Group in late December 2013, the procurement exercise was formally terminated.

Within the last document the Panel received, it was explained that the Department and Social Security were engaged in discussions with representatives from the Primary Care Body, and will be looking to re-engage with primary care practitioners to develop a strategy for the way forward[106]. It was agreed in March 2014 that the sustainable primary care work should be led on-island, in partnership, drawing on external expertise when required.

The delay in selecting a partner to develop options for a sustainable primary care model has had a major impact on the delivery of a new model of primary care. The terminated exercise has undoubtedly incurred costs to the States of Jersey and, itself, represented an unproductive use of time and other resources.

The Panel was advised that the Health Department plans to put forward a strategy by around April 2015, and prior to that a number of publications would be available from the Sustainable Primary Care Project Board. The Board was launched officially in April 2014 and includes all key stakeholders. The aim of the Board is to look at key policy and principle issues that will help frame a future strategy around primary care[107]. The Chief Executive Officer explained the plan for the project and advised that, contrary to what was agreed within P.82/2012, the States can expect to consider a strategy, with funding options, in April 2015:

> **Chief Executive Officer:**
> *The plan for the project is for us to co-design, with primary care practitioners, a new and sustainable way of providing primary care. That will also be costed and we will look at the way the money flows around the system because, as you know, at the moment there are some perversities in the way funding flows, which does not necessarily help the delivery of the type of primary care that, for example, we know general practitioners want to provide, which is a much broader and holistic set of services in their practices. But at the moment the way the funding goes into practice then the Health Insurance Fund does not necessarily support that. So we will be both co-designing the system, but also in looking at how we fund the system, and then, if there are issues around the levels of funding, obviously that would be an issue that comes back to the States for further consideration.*
>
> [….]

[104] Appendix 2 of response to Panel letter to the Minister for Health and Social Services dated 13th January 2014
[105] Appendix 2 of response to Panel letter to the Minister for Health and Social Services dated 13th January 2014
[106] Appendix 2 of response to Panel letter to the Minister for Health and Social Services dated 13th January 2014
[107] Public Hearing with the Minister for Health and Social Services, 16th June 2014, page 4

The Deputy of St. Ouen:
So, just to be clear, April 2015 we can expect, or the States can expect, to be able to consider a strategy together with the funding options that will need to be required to take forward the new primary care model?

Chief Executive Officer:
Yes[108]*.*

The delay in selecting a partner to develop options for a sustainable primary care model has had a major impact on the delivery of new model of primary care.

RECOMMENDATION: Proposals for the new model of primary care should be finalised and agreed by the States at least two months before the Medium Term Financial Plan 2016 – 2019 is debated.

[108] Public Hearing with the Minister for Health and Social Services, 16th June 2014, page 5

10. The Future Hospital

P.82/2012 set out the visions for an integrated system and a programme of change that would meet the challenges facing health and social services. It emphasised the importance of new modern hospital services to the future of health care delivery in Jersey. P.82/2012 was approved by the States, and the Council of Ministers was charged with bringing forward proposals for investment in hospital services and detailed plans for a new hospital (either on a new site or rebuild on the current site) by the end of 2014. This included full details of all manpower and resource implications necessary to implement such plans.

Central to the Department's case for the redesign of health and social services is the need for a hospital which is fit for purpose, embedded in the proposed whole system for health and social care and capable of meeting the population's needs for general and acute care. This section relates to key enabler 2 (estates and facilities) which is to ensure services are delivered from buildings that are fit for purpose and compliant with required standards.

The Minister published an interim report into the hospital pre-feasibility spatial assessment project in 2012 (R.125/2012) that explained that the new hospital will need to address a number of pressing issues, which fall into 2 key groups:

1. Responding to the strategic imperatives of developing an integrated care service on the Island where the acute hospital and community-based health services are designed to complement and support one another as part of an integrated care strategy.

2. Responding to the physical requirements for a new hospital to address the following key issues with the current hospital infrastructure-

    a. Inefficient and aging design – poor clinical adjacencies
    b. Poor space standards compromising effective care delivery
    c. Inadequate provision to control the potential spread of infection
    d. Lack of flexibility in the use of space
    e. Inadequate separation of clinical and non-clinical movements
    f. Poor gender separation and lack of privacy and dignity
    g. Deficient supporting mechanical and engineering infrastructure
    h. Poor provision of fire control and escape measures such as compartmentalisation to allow progressive horizontal evacuation

In addition to setting out a vision for the new hospital, P.82/2012 emphasised the need to ensure that hospital services remained viable and sustainable during the transitional 10-year period before a new hospital could be opened. Consequently, it highlighted an urgent need for significant investment in current hospital buildings, many of which are no longer fit for purpose, and also in critical infrastructures such as patient information systems to support effective patient care and clinical governance.

The Panel in S.R.7/2012 accepted this by acknowledging that a continuing programme of refurbishment was necessary to continue to bring hospital standards to an acceptable level.

KEY FINDING: Proposition P.82/2012 "Health and Social Services: A New Way Forward" required the Council of Ministers to bring forward proposals for investment in hospital services and detailed plans for a new hospital (either on a new site or rebuild on the current site) by the end of 2014. This included full details of all manpower and resource implications necessary to implement such plans.

Timeline of hospital planning process

A number of issues have arisen during the process to identify and select a hospital site. These are discussed below. First a timeline is provided showing the key events in planning for new hospital services

Event	Date	Summary
KPMG appointed to review how services are provided and what steps will be required to ensure that Jersey can offer quality care	Completed in May 2011	As a result of KMPG's work, three strategic scenarios were identified which encompassed the options of the future of health and social care in Jersey.
Green Paper: Caring for each other, Caring for ourselves	Published in May 2011	Following the KPMG report, the Department published a Green Paper which asked for views on health and social services and recommended support for scenario three "A new model for health and social care"
White Paper: Caring for each other, Caring for ourselves	Published in May 2012	Following the Green Paper consultation, the Department developed detailed plans for the next 10 years. The White Paper outlined these plans and sought further feedback from the public.
W.S. Atkins development of Pre-Feasibility Spatial Assessment and Strategic Outline Case	Appointed on 31st May 2012	W.S. Atkins worked on producing the pre-feasibility study between May 2012 – May 2013
W.S. Atkins submit Strategic Outline Case to States of Jersey	31st August 2012	This was the initial evaluation of site options
Panel's Report on Health White Paper: S.R.7/2012	15th October 2012	The Panel concluded that the proposition should be welcomed in general terms, and emphasised that its scope and scale would necessitate a challenging process of synchronising the introduction of many new services, some of which were reliant on the recruitment of specialised staff. In particular, the Panel recognised the importance of carefully phasing the development of services in the community with any change in the role and volume of hospital services.
Ministerial Response to Panel's report: S.R.7/2012	13th February 2013	

		The Panel made 21 recommendations in total. The Minister accepted 12, noted 8 and rejected 1 of the recommendations.
R.125/2012 Hospital Pre-Feasibility Spatial Assessment Project: Interim Report	Presented to the States on 18th October 2012 by the Council of Ministers	The report set out the progress to date in developing the proposals for a new hospital.
P.82/2012 Health and Social Care: A New Way Forward	Lodged on 11th September 2012 Approved by the States Assembly 23rd October 2012	The States approved a radical change to the way Health and Social Services are delivered in Jersey, with an increasing emphasis of health being delivered in community settings with associated benefits for patients and enabling hospital services to focus on the increasing demand posed by demography and an ageing society[109]
W.S. Atkins is informed at a Ministerial Oversight Group meeting of the potential for a £250 million budget cap	February 2013	The budget was not confirmed until further validation and cost challenge work was undertaken in May 2013
Review of funding options and affordability	June 2013	A decision to set an indicative budget of £250m was made by Ministerial Oversight Group[110]
Ministerial Oversight Group decision	June 2013	The outcome of MOG's consideration was that a phased redevelopment and expansion of the existing Jersey General Hospital in St. Helier was the preferred solution[111]
Ministerial Oversight Group decision	18 June 2013	Ministers requested that a refined proposal, based on the findings and recommendations of the previous Pre-Feasibility Strategic Outline Case, but within the identified funding available, be drawn up by a Design Champion (to be appointed), to inform the States Assembly of the approach to be adopted within a more detailed Feasibility Study[112]
Development of 1st phase concept	July 2013 – August 2013	Design champion was appointed in July 2013, who first proposed a dual site solution. W.S Atkins was introduced to the design champion in

[109] Future Hospital Feasibility Study: Strategic Brief
[110] Notes received prior to the Public Hearing with the Treasury and Resources Minister, 13th June 2014
[111] See p6, line 3 of States of Jersey, The States of Jersey Hospital Pre-Feasibility Spatial Assessment Project: Jersey General Hospital: Refined Concept Addendum to the Strategic Outline Case, 3rd October 2013
[112] See p6, lines 5&6 of States of Jersey, The States of Jersey Hospital Pre-Feasibility Spatial Assessment Project: Jersey General Hospital: Refined Concept Addendum to the Strategic Outline Case, 3rd October 2013

		August 2013.
W.S. Atkins refined concept: pre-feasibility spatial assessment	Post July 2013 –3 Oct 2013	The refined concept was developed in consultation with Clinical Directors. A potential new model of working for a dual site solution was subsequently identified.
Accepted Budget 2014	5th December 2013	The States approved that the Strategic Reserve would be used to fund the new hospital and that an initial sum of £10.2 million should be transferred from the Fund (under the revised policy) for the first stage of the project.
Tender for Feasibility Study	April 2014 – December 2015	In April 2014 the States of Jersey sought to procure a supplier that would deliver Independent Client Technical Advisor Services relating to the delivery of the planned future hospital project. In June 2014 technical, legal and financial advisors were appointed[113].

This timeline is reflected in the discussion that follows as it is important to understand the path that the decision process took.

The decision making process

There has been considerable work on the development of plans for new hospital facilities and a multitude of documents have been produced with various options included at various stages. It can be difficult to follow exactly what has been changing throughout this process, and what the basis for the current decision is. The crux of the matter is the preferred choice of site(s) for the delivery of acute hospital services: this section looks at how that choice evolved.

W.S. Atkins International Ltd (hospital planning consultant) was appointed to undertake the Hospital Pre-Feasibility Spatial Assessment Project under cover of correspondence from States of Jersey dated 31 May 2012. Formal contract documents embodying the scope of services and terms and conditions of appointment were prepared, exchanged and signed in October 2012, including a fee of £150,000[114].

The terms of reference for the initial appointment covered the evaluation of various potential sites for the hospital on Jersey and the production of a Strategic Outline Case for the project following the protocols set out in HM Treasury's business case guidance. The evaluation of potential sites took place during June, July and August of 2012 and the Strategic Outline Case was submitted to States of Jersey on 31 August 2012 for review and comment[115].

Prior to the engagement of W.S. Atkins, officers within Jersey Property Holdings and the Planning Department had generated a long list of 25 potential development sites for the new hospital. These

[113] Ministerial Oversight Group Minutes, 25th June 2014
[114] Public Hearing with the Treasurer of the States, 2nd May 2014, page 19
[115] Correspondence from W.S. Atkins, received 3rd July 2014 [full version may be found in Appendix 1]

were reduced to 10 sites and W.S. Atkins was asked to examine the potential of each of these. The sites were[116]:

- Site 1 - existing General Hospital site (with potential additional purchased areas)
- Site 2 - Overdale Hospital
- Site 3 - St Saviour's Hospital (with Clinique Pinel and Rosewood House)
- Combined Sites 4+14- Site 4 Esplanade Car Park and Site 14 Zephyrus / Westwater / Crossland site
- Site 8 - Land at airport (fields to south)
- Site 10 - Warwick Farm
- Site 16 - Jersey Gas site, Tunnel St, St Helier
- Site 19 - Westmount Quarry, St Helier
- Site 21 - Samares Nurseries
- Site 22 - Field 1219, La Grande Route de Mont a L'Abbe, St Helier

W.S. Atkins ranked the 10 sites on a range of benefit criteria and operational and construction risk criteria and shortlisted 3 sites:

- Site 1 - existing General Hospital site (with potential additional purchased areas)
- Combined sites 4+14 - Site 4 Esplanade Car Park and Site 14 Zephyrus / Westwater / Crossland site
- Site 10 - Warwick Farm

These were presented to the Project Board on 31 July 2012, and then to the Ministerial Oversight Group on 2 August 2012 which accepted sites 1 and 10 but rejected the combined Site 4+14 on the basis that no alternative financial centre could be identified or costed during the shortlisting process and therefore a meaningful financial analysis could not be conducted[117]. However, the Assistant Minister for Treasury and Resources suggested that a new variant on the combined site option Site 4+14 be considered including the cinema site adjacent to site 14 along with site 4[118]. This proposal was accepted and designated as Site 14 + a new Site 28 (comprising the Aquasplash / Cineworld complex), and became known as the Zephyrus / Crosslands / Aquasplash / Cineworld option[119].

Within the Strategic Outline Case W.S. Atkins had identified several disadvantages of the initial combined sites option: "*the separation of the sites by the main road presented significant obstructions to providing the necessary clinical and operational links between the sites and the Ministers believed that the potential development of these sites for the Jersey International Finance Centre should have priority as it offered a greater potential contribution to the island's economy[120]".*

So, one of the reasons for rejecting the Zephyrus site was the separation of the sites by the main road which would present significant obstruction to providing the necessary clinical and operational

[116] W.S. Atkins Hospital Pre-Feasibility Study, May 2013, pages 28/29
[117] File Note of meeting on 2nd August 2012, HSSD White Paper, Ministerial Oversight Group
[118] File Note of meeting on 2nd August 2012, HSSD White Paper, Ministerial Oversight Group
[119] Hospital Pre-Feasibility Spatial Assessment Project, May 2013, page 29
[120] Hospital Pre-Feasibility Spatial Assessment Project, May 2013, pages 28/29

links between the sites. This raises the question of whether the same concerns have been identified with operating a dual site hospital from the current hospital site and Overdale, involving a substantially greater degree of physical separation.

KEY FINDING: One of the reasons for rejecting the Zephyrus site was the separation of the sites by the main road which would present significant obstruction to providing the necessary clinical and operational links between the sites. This is inconsistent with the later proposal by the Minsiterial Oversight Group to operate a dual site hospital from the current site and Overdale, which involves a substantially greater degree of physical separation.

W.S. Atkins took these 3 short-listed sites forward for further development, appraisal and evaluation, as agreed by the Ministerial Oversight Group on 2 August 2012, and produced a further ranking of these 3 sites on a range of benefit criteria and operational and construction risk criteria, W.S. Atkins concluded that Site 1 and Site 14+28 [121]were equally placed as the best of the three. This was presented in the Hospital Pre-Feasibility Spatial Assessment Project Strategic Outline Case (V3) delivered to the States of Jersey on 7 September 2012. The outcome of the site assessment was presented at a Ministerial Oversight Group meeting on 11 September 2012 and a subsequent meeting on 25 September 2012. At this point W.S. Atkins was presenting costed proposals for each of these options with a range from £409,297m (site 10 Warwick Farm) to £503,760m[122] (site 14/25 Zephyrus / Crosslands / Aquasplash / Cineworld).

No decision was made on the preferred site. Instead W.S. Atkins was asked to consider further sites for evaluation. As a result 4 more options were added to the sites under consideration, a decision made at the Ministerial Oversight Sub Group meeting on 5 December 2012. These were:

- Site 1B – extended General Hospital site[123]
- Site 2B – Westmount Health Quarter (Overdale with additions)
- Site 14B - Zephyrus / Crosslands / Cineworld / Les Jardins de la Mer
- Site 14C - Zephyrus / Crosslands / Les Jardins de la Mer

The Strategic Outline Case explained that although Warwick Farm offered the opportunity of a new-build development option on a green-field site, the Ministers did not consider this site to be suitable because it would require re-designation of green zone land. In addition, the visual development impact of such a large building in a rural setting would have been out of keeping with the surroundings coupled with considerable transport impacts which were not considered sustainable[124]. As a result, although an initially cheaper option, Warwick Farm was not taken forward for any further consideration.

Ministers also requested a subsequent review of different configurations of the two remaining shortlisted site options – the current hospital site and the Waterfront site[125]. The results of this further review were presented to the Ministerial Oversight Sub Group meeting on 1 February 2013.

[121] Correspondence from W.S. Atkins, received 3rd July 2014 [full version may be found in Appendix 1]
[122] Council of Ministers Report, 4 October 2012 Agenda Item - Hospital Pre-feasibility Spatial Assessment Project, paragraph 3.3.
[123] Extended elements include purchase of additional properties along Kensington Place to provide a greater site and potential development area, thus assisting in reducing the height of the new development along Kensington Plan from that indicated in site option 1A
[124] Hospital Pre-Feasibility Spatial Assessment Project, May 2013, page 30
[125] W.S. Atkins Hospital Pre-Feasibility Study, May 2013, page 30

Between these meetings the following issues emerged:

- Concerns from the States of Jersey Development Company regarding Waterfront Option 14C
- Concerns from the Minister for Planning and Environment about the permitted height of buildings on the current hospital site, in particular the potential height of 9 storeys
- Concerns from the Chief Executive of the States about the affordability of the emerging financial costs

W.S. Atkins provided cost estimates for the 5 site options to the Ministerial Oversight Sub-Group meeting on 1 February 2013 as follows:

- Site 1A – Existing General Hospital - £480million
- Site 1C[126] – Extended General Hospital - £490million
- Site 1D - Current General hospital site (a variant of 1C) - £500million
- Site 14A - Zephyrus/Crosslands/Cineworld/Aquasplash - £506million
- Site 14C - Zephyrus/Crosslands/Les Jardins de la Mer - £468 million.

And Site 1E – Current General hospital site (a variant 1C but with reduced development along Kensington Place) - £492million.

These sites were worked up into costed proposals, one of which, based on the existing hospital site, was presented as three options, so the five in total[127] were:

- Site Option 1A: Redevelop on the existing hospital site with some purchase of properties on Kensington Place and Edward Place;
- Site Option 1B: Redevelop on the existing hospital site with some purchase of properties on Kensington Place and Edward Place as in Option 1A but with purchase of additional properties on Kensington Place;
- Site Option 1C: Redevelop on the existing hospital site with same purchase of properties on Kensington Place and Edward Place as in Option 1B but with more intensive use of existing hospital area resulting in reduced heights of new build;
- Site Option 14A: New development at Zephyrus/Crosslands/Cineworld/Aquasplash requiring purchase of Cineworld and Aquasplash sites;
- Site Option 14C: New development at Zephyrus/Crosslands/Les Jardins de la Mer: all sites currently owned by States of Jersey.

The Chief Executive of the States of Jersey expressed a view that '*unless the cost of the scheme could be reduced down to the levels identified in R.125/2012* [between £389m - £431m]*, it would*

[126] This option requires the purchase of the same additional properties along Kensington Place as identified in site option 1B to provide a greater site and potential development area but retains the existing phase 2 tower and redevelops the area of the exiting hospital more intensively, thus reducing by a further storey, to six storeys, the height of the new development along Kensington place.

[127] Work on a fourth option, Option 10, to use Warwick Farm which would have had to be purchased, appeared in the original Strategic Outline Case presented by Atkins in May 2013 but appears to have been dropped in February 2013 as Ministers did not consider it suitable as it would require re-designation of a green zone land site.

be necessary for the project to consider what clinical compromises were necessary to achieve a total project cost of below £400 million[128]'.

KEY FINDING: At Ministerial Oversight Group Sub-Group meeting in February 2013, the Chief Executive of the States expressed a view that unless the cost of the scheme could be reduced down to the levels identified in R.125/2012 (between £389m - £431m), it would be necessary for the project to consider what clinical compromises were necessary to achieve a total project cost of below £400 million.

It was noted at this meeting that W.S. Atkins's view remained that a new site was preferred over the current site. The Group recommended that sites 1E (a variant of the existing General Hospital site) and 14C (new development at Zephyrus/Crosslands/Les Jardins de la Mer) be taken forward for short-listing evaluation.

Following further consideration of the two sites, the Ministerial Oversight Sub-Group confirmed that Zephyrus / Crosslands / Aquasplash / Cineworld site should not be considered further as the positive benefits and risks associated with the development of this site option could not overcome the significant financial penalty arising from the re-provision and re-location of current occupiers of this site. Therefore, Ministers confirmed that this option should be replaced with an alternative Waterfront site replacing the Aquasplash and Cineworld sites with Les Jardins de la Mer[129].

These 2 sites were assessed and scored against the same range of benefit and risk criteria and cost assessment previously identified within the short-list evaluation process, and the Zephyrus / Crosslands / Les Jardins de la Mer was found to perform higher on benefits, lower on risks, and lower on costs[130].

The result in terms of estimated cost[131] was:

- Option 1E - extended General Hospital site - £461,693,000
- Option 14C - Zephyrus / Crosslands / Les Jardins de la Mer - £432,765,000

This is a reduction in costs compared with the figures provided at the meeting on 1 February 2013. This is primarily because of a decision to reduce the provisional location adjustment (Jersey factor) from 40% to 30%[132]. This is discussed further on in the report.

At this point the issue of affordability was raised again. Thus the note states that: '*The Project Board Sub-Group consider that setting an arbitrary affordability figure at this point would be unwise as this might artificially prevent the development of a clinically fit for purpose hospital, but the Group recognise that the two shortlisted options may not be affordable*[133]'.

[128] File note of meeting Ministerial Oversight Sub Group, 1 February 2013, section 5
[129] Hospital Pre-Feasibility Spatial Assessment Project, May 2013, page 31
[130] Hospital Pre-Feasibility Spatial Assessment Project, May 2013
[131] Hospital Pre-Feasibility Spatial Assessment Project, May 2013, pages 31
[132] Ministerial Oversight Group Hospital Pre-Feasibility Spatial Assessment Project Sub-Group, Summary of key Points for Ministers 22 February 2013. Section 3.
[133] Ministerial Oversight Group Hospital Pre-Feasibility Spatial Assessment Project Sub-Group, Summary of key Points for Ministers 22 February 2013, Conclusions.

With these estimates, however, it is important to note that W.S. Atkins did not take account of the indirect impact of a Waterfront development reducing a potential source of income for the States from existing uses of the site which would be needed to support general funds at a time when the hospital would need to be paid for. Nor did it take account of the full impact that the long-term development of a hospital in the central business district of the Island might have on the future economic development of the Island[134]. But equally, account had not been taken of the opportunity cost of alternative uses of existing sites that were owned by Jersey Property Holdings, for example the existing hospital site or the Overdale site.

With this in mind, the Ministerial Oversight Group Sub-Group agreed in February 2013 that, although the Waterfront options had attractions in terms of potential benefits, costs and ease of construction, any Waterfront option would be out of keeping with the existing Esplanade Quarter Masterplan and would involve considerable opportunity costs to replace or compensate for the loss of existing uses. Furthermore, the options developed were considered likely to have a detrimental impact on the development of the Jersey International Finance Centre which would form an income stream considered essential for the development of the new hospital. The Minister for Treasury and Resources told the Panel: "*Firstly, using the Waterfront site would mean that the States would forego the revenue and the dividends from the redevelopment of the Waterfront and that would certainly be within our expected range, irrespective of the timing of the office development or use of residential*"[135].

Consequently, Ministers confirmed that there should be no further consideration given to any Waterfront site option[136].

It is clear from the discussion in the Strategic Outline Case that the decision to go ahead with the existing site in preference to any of the Waterfront options or the Warwick Farm site was not based on estimates of costs as the Waterfront was a potentially cheaper option, but on other considerations the value of which could not be included as a financial figure. So, at this point the only option to be taken forward was the use of the existing hospital site.

KEY FINDING: Although the Waterfront options had attractions in terms of potential benefits, costs and ease of construction, the Ministerial Oversight Group Sub-Group agreed that any Waterfront option would be out of keeping with the existing Esplanade Quarter Masterplan and would require considerable lost opportunity costs to replace or compensate for the loss of existing uses. Furthermore, the options developed were considered likely to have a detrimental impact on the development of the Jersey International Finance Centre which would form an income stream considered essential for the development of the new hospital.

The original indicative range of costs of shortlisted options was assessed by W.S. Atkins, who summarised the capital construction and development costs as being £389 - £431 million (as detailed in R.125/2012).

[134] Hospital Pre-Feasibility Spatial Assessment Project, May 2013, pages 30/31
[135] Public Hearing with the Minister for Treasury and Resources, 13th June 2014, page 14
[136] Hospital Pre-Feasibility Spatial Assessment Project, May 2013, page 32

The Hospital Pre-Feasibility Spatial Assessment Project was considered by the Ministerial Oversight Group who agreed that a phased redevelopment and expansion of the existing Hospital site in St Helier was the preferred solution[137] as explained in detail earlier on in the report.

KEY FINDING: A wide range of sites were considered by W.S. Atkins between May 2012 and June 2013 including Greenfield sites, and many of these were worked up into relatively detailed costings. The preferred option that emerged was to rebuild on the existing General Hospital site. However the introduction of a reduced budget envelope necessitated a reconsideration of this choice.

Pre-feasibility study and its addendum

The preferred site option developed in the Hospital Pre-Feasibility Spatial Assessment Project identified a total new construction and land cost of approximately £462 million, however, the Ministerial Oversight Group subsequently identified a maximum sustainable total capital funding package of £250 million (excluding contingency) spread over 10 years coupled with a 10 year programme of investment for the priority maintenance of the existing hospital buildings.

In June 2013, W.S. Atkins prepared a Phase 1 concept to meet a list of priority objectives identified by the Health Department and an indicative budget of £250 million excluding contingencies. The Project Board met informally and agreed that the Phase 1 Concept did not meet key outcomes and recommended an alternative approach. W.S Atkins said:

> *"We were surprised that the Project Board concluded that our Phase 1 Concept did not achieve key outcomes. The priorities we had discussed at the inception of that stage of the commission centred around the provision of single bedded accommodation, the re-provision of theatres, the provision of intensive care beds, the provision of women and children's accommodation and how this could all be achieved within a phased redevelopment of the site. The solution we proposed achieved these objectives, albeit over a period of time. Feedback we received from the Project Director indicated that the solution achieved the brief we had been given however, there was concern from the Project Board that the investment required to acquire properties down Kensington Place did not result in immediate benefits for patient care. The phased redevelopment provided in the Board's view a less attractive solution for the population of the island".*

The Ministerial Oversight Group also considered the Phase 1 Concept and proposed funding strategy in June 2013 and requested that a refined proposal, based on the findings and recommendations of the previous pre-feasibility strategic outline case, but within the identified funding available (£297m), be developed[138]. Therefore, it is understood that W.S. Atkins was given a revised development brief to its pre-feasibility spatial assessment project. An addendum to this study was issued in October 2013. The aim of the addendum study was to identify a refined concept proposal for new hospital capacity within a reduced, and sustainable funding package. Availability of funding was the key driver in developing the revised proposals.

[137] Hospital Pre-Feasibility Spatial Assessment Project: Jersey General Hospital Refined Concept: Addendum, 3rd October 2013, page 6
[138] Hospital Pre-Feasibility Spatial Assessment Project: Jersey General Hospital Refined Concept: Addendum, 3rd October 2013, page 6

The cost of the hospital project set out within the addendum is £275 million. The Funding Strategy within the Budget 2014 includes an allowance for a cancer care facility (£14.5m) and Transitional Capacity (£7.5m) giving a total of £297m[139],(a total which was considerably less than the £389 to £431m contained in R.125/2012 which was considered alongside P.82/2012).

Within the addendum, W.S Atkins was also tasked to incorporate the development of a dual site proposal identified by a health design champion who had been appointed separately and directly by the States of Jersey in July 2013[140].

KEY FINDING: Although the preferred site option developed by W.S Atkins identified a total new construction and land cost of approximately £462 million, the Ministerial Oversight Group subsequently determined a maximum sustainable total capital funding package of £250 million (excluding contingency).

The Design Champion

The decision to appoint a design champion was made following a Ministerial Oversight Group meeting in June 2013, which was made in agreement with the Project Board. It was surprising that such an important post was not advertised, and the reason given for this by the Treasury Department was that: *a highly experienced and suitable candidate was known to the Treasurer and was available to provide input to the tight timescale desired".*[141]

W.S. Atkins have indicated that they were surprised by the appointment of a design champion to undertake further development work in July/August 2013. In a letter to the Panel, W.S. Atkins state: "*We did not bid for this element of work and were unaware that the States had sought offers for such consultancy. We were not asked to put forward a proposal for this element of work. As far as we were aware, the Design Champion's appointment was a direct commission from the States without any tendering process. Our introduction to the Design Champion was at a meeting held in Jersey Property Holding's offices on 6th August 2013".*

Although there was a tight timescale, it is of concern that others were not given an opportunity to apply for the post and that the States' existing consultants (W.S Atkins) were unaware that an appointment was being made to conduct work of direct relevance to their own pre-existing and continuing appointment.

It is understood that the design champion identified that a single investment in the General Hospital site would not maximise the benefit of the available investment and would result in a more lengthy and complicated construction programme causing significant disruption and inconvenience to patients[142]. In the interests of transparency the Panel note that there appear to be no details of his analysis on public record to enable an assessment of the factors taken into account or the robustness of judgements derived from it.

[139] Appendix 4 of response to Panel letter to the Minister for Health and Social Services dated 13th January 2014
[140] Hospital Pre-Feasibility Spatial Assessment Project: Jersey General Hospital Refined Concept: Addendum, 3rd October 2013 page 6
[141] Notes received prior to the Public Hearing with the Treasury and Resources Minister, 13th June 2014
[142] Minister for Health and Social Services Statement on future hospital project, 8th October 2013

KEY FINDING: The design champion identified that a single investment in the General Hospital site would not maximise the benefit of the available investment and would result in a more lengthy and complicated construction programme causing significant disruption and inconvenience to patients. The Panel has found no evidence analysis on public record to enable an assessment of the factors taken into account or the robustness of judgements derived from it.

RECOMMENDATION: Work undertaken by the design champion should be independently reviewed by a fully qualified cost advisor to ensure that the overall cost of the dual site option can be compared with other options considered by W.S. Atkins on a level playing field basis. The result of this work should be published and reported to the States within a six month period.

There were added difficulties relating to existing planning restrictions on some hospital buildings which could impact on the ability to develop a building large enough to house modern healthcare services[143]. The design champion proposed a dual site concept utilising the current general hospital site and parts of the Overdale site. The Panel believes this was the first occasion when the combination of these two sites was put forward as an option for the future delivery of acute hospital services within a mix of new and refurbished facilities.

W.S. Atkins explained this concept, in the addendum and refined concept, showing how some buildings at the Overdale Hospital site could be replaced with a new ambulatory care out-patient hospital. This entails splitting the proposed clinical services between two separate sites[144] - the existing hospital site and Overdale.

The dual site option consisted of partial redevelopment on the old General Hospital site plus the transfer of some services to the new site where the Overdale Hospital now is. Outpatient services, pathology laboratories, pharmacy, renal dialysis facilities, and possibly a cancer care centre will be located in new buildings on the Overdale site[145]. Other services will be retained on the General Hospital site.

This differs from previous options in that as well as splitting services across two sites which are a considerable distance apart, it also involves much less new build than had been previously envisaged. The total dual site solution is 44% new build 30% refurbishment and 26% existing (which is largely facility management and offices).

The Ministerial Oversight Group agreed in September 2013 that the W.S. Atkins addendum and refined concept was appropriate to recommend to the Council of Ministers for progression to feasibility study. Subsequently, the Council of Ministers agreed in October 2013 that the refined concept was suitable to recommend to the States Assembly for funding within proposals for the Budget 2014[146].

[143] Minister for Health and Social Services Statement on future hospital project, 8th October 2013
[144] Hospital Pre-Feasibility Spatial Assessment Project: Jersey General Hospital Refined Concept: Addendum, 3rd October 2013 page 16
[145] Hospital Pre-Feasibility Spatial Assessment Project: Jersey General Hospital Refined Concept: Addendum, 3rd October 2013
[146] Hospital Pre-Feasibility Spatial Assessment Project: Jersey General Hospital Refined Concept: Addendum, 3rd October 2013 page 43

Was the decision process effective?

The previous section describes the rather long drawn out process that appears to have resulted in a choice of a preferred option for the hospital site. There are features of the process that are of concern.

W.S. Atkins explained to the Panel that, at times, they were set unrealistically short timescales for the delivery of information or reports: *"…with hindsight, we did not challenge these demands firmly enough. We did not engage fully with key members of the Project Board….As a consequence, it was more difficult to ensure that they fully understood the challenges of proceeding down a particular route or direction of travel"*[147].

KEY FINDING: W.S. Atkins felt that at times they were set unrealistically short timescales for the delivery of information or reports. They also felt that were not able to engage fully with key members of the Project Board and as a consequence it was difficult to ensure that they fully understood the challenges of proceeding down a particular route or direction of travel.

Initial absence of a budget envelope

While it may be appropriate that in the initial stages the contractor, in this case W.S. Atkins, in producing a Hospital Pre-Feasibility Spatial Assessment was not limited by budget, it should become clear very early on what the budget envelope is likely to be so that appropriate value is obtained from consultant time and expertise. It appears to the Panel that the process employed in this case may have been sub-optimal

The Ministerial Oversight Group was aware of the potential cost of the new hospital as early as August 2012. However, it was not until May 2013 that W.S. Atkins was advised that the Treasury Department wished to limit any capital expenditure for a replacement hospital to £250 million[148]. Indeed, at a meeting in February 2013, the Chief Executive of the States referred to the need to remain within a budget of £400 million which reflected the figure given in R.125/2012. W.S. Atkins received an email from the Project Director on 10th June 2013, which was the first written confirmation from the States of Jersey that there was a budget cap for the project[149].

The effect of a reduced budget means that the 100% new build hospital will no longer be provided.

KEY FINDING: It was not until May 2013 that W.S. Atkins were informed of the available budget for the future hospital project. While it may be appropriate that in the initial stages the contractor is not limited by budget, it should become clear very early on what the budget envelope is likely to be so that appropriate value is obtained from consultant time and expertise

Extraneous factors

A number of other factors seem to have come into play in determining that a greenfield site would not be chosen, even though this would have scored higher in terms of less risk, more benefits and

[147] Correspondence from W.S. Atkins, received 3rd July 2014 [full version may be found in Appendix 1]
[148] Correspondence from W.S. Atkins, received 3rd July 2014 [full version may be found in Appendix 1]
[149] Correspondence from W.S. Atkins, received 3rd July 2014 [full version may be found in Appendix 1]

a lower overall cost. It is unfortunate that these factors were not taken into account much earlier in the process. This includes the decision to incorporate a partial rebuild rather than a complete rebuild hospital.

In any event, a new build on a single site would always be the preference.

KEY FINDING: A greenfield site for a new hospital would have been the best option in terms of less risk, more benefits and a lower overall cost.

Late decision to change advisors

There would seem to have been a loss of confidence in the W.S. Atkins team that resulted in a new consultant being brought in to look at alterative solutions (the design champion). The Treasurer of the States told the Panel that although W.S. Atkins were very strong technical advisers, the Health Department was concerned about the future delivery of health services in Jersey and the need for change and improvement in order to manage risk. The Treasurer went on to say that someone with knowledge and skills on both sides was required in order to bridge the gap between the requirements of health and the technical brief[150].

Although W.S. Atkins had undertaken at some expense, a review of many options, the preferred option seems to have emerged as the sole choice developed by the design champion appointed by the States of Jersey.

KEY FINDING: The process followed to appoint the design champion was flawed. Others were not given the opportunity to apply for the post and W.S Atkins were unaware that an appointment was being made to conduct work of direct relevance to their own pre-existing and continuing appointment.

Dual-site Hospital Proposal

Within the addendum and refined concept developed by W.S. Atkins dated October 2013, there is an explanation of the proposals to redevelop and regenerate part of the Overdale Hospital site, replacing the current buildings with a new ambulatory care out-patient hospital. This is one of the first documented accounts of the dual site proposal.

W.S Atkins explained in the refined concept that the splitting of proposed clinical services between two separate sites would require the consideration of a different model of care and significant consultation with the clinical and medical directors and senior nurses to ensure that the proposed model would operate safely and sustainably[151].

It is understood that the design champion subsequently held a number of consultations with members of the Project Team, the Clinical and Medical Directors and senior nurses. Alternative configuration of services across the two sites were considered and a proposal was taken forward

[150] Public Hearing with the Treasurer of the States, 2nd May 2014, page 20
[151] Hospital Pre-Feasibility Spatial Assessment Project: Jersey General Hospital Refined Concept: Addendum, 3rd October 2013 page 17

that envisaged an ambulatory care centre be developed on the Overdale site along with a separate renal and diabetes centre, the main pharmacy and laboratories[152].

During a Public Hearing with the Pathology consultant and Pathology Manager, they explained that the current model of providing the pathology service between two sites was to have the main pathology laboratory situated at Overdale, and a small laboratory situated at the main hospital. It was their view that there should only be one pathology laboratory and this should be located at the main hospital. Their justifications are explained below:

> **Pathology Manager:**
> *The key thing is that the three-quarters, the non-urgent work, can easily be transported around, so you could set up the Overdale site and the only interaction with pathology could be a plastic box that people put specimens in and someone comes and collects it every couple of hours and takes it down to the main laboratory. That will not affect the turnaround times for any of those patients in that setting at all. They are not going to need the results until the next time they come back for their outpatient's appointment in a week's time. If it takes us a week to produce the number, no one knows, no one cares, no one notices. Down at the acute site, people are coming in through A. and E. with acute issues that need resolving straight away and so we have to provide an immediate response. You cannot do that from another site, so you have to do that on the acute site, and then as soon as you have got your laboratory there on the acute site providing the A. and E. and the critical care service, you might as well also use it for the inpatient work which is originating on that site and requires a reasonably quick turnaround time[153].*

It is understood that an external review of pathology will be undertaken to determine the best outcome for its location and how it will be run in the future[154].

The Panel asked W.S. Atkins whether the risks associated with the dual-site option are much less than those identified in the schemes put forward in May 2013. They said: *"The risks of the dual site option should be lower and more controllable than the single site re-development, however, there is still likely to be a significant amount of reconfiguration of the existing General Hospital site and hence still significant risk. One of the key difficulties in developing the single site option on the existing site, was creating enough 'free space' upon which new facilities could be constructed. In our investigations, we concluded that the sequencing of redevelopment was extremely complex, (and would have required further examination), to ensure that each department within the hospital could continue to function satisfactorily whilst major re-construction was underway in close proximity. The development over two sites will certainly help to relieve some of the pressure on the existing General Hospital site, but the complexities of maintaining safe and controlled services whilst major construction works are underway, should not be understated"*[155].

KEY FINDING: Although the dual site offers a potential solution for a reduced budget, the current proposal means that 44% of the existing hospital will be new build, 30% will be refurbished and the remainder will be for existing. This will inevitably result in a need for further capital investment in the future.

[152] Hospital Pre-Feasibility Spatial Assessment Project: Jersey General Hospital Refined Concept: Addendum, 3rd October 2013 page 17
[153] Public Hearing with Pathology Consultant and Pathology Manager, 7th May 2014, page 12
[154] Public Hearing with Pathology Consultant and Pathology Manager, 7th May 2014, page 14
[155] Correspondence received by W.S. Atkins, received 3rd July 2014 [full version may be viewed in Appendix 1]

Who identified the dual site solution?

A question has arisen as to who first identified the dual site solution. There appear to be different views on this depending on who is asked.

Once W.S. Atkins had evaluated a long-list of 10 sites which included the Overdale hospital site (and fields 1550 and 1551) as detailed in the pre-feasibility study dated May 2013. Each of the long-list site options were developed and assessed by W.S. Atkins on the basis of providing a single-phase, new-build hospital on each site with all accommodation to current UK NHS space and design standards (with the exception of the existing hospital site option which was based on a phased redevelopment)[156].

Each site option was scored against a benefit and risk criteria and the sites which scored the lowest were excluded. Additionally, where material shortfalls in the suitability of sites were found (such as overall size restrictions), these sites were also excluded. Therefore, on the basis of the long-listing analysis, the following sites were recommended for further, more detailed short-listing appraisal[157]:

- Redevelopment of the existing General Hospital site
- New build development on the Esplanade Care Park and Zephyrus/Westwater/Crossland site
- New-build development on the Warwick Farm site

At this point, the Overdale site had been excluded from further analysis, and there had been no mention of a dual site option between it and the current hospital site. However the Panel was advised by the Treasurer of the States that the site solutions were decided over a long period of time which included dual site and single site:

> **Senator S.C. Ferguson:**
> *What made you think that you needed a design champion?*
>
> **The Minister for Treasury and Resources*:***
> *I have already said you needed a design champion to confirm and to put further granular detail on the option to the Ministerial Oversight Group based upon advice about delivering the hospital on a dual site.*
>
> **Senator S.C. Ferguson:**
> *But it was his idea to have a dual site, was it not?*
>
> ***[……]***
>
> **The Minister for Treasury and Resources:**
> *It was clear from the work of Atkins that we were heading towards using the existing site as the main anchor. The debate ...*

[156] W.S. Atkins Hospital Pre-Feasibility Spatial Assessment Project, May 2013, page 28
[157] W.S. Atkins Hospital Pre-Feasibility Spatial Assessment Project, May 2013, page 28

Senator S.C. Ferguson:
Yes, but we were told that it was the design champion' recommendation to go for a dual site.

Treasurer of the States of Jersey:
No, Chairman. The site solutions were decided, as we explained at a previous meeting, over a very long period of time and we started with a whole range of different options, which included dual site and which include single site. Bear in mind, when we started this work we did not even know where all the possible sites were and we had to do a lot of work with the help of the Planning Department to identify sites that were potentially big enough.

Senator S.C. Ferguson:
Well, the other day we asked whose idea it was and we were told the design champion.

Deputy J.A. Hilton:
Yes, we have been told previously in a hearing that it was the design champion who had come up with dual site option.

The Minister for Treasury and Resources:
No.

Treasurer of the States of Jersey:
No, that is factually incorrect.[158]

The result of the pre-feasibility study dated May 2013 was that the phased development of the existing hospital site offered the best location for key investment in future hospital capacity. It is understood that the Treasury Department undertook a review of potential funding sources for major capital projects and identified an outline budget and funding strategy for the hospital (as set out in the Budget 2014)[159].

In May 2013, a draft Report and Proposition (R & P) was prepared detailing the outcome of the pre-feasibility study. Although the draft R & P was never lodged, it is important to consider as it explains that the Council of Ministers recommended that a feasibility study be commenced to bring back firm proposals to the States to consider the redevelopment of a new hospital on the existing general hospital site. It did not mention Overdale hospital or the dual site concept.

It is worth noting at this point that the pre-feasibility study undertaken by W.S. Atkins was completed in May 2013. The design champion was appointed in July 2013, and the addendum to the pre-feasibility study was completed in October 2013 which identified the dual site solution. In a Hearing with the design champion, he described the process of the dual site solution:

Deputy J.A. Hilton:
Can you just tell us when you first came up with the dual site option?

Design Champion:
Fairly quickly. When I looked at the site, the General Hospital site, and I looked at some of the proposals that had been put forward, it was clear that the latest proposal, which was to

[158] Public Hearing with the Minister for treasury and Resources, 13th June 2014, page 26/27
[159] Future Hospital Feasibility Study: Strategic Brief, page 5

> *bring the cost down to, I think, £250 million, did do that but left a great deal of work to be done at some future time to put in the rest of the facilities. It became clear at that point that there was no more money to come in the future, and therefore anything that was proposed really had to be complete in its own right. The first thing I saw was the congestion on the General Hospital site, and the very great difficulty there would be in developing any new facilities on that site. An analysis of the site showed a number of things, for example the centre of the site is occupied almost entirely by laboratories and the pharmacy. Both of those facilities can and have been, on other projects, developed outside the confines of the main working hospital site. Then, after discussion, we began to look at Overdale, which appeared to be one of the sites that was available. I looked further, in discussion with Health, as to what other facilities might be able to be moved and the discussion then built into the idea of having an A.C.A.D. (ambulatory care and diagnostic centre) up at Overdale, and that built and built and built, until it became a really live option, which attracted a lot of support…*[160]

It is apparent that not all views can be true. On the balance of the evidence, having looked at the relevant minutes over this period and taking into consideration the draft Report and Proposition dated May 2013 which made no mention of the dual site concept, it seems most likely that the dual site option was not on the table until it was introduced by the design champion in July-August 2013.

KEY FINDING: The result of W.S. Atkins pre-feasibility study dated May 2013 was that a phased development of the existing hospital site offered the best location for key investment in future hospital capacity following which a draft Report and Proposition was prepared detailing the outcome of the pre-feasibility study. The Panel note that this did not mention Overdale hospital or the dual site concept.

KEY FINDING: There are conflicting views on who identified the dual site solution. On the balance of the evidence, it seems most likely that the dual site solution had not been identified as an option until it was introduced by the design champion in July/August 2013.

Are options comparing like for like?

In a process such as this where options have been continually developing it can be difficult to maintain a consistent view of each option. As assumptions change the basis for comparisons also change. It is necessary therefore to present clearly what is included in the various options. This is not apparent in the documentation provided.

In particular the dual site option is not the equivalent of the previous options produced by W.S. Atkins, and reflected within the original brief, which in turn reflected the intention of P.82/2012. The total dual site solution is 44% new build 30% refurbishment and 26% existing (which is largely facility management and offices). This contrasts starkly with the many other options that were considered which were 100% new build[161].

[160] Public Hearing with Design Champion, 16th May 2014, page 8
[161] 1.10 – HSSH Scrutiny Panel – Treasury Minister Public Hearing Feasibility Study Project HSSH Scrutiny Panel Questions for 13th June 2014, questions 14 &15

The reason for this seems to be based on the need to fit within a budget figure of between £250 million and £300 million which somewhat belatedly came into play in the decision-making process. W.S Atkins advised the Panel that the cost advisors followed an accepted protocol by assessing the refurbishment cost utilising the Health Department's Health Premises Cost Guides, removing the structural elements associated with departmental cost build ups[162]. Therefore the refurbishment will cost 75% of new build; on this basis a rough calculation suggests that the composition of the dual site solution saves around one-third of costs compared with the 100% new build of all the other options known by the Panel to have been considered.

The impact on patient care of this decision to go with a lesser mix of new build and refurbishment has not been made clear and appear to fall some considerable way short of the spirit of the decision to provide new modern hospital facilities in Jersey.

KEY FINDING: During the development of the future hospital, options have been continually developing. As assumptions change the basis for comparisons also change and it is therefore necessary to present clearly what is included in the various options. This has not always been apparent in the documentation provided to the Panel and it is therefore questionable whether all option have been compared on a like for like basis.

KEY FINDING: The proposed dual site option is not included in previous options produced by W.S. Atkins and which reflected the original brief, which in turn reflected the intention of P.82/2012. The impact on patient care of this decision to go with a lesser mix of new and refurbishment has not been made clear and is not in the spirit of the decision to provide new modern hospital facilities in Jersey.

The basis for cost assumptions: an analysis

This section considers the estimated costs associated with various hospital site options. The critique below has been developed by the Panel's advisor and provides a view of the costs associated with various options and highlights the differences.

These costs are divided into 5 sections. The first is the works costs which reflect the actual build costs and are split between general works i.e. building, and site specific on-costs (costs that relate specifically to making the site fit for purpose or to the nature of the site). These are based on UK averages (Healthcare Premises Cost Guides – HPCGs[163]). A premium has then been added to these to reflect greater costs of construction in Jersey. This has been variously 40% and 30% and has been applied at first to the total works costs and then just to general works.

The next section is professional fees (architects, quantity surveyors, project managers, engineers and so on) which have been set as a proportion of the total works costs, and set at 15% for most options but 16% for the existing Jersey general site to reflect greater complexity.

The third section is site-specific non-work costs and includes any purchase of land as a separate item, costs of re-provision of services elsewhere for example swimming pool, or transport

[162] Email received from W.S. Atkins, dated 21st August 2014
[163] The Department of Health in England produces a Healthcare Premises Cost Guides (HPCGs) which it updates periodically

enhancements, and a fixed percentage for arts as required by States of Jersey planning policy (set at 0.75% of the total works costs). The fourth section is equipment and includes certain types of hospital equipment including installation and shipping. These 4 sections give the total project cost.

Finally there is a fifth section that comprises various contingencies and inflation. The HPCGs indicates a figure of 5% for design development risk for example unrealistic programmes, planning constraints. This has been taken as included in the costs already for all options. A planning contingency of 5% is also included for all options to reflect any unforeseen changes required during the planning approval process. This has been included for all options as employer other risk. A figure of 10% has been included for optimism bias, construction risk, and client change risk combined, and covers elements such as changes in timescale, unforeseen ground conditions, employer driven changes. This has been included across all options.

A figure for inflation has been included as costs are given at a point in time but will be incurred over a time period of up to 10 years, and hence it is assumed that the construction, equipment and labour costs will increase over time. This is a normal assumption although in recent years there has been a slowdown in the rate of inflation as reflected in these indices. The figure has alternately been provided as an average for some options or as a figure for each phase in other cases (which also produces an average overall figure).

The cost of the dual site option is less than that estimated for the other options. The Warwick Farm option was the cheapest of these, followed by a variant on the Waterfront option and then the Jersey General site. These differences are enhanced in absolute terms when the considerable level of extra costs are added to the total works cost (as proportions of existing costs). It is noted that the reduction in the costs of general works is around 40% for the dual site option when compared with other options; however other options are all new build whereas the dual site option involves just 44% new build. In addition, the original options reflected the Department's Health Premises Cost Guides (HPCGs) whereas the dual site option was based on reduced requirements, resulting in an overall reduction in size of some 8%.

The contingency costs while lying within HM Treasury guidelines (if towards the upper end of the range) add a substantial sum to the cost of the project, from £42.4 million to £49.6 million for the original three options, and £28.5 million for the dual site option. This is one factor in the decision that a replacement for the old hospital cannot be constructed without substantial reductions in the amount of new build, given the new budget envelope that has been introduced by the Ministerial Oversight Group. As the specification for the hospital becomes clearer the size of this contingency would be expected to fall. The assumption that the cost of construction in Jersey will be 30% more than the UK average is another factor as is the assumption that cost inflation will be at a high level, adding up to £60 million to the forecast outturn cost.

It is noted also that in the dual site option there is a considerable reduction in equipment costs from more than £24 million under the other options to £14.7 million, which it is assumed can only reflect an actual reduction in new equipment. In addition the arts budget under the dual site option has been cut by between £1.5 and £1.7 million.

W.S. Atkins also provided an option that recognised the need, as a result of the reduced budget, to limit the extent of building. This was essentially an option similar to Option 1E but phased so that parts of the new build (some adult acute beds, a new emergency room, imaging and endoscopy)

were not completed. The result was an option that came in at £215 million excluding contingencies and inflation, which would have risen to £343 million if all phases were eventually completed[164].

The 2 greenfield sites (10 and 14C) would each have come in within the original budget figure given in R.125/2012, which was deemed acceptable when the process of choosing a site for the new hospital began.

The development of options for a new hospital has resulted in the choice of an option (the dual site option) that was introduced into the decision process only at the last moment. It is still not clear why this decision was made, and it has been difficult to compare like with like across all the options that have been considered. The impact of this decision is a lesser mix of new and refurbishment, and a split of services across two sites, with no clear analysis of the likely impact on patient care, or on staff and the Jersey public. This is a far cry from the spirit of the decision to provide new modern hospital facilities in Jersey.

How much would a dual site hospital cost to run?

W.S. Atkins included high level revenue costs within the pre-feasibility spatial assessment study. It is noted that the full cost effect in 2042 (excluding inflation) of implementing the dual site concept is £6.863 million. This is not limited to the additional costs of duplicated services due to dual site operation – it also includes an estimate of the costs of the operation of services based on increased bed numbers, single bedded rooms and transport costs, as detailed in the table below[165]. The table has been provided by the Treasury Department:

Relevant Revenue Cost	Cost estimate (million)
Additional lifecycle costs for buildings and equipment	3,511
Reduction in existing lifecycle and maintenance costs	-1,604
Additional portering costs – based on additional area adjusted for efficiency of design	517
Additional heat, light and power costs, based on additional area adjusted for efficiency of design	417
Additional ward nursing costs based on increased bed numbers and single room layouts	2,388
High level estimate of additional costs associated with separation of clinical and support activities across two sites	1,419
Total	**6,863**

[164] Hospital Pre-Feasibility Spatial Assessment Project Phase 1 Concept, W.S. Atkins, undated.
[165] Correspondence from Minister for Treasury and Resources, dated 30th June but received 9th July 2014

As part of the Long-Term Revenue Plan work, the most recent estimate of the additional cost of operating on a dual site has been carried out at high level. This is estimated to be an annual recurrent cost of £1.7 million in 2019 when the Overdale site is planned to be opened. Estimations are based on what is likely to be located at Overdale, and therefore what the additional staff and non-staff costs would be[166]. The Panel has been advised that the figures will be refined alongside the detailed feasibility work.

KEY FINDING: Although estimated revenue figures will be refined alongside the detailed feasibility work, the additional cost of operating on a dual site is estimated by the Treasury Department to be an annual recurrent cost of £1.7 million in 2019 when the Overdale site is planned to be opened. The Panel has found that as the dual site concept was identified at a late stage, a high level analysis of the estimated revenue consequences had not been undertaken when all other options were being considered.

Determining the cost of the Hospital

The work undertaken by KPMG for the Health Department to inform "Caring for each other, Caring for ourselves"[167] (the Health White Paper) suggested that a future hospital might cost in the region of £300 million. This was using a rule of thumb figure for acute beds of £1 million per bed as the capital costs of a new hospital – 300 beds equals £300 million. The Medium Term Financial Plan 2013 – 2015 (P.69/2012) therefore identified the extent of likely funding of the future hospital at £300 million plus £30 million for transitional capacity[168].

However, during a Public Hearing with the Chief Executive of Health and Social Services, the Panel asked if the KPMG figure of £300 million was used to determine the cost of the hospital:

> **Chief Executive Officer:**
> *I do not know, because it was not a figure that we invented within the Health Department. They came to a figure, I think we have talked about this before, it was based on their very broad-brush knowledge that generally speaking you work on a million a bed, so if you are going to have a 300-bed hospital you would have roughly £300 million, but that is at U.K. prices and we know there is a premium for building on Island. But I would imagine, and obviously it is for my political masters to say yay or nay to that, but I would imagine it is quite hard to understand why, if KPMG are saying roughly £300 million, you end up with something that is sitting at £400 million, £450 million. So I think it is that sense of unease about this is an awful lot of money, could the Island really deliver that sum of money? So really the £250 million, it ended up at £300 million, was just a "let us see what we could get for that".*[169]

W.S Atkins spatial assessment study confirmed that the preferred site for the future hospital was the current General Hospital site[170]. The Treasury Department advised that it did not set an arbitrary target for the initial W.S Atkins work because it wanted to get an independent technical assessment of the cost of a new hospital. The W.S Atkins whole new hospital solution developed

[166] Correspondence from Minister for Treasury and Resources, dated 30th June but received 9th July 2014
[167] R.63/2012 and R.82/2012
[168] P.69/2012 – Medium Term Financial Plan, pages 508 and 266
[169] Public Hearing with the Minister for Health and Social Services, 16th June 2014, page 34/35
[170] Treasury and Resources Summary – submitted to Panel April 2014

between July and September 2012 (as set out within the pre-feasibility spatial assessment study) resulted in the estimated cost of future hospital options ranging from £400 million to £500 million[171].

The Panel was advised that the Treasury Department undertook work to identify funding strategies for all the major capital projects proposed by the States within the 2014 Budget, namely housing, the hospital and liquid waste. This work confirmed that a whole new hospital was unlikely to be affordable and Ministers and Officers were also concerned that the affordability of such a scheme for an Island of 100,000 people was not considered sustainable[172].

Other considerations for the hospital solution included whether the Health Department's preferred approach of single bedded en-suite wards added significant costs, whether parts of the hospital could be refurbished for on-going clinical use, undertaking benchmarking work considering other hospital models and cost benchmarking to see why other hospitals appeared to be procured at lower capital cost[173].

KEY FINDING: There is a lack of clarity around the decision-making process in determining the size of the budget and why a 100% new build hospital was unaffordable.

RECOMMENDATION: Further work should be undertaken to determine what impact the proposed dual site option based on a budget of £297 million will have on patient care in both the medium and longer term and a detailed explanation should be provided to the States on why a 100% new build hospital is unaffordable. This should be completed before seeking a formal decision on the site of the future hospital.

Budget 2014

During his statement on the Budget 2014, the Minister for Treasury and Resources explained that £10.2 million was being proposed for the first phase of the hospital redesign (which is planning and not actual building works), preliminary works and the needs of transitional capacity in 2014.

He also explained that in 2010 the States established a Common Investment Fund, and since the end of 2010 the investment strategy for the fund had changed. There has been a move away from assets with a low-rate of return, such as cash and sovereign bonds, to assets with a higher-rate of return, such as equities and corporate bonds. He advised the States that investment returns since that time have increased substantially and in that period the Strategic Reserve Fund has increased from £550 million in July 2010 by over £270 million in July 2013. Therefore the Budget proposed that the funding for the new hospital should be met from the investment returns from the Strategic Reserve Fund[174].

The Minister went on to say that the hospital project will be fully paid for by the time it is completed and there will be no cost to the taxpayer and no debt for future generations. He explained that the central assumption is based upon investment returns averaging 5 per cent over the next 10 years. With an investment return averaging 5 per cent over the next 10 years the hospital funding of £297

[171] Treasury and Resources Summary – submitted to Panel April 2014
[172] Treasury and Resources Summary – submitted to Panel April 2014
[173] Treasury and Resources Summary – submitted to Panel April 2014
[174] Minister for Treasury and Resources Statement on Budget 2014, 8th October 2013

million can be fully met and the Strategic Reserve would rise to a value of £810 million[175]. It is unclear however, what the plan is if the fund does not return the anticipated sum of money when it comes to funding the capital projects.

Therefore in monetary terms, the States approved the transfer of £10.2 million from the Strategic Reserve to the Consolidated Fund for subsequent use as part of the 2014 Capital Programme. It is anticipated that the Minister for Treasury and Resources will return in due course with proposals to transfer much larger sums in order that the remainder of the hospital project can be financed[176]. This is highlighted in the table below which sets out the estimated cost of the hospital project and the estimated spend profile for the delivery of the future hospital project:

	Dec 2014	Dec 2015	Dec 2016	Dec 2017	Dec 2018	Dec 2019	Dec 2020	Dec 2021	Dec 2022	Dec 2023	Dec 2024	Total
£'m	10.2	22.7	55.9	41.4	41.3	28.9	28.9	28.9	13.1	13.1	12.6	297

The Panel queried whether a States decision would be required if money was transferred from the Strategic Reserve into a new fund. The Treasury Department advised that under the Public Finances (Jersey) Law 2005 any request to transfer money out of the Strategic Reserve would have to be approved by the States and the only person who can take such a proposals to the States is the Minister for Treasury and Resources[177].

If the States were to approve such a request the amount approved would have to be paid into the consolidated fund and therefore could not be paid directly into a special fund. Any transfer out of the consolidated fund into a special fund would have to be approved by the States and follow the normal approval processes for the Medium Term Financial Plan and Budget as set in the Public Finances Law[178].

KEY FINDING: The Minister for Treasury and Resources stated that the central assumption for growth in the Strategic Reserve is based upon investment returns averaging 5 per cent over the next 10 years. The Minister also stated that with such an investment return, the hospital funding of £297 million can be fully met and the Strategic Reserve would rise to a value of £810 million. It is unclear what the plan will be if the fund does not return the anticipated sum of money when it comes to funding the capital projects.

RECOMMENDATION: The Treasury Minister should provide a detailed plan setting out what actions would be taken if the Strategic Reserve does not return the anticipated return expected from investments within the next six months.

Budget 2015

Within the Budget 2015 proposition, the States is being asked to approve the transfer of a further sum of £22.7 million from the Strategic Reserve Fund to the Consolidated Fund in 2015 as to provide for the planning and creation of new hospital services in the Island.

[175] Minister for Treasury and Resources Statement on Budget 2014, 8th October 2013
[176] Corporate Services Scrutiny Panel: Draft 2014 Budget Report, S.R.13/2013, page 53
[177] Email from Treasury and Resources, 23rd May 2014
[178] Email from Treasury and Resources, 23rd May 2014

As mentioned within the Budget 2014 section of this report, the Minister for Treasury and Resources made a commitment that the hospital project will be fully paid for by the time it is completed and there will be no cost to the taxpayer and no debt for future generations. The Budget 2015 maintains this view and states that the estimated £297 million to be spent over the years 2014 to 2024 should be drawn down from the Strategic Reserve Fund thereby meeting the cost of the hospital from the investment returns on the Fund[179]. This means that the hospital costs can be fully met over the 10 years of development from the Strategic Reserve.

The Panel is aware that the States will be asked to agree *"the Strategic Reserve balance of £651,216,000 as at 31st December 2012 should be defined as the capital value of the Strategic Reserve and that, for future years, the capital value be maintained in real terms by increasing the capital value in line with increases in Jersey Retail Price Index (Y)".*

KEY FINDING: The Minister for Treasury and Resources made a commitment within the Budgets 2014 and 2015 that the hospital project will be fully paid for by the time it is completed and there will be no cost to the taxpayer and no debt for future generations.

Was there a States Assembly decision on the dual site proposal?

The Panel asked the Minister for Health and Social Services, the Minister for Treasury and Resources and the Chief Minister whether the dual-site hospital was approved by the States. It is the Panel's view that the States has never formally been asked, or agreed, that there should be a dual site hospital. There are only two States decisions that relate to the hospital. The first came in the Health White Paper proposition (P.82/2012) where the decision on paragraph (i) said –

> *"The States ….agreed (….) to request the Council of Ministers to co-ordinate the necessary steps by all relevant Ministers to bring forward for approval (i) proposals for the priorities for investment in hospital services and detailed plans for a new hospital (either on a new site or a rebuilt and refurbished hospital on the current site) including full details of all manpower and resource implications necessary to implement the proposals, by the end of 2014."*

The Panel's understanding of the words "to bring forward for approval" are that they mean that something will be brought to the States for debate and approved in that way. This understanding is reinforced in the interim report (R.125/2012) Hospital Pre-Feasibility Spatial Assessment Project published immediately before P.82/2012 was debated: *"It is anticipated that a preferred site will be proposed to the States in the early part of 2013 to enable a detailed feasibility study to be commenced, and detailed plans for a new hospital (either on a new site or a rebuilt and refurbished hospital on the current site) brought to the States for consideration by the end of 2014".*

The second relevant decision is within the 2014 Budget. There was a policy decision that the Strategic Reserve could be used to fund the new hospital and then the States agreed that an initial sum of £10.2 million should be transferred from the Fund (under the revised policy) for the first

[179] Budget 2015, page 84

stage of the project. As far as the Panel can see there was nothing in the Budget proposition that mentioned a dual site option.

It is the Panel's view that the full Report accompanying the Budget is confused about the project. On pages 60-61 there is no mention of a dual site and page 79 says specifically that no site has been selected although the bottom of page 79 alludes to a dual site option. However on pages 124 to 127 there is direct reference to the dual site option and even a map of the proposed Westmount site. It was the Treasury Minister's view that when members voted on the Strategic Reserve Fund policy change in the Budget they were aware that they were taking this decision in the context of the report which mentioned dual site and that, by implication, this option was 'approved' as the way forward[180].

Therefore, the Panel is unclear on the impact of paragraph (i) of P.82 as quoted above. What was the intention of the Council of Ministers in saying that the new hospital plans would be brought forward 'for approval'? Do the Council of Ministers intend to have any further debate on the dual site proposal or will Members simply be asked to approve the funding in a future Budget?

In a letter to the Panel, the Chief Minister confirmed that when Members voted to approve P.122/2013 they would have been aware that they were voting to support the further development of the dual site approach. He did not believe that the statements on page 79 of the Budget are contradictory to other Statements in the Report and that they merely confirm Ministers' intent to bring back detailed proposals in response to the requirements of P.82/2012. Page 79 of the Budget states:

> *This report does not seek decisions about the final outcome of the process that will determine which of the sites is eventually chosen as the best option nor about the detail of the design and configuration of the buildings.*

At the bottom of page 79 and it states:

> *The same issues and principles need to be addressed when considering funding options, regardless of the final decision on the site and design. This paper is about funding mechanisms. For the purposes of this paper one of the options has been used as the basis for assessing the most appropriate and affordable funding option. This option is summarised in Appendix A at the end of this section. In brief, the costed option is to refurbish and undertake some new building works on the existing site and in addition to develop a substantial new building for the treatment of patients with long term conditions at Overdale. Facilities such as the diabetic clinic, renal dialysis, the pain clinic and day surgery could be included at Overdale in a two site solution that has the potential to maximise the investment made in the existing hospital and provide a long term solution to meet the current and future pressures.*

P.82/2012 explicitly commits Ministers to bring forward investment plans for hospital services 'and detailed plans for a new hospital (either on a new site or a rebuilt and refurbished hospital on the current site). The Panel believe that it is stretching the language to describe the dual site approach as a new hospital on a new site or a rebuilt and refurbished hospital on the current one. Rather it is a partial refurbishment on the current site and new build on a second site. The proportion of the

[180] Public Hearing with the Minister for Treasury and Resources, 13th June 2014, page 17

total dual site solution is 44% new build, 30% refurbishment and 26% existing (which is largely facility management and offices). The acute service development at the Overdale site is 100% new build[181].

This is a completely different concept from that previously approved in P.82/2012 and its substantial modification is implied rather than made explicit in the Budget 2014 Proposition. It is also questionable how far the supporting paper to the Budget is clear that the plans for the extent of re-build/refurbishment of the existing hospital have been scaled back.

The Panel conclude that although mention was made of the dual site proposal in the 2014 Budget report, no formal decision has been taken on this issue as it was not included in the proposition. The Panel considers it is not unreasonable to conclude, therefore, that other options existed at this time and that a final option would be brought forward for approval in 2015. It is concerning how far short the current proposals fall from the original concept and the Panel question the extent to which it can legitimately be argued that it is 'providing similar benefits at an affordable cost' as expressed by the Chief Minister in his letter to the Panel.

The Chief Minister advised that the feasibility study for the future hospital will be completed in the autumn of 2015, where full details of all manpower and resource implications will be submitted to States Members within a Full Business Case to accompany submissions for the Budget 2016.

KEY FINDING: The Panel conclude that although mention was made of the dual site proposal in the 2014 Budget report, no formal decision has been taken on this issue as it was not included in the proposition.

RECOMMENDATION: The Council of Ministers should lodge a proposition prior to the lodging of the Medium Term Financial Plan 2016 - 2019 to ask the States Assembly to decide on the site for the future hospital in order for a formal decision to be made on this issue.

Two Hotels in Kensington Place

The inclusion of the two hotel sites situated on Kensington Place had been considered an intrinsic part of the project by W.S Atkins when a whole new hospital new build solution was under consideration. However, once a phased and partly refurbished solution was confirmed as necessary, the Project Board considered that the inclusion of the hotel sites did not confer sufficient advantages to justify the cost of the purchase[182]. The Treasury Department explained: *"This is because a part refurbished solution requires continuing use of the granite block which is not considered suitable for ward or theatre space and is therefore earmarked for imaging. As imaging, theatres and the emergency centre need to be in close proximity, these departments need to be located immediately adjacent to the granite block. Redevelopment of the hotel sites is not necessary under such a scheme because sufficient floor area, more efficient use of land and better clinical adjacency can be achieved in the existing hospital footprint".*[183]

[181] Notes received prior to the Public Hearing with the Treasury and Resources Minister, 13th June 2014
[182] Treasury and Resources Summary – annex 5 – Submitted to Panel April 2014
[183] Treasury and Resources Summary – annex 5 – Submitted to Panel April 2014

Nonetheless the purchase of the hotels in Kensington Place would still make a sensible strategic investment. The Treasury Department advised that, following a Ministerial Decision to allow Property Holdings to establish what the likely cost of the hotels might be, it appears that there is a large difference in the valuations of Property Holdings and those of the owners. The Department has acknowledged that the hotel sites may offer short term benefits to the future hospital in terms of access, build ability and site worker accommodation but they have yet to determine a long term use for the sites.

It is understood that the sites may yet form part of the States estate[184]. At a Public Hearing with the Treasury Minister he said: "*I think what I am prepared to say on that is that we continue to give active consideration to the opportunity of purchasing the adjacent sites, but it is important to state that they are not currently required in order to deliver the plans, and clearly those are old and tired hotels which are coming to the end of their useful life, and it would be in both the States and probably those adjacent sites interests for them to be combined, but we have considered all sorts of options*"[185].

KEY FINDING: The purchase of the two hotels in Kensington Place would make a sensible strategic investment for the States of Jersey as well as providing space to facilitate the development of the existing site.

Single Bedded Rooms

The provision of single en-suite room formed part of the "Future Hospital Project Brief". Part of the reason for change and why a new hospital is required is because of the existing provision of the numbers of beds available and the provision of single bedroom accommodation: "[These] *do not meet current emergency demand, nor projected future daily demands whilst operating at recognised best practice occupancy rates*"[186].

Work provided by W.S. Atkins included an analysis of current activity based on 2011/12 data, which demonstrated that there is pressure on beds to cope with current demand. Furthermore, the way the current bed stock is configured does not allow them to be used as flexibly as desired. W.S. Atkins explained that re-provision of beds in a more flexible manner, such as a high number of single rooms, would allow sufficient capacity to cope with future demand[187].

When W.S. Atkins developed the refined concept, consideration had been given of the investment priorities which had been identified by the Health Department and endorsed by the clinical and nurse leadership teams. One of the priorities was that 100% single bedded rooms should be provided[188] and it is noted that the refined concept enables this priority to be achieved.

W.S. Atkins explained that, because of the desire to achieve the most for the available funding, a target figure of a 15% reduction of room sizes below the UK NHS spatial guidance had been

[184] Treasury and Resources Summary – submitted to Panel April 2014
[185] Public Hearing with the Minister for Treasury and Resources, 13th June 2014, page 39
[186] Hospital Pre-Feasibility Spatial Assessment Project: Jersey General Hospital Refined Concept: Addendum, 3rd October 2013 page 9
[187] Hospital Pre-Feasibility Spatial Assessment Project: Jersey General Hospital Refined Concept: Addendum, 3rd October 2013 page 13
[188] Hospital Pre-Feasibility Spatial Assessment Project: Jersey General Hospital Refined Concept: Addendum, 3rd October 2013 page 20

adopted within the addendum study. This is accepted by the Health Department as an acceptable planning assumption at Departmental level and would be reviewed for service level clinical acceptability within the feasibility stage of the project[189]. The Panel asked the design champion whether this was usual practice:

> **Deputy J.A. Hilton:**
> *"Is it accepted practice to reduce the size of rooms by as much as 15 per cent currently?*
>
> **Design Champion:**
> *It is. Every single P.F.I. [Private Finance Initiative] project in the U.K. would have had that factor applied because they need to be competitive, just as you do. It is also being compared with U.S. (United States) and French standards and it is compatible with that. I am afraid the U.K. building note areas are a bit bloated and that is pretty well generally recognised"[190].*

At a Public Hearing, the Minister for Health and Social Services explained that a decision had not yet been made for 100% single rooms, and it would be the Ministerial Oversight Group who would make the decision[191]. The Minister said: "*I do not think a decision has been made, but I made it extremely clear that my preference is for, as far as possible, 100 per cent single rooms. You know the reasons why, and I am very much aware that there are some areas like critical care and perhaps the children's ward that are not conducive to single rooms, but however far as possible, it should be single rooms. I am happy to go down very many avenues for the reason why".*

The Panel also spoke with the Chief Nurse who supported the 100% single room proposal and saw it as an essential part of the new hospital, provided rooms had en-suite facilities. She explained that single rooms would improve patient safety, privacy and dignity[192]. Although it is unclear whether 100% single rooms would increase workforce demands. The Chief Nurse explained that until the design and layout of the wards had been developed, it would be difficult to know what the staffing demands will be[193].

In a separate review undertaken by W.S. Atkins about the policies and clinical benefits of single rooms it concluded: "*Informed opinion across the world does vary quite widely on the subject. There is no "accepted" norm at present; it is a matter for an individual authority to determine "best-fit" for their population and clinical activity. There appears to be a greater patient preference for single bedroom provision in acute facilities which is likely to increase as experience of single rooms becomes more widespread".[194]*

KEY FINDING: Due to the limited budget proposed by the Ministerial Oversight Group, W.S. Atkins explained that a target figure of a 15% reduction of room sizes below the UK NHS spatial guidance has been adopted.

[189] Hospital Pre-Feasibility Spatial Assessment Project: Jersey General Hospital Refined Concept: Addendum, 3rd October 2013 page14
[190] Public Hearing with Design Champion, 16th May 2014, page 30
[191] Public Hearing with the Minister for Health and Social Services, 16th June 2014, pages 44/45
[192] Public Hearing with Chief Nurse, 12th May 2014, page 16
[193] Public Hearing with Chief Nurse, 12th May 2014, page 15
[194] W.S. Atkins - Hospital Pre-Feasibility Assessment Project. Single Bedroom Assessment: Review of Policies and Clinical Benefits page 6

1960s Building and Peter Crill House

The 1960 building situated at the current hospital site has been excluded from the planning as it is not fit for purpose for clinical use[195]. The Panel was advised that at the end of the project the 1960s building will still stand, but it is not clear what it will be used for in the future: "*It could be demolished. It could be used for other non-clinical activities depending on the state and condition of the building and whether it is viable to do so. It could be used for other States needs that may be helpful to ally next to the General Hospital so that could be sort of office-based or community-based needs. At the moment, I think we do not know, is the answer, because the programme of phasing means that we will need that building for a fairly lengthy period during the phasing of works on the General Hospital site. But, at the end of that phasing, that building is surplus to requirements but it will be quite an elderly building by that time*"[196].

Although there will be improvements in the facilities, some buildings such as the 1960s building will remain untouched at the end of the project. Furthermore, in order to reduce costs some buildings will remain such as Peter Crill House education and office block[197]. This confirms the Panel's finding that the current proposals fall short of the original concept as identified in P.82/2012.

KEY FINDING: The 1960s building situated at the current hospital site has been excluded from the planning as it is not fit for clinical use. Therefore, at the end of the hospital project, the 1960s building will still stand but it is not clear what purpose it will serve in the future, or whether optimum value from the current site is being achieved.

Timescales for the Hospital Development

The project milestones and initial anticipated dates for the transitional 10 year period for redeveloping the existing hospital and Overdale site are outlined below[198]:

Milestone	Redevelopment Programme
Consideration of funding strategy and pre-feasibility outcome as part of Budget 2013 debate by the States Assembly	October – December 2013
Appointment of Feasibility Design Team	December 2013
Feasibility study Enabling works and relocation of services at Overdale Hospital Planning applications for enabling works and Masterplan	January 2014 – June 2015
States approval of construction procurement strategy	September 2015

[195] Public Hearing with Senior Health Officials, 8th May 2014, page 7
[196] Public Hearing with Design Champion, 16th May 2014, page 17
[197] Hospital Pre-Feasibility Spatial Assessment Project: Jersey General Hospital Refined Concept: Addendum, 3rd October 2013 page 16
[198] Hospital Pre-Feasibility Spatial Assessment Project: Jersey General Hospital Refined Concept: Addendum, 3rd October 2013 page 42

Mobilisation of Contractors	October – December 2015
Westmount Health Quarter Construction Extension of 1980's block construction	January 2016 – December 2021
General Hospital New Build Construction	January 2019 – December 2021
Refurbishment of General Hospital	January 2022 – December 2024

RECOMMENDATION: A ten year timeframe to develop a new hospital is unacceptable and the Council of Ministers should review both the timescale and the overall budget envelope to ensure that any new hospital will meet the future needs of the Island. This should be completed within the next twelve months.

How much has the future hospital project cost so far?

At this stage, the cost of the pre-feasibility project totals £574,534. A breakdown is provided in the table below:

Cost element	Cost
Pre-feasibility and related studies	361,294
Property Valuation	9,615
Focus groups	9,961
Design Champion	46,446
Video	6,700
Social media campaign	6,230
Design and branding	5,582
Animation	6,000
Marketing	178
Fees (States of Jersey client costs)	121,346
Total Costs - Pre-feasibility Spatial Assessment Project	**574,534**

KEY FINDING: Although the plan is for the Overdale site to be completed by 2019, the overall future hospital project will be completed by December 2024. The cost of the project so far totals £574,534.

Percentage for Art

The Panel notes that a percentage for art is an internationally recognised funding mechanism where developers are encouraged to allocate a percentage of the capital costs, towards the provision of public art, of any new building(s) or refurbishment. The percentage for art contribution is agreed between the developer and the planning officer based on 0.75% of the total construction cost of the development.

Although the States of Jersey has already shown its commitment in this area by endorsing a percentage for art in the Island Plan and there will, therefore, be an expectation that it will wish to set an example, the Panel wonders whether there should be an exception in this instance.

RECOMMENDATION: The Panel recommends that percentage for art (based on 0.75%) for the total construction cost of a development should not be allocated for the future hospital project.

On-Island/Off-Island Services

The Panel's previous report[199] emphasised that the range and scale of future hospital services depends on a complex mix of factors including:

- The volume and kinds of needs that emerge in coming years
- The volume and kinds of services provided outside hospital by health, social care and other services such as housing, social security and the voluntary and community sector
- The respective roles of primary care and community health services including the voluntary and community sector
- The implications of increasing specialisation and technological developments
- The costs, effectiveness, risks and acceptability of providing services on-island or off-island

Such factors are common to most jurisdictions but they present particular challenges to small island communities. As a result, a range of choices may have to be made between, for example, the magnitude of acceptable risk, the degrees of specialisation and local access compared to mainland services for a similar population but with readier access to more specialist hospital services.

One way of addressing such tensions is through strategic partnerships with other jurisdictions and services. This could involve the subcontracting of service provision to providers off-island by their with some combination of their staff travelling to the island and/or islanders travelling to the providers. This already happens in the case of more specialist treatment, as it does on the mainland. The Panel also identified that in the modern era, complete self-sufficiency is not an option.

The Health White Paper stated that opportunities for strategic partnerships had been examined and would be explored further. At the time of the Panel's report in 2012, it had not been provided with any formal details about which strategic partnerships had been explored and in what detail.

[199] S.R.7/2012 Health White Paper review, 15th October 2012, page 27

Nor had it seen detailed work about the level and range of service that could be provided in the new hospital.

The Panel wanted to assess how much progress had been made in this area and inquired about off-Island clinical activity and its relationship to on-Island clinical activity both in terms of service provision and value for money. The Panel was advised that the Health Department will always need acute services provided by mainland hospitals for complex, rare conditions or new treatments and technologies. The Deputy Director of Commissioning advised that as the Department develops strategic relationships with mainland providers, it can look to clinical network models where the skills and expertise comes from off-Island providers with services delivered on-Island where it is safe, sustainable and affordable to do so[200].

As the acute services strategy is being developed the Department will consider what could/should be provided on-Island to ensure that each service strategy is safe, sustainable and affordable. The Deputy Director of Commissioning (acute) explained that the development of regional specialist centres in the UK is creating opportunities for the Department to develop partnerships with hospitals in England who may not have populations large enough to maintain some procedures or services at a local level. Partnering with the Health Department could help keep services local to their population by delivering them for the public either on or off-Island. Although it was advised that this is more likely to happen on-Island when modern health care facilities planned under the "Future Hospital" programme are implemented[201].

As mentioned earlier on in the report, the Comptroller & Auditor General (C&AG) recently published a report titled "Use of Management Information in the Health and Social Services Department – Operating Theatres". The C&AG explained that when deciding whether clinical procedures are undertaken on or off Island cost information is important in supporting decisions on affordability. The Department's cost information is not routinely captured or matched to activity information to inform decisions:

> *Deciding on whether clinical procedures are undertaken on or off the Island is predominantly driven by clinical safety and then by affordability. Information about the cost of individual patient procedures is important in supporting decision on affordability. Cost information is not routinely captured or matched to activity information to inform decisions. Work to model the impact of different interventions and changes in service delivery on the costs of patient pathways is being piloted in cardiology. The current modelling is relatively crude, relying as it does on poor quality data on theatre utilisation. HSSD is considering a number of opportunities to improve costing information and has recently appointed a full-time accountant to focus on the cost of individual patient procedures[202].*

KEY FINDING: There appears to be a lack of progress in strategic planning for acute services and services provided on-island/off-island since 2012. The acute services strategy is not complete and as with the absence of a primary care strategy, has created major difficulties for the Panel in reaching a conclusion about the robustness of the plans for the role, range and scale of future hospital services.

[200] Email from Treasury, received 28th May 2014
[201] Email from Treasury, received 28th May 2014
[202] Jersey Audit Office, Comptroller & Auditor General Report: Use of Management information in the Health and Social Services Department – Operating Theatres, July 2014, page 12

How are future hospital projects managed elsewhere?

Besides funding concerns, one of the other reasons why a dual site concept was identified was because of the impact redeveloping wholly on the current hospital site would have on staff and patients. The design champion said: "*building wholly on the General Hospital site would be 10 years of hell with so much disruption and so many difficult and risky decisions taking place during that 10 years that it was the wrong thing to do*"[203].

Like Jersey's general hospital, Great Ormond Street hospital is battling with buildings that are nearing the end of their useful lives and must urgently be replaced. Phase 1 of its redevelopment was completed in 2006 at a cost of £88 million. This was part of a redevelopment programme of its predominantly 1930s-built estate and included new clinical facilities, the patient and family hotel and improved outpatient facilities for some of the services within the neighbouring Royal London Hospital for Integrated Medicine. The hospital is currently in Phase 2 of its redevelopment programme and is expected to cost £321 million to complete. Phases 3 and 4 are yet to be fully costed but all work is aimed to be completed by early 2025[204].

BAM, the construction company who built the new clinical wing at the hospital during Phase 1 said on their website: *We successfully met the challenge of ensuring that our work did not impact on the care being delivered in the working parts of the Hospital, a few inches away from the outer walls of the construction site[205].*

Another example where major redevelopment has taken place on site is King's College Hospital. Plans for the redevelopment of King's Emergency Department (ED) were agreed in 2009 which would increase the size of the ED and include building a new walk-in entrance, refitting and expanding the resuscitation area and creating a separate, designated suite for mental health patients and a new treatment area/urgent care centre for people with minor injuries and ailments.

The work is expected to be completed by the end of 2014, and patients who use the ED as well as key stakeholders have been involved in the redesign project from the start and will continue to play a key part in the plans[206]. It is understood that this is one element to a £1 billion redevelopment programme which is transforming the Hospital's estate.

KEY FINDING: One of the reasons for the dual site concept was because of the potential disruption redevelopment of the current hospital site would cause for staff and patients. The Panel accepts that construction by its very nature does cause disturbance, but there are ways to minimise this both for patients and staff. Lessons and experience from other hospital redevelopments which have managed their levels of disturbance well could have been explored further rather than opting for redevelopment and new build over two sites.

[203] Public Hearing with the Design Champion, 16th May 2014, page 12
[204] Great Ormond Street Hospital Charity website at www.gosh.org
[205] BAM Construct UK Ltd website at www.bam.co.uk
[206] King's College Hospital website at www.kch.nhs.uk

11. Implementation and Funding

Sustainable Funding Mechanism for Health and Social Care

The Treasury is the lead Department for Fiscal Policy and funding issues including the work on the sustainable funding mechanism for health and social care[207]. P.82/2012 identified that providing health and social care will cost more money over the next 20 years, and that implementing the new system for health and social services will require significant investment on both a one-off and recurring basis[208].

One of the key pieces of work the Treasury Department has been working on over the last 2 years is developing a Long-Term Revenue Plan for the Island. The Long-Term Revenue Plan will cover the next Medium Term Financial Plan period plus a year, and will be published alongside the Budget 2015. This enables the Department to have a long-term view, from 2016 until 2020, on future funding needs[209]and forms part of the work for the sustainable funding mechanism for health and social care.

The Panel has been advised that the Treasury Department has taken advice from the Fiscal Policy Panel, KPMG and Ernst and Young on the alternatives available and the affordability of options. The Long-Term Revenue Plan will set out the outcome of this advice in detail for the States Assembly to consider[210].

The Treasury Department explained that the Long-Term Revenue Plan will confirm the level of investment in health and social services into the future. However, it will not propose a separate health fund in addition to the existing Health Investment Fund and Long-Term Care Plan. This is because health services are and will continue to remain a public good. As such they must be rationed to prevent an unsustainable impact on the wider Jersey economy and this will continue to be the case in the future[211]. The Panel was surprised to learn that it is the Treasury's view that services are to be rationed.

The Long-Term Revenue Plan will aim to provide a higher level of funding certainty and will enable long-term sustainable financial planning by the Health Department[212]. The Treasury Department's intention is to achieve a sustainable funding mechanism for health and social care, through the completion of the Long-Term Revenue Plan, by the end of September 2014, as agreed in P.82/2012[213].

KEY FINDING: The Long-Term Revenue Plan is being developed by the Treasury and Resources Department. This aims to provide a higher level of funding certainty and will enable long-term sustainable financial planning by the Health Department. It is understood that the sustainable funding mechanism for health and social care will be achieved via the Long-Term Revenue Plan by the end of September 2014 as agreed in P.82/2012.

[207] Appendix 3 of response to Panel letter to the Minister for Health and Social Services dated 13th January 2014
[208] P.82/2012 Health and Social Services: A New Way Forward, page 65
[209] Public Hearing with the Treasurer of the States, 2nd May 2014, page 2
[210] Notes received prior to the Public Hearing with the Treasury and Resources Minister, 13th June 2014
[211] Notes received prior to the Public Hearing with the Treasury and Resources Minister, 13th June 2014
[212] Notes received prior to the Public Hearing with the Treasury and Resources Minister, 13th June 2014
[213] Public Hearing with the Treasurer of the States, 2nd May 2014, pages 3/4

KEY FINDING: The Long-Term Revenue Plan will confirm the level of investment in health and social services into the future. The Panel were informed that it will not propose a separate health fund in addition to the existing Health Investment Fund and Long-Term Care Plan. The Treasury Department explained health services are a public good and as such must be rationed to prevent an unsustainable impact on the wider Jersey economy.

How does a New Model of Primary Care fit in with the Sustainable Funding Mechanism for Health and Social Care?

Within her response to the Panel's previous report, the Health Minister explained that GPs and other primary care practitioners will be actively engaged in the ongoing development of primary care services. Furthermore, she recognised the need to make sure that the funding mechanisms for primary care link with the sustainable funding streams for the whole of health and social care (i.e. proposition bii and biii contained in P.82/2012 link together)[214].

As the Panel has already identified in this report, the new model of primary care will not be completed by September 2014 as originally intended. The Panel was told that the States can expect to consider a strategy, with funding options, in April 2015. It is unclear what impact this delay will have on the work regarding the sustainable funding mechanism for health and social care, which is due to be completed via the 2015 Budget and Long-Term Revenue Plan.

There can only be certainty over the size and cost of the hospital once a new model of primary care has been agreed along with the sustainable funding mechanism for health and social Care.

KEY FINDING: The Minister for Health and Social Services recognised the requirement that the funding mechanisms for primary care link with the sustainable funding streams for the whole of health and social care and that proposition bii and biii in P.82/2012 link together. It is therefore unclear what impact the delay in completing the new model of primary care will have on the sustainable funding mechanism for health and social care.

<u>Health Insurance Fund</u>

The work surrounding the new model of primary care and sustainable funding mechanism will also impact on the Health Insurance Fund held within Social Security. At a quarterly hearing with the Social Security Minister the Panel was told:

> **The Minister for Social Security:**
> *Funding is a separate stream that is being led primarily by the Treasury. We are aware that meetings have been taking place with Health, because Health will have to provide estimates of their budgets going forward into the next Medium Term Financial Plan and those have to be built into the total picture for not only the primary health care model but also sustainability of Health and Social Services going forward for the next 3 to 4 years. There is clearly going to be a need to review the role of the Health Insurance Fund going forward and also how if there is substantial rises in the costs, which there will be, for delivering care in the community, how that is funded going forward.*

[214] Ministerial Response to S.R.7/2012 Health White Paper review

The Deputy of St. Ouen:
So you say you are planning to review the role of the Health Insurance Fund, this is the most favourable option that has come out of the discussion to date, that you would broaden the range of the Health Insurance Fund and increase the contributions made by individuals.

The Minister for Social Security:
It is likely that that will feature in the proposals. The reality is, of course, that the Health Insurance Fund, we are just awaiting the latest Government Actuary Department review of the fund, is that we are already at a point where we are not breaking even with the costs going out of the fund as against the income. So the services we currently provide, particularly the high cost of drugs and the other G.P. consultations, et cetera, the draw on the fund is now at a stage where we will be needing to consider increasing contributions in any event, let alone providing additional services funded by the Health Insurance Fund[215].

KEY FINDING: The work being undertaken to develop a new model of primary care and sustainable funding mechanism for health and social care is likely to impact on the Health Insurance Fund held within the Social Security Department. It is expected that an increase in contributions will be required from individuals in the future.

RECOMMENDATION: In parallel with the work being undertaken to develop a new model of primary care and sustainable funding mechanism for health and social care, the Social Security Minister should present to the States the long-term contribution proposals to support the existing Health Insurance and Social Security Funds.

Long-Term Capital Plan

The Long-Term Capital Plan (LTCP) is a financial planning tool for the States of Jersey. It was published as an appendix to the Medium Term Financial Plan 2013 – 2015. As explained in P.82/2012: "*It aims to ensure that capital expenditure is approved and delivered in an optimum way, prioritised towards the delivery of key Strategic Aims, at the appropriate time, based on best available information and delivering best value from constrained States financial resources*[216]". The LTCP covers the period 2012 – 2032 and informs the Medium Term Financial Plans.

It is envisaged that the LTCP will be updated in the future but the current plan is based on the model identified in the Health White Paper and details those projects that have been identified as priorities. The LTCP estimated that £332 million would be required in 2016 for the hospital but this figure would be developed once there is greater certainty arising from the feasibility work[217]. Of the £332 million, £300 million had been provided as an estimate of the cost of a brand new hospital and this was derived using standard benchmark costing information from similar projects in the UK (as detailed in the KPMG report). £32 million relates to the creation of new wards on the existing site which cannot wait for the outcome of the main project[218].

The Panel has been told that it is standard practice to add a Jersey cost premium to any estimates based on the cost of construction in the UK. It is therefore difficult to understand why the LTCP

[215] Quarterly Public Hearing with the Minister for Social Security, 25th June 2014, pages 16/17
[216] P.82/2012 Health and Social Services: A New Way Forward, page 73
[217] Medium Term Financial Plan 2013 – 2015: Appendix 4, page 262
[218] Medium Term Financial Plan 2013 – 2015: Appendix 4, page 266

was based on the cost of similar projects in the UK as claimed. As noted already, in working up more detailed proposals, W.S. Atkins were instructed to apply first a premium of 40%, and then of 30%, and hence the cost was bound to be greater.

KEY FINDING: The Long-Term Capital Plan, published as an appendix to the Medium Term Financial Plan 2013 – 2015 and developed by the Treasury and Resources Department estimates that £332 million would be required in 2016 for the hospital but this figure did not reflect additional costs of construction in Jersey compared to the UK. The budget figure was to be developed once there was greater certainty arising from the feasibility work.

Long-Term Care Scheme

The Department's consultation on the Health White Paper identified that, in relation to longer-term care, some Islanders expressed concern that individuals who had paid into the social security system during their lifetime should not have to sell their homes in order to pay for care, particularly in old age[219].

In July 2011 a new long-term care law (P.108/2011) was debated by the States Assembly. The majority of Members were in support of the proposition, and this was reflected in the result of the vote, which was approved unanimously by all 48 Members who were present at the time[220].

The principles of the law were to collect money from social security contributors to be paid into a new ring-fenced fund and to use that money to help adults aged 18 and over to pay for long-term care. To encourage the growth of care services in the community, it was proposed that the new benefit would be available to people receiving care in their own homes, as well as those living in a care home[221].

Accordingly, the proposition detailing the proposals for the long-term care scheme was lodged on the 22nd August 2013 (P.99/2013) by the Minister for Social Security. The Panel reviewed the proposals and presented a report to the States on the 6th November 2013. The Scheme was approved by the States Assembly on 11th December 2013. The development of the Long-Term Care Scheme partly relates to key enabler 8 (legislation and policy) which is to co-ordinate the drafting of legislation and policy in line with States planned timescales[222].

In reviewing the Social Security Minister's proposals for long-term care, the Panel looked back at its work reviewing the redesign of health and social care. P.82/2012 explained that work to review and develop proposals for sustainable funding mechanisms would be led by Treasury and Resources, who would be working closely with Social Security and Health and Social Services during 2013 and 2014[223]. It also states:

> *Work will now continue to develop a long term sustainable funding mechanism for Health and Social Services by 2014, this work will consider all the current funding elements,*

[219] P.82/2012 Health and Social Services: A New Way Forward, page 65
[220] S.R.11/2013 – Long-Term Care Scheme, 6th November 2013
[221] S.R.11/2013 – Long-Term Care Scheme, 6th November 2013
[222] Other legislation and policy developments include Medical Practitioners (Registration) (General Provisions) Order, Medical Practitioners (Registration) (Responsible Officer) Order, Health Insurance (Performers List) Regulations, Mental Health Law, including Mental Capacity, Regulation of Care Law, Health Insurance Law
[223] P.82/2012 – A new way forward for Health and Social Services, page 65

> *including contributions made to the Health Insurance Fund, co-payment arrangements and base budget allocations. It will also take account of the proposed Long Term Care Fund and the provision of contracts with General practitioners and other healthcare providers.*
>
> *All these elements will be reviewed in order that proposals can be developed for a comprehensive but simple method of ensuring sustainable funding to the Health and Social Services Department in the coming years*[224].

The Panel's previous report into the Health White Paper identified that it was unclear how the long-term care benefit would underpin the costs of existing or future health and social services.[225] In her response to that report, the Minister advised that the Health Department was working with Social Security on the impact of introducing a long-term care benefit and how it would interface with existing funding mechanisms and service provision. Furthermore, consideration would be given to how the current system operates, which would include the long-term care benefit[226].

The Panel heard that discussions were taking place between Social Security, Treasury and Resources and Health and Social Services regarding what services currently provided by the Health Department would be passed onto the long-term care fund.

The Panel recommended that in order for the Council of Ministers to fulfil what was approved by the States in P.82/2012, the long-term care charge should not be increased above 1% until further consideration is given to the sustainable funding mechanism for health and social care. The Minister for Social Security's response stated: *P.99/2013 sets the LTC contribution rate at 1% in 2016, and confirms that the Minister plans to hold the 1% contribution rate until the end of 2018. During the first 5 years of the scheme, work will be undertaken to review the contributory requirements for the LTC Fund. The LTC contribution rate is set by Regulations and requires States approval to be changed. The Ministers for Social Security and Health and Social Services will continue to work together on the commitments included in P.82/2012*[227].

Since the Panel's report was published, the Social Security, Treasury and Resources and Health and Social Services Departments have agreed the areas where responsibility for existing health funding will be allocated as a payment to the LTC fund, and those where it will remain within the Health Department. Furthermore, the Minister for Health and Social Services and Minister for Treasury and Resources have agreed that the Health Department's budgetary value to be allocated as a payment into the LTC fund in 2014 is £4.7 million and £9.8 million in 2015. The Minister for Social Security and Minister for Treasury and Resources also agreed that Social Security's budgetary value to be allocated as a payment into the LTC fund in 2014 is £8.7 million and £18.1 million in 2015[228].

However, the Budget 2015 has proposed deferral of contribution to the Long-Term Care Fund in 2014 in order to balance the Consolidated Fund:

> *"There is currently a proposal for an element of the forecast underspends in Social Security budgets to be transferred to supplement the contributions to the Long Term Care Fund in*

[224] P.82/2012 – A new way forward for Health and Social Services, page 68
[225] Key Finding 30 – S.R.7/2012
[226] S.R.11/2013 – Long-Term Care Scheme, 6th November 2013
[227] S.R.11/2013Res – Long-Term Care Scheme, Response from Minister for Social Security, 4th December 2013
[228] Draft Long-Term Care (States Contribution)(Jersey) Regulations 201- (P.140/2013) addendum, December 2013

2014 and 2015. These proposals are intended to ensure there is sufficient funding for the Long Term Care scheme from July 2014, ahead of the introduction of the new Long Term Care contributions starting at 0.5% in 2015. Consideration will be given to deferring the transfer of this funding in 2014 providing sufficient funds exist in the Long Term Care Fund to manage expected commitments in 2014 and 2015[229]*.*"

KEY FINDING: Within the 2015 Budget it is proposed that contributions to the Long-Term Care Fund in 2014 and 2015 are deferred in order to balance the Consolidated Fund.

[229] Budget 2015, page 58

12. Conclusion

The Panel conclude that, since its last report regarding health care reform was published in 2012, a lot of work has been undertaken by the relevant Departments to develop the proposals contained in the White Paper.

This report has again emphasised that if the White Paper's objectives are to be achieved a more integrated approach to planning and developing services across the whole system of health and social care should be adopted. This must include all acute services within the hospital and out-of-hospital services in community settings as one service cannot be viewed in isolation of another.

The Panel has found that some areas have been developed more rapidly than others, such as the successful implementation of some community services. However, other areas are not as advanced and still require further development which raises the question of whether a whole systems approach is being undertaken. This is concerning to the Panel because if one work-stream is developed without cognisance of the other, the successful delivery of the redesign programme is put at risk.

A comprehensive acute services strategy is being developed by the Health Department, however, a decision already appears to have been taken by the Ministerial Oversight Group on both the size and location of the acute hospital facilities. The Panel considers that the size and scale of the hospital cannot realistically be decided until there is a clear direction on what services are going to be provided in hospital along with detailed information on the overall funding required to provide those services.

The report and proposition (P.82/2012) which followed the White Paper set out a vision for the new hospital and emphasised the need to ensure that hospital services remained viable and sustainable during the transition 10-year period before a new hospital could be opened. As a consequence, urgent investment was required for current hospital buildings. This report and the Panel's previous report accepted this by acknowledging that a continuing programme of refurbishment was necessary to continue to bring hospital standards to an acceptable level.

It is a shame that, had some of the reform's proposals been introduced some years ago, Jersey residents would today have services under less substantial pressures, more modern facilities and the right balance of services provided within the community and hospital.

The Panel has found that considerable work on the development of plans for new hospital facilities has been undertaken and a multitude of documents have been produced with various options included at various stages. At the end of this process, the preferred choice of site is the current hospital with split services being provided at Overdale equating to a dual site hospital.

The Panel has reviewed how this decision by the Ministerial Oversight Group was reached and concludes that a strong emphasis in reaching the decision was put on the overall budget envelope. W.S. Atkins were not provided with a budget envelope and originally estimated a total new construction for the hospital and land cost of approximately £462 million. However, the Ministerial Oversight Group subsequently identified a maximum sustainable funding package of £250 million spread over 10 year (together with the 10 year programme of urgent investment for current

hospital buildings). The Panel are still unclear as to how this figure was arrived at and why it took so long to determine the maximum funding available.

While it may be appropriate that in the initial stages the contractor, in this case W.S. Atkins, is not limited by a budget, it should become clear early on what the budget envelope is likely to be so that appropriate value is obtained from consultant time and expertise. The Panel has found that the process employed in this case highlights the fact that an integrated approach to planning and developing services across the whole system of health and social care is lacking.

The effect of a reduced budget means that a 100% new build hospital will not be provided. This is disappointing because new build as opposed to refurbishment is always the preferred option since it could be built to the very latest healthcare standards, and all services could be provided under one roof.

Whilst the Panel support the redevelopment of the Overdale as a site for improved mental health facilities, the Panel is of the opinion that acute services should, if at all possible, be retained on one site.

Following the completion of its review, the Panel remains unconvinced that a dual site hospital is the right way forward for Jersey's acute health care. As one member of the public writes in a submission: *"As an Island, we now have a wonderful opportunity to provide the very best hospital services for the future. Let's get it right".*

13. Appendix One: Panel and W.S. Atkins correspondence

States of Jersey
States Assembly

États de Jersey
Assemblée des États

Scrutiny Office

W.S. Atkins
Mr I. Tempest

Our Ref: 517/21(5)

2nd June 2014

Dear Mr Tempest

Health, Social Security and Housing Scrutiny Panel

Redesign of Health and Social Services: Full Business Cases and Hospital Review

The States of Jersey Treasury Department has passed on your contact details so that we are able to contact you regarding the work W.S. Atkins undertook on the Future Hospital Project. We have been reviewing the proposals for the redesign of Health and Social Services since 2012, and would be very grateful if you could provide written answers to the following questions in order to assist us with our review –

1. What projects have you been involved with for the States of Jersey since 2009? Which of these are ongoing?

2. When were you first engaged to work on the development of plans for new hospital facilities? What were the terms of your engagement, when did you finish this piece of work, and what was the outcome?

3. Where you ever given any indication of an overall budget figure that you would be expected to work within to deliver the required options? If so, what was the budget, when were you first given a figure, and by whom?

4. If no, was this unusual in your experience to be asked to produce a pre-feasibility spatial assessment and strategic outline case without being given any indication of what the budget envelop might be?

5. How did you deal with this task without a budget constraint?

6. When did you deliver the outcome of this study? If it was phased, can you describe the phases?

7. When were you aware that there was a review of funding options and affordability going on in parallel to your production of a pre-feasibility spatial assessment & strategic outline case?

8. What was your involvement in this review of funding options, if any?

9. When were you made aware of the outcome of this funding review?

   According to HSSH briefing pack (March 2014,) in June 2013 Atkins put forward a Phase 1 Concept that met a list of priority objectives identified by HSSD within a budget of £250 million excluding contingencies. The project Board then met at some time in June and agreed 'informally' that this Phase 1 Concept did not meet key outcomes and recommended an alternative approach involving clinical engagement. This was then approved by MOG in an evening workshop at some time in June.

10. Why did you put forward a concept excluding contingencies? What was the cost of the Phase 1 Concept if contingencies were included?

11. Were you surprised to find that the Project Board decided that your Phase 1 Concept did not meet key outcomes? Had you been made aware that these were key outcomes? If the outcomes were key, why did you produce a solution that did not take them into account? Do you feel that your time and resources could have been better employed if you had access to this information from the start of the assignment?

12. It seems that the essence of the alternative approach suggested by the Project Board and agreed by the MOG was that it 'involved clinical engagement'. Was this the first time clinical engagement had been sought in the process? If yes, why was this, given that this is common practice in most large-scale developments in the UK? Would you not always seek clinical engagement in large-scale hospital projects, or indeed any scale of project?

13. Were you surprised that a new consultant (Design Champion) was brought in to undertake further work on the development of the hospital at this point?

14. Did you bid for this element of the work? If no, why not? Were you encouraged to bid for it?

15. Were you surprised when the Design Champion suggested a dual-site solution for the hospital?

16. Did you consider that option? If no, why not? If yes, why did you rule it out?

17. Do you believe that the risks associated with the new dual-site option are much less than those you identified in the schemes put forward in June 2013?

18. What lessons have you learnt from your experience in working on these projects with the Health Department and Treasury of the States of Jersey?

We aim to report on our findings at the beginning of July 2014, and would be grateful to receive answers to these questions by Monday 23rd June 2014.

Yours sincerely

Deputy J. Hilton
Vice-Chairman
Health, Social Security and Housing

Response to Correspondence dated 2nd June 2014 received from Scrutiny Office of States of Jersey

Hospital Pre-Feasibility Spatial Assessment Project

1. According to our records, the appointment to undertake the Hospital Pre-Feasibility Spatial Assessment Study and associated Strategic Outline Case is the only commission that Atkins has undertaken for the States of Jersey since 2009. There have been variations and additions to the appointment, that have been instructed by both Jersey Property Holdings and the Health and Social Services Department but this consultancy has now been completed and hence there are no ongoing current commissions with the States of Jersey.

2. WS Atkins International Ltd was appointed to undertake the Hospital Pre-Feasibility Spatial Assessment Project following a pre-qualification, bid submission and interview process, under cover of correspondence from States of Jersey dated 31st May 2012. Formal contract documents embodying the scope of services and terms and conditions of appointment were prepared, exchanged and signed in October 2012. The initial appointment covered the evaluation of various potential sites for the hospital on Jersey and the production of a Strategic Outline Case for the project following the protocols set out in HM Treasury's business case guidance. The evaluation of potential sites took place during June, July and August of 2012 and the Strategic Outline Case was submitted to States of Jersey on 31st August 2012 for review and comment.

3. We were not provided with a budget for the overall project, as the initial emphasis was upon the evaluation of optional sites that would be capable of accommodating health care facilities suitable for delivering health care services to the changing demographic of Jersey. The focus of the study was upon the identification of preferred sites upon which a replacement hospital could be constructed, the development of a functional content schedule of accommodation capable of accommodating the changing demographics and the assessment of the potential cost of such a facility constructed on Jersey. As a consequence of our research prior to appointment, we were aware of work that had been undertaken by KPMG on behalf of the States, culminating in their report entitled ' A Proposed New System for Health and Social Services ' published in May 2011. This report made reference to an anticipated requirement for capital expenditure of £300m to replace the existing General Hospital. We were however directed at the outset of our appointment by States of Jersey to disregard that figure. It was not until May 2013, that we were advised that States Treasury Department wished to limit any capital expenditure for a replacement hospital to £250m

4. Given that the emphasis of the Pre Feasibility Spatial Assessment Study, was upon the identification of potential sites on the island that could accommodate the likely healthcare care facility, it was not too unusual for the study to be carried out without a budget envelope. The Strategic Outline Case undertook a non-financial appraisal of the various sites to help identify through assessment against a range of benefit criteria, which sites offered the best potential for further investigation. The Strategic Outline Case identified a range of potential capital costs for the options considered and recommended a more detailed financial appraisal be undertaken at the next, Feasibility and Outline Business Case stage.

5. V3 of the Strategic Outline Case which incorporated comments and observations made by the States' Project Team, and was submitted on 7th September 2012, followed the protocols recommended by HM Treasury's 'Green Book'. The SOC established the strategic case for the re-provision of healthcare facilities and made recommendations in respect of the next stages of development and the more detailed financial appraisals.

6. We delivered the Pre-Feasibility Spatial Assessment Study and Strategic Outline Case (V3) to the States of Jersey on 7th September 2012. In the Autumn of 2012, the findings of the SOC

were considered by States of Jersey resulting in further sites being offered for evaluation, this resulting in an updated Strategic Outline Case which was issued to the States on 5th March 2013. This version of the SOC incorporated the investigations that were undertaken into the 'Health Quarter' initiative that was promoted by the Planning Minister. Further revisions were requested by the States in the late spring of 2013 leading to V6 of the SOC being issued to the States on 9th July 2013. Appendices were updated to reflect the dual site option that was developed in August / September 2013 and these were issued to the States on 14th October 2013.

7. We became aware of concerns in respect of affordability issues in February and March 2013, as the issue was raised at a MOG sub group meeting that some of our team attended. However, we were not aware of a review of Funding options that was being undertaken by the Treasurer's Department. Around this time we were asked to source benchmark data in respect of recent hospital construction costs in the UK and we provided this information to the States as evidence of the validity of the Dept of Health's Health Premises Cost Guides, which our team had used to develop our cost estimates.

8. We were not involved in any review of funding options, other than the provision of benchmarked data from other healthcare projects as noted in Point 7 above.

9. On the 10th June 2013 we received an e-mail from the Project Director instructing our team to undertake further analysis, with a request that this activity be completed by 18th June. In that e-mail, we were advised to assume that *'...the Project Cost Total has to be within an affordability envelope of £250 million, (i.e. this should therefore include in outline the General Works Costs, Site Specific Works Costs, UK location adjustment, Consultant and Design Fees, Site Specific Non Works Costs and Equipment costs but to exclude HPCG allowances for contingency, optimism bias or inflation adjustments, which for the purposes of this project we request be assumed to be captured within a 5% contingency sum please as there remains concern amongst the Project Board that there is a perception that such contingency is not required in the Jersey context.)'*

10. On the 14th June Currie & Brown submitted 2 cost summaries to Atkins copied to States of Jersey; one summary was prepared in accordance with the Project Director's email of 10 June 2013 and one that was as per the NHS Dept of Health's Health Premises Cost Guides & RICS guidelines. The email included a paragraph stating that we would not recommend progressing with only a 5% level or risk & contingency at this stage and that if this was the proposed route forward by the Client they should hold a non-declared contingency separate from the declared contingency.

11. We were surprised that the Project Board concluded that our Phase 1 Concept did not achieve key outcomes. The priorities we had discussed at the inception of that stage of the commission centred around the provision of single bedded accommodation, the re-provision of theatres, the provision of intensive care beds, the provision of women and children's accommodation and how this could all be achieved within a phased redevelopment of the site. The solution we proposed achieved these objectives, albeit over a period of time. Feedback we received from the Project Director indicated that the solution achieved the brief we had been given however, there was concern from the Project Board that the investment required to acquire properties down Kensington Place did not result in immediate benefits for patient care. The phased redevelopment provided in the Board's view a less attractive solution for the population of the island.

12. We had recommended and sought clinical engagement from the outset. Indeed, it featured in our initial interview presentation and was something we commended on numerous subsequent occasions. It was a process with which we were very familiar from other projects with which we had been involved. When evaluating the various site options, clinical engagement was not

so important but, as the study progressed we highlighted in each of the SOC's we submitted, that we considered clinical engagement was essential to ensure that the Hospital Management Team were properly considering their proposed models of care and were securing the 'buy-in' of the clinical leadership. We did find it frustrating that we were not afforded the opportunity to participate in any clinical team engagement during our commission. The priority of our commission was to identify an appropriate site on which acute healthcare services could be delivered

13. We were surprised that a Design Champion had been appointed to undertake further development work in July / August 2013. We understand that he had provided some guidance to the Treasurer in respect of the costing of healthcare facilities in the UK although we were surprised, given that his professional background was not that of cost adviser.

14. We did not bid for this element of work and were unaware that the States had sought offers for such consultancy. We were not asked to put forward a proposal for this element of work. As far as we were aware, the Design Champion's appointment was a direct commission from the States without any tendering process. Our introduction to the Design Champion was at a meeting held in JPH's offices on 6th August 2013.

15. The dual site option proposed by the Design Champion was slightly surprising as one of the key drivers communicated by the hospital team at the outset, was the retention of all acute care on a single site. We had discussed with the Project Director, another project with which we had been involved which resulted in the concentration of acute in-patient care on 5 discrete sites across a city and the establishment of 2 new ambulatory care and diagnostic centres on other non-acute sites. We were therefore familiar with the concept of split site solutions although not where serving a population of 110,000 inhabitants.

16. As noted in point 15 above, we were already aware of the possibility of 2 site options, (though not on the scale of Jersey), with out-patient functions being removed from the main acute site. We were concerned that clinicians may have been reluctant to accept the impact upon their working practices (across 2 sites) and within the two week period we had to investigate the refined Concept, it was not possible to explore that option in any detail.

17. The risks of the dual site option should be lower and more controllable than the single site re-development, however, there is still likely to be a significant amount of reconfiguration of the existing General Hospital site and hence still significant risk. One of the key difficulties in developing the single site option on the existing site, was creating enough 'free space' upon which new facilities could be constructed. In our investigations, we concluded that the sequencing of redevelopment was extremely complex, (and would have required further examination), to ensure that each department within the hospital could continue to function satisfactorily whilst major re-construction was underway in close proximity. The development over two sites will certainly help to relieve some of the pressure on the existing General Hospital site, but the complexities of maintaining safe and controlled services whilst major construction works are underway, should not be understated.

18. At times, we were set unrealistically short timescales for the delivery of information or reports and with hindsight, we did not challenge these demands firmly enough. We did not engage fully with key members of the Project Board and so they were unaware of the detailed considerations by our team that were underway in the background. As a consequence, it was more difficult to ensure that they fully understood the challenges of proceeding down a particular route or direction of travel.

14. Appendix Two: Peer Review of Reform of Health and Social Services

Terms of Reference – Peer Review of Reform of Health and Social Services

1) To receive a full briefing on the background and context to Report and Proposition P82/2012 including the underpinning technical report by KPMG, utilising the Bailiwick Model.

2) To receive and review progress reports on the 4 parts of the proposition:

   - to approve the redesign of health and social care services in Jersey by 2021 as outlined in Sections 4 and 5 of the Report of the Council of Ministers dated 11 September 2012

   - to request the Council of Ministers to co-ordinate the necessary steps by all relevant Ministers to bring forward for approval:

     (i) proposals for the priorities for investment in hospital services and detailed plans for a new hospital (either on a new site or a rebuilt and refurbished hospital on the current site), by the end of 2014. (to be led by the Treasury & Resources Minister and the Minister for Health and Social Services)

     (ii) proposals to develop a new model of Primary Care (including General Medical Practitioners, Dentists, high street Optometrists and Pharmacists), by the end of 2014 (to be led by the Minister for Health and Social Services and the Social Security Minister);

     (iii) proposals for a sustainable funding mechanism for health and social care, by the end of 2014 (to be led by the Treasury & Resources Minister).

3) To consider and offer comment on progress to date across all aspects of the programme of reform for health and social services as set out in P82/2012 and, in particular, in the context of the overall States of Jersey Reform programme and latest strategic and system thinking emerging from expert organisations such as the King's Fund and the Nuffield Trust.

4) To consider and offer comment on the short term and longer term approach and options for sustainable funding of Health and social services, taking into account work undertaken by KPMG.

15. Appendix Three: Evidence Considered

Evidence Gathered

An extensive number of documents were considered by the Panel and its expert advisors during the review. Below is a list of the key documents:

1. *Hospitality Pre-Feasibility Spatial Assessment Project: Interim Report* (R.125/2012)

2. *Health and Social Services: A New Way Forward* (P.82/2012)

3. *Health and Social Services: A New Way Forward (P.82/2012) – Amendment* (P.82/2012(Amd))

4. *Hospital Pre-Feasibility Spatial Assessment Project Outcome* (Council of Ministers Report) - 2nd October 2013

5. Council of Ministers Part B Minutes relating to the Health White Paper, FBC Process and Future Hospital

6. *Jersey General Hospital: Refined Concept – Addendum to the Strategic Outline Case*

7. *Jersey General Hospital: Refined Concept – Addendum to the Strategic Outline Case – Appendices*

Public Call for Evidence

The Panel advertised the following Call for Evidence in the Jersey Evening Post:

HEALTH, SOCIAL SECURITY AND HOUSING PANEL

CALL FOR EVIDENCE

Jersey Hospital services are in need of modernisation. It is proposed that the future hospital will cover two sites with a new building on the site of the current Overdale Hospital at Westmount. This will provide outpatient care including the diabetes and cardiology centres and the renal unit. New laboratory and pharmacy facilities and an enhanced rehab unit will also be provided on the Overdale site. Once these plans have been developed, all patients requiring routine appointments, without the need to be admitted to hospital overnight, will be treated at the new Overdale site.

The Health, Social Security and Housing Scrutiny Panel would like to hear your views, for example on:

- **What do you believe the main challenges would be if the future hospital provided care from two sites, as proposed?**
- **What in your view would be the impact on patients, staff and visitors?**

For Terms of Reference please visit our website at **www.scrutiny.gov.je**

For further information on the review contact:
Scrutiny Office, Morier House, St Helier, JE1 1DD Telephone: 441080

Written submissions should be emailed to:
scrutiny@gov.je by Tuesday 6th May.

States of Jersey States Assembly — États de Jersey Assemblée des États

In order to generate as much public interest as possible, the Panel also asked for people's views via the radio station Channel 103.

Meetings, Briefings and Public Hearings

Meetings

During a visit to Jersey on Thursday 28th February 2013, expert advisor Mr Sean Boyle held meetings with the following people:

- Mr J. Pinel, Chief Executive of the Voluntary and Community Sector
- Mr J. Hopley, Honorary Chairman of the Voluntary and Community Sector
- Mrs H. O'Shea, Managing Director of the Hospital
- Mrs J. Garbutt, Chief Executive Officer of Health and Social Services
- Ms R. Williams, Director of System Redesign and Delivery
- Ms W. Hurford, President of Brighter Futures
- Mr J. Bugbird, Chairman of Brighter Futures
- Ms J. Cummins, Manager of Jersey Alzheimer's
- Ms S. Wareing-Jones, Counsellor and Family Support Co-Ordinator of Jersey Alzheimer's
- Ms K. Averty, Secretary of Jersey Alzheimer's

During a visit to Jersey on Tuesday 25th February and Wednesday 26th February 2014, expert advisor Mr Sean Boyle held meetings with the following people:

- Mr R. Jouault, Managing Director of Community and Social Services
- Dr P. Venn, Primary Care Body
- Mr J. Hopley, Honorary Chairman of the Voluntary and Community Sector
- Dr N. Minihane, Chairman of the Primary Care Body
- Mr W. Gardiner, Project Director
- Mr R. Foster, Director of Estates from Jersey Property Holdings
- Mr B. Place, Hospital Project Manager

During a visit to Jersey on Monday 31st March and Tuesday 1st April 2014, expert advisors Mr Sean Boyle and Mr Gerald Wistow held meetings with the following people:

- Ms L. Rowley, Treasurer of the States
- Dr G. Prince, Clinical Lead on I.T
- Ms J. Yelland, Deputy Director of Commissioning

Site visits to Jersey's General hospital and Overdale hospital site were also organised during the review.

Briefings

The Panel also received several briefings from the Minister for Health and Social Services and her Department during 2013 and 2014.

Public Hearings

The following Public Hearings were held during the review:

Witness	Date
Ms H. O'Shea: Managing Director of Hospital Mr M. Siodlak: Chair of Clinical Directors Group Dr N. Minihane, Chair of Primary Care Body	Friday 22nd February 2013
Dr S. Turnbull, Medical Officer for Health	Friday 22nd February 2013
Dr M. Siodlak: Chair of Clinical Directors Group	Friday 11th April 2014
Dr G. Prince: Clinical Lead on I.T	Monday 14th April 2014
Ms R. Naylor: Chief Nurse	Monday 14th April 2014
Dr N. Minihane: Chair of the Primary Care Body Dr P. Venn: Primary Care Body	Monday 14th April 2014
Ms L. Rowley: Treasurer of the States Mr W. Gardiner: Project Director, Future Hospital Mr B. Place: Project Director, Future Hospital	Friday 2nd May 2014
Dr P. Southall: Consultant Histopathologist Mr A. O'Keeffe: Chief Scientific Officer, Health and Social Services	Wednesday 7th May 2014
Ms J. Garbutt: Chief Executive Officer, Health Ms H. O'Shea: Managing Director of the Hospital Ms R. Williams: Director of System Redesign and Delivery Mr B. Place: Project Director, Future Hospital	Thursday 8th May 2014
Ms R. Naylor: Chief Nurse	Monday 12th May 2014
Mr J. Turner: Director of Finance & Information	Monday 12th May 2014

Ms J. Yelland: Deputy Director Commissioning Mr D. Hoddinott: Deputy Director Commissioning Mr A. Heaven: Deputy Director Commissioning Ms R. Williams: Director of System Redesign and Delivery	Monday 12th May 2014
Mr G. Underwood: Hospital Architect Mr R. Foster: Director of Estates, Jersey Property Holdings	Friday 16th May 2014
Senator P.F.C. Ozouf: Minister for Treasury and Resources	Friday 13th June 2014
Deputy A. E. Pryke: Minister for Health and Social Services	Monday 16th June 2014