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Assemblée des États

Future Hospital Review Panel

Review of Preferred Hospital Site Recommendation

Witness: Deputy Chief Minister

Tuesday, 13th October 2020

Panel:

Senator K.L. Moore (Chair)

Deputy M.R. Le Hegarat of St. Helier

Deputy R.J. Ward of St. Helier

Witnesses:

Senator L.J. Farnham, Deputy Chief Minister

Deputy R.J. Renouf, The Minister for Health and Social Services

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

Mr. C. Parker, Chief Executive

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

Mr. A. Handa, Clinical Director, Our Hospital

Mr. R. Bannister, Development Director, Our Hospital

Ms. J. Larkin, Head of Finance Business Partnering, Our Hospital

Mr. C. Ellis, Head of Health Strategy, Archus

Mr. J. Setra, Managing Director, K2 Consultancy

Mr. R. Darch, Chief Executive, Archus

[14:14]

Senator K.L. Moore (Chair):

This is a slightly unusual hybrid version of a Scrutiny Panel hearing; the Future Hospital Review Panel public hearing with the Deputy Chief Minster and the Minister for Health and Social Services. We have 8 of us in the room, one Scrutiny officer, 3 panel members and the Deputy Chief Minister,

the Minister for Health and Social Services, the chief executive and the director general for Health and Community Services. We are joined by a number of people on the line. We will go round the room and down the line to ask everybody to introduce themselves just for transcribing purposes.

[14:15]

If everybody could leave their microphones if they are not physically in the room, it appears we are picking up a little bit of sound through the videoconferencing in the middle of the table. We will do the introductions for the transcriber. I am Kristina Moore, and I am the chair of the Future Hospital Review Panel.

Deputy M.R. Le Hegarat of St. Helier:
Deputy Mary Le Hegarat of the Hospital Review Panel.

Deputy R.J. Ward of St. Helier:
Deputy Rob Ward, part of the panel.

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

The Minister for Health and Social Services:
Deputy Richard Renouf, Minister for Health and Social Services.

Chief Executive:
Charlie Parker, chief executive.

Director General, Health and Community Services:
Caroline Landon, director general, H.C.S. (Health and Community Services):

Senator K.L. Moore:
If everybody could work from the top of the participants line down introduce themselves please and their role.

Clinical Director, Our Hospital:
I am Ashok Handa, the clinical director for the Our Hospital project.

Head of Health Strategy, Archus:
Conor Ellis, I am head of health strategy for Archus, as part of the evaluation team.

Assistant Minister for Health and Social Services:

Assistant Minister for Health and Social Services and vice-chairman of the P.O.G. (political oversight group) with regards to the hospital.

Head of Finance Business Partnering, Our Hospital:

I am Jo Larkin. I am the head of Finance Business Partnering for the Our Hospital project.

Managing Director, K2 Consultancy:

I am John Setra, M.D. (managing director) of K2 Consultancy, part of the external scrutiny adviser panel.

Chief Executive, Archus:

Good afternoon, Richard Darch, chief executive of Archus, also part of the expert panel advising the Scrutiny Panel.

Development Director, Our Hospital:

Richard Bannister, Our Hospital project, development director.

Senator K.L. Moore:

I believe that is everybody who is going to be contributing to the hearing today, so we will get started now. We have lost a little time, which I am sorry about, but it is valuable that we have managed to find an I.T. (information technology) solution to us all conducting this hearing together. The first topic of questioning is R.54, New Hospital Project: Next Steps; this is setting out the Government's wishes for selecting a new hospital. Why has the site been decided now, Deputy Chief Minister? In your proposition the site would not be selected until the requirements of the new hospital were known?

Deputy Chief Minister:

Could you repeat the question please?

Senator K.L. Moore:

R.54, Next Steps, the report sets out some of the wishes of the Government for setting out of the report. The question is: why has, at this stage in the process, the site now been decided upon and in the proposition the site would not be selected until the requirements of the new hospital were known. At the moment we are still awaiting a functional brief and the S.O.C. (strategic outline case).

Deputy Chief Minister:

First, the site has not been selected. We have recommended a site. Secondly, I am not quite sure I understand the rationale behind that question. We are trying to get a hospital built. This process is about selecting a site and I think we know, generally speaking, what we need to incorporate in the new hospital and the new hospital campus. If you want some more technical detail around that, I am quite happy to provide that but perhaps Richard Bannister could answer the question on the functional brief and I could help with the S.O.C. Which way would you like to deal with it?

Senator K.L. Moore:
Whichever way you think would be most expedient.

Deputy Chief Minister:
Richard, do you want to just talk, you and Ashok, about the functional brief between you so that we can show that we have started that work and that does form part of the rationale for choosing the site?

Development Director, Our Hospital:
Firstly with the draft functional brief, I will let Ashok speak in a moment about the content of it, but the draft functional brief was produced some time ago and it was known as the draft functional brief because there was work needed to take it forward. That draft included within it the predictions at that time of what uses would be required on the ground floor of a building and was, as everybody is aware, used to enable us to do the site selection process because it provided us with the minimum areas. The draft functional brief has been developed over the last couple of months through a lot of engagement with clinicians. Again, Ashok can help us and explain some more detail on that. The draft functional brief becomes the functional brief on or around 17th November, at the same time as we produce the employers' requirements document, which hopefully will include the site on which we want the hospital located.

Clinical Director, Our Hospital:
If I can follow that up. Thank you, Senator Moore, for this important question. As Richard said, the initial very first draft thoughts on the functional brief, we had also said that in this project we would start with using any work that had already been undertaken for the Future Hospital project so that we did not duplicate work that was unnecessary and hence waste taxpayers' money, and so we started with that. We then had a period of consultation through last summer with me having 30 individual one-to-one meetings with key opinion leaders, clinical leads, associate medical directors, the H.C.S. executive and with primary care leaders. I piggy-backed on to many of the J.C.M. (Jersey Care Model) meetings so I could have exposure to as wide a group of commissions and service users as possible. We used all of that into producing an initial draft functional brief. We also had some simulations on what the healthcare needs would be for the States of Jersey by 2036. We

featured that into it. We also looked at the aspirations of H.C.S. for Islanders' health looking forward to the next 20 to 30 years. Over this summer, and that was a process of intense clinical engagement, which we had planned for April and May this year, which out of necessity, due to COVID, was suspended. We spent over 5 weeks' time to have 50 clinical user group meetings with meeting over 120 staff, and I personally met an additional 16 clinicians on a one-to-one basis to feed into what is now going to be our final functional brief. We have used that period intensively to both look at what the changing world has been due to COVID, where future hospitals need to be COVID-type secure and, at the same time, use the knowledge from other healthcare systems around the world on what would be best in class for healthcare. That is the process of getting it to draft brief. Of course we have given some initial work to the project development director, Richard Bannister, and the team, on the minimum size to help with site selection on the basis of what must absolutely be in any good functioning hospital for the future on the ground floor. So I hope that answers your question as to where we are, where the process is now of taking back all of the comments from the clinicians. We have had 4 separate meetings with them, with each group, to finalise that and we aim to have that done ahead of the deadline of 17th November.

Senator K.L. Moore:
Thank you very much for that.

Deputy Chief Minister:
I am not sure, Charlie, if you want to touch on the strategic outline case.

Chief Executive:
Yes, Joanne can come in as well. The strategic outline case is forming part of the full business case and obviously we took the decision that we would first off bring the site and then we would bring the finance, which we are proposing to do for the summer of 2021. That will be lodged as a proposition, which the Assembly will vote on. In order to prepare that financial business case, we need to be able to get the site, and the site then drives some of the costs that would be associated with that. It is a chicken and egg and that is part of ...

Senator K.L. Moore:
Indeed it is and certainly States Members, if I may, feel rather that the cart has been put before the horse somewhat. That they are being asked to agree to a site without knowing the full impact of the costs.

Chief Executive:
They will not necessarily not make that decision but at the right time. It is always laid out, right from the beginning of the process, that in order to meet the timelines that were also set out in the Chief

Minister's report, and there was going to be some parallel running, and the sequential arrangements were not something that we could follow in the normal standard events.

Senator K.L. Moore:

Parallel running is one way of describing it but for States Members who have to be responsible for the decision-making they can feel that the parallel running is interfering in the process. We all recall the Comptroller and Auditor General's report about the previous decision-making process. The criticism that was made of that. There are members of the public, it has to be said in this forum, who feel that the interference in this process has been quite significant.

Chief Executive:

I am not sure where the evidence of that is. In all the publications, the information that has gone on, and the briefings that we have given you to date, it has been very clear that politicians have not interfered, that they have allowed a process to be granted. That process was following a project and programme management set of arrangements. Following that it has been outlined. We had a sequential test process put in place that was then driven through a clinical specification followed by the citizens' panel arrangements for the prioritisation, which gives you the rationale for how the sites process then was conducted. Indeed, the politicians did not know all the finer details of each of the sites until they came down to the individual review processes. That was exactly where the C. and A.G. (Comptroller and Auditor General) had previously criticised the process, that there was a sort of retrofitting of the site without following the logical set of arrangements, which I do not think is the case here. But going back to the second point, which is we do have the construction costs, which are key to determining the first part of the S.O.C.

[14:30]

The issue that has been raised is about the wider financing costs and, of course, you cannot determine that until you make the decision about the site. In the context of that, the site decision would then drive further work and it is in that context I was referencing the parallel running. It is not about in any shape or form undermining the recommendations that came out of the C. and A.G. report. On the S.O.C., which is the question that you asked, the work is being prepared at the moment and the final business case will obviously bring all of the strategic issues in relation to the costs and finances together. We expect that work to move forward rapidly over the next period. We have done a lot of draft work and again, following on from the previous contribution that Ashok and Richard have just made, there will be, by the time we get to the debate, much more clarity on the outlines of those costs. But, as we know, the costs are also skewed by the work around the contingency sums and the optimum advice arrangements that we have used to ensure that we have an understanding of the totality of what we expect the overarching budget to be but that will not

necessarily be the final costs, but they are expected to be done. I do not know if Joanne wants to come in with any other details on that.

Senator K.L. Moore:

I would just like to push back at that slightly when you talk about the totality of costs. One of the key factors here is the inclusion of the Jersey Care Model, which is also yet to be agreed by the Assembly. That of course has an impact on costs and also size of the hospital so it seems that everything is somewhat bunched up into quite some tangle.

Deputy Chief Minister:

I am sorry, that is your observation but what evidence do you have to support most of what you have said this morning, including an accusation that political ...

Senator K.L. Moore:

That is simply a matter of time taking ...

Deputy Chief Minister:

Your evidence in due course. But I think, as I have said all along, the healthcare model and the Minister for Health and Social Services, the chief executive of the department as well, this hospital in its lifetime will probably see a number of healthcare models, which is why the flexible design and nature of the whole hospital campus is paramount. If you would like a comment on the healthcare model and how that upscales, I will ask Caroline just to briefly provide an update on that.

Director General, Health and Community Services:

Really it is to reflect what the Minister has said that the hospital is just one part of the health economy and one part of the model, and there will be several different models in the lifetime of the hospital. That is why we have ensured that the design of the hospital maximises flexibility so that it is able to cope with any eventuality.

Deputy R.J. Ward:

My question was just something that was said by Charlie, regards information to the State Assembly regards costs, whatever that cost maybe, whatever the information is, will come to us before the debate. How long will we have before the debate to digest it? I say that on purpose, if it is the night before just to say we need a reasonable amount of time to digest any information that comes.

Deputy Chief Minister:

We are going to have a number of debates. The first debate is to choose the site where we will present the outline costs and put as much detail as we can around that, as outlined in the report and

proposition. Then the process continues to nail down the costs during the course of next year and then the Minister for Treasury and Resources and Treasury team will work on the financing and the forecasting, which will come to the States for approval. So are you talking about a further breakdown of our current estimations or the debate on the funding?

Deputy R.J. Ward:

It could be both as you mention it, but in terms of the initial outline costs before debating site selection, I was just talking about very specific of the time span between us getting those outline costs to States Members and the debate.

Chief Executive:

We will not have the full costs because that cannot be done until ...

Deputy R.J. Ward:

No, I understand that. Whatever costs you are going to give us, whatever you can provide us with, even if it is just: "Well we can give the cost of the canteen", to put it in context, whatever costs you can provide, what time span will it be before the States Assembly? I ask this simply because often we are given things very late and on such an important debate it would be important to have as much information as possible?

Chief Executive:

The work that we are currently involved in on the S.O.C., which will not be complete in the way that everyone ideally would have liked to have done, as I have referenced earlier. We will share that as far as we can in advance to the debate, and that information will be certainly made available to Scrutiny, which was always the rationale, and you know that we have been providing information as soon as is possible to Scrutiny in advance of the normal processes that we would do in an ideal situation. We will do that. I cannot give you today when that exactly will be but it certainly will not be the night before, which is your point, but whether it is a week before or whether it is 2 weeks before or whether it is 10 days before I cannot tell you at the moment. But it will not be the night before.

Deputy R.J. Ward:

But we are targeting a reasonable number of days?

Chief Executive:

Yes.

Deputy R.J. Ward:

That is all I wanted to hear.

Chief Executive:

The work will be what it is at that point and we need to be upfront about that.

Deputy M.R. Le Hegarat:

I would just like to ask a few questions in relation to fairness and clarity. What standard was used to ensure each step of the selection process was carried out in line with best practice?

Development Director, Our Hospital:

I am happy to but could you just repeat that question please? I did not get it.

Deputy M.R. Le Hegarat:

Certainly. What standard was used to ensure each step of the selection process was carried out in line with best practice?

Development Director, Our Hospital:

Best practice, I am not certain about whether we took time to collect best practice from around the world or anything when we first set out on the process, but what we did was looked at the work that was done on the previous version of the project and particularly took the observation that was made by the Auditor General to make sure that all of those lessons learnt and observations were included. We followed recognised protocols in terms of project management and used the PRINCE2 approach for the establishment of the project and the project management of the project. So they were the things that we did in terms of giving ourselves guidance. We then consulted extensively with health planners, our own clinical colleagues and with the consultants that were helping us, that is PwC and EY, to establish how we should approach this. As a team, came up with and developed and tested a model that we felt we could apply, taking on board all the lessons that we learnt. In applying those criteria, we then made the tests with the citizens' panel to make sure that the criteria that was being used were the correct criteria and, furthermore, that we applied the criteria in the correct sequence to help us to select the sites. Until such time as we got the delivery partner on board we did not really have access to absolute world-beating talent in terms of hospital design and hospital development. When they came on board they looked at the criteria that had been applied and analysed it. They also applied the planning criteria as set out by our own on-Island criteria but also on lessons from elsewhere. In terms of the consultation, they use models from elsewhere again that they described as world-class approaches to make sure that the criteria that were being applied were being applied correctly and were appropriate. That was the process that we followed. Ashok, I am not sure if there is anything that we can add to that or whether you feel I have missed anything.

Clinical Director, Our Hospital:

No, I think you have covered it all.

Deputy M.R. Le Hegarat:

Following on from that, was all the information shared appropriately and correctly with States Members and Scrutiny?

Senator K.L. Moore:

For example, we have not received the draft functional brief yet, I do not think.

Development Director, Our Hospital:

I am happy to take that. Again, Ashok, if there is anything I miss please add in. The draft functional brief has never been made available as a public document but it was shared in its draft format. I have never been given the requirement that the draft functional brief needs to be sent to States Members so the sharing and the consultation, as I recall, was with our political oversight group and with the Council of Ministers where requested. Those documents have been made available but not publicly because they are just not ready. With it being a draft document it needed a lot of consultation with the clinicians before it could be considered a functional brief that is ready for sharing publicly.

Chief Executive:

The July P.O.G. papers, which were circulated to Scrutiny, contains the work that was done at that time.

Clinical Director, Our Hospital:

To add to that, it is still not a completed piece of work, which is why it is not ready to be in the public domain. We gave an undertaking to the clinicians we met that we would work with them, we would listen to them and we would feed into the final functional brief their desires. At the same time, there would be a period of challenge and critique both ways from them to the hospital team and from me to them on what the real requirements are on the basis that we want to build a hospital that is flexible and fit for the future, as outlined by the director general, but at the same time not extravagant. If you talk to clinicians they will want 20 of something when the population probably only needs 12. We have had to go through that process and I think to make it public in any point during that development process would be a gross error and negligent on my part to do that because it is not a completed piece of work. This is a very important document and when it is produced it needs to have the due diligence and checks and balances before it is made publicly available. That is the process I am taking it through, on your behalf. We have 3 more checks to do. One is to go to the clinical and operational client group. It will also go to all the associate medical directors and wider

staff group, and then it will be finally signed off by the H.C.S. executive and the director general. Then it will be ready to be delivered and we will deliver it ahead of schedule before 17th November.

Deputy M.R. Le Hegarat:

I just want to make a comment here. Accepting that we received a brief in July, we are now in the middle of October. This is my observation. We are not the public. We are Scrutiny and we are States Members. So therefore, from my perspective, it is not the same as issuing a document to the public. So I was anticipating and would expect Scrutiny to be able to be on that journey. What I am saying is if the document has moved forward from July I would have anticipated and expected at the end of August or at some stages when significant work has been done on that document we would have had an update.

Clinical Director, Our Hospital:

If I could just remind the Deputy that this was work that was scheduled to start in April and May of this year. Our work was disrupted by the H.C.S. executive and healthcare services looking after the health of the Island and protecting you from COVID. I was forbidden from having any of our clinical user group meetings. Without that clinical engagement the document would be useless. So we ended up having 50 meetings in a period of 5 weeks during August; a huge thanks and credit to all the clinicians and non-clinical members of the H.C.S. team who made time during their summer holiday, despite coming out of COVID, to make sure that we could have those 50 meetings. The detailed work required to incorporate all of that into it is not something that you can rush. We have already contracted a piece of work that should have started in April and be finished by the end of September, from starting in August and we aim to have it finished by the early part of November. It is still a further faster programme. You have to remember that we need to take time out of clinicians' busy time looking after the health of the Islanders to do this additional work.

[14:45]

Again, I would give my thanks to those clinicians who have, despite all of that, sometimes met me up to 8 o'clock in the evening to make sure that we get this work done. I hope that answers why it is taking from July to the beginning of November to do work that we would have liked to have started in April and May, and without those face-to-face meetings with the clinicians it would have been a useless piece of work and not worthwhile undertaking, I am afraid to say.

Deputy M.R. Le Hegarat:

Can I just interject because I think you totally misunderstood what I said? I think all of us are fully aware of the situation that us, as well as the rest of the world, have been in since the very beginning of this year, particularly from our perspective from the end of March when we went into lockdown,

so that was not really what I am saying. I fully appreciate everybody within the medical service, everybody has been working their socks off for the entire period of time. What I was saying, was that if you have moved your document forward and information forward then we would have appreciated an update. I am not saying that I was asking for the document to have been finished or anything like that. All I am saying is that if there was a significant update to the documents that were available in July that we would appreciate an update. I think you misunderstand that I was being critical. I certainly was not. What I was trying to say is that if there is an opportunity for an update then we would appreciate that update. I think what you have to accept is that for the people that sit in this room we do not have a full understanding of building a new hospital and in relation to health. From our aspect, and from any advice that we might get from outside of our own panel, we need to be able to understand it fully. What you might take half a day to read I am going to take 5 days to understand it and that is all I am saying is that we would appreciate getting updates as much as we possibly can.

Deputy Chief Minister:

That is understood, Deputy. Can we get an update? Is it possible we can have an interim update while the work is being completed, perhaps, Charlie?

Chief Executive:

I will take that away and see if we can provide some further updates.

Senator K.L. Moore:

Thank you, that will be helpful as the time is now running rather short, is it not? Going back to the comments of the Comptroller and Auditor General, one of the main points that she made at the time was the order of engaging with those contractors in the process that went on before. You think PRINCE2 methodology, as Mr. Bannister had laid out, I believe normal practice for the S.O.C. to be approved prior to site selection, would that not be the case?

Chief Executive:

I think we made the point that you could, in an ideal world, follow everything through sequentially. When the original R. report was put out we made it clear that the challenge of meeting the target date was going to be such that we would be running, as I said, a number of activities in parallel. So we had an outline of S.O.C. work that we have been developing, which has informed sufficiently, using the PRINCE2 methodology as well, for us to be able to make a series of recommendations, which has resulted in the site selection coming down. The strategic outline case, which is what the S.O.C. is, obviously is part of an iterative process that we are engaged in. The draft S.O.C. went to Scrutiny as part of the P.O.G. papers previously. The further work will come to you, as has been requested, prior to the debate. We will populate the S.O.C. numbers, which is part of what I think

you are looking for at Scrutiny. The main numbers are already in the report and proposition that we have been working off to effect the site. So in the context of your question, we have not not done the work in the way that the PRINCE2 methodology would have required. What we have done is to run some processes in parallel. That always was going to be the challenge if we were going to be able to get the construction completed for 2026, which is what the States Assembly was really asking the project to be able to deliver on. We were clear at the time that would require us to adopt a slightly more fluid approach to some of the methodology. In an ideal world we would have done it in a more structured sequential way, but that would not meet the target date for 2026. The Island wants this hospital built sooner rather than later. The issues I hope are not about obfuscation, it is about ensuring that we manage all of it. We have given you the drafts before, in the same way that we have the functional brief. I take on board the point that you like to be kept up to speed with the next iteration. We will do that. But we also have to take it through the political process and not all of these documents go through the political process in a way that means that we can ensure that Scrutiny is getting something that everybody else is seeing in the right way. Both Ministers have been very clear, as soon as they get it and they have seen it, and agreed it, it goes straight to you; there is no debate about the fact that we are sharing as much information as we possibly can to you.

Deputy M.R. Le Hegarat:

In relation to the site at Overdale, this was rejected in 2015 for various reasons. How has the criteria changed to award Overdale the final status now? For example, it said "impact on community-based services which are currently sited." What criteria has changed in relation to Overdale so that it is now considered the final site from what it was in 2015 and been rejected?

Chief Executive:

The first thing is, in the Future Hospital we were dealing with a very different size and scope of hospital. Part of the rationale for the site for the choice of Overdale has been around the ability for it to be able to be a campus that can contain everything on that site.

Senator K.L. Moore:

Given that it was previously rejected for impact on the site and it is now a larger hospital, it is very difficult for people to understand why it can now be accepted.

The Minister for Health and Social Services:

At the same time as planning a future general hospital we were planning a separate mental health facility in the early stages of planning but that was intended to be separate at the time. Then, I think, we collectively saw the sense and realised that there is no health without mental health and the mental health provision needed to have parity. So this iteration of the hospital planning has included the mental health facilities within it, which does add to the area that is needed.

Senator K.L. Moore:

It would be helpful if you could perhaps provide the evidence about that because the understanding about mental health obviously, yes, it equals physical health and we all know and understand the impact of that. But the environment within a therapeutic setting of mental healthcare should be quite different to a buzzy, very rapid hospital setting, particularly if patients tend to be in that facility for a very prolonged period of time. Having spoken to one mental health patient who spent over a month at Orchard House recently, because of the way the secured facility is sometimes used it means that the in-patients have no access to outside areas. If you could provide that evidence of why the General Hospital would be the correct therapeutic environment for mental health patients, it would be helpful.

The Minister for Health and Social Services:

Yes, we can detail that. There are good plans to have a separate building but still be integral with the hospital site but the quietness is important, the things you have mentioned are certainly not overlooked. It is not going to be a place of stress and noise.

Chief Executive:

Part of what I think you were referencing in going back to the question about Overdale was that scale and the totality of the site. I think I have said earlier that the recommendation is based on the opportunity to have a more integrated hospital campus of which you can still have separation to be able to create some of those spaces and environments, which are more appropriate in certain types of use. By way of example, if you wanted to build a secondary facility around specialist campus services they will be very different to the requirements that you would have for your urgent treatment centre arrangements. So the site provides scope and flexibility, to go back to your original question, Deputy, which then enables us to respond to the future expansion opportunities. In the context of, I think what Ashok and the Minister was saying earlier, there will be more than one care model likely over the next 40, 50 years for you to be able to have that ability to futureproof the site in a way that gives us as much flexibility as possible. The other bit around Overdale is that we all know that no site is the ideal site on the Island. There are always going to be compromises, whether it is Overdale or whether it was gong to be People's Park or whether it was going to be anywhere else. The challenge has been about making sure that you can deliver on time and within the requirements. That was one of the drivers also for being able to consider the site. So clinical adjacencies, location, environment, planning policies, economic and social impact on St. Helier, were all part of the criteria that we looked at to determine. Overdale, in the context of this particular hospital project, alongside the People's Park, both would have delivered a first-class hospital facility for the Island. Then there were all the risks that come into that about delivering it. The political risks, vis-à-vis the existing restrictions that were on People's Park versus transport and other operational risks for getting the

site prepared. So I think, as the Minister for Health and Social Services has said, this is a difficult project for scale and size. We can deal with, we think in the planning frameworks, some of the Overdale issues better because we will approach that from a different angle this time, and as a consequence that is - alongside all of those criteria I have just highlighted - one of the reasons why Overdale this time, Deputy, would be seen to be the preferable site.

Deputy M.H. Le Hegarat:

The original date that your department has projected from 2010 to 2040; this was a 30-year future plan. What is the current projection?

Clinical Director, Our Hospital:

The projection for this is what we would need for 2036. The current timeline for the hospital, as you know, is to be built by December 2025 but commissioned by 2026, and then we will look 10 years ahead of that. As part of the design, as the director general said, there is future flexibility built in both as far as additional ground floor space of 15 per cent but also a very flexible interior design that allows for repurposing of function depending on both the healthcare needs of Islanders but also changes in the way healthcare is likely to be delivered. Some of that we could have - I would not say crystal ball - but a pretty good prediction of some of the changes, and others we simply cannot predict, and that is why we want to have this flexible design. So those are the timelines. Of course it does mean that we have the great opportunity between now and December 2026 to make sure that the transformation programme that the Director General is undertaking with her team will be aligned to the operational functionality of this new building, this future proof building. So the purpose of the clinical engagement meetings is a dual purpose; one is to inform us on what we need to build and how we need to design it, but it also works in the other direction in facilitating the transformation we need. I just thought that might be helpful for the panel to know.

[15:00]

Deputy M.H. Le Hegarat:

Thank you. What amount of overcapacity or future flexibility will be incorporated in the design and with the size of the site to allow for expansion?

Director General, Health and Community Services:

In the design we are putting bedhead services in all public areas. So in a room like this there would be bedhead services within the walls, so that if we needed to open up additional beds we are able to put additional beds into public areas. So if there was a situation, as we face now, we would not necessarily have to build a Nightingale hospital because we would have that capacity built within the actual hospital itself. It is something we learnt from when we went to Sweden and we saw a

hospital there, which is one of their continuity measures that they have taken. You do not necessarily need beds, you just need the bedhead services. As around the site, did you want to talk to that, Richard?

Development Director, Our Hospital:

Yes, thank you. I would say that the site includes the 15 per cent flexibility that Ashok referred to earlier on, so we do have the ability to expand, and within the initial sketches and layouts that have been done you have seen in the reports there are areas shown within those as to where that expansion could occur. I think the other thing to say is that the sizing of the entrances and all of the common areas has been made to take account of the potential for having to move more or less people through, as well as being able to accommodate those additional bedhead services and things that Caroline refers to, so that we are able to convert an office into a ward or whatever it is we need to do, to be able to provide that flexibility both in a planned way and also in an emergency way if needs be.

Deputy M.H. Le Hegarat:

Can I just confirm one thing though, that this does not mean that we are going to end up with beds in the corridors?

Clinical Director, Our Hospital:

No, absolutely not. We are focusing on day case facilities because we want to do more and more day cases. We are still not doing as many day cases when we benchmark against other jurisdictions; not just the U.K. (United Kingdom). So for us it is about ensuring that we have suitable day case capacity that is accessible and flexible, and that indeed it can be used by other practitioners within the community. But absolutely, Deputy, there will not be patients on beds in corridors in Jersey.

Senator K.L. Moore:

If I could just ask, so there is flexibility in regards to the 2 car parks that are in the current map; is that right?

Clinical Director, Our Hospital:

There is also flexibility around courtyards. So as part of the design we are putting courtyards in between various parts of the building blocks, both to enable light and accessibility to staff and patients, but also if we should need to we are able to build into that space. Again when we went on the hospital tours we saw hospitals that had incorporated courtyards with foundations in so they were able to quickly build if required. Richard, I think you are more of an expert than me, I do not know if you wanted to add to that around the courtyards?

Development Director, Our Hospital:

Yes, just before I bring you in, Ashok, you will notice on the plans for Overdale there are particular areas shown for expansion. For example in the northern part of the site there is an office which is currently the water company's office, Jersey Water, and it could be that if we need to provide secure expansion in time to come we could move into that location. So there are opportunities within the site that is already owned and there are opportunities for expansion up there to fit in with plans, such as Jersey Water, who are looking to move and consolidate their offices anyway. So I think that gives us quite a few options. Ashok, could you say anything further about the internals?

Clinical Director, Our Hospital:

Yes, just to summarise that. So there is 15 per cent ground space built in additionally, there is an additional 15 per cent within the courtyards as Caroline has outlined, and then the design within the spaces so, for example, when we have been having these user group meetings we say: "Well we need one echocardiogram room and one procedure room, one is 8 square metres and one is 12." We say: "We would rather build you 2 that are 12 because you may not need echoes in the future; you may need many more procedures." So we have built the design within it to also do that, and we have done all our modelling on a 75 per cent bed occupancy whereas, for example, within the U.K. the N.H.S. (National Health Service) would design on an 85 per cent bed occupancy and that is because of being special needs of an Island where we cannot just send somebody 10 miles down the road if we are full. We are not going to have patients in corridors, in answer to the question, by having that additional flexibility. Of course we are also building another 30 rooms for a private facility which again can be stood down if there is need for public patients. So there are layers and layers of flexibility built in which is why I am confident that this is future-proofed because a single layer would just not be enough, and not reliant enough in the unpredictable world of healthcare.

Deputy R.J. Ward:

I am going to ask a question but before I do, just because people do listen back, can somebody in no more than 2 sentences describe what the draft functional brief is for people who are listening?

Clinical Director, Our Hospital:

The draft functional brief is a document that goes and gives you the overriding principles of how the hospital will work and hence how the design will facilitate the way it wants to work. Then it goes through each service by service saying what the ethos of that service is, what the high-level operational policies of that service will be, and then it details the facilities within that service, the infrastructure. That is the kind of stuff that people get focused on; numbers of beds, numbers of clinic rooms, numbers of washrooms, teaching facilities, that kind of stuff. So that is what the draft functional brief does. We then go and do a set of further really detailed work which gives you a room sheet, and that looks at every single room, how many power points there will be, that kind of stuff.

So it is the process of giving that; it is that overarching bit of how the hospital will work, its culture, its operational policies at the very high level. It will not tell you if you come in with a stubbed left big toe, but it will say that people that come in with injured feet or orthopaedic problems will in general be looked after in this way.

Deputy Chief Minister:

Just following on, it might be helpful for Charlie or Joanne just to do a very, very quick synopsis of the strategic outline case as well for the same reason.

Deputy R.J. Ward:

Yes, I am just conscious of terminology being used, but I do not want to take up too much time.

Senator K.L. Moore:

Could we move on to John Setra's question please before Deputy Ward carries on? I am just mindful of the time.

Managing Director, K2 Consultancy:

We have heard a 15 per cent allowance for future flexibility in floor space and we have heard that we are looking at a maximum of 75 per cent bed occupancy. Is there a danger that we have almost built in too much head room here when we add those 2 figures together?

Clinical Director, Our Hospital:

If I could answer that. That is a target 75 per cent. Of course you know that for any occupancy you have a range and the range will be at 75 per cent, it might go down to 50 per cent, it might go to 100 per cent. But we have chosen 75 per cent because we know from the health service in the U.K., and in other parts of the world, that if you have a target of 85 per cent many of those end up working at around 100 to 105 per cent, which we would find for Jersey to be unacceptable. We know that the higher occupancy close to 100 per cent or above your infection rate goes up, and we do not want that. So really good, safe care on our Island a target of 75 per cent is the right one to have if you are in a middle-high income country. If you are a low-middle income country like Kenya where I have recently been visiting, their national hospital is built with 1,000 beds and at any one time they have 2,000 inpatients. That is not something we are designing to ever have in the States of Jersey. I think there is a small danger that we will be over target but of course just because you have the beds does not mean you staff them or use them. That is the bit about the flexible use is both ways; we can use it for more beds or we can use it for less beds and use for other purposes.

Deputy R.J. Ward:

The reason I asked about the draft functional brief - and thank you for that - is that best practice was used to look at what would be on the ground floor and indeed other floors for the draft functional brief which would in turn, if I am thinking correctly, determine the type of site we want and, therefore, in turn determine where the site is. So these things are all linked together. What methodology other than best practice was used to establish the clinical services required on the ground floor, and indeed other floors, of the hospital?

Clinical Director, Our Hospital:

Consulting the clinicians in Jersey and then looking at the health planners who have designed over 400 hospitals in 80 jurisdictions around the world, using the expertise from the health planners, and then using my own external view based on working in 5 major teaching hospitals but also 25 smaller district hospitals much more like Jersey. The Jersey Hospital is slightly strange because on the one hand the population it serves is equivalent of a medium to small sized district hospital in England and Wales, but at the same time many of the services, because it is an Island, are almost up to tertiary level. So it is a strange mix; if someone said to me: "Why can you not just get a design from somewhere else that is just like Jersey?" Well, there are very few places in the world that are just like Jersey. That is meant to be a compliment, not anything else.

Deputy R.J. Ward:

So the methodology you used, how was that derived in terms of the establishment of those clinical services, because it appears to be a yes/no answer sort of matrix?

Clinical Director, Our Hospital:

It is, but some things that are very clear to clinicians such as you want to have your Emergency Department on the ground floor easily accessible, you want to have radiology, outpatients and diagnostic easily available to patients. Yes, you could have some of those somewhere else but you have to say what is the optimum ideal, and if it was ideal you would have somebody in the clinical user groups ... we asked all of the clinicians that and we would have built 9 different hospitals on one campus site; we would have built you a children's hospital, a heart and lung hospital, a women's hospital, a mental health hospital, et cetera. So you then have to be pragmatic and say if you really had to be choosing, you are paying for it, where would you want to have everything done or, more importantly, if you were a patient or close member of your family coming in? That is the type of questioning and challenging we use with both the health planners and the clinicians to come up to that decision. But of course you then benchmark it against as close to it as you can other hospitals around the world, and we have the benefit of working with people who have built and designed, as I said, over 450 hospitals. Then we know that we are getting the right answer for Jersey.

Deputy R.J. Ward:

Was there a sort of weighting system for those needs or was it a simple yes/no?

Development Director, Our Hospital:
Weighting wise; we tried to avoid weightings because previous versions of the project had struggled with weightings being applied. So in terms of site selection, we definitely took advice from the clinicians on the priorities that we should use in terms of the sequence of questioning, and then with the citizens' panel criteria for the sites we used again a sequence that they felt was appropriate. So we avoided weightings but we used sequencing; so I think that is worth saying. The other thing just to add to Ashok's challenge of the work that was done by MJ Medical, who are our health planners, was that once those areas were brought forward they were challenged by the team. They were challenged from a cost perspective, by a land-take perspective, and also challenged as to if you included a basement does it make a difference if you do not include a basement, and furthermore whether everything had to be on one site or whether things could be adjacent, and if adjacency was acceptable how many minutes travel would be acceptable to those adjacencies. So it was not just about the functions on the ground floor.

Deputy R.J. Ward:
Okay, we will move on because I am conscious of time.

Deputy M.H. Le Hegarat:
The site selection criteria; sites have been excluded based on not being required due to the size, sites have also been excluded based on relocation of services not allowing the timetable to be met, however, there is no explanation as to what the relocation services are and their likely impact.

[15:15]

Sites have been included based on meeting the size criteria, even though this does not appear to be the case, as per the example in People's Park. What confirmation do you have that relocation of services would not allow sites to meet the timetable?

Development Director, Our Hospital:
The judgments were made based on whether it was anticipated that the relocation of something on a site would require a new site and new construction and, therefore, a planning application. So if, for example, there was a business on the site or an operational use of the site that would need relocation, but to enable it to relocate it would require a planning application and, therefore, a planning consent, we knew that the timetable associated with such a process would not allow it to be delivered in time for a March 2022 start on site and, therefore, would not be able to achieve our overall timetables. So if it was a definite no then it got red allocation, whereas if we were not sure it

was given an amber, and if there definitely was not anything because it was a greenfield or something that we already owned then it was awarded a green. So that was the simple criteria.

Deputy M.H. Le Hegarat:
Okay, so therefore based on that why was South Hill eliminated due to not meeting the size criteria for either option when in fact it is more than large enough to accommodate?

Development Director, Our Hospital:
There is obviously a difference in figures; I need to see the figures you are referring to there. When South Hill was considered there was the footprint of the site itself but when the detail of topography was looked at it became clear that quite a large amount of that topography was taken up by steep hills and various different things, which meant that the developable area of the site is not the same as the redline boundary of the site. But what figures you are looking at there, I am not sure.

Senator K.L. Moore:
I think we are looking at the figures that were supplied by yourselves, and I think in particular it was South Hill plus the Fort Regent swimming pool site that is currently being deconstructed that was really - if I recall correctly - in terms of the size of the footprint for the needs of the project, but it was not clear as to why that was not selected. It would be helpful to have an answer to that because it is something that has puzzled us for some time.

Development Director, Our Hospital:
I will have to check back on the detail of the report and make sure that I get exactly the right answer for you. But if we were looking at South Hill in conjunction with Fort Regent - which I must say I do not recall doing - if we were doing that then we would have ... sorry?

Senator K.L. Moore:
South Hill plus Fort Regent swimming pool is one of your identified sites on the longer list.

Development Director, Our Hospital:
Okay, so we would have had to allow for the reprovision of any facilities lost at Fort Regent. Again, that would take us ...

Senator K.L. Moore:
It is currently being deconstructed.

Deputy Chief Minister:

This is the Glacis Field, Richard. There were huge planning issues around the Glacis Field, if you remember.

Senator K.L. Moore:

It was not including the field; it was simply the pool site that is currently being deconstructed plus South Hill. which is an empty office building in public ownership.

Chief Executive:

Just so that you are clear, the pool site forms part of the redevelopment redline for the Fort Regent opportunity ...

Senator K.L. Moore:

Well that then becomes a public decision, does it not, because the future use of that site might be considered for one purpose by the Government at the moment but that is public land and if a hospital is considered more important than that redevelopment then surely it should be given proper airing in public and the public should be consulted upon it? If it is a question of value in deciding what is more important publicly and perhaps the political oversight group had a view on that. Did you, Deputy Chief Minister?

Deputy Chief Minister:

Are you seriously suggesting that part of the hospital be built where the swimming pool is and the other at South Hill?

Senator K.L. Moore:

Well it was considered, it was on the long list.

Chief Executive:

So the site is not considered large enough, which is what ...

Senator K.L. Moore:

I am a bit surprised that the Deputy Chief Minister was not aware; have you not looked at the long list?

Deputy Chief Minister:

Yes, I am aware of the long list, the 82 down to 17 down to 5, I am aware of all of those, but I am surprised that you are suggesting a feasible option was building part of the hospital on the Fort Regent swimming pool site and the other part on South Hill.

Senator K.L. Moore:

It would be a therapeutic environment, would it not. It is in public ownership. It is currently being deconstructed, as we said, and the other part of the site is empty and in public ownership. It seems rather simple, and it was green according to the criteria. We simply could not see or understand what made it not moved down to the next level.

Chief Executive:

The reality was that it was unlikely to meet the timescale because of the ...

Senator K.L. Moore:

How so?

Chief Executive:

Because you are having to take out the swimming pool and ...

Senator K.L. Moore:

That is currently being ...

Chief Executive:

It is a very, as you know, laborious and slow process and it has been not something without its challenges, adding to that particular difficulty, so that is one issue. So while the site might have been big enough the second issue was that there were already proposals for both South Hill and the Fort that were under consideration and are being brought forward. As a combination of opportunities it does not ...

Senator K.L. Moore:

I thought we were all here to deliver a hospital and that is our priority, is it not? I mean, that is a political question and it would also be interesting to know at what level, was this an official level then that the decision ...

Chief Executive:

No, I am just reading what is in the report. The report said what I have just said. So you are asking the question why was it not considered and the report gives you the answer.

Senator K.L. Moore:

Thank you, okay, well we are grateful for that. So did that have any political influence at that time? Was that something that your ...

Deputy Chief Minister:

There was no political interference whatsoever in the site selection process.

Senator K.L. Moore:

So you had no opportunity to decide whether you would prefer to put housing on South Hill to turn a profit or build a hospital before 2026?

Deputy Chief Minister:

The criteria was set out by the citizens' panel and we followed that criteria, and that criteria will encompass ... you can easily go back after this then and look at all the permutations ...

Senator K.L. Moore:

I think it had already fallen off the list before the panel criteria was implemented, it was at 17 at last sight, so I am just trying to understand politically what your objectives are and what your values are in relation to this.

Deputy Chief Minister:

My objectives are to build a hospital and to start ...

Senator K.L. Moore:

Indeed so, therefore, considering sites that hold well in terms of size and location and fit for publication already and have no current use ...

Deputy Chief Minister:

Are you expecting an opinion here ...

Senator K.L. Moore:

No, I am just asking you. It seems to be fulfilling a number of the criteria so I am wanting to understand why it was disregarded.

Deputy Chief Minister:

I will just repeat again; I am not going to comment or refer back to any of the sites that have fallen away. As far as I am concerned they are history. We are only going to look forward with this. There has been no political interference. I am not about to start, before we finish this process and hopefully get agreement from the States Assembly ...

Senator K.L. Moore:

But I thought you were intent on achieving a hospital on a realistic site ...

Deputy Chief Minister:
Despite your best efforts, I am.

Senator K.L. Moore:
Now, please, that is really unnecessary, Deputy Chief Minister.

Chief Executive:
If you go back to your report, there were a set of criteria that were outlined which we followed for sites. Included in that site was development facilities, of car parking capability, suitability of the site, the relocation of services and the timelines it would take to be able to complete the decommissioning in line with the development timetable for delivering a hospital. As a consequence of not meeting any of those requirements it failed to go forward. There were a number of different criteria, all of which were part of a process that was used to assess all 80-odd sites that were brought through. Within the context of that, I think you would have the documentation that outlined that, the rationale. The political oversight group did not get into a decision where they chose a site and then tried to retrofit a hospital to it.

Development Director, Our Hospital:
I just wanted to clarify, having now had the chance to check back on the report, the other aspect is that neither of the footprints offered by those 2 sites was enough to accommodate the basic stuff that had to be together. You will remember we talked about the stuff that needed to be together and the stuff that could be a certain travelling distance. Neither site was able to accommodate the together part of that.

Head of Health Strategy, Archus:
A question really in relation to just current areas. The scheme has moved over the period, as is normal, to just over 69,000 metres. Obviously when design occurs - and you have obviously looked at People's Park versus Overdale and bringing that on to site - you update your requirements and obviously as you lay out the plans things can change. Ashok has already said that you have made some revision to the clinical requirements. Can you just confirm then that the block plans that you had drawn by Llewellyn Davies Architects are now very close to the 69,000 metres as in the drawings that you have shown over the last week or so?

Development Director, Our Hospital:
The work that has been done so far, Conor, is to try and look at the square footages that have been developed to try and see how they could be arranged on all of the various different sites to see whether or not those sites are able to accommodate. So there has been some further refinement of

the work that was done for the draft functional brief and the areas that were set out there. That work involves not just laying out on a horizontal basis, it also looks at the vertical arrangements of the various different departments. So through that work - which they call the block and stack work, it is definitely not design, it is definitely still layout work - they have looked at the arrangements to make sure that the various circulation space that would be necessary between various departments and uses have been taken into account. So there will have been some change to overall square footage because we are moving from theoretical, what is the minimum size, and that was the test that we were applying to the site so that we did not inadvertently rule a site out. So they have gone from the minimum to arrangements that give the options for the layouts. Is there anything I have missed there?

Clinical Director, Our Hospital:
Just to build on that, so essentially when you go into those detailed discussions, as I said we met with each service on 4 occasions and there is an iterative process. Some departments, we had made some assumptions of what they would need, and it turns out they need something a bit less. Others, they need a bit more. After the challenge process we come to an agreed position. So it is really like a 4-stage negotiation, if you like. But also informed by best practice elsewhere, by expertise from Bothwell and Davis, who have designed over 250 hospitals, plus MJM who have designed this as well. So we have this expertise in the room but we have the people on the front line and we are going through that process. Some areas at the end of the functional brief, compared to the draft, will be smaller, some will be bigger, a bit like the financial markets I guess can go up or down. But we are anticipating that the overall size will still be quite close to that 69,000 to 70,000 figure. Of course it will be informed also by the site. When we first started the process we still had 5 sites in play and then we got to our fourth meeting, by which time we were down to 2 sites. "On this site this is the design or block on site we could deliver, would that work for you?" Obviously, we have that more detailed work to do, depending on what the outcome is in the middle of November. I do not know if that answers your question. It is not an exact number and it will not be until we do that really detailed planning once we have the site determined. But it will not be far off that number.

Head of Health Strategy, Archus:
Yes, that is the basic point, is it not, because ultimately what we are looking for is consistency of choice against the 5 to the 2 and ensuring that then the comparisons for the site will be laid out accordingly.

[15:30]

Because obviously if you bridge over the 70,000 by any considerable amount you are obviously impacting on timescales and costs.

Clinical Director, Our Hospital:

We are intending to do that but I could not say to you today, hand on heart, it will only be 69,000. It will be very close to it. There is a chance it might be a bit less, which would be great because then the costs will come down. But there is a chance it might be a little bit more and that is within the error margin of doing this enormous project.

Deputy R.J. Ward:

I will ask a few questions, I recognise we are running out of time, regards public engagement. I will just change it slightly because we are being presented with one site now. What public engagement, in particular for those impacted by this site, was undertaken and will be undertaken? Because I agree, wherever it is put, there will be issues for people. But how are you going to sensitively deal with those issues and sensitively deal with people who are impacted in this way?

Deputy Chief Minister:

While we were going through the process, when it became clear that we were dealing with 2 sites, the team made contact with the property owners. All of those that were or could possibly be affected have had their properties purchased. Outside of that, the neighbours to those adjacent properties, we did not start to speak to them until after the public announcement and that is a process that is going on now. Obviously, since the announcement, not just the immediate neighbours to Overdale, I can categorise it if you like, you have the properties that are potentially being purchased and then you have the immediate neighbours to those properties. Then you have the immediate neighbours to the south of Overdale and then other people who live in the vicinity. So we are starting to make contact with the broader stakeholders. But all of those impacted or likely to be impacted were spoken to ...

Deputy R.J. Ward:

We have those who are concerned about effectively what would be an increase in traffic because of the ...

Deputy Chief Minister:

There will be, in terms, depending on where they are located, an increase in traffic and footfall in the area and disruption to the neighbourhood during the construction process. There is concern about the expansion of the road where houses were in a cul-de-sac, for example, they are now going to be closer to the road. There are all sorts of concerns now surfacing from neighbours.

Deputy M.R. Le Hegarat:

Essentially the district is really important. We have had significant correspondence in relation to those individuals who have not been spoken to and were disappointed that they find themselves in the middle of this without any consultation. The thing is that it is not only about those whose properties are being looked to be compulsorily purchased, but more than anything they are sharing services within those areas and of course it is then going to be difficult as to how that is going to all pan out. I will say it publicly, I am a little disappointed and would have assumed that those individuals would have been spoken to. Because, with my colleagues within that district, we said with the site at Overdale: "Has anybody come to you?" Everybody said: "No, no, they have not." Then all of a sudden it literally all came; I have to say it is more a statement than a question. But I am very disappointed that there was an awful lot of people that live on Westmount Road in particular who are going to be significantly impacted by this where no consultation has taken place.

Deputy Chief Minister:

I would also like to reassure the panel that consultation now is taking place and will be taking place over the weeks ahead. We are speaking to people we have spoken to before and some that we have not. We have also asked that names of people who might not be close to Overdale, but they might be on the route there, to also speak to us. The point is well made, Deputy, and we are increasing our efforts to make sure we speak to everybody that could be impacted, no matter how slightly.

Deputy R.J. Ward:

Just one more, the R.54 report said that engagement with children who are regular users of the hospital should take place. Has that happened?

Deputy Chief Minister:

Who is going to talk about the social impact programme? Richard, is that something that you want to touch on? That is a really good piece of work that we are going to be sharing imminently about public engagement, and not just now, but right throughout the project to completion, including a lot of contact and information sharing with schools and the education system. Richard, do you want to touch on that?

Development Director, Our Hospital:

Yes, by all means. Is this a question about the social values strategy that we are putting in place?

Deputy Chief Minister:

The question is how are we going to engage with children, which is covered in the social values strategy. I do not know if you wanted to touch on that?

Development Director, Our Hospital:

In terms of engagement with children directly associated with Overdale, obviously there is a facility up there where we are dealing with sites to make sure that we deal with the potential for the relocation of those services. In terms of the social values strategy, we have obviously an emerging strategy, which deals with local economic benefit, engagement with various different charities, engagement with the local supply chain, training for young people coming through. Not just in the professions associated with construction, whether that be trade or professional professions, but also expanding those strategies and schemes into healthcare provision as well. So we have a backbone now for a strategy that we can roll out. We have a certain number of graduates and apprentices that have already been appointed into the project through the supply chain, particularly through the delivery partner. We are rolling out with the education institutions, at all age levels and qualification levels, general qualifications related to the construction industry that we can roll out. I am not sure how much depth you want me to go into in relation to the strategy at the moment. Because it is not a document that has come through P.O.G. as yet.

Deputy Chief Minister:

That is a work in progress. We have seen the draft last week and that is something we need to share with Scrutiny as soon as we finish the drafting process.

Senator K.L. Moore:

In order to assist us and to understand how the decision-making process flows, you will take this document, for example that document will be presented to the P.O.G. and then you as the chair of the P.O.G. decide what will be done?

Deputy Chief Minister:

The instruction from the political oversight group to officers, as soon as the documents have been through the political oversight group, they go to Scrutiny. Scrutiny can have absolutely ...

Senator K.L. Moore:

In terms of the decision-making process, you take your decision at that P.O.G. meeting as in what happens to that decision? So it does not need to go to anyone else, it is not part of the Council of Ministers, it is simply the final decision rests with the Deputy Chief Minister?

Chief Executive:

No, the political oversight group makes, on behalf of C.O.M. (Council of Ministers), the operational decisions in relation to the development of the specifications. The Council of Ministers obviously are included in any of the major decisions and the P.O.G. make the recommendations to the Council of Ministers for the ...

Senator K.L. Moore:

Given that sites have not been an issue that has gone before P.O.G., could you give me an example of further decisions that have been taken by them?

Chief Executive:

The process for sites, i.e. P.O.G. had sight of the fact that we had 80 sites, went down to 17, as the Deputy Chief Minister said, and then went down. The process for determining the technical specification for each site, the process was agreed, but the P.O.G. then did not get involved in the day-to-day bit around it. That is what I am trying to, as I said earlier, there has been no political machinations around that. But the P.O.G. make the decisions on the recommendations of officers and then decide whether they are going to the C.O.M., which is what has happened in one of the cases. So when we went down to 5 sites, going down to 2 sites, going down to one site. C.O.M. get updates, which is what has happened, and of course the documentation, as the Deputy Chief Minister said, comes through to you in quick order once it has been into the P.O.G.

Senator K.L. Moore:

But, apart from those final site decisions, could you give me an example of other decisions that the P.O.G. has taken?

Chief Executive:

The P.O.G. has been involved, for example, in some of the discussions around the Jersey Care Model and the relationship with the hospital. The P.O.G. have been involved in the decision-making regarding the contractor for the hospital. The P.O.G. have been involved in the approval of the site approvals and supported the development of the work for the hospital. The P.O.G. have been involved in discussions around transportation issues where appropriate into sites. The list can go on.

Senator K.L. Moore:

That is helpful.

Chief Executive:

So each one is different for each key decision but that follows the principal methodology that we have adopted. But the P.O.G. have been involved in those key decisions, so generally in the day-to-day management of the project. Can I, just for your benefit, it may be helpful for you, we provided to Scrutiny a project manual, which identifies how decisions are made and who makes them. You may wish to go back to that project manual in order to be able to look at where the delegations sit

and how, where and what, the relationship between the P.O.G., the various operational groups, and then C.O.M. That might be worth you going back to, but we provided that some time ago.

Senator K.L. Moore:
Given that we had a bit of a shaky start, is everybody okay if we carry on?

Deputy R.J. Ward:
I will ask the timescale questions that we have. The new hospital will require multiple planning applications being successful. It would appear the timescale is challenging. Have the risks of delay adequately been identified and assessed through those multiple things that would have to fit together?

Director General, Health and Community Services:
There is a fully mitigated risk register that is reviewed on a monthly basis as part of the project governance. I sit on that as S.R.O. (senior responsible officer), so we have a very robust process around that. Richard, I do not know if you wanted to elaborate?

Development Director, Our Hospital:
Yes, so you are quite right. The planning process does pose a risk to the timetable for the project and of course if you have more planning applications you have more risk. So that is quite straightforward. When we were doing the detailed analysis of the timetable with the delivery partners, which was during the bidding stages of the selection, both of the companies that went all the way did detailed programmes that suggested that we could not go for a more relaxed approach, as we had in the past, of an outline application followed by numerous reserved matters applications. That was for 2 reasons, one was the out and out time it would take. Secondly, the risk level associated with it was much higher because each of the reserved matters applications would have the opportunity for further challenge and therefore further delay. So the decision was taken that the only way to deliver would be to go for detailed applications. With Overdale and with People's Park, when the detailed analysis was revisited, it became apparent that the highway works for either scheme could not be delivered if we waited for the timetable. For Overdale it was even tighter because the road up to Overdale needed to be delivered before construction vehicles of the appropriate size would be able to get up and down from the site. So this dictated that we had to go for a separate planning application for the highway work at Overdale and then of course increasing the risk of challenge, increasing the risk to the timetable, and absolutely meaning we are to the wire still, even with an early application, for completion by 2025 and commissioning by 2026. So that risk, as Caroline says, still remains on the programme.

[15:45]

Deputy R.J. Ward:

Just to ask, is the delivery partner sharing the risk in some sort of pain-share/gain-share arrangement?

Chief Executive:

Richard, do you want to just explain that? Because we have done something, which does de-risk some of those exposures to risk with the delivery partner?

Development Director, Our Hospital:

So in terms of the risks, first things first, the contract has to have an accepted programme, which is a detailed programme that sets out how each of the different things is going to be delivered. But the direct relationship with time is cost and, as you mentioned, there is a pain and gain share arrangement within the contract. If we go later, and therefore our costs increase, then the costs associated with that are borne by both Government and the delivery partner up to a certain level. Once you go beyond that level, the pain is all to the delivery partner. Likewise, if we are quicker or we are cheaper, there is a share in the gain. That works that the gain is broadly shared between Government and the delivery partner up to a certain level of saving, thereafter it is not shared at all, it is all taken by Government. So that is the mechanism in place and therefore there is an incentive for the delivery partner to deliver within the affordability limits and, in due course, the target costs set for the programme.

Senator K.L. Moore:

Could we now move to John Setra who has a question?

Managing Director, K2 Consultancy:

Just on that point around timetable and the planning applications, we are aware that the current programme is looking to submit a planning application in autumn 2021 with a planning consent really required by spring 2022 to hit the timeframes. How does the team feel about this given that this is a major application? Does it allow for adequate consultation? Does it allow for a period of judicial review and dealing with pre-commencement conditions? It seems extremely challenging.

Development Director, Our Hospital:

Yes, you are right, it is challenging. This programme is challenging. There is no other way of saying that. In relation to the timetable that has been allowed for the planning process, it is based on a detailed application and, as mentioned before, we would need to now make 2 applications and not one. But firstly dealing with the question that you have raised on the one application; it is September that we need to submit our application for the hospital to enable us to get consent by the back end

of February 2022. That timetable between September and February has been planned by the planners and it takes account of the process of review, the inspector's work, the inspector's advice, then eventually the decision. So that is the timetable we have worked on. Of course it is critical, for that to work, the consultation has to be done on the lead-up. So the consultation that is being planned at the moment is for normal end-of-stage or end-of-R.I.B.A. (Royal Institute of British Architects) stage design process. We would have a consultation at each of those stages. When the impact analyses are done in accordance with the planning requirements, each of those impact analyses will be given public consultation as well as statutory and other advisory consultation that we might need to take account of. So we will do everything we can to know that generally everybody, as best as we possibly can, is content with the application before we submit it in September. I bet not everybody will be happy with it and therefore there are going to be some tough decisions to be made as we go through this process as to what is acceptable and what is not acceptable. This is set out for us in the supplementary planning guidance that has been provided by the Minister, which describes the public interest test. So we would always be applying the public interest test. The reason we know that is because neither of the final sites fit perfectly within the Island Plan. You will probably know that the Island Plan is not going to be reconsulted upon until we get to something like March 2022. That means that our planning application has to be made on the basis of an Island Plan that does not allow for a hospital. So this gives us some challenges and makes it even more important that we consult. But where it does help us is that, if the decision by Government in November is to build at Overdale, in the draft Island Plan that goes out for consultation, Overdale and its access roads can be identified. Again the public will have an opportunity to make comment about the allocation of that site, so that is another level of consultation. The other point to make, John, whereas your dates are slightly out, is that to enable the road to be built in time to enable the construction vehicles to go up, we need really to be making our planning application a lot earlier for the road. In fact we need to start the construction of the road around about October of next year. As you can work out, that will be during the planning consideration for the main hospital, which again gives us another challenge from a planning perspective as per the previous question.

Managing Director, K2 Consultancy:

My point was really around the main hospital, but you have covered that well. So what you are saying is that the design and costing of the hospital to a certain level really needs to be well-advanced by the summer of next year. Because clearly you do not want to submit a planning application that you are not confident on in terms of its functionality or its cost.

Development Director, Our Hospital:

Yes, there are 2 things there. The design most definitely needs to be advanced enough that we are able to make a detailed planning application. The planners will set out for us exactly what that level of detail is that is required. It is anticipated it will be somewhere after R.I.B.A. stage 3, which is

detailed design. It may not have full design for all of the mechanical and electrical systems and things, but all the things that are needed for the planners to be able to consult and consider will be included. From a cost perspective, we will by that time, by the time of submission, have completed our O.B.C. (outline business case) and that will hopefully have been approved by our Government and hopefully the financing of the project will be approved before then by our States Members as well.

Deputy M.R. Le Hegarat:

I would like to just wind back a little bit, just because you have been talking about access roads. What confidence do you have there have been the surveys undertaken to ensure the proposed access routes will be the least invasive to residents? There were several proposed access routes. Can you confirm that the access through Westmount Road is truly the safest and most expedient way for all to travel to the future hospital? Sorry for this, but if we have not been, because I cannot remember, provided with this information, can we please have it?

Development Director, Our Hospital:

On the first part of the question, getting up to Overdale is difficult. The thing that makes it difficult is the 60-metre difference in levels predominantly. There were 4 broad options that were considered, one went through George V Homes. One went across Lower Park, one option was to come through the woodland at the back, the other option was to come along the front, the precipice of Overdale, through the houses that face there. The third option was to come up through an improved Westmount. The fourth option was from the north, Tower Road. The north, Tower Road, is a very constrained access with some things that just cannot be moved up there to make the road wider or improve it and would have a serious impact on numerous residences and other properties. But it does remain as an option for us in terms of secondary access, blue light access, in the case of a problem from other areas, from the south. Coming through George V Homes did not work technically because it did not deal with the change in level, the 60 metres, plus it would have taken out that community completely. The access along the front again did not work because if you came through the woodland area you ended up coming in at the wrong level and if you came along the precipice you disturbed numerous houses across the front. When I say “disturbed”, we would have had to acquire and take them down and replace them with a road. So Westmount became the best and most feasible deliverable option available to us. In terms of considering the impact on residences, there is no solution that we could come up with that would give sufficient capacity for that road without affecting some residences. Broadly, we would need to widen the road either on one side of it or the other, either to the west or to the east. The option of going to the east disturbs 3 homes and it obviously affects more than 3 homes but it disturbs and needs the removal of 3 homes. If you go to the west of that road, you impact on one home and one apartment block. The apartment block, you would basically sever access to, which affected all of the residents of that apartment block. So

the impact in terms of number of residences affected is lower if you go to the east. Notwithstanding, for those people that are affected, it clearly is quite a devastating thing. That was the only way that we could go. So to answer the question, in terms of minimising the impact on residences, we did go for the lowest impact option. The second part of your question, yes, that information has been presented to all parties, including Scrutiny, and it is part of the large report that you have that takes you through the various different options.

Deputy M.R. Le Hegarat:
I am just concerned, just for myself, are we building a road to be able to build a hospital or are we building a road to access the hospital? Does that make sense?

Deputy Chief Minister:
It is both.

Deputy M.R. Le Hegarat:
From my perspective, we would not have to necessarily widen a road in order for people to be able to go to the hospital at Overdale but it is more about building the hospital than it is about accessing it at a later stage.

Deputy Chief Minister:
It is both of them. The advantages are, so the reshaping and repaving, if you like, of the Westmount Road will also provide much better pedestrian access and cycle path access along the side. So you are creating ...

Deputy M.R. Le Hegarat:
I assume it is going to be a one-way road.

Deputy Chief Minister:
No.

Senator K.L. Moore:
I am mindful of the time. Can I just ask one more question please and that is about the financing of this project? In the report that was published it gave the price of the hospital build as £550 million. Using the Treasury Green Book principles, what is the cost of the hospital currently projected including the site-specific costs, inflation, and of course contingencies that was previously built into the cost made public for the previous site?

Chief Executive:

Joanne may wish to come in on this particular point. In the proposition there is a complete breakdown of construction costs, so the design and delivery partner costs in table 1, £550 million with contingency, and then table 2, which is the site acquisition to the optimism, so the accounting and commercial opportunities and so forth. So do you want an explanation of both of those? So that would add £254 million to the £550 million. So, Joanne, if you could just perhaps provide a little bit more detail around those 2 tables?

[16:00]

Head of Finance Business Partnering, Our Hospital:

The £550 million includes the construction of the hospital, it includes furniture, fixtures and equipment for fitout of the hospital, and it includes site-specific costs and the costs of the preconstruction services agreement with the delivery partner. So that gives us the £550 million that we are working towards for the delivery of the employers' requirements as we have previously mentioned. Now, in terms of the Green Book, we are required to follow Green Book guidance, and that then does require us to include levels of optimism by us and client contingency within that, which we have done. I can go into a little bit more detail on that if you so wish. In addition to that, we have costs in relation to the site acquisition, which we have outlined. We have included costs in relation to the relocation of services currently delivered from Overdale. We have also looked at the demolition costs. What needs to be mentioned as part of this is that these are costs at a certain stage. We are more advanced at this stage than we would normally be. We have had obviously the benefit of specialist advisers and the delivery partner on board. So that has enabled us to have much more granular and robust information than we would normally have at this stage. But you have to recognise that all the costs are estimates at this point and they will change over the next 6 to 8 months during the development of the outline business case where we will get to R.I.B.A. stage 2, and will have much more granular detail at that time from the design of the scheme. In terms of how we have looked at validating some of those costs, we have our cost consultants on board. So they have validated those cost estimates that we have worked with the delivery partner on. Those costs have also been benchmarked against other similar schemes in the U.K. by our cost consultants who have been involved in the development of lots of different hospitals. So we have included an appropriate level of risk. Risk has been mentioned quite a lot. We also are expecting that, once we go through the outline business case and the full business case, that we will do a lot of market testing at that point. But we are using targets and value design, so we are working towards designing to a cost rather than the opposite way around. So, as I said, at this stage we think that we have more advance costs than we would normally have and we are fairly comfortable with where we are up to. Do you want to ask any questions on that?

Senator K.L. Moore:

That was very helpful, thank you. I am very mindful of the time so I think we do need to wrap up and I am grateful to everyone who has stayed here. Before we go, I would however ask the Deputy Chief Minister what was the conclusion of the P.O.G. when they were given that overall cost based on the Treasury Green Book?

Deputy Chief Minister:

The conclusion in relation to the fact that it exists?

Senator K.L. Moore:

No, the conclusion of the site and then the cost alongside it, mindful of course that the previous price that was considered too much by some people who are now on the Council of Ministers at £466 million, and now this project is heading to more than £800 million as a direct comparison?

Deputy Chief Minister:

The political oversight group has been, I think, driven by the clear requirement of the Island to have a new hospital and not to incur further costly delay. The procrastination, the indecision of previous Governments and States Assemblies, have put us in this position. So I believe at the forefront of all P.O.G. members' minds is that they want to get this hospital built for Islanders. We are very lucky to have an absolutely brilliant team. You have heard some touch on the depth of the level of expertise that we have governing us here. That has enabled us to put together, not only a process that I believe has been very, very good and will stand up to full scrutiny, but also provide the evidence we have needed to get to this stage. The P.O.G. I think have been driven by the need to build a new hospital and not incur further cost.

Senator K.L. Moore:

Sorry, when you say "not incur further cost", an additional £340 million is a considerable cost.

Deputy Chief Minister:

The increased cost is, as I said before and I will say it again, indecision of previous States. In fact we have, all of us, failed to deliver the hospital and we just have to face up to it and we have to be determined to deliver it now. Because a vote against this will set the project back for many years. First of all, we are not building similar hospitals. The cost of Gloucester Street was for a 55,000 square metre hospital, split site hospital, whereas the one we are proposing now is for a one-site solution. So we are not comparing apples with apples. These are completely different solutions we have come up with. So that is probably somewhere in the region of about a 25 per cent larger footprint. In addition to that, there is obviously inflation and lots of different market forces and economic circumstances, which have led to the increase in cost. If we do not get on and build it then those costs are probably only going to escalate further. But, having said that, outside the costs

above the design and delivery part, the cost of £550 million, are in line with the right procedure and Treasury, we built in optimism and contingency, and in my opinion we hope we are not going to need them. Of course those costs are built in because, just going back to this, the project could be severely disrupted by the onset of COVID. So we are ...

Senator K.L. Moore:

So you are saying that this Assembly, it is a pretty cheap shot to throw everything back at the previous Assemblies, this one also had the same role to play and they have considerably taken time. But this scrutiny process is an objective one of course and we are here to listen to what it is and to understand what the process is currently. I would like to impress that upon you that we are here to ask questions and you are obviously here to answer them and to answer them correctly. In saying that, I would like to ask you to consider withdrawing the personal comment you made about me and my conduct during this hearing today because I do feel that it was inappropriate. My role here is to ask questions and I do so on behalf of the public who we are all here to serve. We are here to ensure that we get the best possible hospital at the right price for the public of this Island who do require it and they deserve it. Making personal comments of that nature is really inappropriate and particularly for a senior Minister and I would ask you to consider withdrawing it.

Deputy Chief Minister:

First of all, I have taken no cheap shots at previous Assemblies, no cheap shots at all. I am clearly stating the fact that we have failed politically to deliver a hospital. That is the fact.

Senator K.L. Moore:

But you have consistently repeated today comments, negative comments, about previous Assemblies and of course it was not a perfect process otherwise we would not be building a hospital today. That is obviously the past. There is no point crying over spilled milk, as we say, but you also have to take into account the fact that a rejection of the Gloucester Street site was taken by this Assembly, therefore this Assembly and that decision is what has put us in the situation we are in today where we are still looking for agreement on the correct site and the correct project for the hospital for Jersey.

Deputy Chief Minister:

The comments I have made in relation to indecision have been in response to your comments about why are we facing increased costs and those are the facts. We are facing increased costs because we have failed to deliver the hospital, we have failed to bring it in the past. In relation to ...

Senator K.L. Moore:

I am sorry, I am sorry, but if I may, the £466 million solution that was turned down by this current Assembly would be underway had that decision not happened. Therefore we are now at a point where we are considering a hospital in a like-for-like comparison of £800 million. Therefore it is absolutely reasonable to ask the question about affordability and about the difference in costs because we are where we are. But we still know what we did about the previous sites and we are simply here as Scrutiny to ask those questions and to ask them in public so that the public have the opportunity to see how they are answered. Simply shooting the messenger is not really good sport, is it?

Deputy Chief Minister:

I am not shooting any messenger ...

Senator K.L. Moore:

I ask you again, and the point of my question, or the point of my statement at this stage, in this long sitting was to ask you to withdraw your comments.

Deputy Chief Minister:

I am going to come to that in a bit. I stand by my comment. The previous hospital failed to win planning permission; that was refused. With hindsight, it is a good job we did not build a 55,000 square metre hospital because it would not have been enough. I reiterate, the comments I have made about the States' indecision was in response to the increase in costs. Simply the time we have taken to complete this process has been very expensive and the longer we take the more it is going to cost the taxpayer. In relation to the comments on Scrutiny, now I have done everything in my power to ensure, it has not been perfect and I do admit we have failed at times to get information quickly enough to Scrutiny and we are going to keep addressing that. But right from the word go the instruction from myself and other board members is to work as closely as we possibly can with Scrutiny. It is important we have a clean bill of health from Scrutiny and I look forward to receiving guidance from Scrutiny and hopefully we can act on the advice you give us. But the number one priority is to deliver the hospital on time. In relation to the comment I made in relation to when I said: "It does not feel like it", I withdraw that. I am sorry; it was not meant to be a personal comment and I am sorry if it was inappropriate. But I do also feel frustration at times at the process because all of us, despite our different opinions at times, want to get this done for the people of Jersey. So I apologise and withdraw that comment, Chair. It was not meant to be personal.

Chief Executive:

Could I just make one comment? You said about like-for-like hospitals. It is not ...

Senator K.L. Moore:

I appreciate the size because we are moving on in terms of ...

Chief Executive:

Also the previous proposition did not have the mental health facility. I just wanted to put that on record.

Senator K.L. Moore:

Thank you. That will be revisited in the current Assembly and not the past one.

Chief Executive:

The previous site at Gloucester Street ...

Senator K.L. Moore:

That is the inclusion of mental health in the General Hospital.

Chief Executive:

No, sorry, I was trying to say that the previous hospital costs did not include the costs for building that facility, which would have been more expensive than that that is being proposed in this site.

Senator K.L. Moore:

Chief Executive, you might have the information available in terms of the mental health facility at Overdale. I do not recall what the cost in relation to that was.

Chief Executive:

The estimated costs are more than that that were proposed and we can show that and come back to you on that. But what I was trying to point out is that the current proposed cost estimate is not a like-for-like comparison with the previous cost estimate for Gloucester Street and that is just fact. The £456 million would not have been the final bill for the completion of the health service as we are proposing at Overdale with a single-site solution, it would have been considerably more.

Senator K.L. Moore:

But it still would have been a general hospital, yes. Anyway, we are now in the realm of semantics and I think very much I just wanted to say it is time and everybody has meetings to go to. So I will close the hearing and thank you for indulging us.

[16:15]