Health, Social Security and Housing Scrutiny Panel

Redesign of Health and Social Services Review

FRIDAY, 16th MAY 2014

Panel:

Deputy J.A. Hilton of St. Helier (Acting Chairman)

Deputy J.G. Reed of St. Ouen

Witnesses:

Hospital Architect

Director of Estates, Jersey Property Holdings:

[10:37]

Deputy J.A. Hilton of St. Helier (Acting Chairman):

Good morning, and welcome to the Health, Social Security and Housing Scrutiny Panel. We are meeting today to discuss the new hospital project. We will start by introducing ourselves. I am Deputy Jacqui Hilton, Acting Chair of the panel.

Deputy J.A. Hilton:

Thank you very much indeed. I just would like to give the apologies of the Deputy of St. Peter, our Chair, who is currently not well. Thank you very much indeed for agreeing to meet with us this morning. I would just like to start by asking you if you could generally describe the work that you do and the kind of places and the circumstances in which you have worked over the past couple of years.

Hospital Architect:

I have a longer career than that. I have spent pretty well the whole of my professional life involved in designing healthcare facilities in many different parts of the world. Over the last couple of years I have been not quite so active. I thought I had retired at one point, but apparently I had not.

Deputy J.A. Hilton:

All right. Can you just give us some indication; you said that your entire professional life has been involved in developing healthcare.

Hospital Architect:

Well, designing.

Deputy J.A. Hilton:

Designing?

Hospital Architect:

Designing healthcare facilities.

Deputy J.A. Hilton:

What was your last major project in the U.K. (United Kingdom) before you semi-retired?

Hospital Architect:

I am going to cheat a little bit. The last project was a cardiac and renal unit in Cork. I know it is not part of the U.K., but it was a very familiar environment and a very successful project.

Deputy J.A. Hilton:

Yes, okay.

The Deputy of St. Ouen:

When was that completed?

Hospital Architect:
2011, it was finished.

Deputy J.A. Hilton:
Have you always had your own company, or have you worked for health authorities, been employed by health authorities?

Hospital Architect:
I was a partner of an architectural practice, an international architectural practice in London, and I retired as group chairman of that practice.

Deputy J.A. Hilton:
We just wanted to go on and ask you how you became involved in the Jersey project.

Hospital Architect:
I had previously worked for your Treasurer when she was Director of Resources in Shrewsbury and we did some P.F.I. (private finance initiative) projects for her, and they went very well indeed. She knew I specialised in hospital work and she asked me initially if I had any advice as to places that you might like to go and visit to make comparisons. The first one was Cramlington, which I think you are familiar with, as a reference.

Deputy J.A. Hilton:
Yes.

Hospital Architect:
Then I was asked to give a view on the present state of your hospital development, because there was a feeling that it was unaffordable, and then that is where I stepped in.

Deputy J.A. Hilton:
It was a question, basically, of the Treasurer coming to you and asking for your professional view, giving you an outline, presumably, of the work that had taken place to date?

Hospital Architect:
She did not give me the outline, but she introduced me to Property Holdings and Health, and I had a couple of meetings and was able to take a view on the current state of the hospital project.

The Deputy of St. Ouen:

Can I ask, during your time spent designing healthcare facilities, at what point do you normally get involved in the process?

Hospital Architect:

As an architect?

The Deputy of St. Ouen:

No, as an adviser, or ...

Hospital Architect:

As early as possible. It does vary from one project to another. Sometimes projects have been going on for years, in one form or another and a lot of stop-start goes on in hospital development and design, so it can be at any point. I like to get in as early as possible.

The Deputy of St. Ouen:

Just to be clear, how would you describe yourself? I mean, everyone is using this word "hospital champion". You say you come from an architectural background, but can you just elaborate on your expertise, if you like?

Hospital Architect:

Yes. My role here was to examine the current state of the proposals, acknowledging that a huge amount of work had been carried out in analysis and research, and you had a really good dataset based on that, and client aspirations. Then, and this is fairly common, to seek new ways of satisfying the brief and affordability, which was key, within, I would like to say an imaginative framework, that would provide a setting for modern care into the future and relate much more closely to the Jersey community, because I saw that as a prime driver here. I thought I could improve your position on that and I think I have done.

The Deputy of St. Ouen:

Can I just ask, the advice that you are providing, is it primarily focused around the design of a building, the architectural aspects of a building, or is it around cost and the delivery of a building or buildings within a cost envelope? Can you just explain it to us?

Hospital Architect:

It is really all those things, which I like to think are all within my skills. If you say the architectural design, I am not talking here about the appearance of the building, the facades, the elevations; that actually comes later. However, there is a quality which I have been very conscious of and

tried to develop. There is a quality of the kind of spaces that are involved in the design. The present concept, as you certainly know, is a dual site, partly at Overdale and partly at the General Hospital. They are very different architectural problems. I am sorry, not problems. They are very difficult architectural opportunities.

Deputy J.A. Hilton:
Challenges? Opportunities.

Hospital Architect:
I think that the refined concept addresses those factors. I am not saying that I have completely ignored the architectural, if we are talking about character of facades and building design. I have not ignored it but I have not either had the brief to do so or the opportunity so far to influence those.

[10:45]

The Deputy of St. Ouen:
Generally architects, obviously, are primarily known for their experience in design layout and so on and so forth. They are not necessarily individuals who can actually determine cost and provide the detail necessary to understand the overall cost of delivering a particular project; they look to somebody else. How do you, as an individual, deal with those 2 matters?

Hospital Architect:
I do rely on professional advice from other people within the team, particularly in this case in Property Holdings, and the data that was provided originally by Atkins, which gave us, for example, the number of square metres required to provide the service, provide all the facilities. From the number of square metres it is not much more than a bit of arithmetic to multiply those square metres by a rate and then look at on-costs, such as the amount of new build compared with the amount of refurbishment, which is actually fundamental to the solution we have come up with.

Director of Estates, Jersey Property Holdings:
I think it is worth mentioning that Graham's involvement in July 2013, when you were first involved, is in the strategic outline case, so the level of architectural input that would go into that strategic outline case is, by necessity, at a fairly high level. It is looking at quantum; it is looking at adjacencies; it is looking at buildability. All of those things help to drive a budget and, vice versa, a financial limit or a financial envelope will restrain, perhaps, the design element to look at efficient build. So the 2 things work hand in hand but at a strategic outline case level. You are not into the

sort of level of design detail that you would take through when you get into an outline business case, a full business case, and then into a level of detailed design. Depending on your procurement route, that would either be undertaken by the architect or the contractor's architect. It is still fairly conceptual. I am conscious I am treading on Graham's professional toes, but it is still fairly conceptual but it is conceptual within some quite standard arrangements; the health building notes determine size of buildings and usage and activity levels. Putting the various activities together creates logical space usage and, if I may say, the "2 plus 2 is 5" that Graham brings is to look at how those can be fitted together within our particular scenario to improve the efficiency such that we can build a strategic outline case within the cost envelope.

The Deputy of St. Ouen:

You spoke about being part of a team. For the record, could you just tell us who the members of the team are and what are their particular roles and skills?

Hospital Architect:

The members of the team are the resources of Property Holdings. I have been working most closely with Will Gardiner, who is the project director, and I think he and I have a very good working relationship. I have been working with Ray and other colleagues, plus Helen O'Shea, Julie Garbutt from Health, a number of other people from Health at Overdale for example. That is the team.

The Deputy of St. Ouen:

Just one final point on that. Have you found it necessary to access any specialist advice outside of the resources that were provided by the States, within the States?

Hospital Architect:

Yes, the specialist advice available from the Department of Health, and that is to do with standards, to do with new thinking. One set of data that comes to mind is a recent publication by the U.K. Department of Health for repeatable rooms and looking at the design options, for example, for single rooms. There are a number of different ways in which they can be configured and there are advantages and disadvantages of each one. It is that kind of level of published information. I have not sought any personal expert information.

Deputy J.A. Hilton:

Can you just, for the record, tell us how your role differs from Atkins, and why Atkins could not have looked at ... I do not know what their job description was at the time. I am just interested to know how your role differs from theirs.

Director of Estates, Jersey Property Holdings:

I think it is probably unfair to ask Graham to comment on Atkins' role, because he was not part of the team that engaged Atkins.

Deputy J.A. Hilton:

All right, okay.

Director of Estates, Jersey Property Holdings:

Atkins did produce a strategic outline case, a business case. They did a lot of work on activity analysis and they did a lot of costing work based upon the information that was received through that process. The point that Atkins got to in terms of their work was still not delivering ... there was a further step that we needed to take to look at how we could take that work a step further and look at what alternative approaches ...

Deputy J.A. Hilton:

Was that because of the cost envelope, primarily?

Director of Estates, Jersey Property Holdings:

Partly. Cost was an issue, but we wanted some other innovative thinking as well, and that is what, I think, Graham brings to the party, as it were, is that innovative approach and looking at the work that has been done, because the basis of Graham's work has not redone the Atkins work, the solid work that Atkins has done is good.

Deputy J.A. Hilton:

It is in addition to it?

Director of Estates, Jersey Property Holdings:

It is actually layering something on top and taking that work and looking at it with a fresh pair of eyes.

The Deputy of St. Ouen:

Can I ask, Mr. Underwood, whether or not you have personally met with any of the Atkins individuals or had any discussions with the consultants that produced the original feasibility studies?

Hospital Architect:

Yes, I have. At Property Holdings there have been a few meetings where 2 of the Atkins directors attended as well, and they were able to clarify some of the data that had been put into the original

set of documents. They also carried out some drafting work, did they not, Ray, to produce some scale drawings of the existing accommodation?

The Deputy of St. Ouen:
Okay, thank you.

Deputy J.A. Hilton:
I think you mentioned previously that you first came to Jersey in July 2013 at the behest of the Treasurer who you previously did some work with a few years ago.

Hospital Architect:
Yes.

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

Hospital Architect:
Fairly quickly. When I looked at the site, the General Hospital site, and I looked at some of the proposals that had been put forward, it was clear that the latest proposal, which was to bring the cost down to, I think, £250 million, did do that but left a great deal of work to be done at some future time to put in the rest of the facilities. It became clear at that point that there was no more money to come in the future, and therefore anything that was proposed really had to be complete in its own right. The first thing I saw was the congestion on the General Hospital site, and the very great difficulty there would be in developing any new facilities on that site. An analysis of the site showed a number of things, for example the centre of the site is occupied almost entirely by laboratories and the pharmacy. Both of those facilities can and have been, on other projects, developed outside the confines of the main working hospital site. Then, after discussion, we began to look at Overdale, which appeared to be one of the sites that was available. I looked further, in discussion with Health, as to what other facilities might be able to be moved and the discussion then built into the idea of having an A.C.A.D. (ambulatory care and diagnostic centre) up at Overdale, and that built and built and built, until it became a really live option, which attracted a lot of support. That then gave us a space within the ... forgive me, this is not strictly in sequence.

Deputy J.A. Hilton:
No, that is fine.

Hospital Architect:

This was a process that was iterative. That gave us a space on the main hospital site which was strategically, in terms of hospital planning, very valuable, and where we could put some new facilities which would link extremely well to existing facilities. It included day surgery, critical care, endoscopy at the lower levels, and then at the upper levels a new development of single beds rising up through the middle, and all connecting to refurbished accommodation at each side. The value engineering work, which was vital because we were still struggling with costs, related to areas of refurbishment. Refurbishment is about between 60 per cent and 70 per cent of the cost of a new build, so the balance between refurbishment and new build was absolutely critical. We took into account the quality of the buildings on site and what it would be possible to do to bring them up to modern standards, again fighting this cost limit all the time. We have arrived at a solution to that which is within the cost, just, and provides a practical solution for modern healthcare on the ... by the way, the challenge was always at the General Hospital. The Overdale site is relatively straightforward and it has turned up with a solution that provides modern, safe healthcare.

Deputy J.A. Hilton:

Okay.

Hospital Architect:

As an example, it provides a pretty complete separation between clinical traffic and public traffic. Some people call it a “pyjama route” but the public come in and they never see ...

Deputy J.A. Hilton:

Patients ...

Hospital Architect:

... patients ...

Deputy J.A. Hilton:

... being trundled along and on foot, yes.

Hospital Architect:

... being trundled along, that is right, because that is not safe.

Deputy J.A. Hilton:

No, it is not nice for the patients either.

Hospital Architect:
No, it is not.

Deputy J.A. Hilton:
From a privacy point of view.

Hospital Architect:
Privacy, dignity and patient safety.

Deputy J.A. Hilton:
Yes.

Hospital Architect:
They have really been our priorities.

Deputy J.A. Hilton:
Yes, okay.

The Deputy of St. Ouen:
With regard to the General Hospital, were you made aware of the possibility of it increasing the current site by the possible purchasing of the adjacent building?

Hospital Architect:
Yes, I was.

The Deputy of St. Ouen:
Did you take that into account as you sort of tried to develop an alternative solution?

Hospital Architect:
We did. We did not dismiss it out of hand. We did look at it quite carefully. Basically, we could develop the hospital economically and practically without it. That was the first thing. The second thing is that ...

The Deputy of St. Ouen:
Given that you were going to use Overdale presumably.

Hospital Architect:

Oh, no, we would not have done for that because the site of Kensington Place would pretty well drive us into a long, thin building. That is quite difficult to develop into somewhere which deals with what I was just talking about; the separation of the 2 kinds of traffic.

Director of Estates, Jersey Property Holdings:

It would also move quite significantly the ratio of new build to refurbish to increase the amount of new build which then starts to become very difficult on the affordability envelope.

[11:00]

Deputy J.A. Hilton:

Okay.

Hospital Architect:

Yes, and the planners did not like it very much.

Deputy J.A. Hilton:

Okay, just coming back, because you mentioned fighting the cost limit, when you first arrived in Jersey, you must have been given the envelope of money that was available. Is that how it happened or did you just ...?

Hospital Architect:

Not quite. If I can just elaborate on that a little, I was conscious that the full development, fulfilling all of the client brief and all the accommodation, had been quoted at about £450 million. I had in fact seen figures which were larger than that and were approaching £500 million. It seemed pretty clear to me, even as a stranger, that that did not compute with a population of 100,000. There had been a previous target set and I do not know by whom but it was just generally quoted that £250 million might be affordable and Atkins did produce a scheme - and correct me if I am wrong, Ray - for £250 million but it did not provide all the accommodation that you required.

Deputy J.A. Hilton:

You mean the single-bedded units?

Hospital Architect:

Well, not just the single-bedded units. It did not provide new critical care.

Deputy J.A. Hilton:
Oh, right.

Hospital Architect:
It did not provide a new emergency centre. It did provide a number of beds. It did not address the holistic issues relating to the hospital within a target or a cost envelope of that size.

Deputy J.A. Hilton:
Have you worked on similar projects and with the similar problems that we are facing here in Jersey?

Hospital Architect:
Well, there are so many similar opportunities.

Deputy J.A. Hilton:
Yes.

Hospital Architect:
Pretty well every hospital that I worked on, the complete green field new build is pretty rare or it was pretty rare before P.F.I.

Deputy J.A. Hilton:
Yes.

Hospital Architect:
P.F.I. has done a few of those at P.F.I. cost and so nearly every scheme I have worked on has involved working within an operating hospital which is difficult and it is one of the other reasons, which I did not mention, why building wholly on the General Hospital site would be 10 years of hell with so much disruption and so many difficult and risky decisions taking place during that 10 years that it was the wrong thing to do.

Deputy J.A. Hilton:
Okay.

Hospital Architect:
It was clear to me. Other similarities on other projects is perhaps isolated communities. I did a number of hospitals in other countries but let us start with what I think is similar, which is Northern Ireland which has a very small population. It has got the same population as Leeds and they have

about 20 hospitals, all of which are pretty new and all of which are in very tight communities. It is not quite like an island but it does have similarities in the types of communities that you have which, as you can imagine, in Northern Ireland are very complex and relate locally to each other in very much the same way that yours does.

Deputy J.A. Hilton:
Yes, okay.

Hospital Architect:
Sorry, did that answer your question?

Deputy J.A. Hilton:
Yes. No, that is fine. That is fine, thank you. We wanted to ask you what has been or what is your current contractual arrangements with the States of Jersey?

Hospital Architect:
I think perhaps Ray can take that.

Director of Estates, Jersey Property Holdings:
Yes, we can give you details but Graham is on a professional services contract with the States of Jersey so ...

Deputy J.A. Hilton:
Okay.

The Deputy of St. Ouen:
For a specific period of time? I suppose that is the only question we have got.

Director of Estates, Jersey Property Holdings:
The details are within the contract he is engaged for to deliver services. They are set out in that contract.

Deputy J.A. Hilton:
All right, okay.

The Deputy of St. Ouen:
It will be open-ended?

Director of Estates, Jersey Property Holdings:
It is a contract that has a finite ...

Deputy J.A. Hilton:
Got one date.

The Deputy of St. Ouen:
Right, yes.

Director of Estates, Jersey Property Holdings:
Well, yes, if there were to be further contracts, they would be subject to review, if we get to that point.

Deputy J.A. Hilton:
What are the major issues emerging from the White Paper proposals, about which you have been asked for input? The whole idea of the *Health White Paper* was increasing services in the community and to try and reduce the number of hospital beds that were going to be required and also because people prefer to be at home recuperating anyway.

Hospital Architect:
I agree. I fully understand that but it is not within my brief.

Deputy J.A. Hilton:
All right, okay.

Hospital Architect:
That is Health who have to decide about bed numbers, locations and the division between different services and that type of thing.

Deputy J.A. Hilton:
Okay, so you have not been made aware of the *Health White Paper* that was agreed, P.82, and you have not been asked to comment on that in any way with regards to that?

Hospital Architect:
No.

Deputy J.A. Hilton:
Okay.

Director of Estates, Jersey Property Holdings:

I think the information and the ethos of the hospital White Paper and the process that the White Paper underpinned the work that Atkins did in terms of activity based upon us that the White Paper delivery assumptions had been fed into the thinking that Graham has provided to this project. So the sort of underlying information is there but Graham's role is not to challenge the White Paper.

Deputy J.A. Hilton:

No.

The Deputy of St. Ouen:

In your own opinion, have you reached a conclusion that an appropriate provision of additional services in a community is able to reduce pressures on hospital size and facilities provided?

Hospital Architect:

I can give you a layman's view of that because it is not within my brief to look at the balance between communities.

The Deputy of St. Ouen:

Yes, your personal opinion.

Hospital Architect:

Well, I can go by what I have heard in discussions with various people in Health and Property Holdings and there seems to be a pretty high level of confidence that that can be achieved but, you know, it is not something ...

The Deputy of St. Ouen:

That is fine.

Deputy J.A. Hilton:

No, okay, thank you. What was your impression of the degree of progress that had been made in deciding on viable options for the new hospital facilities?

Hospital Architect:

What, before I became involved?

The Deputy of St. Ouen:

Yes.

Deputy J.A. Hilton:
Yes.

Hospital Architect:
Well, there had been a number of options. I think, again, this is historical hearsay because I was not involved in those but I think there were 23 sites looked at but there were a large number of sites, yes.

Deputy J.A. Hilton:
There was, yes.

Hospital Architect:
The only other experience that I have is the proposals that Atkins did, mainly the latter proposals, to try and get it down to £250 million. That is my only experience of that.

Deputy J.A. Hilton:
Okay.

The Deputy of St. Ouen:
So, again, generally in other places, what sort of timescale and progress would you expect to see, you know, when developing, you know, a new hospital or delivering a new hospital?

Hospital Architect:
Delivering a new hospital? Well, if we look at this one, the programme says it finishes in 2023 and that is because of the phasing which is necessary because even with devolving on to the Overdale site, there are still a number of phases. Overdale happens to be the first phase and that, I believe, should come on in 2017 so the full A.C.A.D. should be available in 2017. But then with the other phases, as soon as you have done Overdale, you have to come back on to the General Hospital site and demolish the bit in the middle and start building that and then the final part of the process. I am condensing this because there are about 6 phases.

Deputy J.A. Hilton:
Yes.

Hospital Architect:
The final part of the process is to refurbish the existing buildings including the parade high rise and Gwyneth Huelin.

The Deputy of St. Ouen:

By refurbishing existing 1960s buildings, for instance, what anticipated distance of lifespan can we expect?

Hospital Architect:

Thank you for that question. If I can start with reference to the 1960s building, that is surplus to requirement and we do not consider it suitable for any clinical use.

The Deputy of St. Ouen:

Clinical, but it is still going to be refurbished?

Hospital Architect:

No, it is not.

The Deputy of St. Ouen:

No, it can be demolished? Are you demolishing it?

Director of Estates, Jersey Property Holdings:

At the end of the project, the 1960s building still stands. It could be demolished. It could be used for other non-clinical activities depending on the state and condition of the building and whether it is viable to do so. It could be used for other States needs that may be helpful to ally next to the General Hospital so that could be sort of office-based or community-based needs. At the moment, I think we do not know, is the answer, because the programme of phasing means that we will need that building for a fairly lengthy period during the phasing of works on the General Hospital site. But, at the end of that phasing, that building is surplus to requirements but it will be quite an elderly building by that time.

Hospital Architect:

It is quite a narrow building in plan which limits the kind of clinical accommodation that can be put in it, although I do believe that the hospital has done fantastic work over the years in keeping that going. The floor-to-floor heights are very low which means that the false ceilings everywhere are only about that deep and getting modern hospital services into that kind of void is difficult. The floors are precast concrete and they are all cracking and you cannot repair precast concrete, neither can you easily drill holes in it to get new services in. That is why, if you look at a 1960s building, you have got 2 stainless steel pipes going up the outside. Finally, there is asbestos in it. I think I have finished singing its praises but it is not a building that anyone on the hospital side has any ambitions to keep.

The Deputy of St. Ouen:
Why keep it?

Director of Estates, Jersey Property Holdings:
It is utilised through the development. At the end of the development, the building physically exists. The decision can be either to demolish it and replace it with something else or to utilise it for another purpose, if there is another purpose. The expectation will be that the building is of an age and of a condition that doing refurbishment works to that building for another purpose is unlikely to be cost-effective but it is basically a spare piece of real estate at the end of the project. The site that it sits on is more valuable in terms of what it could be used for going into the future because it could provide expansion space for the hospital going forwards at the end of this project looking forwards to the next 20 or 30 years. So it provides an area within the General Hospital curtilage that does not have a critical function on it at the end of the proposed schedule of build.

The Deputy of St. Ouen:
Could you just talk us through the outline? So we said that the 1960s building remains.

Hospital Architect:
Yes.

The Deputy of St. Ouen:
What other buildings?

Hospital Architect:
Remain?

The Deputy of St. Ouen:
Is it the 1980s block?

Hospital Architect:
The 1980s block? The high rise? As you know, the top 2 floors of that are converted into single beds right now for private patients but only on one side of the building. On the other side, there are some single beds but they are not fully en suite. The cladding of that building requires to be replaced and we proposed under our value engineering that that new cladding should be brought forward to the ... am I maybe going into too much detail?

The Deputy of St. Ouen:
No.

Hospital Architect:
Forward to the front of what look like balconies but they are not usable balconies and that gives us enough space to put in fully en suite rooms and to copy the single rooms from the top all the way down through the building. It is not a bad building and it is quite capable of taking it. Coming back to your previous question as to how long has a patient got to live, I think when we have finished the refurbishment, it will be a substantial time. It will have given that building new life. I could not put a number of years on it and I do not think I could put a number of years even on the new build.

The Deputy of St. Ouen:
Just basing on dates or decades, should I say, if it was a 1960s buildings, obviously it is concrete and so forth and it is now deteriorating and it is getting to the end of its life. A 1980s building generally is younger but is it too simplistic to believe that obviously another 20 years down the line, you could also have issues with the concrete problems and cracks and so on and so forth?

[11:15]

Hospital Architect:
It is a different type of construction.

The Deputy of St. Ouen:
All right.

Hospital Architect:
It is a concrete-framed construction and the floors are, shall I say, properly constructed with in situ reinforced concrete.

The Deputy of St. Ouen:
Okay, I see.

Hospital Architect:
Well, I am pretty confident that with the work that we are doing to that building, it could be brought to a standard which would be completely in-keeping with its intended purpose. The other buildings on the site, if I can just go on to those, Gwyneth Huelin is probably physically the best building on the site. Its position is very important in relation to the rest of the clinical accommodation, whereas of course the tower block is not because it is on the end and you can connect into it. Gwyneth Huelin is right in the middle and it is an important building. We would like to see a solution where Gwyneth Huelin was replaced by a new build but it is out of the question right now because of the affordability. That does not mean that it is a bad solution. The other side of Gwyneth Huelin

which, at the moment, is mainly outpatients, is going to be at Overdale and, basically, most of it is single storey sticking out on to Newgate Street. That means that we do not have any headroom problems. We are going to use that for an emergency centre. You are not allowed to call it A. and E. (accident and emergency) any more, by the way. It is an emergency centre which has a slightly different philosophy but provides for emergency services. It is a matter of terminology. I call it an A. and E. sometimes but I get told off.

The Deputy of St. Ouen:

No, that is great. Thank you. That has been very helpful.

Deputy J.A. Hilton:

Could I just ask you a question around contingencies, because it is my understanding that in the Atkins plan, there was quite a large amount put by for contingency?

Hospital Architect:

Yes.

Deputy J.A. Hilton:

I wanted to understand whether the contingency that had been set aside for the plans that are now being developed was proportionate to the size of the spend or what ...

Hospital Architect:

We have not touched the contingencies.

Deputy J.A. Hilton:

Do you know how much contingency has been allowed for within the £297 million?

Director of Estates, Jersey Property Holdings:

Yes, there are a number of issues about contingency. I have not brought the papers with me so I would rather not quote figures, but contingencies will include things like inflation allowance going forwards. There will be a contingency in terms of contract contingency. We are looking at something that is known as optimism bias.

Deputy J.A. Hilton:

Okay.

Director of Estates, Jersey Property Holdings:

So we would be looking at a sum of money - and this is the 10 per cent that Graham is talking about - in relation to you can assume you can do something and then when you get further down into the detail, you find it is a bit more complicated than you expected.

Deputy J.A. Hilton:

Okay.

Director of Estates, Jersey Property Holdings:

There is also funding and contingencies in relation to build cost differentials between the Channel Islands and the U.K. so there are a number of areas that you could put under the wide banner of contingencies. The documentation that you will probably have already had within the funding envelope, that is the £250 million plus the cost of bringing it up to the £297 million budget, will have contingencies set out. We can send you that again and highlight what we would consider to be contingency elements within that if that is helpful.

Deputy J.A. Hilton:

Okay.

The Deputy of St. Ouen:

I think, basically, we wanted to get from the hospital champion his expert view on what degree of financial contingency was necessary relating to delivering a project of this nature and, as an architect, obviously you are well aware that there is one issue around looking generally at a high level but when you come to design details on the table, the cost has gone up. It has escalated.

Hospital Architect:

Yes.

The Deputy of St. Ouen:

It was really just that was the question I think that we were looking to have answered.

Hospital Architect:

Costs of the proposals are going forward and they are called the “refined concept” and the costs of those were provided by Currie & Brown, being the cost advisers to Atkins during that process. Perhaps I did not make this clear. We have had discussions with Currie & Brown who have looked at what was proposed now and have produced the figures for that and the contingencies and optimism bias are contained within those figures. I have not got them with me at the moment.

The Deputy of St. Ouen:

Can you just confirm, Ray, Currie & Brown have now completed that work?

Director of Estates, Jersey Property Holdings:

Yes. Task completed, yes.

The Deputy of St. Ouen:

Thank you.

Deputy J.A. Hilton:

I just wanted to ask you this question. Would you ever recommend that the configuration of hospital services, including plans for the scale, physical location and cost limits, should be drawn up in advance of completing a review of the strategy for acute and other services inside and outside of hospital?

Hospital Architect:

If I have understood your question, Chair, I think if that was to be done a lot of that work is at risk of being aborted. For example, do we do anything to design Overdale before there has been a decision to put something there in the first place? Do we design a refurbishment of Gwyneth Huelin knowing that possibly we might be able to replace it by a new build? It is a process that I do not think I can give you a yes/no answer to that.

Deputy J.A. Hilton:

Okay, but we are well aware at the moment that there is an acute services review being carried out and we just wanted to try and understand, with these sorts of really important pieces of work not being completed, how one knows what they need to provide without that work being completed.

Hospital Architect:

I think that is in the next stage, is it not, Ray?

Director of Estates, Jersey Property Holdings:

It is. The work that Atkins has done has provided information on numbers and activity planning,. The acute services planning - and the detail of this question is really for the Health colleagues - will look at each service and it will challenge and it will refine some of the assumptions that are sitting really in the Atkins model upon which the concept designs to date have been undertaken. That work will be pulled together in the next phase with the technical adviser that will come on and work alongside, with their planning hat on, design hat on, looking at how those acute service plans work

within the space configuration. The expectation is that the direction has been set for those plans. Working through the refinement of those plans is likely to cause changes and challenges but they are probably on the margins. I do not think we are going to see major revolution in the way the White Paper proposals are going to be delivered. The service planning will assist that and it will be fed in iteratively as we go through the next phase of the feasibility work, so there will be refinement but it is unlikely to be revolutionary change and I think that helps.

The Deputy of St. Ouen:

We have been told that, following a decision made by the Ministerial Oversight Group that overall funding for the hospital project was unaffordable at £450 million and it should be delivered at £250-ish million, a prioritisation process was gone through. Have you been involved in that?

Hospital Architect:

No.

The Deputy of St. Ouen:

Have you seen the results of that work?

Hospital Architect:

I have been working on the basis of the Atkins schedule of accommodation and services and everything that was put in that is now contained within the refined concept.

The Deputy of St. Ouen:

Have you been involved in any discussions about on-Island and off-Island services?

Hospital Architect:

Only peripherally. It is not part of my brief to be involved in decisions on that. I know in some cases what has been discussed.

The Deputy of St. Ouen:

If you are designing a hospital, surely one of the things that you need to be very clear about is what services are going to be provided in that hospital.

Hospital Architect:

Yes.

The Deputy of St. Ouen:

Have you got that clarity at the moment or been provided with that clarity?

Hospital Architect:
In terms of on-Island, off-Island?

The Deputy of St. Ouen:
Yes.

Hospital Architect:
I know I have been instructed by my clients in Health what needs to be provided and the work that I have done reflects that, with one possible exception which is cancer, radiotherapy.

The Deputy of St. Ouen:
Have you had cause to question, or challenge should I say, the Health Department and individuals within the Health Department on some of the services that perhaps they are wishing to provide within the hospital against cost implications?

Hospital Architect:
No, it is not part of my ...

The Deputy of St. Ouen:
Or space implications?

Hospital Architect:
No, it is not my brief at all.

Deputy J.A. Hilton:
You mentioned radiotherapy. Currently Jersey does not deliver radiotherapy to its patients. Everybody travels off-Island for that. What has your work been? What have you been asked to do around that?

Hospital Architect:
I have reflected and respected the option to include radiotherapy within the proposal, and that is what I have done. It just means I have drawn some. I have drawn a place for it. I am not involved with the discussions. I am aware that it is not as simple as saying: "We will have some radiotherapy" because there are operational matters that are completely outside my brief, and competence by the way.

Deputy J.A. Hilton:

But as far as you are concerned, you have made space on the site, on the General Hospital site, that if the decision ...

Hospital Architect:

On Overdale.

Deputy J.A. Hilton:

Overdale, sorry. So if a decision is made to deliver radiotherapy, the space is there to do so.

Hospital Architect:

Yes.

Director of Estates, Jersey Property Holdings:

I think I need to come back to this is still a refined concept scheme. That concept will change. The fundamental sort of principles of the concept are there and they have been tested to demonstrate that we can get all we need in a logical, appropriate configuration for the funding that we have got available, but things will change as we go through the next few stages of feasibility study.

Deputy J.A. Hilton:

Have you any idea when the decision might be made on that?

Director of Estates, Jersey Property Holdings:

I could not say at the moment. I am not aware of that.

The Deputy of St. Ouen:

I believe at the beginning of our meeting you mentioned that you had advised various officials to go and look at Cramlington Hospital.

Hospital Architect:

Yes.

The Deputy of St. Ouen:

Can you just confirm whether that is a completed hospital yet?

Hospital Architect:

The build is nearly completed. It is not fully operational. But I personally have not seen it. I was asked to quote somewhere that would ... and it was just before my appointment so I did not go on the visit. I do know some of the thinking behind it and the examples that were taken from that visit were almost entirely to do with value for money and the importance of very strong clinical involvement in the process. It is not to do with the planning example, because it is not an A.C.A.D. It is an emergency hospital which can only exist with the support of half a dozen other hospitals in the region.

The Deputy of St. Ouen:

Was it a good model for delivering value for money? Why do you consider it to be a good model?

Hospital Architect:

Well, because of the cost per square metre of that hospital. It is probably the best value in the U.K.

Deputy J.A. Hilton:

How has that been achieved?

Hospital Architect:

Can I start by saying there was a little bit of luck? They went out to tender when the market was at rock bottom and they got very, very good tenders in, and they admit it themselves. They say that is one of the reasons why it is good value for money. I think they also had a very good contractor and it is a very unusual design and some of the operational decisions that they took, like no waiting rooms, were pretty brave but some of those decisions came back with a saving. So, yes, it was good value.

The Deputy of St. Ouen:

But, as many would say, the proof of the pudding is going to be in the eating.

Hospital Architect:

Indeed.

The Deputy of St. Ouen:

Looking at a building in development is certainly different than operating from a completed building.

Hospital Architect:
Yes.

The Deputy of St. Ouen:
Were there any other examples of completed new hospitals that you were aware of and you advised the local department to look at?

Hospital Architect:
The honest answer is no, I did not advise that, because I was not asked to.

[11:30]

We have recently, and it has been a continuous fact-finding process. When we were looking at the tenderers for the technical adviser role, we asked each one of them to quote a case study that they were proud of and we have been to look at each one of these as a team and learnt some very useful things. So we are taking some of those and bringing them into the project. I am not sure I have answered your question properly, have I?

The Deputy of St. Ouen:
No, that is fine. Going on from that, what lessons, if any, are there for Jersey to learn from that clinical model that you were speaking about that underpins the Cramlington Hospital?

Hospital Architect:
Cramlington is a very specialised example in that it is an emergency hospital. It does not really have outpatients; it does not have a load of other facilities. It is simply like a big A. and E. although there is some surgery there. So it is not strictly comparable. It is comparable in scale, building scale, with the Overdale development but there are not really any operational lessons to be learned from it.

The Deputy of St. Ouen:
Thank you.

Deputy J.A. Hilton:
Can I ask you a question about single-bed units? A feasibility study has been carried out or is being conducted at the present time. Do you know how the figure for the hospital beds has been arrived at?

Hospital Architect:
I am told by the data that it is based on a prediction of need in 2040.

Deputy J.A. Hilton:
Need in 2040?

Hospital Architect:
Yes.

The Deputy of St. Ouen:
With regards the services provided at the hospital and a service study that was undertaken by the Oak Group, as presented in June 2013, I have 2 questions. First of all, have you had an opportunity to look at the study?

Hospital Architect:
No.

The Deputy of St. Ouen:
So the second question is a waste of time because the second question was going to be has that study influenced any of your thinking or decisions, but that is fine. Okay, that is great. Can you tell us what evidence have you seen that would give you some assurance that the size of the hospital, and in particular the beds, single-bedded rooms or otherwise, that are going to be provided in the hospital will satisfy the needs of the Island, both in the short and longer term?

Hospital Architect:
I can honestly only go by the Atkins data that was provided by the hospital planners for their sub-contractors, looking quite closely at activity now and predicting activity, based on demographics, through to 2040.

The Deputy of St. Ouen:
So you have not been asked to reassess that with regard to reducing the cost?

Hospital Architect:
No.

The Deputy of St. Ouen:
Can we say with absolute confidence that what was presented by Atkins with regards the provision for hospital beds will be identical to that that will be provided in the dual site option?

Hospital Architect:

If I understand this correctly, and forgive me, the Atkins predictions for activity and bed numbers in 2040 is included in the refined concept and I have no reason to question their workings, but I am not really competent to question their workings anyway. I have taken that as a given, part of the brief.

The Deputy of St. Ouen:

Just to be absolutely clear, even though we have moved from a £400 million, £450 million cost, identified by Atkins, to deliver the complete hospital that will meet the needs of the Island, even though that cost has been reduced potentially to £300 million now ...

Hospital Architect:

£297 million.

The Deputy of St. Ouen:

£297 million ... the number of beds and the accommodation that was identified by Atkins will be identical in the new proposal?

Hospital Architect:

We have not taken anything out. I will qualify that slightly. Because we had to value engineer the whole proposal to meet the affordability target, we have taken a view which is very common in the U.K. among competitive schemes of reducing areas below the areas provided by the N.H.S. (National Health Service) building notes. That has been ... I will not say underwritten but that has been commented on by a number of other developers, including the ones that we have been to see over the last couple of weeks, and they are entirely comfortable with that. It is a 15 per cent reduction in area overall, which was important for the costs, but we are not reducing the area of critical rooms.

The Deputy of St. Ouen:

Which developers have you been to see in the last couple of weeks?

Hospital Architect:

I will quote the hospitals. I cannot really quote the ...

Director of Estates, Jersey Property Holdings:

We can give you that information separately in detail.

Hospital Architect:
If you do not mind. There are 5 buildings right now.

The Deputy of St. Ouen:
All right. Five separate sites?

Hospital Architect:
Yes.

Deputy J.A. Hilton:
Is it accepted practice to reduce the size of rooms by as much as 15 per cent currently?

Hospital Architect:
It is. Every single P.F.I. project in the U.K. would have had that factor applied because they need to be competitive, just as you do. It is also being compared with U.S. (United States) and French standards and it is compatible with that. I am afraid the U.K. building note areas are a bit bloated and that is pretty well generally recognised.

Director of Estates, Jersey Property Holdings:
There is also an issue of building efficiency. We look to try, given the sites we have got, to make the buildings efficient so you are not building a lot of ancillary space relative to critical care space. So the savings would be sought disproportionately on the ancillary space.

The Deputy of St. Ouen:
What account have you been asked to take, if any, with regard to the operational ongoing costs of maintaining 2 sites?

Hospital Architect:
That is not within my brief but colleagues at Health and Property Holdings are examining that very closely.

The Deputy of St. Ouen:
That is fine. You would not have been able to identify any risks to effectiveness of the services that may or may not be able to be provided in relation to dual sites?

Hospital Architect:
There are opportunities and there are risks. I did make a few notes here. The General Hospital will be less busy and the patients will have a freer and less stressful environment, and that is quite

important. Buildability is improved at the General Hospital because you have not got this 10 years of hell which I referred to before. Risk is reduced by the opportunity to separate patient flows. That does not apply in Overdale so much because it is an outpatient service and therefore you do not have the same privacy and dignity issues that you do at the General Hospital. The risk to patients is reduced by having a clear site. There is a risk of revenue costs rising with single rooms. However, the information we have gathered recently, particularly on visits to hospitals which do have 100 per cent single rooms, is pretty clear that although there is an often quoted view that nursing costs are higher because you need more nurses, every single one that we have been to see has said: "It depends what you are comparing it with because we were always understaffed. We could never get enough nurses. Now we have got enough nurses and it is more than we had before but it is not a real increase because we should have had all these before." Part of that is, I think, doubtable but nevertheless I can see the case for it. There is an overwhelming case for patient safety.

The Deputy of St. Ouen:

Just coming to the overall costs, the £297 million, if we are going to undertake a development, a significant and sizeable development over a 10-year period, although we might talk of a today figure of £297 million, what do you believe the overall cost will be of the project given that it is going to be delivered over the 10-year period?

Hospital Architect:

Those factors have been taken into account by the Currie & Brown figures. They have looked at inflation over the 10 years.

Director of Estates, Jersey Property Holdings:

The cost information has factored in the inflation or the value of money over time such that the £297 million is the outturn cost budget.

The Deputy of St. Ouen:

Are you saying to us today that by the time that the redevelopment of the hospital is completed on the 2 sites the total cost is going to be £297 million?

Director of Estates, Jersey Property Holdings:

I am telling you that the Treasurer has told me I have £297 million.

The Deputy of St. Ouen:

Today?

Director of Estates, Jersey Property Holdings:
In total the outturn budget is £297 million.

The Deputy of St. Ouen:
I think we will be challenging and we will want to be looking very closely at some of the figures and the assumptions that you are making because I find it very difficult to believe that you can commit to an overall figure for delivery of a project that is going to take 10 years to complete. Maybe Mr. Underwood can assure me that you can do that.

Hospital Architect:
It has been done before.

The Deputy of St. Ouen:
Can you give us examples?

Hospital Architect:
One example that we did go to see, which has similarities in that it is at least as complex as the General Hospital, is Great Ormond Street where they have carried out 20 years of redevelopment on a site that is more difficult than this one and is also full of children. The vast majority, I will not say every project but the vast majority, have been on time and on budget because they have been managed very well and the clinical involvement has been very clear and strong.

The Deputy of St. Ouen:
Were Great Ormond Street, for instance, able at year one to say: "And the overall cost is going to be ..."?

Hospital Architect:
They were able to say at the beginning of the project. I do not know when year one is. Is year one when they dream that they are going to have a paediatric ...

The Deputy of St. Ouen:
As soon as they started.

Hospital Architect:
Yes. They said that it would cost this and they have a very, very good record of delivering to those costs because they had a very firm, very strong clinical vision and a strong team, just as you have, who were able to carry it through. There is a design concept and then there is a clinical concept

and the job is to get those together. Part of my job is to make sure that the ball does not get dropped.

The Deputy of St. Ouen:
One further question around that. You spoke about Cramlington and value for money, and obviously you highlighted the fact that there was a bit of luck involved because they hit it just right; the economy was depressed and so forth, builders, construction firms were looking for business and so forth. We, on the other hand, are going to be smack in the middle of a growth period for construction on the Island.

[11:45]

What views have you got with regard to the costs of the project and so on and the difficulties, bearing in mind the sort of scenario that we are going to be entering into, that you will be able to maintain and keep within a fixed budget that is being set 5 years, 10 years before the project will be complete?

Hospital Architect:
I cannot give you that guarantee. I do not think anybody can. We could have another recession.

The Deputy of St. Ouen:
How do you provide for it?

Hospital Architect:
The professional calculations done originally by Currie & Brown, and from this point on by another cost adviser, will take that into account to the best of their ability.

The Deputy of St. Ouen:
It is the level of contingency that provides that future proofing? Is that what we are saying?

Hospital Architect:
The budgets look forwards to delivery of this project in slices, although the contract forward mechanism we still need to discuss with our advisers, but recognise the fact that it is being delivered over a long period of time and calculate the cash flow, in effect, with relation to estimates on future inflation.

The Deputy of St. Ouen:

Just one last thing on your experience and your involvement in hospitals and development of healthcare facilities, have any of those facilities been in or on an island?

Hospital Architect:

Been on an island? Going back a few years, the Seychelles, the Bahamas, but I would not regard those as comparable at all. No, is the answer.

The Deputy of St. Ouen:

Are you aware of any similar hospital or facilities that have been provided on other islands within the U.K. that maybe we should be looking at as a comparison rather than necessarily the U.K. mainland?

Hospital Architect:

I think there is an apples and oranges issue because any archipelago like the Bahamas, like the Caribbean, has a number of hospitals on it. I know some of them, but they do not even compare well with each other because the societies are different, the communities are different, there are different conditions, different costs. I am afraid I cannot satisfactorily answer your question.

The Deputy of St. Ouen:

It would have been useful if there was a model out there that we could go and look at. Thank you.

Deputy J.A. Hilton:

I would just like to adjourn for a couple of minutes. We will just step outside.

(break in audio)

Deputy J.A. Hilton:

I wanted to go over the 2 hotel sites again on Kensington Place. We did speak briefly about that right at the very beginning. Can you just tell us again what you have been told in that regard with the hotel sites, whether they were available or not available? What was your view on that?

Hospital Architect:

Is this for me, what I have been told?

Deputy J.A. Hilton:

Yes.

Hospital Architect:

I have been told that they might be available and I do not think it has gone very much further than that. I think I was asked whether it would be an advantage to have them and I think what I said, which is what I think, is that they are not needed for this development but in terms of a strategic purchase for the hospital that is something for the States to consider, because when they are gone they are gone.

Deputy J.A. Hilton:

Strategically, in your opinion, do you think that would be a good idea for the States to purchase those sites?

Hospital Architect:

Taking the money aside for a moment, because certainly the current scheme cannot afford new build on that site, I think, as with any landlocked hospital which is very tight for space, if you have the opportunity and you have the money then it is probably a good thing to do. Taking into account maybe the 1960s block that at the end of this scheme at the particular site will become free, it is possible to consider that.

The Deputy of St. Ouen:

With regard to the flexibility and future provision of meeting future need, can you confirm what opportunities will exist once the Overdale site is developed on that whole area?

Hospital Architect:

On the Overdale area?

The Deputy of St. Ouen:

Yes.

Hospital Architect:

The Overdale site will not be overdeveloped to begin with. There will be space to add accommodation to that. It would be better if it was added before it was built rather than after and there is an opportunity to do that.

Deputy J.A. Hilton:

Can I just stop you there? You said it would be better to add it before it was built. What, the additional accommodation?

Hospital Architect:
Yes.

Deputy J.A. Hilton:
For services being placed there?

Hospital Architect:
Yes, but we cannot afford it.

Deputy J.A. Hilton:
No. Money is always a big issue.

Hospital Architect:
Overdale is all new build so every square metre you build at Overdale is at a higher cost than refurbishment on the General Hospital.

Director of Estates, Jersey Property Holdings:
On completion of the planned work at Overdale, there is space with Overdale for some further expansion if necessary in the unbuilt areas and also in some of the older buildings, the Poplars, William Knott, which are halfway through their life cycle. At some stage, talking 20 years' time, the expectation is that you would look at those buildings as part of your rebuild and there might be the ability to intensify more the use of that area of the site if you needed to.

The Deputy of St. Ouen:
One final question that I have is how are you aiming to address the concerns raised by the clinical directors around which services are sited on which site and so on and so forth?

Hospital Architect:
The person who is leading this is Bernard Place who is Clinical Director for Planning. He is currently engaging closely with the clinicians and I expect to be involved with that at certain stages, but he is talking much more about the services provided than I do. I am a simple architect. It is very interesting listening to what he has been discussing with them.

Deputy J.A. Hilton:
I have got one final question and it is around pathology. There has been concern expressed to us about having the main pathology up at the Overdale site. In your experience, in the projects that you have been involved in during the last X number of years, is that a normal thing to happen where you have a dual site option that pathology is placed away from acute services?

Hospital Architect:

It is not uncommon. It is not common but it is not uncommon. I was talking to Bernard this morning and he is reaching some greater level of understanding with the clinicians than he had been before. That is all I know about it.

Deputy J.A. Hilton:

All right. That is lovely. I shall at this point thank you very much for giving up some time for us this morning and close the meeting.

[11:57]