Government of JERSEY

# Our Hospital

R.124-2021
(re-issue)

# Our Hospital Project

## Outline Business Case

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# 1. INTRODUCTION

## 1.1 The Our Hospital Project

On 13 May 2019, the Chief Minister announced proposals to establish an entirely new project 'Our Hospital' to deliver a new hospital by 2026.

The purpose of this Outline Business Case ("OBC") is to set out the case for a new hospital to be built to replace the existing Jersey General Hospital and builds on the Strategic Outline Case ("SOC") which was approved in November 2020. The subsequent chapters set out this case in considerable detail but before going into the detail of the Outline Business Case, it is first important to provide a recap of how this stage has been reached and the project approvals which have already been obtained.

## 1.2 The Our Hospital SOC (November 2020)

The SOC was developed during 2020 and was approved by the Our Hospital Project (OHP) Governance in November 2020. The SOC primarily set out the Case for Change and performed a long-listing exercise which resulted in the short-listing of the New Build Option and a baseline comparator Do Minimum option (also referred toas the Baseline Comparator Option) for further development at OBC Stage.

The SOC was more advanced than a traditional SOC would be in a UK for a number of reasons which are set out below:

- **Commercial Case** - The procurement strategy had concluded that an early appointment of a Design & Delivery Partner ("DDP") would deliver the best outcome for the Project. The process to tender and appoint a Design & Delivery Partner (ROK/FCC JV) had successfully concluded before the completion of the SOC and therefore the Commercial Case was largely complete at the SOC stage with fairly limited updates needed in the OBC.
- **Management Case** – the early appointment of the DDP also resulted in the management processes and governance being more advanced than would typically be seen at the SOC stage.
- **Economic Case** – the early appointment of the DDP led to more detailed cost information being available than would usually be available at SOC Stage. However, all cost information is being refreshed in this OBC to reflect the significant development of the design to RIBA Stage 2.

## 1.3 Pre-OBC Approvals

The following OH Project approvals had already been made before work commenced on this OBC in January 2021:

- Chief Minister formally established the Our Hospital Project – May 2019
- Appointment of ROK/FCC JV as the Design and Delivery Partner with a specific contract to deliver the Pre-Construction Services Agreement ("PCSA") works – July 2020 (OHP Governance approval)
- Selection of Overdale as the site to deliver the new hospital – November 2020 (States Assembly approval). Following the decision on site evaluation in November work has progressed on the preferred option as identified and agreed at SOC stage including land assembly / site acquisitions and design

## 1.4 The Our Hospital OBC

This OBC has been developed following the principles set out in the UK HM Treasury Green Book 5 Case Business Case Model. The Green Book is internationally recognised as being a gold standard process for developing a business case and is therefore being followed by the Government of Jersey for major

Projects and in the development of this project. The OBC is the second stage of the Green Book process with its primary purpose typically being to assess the shortlisted options in more detail and select a preferred option whilst gaining clarity around the affordability of the scheme and its proposed procurement.

This OBC sets out each of the Green Book 5 cases and builds on the work undertaken at SOC Stage:

- **Strategic Case** - sets out the overall context for the project and makes the Case for Change alongside setting out the Project Objectives and the Critical Success Factors. The Strategic Case was largely complete at SOC stage and therefore the case has only been updated to reflect these changes.
- **Economic Case** – sets out the long-listing process and assesses the shortlisted options considering cost, benefit and risk. This OBC describes the work that took place at SOC stage to consider the long-list of options and to produce the shortlist, before developing the analysis of the shortlisted options. More detailed cost, benefits and risk analysis is also presented
- **Financial Case** – considers the funding options available to deliver the project and sets out the indicative financial position of the shortlisted options
- **Commercial Case** – sets out the options for delivering the proposed options and how those will be procured. This OBC builds on the detailed procurement process that was undertaken at the SOC Stage and presents more detail on the proposed design and commercial solution
- **Management Case** – details the management structure and processes put in place for the project and sets out the required project management costs

In addition to this, the OBC has also been informed by the principles of the PRINCE2 Business Case Development process which has significant cross over with the Green Book process particularly in the areas of options appraisal, benefits and investment appraisal techniques.

## 1.5 The Scope of the Our Hospital Project OBC

The purpose of this Our Hospital OBC is to present the case for a new hospital to be constructed in Jersey. There are a number of other strategies being developed which are linked to the Our Hospital Project, but these sit out-with the scope of this Our Hospital OBC. These include:

- **The Jersey Care Model ("JCM")** – the JCM was developed in 2019 / 2020 and the outputs of the JCM, alongside General Hospital design requirements, were used to help inform the Functional Brief and in turn the site evaluation process. The Functional Brief has been designed with the aim of providing sufficient flexibility in order to be fit for any likely model of care designed to meet the needs of the Jersey population in the future, including the currently proposed JCM. The delivery of the Our Hospital Project is based on the assumptions set in the Functional Brief, with the JCM siting outside the scope of this OBC.
- **Digital** – the Capital costing for the new hospital as set out with this Our Hospital OBC assumes that the backbone infrastructure for the GoJ of Jersey digital solution needs to be provided as part of the design. HCS has developed a wider digital strategy, to deliver the new equipment and software which will be used in the new hospital. The delivery of the Our Hospital project is based on the digital requirements set out in the Functional Brief, which is in turn informed by this Digital Strategy, however the Digital Strategy is outside the scope of this OBC.
- **Facilities Management** – a separate Facilities Management Business Case is being prepared and will be presented for approval separately. This will consider the future operating model for Facilities Management. This Our Hospital OBC has therefore not included any costs or benefits associated with future Facilities Management Services.

## 1.6 Green Book (2020)

During the course of the production of this OBC the UK Government have published The Green Book (2020), the latest update to the Green Book Guidance. A review of the updated guidance has informed the development of this OBC.

## 1.7 OBC independent review

Global Construction advisor, Mott McDonald has been appointed to undertake an independent review on the OBC as the drafts progress. The outputs from this review have been incorporated into this OBC. Mott McDonald are currently working with the UK Department of Health to review business cases being developed in the UK for the UK Government Hospital Building programme and are therefore uniquely placed to carry out this review.

## 1.8 Purpose of the OBC

The Purpose of this OBC is:

- To meet the Jersey Public Finance Manual ("PFM") requirement for a major project to develop an OBC prior to implementation; and
- To help inform a detailed Proposition which is being developed which will be presented to the States Assembly for debate in September 2021 and will include a request for approval to fund the Our Hospital Capital Costs set out within this OBC

## 1.9 Full Business Case

Following successful approval of this OBC, the next stage of the Business Case process is a Full Business Case (FBC) which is typically completed on the point of execution of the main construction contract. It is anticipated that the Our Hospital Project will reach FBC Stage in 2022 and it is understood that oversight of the FBC would be through the OHP Governance Structure (i.e. the Senior Officer Steering Group and the Our Hospital Project POG).

# 2. EXECUTIVE SUMMARY

This section has been provided to give a summary of the information that is set out in the subsequent chapters, providing an overview of each of the 5 cases.

## 2.1 The Strategic Case

### 2.1.1 Introduction

The Our Hospital SOC sets out, in considerable detail, the overview of the Island's healthcare system and the case for change. Whilst this detail is still presented in the main body of this OBC, it has been summarised as follows at a high level for the Executive Summary as there have been very limited changes since the SOC Stage:

- Overview of the Island's Healthcare System
- Healthcare Delivery
- Heath and Community Services
- The current health estate
- The case for change
- The current condition of the hospital building and the HCS estate
- High risk of failure of some elements of the hospital detailed in the Six Facet Survey unless there is significant intervention
- Reconfiguration of the current building would incur significant costs to address the infrastructure issues and high ongoing lifecycle expenditure
- A significant refurbishment would not facilitate changes to space, clinical flow and adjacency issues
- Issues caused by the lack of co-location of key functions, including Mental Health Services

The case for change has concluded that in around five years the existing hospital risks becoming life expired and without significant investment the physical structure of the building could start to pose a risk to patient and staff safety if no action is taken. The running costs will quickly become unaffordable due to the amount of investment required to bring the hospital up to the statutory and regulatory standards required.

### 2.1.2 Work re-confirmed at the OBC Stage

#### 2.1.2.1 Our Hospital Project investment objectives

The Project investment objectives for any potential investment were developed using a workshop approach to ensure that the outcomes required by key stakeholders have been considered and included.

During the development of the OBC, a workshop was held with the Our Hospital Project team on Monday 8th February 2021 to review the Our Hospital Project Investment Objectives.

The key objectives of the Our Hospital Project were agreed to be:

1. To provide high quality, efficient and effective care for all patients and service users that is timely, accessible and delivers the best possible experience for patients, service users, visitors and staff
2. To deliver integration of physical and mental health care and services including co-location of an Acute and General Hospital and Mental Health Services
3. To deliver an Acute and General Hospital with co-located mental health and other services currently delivered offsite that is safe, compliant, flexible, delivers an optimised planned

preventative maintenance regime and is right sized for the future delivery of clinical and other services, and enables service transformation
4. To deliver a new hospital that ensures the financial sustainability of the health economy
5. To deliver a new hospital that contributes to building a thriving community and well-being of staff and patients with positive socio-economic and environmental impacts

The updated objectives were reviewed and confirmed at the Clinical & Operational Client Group (COCG) meeting held on Thursday 4th March 2021.

### 2.1.2.2 Benefits

During the OBC workshop the long-list of benefits at the SOC was reviewed. The following revised set of benefits was produced which takes into account the development of the Project over the past 12 months and including the impact of the Covid-19 pandemic.

**Figure 1: OBC Benefits**

| Stakeholder | Benefits |
|---|---|
| Patients | 1. Safe, reliable and quality assured care with improved and predictable outcomes for patients and parity for mental health<br>2. Improved patient satisfaction and experience<br>3. Facilities which address the healthcare needs of all patients<br>4. Continued provision of immediate and urgent care 24/7/365<br>5. Optimising the privacy and dignity of patients<br>6. Hospital environment and internal architecture which supports the health and wellbeing of patients and their families<br>7. Improved outcomes for all, particularly for children through Putting Children First<br>8. Delivering greater accessibility for all including car parking<br>9. Improved patient safety and security<br>10. A design which is flexible and future proof by offering resilience and continuity<br>11. Better signposting, easier wayfinding leading to a more efficient patient experience – i.e. the patient needs be met in one place |
| Staff | 12. Increased job satisfaction due to improved facilities and physical surroundings, leading to a more attractive place to work<br>13. Support the development of staff skills including education, training and development<br>14. New facilities will deliver greater standardisation (including room layout and equipment)<br>15. The environment will enable greater multi-disciplinary team working<br>16. Single site working benefits for staff who work across HCS and the third/private sector<br>17. Hospital facilities which attract highly skilled staff and increased existing staff retention<br>18. Improved staff wellbeing |

| Stakeholder | Benefits |
|---|---|
| Health and Community Services | 19. Greater flexibility to changes in demand and evolving standards in clinical practice<br>20. Increased integration enabling greater efficiency across services<br>21. Healthcare facilities which are to the standard islanders expect/compliant building standards<br>22. Promote integration of health services<br>23. Deliver greater choice for patients<br>24. Design to optimise and facilitate planned and preventative maintenance<br>25. More efficient maintenance provision due to co-location and modern facilities<br>26. Contributing to sustainable well-being to help achieve the community vision set out in Future Jersey<br>27. A facility that is owned and trusted by the people of Jersey and acts as an integral point for the local community, promoting a sense of pride for islanders<br>28. First class healthcare facilities |
| Wider Community | 29. Provisioning for community diversity<br>30. Hospital facilities and public realm which could be used by the wider community. The hospital can be seen as a catalyst for wider community engagement/ improvements<br>31. Job creation opportunities for local residents<br>32. Development of apprenticeships and increased training opportunities<br>33. Creation of low carbon generating facilities<br>34. Increased private patient provision to deliver a surplus which can be reinvested into HCS services<br>35. The opportunity to re-provision, re-develop or realise a capital receipt at a number of buildings which could become vacant following the completion of the new hospital |

The updated benefits were reviewed and confirmed at the Clinical and Operational Client Group (COCG) meeting held on Thursday 4th March 2021.

### 2.1.3 Constraints

The constraints of the project are:

- Physical safety of the hospital's patients and staff must be maintained throughout the life of the project by ensuring sustainable provision of healthcare services
- Meeting the Planning requirements
- Achieve completion of Clinical Commission by the end of 2026
- Leading to a fast-tracked compressed timetable
- Affordability of the project
- Lack of construction supply chain choice due to industry demands
- Political uncertainty.

### 2.1.4 Dependencies

The dependencies of the project are:

- An adequate financing option is available and affordable
- Ensuring there are sufficient public transport options to the site for patients and staff
- Planning consent for the construction of the hospital is vital to the project
- The business case is approved by the Government of Jersey and any other relevant bodies
- Acquisition of the land required to deliver the project, through use of CPO Powers if required

## 2.2 The Economic Case

### 2.2.1 Purpose of the Economic Case

This Economic Case sets out the longlist of potential options for intervention and summarises the shortlisting exercise which was undertaken at the SOC stage using the project's Critical Success Factors. The site evaluation appraisal process was taking place in parallel with the development of the SOC, and therefore the new build option set out in the Longlist below was site agnostic at the SOC Stage.

In the OBC, the two shortlisted options from the SOC stage are assessed in more detail considering costs (both capital and revenue), benefits and risk. The case concludes with the recommendation to proceed with the preferred option.

### 2.2.2 Work undertaken at the SOC stage and updates to the Case in this OBC

**SOC Stage**

During the development of the SOC, the following process was undertaken:

- A longlist of options was developed and assessed using Critical Success Factors. This identified that a New Build option was the only option that met the project's strategic objectives and was shortlisted along with a Do Minimum comparator (as required by the Green Book). This shortlisting was approved through the HCS Executive and subsequent SOC approval process through the project governance.
- The New Build option was site agnostic at the time of shortlisting, as the process was being run in parallel to the site evaluation process.
- The site evaluation process assessed a broad range of locations, with a final recommendation of a new build at the Overdale site. The selection of Overdale was recommended by the Political Oversight Group (POG) to the Council of Ministers (COM), who endorsed that decision and took the proposition to the States Assembly for Approval. Approval was given by the States Assembly in November 2020.
- High level analysis on cost, benefits and risk was undertaken on Overdale versus the Do Minimum Comparator and the new build at Overdale was selected as the preferred way forward.

**OBC Stage**

The OBC builds on the analysis undertaken at SOC stage, and in particular provides new analysis on costs, benefits and risks with a new Economic Appraisal (including NPC analysis), the key updates for which are:

- Development of the Do Minimum comparator: further work was undertaken to define and cost the Do Minimum comparator which highlighted that to continue the existing health services in Jersey, significant construction work around the HCS estate would be required, leading to increased costs. This option is referred to as the Baseline Comparator Option. A specific costed risk register for this has also been prepared by the GoJ Cost Consultant.
- Development of the New Build option (preferred way forward): A RIBA2 design has been developed with the Design & Development Partner, and RIBA3 design is now commencing, picking up feedback received on RIBA2. This has been costed by the Design & Delivery Partner and benchmarked by the GoJ Cost Consultant to assess risk and opportunities. As with the Baseline Comparator, a risk register has also been prepared and costed.
- Benefits: Additional work to identify and refine benefits has been undertaken, and particularly to start the process to quantify benefits where possible. Workshops were undertaken to qualitatively score benefits and approved through a number of sessions with the HCS Executive, the Our Hospital Citizens' Panel and the Our Hospital Health Worker's Panel.

This Executive Summary only deals with the key updates to the Economic Case which have taken place in the OBC phase and focuses on Costs, Benefits, Risks and Net Present Cost (NPC) analysis. Sections of the Economic Case which were completed at the SOC stage have not been re-presented in the Executive Summary.

### 2.2.3 Critical Success Factor and Shortlisted Options

During the development of the OBC, a workshop was held with the Our Hospital Project team on Monday 8th February 2021 in order to review the Our Hospital Project Critical Success Factors and consider if any changes to the long-list and shortlisting process were required.

It was agreed at this meeting to remove Critical Success Factor 6 (affordability) as a Project CSF with affordability now being assessed as part of the cost analysis set out later in this Economic case.

The agreed shortlisted options from the SOC were re-confirmed and taken forward for more detailed assessment in this OBC and from this point onwards in the Economic and Financial Case the options shall be referred to as the:

- **New Build Option** (which had been shown at SOC stage to achieve the CSF). The New Build Option aims to provides a new general hospital for Jersey by Dec 2026 that meets both the requirements of the Functional Brief and Employer's Requirements.
- **Baseline Comparator Option** (which did not achieve the CSF but was selected as a comparator to comply with Green Book guidance).

This Baseline Comparator Option (which was originally named the "Do Minimum" Option in the SOC in line with Green Book terminology) seeks to provide a refurbishment of certain elements of the existing HCS estate and recognises that the condition challenges set out in the Case for Change represent significant challenges

The capital costs associated with each option is set out in more detail below.

### 2.2.4 Site Evaluation

The SOC has already detailed the Site Evaluation Process that led to the States decision to confirm Overdale as the preferred site to deliver the Our Hospital Project.

### 2.2.5 Functional Brief

The Our Hospital Functional Brief (version 6.1) was completed by MJ Medical in November 2020 and adopted as the core of the projects Employer's Requirements.

A discrete event simulation model was developed which estimated the flows of demand through the new hospital, taking account of peaks/troughs in demand during the course of the year.

The model utilised data from the calendar year 2019 as its baseline position, including information on demand for the Emergency Department, inpatient beds, day case trolleys, theatres and outpatient clinics. There were also a number of areas that were additionally built into the modelling such as demand for critical care, chemotherapy chairs, etc. All of the modelling was split by elective and emergency pathways and was further subdivided into medical and surgical specialties to take account of the very different pathways for each of these types of care.

The model was initially run through to 2036 on a 'do nothing' basis. In doing this, it made use of Statistics Jersey's +1,000 net migration population projections to estimate an age-adjusted growth for services over this period.

Following this, a series of interventions as identified through the Jersey Care Model programme were applied to create the 'do something' case.

The outputs of the demand and capacity modelling were used to inform the discussions on the Functional Brief for the new hospital, where additional operational adjustments were made (e.g. to take account of the fact that operationally three Resus bays will be required in the Emergency Department even though the daily demand for these bays would not directly support this).

The Functional Brief was developed with the Design and Delivery Partner as part of the Employers Requirement's to inform the design for the new hospital and included the detailed functions which needed to be included in the Our Hospital design.

### 2.2.6 Baseline Comparator Capital Costs

The Baseline Comparator Capital costs set out in the table below have been produced by the GoJ Cost Consultant T&T based on the work undertaken to date on the Baseline Comparator Option.

The costs for the new hospital included herein benchmark in line with comparable current major UK hospital schemes, taking into consideration the applicable regulations, Jersey location factor, and abnormal aspects of the Our Hospital programme of works.

A summary of the assumptions used are set out below:

**Table 1: Baseline Comparator Capital Costs**

| Cost Categories (£m) | Baseline Comparator |
|---|---|
| Main works | 406.2 |
| Design and Professional Fees | 79.8 |
| Non-works Costs | 11.1 |
| Equipment Costs | 46.2 |
| Contractor Contingency | 40.6 |
| **Sub-total** | **584.0** |
| Optimism Bias | 113.9 |
| Inflation adjustments | 129.5 |
| GoJ Team Costs | 39.8 |
| Client Contingency | 73.1 |
| **Total Capital Costs** | **940.2** |

### 2.2.7 New Build Capital Costs

As the DDP has been appointed they have supported the development of the OBC, and have provided guidance on the costs for the New Build Option including informing costs for the main works, design and professional fees, inflation, the DDP contingency, the Pre-Construction Stage Agreement (PCSA) phase, overhead and profit percentages, demolition and the decant and re-provision of services from Overdale.

Advice was sought from the DDP on preliminaries (the element of the costs related to providing general plant, site staff, facilities, site based services and other items not included in the main works costs) and the DDP provided an initial position. However the level indicated was not within the typical values expected for a project such as this, and so the current cost plan uses a preliminary allowance based on the advice of the GoJ's professional team, and benchmarked against other similar projects, with allowance made for the unique challenges of delivery in Jersey. Further work to continue to market test and review the preliminaries is scheduled to take place during the next stage.

**Table 2: Total Capital Costs**

| Cost Categories (£m) | New Build Option |
|---|---|
| Main Works (incl. demo) | 311.7 |
| Preliminaries | 53.4 |
| Design & Professional Fees | 33.6 |
| Inflation | 34.6 |
| Equipment | 56.3 |
| Contractor Contingency | 35.8 |
| PCSA Costs | 34.2 |
| Overhead and Profit | 44.7 |
| Re-provision of Services from Overdale | 14.6 |
| Decant & Migration | 0.6 |
| **Sub Total** | **619.5** |
| Optimism Bias | 38.1 |
| **Sub Total** | **657.6** |
| Client Contingency | 73.1 |
| GoJ Team Costs | 39.5 |
| Land Acquisition / Re-provision Costs | 34.3 |
| **Total incl. Other Costs** | **804.5** |

## 2.2.8 Benefits Appraisal

The benefits expected from the Our Hospital Project are set out by beneficiary in section 3.7 of the Strategic Case. In the Economic Case this is further developed by looking to quantify and evaluate the benefits by allocating them to categories and identifying the financial, economic or non-quantifiable impacts that the Our Hospital will deliver.

This assessment then forms part of the overall evaluation of the options to determine the preferred option.

The Green Book splits UK benefits into the following four categories:

- Cash releasing benefits
- Monetisable non-cash releasing benefits
- Quantifiable but not monetisable benefits
- Qualitative unquantifiable benefits

For the purposes of the Our Hospital OBC, benefits to the staff, patients, the GoJ public sector as a whole and the wider benefits to Jersey society are considered.

### 2.2.8.1 Approach taken for qualitative benefits

The benefits identified for qualitative scoring were initially assessed and scored at an Our Hospital Project Team workshop on 8th February 2021. During the workshop, the following was considered and agreed:

- A confirmed long-list of benefits
- Identification of benefits which could be quantified
- A qualitative scoring methodology
- Weighting for each qualitative benefit
- Indicative scores for each qualitative benefit for both the New Build Option and the Baseline Comparator

Following the conclusion of the benefits workshop, the outcomes were subsequently tested and ultimately confirmed at:

- HCS Executive – February 2021
- Clinical and Operational Client Group (COCG) – 4th March 2021.
- The Health Workers Panel – 13th April 2021
- The Citizens Panel – 15th April 2021

Further details on the outcomes of this process are set out below.

### 2.2.8.2 Qualitative Benefit Scoring

As described above, each of the benefits has been scored as part of a workshop and further feedback sought from a wide range of stakeholders. The final approved scores, and corresponding rationale, for both the Baseline Comparator and Our Hospital options are:

- Baseline Comparator Option – 1.9
- New Build Option – 4.2

### 2.2.8.3 Future quantification of benefits

**Currently identified benefits for quantification**
All benefits have remained qualitative for the purposes of this OBC. However, extensive discussion has been undertaken and work is underway to quantify and/ or monetise a number of benefits for the New Build option and progress is described in the Economic Case. Benefits where quantification has commenced include:

**Monetised benefits (cash and non-cash releasing)**

- 17: Hospital facilities which attract highly skilled staff, assists in closing vacancy factor and improves existing staff retention
- 25: More efficient maintenance provision due to co-location and modern facilities
- 34: Increase private patient provision to deliver a surplus which can be reinvested into HCS services

**Quantified benefits**

- 3: Facilities which address the healthcare needs of all patients
- 11: Better sign-posting, easier way-finding leading to a more efficient patient experience
- 29: First class Healthcare facilities
- 20: Increased integration enabling greater efficiency across services
- 18: Improved staff wellbeing
- 31: Job creation opportunities for Islanders
- 32: Development of apprenticeships and increased training opportunities
- 34: Creation of low carbon generating facilities.

### 2.2.8.4 Benefits appraisal conclusion

The Baseline Comparator option continues to be constrained by the existing location and layout of the Jersey General Hospital and the wider HCS estate. This means that there is limited scope for the functional improvement of the hospital to meet the strategic objectives and result in low qualitative scores against the expected benefits. The limited improvements to the functional space means that the wider benefits to patients, staff and the community can also not be achieved.

In contrast, the New Build Option will deliver significant benefits to all types of beneficiaries from the GoJ public sector through to patients using the facilities. Further work will continue to quantify and/ or monetise

these benefits as far as possible to demonstrate the positive impact the New Build Option will have and enable the benefits to be managed and realised.

### 2.2.8.5 Risk appraisal

To assess, and where possible, quantify the risks an OBC Project Risk Register has been produced to summarise the key project risks for the OBC stage for the New Build Option.

The OBC Project Risk Register was developed by MACE, T&T and EY to combine the GoJ allocated risks that had been identified through the project risk appraisal processes. These risks have been scored on a likelihood / impact basis and, where possible, have been quantified.

In addition, as part of the development of the Baseline Comparator Option, a GoJ Baseline Comparator Risk Register has been produced. This has been developed by MACE, T&T and EY and has been scored on a likelihood / impact basis and where possible the risks have been quantified.

Both Risk Registers were tested with OBC Project Team on 19th May 2021.

## 2.2.9 NPC Analysis

The Net Present Cost of the capital and revenue costs for each option is set out below and indicates that New Build Option offers the lower Net Present Cost (£745.4m) compared to other the Baseline Comparator Option (£764.5m) and a significantly lower Net Present Cost per Weighted Benefit Point.

**Table 3: NPC per Weighted Benefit Point**

| | Baseline Comparator Option | New Build Option |
|---|---|---|
| NPC | £764.5m | £745.4m |
| Weighted Benefit Score | 1.9 | 4.2 |
| NPC per Weighted Benefit Point | £402.4m | £177.5m |
| Rank | 2 | 1 |

The Economic Case also sets out Sensitivity Analysis that has been carried out to provide further analysis on the findings set out in the Economic Case.

## 2.2.10 Conclusion

The Our Hospital Project New Build Option at Overdale represents an exciting and ambitious scheme which can help deliver a meaningful change to the delivery of health services in Jersey and deliver a hospital which is fit for purpose today and for the future.

The Economic Case reconfirms the New Build Option at Overdale as the Preferred Option for re-developing the healthcare estate in Jersey, for the following key reasons:

- The New Build Option is the only option that achieves the CSF
- The New Build Option is cheaper is absolute terms and NPC terms than the Baseline Comparator Option
- The New Build Option delivers greater benefits to patients, staff, HCS and the wider community

The New Build Option will deliver significantly more benefits to all stakeholders, scoring 4.2 out of 5 against the Baseline Comparator 1.9 for the weighted benefit score. Work is currently underway to quantify and/or monetise these benefits where possible, particularly around the clinical and social benefits that the hospital will bring which is expected to reinforce the case for the New Build option.

The Our Hospital Project offers an opportunity to modernise not just the healthcare facilities in Jersey, but to be a key enabler of change for the wider Jersey healthcare system. The new hospital will provide a facility which conforms to the highest standard of clinical care, both now and into the future and will be a centrepiece of which the Island can be proud.

In contrast the Baseline Comparator Option will not be able to achieve these benefits. The facilities in their current state, and even following significant refurbishment, will remain restricted by the functional layout and quality of the building structures. This prevents the current hospital ever being able to deliver any improvements to adjacencies or co-location of mental health services, thereby not meeting the expectations of patients, staff or the wider community.

The Baseline Comparator option also does not deliver a sustainable solution for the delivery of healthcare services at the existing Jersey General Hospital site – and represents a more expensive option in both absolute terms and in NPC terms due to the significant refurbishment that would be required. On top of this, the Baseline Comparator option carries substantial risk both in terms of the condition of the existing facilities and the ability to attract and retain the best possible clinical staff for the Island.

In addition, any deferral of a decision to invest in the hospital at this stage could potentially have a significant impact in the future. This is because of the expected pressure on the construction industry due to the pipeline of hospital developments in the UK and the high construction inflation rates in Jersey.

## 2.3 The Financial Case

### 2.3.1 Introduction

As detailed in the Economic Case, a Preferred Option (i.e. the New Build Option) has now been selected and this Financial Case sets out the financial implications of delivering that Preferred Option. This involves setting out the up-front Capital Cost, the whole life financing implications of those capital costs and the whole lifecycle associated with the Preferred Option.

A detailed Proposition is being developed which will be presented separately to the States Assembly for debate in September 2021 and will include approval to fund the Our Hospital Capital Costs set out within this OBC. The Proposition will outline the options that have been considered in relation to funding the Our Hospital Project. For the purposes of the Our Hospital OBC, a series of funding assumptions have been made by the GoJ Treasury, but the ultimate decision will be made by the States Assembly when the proposition is debated in September 2021.

### 2.3.2 Our Hospital Project financial impact

**Table 4: Capital costs for New Build Option**

| Cost Categories (£m) | Total | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|---|---|---|---|---|
| Main Works | **311.7** | - | - | - | 20.4 | 68.0 | 138.9 | 83.7 | 0.7 |
| Preliminaries | **53.4** | - | - | - | 13.0 | 12.3 | 12.3 | 12.3 | 3.5 |
| Design and Professional Fees | **33.6** | - | - | - | 10.3 | 11.2 | 6.8 | 5.4 | - |
| Inflation | **34.6** | - | - | - | 2.3 | 7.5 | 15.4 | 9.3 | 0.1 |
| Equipment | **56.3** | - | - | - | - | 33.8 | 22.5 | - | - |
| Contractor Contingency | **35.8** | - | - | - | 2.3 | 7.8 | 16.0 | 9.6 | 0.1 |
| PCSA Costs | **34.2** | - | 6.2 | 21.8 | 6.2 | - | - | - | - |
| Overhead and Profit | **44.7** | - | - | - | 4.4 | 10.1 | 18.2 | 11.5 | 0.4 |
| Re-provision of Services from Overdale | **14.6** | - | - | - | 1.0 | 3.2 | 6.5 | 3.9 | 0.0 |
| Decant & Migration | **0.6** | - | - | - | - | - | - | - | 0.6 |
| **Sub Total – Construction Costs** | **619.5** | **-** | **6.2** | **21.8** | **59.8** | **153.9** | **236.6** | **135.7** | **5.4** |
| Optimism Bias | **38.1** | - | - | - | 3.5 | 8.4 | 15.8 | 10.0 | 0.4 |
| **Total Capital Costs Incl. Risk** | **657.6** | **-** | **6.2** | **21.8** | **63.3** | **162.3** | **252.4** | **145.7** | **5.9** |
| Client Contingency | **73.1** | - | - | 1.7 | 6.6 | 14.7 | 30.3 | 19.2 | 0.8 |
| GoJ Team Costs | **39.5** | 0.5 | 4.4 | 9.4 | 6.3 | 4.8 | 4.7 | 4.7 | 4.7 |
| Land Acquisition / Re-provision Costs | **34.3** | - | - | 25.5 | 8.8 | - | - | - | - |
| **Total Costs incl. Other Costs** | **804.5** | **0.5** | **10.6** | **58.4** | **85.0** | **181.7** | **287.4** | **169.6** | **11.3** |

Funding has already been provided for the Design & Delivery Partner Pre-construction and Government Team Costs / land assembly for 2019 (£0.5m), 2020 (£10.6m) and up to 30 June 2021 (£20m).

For illustrative purposes only, an indicative funding example has been set out below based on an estimated bond charges and funding requirement. The final funding requirement will be agreed via the Proposition that will be debated in the States Assembly in September 2021.

Table 5 below sets out the annual revenue impact in 2027 (unindexed and indexed) of the New Build Option. The example below shows the impact of setting aside a flat bond principle repayment annually in order to ensure funds are available to meet the liabilities when they fall due.

The average annual cost of the bond interest is £19.3m p.a. over a 30-year (Bond A) and 40-year (Bond B) tenor, at which point the bond would need to be either repaid or refinanced. The payment of the annual bond coupon is a new cost to Government and a funding source will need to be identified

The additional spend for Year 1 of the new hospital is detailed in the table below. Indexation is applied at the Jersey standard inflation rate of 3% in the Indexed column:

**Table 5: Year 1 Annual Revenue Cost (2027) for New Build Option**

| Year 1 Annual Revenue Cost (Ye 31 December 2027) £m | Overdale | |
|---|---|---|
| | Unindexed | Indexed |
| | | |
| Shuttle Bus | 1.0 | 1.1 |
| Lifecycle (average annual over 60 years) | 4.0 | 15.5 |
| Bond Interest Charge (A+B) | 19.3 | 19.3 |
| **Year 1 Annual Revenue Charge 2027** | **24.3** | **36.0** |
| | | |
| Annual Cost of Bond Repayment if repaid annually (A+B)* | 19.3 | 19.3 |
| **Adjusted Year 1 Additional Revenue Requirement** | **43.6** | **55.3** |

### 2.3.3 Affordability

The financial analysis currently performed on the New Build Option shows the revenue impact of the financing charges, lifecycle and shuttle bus costs. The impact of Facilities Management and Utilities along with potential clinical, operational and financial benefits is excluded for the analysis set out above. Work on benefits will continue during FBC stage.

Based on the information set out above, the GoJ will need to fund on-going financing, lifecycle and shuttle bus costs.

The decision to fund the on-going revenue costs associated with the scheme will be made by the GoJ and therefore the scheme will be affordable if the GoJ agrees to fund it.

## 2.4 The Commercial Case

### 2.4.1 Introduction

The Commercial Case presented in the SOC provided detail on the procurement strategy and process which led to the appointment for the pre-construction stage of the ROK FCC Joint Venture “ROK / FCC JV” as the Design and Delivery Partner “DDP”. These sections are not summarised in this Executive Summary but are updated for the OBC.

In addition to this, a number of commercial opportunities and land transactions associated with the proposed new hospital are described in the OBC.

This commercial case also sets out the key design work undertaken to date by the DDP.

### 2.4.2 Form of contract

As was set out at SOC Stage the form of contract utilised is the NEC3 Option suite of Standard Forms of Contract, an industry and market accepted suite of contracts and agreed to be best suited to the project.

### 2.4.3 Current Status of DDP Contract

The ROK/FCC Pre Construction Services Agreement ("PCSA") Contract was signed on the 23rd July 2020. The PCSA contract is now expected to run until c. mid-2022. Following satisfactory completion of the PCSA stage the arrangement enables the project to proceed through entering into NEC3 Option C Target Cost Contract with the DDP. The target cost within that contract would be subject to a pain/gain share between the DDP and the GoJ.

### 2.4.4 DDP Supply Chain Procurement Strategy (Stage 2 Procurement)

The SOC sets out the principle of adopting a two stage procurement approach to drive greater value for money in the tendering of construction packages. Whilst this strategy leads to the DDP being responsible for tendering the works packages, in line with the strategy below, the GoJ will need to pre-approve the letting of each package and also approve the appointment of the successful bidder following a robust tender evaluation.

The OBC has been updated to summarise the DDP strategy for this procurement which has now been developed to set out plans for the procurement of their supply chain. This DDP Supply Chain Procurement Strategy sets out the plan to deliver the GoJ objectives with the intended outcome of delivering best value for the OH Project and the GoJ. The overarching strategy is to achieve maximum value by promoting a high-performance, collaborative culture throughout the supply chain, which underpins resilient delivery, mitigates risk and maximises the impact of the supply chain in legacy activities

This strategy will evolve as the project develops and progresses and further revisions of the strategy will be issued to reflect this.

### 2.4.5 Land transactions associated with the project

Various land and buildings close to, or adjacent to the Overdale site were identified as necessary to enable the Our Hospital Scheme.

At the time of this OBC, a number of sites/properties have already been successfully purchased by the GoJ, with a number of others still being negotiated. The current total estimated costs of the sites / properties is £34.3m (this includes sites that have already been purchased and those still in negotiation, and includes costs associated with CPO should this be required).

### 2.4.6 Build Scheme information

The RIBA Stage 2 Concept Design Report ("RIBA 2 Report") for the Our Hospital Project was completed and shared by the DDP in May 2021. The purpose of the Stage 2 report was to "*prepare outline proposals which reflect a series of relevant project and design strategies and establish the clear direction and content of the project*". Work has now commenced on the RIBA Stage 3 Developed Design, incorporating feedback on the RIBA 2 report to develop a design which will enable the scheme to be submitted as a Full Planning Application in late 2021.

## 2.5 The Management Case

### 2.5.1 Introduction

This section of the OBC addresses the ‘achievability’ of the preferred way forward. The Management Case sets out the reporting structure, management arrangements and details of the delivery teams in place to deliver the programme.

The Management Case section of this OBC has been produced in line with UK HM Treasury Green Book Guidance and also the principles of PRINCE2.

The Management Case at SOC stage already covered the key areas outlined below due to the stage of development of the programme:

- An overarching project management approach, including stakeholder and change management
- The outline programme timeline and milestones
- Summarised approach to risk and benefit management, including contingency plans and post-project evaluation

To reflect the progress made in the programme to OBC, the following additional information or updates have been made to the Management Case:

- The project plan has been updated to reflect the information on the construction programme prepared as part of the RIBA 2 design process
- Project management approach has been updated to reflect the latest Project Manual
- Costs have been updated to reflect the latest cost information

Other sections of the Management Case have been reviewed and updated where required but remain substantively the same as those in  the SOC and are included for reference.

# 3. THE STRATEGIC CASE

## 3.1 Introduction

### 3.1.1 Purpose of the Strategic Case

The Strategic Case sets out the background to the delivery of healthcare services in Jersey and then details the reasons that an intervention is required in the Case for Change.

### 3.1.2 Work undertaken at the SOC Stage and updates to the Case in this OBC

**SOC Stage**

During the development of the SOC, the following was detailed in the Strategic Case:

- An overview of the Jersey Healthcare System including the current model of care, acute services, children's services, complex off-island care, ambulance and mental health
- The structure of Health and Community Services (HCS)
- Healthcare policy, system transformation and proposed future model of care
- Overview of the existing estate and the issues associated with it (e.g. physical condition of buildings, lack of co-location)
- The Case for Change (e.g. poor condition of estate, limited options to redevelop)
- Project Investment Objectives and Critical Success Factors
- Long-list of Benefits
- Constraints and Dependencies.

**OBC Stage**

As outlined above, the Strategic Case was substantively complete at the SOC Stage and therefore the only changes made related to either new information becoming available or re-testing of previous assumptions. The key updates that were made are outlined below:

- A workshop was held with the Our Hospital Project team on Monday 8th February 2021 in order to review the Our Hospital Project Investment Objectives and long-list of Benefits. This resulted in some updates to both which are presented in the relevant section of this OBC.
- The benefits agreed above were then assessed using SMART (Specific, Measurable, Actionable, Relevant, Time-based)

Other sections of the Strategic Case have been reviewed and updated where required but remain substantively the same as with the SOC and are included for reference.

## 3.2 System and Organisational Overview

### 3.2.1 Overview of the Island's Healthcare System

**Healthcare delivery**

The Health and Community Services Department (HCS) is the principal provider of health care in Jersey. It operates in the context of a wider primary care system. Primary care is provided by independent GPs, dentists, pharmacists and optometrists, a comprehensive network of voluntary and community organisations and independent provision to support health and social care. Acute secondary care is

delivered through the islands General Hospital, located in St Helier and mental health inpatient services in Orchard House.

Jersey has 14 general practices, which are used for first stage diagnosis and treatment, as well as a referral function to secondary care. General practice operates under a co-pay system, with the Government of Jersey paying a top-up to supplement the private cost of visiting a GP. The cost is on a payment for service basis, with each face to face appointment attracting a fee. Analysis suggests that private primary care is a contributory factor linked to disproportionately high attendance levels at the hospital for both emergency treatment and follow up appointments.

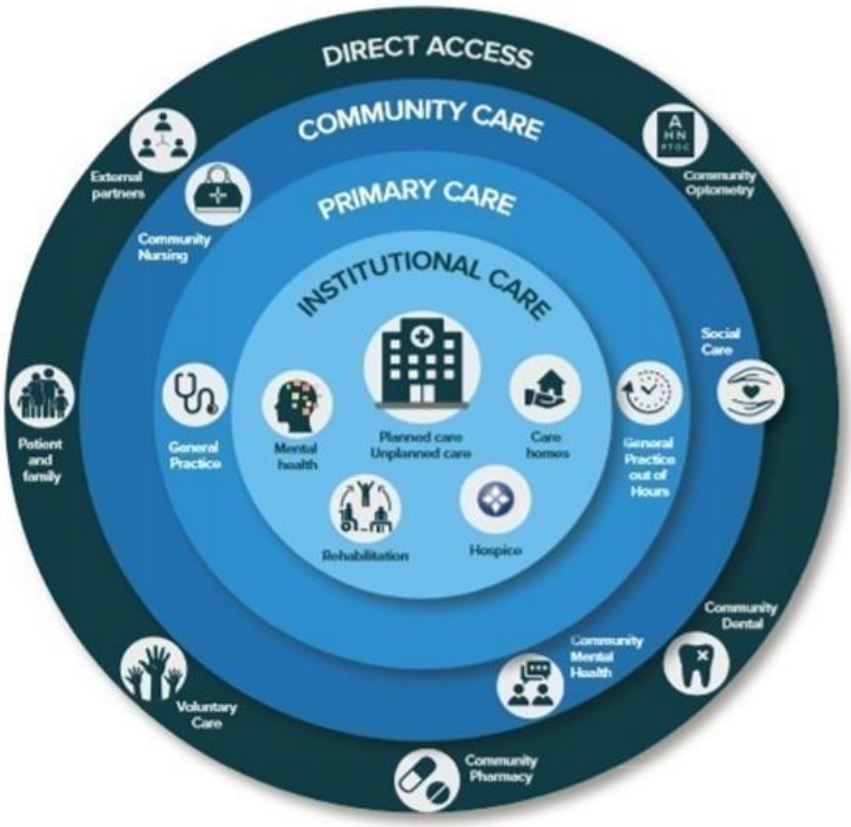
HCS delivers a broad range of key functions covering the operational delivery and governance expected within any modern, comprehensive healthcare system. HCS is a significant employer on the island, with a workforce establishment of circa 2,400 whole time equivalent (WTE) staff and a budget of £239m (revenue) and £9m (capital) in 2020.

Specialist tertiary level services are provided at off-island locations, typically across the UK. Arrangements for the care of these patients is managed by the General Hospital.

The Island has an active private healthcare sector which operates both within the hospital and at other independent locations on the island. There is significant scope to expand on the current private practice offer, given the level of underutilised private insurance many islanders hold.

The current model of care is summarised in the diagram below, which shows the hospital in the centre of care.

**Figure 2: Current model of care**



**Health and wellbeing**

In 2019, almost three-quarters of adults in Jersey (73%) described their health as good or very good. This proportion is down from 81% in 2018. The percentage describing their health as good, bad and very bad was fairly constant over all age groups. Those describing their health as very good decreased with age, with a corresponding increase in those who described their health as fair.

In 2019 25% of Jersey adults reported having a longstanding physical or mental health condition.

In 2018 the median age of death for Jersey residents was 81 (female 83, male 78).

Statistics Jersey's Life Expectancy report says that between 2016 and 2018 the average life expectancy for new-born Jersey females was 84.6 years, while for males it was 80.8 years.

By comparison English women can expect to live for 83.2 years, while for men the life expectancy is 79.6 years. Figures for 65-year-old Islanders indicate that men who have reached that age can expect to live for a further 19.4 years, on average, and women will on average have an extra 21.8 years of life.

**Morbidity and disability**

Neoplasms (cancers) remain the most frequent cause of death, accounting for almost one in three (30%) of all deaths (2018 data). On average, there are 977 malignant cancers diagnosed each year in Jersey (2010-2014). Non- melanoma skin cancer (NMSC) accounts for around 39% of the annual mean count, with the three most commonly registered cancers after NMSC being prostate, breast and lung cancer. The age-standardised rate for head and neck cancer, hepatobiliary cancer, lung cancer, malignant melanoma, prostate cancer and paediatric cancers in Jersey was higher than in the South West of England and England as a whole. However, death rates are largely similar to those in England.

It is estimated approximately 13% of the population suffer from hypertension compared to 20% in the UK. Obesity levels in Jersey at 17% are lower than the estimated 29% of UK population.

In 2019 a quarter (25%) of all adults reported having a longstanding physical or mental health condition: similar to 2018 (27%), while 47% said that their life was limited a little by their health and 19% said their life was limited a lot. The proportion of adults that reported a longstanding health condition increased with age.

Around 8% of the island population have two or more conditions. This increases to more than half of the population over 60.

In 2015, the States of Jersey Social Policy Unit commissioned a survey of households to establish the prevalence of disability in Jersey. The survey found 14 per cent of all residents living in private households (around 13,900 residents) had a disability as defined by the UK Equality Act 2010 (this is that they have a physical or mental condition or illness lasting or expected to last 12 months or more which impacts on their ability to carry out day to day activities a little or a lot).

**Mental health**

Islanders report an average mental wellbeing score on the short Warwick-Edinburgh scale as 26 – in line with the rest of the UK. However, 27% of Islanders have high levels of anxiety; 21% are lonely often or some of the time; and 49% of working Islanders say they spend too much time at work – a figure which has steadily risen from 37% in 2013. 71% of working adults say they spend too little time on hobbies and interests, and more than half say they spend too little time with their families.

The number of attendances presenting to the Emergency Department (ED) with a mental health problem has been rising, with a rate of 873 attendances per 100,000 population in 2019, the highest rate since 2013. 22% of these attendances involved deliberate self-harm and over the last three years, the ED has dealt with an average of 204 self-harm cases a year.

Existing ED activity analysis conducted for the Jersey Care Model (JCM) review shows that 2.4% of ED activity (960 attendances in 2018) may be due to mental health. These include activities associated with attempted suicide, deliberate self-harm, or referred to psychiatric liaison team.

Of these:

- 41.6% of mental health related attendances were discharged home
- 22.1% were referred to Psychiatric Liaison Team
- 7.3% were transferred to Orchard House

**Infant and child health**
In 2019 the crude birth rate was 8.89 live births per 1,000 population, which is a decline from previous years. Over the three-year period 2015-2017, the infant mortality rate for Jersey was 1.0 per 1,000 live births. This is lower than the 3.9 per 1,000 seen in England during the same timeframe. In 2018 there were 2,771 children under the age of 13 seen at the Emergency Department following an accidental injury.

The Jersey School Survey (2018) reveals that 51% of respondents aged 12-13, 24% of respondents aged 14-15 and 8% of respondents aged 16-17 had never drunk alcohol. Over the three-year period 2016-2018, there were 55 admissions to hospital of under 18-year olds with a primary or secondary diagnosis for an alcohol-specific condition. During the same three-year period the alcohol-specific hospital admissions for children under 18 years per 10,000 children was 9.10.

The Jersey School Survey (2018) also shows that 81% of respondents aged 12-13, 67% of respondents aged 14-15 and 48% of respondents aged 16-17 had never smoked. The survey also found one in ten (11%) of children reported someone smoking in their home, and one in twenty (5%) reported someone smoking in their car, at least occasionally. The Jersey School Survey (2018) also revealed 2% of respondents aged 12-13, 15% of respondents aged 14-15 and 28% of respondents aged 16-17 had ever taken a drug.

During the 2018/2019 academic year one in five (21%) 4-5 years olds were overweight or obese, compared to around one in three children aged 10 to 11 (30%). The 2018 Jersey School Survey found that 18% of surveyed children and young people (Years 6, 8, 10 and 12) reported meeting the recommended level of physical activity. Older respondents were found to be less physically active. This was also higher in males (20%) than females (16%).

**Lifestyle**
In 2015, 12% of adults smoked daily, compared with 19% in 2005. The latest Jersey Annual Social Survey to look at alcohol use in Jersey (2018) showed that 10% of respondents reported never drinking alcohol but of those who drank around a quarter (23%) were found to be drinking at hazardous or harmful levels. The last time children and young people were asked about alcohol (2018 school survey) showed the proportion of pupils who had drunk alcohol in the 7 days prior has reduced for all year groups since 2006, from 40% of Year 10s and 21% of Year 8s in 2006 to 24% of Year 10s and 5% of Year 8s in 2018

Alcohol played a role in **14% of all crimes** recorded in Jersey in 2018. Of specific types of crime:

- One-in-four assaults and more than **one-in-three serious assaults** were recorded by police as involving alcohol.
- Two-fifths of domestic assaults involved alcohol.
- Two-fifths of assaults and half of the serious assaults in the St Helier night-time economy involved alcohol.

The population has relatively low levels of ethnic diversity. 46.4% of individuals identify as ‘White Jersey’ and 32.7% identify as ‘White British’. 8.2% of residents were born in Portugal/Madeira. 3.3% of residents are Polish whilst 7.1% of residents are Irish, French and Other White compared with 19% in 2005 (2013 – UK 19%).

### 3.2.2 Population and Demand

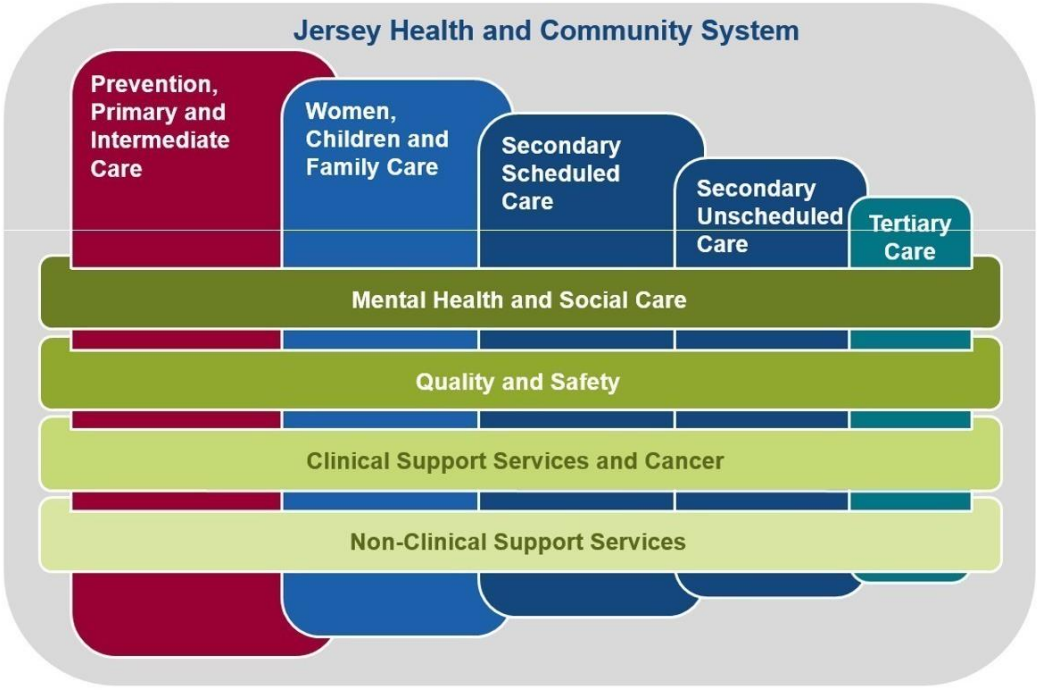
Population and demand assumptions have been used to help inform the functional brief for the proposed Our Hospital. This is set out in more detail in section 4.6 (Functional Brief) of the Economic Case.

### 3.2.3 Structure of HCS

HCS has a mandate to provide safe, sustainable, affordable and integrated services which enable Islanders to live longer, healthier and productive lives.

The Government structure for the overall Jersey Health and Care system is built around five groups with four cross cutting services as outlined in Figure 3 below.

**Figure 3: Jersey Health and Community Services Care Model Structure**




The HCS groups and services include:

- **Prevention, Primary and Intermediate Care**: Within this care group HCS supports the care co-ordination, primary care governance and operational oversight and partnership working with Primary and Community Care providers.

- **Women, Children and Family Care**: This care group provides services throughout the Hospital and Community that relate to Women, Children and Families. These include functions such as maternity, gynaecology, assistive reproduction and the special care baby unit. This Care Group provides leadership in partnership work with the Department of Children, Young People, Education and Skills around Child and Adolescent Mental Health services.

- **Secondary Scheduled & Tertiary Care**: Relates to many of the specialist hospital functions covering inpatient wards, acute medicine and surgical services. This Care Group leads on partnership with wider Government colleagues in Justice and Home Affairs who lead the Ambulance Service, a critical part of the unscheduled care pathway.

- **Tertiary Care**: This is the function that facilitates and enables off island care in emergency and planned circumstances. The majority of tertiary care services are provided by NHS hospitals within the UK.

- **Secondary Unscheduled Care**: Supports emergency care services covering the Accident and Emergency Department and Emergency Assessment Unit at the hospital. As noted above, the Secondary Scheduled & Tertiary Care Group also forms a critical part of the unscheduled care pathway.

- **Social Care**: Is the function that commissions personal care and co-ordination which is led by the Social Worker profession. This service has oversight of Learning Disability services and works in close conjunction with the Mental Health Care Group.

- **Mental Health**: Covers HCS's inpatient units and community facing services including functions like Jersey Talking Therapies and Drug and Alcohol services.

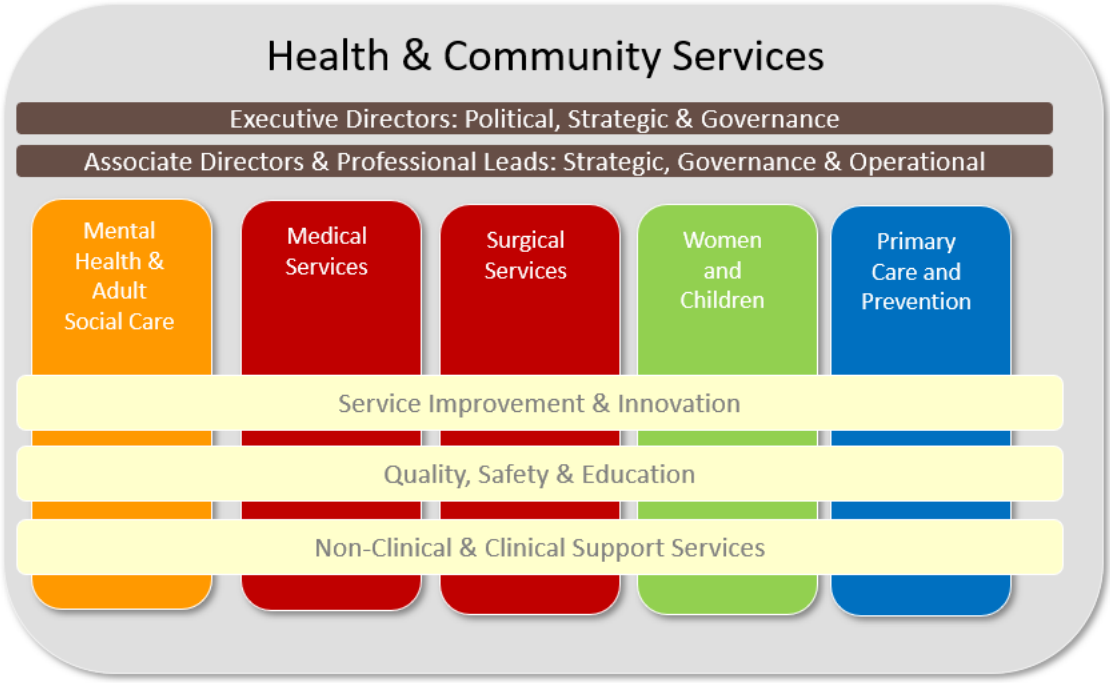
- **Quality and Safety**: Overarching over all of the Care Group functions is the Quality and Safety Care Group which incorporates the offices of the Chief Nurse and Group Medical Director. This care group ensures services are delivered to the required professional and quality standards with the appropriate level of oversight and assurance. Infection prevention and control is also part of this Care Group.

- **Clinical Support Services and Cancer**: Brings together all of the diagnostic functions such as pathology and radiology as well as important support functions like pharmacy. This care group is responsible for servicing all of HCS's Care Group functions and objectives and also develops the Cancer Strategy for the Island.

- **Non-Clinical Support Services**: Includes all of the estate, facilities and non-patient facing services such as administrative services.

These are further illustrated in the in the figure below.

**Figure 4: Jersey Health and Community Services Care Group Structures**



Within the HCS Care Groups, the organisation aligns its people and resources to the service requirements. Each of these groups:

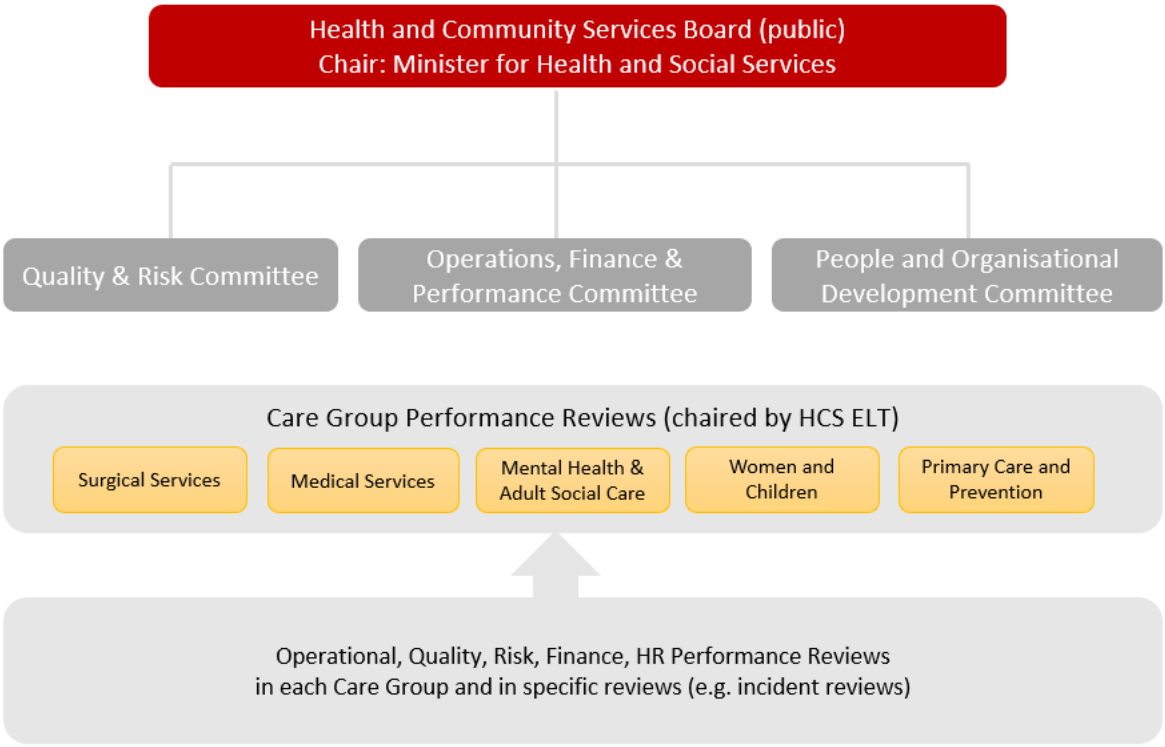
- has direct accountability for delivering a group of related services.
- is clinically and professionally led.
- is required to work collaboratively with other groups for the benefit of the whole system.

In addition to the Care Group structures, HCS also has an Improvement portfolio which drives the strategic change programme. The oversight and delivery of digital change projects sits within the central Modernisation & Digital Directorate which is part of the Chief Operating Office of the Government of Jersey.

The key objective as a department is to drive the integration of Health and Community services, enabling continuity of care for patients and clients to the required care standard.

This structure is further illustrated in the in the figure below.

**Figure 5: Jersey Health and Community Services Governance Structure**




### 3.2.4 Complex care – off island services

For reasons of scale, where volumes are too low to provide a safe and sustainable service, tertiary care is delivered off Island, in the UK. Currently the majority of services provided off Island are low volume, high cost specialities or sub-specialities.

In 2019, 2,478 patients received 5,938 treatments from UK healthcare providers at a cost of £13m. In addition, there were 301 Jersey Emergency Transport Service Charter Flights. The size of this, 'virtual capacity' i.e. in-patient beds, operating theatre sessions, workforce and some out-patient and ambulatory capacity not physically provided on Island in the current and future General Hospital reflects a clinical

choice, where patient safety and clinical outcomes determine the number and types of patients who receive treatment off-island.

It should be noted that the above relates strictly to acute and general hospital activity. Mental health is commissioned on the basis of individual patient need as required.

In the future, the number and relative proportion of Islanders needing care off Island may potentially increase, with a consequent growth in the cost and clinical risk in providing tertiary and emergency treatment in this way. Alternative strategies may help to mitigate this growth, but the impact is anticipated to be limited. For example, current General Hospital patients benefit from specialist skills provided by visiting Consultants. This approach is only effective if the conditions of such patients allow them to be 'batched' e.g. types of surgery. It does not provide a solution for Islanders requiring emergency or complex acute medical care.

Referrals for complex care are based on the patient need basis. 80% of all off island activity is sent to 10 UK hospitals (listed below); the other 20% is made up by a further 80 hospitals.

**Table 6: Acute Care Providers**

| Acute Care Provider | |
|---|---|
| 1. Southampton General Hospital | 6. Guys and St Thomas' Hospital, London |
| 2. John Radcliffe Hospital, Oxford | 7. Queen Alexandra Hospital, Portsmouth |
| 3. Addenbrookes Hospital, Cambridge | 8. Great Ormond Street Hospital, London |
| 4. Royal Bournemouth Hospital | 9. Royal Marsden Hospital, London |
| 5. UCLH, (National Hospital/Queen's Square) | 10. Kings College Hospital, London |

### 3.2.5 Digital transformation

**Digital Background**

Digital Delivery of the health digital programme and strategy sits with the central Modernisation and Digital Directorate which is part of the Chief Operating Officer (COO). The clinical lead is the Clinical Chief Information Officer (CCIO) who sits within HCS.

The wider underpinning programme for digital infrastructure is also led across Government by the Chief Operating Officer (COO). The programme and funding included in the government plan for 2021-2024 includes Cyber security, Microsoft upgrades and infrastructure. As such, the Our Hospital Project will provide the backbone for the delivery of the Digital Strategy with the new hospital and not the programme itself.

**Digital strategy for health and care in Jersey**

The Digital Strategy for Health and Care in Jersey set out the broad ambitions and approach to 'digitising' the whole health and care system so that the benefits of digital technologies can in turn deliver benefits to patients, service-users and care professionals alike.

The vision is: “Jersey is a ‘digitally integrated’ health and care system that uses technology to deliver accessible, joined-up, person-centred care that is safe, effective and efficient, where data is used intelligently to improve every aspect of care, and where innovation flourishes”.

In order to achieve this vision, Jersey will put in place a number of key technical and operational components over the next five-ten years:

- Ensuring that each part of the health and care has a core patient / service user records-keeping and administration system in place, which meets basic ‘maturity’ levels and supports ‘open standards.
- Implementing a universal identifier for all persons, based around the “People Directory”, and integrating that into electronic systems, interfaces and interchanges between all parts of the health and care landscape.
- Implementing a Jersey Care Record; a universal online record of individuals’ interactions with health and care organisations, and a ‘hub’ for implementing cross-sector ‘business logic’ such as ‘safety alerting’, all accessible through a single public-facing portal.
- Creating electronic care plans, closely coupled with Jersey Care Record, so that all care professionals, and patients/service-users have access to that information, wherever they are
- Supporting pathways of care, in combination with online digital care records, electronic care plans, and intelligent use of data to monitor compliance.
- Facilitating much more effective care professional to care professional communication with technology
- Creating a repository of health and care data and using a combination of human and machine driven analysis, improve how care is planned, delivered and managed.
- Developing the digital competence of care professionals and islanders, so that they can exploit digital technologies effectively.
- Create an infrastructure and environment that promotes health and care research, development and innovation.

The digitalisation of health and care services in Jersey is intended to address a broad range of issues relating to the provision of a digitally enabled and fully integrated health and care system in Jersey. These can be categorised as:

1. **Unplanned care** – for the ambulance service or the hospital emergency department there is no way of accessing a patient’s primary care clinical record other than asking the patient (assuming this is within their capacity). Lack of such information may result in defensive care, less appropriate treatment and possible medication issues.
2. **Care planning** – as people live longer, potentially with multiple co-morbidities the need for sharing care plans with the patient and those health and care professionals looking after them is becoming more and more important, such plans might include:
    a. Patient preferences e.g. do not resuscitate, preferred place of care, patient aware of diagnosis, next of kin
    b. Individual care plans e.g. target ranges for clinical indicators such HbA1c
    c. Multi-Disciplinary Team (MDT) joint decisions regarding patient care pathways
3. **Shared care** – for patients receiving treatment from multiple healthcare providers there is a need to ensure that the overall treatment given is effectively joined up, an example might be a diabetes patient being treated and reviewed by their GP, receiving specialist care from the Diabetes Centre, annual retinal screening from an optician and contributing themselves through a personal health record.
4. **Safeguarding** – where safeguarding concerns are raised either through a health & care provider or in the community there is a need to ensure that this information can be coordinated, accessed and reviewed where needed.
5. **Health data analysis** –a need to use data available from all health & care providers to support:

a. Health resource planning
b. Risk stratification
c. Decision making
d. Improvement of healthcare programmes (population management)
e. Improve quality, performance & workflow

6. **Integrated Care Records** – the need to integrate, access and share patient clinical data such as allergies, medication and co-morbidities is vital in the provision of a high quality health service, for a prescriber this means having access to all relevant patient data that might impact the choice of drug, e.g. a severe allergic reaction to penicillin informing choice of antibiotic, or a drug being given to treat a current condition taken into consideration when treating a newly diagnosed co-morbidity.

### 3.2.6 Learning and Development

The current estate has limited ability to provide best practice learning and development facilities in a location that enables staff to access them easily during the working day. The estate does provide some space for training, but the location and type of spaces do not support modern healthcare learning and development needs.

The ability for Jersey to provide a strong learning and development offer to staff during their training, and through the development of their careers, is critical for staff attraction, retention and development, and to develop links with training hospitals and universities outside the UK.

The Clinical Development & Training team organise and deliver mandatory clinical training, annual major incident and specialist training for all staff. The team also provide training courses to outside organisations and work closely with the Nurse Education Centre and Resuscitation Officer, ensuring clinical training remains a key priority for clinical staff.

### 3.2.7 Ambulance Services

The Ambulance Service provides high-level pre-hospital care to the Island of Jersey 24 hours per day. These services can be split into the following six categories:

- Frontline Operations
- Communications
- Patient Transportation
- Partnerships and Voluntary Services
- Clinical Development and Training
- Fleet and Technical Services

The frontline operations are responsible for the day-to-day running of the Ambulance Service and respond to 999 emergency and urgent care calls from General Practitioners/Health clinicians.

Communication for the Ambulance service is provided by the Combined Control Centre (CCC). The CCC answers 999 calls for both the Emergency Ambulance and Fire and Rescue Services, process and coordinate non-emergency calls and monitor the Occupational Therapy department's Community Alarm Service (CAS).

Patient Transport Services (PTS) operate Monday to Friday for patients to and from hospital outpatient appointments, inter-hospital transfers and day centres. Patient Transportation also includes an intermediary crew who provide a link between the Frontline Operations and PTS, acting as first responders for emergencies when frontline crews are all dispatched to calls.

Several volunteer groups support the Ambulance Service. The Partnership and Voluntary Services include Co-Responders, Community First Responders, an Ambulance Support Unit and Voluntary Care Service.

The Fleet and Technical Services (FTS) team provide services and support to the Frontline/ Patient Transport Services (PTS) Departments, Health Supply/Maintenance teams as well as the greater health community.

The Ambulance Service's Vision is to provide the right care at the right time to ensure those with the most life-threatening problems receive the most urgent and clinically appropriate response.

Through their 70 full-time and part-time staff, the services stated aims are:

- Provide the highest standard of care and compassion to those in need of our Services in the community we serve
- Provide more collaboration and improve the emergency response to the public
- Maintain strong links within Health and Community Services due to the nature of the work undertaken by the Ambulance Service
- Keep patients at the heart of our thinking and service delivery.

### 3.2.8 Policy review

**Policy overview**

The Government of Jersey has set out its vision for Health and Community Services; to create a healthy island with safe, high quality, outcome focussed, affordable care that is accessible when and where our service users need it.

Implicit in this vision is the need to move towards a new care model if we are to provide sustainable and high-quality services for Islanders. Traditionally, health and care in Jersey has relied on a secondary care focused model, which has contributed to centralised, institutional based care, with cumbersome discharge routes back into the community and limited access to reablement. In order to deliver patient focussed, outcome-based care, there is a need to implement a model which allows for a more holistic view of health and care, and to develop a stronger model for out of hospital care services; which will compliment essential in-hospital services.

Through the Common Strategy Policy 2018 to 2022, the Government of Jersey has committed to providing affordable, efficient and cost-effective public services which meet the standards that Islanders expect, and the proposals for Health and Care in Jersey aligns with the five strategic priorities:

- We will put children first
- We will improve Islanders' wellbeing and mental and physical health
- We will create a sustainable, vibrant economy and skilled local workforce for the future
- We will reduce income inequality and improve the standard of living
- We will protect and value our environment

As is explained further in other sections of this Business Case, the new Jersey Care Model (JCM) has an ambition to improve Islanders' wellbeing and mental and physical health, and to enable islanders to enjoy long, healthy and active lives. Our Hospital is a key part in supporting citizens with a need for acute and emergency care that cannot be provided within other care settings of the health economy.

**Policy Journey**

In 2011, the Jersey Health and Social Services published the Green Paper 'Caring for each other, Caring for Ourselves'. This set out a thirty-year vision and a ten-year plan for health and care services in the

Island, including a vision for how health and care services would be modernised and expanded in the community to deliver more round-the-clock care with a view to reducing admissions. It set out a desire to move towards a less medicalised, paternalistic approach to care and mirrored aspirations elsewhere in the world to better integrate services to provide a more joined up approach. The Green Paper also acknowledged the need for a new hospital, and within this context, for the new care model to facilitate a shift to a more community focused model of care at the point at which a new hospital was built.

In 2012, this was developed into a White Paper which set out a ten-year vision in more detail. Consultation on the White Paper highlighted concerns around access to primary care, and in particular the barriers that the current co-payment presented for children and those on low incomes to accessing care.

Following the publication of the White Paper, the States of Jersey published Health and Social Services: A New Way Forward (P.82/2012). This set out a stark imperative for change in the way services are delivered in order to be sustainable and avoid service closures and rationing going forward.

The White Paper set the foundation for the strategic direction of health and social care on the Island. It then signposted business area-specific strategies being created under the main P.82 umbrella: Acute Service Strategy 2015-2024 (2016), A Mental Health Strategy for Jersey 2016-2020 (2015), A Sustainable Primary Care Strategy for Jersey 2015-16 (2016), HSSD Informatics Strategy 2013-2018 (2013), and the Digital Health and Care Strategy (2017).

In 2020, the Government of Jersey published Departmental Operational Business Plans, including HCS. The vision to enable Islanders to live longer, healthier and more productive lives by ensuring the provision of safe, sustainable, affordable and integrated services that are delivered in partnership with others was restated, along with five key objectives:

- Redesign of the health and social care system to deliver safe, sustainable and affordable health and community services
- Improved health outcomes by reducing the incidence of mortality, disease and injury in the population
- Improved consumer experience of Health and Community Services
- Promotion of an open culture based on good clinical and corporate governance with a clear emphasis on safety
- Manage the Health and Community Services budget to deliver services in accordance with the Medium-Term Financial Plan, Government Plan and our aligned efficiency programme.

In March 2020, the Government of Jersey published A Health and Wellbeing Framework for Jersey, which provides further detail on how critical prevention and early intervention actions will be driven forward.

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**Policy/Publications reviewed:**

- Imagine Jersey 2035 (2008)
- Island Plan 2011
- St Helier Development and Regeneration Strategy (2008)
- Strategic Plan 2015-2018 (2015)
- P.82/2012 Health and Social Services: A New Way Forward and its amendment
- The States of Jersey Hospital Pre-Feasibility Spatial Assessment Brief (2013)
- Acute Service Strategy 2015-2024 (2016)
- Health and Social Services Department Business Plan (2017)
- A Mental Health Strategy for Jersey 2016-2020 (2015)
- Out of Hospital and Long-Term Conditions OBC 2016
- A Sustainable Primary Care Strategy for Jersey 2015-16 (2016)
- Jersey Carers' Strategy (2017)
- HSSD Informatics Strategy 2013-2018 (2013)

- Disability Strategy for Jersey (2017)
- Future Jersey 2017-2037 (2017)
- Digital Health and Care Strategy (2017)
- One Health and Community Services (2018)
- Common Strategic Policy 2018 to 2022
- Health and Wellbeing Framework for Jersey (2020)

### 3.2.9 Health and care system transformation

As with any healthcare system, there is a need for continuous review and improvement of how services are being delivered in a streamlined and effective way and the existing structures that support service delivery, ensuring they are both future proofed and able to respond to changing population needs and medical and technological advances.

**Current state**

Assessment has been undertaken on the current provision of health and social care services within Jersey and the following challenges have been identified:

**Secondary Care Focused Model**

- The Hospital is the centre of care for the island, with the system heavily reliant on bedded capacity, particularly for older demographic care
- There is a relatively high rate of low acuity ED attendances which could be more appropriately treated elsewhere
- The theatre suites are underutilised, both in terms of scheduling and volume of day case activity
- Long length of stay in rehabilitation beds and a high flow rate into Long Term Care (residential)
- Outpatient new to follow up ratio is high in comparison with benchmarks.

**Intermediate and Ambulatory Care**

- Rapid response services are not optimised and reablement services are limited
- There is a lack of positive risk taking in the current service configuration
- The current teams are not configured to manage higher risk patients due to lack of 24/7 cover and skills mix
- Jersey runs a hospital led model where patients are brought into hospital as the default option
- Lack of 24/7 Community Nursing means that there is no nursing cover to support people at home overnight, resulting in admission to hospital being the default option
- Mental Health Crisis prevention service requires development to support increased demand.

**Prevention, Primary, Community**

- There are limitations in the services offered due to the funding and payment framework
- The payment model does not incentivise self-care, collaboration or innovation
- Deskilled workforce in primary care due to secondary care focused model
- Long term condition management is typically run in secondary care, e.g. Diabetes
- Lack of standardised approach to how conditions are managed across care settings

**Mental Health**

- Mental health services are not integrated with physical health services and people are often kept in hospital longer than they should, because ongoing care at home is not provided

- Unscheduled Mental Health care within the Emergency Department is interdependent on the mental health service availability
- There is a lack of community specialist resource to facilitate timely discharge from acute settings
- There is a recruitment challenge for key skilled roles such as Registered Mental Health Nurses, Medical Staff and Allied Health Professionals
- The current Mental Health Estate doesn't provide a therapeutic environment of care
- There is a lack specialist resource to provide mental health care co-ordination. However there are good relations with external partners which supports the local provision

**Community Care**

- 24/7 community nursing not in place
- Services are not optimally commissioned and managed
- Social Care model is over-reliant on high cost / dependency residential care
- Limited options for Long Term Care other than residential care
- Community mental health offering over-subscribed and needs development.

**Direct access services**

- Primary care services such as Pharmacy, Dental and Ophthalmology are not optimised
- Funding mechanisms not in place to encourage extended service provision
- Most services are accessed / paid for directly by the public, e.g. Dental and Ophthalmology
- Technology and information sharing are sometimes a barrier to joined up service provision.

**Social Care and External Partners**

- Jersey has a very strong voluntary sector and social care market, but it could be better coordinated and is difficult to navigate, especially in times of crisis
- Over £80m is raised annually, one-in-eight adults on the island are volunteering.
- £18m commissioned services and approved providers, although not through coordinated commissioning
- Duplication of services and back office functions
- Lack of understanding and signposting of all services
- Carers are not adequately supported by the current system as many are supported by the voluntary sector and Parishes.

### 3.2.10 Proposed future model of care

Taking into consideration the outcome of the review of the current state, and building on HCS's ambition (aligned to the Government of Jersey's strategic priority (Common Strategic Policy 2019)) to improve islanders' wellbeing and mental and physical health, HCS have developed their vision for the future of health and community services across Jersey in the Jersey Care Model (JCM).

The aim of for the JCM is to create a healthy Island with safe, high-quality, outcome-focused, affordable care that is accessible when and where service users need it. It will put Islanders at the heart of care. This will start with better self and preventative care, supported by a range of community health services. The hospital will continue to provide both critical services and specialist care.

The JCM was reviewed and stress tested by PwC (Price Waterhouse Coopers) (completed May 2020). The outcome of the review was considered by the HCS team and further refined to take into account the impact of the COVID-19 pandemic. Outputs have been presented to the Council of Ministers and it has subsequently been approved following debate in States Assembly in Q4 2020. The revised model has also been independently reviewed and tested by the Health Scrutiny Committee, supported by their advisors.

Demographic modelling, undertaken by PWC, has determined the physical capacity required for a new hospital based on demographic changes up to 2036. Alongside this, PWC have calculated the impact that the operational improvements (detailed in the JCM) to bring Jersey in line with first class healthcare systems will have on the capacity required. The model utilised data from the calendar year 2019 as its baseline position, including information on demand for the Emergency Department, inpatient beds, day case trolleys, theatres and outpatient clinics. There were also a number of areas that were additionally built into the modelling such as demand for critical care, chemotherapy chairs, etc. All of the modelling was split by elective and emergency pathways and was further subdivided into medical and surgical specialties to take account of the very different pathways for each of these types of care.

The model was initially run through to 2036 on a 'do nothing' basis. In doing this, it made use of Statistics Jersey's +1,000 net migration population projections to estimate an age-adjusted growth for services over this period. Following this, a series of interventions as identified through the Jersey Care Model programme were applied to create the 'do something' case. A summary of the Do Nothing / Do Something Cases is:

1. Do Nothing: healthcare services continue in line with the existing operating model.

2. Do Something: based upon the adoption and implementation of a healthcare transformation programme such as the Jersey Care Model and involving Jersey specific pathway and process improvements to bring healthcare in line with best practice standards e.g.:

    - length of stay reductions
    - introduction of admission avoidance schemes
    - enhanced intermediate care offer
    - increased day surgery rates
    - adoption of emerging healthcare improvement opportunities (e.g. digital advances)

The Do Something model was approved on the basis that transformation and modernisation is custom practice globally across health care systems. The programme in Jersey will be supported through the delivery of the Jersey Care Model and other schemes that develop in line with wider health economy and Government of Jersey quality and service improvement programmes.

The outputs of the demand and capacity modelling were used to inform the discussions on the Draft Functional Brief for the new hospital, where additional operational adjustments were made (i.e. to take account of the fact that operationally three Resus bays will be required in the Emergency Department even though the daily demand for these bays would not directly support this).

## 3.3 Existing Hospital Estate Overview

### 3.3.1 History of the site

Jersey General Hospital is a significant 40,032m² facility located in the heart of St Helier and operates as the only acute and general hospital facility on the island. It is located on a heavily developed town centre site of some 1.85 hectares with blocks extending up to eight storeys high.

Most of the current clinical facilities date from the 1960s, but with the granite block dating back to 1765, and as a result exhibits serious levels of dilapidation. Significant elements of building structure and engineering services are now beyond their useful economic life and will need to be replaced in the near future .

In response to concerns over the extent of dilapidation and functional obsolescence, and to ensure that it adopted a responsible approach to premises management, HCS commissioned a specialist report in 2015

that considered the extent of deficiency against current UK NHS premises standards. It considered the use, condition and compliance of the facilities against the following six key aspects.

**Table 7: Six Facet Survey**

| Survey Facet | Approach |
|---|---|
| **Facet 1** – Physical Condition | Reviewing building fabric and engineering services; |
| **Facet 2** - Statutory Compliance Audit | Reviewing Fire, health and safety and other legislation; |
| **Facet 3** - Space Utilisation Audit | Examining the intensity of use of the hospital's spaces and functional areas; |
| **Facet 4** - Functional Suitability Review | Reviewing the internal space relationships, availability and appropriateness of support facilities and their location. |
| **Facet 5** - Quality Audit | Considering spatial amenity, comfort and design appropriateness and quality; |
| **Facet 6** - Environmental Management review | Considering the overall efficiency of the property, with energy being a critical factor. |

An update to this review was undertaken for a second time in 2019 and the findings of this updated six-facet survey are set out below. The survey confirmed the following:

- With the exception of some refurbished areas, the majority of the hospital's external fabric and engineering services have exceeded design life and are considered to meet classification category C, which is below satisfactory standard and needing major replacements within 1 year for engineering elements.
- Although major refurbishment of some areas, such as operating theatres has been undertaken in the last three years, the building footprint is still significantly below the size and configuration that meet the functional requirements of modern operating theatre standards.
- Some aspects of statutory deficiency are difficult to address due the physical construction of the buildings or where only reconstruction would address the issues.
- Many areas of the hospital exhibit poor functional suitability and are classified as below that which would be considered as unacceptable against UK NHS standards (D).
- Due to their age, many of the operational spaces do not meet current Health Building Notes (HBN) standards, restricting both the effectiveness and safety and have poor positional relationships with other functions within the hospital.
- Some building areas are of poor quality in terms of their effectiveness as working environments and as spaces for modern healthcare;
- Spaces are cramped and wouldn't achieve common healthcare standards such as the HBN standards used in the UK
- There is a general absence of rooms dedicated to confidential conversations with staff, patients and carers and between staff members.
- Cramped and inflexible office areas exist on most floors.

Additional detail of the results of the updated six facet survey is provided within section 3.4 The Case for Change.

**Figure 6: Extract from the 2019 Six Facet Survey**

A summary of the key is set out below.

**Key:**

***A:*** *building complies with all statutory requirements and relevant guidance.*
***B/F*** *building where action will be required in the current plan period to comply with relevant guidance and statutory requirements.*
***C:*** *building with known contravention of one or more standards which falls short of B.*
***D:*** *building areas which are below C standard.*
***X:*** *Supplementary rating added to C or D to indicate that nothing, but a total rebuild, or relocation will suffice (that is improvements are either impractical or too expensive to be tenable).*

| Building block | Year of build | Physical Condition | Functional Suitability | Space | Quality | Fire, Health & Safety Requirements | | Energy |
|---|---|---|---|---|---|---|---|---|
| | | | | | | Overall Fire Assessment | Overall Health & Safety Assessment | |
| Blk A Parade Building | 1987 | C | D/X | F | D | C | C | C |
| Blk B 1960 Wing Building | 1960 | C | C | O | C | C | C | C |
| Blk C Granite Building & Gatehouse | 1860 | C | D | O | C | C | C | C |
| Blk C Gatehouse | 1877 | B/C | *N/A* | *N/A* | *N/A* | *N/A* | B | D |
| Blk D Peter Crill House Building | 1950 | C | B | B | C | B | C | C |
| Blk E Gwyneth Huelin Wing Building | 1979 | C | C | C | C | C | C | C |
| Blk F Pathology/ Pharmacy/ Kitchen | 1983 | C | D | O | D | C | C | D |
| Blk G Engineering Building | 1980 | C | C | O | D | C | B | D |

The poor condition of the existing hospital highlighted in both iterations of the six-facet survey is also of broader concern as:

- Its condition and configuration is not in keeping with modern healthcare and is unlikely to be consistent with the contemporary expectations of the island's population.
- As a strategic asset, the hospital's poor condition and potentially more limited capability due to spatial constraints is likely to form a disincentive or barrier to the islands efforts to recruit key individuals to work and live on the island.
- Adopting a 'watch and wait' estates strategy can only be a very time limited approach as the likelihood of a building failure or statutory breech will only increase.

## 3.4 The Case for Change

The Case for Change detailed below was originally produced by the HCS team as part of the SOC development in 2020. The Case for Change was reviewed and updated where appropriate by the HCS team in early 2021 as part of the OBC Development.

The Case for change was reviewed and confirmed at the Clinical & Operational Client Group (COCG) meeting held on Thursday 4th March 2021. The attendees at the meeting were:

- Director General, HCS (CHAIR)
- Head of Communication - HCS
- Chief Pharmacist
- Associate Managing Director, Modernisation
- Group Director, Commercial Services
- Consultant Gastroenterologist
- Chief Clinical Information Officer
- Operational Programme Manager
- Policy Principal Employment and Social Security

- Head of Estates
- Associate Managing Director, Care Groups
- Therapies Lead

### 3.4.1 The current condition of the hospital estate

As has been set out the General Hospital site comprises of a number of buildings across a large site, with clinical accommodation dating generally from the 1960's but with the Granite Block dating back to 1765. There is a disparate collection of buildings developed over a long time to different health policies, operational practices and construction standards. As a result, facilities are in poor condition with the worst areas of building and engineering infrastructure presenting daily operational difficulty.

As a result of the Six Facet Survey, it is now known that some aspects of the hospital are in a sufficiently poor condition that the risk of building failure is high and is increasing each year. In these cases, the scale of such a failure would severely limit the hospital's ability to manage its way through any emerging crisis resulting in a significant risk of building closure and health service interruption.

A detailed 'six-facet' survey undertaken by specialist consultants in 2015, confirmed that, despite significant capital investment, the decline had continued now to a point where full refurbishment or complete infrastructure replacement would now be required.

Faced with this, the hospital's estates team identified the major areas of concern and implemented a tactical backlog investment plan to address the most serious and technically correctable issues. However, this recognised and relied upon the intention to develop a new hospital and therefore targeted investment to key areas of the poorest condition or of imminent failure only whilst implementing increased monitoring of the hospital's overall condition. Consequently, significant dilapidation remains.

An updated review was carried out in 2019 which highlights further rapid deterioration of the overall condition of the Hospital. Reconfiguration of the current building will, in nearly all aspects, require investment to address infrastructure issues whilst at the same time not addressing the inherent space, clinical flow and adjacency issues.

Complete redesign of the hospital is required to meet the current and future acute clinical needs of the population and detailed clinical reconfiguration will form an integral part of the future development of a new hospital.

The table below summarises some aspects emerging from the 2019 six-facet report and confirms the extent of corrective work needed and which could not be delivered in an active General Hospital with little redundancy.

**Table 8: 2019 six-facet survey summary**

| Estate Element | Condition |
|---|---|
| **Fire Code Compliance** | There is currently limited means of horizontal evacuation for patients possible above the 3rd Floor level of the Parade Block. Investment in sprinkler systems, fire escape lifts and improved fire safety compartmentalisation would severely reduce the functionality of this block given that it was not initially designed to accommodate them. Correcting fire safety would therefore result in a net space reduction.<br><br>Additional fire compartmentation works have been commissioned in ward locations that do not impair on the space or ward activity. |

| | |
|---|---|
| **Fire Alarm Systems** | The Fire Alarm and Detection System was obsolete and failing. A critical system, this was replaced during 2016/17. Requiring full engagement of designers, users, contractors and Estates over a two-year period, with fire detection coverage being maintained throughout, requiring excessive management resources and communication at all times. |
| **Water System Compliance** | The aged design of the current hot and cold-water systems provides a risk of contamination from Legionella and Pseudomonas aeruginosa. Insufficient water flow through pipework due to change of use/models of care within wards/departments, and temperature-controlled water faucets mean that Legionella avoidance will become increasingly challenging. Intensive management controls and continuous investment in remedial works and ongoing system disinfection is completed to reduce risk. However, evidence in other hospitals indicates that system replacement is a high priority but again, could not be achieved without significant disruption to the operational hospital. |
| **Electrical systems and emergency power** | Significant elements of the hospital's electrical distribution system are dilapidated and would not meet common hospital standards such as the UK HBN standards. Emergency generators date from the 1960's and switchgear, transformers and electrical infrastructure installed in the 1970's are well beyond their 30-year life expectancy.<br><br>New generators have been installed within the existing grounds of the General Hospital and connected to the existing electrical infrastructure. |
| **Medical Gas Supply** | The medical gases infrastructure, plant and manifold rooms would not all meet current UK Health Technical (HTM 02-01) Standards. The provision of medical gases to some departments is also below current minimum standards with the Maternity Unit having no piped Entonox, Renal Unit having no piped oxygen or vacuum. Site wide infrastructure is weak, missing elements of plant and pipework needed to meet the level of supply security expected in a modern hospital. The use of cylinder-based supplies is therefore high but poor site configuration and the lack of facilities results in inappropriate storage and poor manual handling practices.<br><br>The existing piped system requires modernisation to comply with current standards such as the UK HBN standards. The existing configuration poses an increased risk to safety shut off and compliance. This is currently being reviewed as part of the safety backlog work. Mitigation has been carried out on elements of the existing MTHW system to reduce risk but ongoing works are still required, on a reactive basis, to manage the system until the new facility is ready. |
| **Mains Drainage** | The current foul drainage systems vary in age, material and design. In many cases they were not designed to meet their current loading and, combined with their poor internal condition, are leading to increased blockages and overflow within the hospital.<br><br>Previous Incidents have required partial ward/department shut downs, requiring deep cleaning and decontamination to IP&C standards and/or the contaminated equipment/furnishings and flooring replacement. |

| | |
|---|---|
| | Existing concealed drainage runs are inaccessible which limits survey, repair and replacement. This has an impact on developing equipment i.e.: macerators cannot be installed. |
| **Air Handling and Ventilation** | Specialist healthcare air handling and extract units providing 24-hour conditioned air for the hospital are corroded failing mechanically, and obsolete. Failure of systems that filter air to Ultra clean standards or provide positive pressures will result in ward and department closure. |
| **Energy Centre** | The current Energy Centre requires major works to replace existing boilers, chimney, primary heating system, ancillary plant items, Building Management System and pipework hangers. As the primary heating and hot water source for the hospital this centre presents a significant single point failure risk if not mitigated. |
| **Asbestos** | There is significant asbestos within the current hospital following its historical use to thermally insulate steam, and other hot water pipework. Its presence makes building maintenance and refurbishment extremely difficult with its specialist removal having to be managed during any building change. Asbestos management plans are in place to ensure the safety of staff, the public and contractors. |

### 3.4.2 Mental health services

Orchard House, St Saviours currently delivers Mental Health Services, including inpatients. The geographical isolation of Orchard House and the current condition of the environment, both internal and external, require the service to be co-located into the new hospital campus.

Orchard house is currently undergoing essential maintenance works at a cost of £670k in order to comply with a Health and Safety Inspectorate (HSI) notice. There may also be a requirement for fire stopping (circa £200k) and failing heating pipes (£TBC) with the expectation that these can be managed within existing contingencies. However, despite this immediate spend, Orchard House is expected to close within the next 18 months with Mental Health Services transferring into Clinique Pinel and Rosewood House. In order to accommodate the transfer of these services in 2021, Clinique Pinel is currently undergoing a £7.9m refurbishment / extension. The project is currently due to complete April 2022.

The challenges facing Mental Health Services are well known and some elements are consistent with most health and care jurisdictions. Key issues include the following:

- Physical and mental health services are not currently integrated.
- There is a recruitment challenge for key skilled roles such as Registered Mental Health Nurses, Medical Staff and Allied Health Professionals.
- The current Mental Health Estate doesn't provide a therapeutic environment of care.
- There is a lack of care co-ordination.
- The wider system of Government such as Housing and Economic prosperity need to be linked to our strategic plans for mental health.

The need for the relocation of the service provided is primarily driven due to the clinical, operational and environmental risks. The upgrade of the current environment was considered but ruled out due to a number of the identified risks not being mitigated through this approach. The key risks are:

**Operational**

- Isolated location, there is no direct support from other health facilities or colleagues during times of challenge.
- Lack of support or resource for physical conditions

**Environmental (These have been mitigated over the past year as best as possible)**

- Poor external lighting
- Potholed roads leading to Orchard House
- Tiles from Queens House falling into outside garden areas
- Poor sight lines
- Inadequate windows (not ligature free)
- Problems with the internal nurse alarm system (possibly due to the amount of granite)
- Legionella risk

**Clinical**

- No enhanced care facilities to Psychiatric Intensive Care Unit (PICU) standards
- Limited availability to provide a Place of Safety
- Risk to patient and staff safety due to young people breaking into Queens House

As a result, facilities are in poor condition with the worst areas of building and engineering infrastructure presenting daily operational difficulty. Complete redesign of the mental health facilities is required to meet the current and future mental health needs of the population.

### 3.4.3 Other healthcare facilities in Jersey

In addition to the Jersey General Hospital and St Saviours sites, there are two additional sites which deliver healthcare services which would be impacted by a new build hospital if a decision was taken to proceed with a new build hospital. These sites are:

- Overdale Hospital site
- Five Oaks

Overdale provides a range of healthcare services including rehabilitation, a children's development and therapy centre, older people mental health and memory services and specialist outpatient facilities and clinical and non-clinical support services.

Five Oaks currently provides the Theatre Sterile Supply Unit which is also being considered for inclusion in a potential new build hospital in order to achieve greater adjacencies and efficiencies. Jersey General Hospital's catering facilities are currently delivered off-site at the St Peters Industrial Park. This is rented at a cost of circa £313k per annum over a 20 year lease (circa £6.2m).

More detail is included in section 4.6 (Functional Brief) which details the range of services proposed to be included in the new hospital and section 6.10 (Opportunities in relation to the Our Hospital Programme) which considers the potential options for sites which could become vacant following the building of the new hospital.

### 3.4.4 Poor functional suitability and configuration of the site

In addition to its poor condition, the estate of Jersey General Hospital is inappropriately configured to deliver safe and effective care. The condition of the buildings and poor layout of the site make it a challenging environment to deliver 21st century care. This poses many challenges in terms of delivering healthcare services at the hospital safely, to a high clinical standard and efficiently.

Consequently, it is not considered appropriate to plan to continue to provide clinical services in the existing hospital given that it fails to meet current building and operational standards, nor can it safely and effectively cater for the projected clinical demand.

In particular, there are increasing levels of operational risk, actual in-service failure and elevated operational cost due to following:

- The existing provision of functional types, sizes and relationships of rooms do not meet current UK healthcare design guidance, space standards and current best working practices
- The existing provision of the numbers of beds available and the provision of single bedroom accommodation does not meet current emergency demand, nor projected future daily demands whilst operating at recognised best practice occupancy rates
- The constraints imposed by an estate comprising a disparate collection of buildings and associated building services' infrastructure of varying vintages from the 1800s to the present day, lead to inefficiencies in linking the various clinical services throughout the hospital and restrict the opportunities for adapting the existing facilities to meet current and future demands
- The alteration and refurbishment of the existing buildings will never, as a consequence of the inherent condition and compromises in space and clinical adjacencies, allow the same level of benefits to be secured as would be possible in the development of a replacement hospital.

Ad-hoc development of the hospital historically has resulted in a number of poor adjacencies between departments. The layout of the hospital is not conducive to efficient or high quality healthcare, with significantly large distances between departments that would benefit clinically from being adjacent. This is both inefficient, involves the public transfer of patients, presenting real privacy and dignity issues and also represents clinical safety and risk issues given the distance with which patients need to be transferred. For example, the current JGH delivers poor adjacencies between diagnostics (such as imaging) and the departments such as Inpatients and Emergency. This increases travel times for both patients and staff, which can be crucial in emergency situations, but which also reduces efficiency day-to-day.

The age and the piecemeal construction of the site has resulted in a lack of flexibility. There is very little generic space that could be used to support changes in services and models of care over time. This means that changes to services require expensive and suboptimal capital developments that have to fit around existing buildings. This limits the potential for future service development as well as the potential for new technology and innovation. It is therefore acknowledged that clinical adjacencies cannot be addressed on the site without major reconfiguration or redevelopment.

The impact of poor adjacency therefore includes:

- Patients’ journeys around the site being below expected standards
- An increased cost for portering services and ambulance services needed to transport patients safely
- Increased clinical risk, in particular due to the lack of adjacency between critical departments such as A&E, maternity, theatres and Intensive Care Units.

Despite significant elements of urgent capital investment, the condition of the hospital has continued to deteriorate in recent years. Alongside this, the hospital has had to contend with increasing activity driven by population change and a general increase in the expectations of islanders. As a result, the pressure on the hospital has never been higher with aspects of poor condition and spatial organisation hampering performance.

The impact of this on the hospital and patients includes:

- Poor privacy, dignity and patient experience
- Only a minority of patients having the choice of a single room - this may have a particular impact on some groups of patients and limits choice to all patients admitted
- Infection control is severely hampered by the lack of isolation facilities

- A poor ability to use space flexibly, in part due to issues with access to toilet facilities
- Large bays in typical wards are difficult to clear without having a major impact on bed availability.

The following headline issues that have been identified remain of significant concern for the provision of health and care services and the urgency for these issues to be addressed is increasing over time:

- The inefficient and aging design of the estate has led to poor clinical adjacencies
- There are poor space standards which are compromising effective care delivery
- There is a lack of flexibility to accommodate service delivery
- There is poor separation of clinical and non-clinical flows
- There is poor gender separation and lack of privacy
- There is poor supporting mechanical and engineering infrastructure
- There is poor fire compartmentalisation to allow progressive horizontal evacuation
- Maintenance costs are continuing to escalate, as mechanical and electrical plant reaches the end of its useful life.

The current configuration of the site means it is not set up to meet these requirements and would need significant redevelopment and change to be in a position to deliver this ambition properly.

These spatial dilapidation difficulties cannot be addressed through piecemeal replacement of building elements and a complete redesign of the hospital will be required to meet the current future acute clinical needs of the population.

In the absence of this, pressure will continue to grow and the hospitals overall contribution to transformation strategies such as the new care models, like the Jersey Care model or the Digital Strategy, will be impaired.

### 3.4.5 Poor resiliency

As detailed above, there is an increasing risk of infrastructure failure to a considerable proportion of the existing campus. Without careful management this would potentially therefore impact on the safe, effective and consistent delivery of operational services and ultimately therefore care for patients. Whilst there is ongoing management to mitigate the risk of failure to the physical environment, this cannot eliminate the risk of a serious failure i.e.: hot water services.

## 3.5 The Case for Change: Conclusion

The Our Hospital Project needs to deliver a meaningful change to the delivery of health services in Jersey and deliver a hospital which is fit for purpose today and in the future. Based on the analysis, there is a clear case for change:

- The condition of the estate is poor and presents significant challenges that will increase in around five years' time. Facilities are in poor conditions with the worst affected areas of the building presenting daily operational difficulty. Some aspects of the hospital are in such poor condition that the risk of failure is increasing.
- In order to achieve the expected benefits of more effective ways of working and/or new models of care, a significant change will be required in the way hospital services are delivered
- Reconfiguration of the current building will, in nearly all aspects, require significant refurbishment costs to address infrastructure issues and high ongoing lifecycle expenditure whilst at the same time not addressing the inherent space, clinical flow and adjacency issues.

There is an exciting vision for the Our Hospital project which can support and enable change across the way health services are delivered in Jersey as well as providing a hospital facility which is fit for purpose and delivers Value for Money to the people of Jersey.

## 3.6 Our Hospital Project investment objectives

### 3.6.1 SOC Stage

As part of the development of the SOC, a workshop was held on Thursday 27th February 2020 with the HCS Executive Group in order to discuss and agree the following:

1. The Our Hospital Project investment objectives
2. The Critical Success Factors
3. A short-list of options to progress to Outline Business Case (OBC).

The following attended the workshop:

- Director General, Health and Community Services (HCS)
- Group Managing Director, Health and Community Services
- Group Medical Director, Health and Community Services
- Chief Nurse, Health and Community Services
- Human Resources Director, Health and Community Services
- Health Modernisation Director, Health and Community Services
- Head of Finance Business Partnering, Treasury and Exchequer
- PwC Healthcare Lead.

The Project investment objectives for any potential investment were developed using a workshop approach to ensure that the outcomes required by key stakeholders have been considered and included.

The key objectives of the Our Hospital Project described at SOC were:

1. To provide high quality, efficient and effective care for all patients and service users that is timely, accessible and delivers the best possible experience for patients, service users, visitors and staff
2. To deliver integration of physical and mental health care and services including co-location of an Acute and General Hospital and Mental Health Services
3. To deliver a healthcare estate including an Acute and General Hospital that is safe, compliant, flexible and right sized for the future delivery of clinical and other services, and enables service transformation
4. To deliver a new hospital that ensures the financial sustainability of the health economy
5. To deliver a new hospital that contributes to building a thriving community and well-being of staff and patients with positive socio-economic and environmental impacts.

The outcomes of the HCS Executive Group workshop were tested and re-affirmed at the Associate Medical Directors meeting on Wednesday 18th March 2020.

### 3.6.2 OBC Stage

During the development of the OBC, a workshop was held with the Our Hospital Project team on Monday 8th February 2021 in order to review the Our Hospital Project Investment Objectives.

The following attending the workshop:

- Clinical Director Our Hospital Project
- Health Modernisation Director, Health and Community Services
- Client Project Manager
- Our Hospital Project Cost Consultants

This workshop proposed an update to Objective 3 in order to recognise that the Our Hospital Project is to deliver a new acute and general hospital, not a full healthcare estate and also to emphasise the importance of delivering facilities which can be more easily maintained in the future. It is intended that this objective captures the requirement to provide a facility that is able to support services transformations, such as the new models of care, and the digital strategy. All other objectives were confirmed as still being appropriate.

The updated objectives are listed below:

1. To provide high quality, efficient and effective care for all patients and service users that is timely, accessible and delivers the best possible experience for patients, service users, visitors and staff
2. To deliver integration of physical and mental health care and services including co-location of an Acute and General Hospital and Mental Health Services
3. To deliver an Acute and General Hospital with co-located mental health and other services currently delivered offsite that is safe, compliant, flexible, delivers an optimised planned preventative maintenance regime and is right sized for the future delivery of clinical and other services, and enables service transformation
4. To deliver a new hospital that ensures the financial sustainability of the health economy
5. To deliver a new hospital that contributes to building a thriving community and well-being of staff and patients with positive socio-economic and environmental impacts.

The updated objectives were reviewed and confirmed at the Clinical & Operational Client Group (COCG) meeting held on Thursday 4th March 2021. The attendees at the meeting were:

- Director General, HCS (CHAIR)
- Head of Communication - HCS
- Chief Pharmacist
- Associate Managing Director, Modernisation
- Group Director, Commercial Services
- Consultant Gastroenterologist
- Chief Clinical Information Officer
- Operational Programme Manager
- Policy Principal Employment and Social Security
- Head of Estates
- Associate Managing Director, Care Groups
- Therapies Lead
- Associate Medical Director Surgical Services (TEAMS)
- Consultant in Anaesthesia & Intensive Care
- Associate Medical Director Medicine
- Head of Clinical Support services and Cancer AMD

### 3.6.3 SMART Objectives

Green Book guidance requires that all objective identified as part of the OBC must be SMART. I.e.

- Specific
- Measurable
- Actionable
- Relevant
- Time-based

The table below sets out how each Objective will be SMART. Work will continue to refine the mechanisms for measuring the objectives, and for setting timescales to achieve them, based on the benefits developed for FBC.

**Table 9: SMART Objectives**

| **Objectives** | **To provide high quality, efficient and effective care for all patients and service users that is timely, accessible and delivers the best possible experience for patients, service users, visitors and staff** | **To deliver integration of physical and mental health care and services including co-location of an Acute and General Hospital and Mental Health Services** | **To deliver an Acute and General Hospital with co-located mental health and other services currently delivered offsite that is safe, compliant, flexible, delivers an optimised planned preventative maintenance regime and is right sized for the future delivery of clinical and other services, and enables service transformation** | **To deliver a new hospital that ensures the financial sustainability of the health economy** | **To deliver a new hospital that contributes to building a thriving community and well-being of staff and patients with positive socio-economic and environmental impacts** |
|---|---|---|---|---|---|
| **Specific** | Efficient and effective care for patients, service users, visitors and staff. | Two areas of health to be integrated. | Delivering services which are safe, compliant, flexible. Enabling service transformation. | Financial sustainability for the health economy | Building a thriving community.<br>Well-being of staff and patients. |
| **Measurable** | Timely, accessible services.<br><br>Users overall experience, Staff and Patient Surveys. | Integration and co-location of two services. | Delivery of an Acute and General Hospital with the co-located Mental Health and other Services. | Delivery of the new hospital.<br>Financial impact on the health economy.<br>Affordability of the scheme to be monitored on an on-going basis. | Delivery of the new hospital.<br>Well-being of staff and patients.<br>Staff and Patient Surveys |
| **Actionable** | Objective to be assessed following opening of the new hospital against current standards and the ongoing results of Staff and Patient surveys | Objective to be assessed following opening of the new hospital against current standards and the ongoing results of Staff and Patient surveys | Objective to be assessed following opening of the new hospital against current standards | Affordability of the scheme to be monitored on an on-going basis | Objective to be assessed following opening of the new hospital against current standards and the ongoing results of Staff and Patient surveys |
| **Relevant** | Improved health services. | Improved health services. | Improved health services. | Financial sustainability of the health economy. | Positive socio-economic and environmental impacts. |

| | | | | | |
|---|---|---|---|---|---|
| **Time-based** | Objective to be monitored for 5 years following new hospital opening | Objective should be achieved with opening of new hospital | Objective should be achieved with opening of new hospital | Objective to be monitored for 5 years following new hospital opening | Objective to be monitored for 5 years following new hospital opening |

## 3.7 Benefits

### 3.7.1 Long-list of benefits produced at SOC Stage

The table below outlines the key benefits of the Our Hospital Project by stakeholder group as developed as part of the SOC development in February 2020.

**Table 10: SOC Benefits**

| Stakeholder | Benefits |
|---|---|
| Patients | • Improved outcomes for patients and parity for mental health<br>• Improved patient satisfaction/experience/place of healing<br>• Facilities which address the specific needs of all patients<br>• Continue the provision of immediate and urgent care 24/7/365<br>• Promotion of the privacy and dignity of patients<br>• Hospital environment and internal architecture which supports the health and wellbeing of patients and their families<br>• Enhance offer for specialist services for patients with long term conditions<br>• Efficiency of patient experience – i.e. can the patient needs be met in one place<br>• Improved outcomes for children through Putting Children First<br>• Delivering greater accessibility for all including car parking |
| Staff | • Increased job satisfaction due to better facilities and a more attractive place to work<br>• Support the development of staff skills including education, training and development<br>• Increased staff retention and recruitment of highly skilled staff<br>• Ensured sustainability of service provision<br>• New facilities will enable multi-disciplinary team working<br>• Improved physical surroundings whilst providing healthcare services<br>• Staff wellbeing |
| Wider Community | • Contributing to the success of the Island<br>• A facility that is owned and trusted by Islanders and acts as an integral point for the local community.<br>• Local job creation during construction and for facilities management<br>• First class Healthcare facilities<br>• Creation of low carbon generating facilities<br>• Provisioning for Community Diversity |
| Health and Community Services | • Greater flexibility to changes in demand<br>• Increased integration enabling greater efficiency across services<br>• Healthcare facilities which are up to the standard islanders expect in relation to the range of healthcare services offered<br>• Facilities which are adaptive to evolving standards in clinical practice<br>• Promote integration of health services |

| Stakeholder | Benefits |
|---|---|
| | • Deliver greater choice for patients<br>• Cyber secure, digitally enabled, paperless and AI healthcare provision |

### 3.7.2 OBC Stage

During the OBC workshop the long-list of benefits at the SOC was reviewed. The following revised set of benefits was produced which takes into account the development of the Project over the past 12 months and in particular the impact of the Covid-19 pandemic.

**Table 11: OBC Benefits**

| Stakeholder | Benefits |
|---|---|
| Patients | 1. Safe, reliable and quality assured care with improved & predictable outcomes for patients and parity for mental health<br>2. Improved patient satisfaction and experience<br>3. Facilities which address the healthcare needs of all patients<br>4. Continued provision of immediate and urgent care 24/7/365<br>5. Optimising the privacy and dignity of patients<br>6. Hospital environment and internal architecture which supports the health and wellbeing of patients and their families<br>7. Improved outcomes for all, particularly for children through Putting Children First<br>8. Delivering greater accessibility for all including car parking<br>9. Improved patient safety and security<br>10. A design which is flexible and future proof by offering resilience and continuity<br>11. Better signposting, easier wayfinding leading to a more efficient patient experience – i.e. the patient needs be met in one place |
| Staff | 12. Increased job satisfaction due to improved facilities and physical surroundings, leading to a more attractive place to work<br>13. Support the development of staff skills including education, training and development<br>14. New facilities will deliver greater standardisation (including room layout and equipment)<br>15. The environment will enable greater multi-disciplinary team working<br>16. Single site working benefits for staff who work across HCS and the third/private sector<br>17. Hospital facilities which attract highly skilled staff and increased existing staff retention |

| Stakeholder | Benefits |
|---|---|
| | 18. Improved staff well-being |
| Health and Community Services | 19. Greater flexibility to changes in demand and evolving standards in clinical practice<br>20. Increased integration enabling greater efficiency across services<br>21. Healthcare facilities which are to the standard islanders expect/compliant building standards<br>22. Promote integration of health services<br>23. Deliver greater choice for patients<br>24. Design to optimise and facilitate planned and preventative maintenance<br>25. More efficient maintenance provision due to co-location and modern facilities<br>26. Contributing to sustainable wellbeing to help achieve the community vision set out in Future Jersey<br>27. A facility that is owned and trusted by the people of Jersey and acts as an integral point for the local community, promoting a sense of pride for islanders<br>28. First class Healthcare facilities |
| Wider Community | 29. Provisioning for Community Diversity<br>30. Hospital facilities and public realm which could be used by the wider community. The hospital can be seen as a catalyst for wider community engagement/ improvements<br>31. Job creation opportunities for Islanders<br>32. Development of apprenticeships and increased training opportunities<br>33. Creation of low carbon generating facilities<br>34. Increased private patient provision to deliver a surplus which can be reinvested into HCS services<br>35. The opportunity to re-provision, re-develop or realise a commercial receipt at a number of buildings which could become vacant following the completion of the new hospital |

The updated benefits were reviewed and confirmed at the Clinical & Operational Client Group (COCG) meeting held on Thursday 4th March 2021. The attendees at the meeting were:

- Director General, HCS (CHAIR)
- Head of Communication - HCS
- Chief Pharmacist
- Associate Managing Director, Modernisation
- Group Director, Commercial Services
- Consultant Gastroenterologist
- Chief Clinical Information Officer
- Operational Programme Manager
- Policy Principal Employment and Social Security
- Head of Estates
- Associate Managing Director, Care Groups

- Therapies Lead
- Associate Medical Director Surgical Services (TEAMS)
- Consultant in Anaesthesia & Intensive Care
- Associate Medical Director Medicine
- Head of Clinical Support services and Cancer AMD

## 3.8 Constraints

The constraints of the project are:

- Physical safety of the hospital's patients and staff must be maintained throughout the life of the project by ensuring sustainable provision of healthcare services.
- Meeting Planning requirements.
- Achieve completion of Clinical Commission by the end of 2026.
- Leading to a fast-tracked compressed timetable
- Accessibility – language, disability access.
- Affordability of the project.
- Lack of construction supply chain choice due to industry demands
- Political uncertainty

## 3.9 Dependencies

The dependencies of the project are:

- An adequate financing option is available and affordable.
- Ensuring there are sufficient public transport options to the site for patients and staff.
- Planning consent for the construction of the hospital is vital to the project.
- The business case is approved by the Government of Jersey and any other relevant bodies.
- Acquiring land, including use e of CPO Powers where required.

# 4. THE ECONOMIC CASE

## 4.1 Introduction

### 4.1.1 Purpose of the Economic Case

The case for change has concluded that in around five years' time the existing hospital will reach a point where significant intervention is required to avoid the estate become unusable. The running costs will quickly become unaffordable due to the amount of investment required to bring the hospital up to the statutory and regulatory standards expected.

The Economic Case considers the potential options for interventions to address these issues and assesses the shortlisted options using costs, benefits, risk and Net Present Cost economic analysis in order to confirm a Preferred Option.

### 4.1.2 Work undertaken at the SOC Stage and updates to the Case in this OBC

**SOC Stage**

During the development of the SOC, the following process was undertaken:

- A longlist of options was developed and assessed using Critical Success Factors. This identified that a New Build option was the only option that met the project's strategic objectives and was shortlisted along with a Do Minimum comparator (as required by the Green Book). This shortlisting was approved through the SOC approval process.
- The New Build option was site agnostic at the time of shortlisting, as the process was being run in parallel to the site evaluation process.
- The site evaluation process assessed a broad range of locations and led to the selection of Overdale being recommended by the Political Oversight Group (POG) to the Council of Ministers (COM), who endorsed that decision and took the proposition to the States Assembly for Approval. Approval was given by the States Assembly in November 2020.
- High level analysis on cost, benefits and risk was undertaken on the New Build versus the Do Minimum Comparator and the New Build at Overdale was selected as the preferred way forward.

**OBC Stage**

The OBC builds on the analysis undertaken at SOC stage, and in particular provides new analysis on costs, benefits and risks with a new Economic Appraisal, the key updates for which are listed below:

- Development of the Do Minimum/Baseline Comparator: further work was undertaken to define and cost the Do Minimum comparator which highlighted that to continue the existing health services in Jersey, significant construction work around the HCS estate would be required, leading to increased costs A specific costed risk register for this has also been prepared by the GoJ Cost Consultant.
- Development of the New Build option (preferred way forward): A RIBA2 design has been developed with the Design & Delivery Partner (DDP), and work on RIBA3 has commenced. The design has been costed by the DDP and benchmarked by the GoJ OHP Cost Consultant to assess risk and opportunities. As with the Baseline Comparator, a risk register has also been prepared and costed.
- Benefits: Additional work to identify and refine benefits has been undertaken, and particularly to start the process to quantify benefits where possible. Workshops were undertaken to qualitatively score benefits and approved through a number of sessions with the HCS Executive, the Our Hospital Citizens' Panel and the Our Hospital Health Workers' Panel.

Other sections of the Economic Case have been reviewed and updated where required but remain substantively the same as with the SOC (e.g. longlisting process, site evaluation) and are included for reference.

## 4.2 Critical Success Factors

At the SOC stage, the Economic Case assessed the options for intervention to establish the preferred way forward. To facilitate this process, a workshop was held on Thursday 27th February 2020 with the HCS Executive Group in order to discuss and agree the following:

1. The Our Hospital Project investment objectives
2. The Critical Success Factors
3. A short-list of options to progress to Outline Business Case (OBC)

The following attending the workshop:

- Director General, Health and Community Services (HCS)
- Group Managing Director, Health and Community Services
- Group Medical Director, Health and Community Services
- Chief Nurse, Health and Community Services
- Human Resources Director, Health and Community Services
- Health Modernisation Director, Health and Community Services
- Head of Finance Business Partnering, Treasury & Exchequer
- Consultant Trauma and Orthopaedic Surgeon
- PwC Healthcare Lead

The Critical Success Factors were developed to support in the shortlisting exercise, giving consideration to the strategic objectives outlined in the Strategic Case. They provide the key outcomes that must be achieved by the project. These were agreed through the workshop set out above with key stakeholders and are provided below:

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

The outcomes of the HCS Executive Group workshop were tested and re-affirmed at the following additional groups:

- Our Hospital Project Team – Wednesday 4th March 2020.
- Associate Medical Directors Meeting – Wednesday 18th March 2020 (virtual meeting).

## 4.3 The long list

### 4.3.1 Overview of the longlist

The longlist of options was identified at a workshop approach with key stakeholders. As outlined above, the site evaluation process was undertaken in parallel to this process and therefore the new build option was site agnostic during the SOC shortlisting process.

The table below outlines the longlist of options.

**Table 12: The SOC stage longlist of options**

| Option | Description |
|---|---|
| Do Nothing | Keep the site running without significant investment in the infrastructure:<br>• Continue with current approved capital programme (£5m in 2020)<br>• Continue to operate under a 'watch & wait' policy for any urgent repairs<br><br>The functionality of the hospital remains the same with:<br>• No increase in capacity in any clinical speciality<br>• No change to current clinical adjacencies<br><br>It is assumed that this option results in the closure of the existing hospital in 2026. |
| Do Minimum | Keep the site fully open and safe, maintaining the current configuration of services & facilities:<br>• Address current backlog maintenance through investment<br>• Address critical clinical compliance issues and bring healthcare services up to modern standards<br>• Targeted investment in new build facilities to increase capacity<br>The functionality of the hospital would remain largely the same with no change to current clinical adjacencies. |
| Minor refurbishment | Undertake the full backlog maintenance as well as invest in minor additional refurbishments to improve patient experience (e.g. rolling ward refurbishment) but operating within the confines of the existing infrastructure.<br><br>This requires the building of a temporary Clinic Block to maintain capacity whilst works are undertaken. |
| Major refurbishment (hospital only) | Phased decant and refurbishment (e.g. floor by floor), making use of existing buildings.<br>This would enable some improvements to functional suitability but working within the site constraints.<br>This requires the building of a temporary Clinic Block to maintain capacity whilst works are undertaken. |
| Major refurbishment (hospital & Orchard House) | As with major refurbishment of hospital, but additionally refurbishing Orchard House. |

| | |
|---|---|
| New build (site agnostic) | The build of a new hospital (site to be determined through separate site evaluation process).<br>This will enable a hospital that is designed to meet the requirements of HCS, with the flexibility to meet service transformation needs.<br>Following the outcome of the Site Evaluation Process, this option will be split into 1 or 2 site specific shortlisted options. |

### 4.3.2 Longlist appraisal

#### Approach

The longlist of options included all potential interventions, including those that may not be viable to implement.

A shortlisting workshop was undertaken to identify the viable and non-viable longlist options. The non-viable options were not be taken through for further analysis at the SOC Stage.

To identify the non-viable options, each option was assessed against the Critical Success Factors set out in section 4.2 using the following criteria:

**Table 13: Critical Success Factor criteria**

| Score | Description |
|---|---|
| Red | Fails to meet CSFs |
| Amber | Meets CSF but is less attractive |
| Green | Meets CSF |

If an option scored red in any of the Critical Success Factors, it was deemed unviable and therefore not short-listed. The outcome of the appraisal is shown in the table below.

**Table 14: SOC stage longlist appraisal**

| No. | CSF | Do Nothing | Do Minimum | Minor refurbishment | Major refurbishment (hospital only) | Major refurbishment (hospital & Orchard House) | New build |
|---|---|---|---|---|---|---|---|
| 1 | Does the option support the safe delivery of high-quality, efficient and effective care in the future? | | | | | | |
| 2 | Can the option be delivered by the required operational date of 2026? | | | | | | |

| No. | CSF | Do Nothing | Do Minimum | Minor refurbishment | Major refurbishment (hospital only) | Major refurbishment (hospital & Orchard House) | New build |
|---|---|---|---|---|---|---|---|
| 3 | Does the option accommodate a mix of co-located clinical and supporting facilities, including mental health facilities? | | | | | | |
| 4 | Is the option flexible enough to support the delivery of healthcare in the future? | | | | | | |
| 5 | Does the option offer the prospect of continuing to provide safe and effective care during the delivery of the new hospital? | | | | | | |
| 6 | Is the option likely to be affordable from both a revenue and capital perspective? | | | | | | |
| 7 | Does the option allow sufficient space for future expansion if required? | | | | | | |
| | **Conclusion** | No | Yes – shortlisted as baseline in line with Green Book Guidance | No | No | No | Yes – shortlisted as the preferred way forward |

It was agreed that CSF6 – Affordability would not be assessed at the SOC stage as the GoJ Treasury was still exploring options around the financing of the proposed scheme. Affordability would therefore be assessed in the OBC Financial Case once the options have been shortlisted and costed in more detail.

The assessment against the CSFs showed that the 'Do Nothing' and 'Do Minimum' options are not viable because they:

- Do not address the existing functional and spatial deficiencies or deliver any operational improvement.
- Will not provide the necessary capacity to deal with future care models or other service transformation
- Do not support delivery of the digital transformation required
- Do not address future patient expectations by offering limited scope for single bedroom provision or co-location of mental health services.

The decision-making process established that all proposed refurbishment options would also not achieve the CSFs because:

- The existing site would not be able to accommodate the co-location of mental health services without a full redevelopment of the site. This therefore meant that the refurbishment options would not support a core requirement of the Our Hospital Project.
- Without a reconfiguration of services to improve functional suitability, the existing hospital is restricted in its ability to support the delivery of future models of care due to condition of the site and building structures.
- The condition of the building does not lend itself to a major refurbishment without causing significant disruption to patients and staff.
- A refurbishment would not rectify the long-term building condition issues at the current hospital with the situation further complicated by the presence of significant asbestos which makes building maintenance and refurbishment extremely difficult with its specialist removal having to be managed during any building change.
- Continuing to use the existing site would have a negative impact on the recruitment and retention of staff at least through the lengthy maintenance works.
- The current layout and clinical adjacencies at the existing site would never allow the same level of benefits to be derived from a refurbishment option as would be possible in a new build option.

As the New Build option enabled full design and scoping flexibility at the SOC stage, it is able to meet all of the CSFs as the hospital can be designed to meet requirements. It is therefore taken forward for further assessment.

## 4.4 The shortlist

Based on the appraisal set out above, the shortlisted options to be taken forward for further assessment in the SOC are detailed below.

**Table 15: SOC stage shortlist of options**

| Option | Description | Rationale for short-listing |
|---|---|---|
| Do Minimum | Keep the site open and safe, maintaining the current configuration of services & facilities:<br>• Address the current backlog maintenance through investment<br>• Address critical clinical compliance issues and bring healthcare services up to modern standards<br>• Targeted investment in new build facilities to increase capacity<br>• The functionality of the hospital would remain largely the same with no change to current clinical adjacencies. | Shortlisted as the main comparator option as it addresses the statutory and regulatory deficiencies identified by the 6-facet survey, addressing clinical compliance issues with some targeted new build to increase capacity. |
| New build (site agnostic) | The build of a new hospital (site to be determined through separate site evaluation process).<br>This will enable a hospital that is designed to meet the requirements of HCS, with the flexibility to meet service transformation needs. | Shortlisted as the most viable option, scoring the best across all CSFs and meets the project strategic objectives and identified as the preferred way forward. |

The Do Nothing Option was not shortlisted as a comparator option for the following reasons:

- Without substantial investment in the infrastructure of the existing Jersey General, the condition of the physical infrastructure of the buildings would make it unsafe to continue to provide healthcare services from the facility and it will not be possible to continue to deliver services beyond 2026. This would result in healthcare services needing to be predominantly delivered off-Island. The level of investment required to keep the hospital open is set out in the Do Minimum Case.
- If the existing JGH was to continue to be used beyond 2026, there would be significant strain placed on the delivery of safe clinical services. For example, a programme of significant remedial works which involved shutting down areas of the hospital for periods of times (i.e. wards, theatres, clinics etc.) would put significant pressure on the ability of HCS to meet patient needs. At a minimum, this would lead to increased waiting times or more patients going of island in the short term, but in a worst-case scenario without any mitigation could ultimately lead to direct clinical risks, especially in instances where remedial work was reactive.
- The recent Covid-19 pandemic has highlighted that the existing estate is not designed to provide suitable patient / public flows through the hospital or to allow for operational hot / cold sites. This issue was managed in 2020 with the building of the Nightingale Hospital but the existing site could not be safely reconfigured without significant disruption and cancellation of services to deliver operational hot / cold sites in the future. The proposed Our Hospital would however have the flexibility built in.

Therefore, the only comparator option which could be deliverable is the Do Minimum option, which has been shortlisted as the comparator option. More detail on the Do Minimum option is set out in section of this Economic Case.

### 4.4.1 Re-testing of Critical Success Factors and long-list at OBC stage

During the development of the OBC, a workshop was held with the Our Hospital Project team on Monday 8th February 2021 in order to review the Our Hospital Project Critical Success Factors and consider if any changes to the long-list and shortlisting process were required.

The following attending the workshop:

- Clinical Director Our Hospital Project
- Health Modernisation Director, Health and Community Services
- Client Project Manager
- Our Hospital Project Cost Consultants
- Our Hospital Project Management Office.

This workshop concluded that whilst affordability (CSF 6) is critical to the overall delivery of the project, it was however not possible to assess affordability during the workshop as the detailed costs information on each option was not available. On this basis it was agreed to remove Critical Success 6 (affordability) as a Project CSF with affordability now being assessed as part of the cost analysis set out later in the Financial Case. As this CSF had not been used as part of the assessment of long-list options at the SOC stage, no update is required to that assessment. The revised confirmed list of Critical Success Factors is set out below:

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

2. Can the option deliver by the required operational date of 2026?

3. Does the option accommodate a mix of co-located clinical and supporting facilities, including mental health facilities?

4. Is the option flexible enough to support the delivery of healthcare in the future?

5. Does the option offer the prospect of continuing to provide safe and effective care during the delivery of the new hospital?

6. Does the option allow sufficient space for future expansion if required?

The long-list was re-tested and confirmed as still being appropriate at the 8th February 2021 meeting outlined above. No changes were proposed to the Critical Success Factor scoring and therefore the New Build Option remained the only shortlisted option with the Do Minimum option also still shortlisted as the comparator option.

The updated Critical Success Factors were reviewed and confirmed at the Clinical & Operational Client Group (COCG) meeting held on Thursday 4th March 2021. The attendees at the meeting were:

- Director General, HCS (CHAIR)
- Head of Communication - HCS
- Chief Pharmacist
- Associate Managing Director, Modernisation
- Group Director, Commercial Services
- Consultant Gastroenterologist
- Chief Clinical Information Officer
- Operational Programme Manager
- Policy Principal Employment and Social Security
- Head of Estates
- Associate Managing Director, Care Groups
- Therapies Lead
- Associate Medical Director Surgical Services (TEAMS)
- Consultant in Anaesthesia & Intensive Care
- Associate Medical Director Medicine
- Head of Clinical Support services and Cancer AMD

## 4.5 Site Evaluation

In a parallel process to the development of the SOC, the Our Hospital Project team undertook a detailed site evaluation process to identify the best site for the development of a new hospital. The first phase was a five stage process engaging with multiple stakeholders to identify a shortlist.

- Stage 1 – Call for sites
- Stage 2 – Clinical criteria for site assessment – site area
- Stage 3 – Clinical criteria for site assessment - timetable
- Stage 4 – Criteria by the Citizens' Panel
- Stage 5 – Application of the criteria by Site Evaluation Panel: Shortlisting

A longlist of 82 sites was identified in stage 1 comprising suggestions made by members of the public through a "call for sites", along with the suggested sites from the previous Future Hospital project.

The longlist of sites was reduced from 82 to 39 in stage 2 through the application of the minimum site requirement. Health Planning experts and colleagues from Health and Community Services determined the minimum ground floor size/footprint of the hospital through an assessment of the clinical services

required on the ground floor. Additional areas to the ground floor brief included areas for internal circulation and service space, external areas (i.e. ambulance drop off and patient drop-off/pick-up), a hospital service yard, essential services which could be located on adjacent or nearby sites and car parking.

Three sizing and configuration options were established which could enable the required hospital to be constructed:

- **Option 1**- main site and directly adjacent ancillary site that could accommodate all support services
    - Essential ground floor hospital area requirement = 23,243m$^2$
    - Adjacent site = 8,504m$^2$
    - Car parking – 800 spaces over 2 x floors = 9,219m$^2$

- **Option 2** – main site with basement to accommodate essential support services and a separate facility within 15 minutes' walking distance for non-essential support services.
    - Essential ground floor hospital area requirement = 22,890m$^2$
    - Adjacent site = 3,590m$^2$
    - Car parking – 800 spaces over 2 x floors = 9,219m$^2$

- **Option 3** – a variant of Option 2 but displacing mental health facilities, theatre sterile supply unit, engineering and estates functions to a separate site no more than 15 minutes' drive from the main site. This option was recommended by HCS clinical and health professionals to not be pursued. HCS considered that this option was not clinically palatable and was an excessive dilution of the ambitions of the JCM, particularly with respect to co-locating within or adjacent to the main hospital. As a result, Option 3 was not explored further.

Option 1 and option 2 were taken forward with the total area then assessed against the long list of potential sites.

In stage 3, each of the 39 sites were then assessed to determine if any factors restricted the deliverability of an operational hospital by the end of 2026. The following factors were considered as part of the deliverability criterion:

- Ownership of the proposed site
- Availability of developed land

The application of the criteria reduced the list of sites from 39 to 17.

A Citizens' Panel was formed following an anonymised selection process from Island applications who met the selection criteria. This process was aimed at ensuring that the Panel was reflective of the Island's population and supported by colleagues from the Health and Community Services.

The Panel developed the criteria that they believed were important in determining the site for the Hospital. This formed the sequential test which consisted of 22 questions in order to narrow down the remaining 17 sites.

Stage 5 applied the criteria determined by the Panel in stage 4. A Site Evaluation Panel ratified the initial assessment of sites in stages 1-4 and tested those sites remaining against the sequential test criteria.

The sequential test involved ruling out any site that did not meet the criteria for a test and was therefore not considered for the remaining tests. The application of the test criteria reduced the list of sites from 17 to 5.

This process resulted in the following five sites being shortlisted:

- Fields to the North of Five Oaks

- Millbrook Playing Fields and fields to the north
- People's Park
- Overdale
- St Andrew's Park, First Tower

The next steps to identify a single preferred site involved detailed feasibility studies (both desk-based and on-site technical assessments) and impact assessments. These were undertaken by the Design & Delivery Partner and included the following stages:

1. Site acquisition and community involvement of the shortlist of sites
2. On-site technical assessments considering the infrastructure characteristics
3. Impact assessment on the site and its surroundings
4. Consult and engage with the Jersey Architecture Commission and the Citizens' Panel
5. Report of the outcomes of the assessments to the Political Oversight Group and then Council of Ministers

Following the completion of the acquisition and community involvement study (July 2020) and the access to the site and preliminary assessments (mid-August 2020), sufficient information emerged that only Overdale and People's Park have the potential to deliver the Our Hospital Project as currently defined. The decision was summarised in a GoJ Paper dated 18th August 2020.

Further work was performed on both remaining options during September 2020 with further detail emerging on the site specific costs of each option. Both options were presented in detail to a Council of Ministers meeting on Thursday 1st October 2020. The decision was made to propose proceeding with Overdale as the preferred site for the new hospital. In support of this, Council of Ministers also decided to propose the use of Compulsory Purchase legislation to make the site available in time. This was then debated during the November sitting of the States Assembly.

## 4.6 Functional Brief

### 4.6.1 SOC Stage

In order to support the site evaluation process, a draft functional brief exercise was undertaken at SOC stage to determine the minimum ground floor sizing requirements of the new build option. This process was primarily to support the site evaluation but also enabled a detailed review and challenge of potential functional areas which could be included in the proposed new build hospital.

A functional brief report was prepared which set out the strategic rationale for additional functional areas, capital cost and revenue impact for each area, and any potential savings from a consolidation onto a single site.

MJ Medical, with support from PwC, developed the indicative sizing for the new hospital, using the current Jersey General Hospital as the starting point, and adjusted the sizing to be in line with current UK regulations and the estimated impact of the HCS efficiency work which was being undertaken at the time:

- Current Jersey General Hospital size (40,032m$^2$)
- Jersey General Hospital uplifted to current standards (55,482m$^2$)
- New hospital without the HCS efficiency work being achieved (uplifting for future demand) (79,618m$^2$)
- New hospital with the HCS efficiency work being achieved (66,947m$^2$)

The Jersey Care Model helped inform the development of the SOC functional brief to support the site evaluation process, but it does not define the clinical and non-clinical design requirements. The Our Hospital Project will be delivered independent of the Jersey Care Model.

### 4.6.2 OBC Stage

The Our Hospital Functional Brief (version 6.1) was completed by MJ Medical in November 2020. This Functional Brief reflects the clinical requirements of the population of the Island, the Our Hospital clinical leadership team, current best health practice, operational aspirations and design principles, as developed through the initial consultation workshops. The starting point for the 'Functional Content' has been created based on the results of a HCS review and stress test of the JCM undertaken from October 2019 to June 2020. The output of the review has been augmented through a series of interactive clinical workshop sessions with the Health and Community Services leadership and the Our Hospital clinical leadership teams. This content has been further developed and refined in consultation with the clinical and non-clinical teams who operate the current hospital. In addition to setting out the functional requirements and key flows and adjacencies of the hospital, it also provided the wider brief for the design for the new hospital, including:

- Site context and character
- Design and operational principles
- Approach to standardisation and repeatable rooms
- Expansion, adaptability and flexibility
- Diversity and equality
- Digital (Information Management and Technology) requirements
- Infection control

The Employer's Requirements, which includes the Functional Brief, was developed with the DDP as the basis for the design of the new hospital, highlighting key areas that needed to be considered in the design to achieve the Critical Success Factors and Strategic Investment Objectives. The DDP have developed their design in response to these requirements, and as set out in more detail in the Commercial Case, their Concept Design report summarises the progress that has been made at RIBA Stage 2 in achieving this.

#### 4.6.2.1 Demand and Capacity Modelling

As has been described in the Strategic Case a discrete event simulation model was developed that estimated the flows of demand through the new hospital, taking account of peaks/troughs in demand during the course of the year.

The model utilised data from the calendar year 2019 as its baseline position, including information on demand for the Emergency Department, inpatient beds, day case trolleys, theatres and outpatient clinics. There were also a number of areas that were additionally built into the modelling such as demand for critical care, chemotherapy chairs, etc. All of the modelling was split by elective and emergency pathways and was further subdivided into medical and surgical specialties to take account of the very different pathways for each of these types of care.

The model was initially run through to 2036 on a 'do nothing' basis. In doing this, it made use of Statistics Jersey's +1,000 net migration population projections to estimate an age-adjusted growth for services over this period. Following this, a series of interventions as identified through the Jersey Care Model programme were applied to create the 'do something' case. A summary of the Do Nothing / Do Something Cases is:

1. Do Nothing: healthcare services continue in line with the existing operating model.

2. Do Something: based upon the adoption and implementation of a healthcare transformation programme such as the Jersey Care Model and involving Jersey specific pathway and process improvements to bring healthcare in line with best practice standards e.g.:

- length of stay reductions
- introduction of admission avoidance schemes
- enhanced intermediate care offer
- increased day surgery rates
- adoption of emerging healthcare improvement opportunities (e.g. digital advances)

The Do Something model was approved on the basis that transformation and modernisation is custom practice globally across health care systems. The programme in Jersey will be supported through the delivery of the Jersey Care Model and other schemes that develop in line with wider health economy and Government of Jersey quality and service improvement programmes.

The outputs of the demand and capacity modelling were used to inform the discussions on the Draft Functional Brief for the new hospital, where additional operational adjustments were made (i.e. to take account of the fact that operationally three Resus bays will be required in the Emergency Department even though the daily demand for these bays would not directly support this).

The following statement is noted in the Functional Brief:

- *"The outcome of the JCM review has provided recommendations for the future direction of integrated care in Jersey, additional system changes that may be required and implementation considerations. The resulting demand and capacity modelling has informed, but not driven, the development of this Functional Brief for the Our Hospital project."*
- *"The starting point for the 'Functional Content' has been created based on the results of a HCS review and stress test of the JCM undertaken from October 2019 to June 2020, and the subsequent secondary care demand and capacity model. The output of the review has been augmented through a series of interactive clinical workshop sessions with the Health and Community Services leadership and the Our Hospital clinical leadership teams."*

In addition to this, the Functional Brief considered the diversity of the local population and the increasing elderly population. The following is also noted:

- *"The Functional Area Assessment ("FAE") is developed around the modelling output following the review of the JCM and moderated further with the hospital leadership and clinical teams, based on the future healthcare needs of the population of Jersey in 2036. Although a transformation model such as the JCM has informed this Functional Brief, both the FAE and the future flexible design of the Our Hospital project mean that independent of the JCM, the hospital will be fit for any model of care designed in line with best clinical and operational practice for the population of Jersey for the next 30-40 years."*

### 4.6.2.2 In-patient bedrooms

The functional brief includes a requirement for 75% individual-occupancy side rooms. This requirement originated through the clinically facing user groups and was subsequently validated by Clinical and Operational Client Group and HCS executive. When benchmarking against comparable healthcare settings, the latest advice from the UK Department of Health (issued in 2004) said the ideal standard was 50%. New guidance is anticipated from the UK Department of Health following the COVID pandemic. It is anticipated that this will advise any new build should aim for a minimum of 70% side rooms. Our Hospital will therefore exceed this, and the design therefore affords adequate isolation capacity for Infection prevention and control.

### 4.6.2.3 Aim of the functional brief

The aim of the functional brief was to:

- *"deliver truly patient-focused, outcome-based care, a One Island-One Government approach will be essential in providing a clear understanding of the building blocks integral to meeting Jersey's overall Health and Care system needs. At the centre, are the core provisions included in a modern Health and Care system:*
    - ***Prevention and Self-Care** – includes the actions that people take to look after, treat and manage their own health, either independently or with the support of the Health and Care system*
    - ***Primary Care** – usually the first point of contact for people in need of Health and Care services, e.g. GPs, nurses, dentists, pharmacists and others •*
    - ***Intermediate Care** – services that provide support for a short time to help people prevent problems from getting worse, recover from an episode of care or increase independence*
    - ***Secondary Care** – specialist treatment for a defined period of time for a more acute serious illness, injury, mental health crisis or other health condition*
    - ***Tertiary Care** – highly-specialised treatment, which for Jersey is provided off the Island."*

The table below summarised the functional brief which was provided to the DDP.

**Table 16: Functional brief**

| Our Hospital High-level Descriptions | Our Schedule of Accommodation Description |
|---|---|
| **Cafeteria, Commercial Centre and Multi- faith space** | Public Entrance |
| **Acute Care Centre and Urgent Treatment Centre (UTC)** | Emergency Department & Urgent Treatment Centre |
| | Acute Floor |
| **Diagnostic Facilities for Radiology & Physiological Monitoring** | Imaging & Clinical Investigations |
| **Pathology** | Pathology |
| **Pharmacy** | Pharmacy |
| **Mortuary** | Mortuary and Post Mortem |
| **Theatres** | Theatre Suite (includes theatres, minor ops and endoscopy) |
| **Critical Care** | Critical Care (Intensive treatment unit (ITU) and High dependency unit (HDU) |
| **Scheduled Inpatient Care** | Ward Central Core |
| | Inpatient Beds |
| **Private Unit** | Private Unit (Outpatients/Beds/Lounge) |
| **Scheduled Outpatients** | Outpatients Public Entrance |
| | Outpatients Unit (Integrated Multi-Speciality) |
| | Women's Health Unit (Gynae & Breast Services) |
| | Clinical Investigations/Cardio & Respiratory |
| | Renal |
| | Medical Oncology, Haematology & Chemotherapy |
| **Women's Unit** | Women's & Children Entrance |
| | Women's Unit - Obstetric Outpatients |
| | Women's Unit - Obstetric Inpatient |
| | Maternity |
| **New-born Unit** | New-born Unit |
| **Paediatric Inpatients** | Paediatric Inpatients |
| **Paediatric Outpatients & Paediatric Assessment Unit (PAU)** | Paediatric Outpatients |
| **Mental Health Care Facility** | Inpatient Mental Health Facility |
| **Engineering and Support Services** | FM Support - Non Clinical |

| | |
|---|---|
| | Engineering and Estates |
| | Fresh Cook Catering Facility |
| **Equipment Library & EBME Workshop** | Equipment Library & EBME Workshop |
| **Theatre Sterile Services Unit (TSSU)** | TSSU |
| **Knowledge Centre** | Knowledge and Training Centre |
| **Administration Support** | Administration and Office Accommodation |
| **Staff Wellbeing Centre** | Staff Wellbeing Centre |

The functional brief document set out the initial required clinical and non-clinical model and key departmental relationships and required clinical adjacencies. As the scheme has developed through the design process this has changed with the most up-to-date position presented in the RIBA Stage 2 Report.

## 4.7 Capital costing of the shortlisted options

The agreed shortlisted options outlined in section 4.3 were re-confirmed and been taken forward for more detailed assessment in this OBC.

From this point onwards in the Economic and Financial Case the options shall be referred to as the:

- **New Build Option** (which had been shown at SOC stage to achieve the CSF). The New Build Option aims to provides a new general hospital for Jersey by Dec 2026 that meets both the requirements of the Functional Brief and Employer's Requirements.
- **Baseline Comparator Option** (which did not achieve the CSF but was selected as a comparator to comply with Green Book guidance).

The Baseline Comparator Option seeks to provide a new hospital for Jersey as soon as is possible, but by 'Doing Minimum' to the existing estate. Due to the condition challenges set out in the Case for Change the amount of refurbishment required remains significant.

The capital costs associated with each option is set out in more detail below.

### 4.7.1 Baseline Comparator Option

#### 4.7.1.1 Further development of the Baseline Comparator Option at OBC Stage

The proposed Baseline Comparator Option was developed at a series of workshops during early 2021 which included the HCS Estates Team, Our Hospital Clinical Team, the GoJ Financial and Commercial Advisors, the Our Hospital Project Managers and the Our Hospital Cost Consultants. The starting point for this group was to consider the high level "Do Minimum" option which was set out in the SOC and build on this so as to present a more robust Baseline Comparator Option in the OBC.

As noted in Section 4.3 above, the Do Minimum Option which was shortlisted for further development as a comparator option at the SOC Stage was described as follows in the SOC:

- *Keep the site open and safe, maintaining the current configuration of services & facilities:*
- *Address the current backlog maintenance through investment*
- *Address critical clinical compliance issues and bring healthcare services up to modern standards*
- *Targeted investment in new build facilities to increase capacity*
- *The functionality of the hospital would remain largely the same with no change to current clinical adjacencies.*

It became clear during the OBC Do Minimum workshops that it would not be possible to deliver a traditional “Do Minimum” option in relation to the existing healthcare facilities in Jersey: in order to continue delivering healthcare services at the existing estates, to the standard expected by Islanders, a major refurbishment would need to be carried out. Therefore, a decision was taken to rename the option “the Baseline Comparator Option” to better reflect the significant phased refurbishment which would need to be carried out in order to deliver the option. The mandate for the project is to achieve completion of clinical commissioning by Dec 2026. The phased nature of the Baseline Comparator doesn’t achieve this, and the programme that has been developed assumes that to enable the best possible programme a team would be established and put in place without delay.

The Baseline Comparator Working Group, therefore developed the following scope which describes what would be undertaken in the option:

### 4.7.1.2 Baseline Comparator description and assumptions at OBC Stage

By delivering the Baseline Comparator, acute healthcare services would continue to be delivered at the existing Jersey General Hospital (JGH) and other sites which are currently used in Jersey (sites listed below in table 17).

The Baseline Comparator option would aim to:

- Deliver acute healthcare to recognised modern standards
- Deliver single occupancy rooms at the JGH (i.e. limit shared wards which are presently the majority of the provision)
- Deliver a sequenced remodelling/refurbishment of the existing JGH
    - This would require the building of a decant facility adjacent to the existing JGH which would be used during the build phase
- Explore opportunities to use Westaway Court or potentially acquire adjacent buildings in order to increase capacity compared to the existing JGH. Please note, no such opportunities have been included in the costed Baseline Comparator Option in this OBC.
- Invest in a number of other sites in Jersey which deliver HCS services which would be delivered at the New Hospital if it was developed but will need to continue to be used under the Baseline Comparator. These relevant sites are detailed in table 17 below.

In addition to these aims, the following constraint with the Baseline Comparator option is also acknowledged:

- Continuing to use the existing HCS footprint would not allow for an increase to the overall capacity (due to space constraints to expand at the existing site and loss of space due to single occupancy rooms)

**Table 17: Sites included in the Baseline Comparator Option**

| Site | Size | Further info |
|---|---|---|
| Jersey General Hospital | 40,032m$^2$ | Phased refurbishment of the existing JGH |
| Five Oaks | 3,739m$^2$ | The following areas of the Five Oaks sites would be re-developed:<br>• Laundry<br>• CSSD/TSSU<br>• Stores<br>A 6 Facet is available for the site. Some work is already being done on Laundry and Stores, but more would be required if Five Oaks is to continue to be used. |
| Maison Le Pape | 863m$^2$ | Office block which would require investment |
| 14 Gloucester Street | 388m$^2$ | Health clinic – minimal investment required |
| Le Bas Health Centre and Woodville Avenue | 2,225m$^2$ | Adult Mental Health/Liaison space and admin |
| Overdale | 11,044m$^2$ | The following areas of the Overdale site would be re-developed:<br>• Portacabin<br>• Overdale - Admin 1<br>• Overdale - Carpenters workshop<br>• Overdale - Hearing Resource<br>• Overdale - Poplars Day Centre<br>• Overdale - Porters Lodge<br>• Overdale - Psychology Admin 3<br>• Overdale - Westmount Centre |

The proposed total size of the Baseline Comparator Option is 54,954m$^2$.

**Backlog Maintenance**

The existing Jersey General Hospital (JGH) is close to the end of its life as a functioning facility and will no longer be able to function beyond 2026 without significant investment.

The current physical condition of the facility is being managed via a £5m per annum (2020 – 2023) backlog maintenance spend which is designed to keep the hospital functional until December 2026 (i.e. the point at which the proposed new Our Hospital would be fully functional). A further spend of £2m in 2024 has now also been agreed through the Government Plan. This backlog maintenance covers some of the items identified within the six facet survey carried out in 2019 which identified a substantial backlog spend (£80.8m) was required between 2019-2033 in order to address urgent environmental/building and infrastructure issues in relation to the JGH.

**Implications of continuing at the current Hospital**

Completion of the Backlog Maintenance, which would require additional funding to the £5m per annum identified for 2020 to 2023, would only partially address the infrastructure issues at the JGH. In order to continue providing healthcare services at this location, a full refurbishment of the facility would need to take place to update the facilities in order to meet safety, clinical needs and improved Infection Prevention & Control standards. To enable this to take place, decant facilities would be required to be built to allow elements of the JGH to be relocated whilst the refurbishment works took place.

The initial construction of the decant facilities would need to be completed by December 2023 in order to be operational to allow the temporary relocation of services to enable the first phase of refurbishment work to commence in January 2024. The phased refurbishment would require multiple reconfiguration of the decant facilities to provide space for the different services to be maintained and based on this and the size of the JGH, it is estimated that a 4 year build programme would be required with a completion of all works in 2028. The multiple phasing will cause significant disruption to healthcare services during this period.

**Baseline Comparator Assumptions**

Based upon the information set out above, the proposed Baseline Comparator option therefore assumes the following:

- Continue to spend c. £5m per annum on the identified backlog maintenance at the JGH until the end of 2025
- Decant facilities pre-construction design phase required to be commenced October 2021
- Decant facilities construction to commence January 2023
- Decant facilities complete in December 2023
- JGH refurbishment programme pre-construction design phase commencing in January 2022
- JGH phased refurbishment programme to commence January 2024
- JGH refurbishment programme complete in January 2028

A Baseline Comparator Risk Register has been produced and where possible, quantified. This is included in section 4.11 of the Economic Case.

The Baseline Comparator option was presented at the Clinical & Operational Client Group (COCG) meeting held on Monday 17th May 2021.

The Capital Costs associated with the Baseline Comparator Option are set out below.

**Table 18: Baseline Comparator Capital Costs**

| Cost Categories (£m) | Baseline Comparator |
|---|---|
| Main works | 406.2 |
| Design and Professional Fees | 79.8 |
| Non-works Costs | 11.1 |
| Equipment Costs | 46.2 |
| Contractor Contingency | 40.6 |
| **Sub-total** | **584.0** |
| Optimism Bias | 113.9 |
| Inflation adjustments | 129.5 |
| GoJ Team Costs | 39.8 |
| Client Contingency | 73.1 |
| **Total Capital Costs** | **940.2** |

### Baseline Comparator Cost Assumptions

The Baseline Comparator Capital costs set out in the table above have been produced by the GoJ OHP Cost Consultant, T&T, based on the work undertaken to date on the Baseline Comparator Option. A summary of the assumptions used are set out below:

***Construction Costs £406.2m***

The Construction Cost is broken down as follows:

- Departmental Cost - £120.2m
- On costs - £238.9m (based on 198.83% of the Departmental Cost)
- Inflation adjustment - £15.8m (an adjustment from PUBSEC 250 to PUBSEC 261 to account for the proposed start of construction)
- Provision location adjustment - £31.4m (a 25% allowance based on the Departmental Costs to account for the Jersey construction factor)

***Professional Fees £79.8m***

Fees are an estimate based on 19.65% of the Departmental Cost total as estimated by the Cost Consultant.

***Non-works Costs £11.1m***

Non-works costs are broken down as follows:

- Land acquisition - £5.0m (estimate for the proposed decant facility land)
- Statutory Charges - £1.1m
- Other - £5.0m

***Equipment Costs £46.2m***

Based on an allowance of 38.44% of the Departmental Cost total as estimated by the Cost Consultant.

***Contractor Contingency £40.6m***

Based on an allowance of 10.00% of all other costs total as estimated by the Cost Consultant

***Optimism Bias £113.9m***

Based on an allowance of 19.50% of all other costs total as calculated by the Cost Consultant in line with Green Book Guidance and reflecting the early stage of scheme development.

***Inflation £129.5m***

Mid-point inflation to Q1 2026 using the appropriate BCIS index.

***GoJ Team Costs £39.8m***

The GoJ team costs of £39.8m have been estimated in-line with the same costs set out in the New Build Option but adjusted to match the Baseline Comparator Construction Profile.

***Client Contingency £73.1m***

Client Contingency of £73.1m has been estimated in-line with the same costs set out in the New Build Option but adjusted to be match the Baseline Comparator Construction Profile.

### 4.7.2 New Build Option

The costs for the new hospital included herein benchmark in line with comparable current major UK hospital schemes, taking into consideration the applicable regulations, Jersey location factor, and abnormal (a construction industry term for site specific costs) aspects of the Our Hospital programme of works.

**Table 19: Total Capital Costs**

| Cost Categories (£m) | New Build Option |
|---|---|
| Main Works (incl. demo) | 311.7 |
| Preliminaries | 53.4 |
| Design & Professional Fees | 33.6 |
| Inflation | 34.6 |
| Equipment | 56.3 |
| Contractor Contingency | 35.8 |
| PCSA Costs | 34.2 |
| Overhead and Profit | 44.7 |
| Re-provision of Services from Overdale | 14.6 |
| Decant & Migration | 0.6 |
| **Sub Total** | **619.5** |
| Optimism Bias | 38.1 |
| **Sub Total** | **657.6** |
| Client Contingency | 73.1 |
| GoJ Team Costs | 39.5 |
| Land Acquisition / Re-provision Costs | 34.3 |
| **Total incl. Other Costs** | **804.5** |

In addition to the capital costs shown in the table above, funding has already been approved for a programme of urgent capital works at the existing Jersey General Hospital. This equates to £5m per annum for 4 years (FY20 – FY23), £20m in total, with work already commenced on urgent backlog maintenance requirements. In addition to this, a further £2m has now been agreed via the Government plan for FY24  will be assessed as part of the next Government Plan. The approved £22m will be incurred

in addition to the cost set out in the New Build Option but may be superseded in the Baseline Comparator Option.

### 4.7.3 Cost assumptions on the New Build Option

The New Build Option capital costs are based on three primary sources:

- Cost information submitted by the Design & Delivery Partner which was subsequently reviewed by the Cost Consultant. These DDP Costs are based on the RIBA Stage 2 design, including the updates to the design that are being incorporated during RIBA3 to respond to the feedback received on the RIBA2 design
- Estimates made by the Cost Consultant and the Property Acquisition Agent where a cost sits outside the Design & Delivery Partner Envelope
- Costs provided by the Government of Jersey

Detailed information is set out for each cost category below.

***Construction Costs £619.5m***

The Total Construction Cost is estimated at £619.5m and is mixture of cost information provided by the DDP and costs estimates provided by the Cost Consultant. The breakdown below explains the origin of the cost information presented. The table above outlines the proposed envelope and cost breakdown for the New Build Option with the detailed assumptions set out below.

***Main works (including demolition costs) £311.7m***

The basis of the capital cost has been derived from the detailed work undertaken by the Design & Delivery Partner as part of their design work and includes the following:

- Elemental cost planning covering the provision of the following buildings:
  - Main Hospital
  - Energy Centre
  - Knowledge & Training Centre
  - Mental Health
  - Multi-storey car park
- External Building Works: Drainage, Roads, Paths, Parking, Site Layout, Walls, Fencing, gates
- Builders Work for Engineering Services
- External Engineering Works: Heating, Hot Water, Gas Supply Mains, Cold Water Mains and Storage, Electricity Mains, Substations, Standby Generating Plant, Water Heater and Associate Plant
- Highways works
- Equipment Cost
- Digitisation Infrastructure
- Site preparation
- UK VAT
- Demolition

The Demolition cost relates to demolition which is required to either construct the new hospital or enable changes to the local road network. Demolition of wider HCS estate that moves to OHP once the project is complete is not included.

Given the stage of development, there is still a medium degree of uncertainty regarding the costs. Although the DDP has provided the elemental costs that has formed the basis of the capital costings, this

is a not a contractual commitment given the stage of their appointment. There are ongoing commercial discussions with the DDP in relation to the breakdown of the capital costs.

In order to mitigate this risk, the Government of Jersey has appointed a Cost Consultant, Turner & Townsend Cost Management Ltd (T&T). T&T have significant experience on major UK healthcare new builds delivered in recent years and have benchmarked the net construction cost and consider it to be a reasonable value in the current market.

The forecast has been proposed by the DDP and reviewed by the Cost Consultant.

***Preliminaries £53.4m***

The cost includes the preliminaries for the DDP e.g. Site Cabins, Contractor's Staff, Cranes, Plant and Machinery. Advice was sought from the DDP on preliminaries and the DDP provided a position. However the level indicated was not within the typical values expected for a project such as this, and so the current cost plan uses a preliminary allowance based on the advice of the professional team, and benchmarked against other similar projects, with allowance made for the unique challenges of delivery in Jersey. Further work to continue to market test and review the preliminaries with the DDP is scheduled to take place during the next stage.

***Design & Professional Fees £33.6m***

The costs for Design and Professional Fees covers the design and professional fees relating to construction phase of the programme and includes; Architects, Structural Engineers, Mechanical Engineers, Electrical Engineers, Quantity Surveyors, Project Management, Site Management, Design Management, Health and Safety Management, Planning Consultant, Communications Management. A forecast was been proposed by the DDP and reviewed by the Cost Consultant.

***Inflation £34.6m***

Mid-point construction inflation using the BCIS indices with a Jersey factor applied.

A forecast was been proposed by the DDP and reviewed by the Cost Consultant.

***Equipment £56.3m***

The cost of £56.3m is an estimate provided by the DDP based on an Equipment Schedule produced by MJ Medical.

A forecast was been proposed by the DDP and reviewed by the Cost Consultant.

***Contractor Contingency £35.8m***

An allowance of £35.8m for DDP risk has been included at this stage.

T&T consider this to be an appropriate contingency allowance which will be replaced with actual costs as the project costs are explored and market tested further beyond its current stage.

A forecast was been proposed by the DDP and reviewed by the Cost Consultant.

***PCSA £34.2m***

The Pre-Construction Services Agreement was fully tendered, and market tested through an Invitation to Tender. The PCSA accounts for all DDP costs up to the end of Stage 1B (Contract Award) which includes

all design costs and all internal costs up to the point of agreeing a target price. This has increased by c. £4.0m since the SOC stage as a result of agreed changes to the programme and scope.

***Overhead and Profit £44.7m***

Fully tendered and market tested rate of 9.5% applicable to all DDP costs.

***Re-provision of Services from Overdale £14.6m***

The cost of temporarily providing facilities at the former Les Quennevais School Site to enable the re-location of services from the Overdale Site in order for building work to commence at Overdale.

A forecast was been proposed by the DDP and reviewed by the Cost Consultant.

***Decant and Migration £0.6m***

An allowance has been made for the decant and migration costs during the project, to allow for moves that may need to take place during construction. A plan will need to be established for relocating staff to the new facilities once they are complete and is not included. The cost estimate is based on a percentage advised by the Cost Consultant and sits outside the DDP Cost envelope.

***Market Testing***

All of the cost categories detailed above will be market tested to ensure that there is competition and that cost estimates are realistic. All elements will be fully benchmarked against other projects allowing for suitable on Island on costs, such as inflation and shipping costs

***Optimism Bias £38.1m***

Included within the current costs are the appropriate allowance for Optimism Bias in accordance with Green Book guidance.

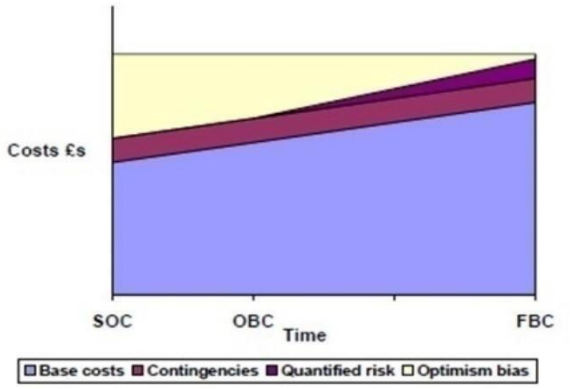
T&T have undertaken an Optimism Bias assessment on the New Build Option which has provided a calculation of 6.50% for the project, which represents an appropriate level for this stage of the business case process.

During the lifetime of the project the Optimism Bias allowance will be replaced with true costs as the design and delivery stages of the project develop, any reductions/savings will be identified, and the client can agree the appropriate course of action for those sums. It should be noted however, that whilst Optimism Bias will decline as the scheme achieves greater cost certainty, the reduction in Optimism Bias will often be replaced by other costs elsewhere and therefore not reduce the total.

By close of the Full Business Case stage any remaining optimism bias should be very low. Costs will have been firmed up and risks identified and included in the risk analysis and risk register.

The diagram below shows this process of the optimism bias diminishing, as the business case develops towards the close of the Full Business Case.

**Figure 7: Project costs timeline**




The area shaded pale yellow is the optimism bias adjustment, which diminishes as the business case develops towards Full Business Case and is replaced with either known costs or known risks with owners.

The horizontal axis represents the passage of time as the Business Case develops from Strategic Outline Case to Outline Business Case to Full Business Case.

The vertical axis represents total estimated capital costs.

The area shaded blue represents 'base costs', which could alternatively be called 'known' costs. They are equal to the sum of the works or capital costs, professional fees, non-works costs and equipment costs rows in the OB1/FB1 forms (at a known, constant cost datum, i.e. Building Cost Information Service Inflation index).

The level of  contingencies is shown by the area shaded in a 'plum' colour.

The area shaded purple is the 'quantified risks' which relates to the monetary value of the quantified risks that is usually fully developed by Full Business Case stage.

***Client Contingency £73.1m***

In addition to the Optimism Bias above it is also good practice to account for a suitable level of contingency to cover those risks that can be quantified such as cost overruns in the building contract for disruption, or cost overruns on the equipment budget or cost overruns on professional consultant's fees, etc.

***GoJ Team Costs £39.5m***

The GoJ team costs of £39.5m are broken down ass:

- ***GoJ Team Costs £10.5m***
    - The internal Government team costs for delivering the OH Project. This includes Governance. These costs have been developed by the GoJ Finance team.
- ***External Advisor Costs £29.0m***
    - The agreed external advisor costs including the Project Managers and Contract Administrators. (MACE), Commercial & Financial Advisor (EY), the Cost Consultant (T&T), the NEC Site Supervisor and Design Intelligent Client (Mott Macdonald) and other advisors such as legal and land assembly.

***Site acquisition/re-provision £34.3m***

This relates to the site acquisition costs of the sites required to deliver the project (£34.3m).

### 4.7.4 Lifecycle expenditure

The table below sets out the lifecycle profiles which are assumed to run 60 years from 2026.

The Pre Year 1 (2021-2025) cost includes all Lifecycle Costs in relation to the Baseline Comparator Option from FY21-FY25. The Baseline Comparator Lifecycle Programme lasts for 65 years starting in FY21, which is 5 years longer than the new build options. This is due to spend being required on the existing JGH from 2021 as opposed to the New Build Option which is only completed in 2026. It is also assumed that due to the Baseline Comparator being a phased refurbishment, Lifecycle will still need to be spent on the parts of the JGH which are refurbed later in the programme.

The Lifecycle programme for the New Build Option has been developed by the GoJ Cost Consultants in conjunction with the DDP.

**Table 20: Lifecycle expenditure**

| Cost Categories (£m) | Total | Year | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Pre Yr 1* | 1 (2026) | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11-35 | 36-60 |
| Baseline Comparator Option | **222.1** | 17.8 | 3.5 | 3.4 | 3.2 | - | 0.5 | 0.5 | 0.5 | 1.0 | 1.0 | 1.0 | 118.7 | 71.0 |
| New Build Option | **232.8** | - | - | - | - | 0.7 | 0.7 | 0.7 | 1.3 | 1.3 | 1.3 | 1.8 | 142.4 | 85.8 |

*Pre Year 1 refers to the period 2020 – 2025

The lifecycle profile for the Baseline Comparator Option and the New Build Option set out above is an estimate provided by T&T based on the work undertaken on each option.

## 4.8 Revenue costs

A Facilities Management Business Case is currently being developed to consider the future strategy and costs associated with delivering Facilities Management services post the proposed new hospital opening.

The timetable for the completion of the FM Business Case is subject to a separate governance which does not align to the completion of the Our Hospital OBC and therefore it will not be possible to include that detail.

Therefore, no future Facilities Management or Utilities Costs are being included in this OBC for the Baseline Comparator Option or the New Build Option. A full update reflecting the approved FM Business Case will be provided in the Our Hospital FBC.

As the FM and Utility costs are not included for either option, the only revenue costs included in this OBC are those associated with the provision of a free shuttle bus service between St Helier and the proposed new hospital at Overdale. This is only required for the New Build Option (given its location) and therefore no costs are included for the Baseline Comparator Option.

Discussions are due to start with Liberty Bus on whether the bus services in the area need to be reviewed to ensure they are appropriate for staff and patients while services are at Le Quennevais (approx. 2022-2026). Revenue costs for the Le Quennevais bus service will be included when available.

### 4.8.1 Baseline Comparator Option

The table below details the revenue costs for the Baseline Comparator Option.

**Table 21: Baseline Comparator revenue costs**

| Cost Categories (£'000) | Total | Year | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11-35 | 36-60 |
| Shuttle Bus | - | - | - | - | - | - | - | - | - | - | - | - | - |
| | | | | | | | | | | | | | |
| **Total Revenue Costs (unindexed)** | - | - | - | - | - | - | - | - | - | - | - | - | - |

It may be that bus / shuttle bus services would be required to facilitate travel to sites during the refurbishment. However to establish this the decant plan would need to be progressed so currently this has not been included.

### 4.8.2 New Build Option

The table below details the revenue costs associated with the provision of a Shuttle Bus for the New Build Option. These costs will be incurred from 2027 (Year 1 in the table below) for 60 years to 2085.

**Table 22: New Build Overdale revenue costs (2027 onwards (full cost, not incremental))**

| Cost Categories (£'000) | Total | Year | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11-35 | 36-60 |
| Shuttle Bus | **56.2** | 0.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 23.8 | 23.8 |
| | | | | | | | | | | | | | |
| **Total Revenue Costs (unindexed)** | **56.2** | **0.0** | **1.0** | **1.0** | **1.0** | **1.0** | **1.0** | **1.0** | **1.0** | **1.0** | **1.0** | **23.8** | **23.8** |

A shuttle bus to transfer patients from St Helier town centre to the Overdale site at a 15 minute frequency is being considered to transport patients. Initial cost information provided by the GoJ Public Transport Planner has been included above for the Overdale Option. As described above some changes to the bus services may also be required to facilitate access to the former Les Quennevais School site.

## 4.9 Potential Savings under consideration

During the development of the SOC in 2020, a number of areas were identified which had the potential to generate savings or efficiencies compared to the capital and revenue costs presented in the SOC at the time. The development of these potential savings/efficiencies is an iterative process which will continue to evolve as the project progresses through the design phase. The following list was set out in the SOC to be explored further during the OBC stage:

- Capital receipts from vacated buildings/HCS estate
- Avoided capital works on existing estate

- Equipment savings from transfer of existing equipment
- Service cost savings from improved adjacencies
- Expansion of the private patients' unit and training centre
- Further refinement of the of the capital build costs including UK standards and future running/service costs

Following the commencement of the OBC work in late 2020, an efficiencies working group was established to further explore the areas set out above any additional areas that were identified during the development of the OBC. The efficiencies working group oversee strong financial management and compliance with Public Finance Law on the Our Hospital to ensure the Island has a value for money Hospital.

The table below summarises the work done in relation to the potential savings and efficiencies. In a number of instances, more detail is set out in other sections of this OBC document and therefore a reference is provided where this is appropriate.

**Table 23: Summary of efficiency work**

| Area | Description | Status/work still being undertaken |
|---|---|---|
| **DDP Capital Cost Baseline** | A detailed review of the cost information produced by the DDP including:<br>• Capital cost baseline<br>• Elemental Cost plans | This was undertaken by T&T as part of the detailed review of all cost information produced by the DDP.<br><br>A summary of the cost assumptions and the review work undertaken by T&T is included in the Economic Case. |
| **DDP Furniture, Fittings & Equipment (FF&E)** | The FFE work includes a detailed review from T&T into the FFE assumptions which the DDP is including into cost plans and also a GoJ level challenge as to any existing FFE which could be safely and economically moved into the new hospital when it is build. | An Equipment Working Group has been established which included representatives from the GoJ, T&T and the DPP. Work is on-going to establish what items of equipment could be safely moved into the new hospital whilst options to lease are also being considered. The fall-back position is that equipment will be purchased new.<br><br>This work will continue during the development of RIBA Stage 3. |
| **DDP Design & Professional Fees** | The SOC included an allowance of 12% for Design & Professional Fees. A proportion of these were included within the previously agreed PCSA costs but there will be ongoing costs during the build phase of the project. | The review of the DDP Design & Professional fee assumptions was undertaken by T&T as part of the detailed review of all cost information produced by the DDP.<br><br>A summary of the cost assumptions and the review work undertaken by T&T in included in the Economic Case. |
| **Digitally enabled hospital** | To consider the cost of a digitally enabled hospital. | The Capital costing for the new hospital as set out in this Our Hospital OBC assumes that the backbone infrastructure for the GoJ digital solution is built in as part of the design.<br>At the same time, GoJ is developing a wider digital transformation strategy which will deliver new equipment and software |

| Area | Description | Status/work still being undertaken |
|---|---|---|
| | | which will be used in the new hospital. Opportunities to maximise efficiencies that lead from the digital transformation have been considered and have informed design. |
| **Avoided capital works on existing site** | Cost savings achieved as a result of the existing HCS estate no longer needing to be maintained as a result of the new hospital being built. | Maintenance and ultimate redevelopment of the existing estate is covered in detail in the Baseline Comparator Option which is set out in the Economic Case.<br><br>In order not to double count the cost of the Baseline Comparator option, no saving is being recognised in relation to the new build option. |
| **Efficient use of Facilities Management and utilities** | The potential for efficiency savings in relation to Facilities Management and Utilities as a result of the new facility. | A separate Facilities Management Business Case is currently under development and is expected to be completed in the final quarter of 2021.<br><br>As a result, no cost information relating to FM services is included in this OBC. Further detail is included in the Commercial Case. |
| **Optimisation of space** | Minimisation of wasted space and optimising of use of space to provide optimum flow.<br><br>Principle to maximise the best use of space and reduce wasted space through design | Work has been ongoing during the development of RIBA Stage 2 and will continue to take place as the design progresses to RIBA Stage 3. |
| **Derogations from building standards** | The potential to reduce the size on non-essential space in the new hospital design by derogating from building standards where doing so is acceptable clinically and functionally eg plant space | A detailed review was undertaken during the development of the RIBA Stage 2 design. This will remain under review during RIBA Stage 3. |
| **Capital receipts** | The potential to generate future capital receipts from buildings which may become vacant following the building of the new hospital. | The decision on the future usage of any sites which may become vacant in the future is out-with the scope of the Our Hospital Project and has not yet been determined. Therefore, for the purposes of the Our Hospital OBC, no firm position in terms of the future usage of any of the potential sites is being assumed. This is a prudent position, that understates the benefits of the New Build Option.<br><br>There are a number of options which could be considered with regard to the future usage of these sites:<br><br>• Seek to dispose of some or all of the sites on a commercial basis and realise a capital receipt |

| Area | Description | Status/work still being undertaken |
|---|---|---|
| | | • Re-provision of some or all of the sites to support delivery of GoJ priorities, for example market rental, social or affordable housing.<br>• Re-provision some or all of the sites for use by other Government of Jersey Departments<br><br>Further detail on these sites is set out in the Commercial Case.<br><br>Further detail on this potential benefit is set out in the Economic Case. |
| **Clinical service cost efficiencies from improved adjacencies and flow** | The potential to generate productivity savings from more efficient flow of services, technological solutions and staffing resource. | This area is dealt with in more detail in the Economic Case. |
| **Private Patients** | The potential to generate an additional contribution to HCS from an expanded Private Patient Unit. | This area is dealt with in more detail in the Commercial Case |

Where noted above, further work will continue to be carried out through to the development of the FBC and an update will be provided at that time.

## 4.10 Benefits appraisal

### 4.10.1 Introduction

The benefits expected from the Our Hospital Project are set out by beneficiary in section 3.7 of the Strategic Case. This case looks to quantify and evaluate the benefits by allocating them to categories and identifying the financial, economic or non-quantifiable impacts that the Our Hospital will deliver.

This assessment will then form part of the overall evaluation of the options to determine the preferred option.

### 4.10.2 The Process for identifying Benefits

During the development of the Strategic Outline Case in 2020, a long-list of Benefits was established and agreed in the Strategic Case.

Following the approval of the SOC and the start of the OBC process, that long list of benefits was re-visited and revised by the Project Team to take into account changes in the project and in particular consider the impact of the COVID-19 pandemic. In order to capture a wide range of opinions, the revised list of benefits was tested and, if applicable amended at the following groups:

- HCS Executive – February 2021
- Clinical & Operational Client Group (COCG) – 4th March 2021. The meeting was attended by:

  - Director General, HCS (CHAIR)
  - Head of Communication - HCS
  - Chief Pharmacist
  - Associate Managing Director, Modernisation
  - Group Director, Commercial Services
  - Consultant Gastroenterologist
  - Chief Clinical Information Officer
  - Operational Programme Manager
  - Policy Principal Employment and Social Security
  - Head of Estates
  - Associate Managing Director, Care Groups
  - Therapies Lead
- The Health Workers Panel – 13th April 2021
- The Citizens Panel – 15th April 2021

### 4.10.3 Allocation of benefits to categories

#### Aligning the benefits to the SMART objectives

As part of the benefits appraisal, the benefits have been aligned to the SMART objectives set out in section 3.6.3 of the Strategic Case and given below:

1. To provide high quality, efficient and effective care for all patients and service users that is timely, accessible and delivers the best possible experience for patients, service users, visitors and staff

2. To deliver integration of physical and mental health care and services including co-location of an Acute and General Hospital and Mental Health Services

3. To deliver an Acute and General Hospital with co-located mental health and other services currently delivered offsite that is safe, compliant, flexible, delivers an optimised planned preventative maintenance regime and is right sized for the future delivery of clinical and other services, and enables service transformation

4. To deliver a new hospital that ensures the financial sustainability of the health economy

5. To deliver a new hospital that contributes to building a thriving community and well-being of staff and patients with positive socio-economic and environmental impacts

#### Benefit Categories

The Green Book splits UK benefits into the following four categories:

- **Cash releasing benefits** - additional income or savings to the GoJ
- **Monetisable non-cash releasing benefits** - Redeployment of existing resources or improved efficiency/productivity (monetary impacts that do not result in additional income or a reduction in spend)
- **Quantifiable but not monetisable benefits** - benefits that do not have a monetary impact, or the monetary impact is difficult to calculate, but where metrics or KPIs can be used to demonstrate impact
- **Qualitative unquantifiable benefits** - benefits for which the impact cannot be monetised (i.e. financial) or quantified (i.e. KPIs) so a scoring process is used

For the purposes of the Our Hospital OBC, we will consider benefits to the staff, patients, the GoJ public sector as a whole and the wider benefits to Jersey society.

## Presentation of the benefit allocations

The table below sets out the allocation of benefits both to the SMART objectives and to the Green Book categories, along with the party to whom the benefit will accrue. For this OBC, all benefits have been scored qualitatively.  The progress on the work to quantify and monetise benefits is set out in further detail in section 4.10.5.

**Table 24: Alignment of Benefits to SMART objectives**

| Objectives | Benefits | Category | Beneficiary |
|---|---|---|---|
| To provide high quality, efficient and effective care for all patients and service users that is timely, accessible and delivers the best possible experience for patients, service users, visitors and staff | 2. Improved patient satisfaction and experience | Qualitative | Patients |
| | 3. Facilities which address the healthcare needs of all patients | Qualitative | Patients |
| | 5. Optimising the privacy and dignity of patients | Qualitative | Patients |
| | 7. Improved outcomes all, particularly for children through Putting Children First | Qualitative | Patients |
| | 8. Delivering greater accessibility for all including car parking | Qualitative | Patients |
| | 11. Better sign-posting, easier way-finding leading to a more efficient patient experience – i.e. the patient needs be met in one place | Qualitative | Patients |
| | 23. Deliver greater choice for patients | Qualitative | Patients |
| | 28. First class Healthcare facilities | Qualitative | Staff, patients, wider Jersey society |
| To deliver integration of physical and mental health care and services including co-location of an Acute and General Hospital and Mental Health Services | 1. Safe, reliable and quality assured care with improved & predictable outcomes for patients and parity for mental health | Qualitative | Patients |
| | 22. Promote integration of health services | Qualitative | Patients, staff, GoJ public sector |
| To deliver an Acute and General Hospital with co-located mental health and other services currently delivered offsite that is safe, compliant, flexible, delivers an optimised planned preventative maintenance regime and is right sized for the future delivery of clinical and other services, and enables service transformation | 4. Continued provision of immediate and urgent care 24/7/365 | Qualitative | Patients |
| | 9. Improved patient safety and security | Qualitative | Patients |
| | 10. A design which is flexible and future proof by offering resilience and continuity | Qualitative | Patients, Staff, GoJ public sector |
| | 15. The environment will enable greater multi-disciplinary team working | Qualitative | Staff |
| | 16. Single site working benefits for staff who work across HCS and the third/private sector | Qualitative | Staff |
| | 14. New facilities will deliver greater standardisation (including room layout and equipment) | Qualitative | Staff, patients |
| | 19. Greater flexibility to changes in demand and evolving standards in clinical practice | Qualitative | Staff, GoJ public sector |
| | 21. Healthcare facilities which are to the standard islanders expect/compliant building standards | Qualitative | Wider Jersey society |
| | 24. Design to optimise and facilitate planned and preventative maintenance | Qualitative | Staff, GoJ public sector |

| Objectives | Benefits | Category | Beneficiary |
|---|---|---|---|
| To deliver a new hospital that ensures the financial sustainability of the health economy | 17. Hospital facilities which attract highly skilled staff, assists in closing vacancy factor and improves existing staff retention | Qualitative | Staff, GoJ public sector |
| | 20. Increased integration enabling greater efficiency across services | Qualitative | Patients, staff, GoJ public sector |
| | 25. More efficient maintenance provision due to co-location and modern facilities | Qualitative | Staff, GoJ public sector |
| | 34. Increased private patient provision to deliver a surplus which can be reinvested into HCS services | Qualitative | Patients, staff, GoJ public sector |
| To deliver a new hospital that contributes to building a thriving community and well-being of staff and patients with positive socio-economic and environmental impacts | 6. Hospital environment and internal architecture which supports the health and wellbeing of patients and their families | Qualitative | Patients, wider Jersey society |
| | 12. Increased job satisfaction due to improved facilities and physical surroundings, leading to a more attractive place to work | Qualitative | Staff |
| | 13. Support the development of staff skills including education, training and development | Qualitative | Staff |
| | 18. Improved staff wellbeing | Qualitative | Staff |
| | 26. Contributing to sustainable wellbeing to help achieve the community vision set out in Future Jersey | Qualitative | Patients, wider Jersey society |
| | 27. A facility that is owned and trusted by the people of Jersey and acts as an integral point for the local community, promoting a sense of pride for islanders | Qualitative | Wider Jersey society |
| | 29. Provisioning for Community Diversity | Qualitative | Wider Jersey society |
| | 30. Hospital facilities and public realm which could be used by the wider community. The hospital can be seen as a catalyst for wider community engagement/ improvements | Qualitative | Wider Jersey society |
| | 31. Job creation opportunities for local residents | Qualitative | Wider Jersey society |
| | 32. Development of apprenticeships and increased training opportunities | Qualitative | Wider Jersey society |
| | 33. Creation of low carbon generating facilities | Qualitative | Wider Jersey society |

| Objectives | Benefits | Category | Beneficiary |
|---|---|---|---|
| | 35. The opportunity to re-provision, re-develop or realise a commercial receipt at a number of buildings which could become vacant following the completion of the new hospital | Qualitative | Wider Jersey society, GoJ public sector |

## 4.10.4 Qualitative Benefits

### Approach taken for qualitative benefits

The benefits identified for qualitative scoring were initially assessed and scored at an Our Hospital Project Team workshop on 8th February 2021. During the workshop, the following was considered and agreed:

- A confirmed long-list of benefits
- Identification of benefits which could be quantified
- A qualitative scoring methodology
- Weighting for each qualitative benefit
- Indicative scores for each qualitative benefit for both the New Build Option and the Baseline Comparator

Following the conclusion of the benefits workshop, the outcomes were subsequently tested and ultimately confirmed at the following groups:

- HCS Executive – February 2021
- Clinical & Operational Client Group (COCG) – 4th March 2021. The meeting was attended by:
    - Director General, HCS (CHAIR)
    - Head of Communication - HCS
    - Chief Pharmacist
    - Associate Managing Director, Modernisation
    - Group Director, Commercial Services
    - Consultant Gastroenterologist
    - Chief Clinical Information Officer
    - Operational Programme Manager
    - Policy Principal Employment and Social Security
    - Head of Estates
    - Associate Managing Director, Care Groups
    - Therapies Lead
- The Health Workers Panel – 13th April 2021
- The Citizens Panel – 15th April 2021

Further details on the outcomes of this process are set out below.

### Scoring criteria

All benefits were scored for the purpose of this OBC whilst work to quantify benefits is still ongoing. The benefits were qualitatively scored using the following criteria:

**Table 25: Qualitative Benefit Scoring Criteria**

| Score | Benefit Scoring dimensions |
|---|---|
| 0 | The option does not meet the sub-criteria expectations in any way or is not considered to be able to do so following any further development. |
| 1 | To option goes some way to meeting the sub-criteria expectations or demonstrates an ability to do so following further development. |
| 2 | The option reflects at least half of the expectations of the sub-criteria but is unlikely to improve on this. |

| Score | Benefit Scoring dimensions |
|---|---|
| 3 | The option reflects at least half of the expectations of the sub-criteria and clearly demonstrates that greater achievement is possible. |
| 4 | The option meets the expectations of the sub-criteria. |
| 5 | The option meets or exceeds the expectations of the sub-criteria and clearly demonstrates that the expectations can be exceeded. |

Note that weighting was considered as part of the scoring process and it was agreed to apply an equal weighting to all benefits. The total weighted benefit score is therefore the average score across all benefits.

### Benefit scores

As described above, each of the benefits has been scored as part of a workshop and further feedback sought from a wide range of stakeholders. The final approved scores, and corresponding rationale, for both the Baseline Comparator and New Build  options are shown below.

**Table 26: Summary of Qualitative Scores and rationale**

| Objectives | Benefits | Baseline Comparator | New Build | Rationale |
|---|---|---|---|---|
| To provide high quality, efficient and effective care for all patients and service users that is timely, accessible and delivers the best possible experience for patients, service users, visitors and staff | 2. Improved patient satisfaction and experience | 2 | 5 | The new estate will lead to a significant improvement in patient experience and outcomes through modern facilities, better layouts and greater integration. The Baseline Comparator would not address any of its existing issues in relation to space, clinical flow and adjacencies. |
| | 3. Facilities which address the healthcare needs of all patients | 1 | 5 | The campus approach means that the new build at Overdale offers the co-location of more services including mental health within the new facility. No further co-location would be delivered via the Baseline Comparator. |
| | 5. Optimising the privacy and dignity of patients | 4 | 5 | The provision of side rooms, theatre direct and pods for day surgery will provide privacy for patients. The Baseline Comparator would continue to provide for the privacy and dignity of patients, but space restrictions would be making any improvements difficult. |
| | 7. Improved outcomes for all, particularly for children through Putting Children First | 2 | 4 | Co-located children's mental health within the new facility will lead to greater integration and |

| Objectives | Benefits | Baseline Comparator | New Build | Rationale |
|---|---|---|---|---|
| | | | | better outcomes for children. The site constraints of the Baseline Comparator would not allow for any meaningful improvements. |
| | 8. Delivering greater accessibility for all including car parking | 2 | 4 | The new hospital design includes greater access for disabled patients and/or wheelchair users. This access is enhanced by delivering more services in a since location which makes it easier for disabled patients to have their needs met in one place. On site car parking will also be provided to improve access for all. The Baseline Comparator option would continue to be constrained by the limitations of the site. |
| | 11. Better sign-posting, easier way-finding leading to a more efficient patient experience – i.e. the patient needs be met in one place | 1 | 4 | The new hospital will enable more patients to have all of their health care needs met in a single location. There will be a particular improvement to patients who need to access acute and mental health services at the same time. Improved clinical adjacencies will also reduce journey times across the hospital for all patients. The Baseline |

| Objectives | Benefits | Baseline Comparator | New Build | Rationale |
|---|---|---|---|---|
| | | | | Comparator would not address any of its existing issues in relation to space, clinical flow and adjacencies |
| | 23. Deliver greater choice for patients | 2 | 5 | The proposed new hospital will deliver an expanded range of services thus giving patients more choice around where and when they receive their treatment. The Baseline Comparator would continue to be restricted by the limitations of the existing site. |
| | 28. First class Healthcare facilities | 1 | 4 | The Design of the new facility will be informed by leading international best practice. This is not the case with the Baseline Comparator option, which will be restricted by the current layout and functionality of the existing JGH. |
| To deliver integration of physical and mental health care and services including co-location of an Acute and General Hospital and Mental Health Services | 1. Safe, reliable and quality assured care with improved & predictable outcomes for patients and parity for mental health | 2 | 5 | Co-location of mental health in the new hospital delivers far greater patient benefit than the current estate, where mental health is separated from the main hospital. This co-location could not be achieved in the Baseline Comparator. |

| Objectives | Benefits | Baseline Comparator | New Build | Rationale |
|---|---|---|---|---|
| | 22. Promote integration of health services | 3 | 4 | The co-location of mental health and other services in one site will promote patients being able to have all of their needs met in a single location. The current geographical spread of services at different locations across the Island will always limit how integrated the health service can be. This co-location could not be achieved in the Baseline Comparator. |
| To deliver an Acute and General Hospital with co-located mental health and other services currently delivered offsite that is safe, compliant, flexible, delivers an optimised planned preventative maintenance regime and is right sized for the future delivery of clinical and other services, and enables service transformation | 4. Continued provision of immediate and urgent care 24/7/365 | 4 | 5 | Slight score differential due to the new build improving on a mental health basis due to co-location. There will also be a purpose built ED with much better ambulance access |
| | 9. Improved patient safety and security | 2 | 4 | The high number of single bedrooms will improve infection control procedures and patient dignity.<br><br>The new hospital will be designed to include clinical wash hand basins at each bed/clinical workspace. |
| | 10. A design which is flexible and future proof by offering resilience and continuity | 1 | 4 | The new design builds in the potential for future growth and lessons learned from COVID (hot/cold site etc). The existing site is hugely |

| Objectives | Benefits | Baseline Comparator | New Build | Rationale |
|---|---|---|---|---|
| | | | | constrained in terms of making changes, even under the Baseline Comparator option. |
| | 15. The environment will enable greater multi-disciplinary team working | 2 | 5 | The co-location of mental health and other services in one site will enable greater working across multi-discipline teams. The current geographical spread of services at different locations across the Island will always limit the ability of multiple team to work together in the most effective way. |
| | 16. Single site working benefits for staff who work across HCS and the third/private sector | 2 | 4 | The co-located services at the new hospital will significantly reduce staff travel time and allow them to devote more of their time to patients. This will not only benefit clinical staff but will allow wider HCS support teams and those who work across the third/private sector. The lack of co-location in the Baseline Comparator will always restrict its ability to achieve this. |
| | 14. New facilities will deliver greater standardisation (including room layout and equipment) | 3 | 4 | The new hospital will be designed to have standard room sizes and equipment throughout. The Baseline Comparator will be restricted by space and will |

| Objectives | Benefits | Baseline Comparator | New Build | Rationale |
|---|---|---|---|---|
| | | | | not be able to achieve this consistency. |
| | 19. Greater flexibility to changes in demand and evolving standards in clinical practice | 2 | 4 | The new hospital has inbuilt flexibility to expand to future demand, with a larger footprint. There are very limited expansion opportunities in the Baseline Comparator. |
| | 21. Healthcare facilities which are to the standard islanders expect/compliant building standards | 2 | 5 | The existing estate is almost life expired and would be very challenging to re-configure to modern standards.<br>The new hospital will provide a first class facility built to modern standards which will enhance all elements of the health care provision on the Island. |
| | 24. Design to optimise and facilitate planned and preventative maintenance | 2 | 5 | The new hospital will not only be built to provide first class services on its first day, but over its design life. The design and construction of the facility will help facilitate maintaining it to the highest standard into the future. Whilst the Baseline Comparator option would be maintained over its life, the limitations and age of the buildings will always limit the options ability to |

| Objectives | Benefits | Baseline Comparator | New Build | Rationale |
|---|---|---|---|---|
| | | | | as well maintained into the future. |
| To deliver a new hospital that ensures the financial sustainability of the health economy | 17. Hospital facilities which attract highly skilled staff, assists in closing vacancy factor and improves existing staff retention | 2 | 4 | The condition of existing estate is a hindrance to attracting and retaining staff. |
| | 20. Increased integration enabling greater efficiency across services | 2 | 4 | The co-location of mental health and the general hospital will lead to greater efficiencies. The campus approach brings together disparate elements of the patient journey into a single location. The Baseline Comparator will not be able to achieve the same co-location. |
| | 25. More efficient maintenance provision due to co-location and modern facilities | 2 | 5 | The design of the hospital is focussed on the whole-life of the hospital, ensuring that future facilities maintenance is improved and more efficient. The co-location will also avoid the maintenance staff being stretched across multiple locations. The limitations and age of the buildings will always limit the options ability to as well maintained into the future |
| | 34. Increased private patient provision to deliver a surplus which can be reinvested into HCS services | 1 | 4 | This is currently limited and the expansion of the service, as well as the design of the unit, will bring |

| Objectives | Benefits | Baseline Comparator | New Build | Rationale |
|---|---|---|---|---|
| | | | | additional private patients (who currently travel to the UK) to have their procedures in Jersey. The Baseline Comparator Option does not allow for the expansion of Mental Health Services. |
| To deliver a new hospital that contributes to building a thriving community and well-being of staff and patients with positive socio-economic and environmental impacts | 6. Hospital environment and internal architecture which supports the health and wellbeing of patients and their families | 2 | 4 | The design of the hospital will be focussed on drawing on latest research and knowledge on the speed of recovery of patients and design features will be delivered to meet these requirements. Consideration to visitors, how patients and people move through the hospital is key to the design. |
| | 12. Increased job satisfaction due to improved facilities and physical surroundings, leading to a more attractive place to work | 2 | 4 | The condition of existing estate is a hindrance to retaining staff. |
| | 13. Support the development of staff skills including education, training and development | 3 | 4 | The co-located purpose built Knowledge and Training centre provided in the Overdale option supports this. The Baseline Comparator Option will continue to deliver these services at the existing locations. |
| | 18. Improved staff wellbeing | 1 | 4 | A new hospital that works better from a functional and integrated point of view will improve ways of working, and staff wellbeing at work. |

| Objectives | Benefits | Baseline Comparator | New Build | Rationale |
|---|---|---|---|---|
| | | | | Better staff facilities will also improve wellbeing. |
| | 26. Contributing to sustainable wellbeing to help achieve the community vision set out in Future Jersey | 1 | 4 | The new hospital will enable the transformation of services onto more preventative care that encourages sustainable wellbeing of the community. The hospital itself will also be a community space. |
| | 27. A facility that is owned and trusted by the people of Jersey and acts as an integral point for the local community, promoting a sense of pride for islanders | 1 | 4 | The current hospital is not treated as a community asset. The new development offers an opportunity for Jersey to develop a hospital that islanders are proud of and utilise as a community asset. |
| | 29. Provisioning for Community Diversity | 1 | 4 | The design of the new hospital incorporates inclusive design features such as inclusive toilets and better disabled access. Community consultations are also a key part of the development through the Citizens Panel. |
| | 30. Hospital facilities and public realm which could be used by the wider community. The hospital can be seen as a catalyst for wider community engagement/improvements | 1 | 4 | The existing hospital is not a place people visit other than for healthcare purposes. The new design will incorporate features that enable the use of the hospital for community engagements. |

| Objectives | Benefits | Baseline Comparator | New Build | Rationale |
|---|---|---|---|---|
| | 31. Job creation opportunities for local residents | 2 | 3 | The construction of the Baseline Comparator and the new hospital both offer job opportunities. Both options will deliver opportunities. |
| | 32. Development of apprenticeships and increased training opportunities | 2 | 4 | Part of the PCSA and construction contracts detail requirements to offer apprenticeships and training opportunities. |
| | 33. Creation of low carbon generating facilities | 1 | 3 | The new hospital will meet the Jersey Island planning requirements and therefore be an improvement on the existing JGH in terms of energy use. |
| | 35. The opportunity to re-provision, re-develop or realise a capital receipt at a number of buildings which could become vacant following the completion of the new hospital | 1 | 4 | The vacation of a number of sites through the new development gives Jersey the opportunity to develop affordable or social housing in these locations or realise a capital receipt. This is not possible under Baseline Comparator. |
| **Total weighted benefit score** | | **1.9** | **4.2** | |

## 4.10.5 Future quantification of benefits

### Currently identified benefits for quantification

All benefits have remained qualitative for the purposes of this OBC. However, extensive discussion has been undertaken and work is underway to quantify and/or monetise a number of benefits for the New Build option. Where beneficial, certain benefits may be quantified against the Baseline Comparator Option assumed base case.

**Monetised benefits (cash and non-cash releasing)**

- 17: Hospital facilities which attract highly skilled staff, assists in closing vacancy factor and improves existing staff retention
- 25: More efficient maintenance provision due to co-location and modern facilities
- 34: Increase private patient provision to deliver a surplus which can be reinvested into HCS services

**Quantified benefits:**

- 3: Facilities which address the healthcare needs of all patients
- 11: Better sign-posting, easier way-finding leading to a more efficient patient experience
- 29: First class Healthcare facilities
- 20: Increased integration enabling greater efficiency across services
- 18: Improved staff wellbeing
- 31: Job creation opportunities for local residents
- 32: Development of apprenticeships and increased training opportunities
- 34: Creation of low carbon generating facilities

Each of these are set out in more detail in the sections that follow.

### Monetised benefits

There are a number of benefits which are assumed to either provide cost savings or additional revenue for the GoJ once the new hospital is developed. These relate to staff cost savings, more efficient maintenance provision and an increase in private patient provision.

**Staff costs**

*17: Hospital facilities which attract highly skilled staff, assists in closing vacancy factor and improves existing staff retention*

Jersey has historically had issues with the attraction of skilled staff to work in the hospital, with a higher vacancy factor leading to significantly greater recruitment costs. By having a world-class health facility, more skilled staff will be attracted to working on the Island and staff retention should be improved. This will lead to cost savings to GoJ, which are assumed to be non-cash releasing (as they will simply reduce HCS overspend).

The financial impact of this is currently being calculated.

**Maintenance provision**

*25: More efficient maintenance provision due to co-location and modern facilities*

Currently the hospital estate is ageing and spread over a number of locations. The maintenance staff are therefore also spread across locations, making maintenance provision more inefficient. By co-locating services on a single campus and with better facilities, maintenance of the hospital will become more

effective and efficient, leading to cost savings. A separate Facilities Management business case is currently being prepared and the outputs of this will be included in the FBC.

**Increase in private patient provision**

*34: Increase private patient provision to deliver a surplus which can be reinvested into HCS services*

As outlined in section 6.12 of the Commercial Case, a detailed Private Patients strategy has been developed for the new hospital. This includes an increase in the private patient provision to generate additional revenue to HCS. The strategy is still under review, and once complete, the additional revenue expected from the increased unit will be included in the economic appraisal.

## Quantified benefits

Further analysis was undertaken as to whether any of the other benefits could be quantified. Benefits were identified that related to the clinical improvements that the new hospital would bring and the wider benefits to the Island of Jersey.

**Clinical benefits**

The following benefits have been identified for future quantification and what measures could be used:

- 3: Facilities which address the healthcare needs of all patients
  - *Proposed KPIs: Available bed numbers, occupancy rates*
- 29: First class Healthcare facilities
  - *Proposed KPIs: Bed days, MRSA/C.Diff/other in-hospital infection cases*
- 20: Increased integration enabling greater efficiency across services
  - *Proposed KPIs: Theatre utilisation, day cases/failed day cases, IP elective wait times*
- 18: Improved staff wellbeing
  - *Proposed KPIs: Staff survey results*

Work is underway to prepare baseline and target measures.

**Wider benefits to the Island of Jersey**

- 33: Creation of low carbon generating facilities
- 31: Job creation opportunities for local residents
- 32: Development of apprenticeships and increased training opportunities

*Environmental benefits*

As outlined in the RIBA2 report, the Sustainability Strategy is under development and is looking to the material (build less, build clever, optimise) and energy (lean, clean, green) hierarchy approaches as a structure to apply sustainability methodology and requirements to the project. Consideration of sustainability from a whole life cycle approach and consideration for the strategy include structure, form, and material efficiency while looking at building fabric performance, energy efficiency and system specification and design. The overall aim is to reduce the environmental impact of the building and maximising the operational performance. Targets for embodied and operational carbon will be determined by current Planning and adopted Policy and form the basis of the ongoing design, construction and operation of the building. These targets will be established based on understanding of good practice and the context of the overall project including consideration of the affordability limit. OHP will be designed to not negatively impact the Island's ability to achieve carbon neutrality (operational energy) by the 2030 target date.

*Job and apprenticeship opportunities*

The Director of Social Value from the DDP intends to establish a structured process for target setting, measurement and contract management of the social and economic impacts from bidding, management to completion. This will embed a consistent and replicable approach with robust KPIs to understand and manage impact throughout the re-provision works and the main build phase backed up by tangible data. The approach to do this is outlined below

1. **Local Needs Analysis**

Needs Analysis is to provide an understanding of the key needs and opportunities, this will help to identify where the project can make a real and long-lasting difference.

2. **Community Consultation**

It is important that local people understand the commitment to generating social, economic and environmental outcomes, but also that those people have the opportunity to inform the Social Value Strategy.

3. **TOMs (Themes, Outcomes, Measurements) Framework**

TOMs Framework (a standard method for assessing social value) will be designed and implemented to capture all social, economic, environmental, and other social value activities across the whole project team.

4. **Social Value Assessment**

To assess the potential social and local economic value that could be generated throughout the lifecycle of the development. The aim of this assessment is to highlight the value being added compared to ‘business as usual’.

5. **Social Value Statement to Provide:**

- A description of the overall Social Value Strategy for the development and the associated Social Value Measurement Framework;
- Key issues arising from the needs analysis and community consultation relevant to social value with a detailed explanation of the tasks delivered and the engagement undertaken;
- Summarising key aspects of the Social Value Assessment and how this value could be unlocked through specific activities and interventions.

6. **Social Value Dashboard & Projects Accounts (Quarterly & Annual Reports)**

To calculate overall Social Value created for reporting in addition to measuring and managing Social Value on a contract-by-contract basis.

Once this work is completed the Director of Social Value will provide metrics/quantification, including job creation and apprenticeships in addition to cost savings to the Government of Jersey.

Using the labour histogram to predict main works resourcing levels it has been estimated that approximately 1,090 construction jobs will be created during the building phase of the main hospital under

the New Build option. A further 182 jobs will be generated for the re-provisioning and enabling works at Les Quennevais. Between Q1 2022 and Q4 2026, it is estimated that a total of 1,272 will be generated.

By applying the KPIs agreed by the project team approximate numbers for some of the benefits that will be realised as part of the New Build can be estimated:

- 127 jobs will be created for new entrants into the construction industry - (10% of resources required to be delivered by new entrants to the industry)
- 38 apprenticeships will be created in construction roles – (3% apprenticeship/traineeship opportunities to be provided)
- 24 placements to help people develop their skills and gain employment in the industry – (2% graduate, summer placement and work experience)
- 127 training opportunities for the team and wider community - (10% Training/other employment and skills opportunities).

**Additional benefits that will be considered for future quantification**

Some further benefits have been identified as potentially quantifiable, but further work is required to identify if/how they will be quantified.

Indicatively, these include the following benefits which may be added to as the business case process and development of the scheme progresses:

- 2: Improved patient satisfaction and experience
- 11: Better sign-posting, easier way-finding leading to a more efficient patient experience – i.e. the patient needs be met in one place
- 15: The environment will enable greater multi-disciplinary team working
- 16: Single site working benefits for staff who work across HCS and the third/private sector

These will lead to a mixture of monetised benefits (e.g. staff cost savings) and quantified benefits through a patient survey that enables a baseline with which to compare.

Work will also take place to define and quantify any further benefits that can be identified around learning and development, the private patient facility and income generation around uses such as pharmacy, retail, parking and Food & Beveridge.

### 4.10.6 Benefits appraisal conclusion

The Baseline Comparator option continues to be constrained by the existing location and layout of the Jersey General Hospital and the wider HCS estate. This means that there is limited scope for the functional improvement of the hospital to meet the strategic objectives and resulting in low qualitative scores against the expected benefits. The limited improvements to the functional space means that the wider benefits to patients, staff and the community can also not be achieved.

In contrast, the proposed new hospital at Overdale will deliver significant benefits to all types of beneficiaries from the GoJ public sector through to patients using the facilities. Further work will continue to quantify and/or monetise these benefits as far as possible against the Baseline Comparator baseline to demonstrate the positive impact the hospital will have.

## 4.11 Risk appraisal

### 4.11.1 Risk Register

The successful management of risk is critical to the successful delivery of the Project. Risk Registers are maintained in order to capture, monitor and manage the risks associated with the delivery of the Project.

- **The Construction Risk Register** - this Register is maintained by the DDP and reviewed on a monthly basis at a risk workshop which is attended by the GoJ Project Team, which includes Mace, T&T and EY. Risks have been allocated as appropriate to the party best able to manage them with in all cases this being either the DDP or the GoJ. Wherever possible, the Risks on the Construction Risk Register have been quantified.
- **The Senior Office Scoring Group (SOSG) Risk Register** – this register is used to escalate and manage risks relevant to SOSG using the process set out in the Manual. It is monitored and maintained by the Government of Jersey's Director of Risk and Audit.
- **Political Oversight Group Risk Register** – this register is used to escalate and manage risk relevant to POG suing the process set out in the Manual. It is monitored and maintained by the Government of Jersey's Director of Risk and Audit.

The Risk Registers outlined above will be continuously reviewed and updated on a monthly basis during the design and construction phases of the project.

### 4.11.2 Quantitative OBC Project Risk Register

In order to assess and where possible quantify the risks which sit with the OBC, an OBC Project Risk Register has been produced summarise the key project risks for the OBC stage.

The OBC Project Risk Register was developed by MACE, T&T and EY to combine the GoJ allocated risks that had been identified through the project risk appraisal processes. These risks have been scored on a likelihood/impact basis and where possible have been quantified.

The OBC Project Risk Register has been tested at the following groups:

- OBC Project Team – May 2020

The table below summarises these risks.

**Table 27: OBC Project Risk Register**

| No. | Risks | Mitigating Actions to reduce risk | Mitigated Likelihood Score | Mitigated Impact Score | Mitigated Risk Score | Quantification Rationale |
|---|---|---|---|---|---|---|
| OBC1 | **Poor communication / consultation** - Project is unsuccessful or delayed as a result of public opposition, partly driven by poor communication / lack of consultation. | The OHP Public Engagement and Communications Strategy outlines the public engagement and consultation approach that is being undertaken as part of the pre-planning application process for Our Hospital Project. To ensure all public consultation is carried out impartially, transparently and thoroughly is a prerequisite of a properly conducted planning process for a project of this significance, Soundings have been appointed as an independent consultant to the Our Hospital Project team. Soundings will ensure that all opinions and thoughts as regards the design of the hospital, and allied early works, such as the Overdale access arrangements, are logged and properly considered by the design team at each stage of the scheme's evolution. Soundings will be responsible for producing the Statement of Community Consultation, which will accompany the planning application documents for consideration on determining the planning application, describing the consultation process and its impact on the final design outcomes. | 3 | 5 | **15** | Cost of a 3,6,12 month delay |
| OBC2 | **Land assembly/ acquisitions -** Negotiated purchase and/or CPO fails or is significantly delayed which results in land not being acquired. | On-going negotiation with parties to agree land assembly position at the earliest opportunity. Significant progress being made, with a number of acquisitions now complete. | 3 | 5 | **15** | Cost of a 3,6,12 month delay. |
| OBC3 | **Site access -** Unable to access and complete the required surveys to inform the design. A less informed design will result in the robustness of the design being impacted and potentially resulting in cost implications down the line. | On-going engagement and consultation with landowners to agree access. Ways of accessing the various roads to carry out the site survey required is being explored through Highway applications. Where access cannot be achieved, the team are exploring alternatives in order to obtain the information required for the design work where possible, mitigating impact to the programme. | 4 | 4 | **16** | Cost of a 3,6,12 month delay |

| | | | | | | |
|---|---|---|---|---|---|---|
| OBC4 | **Pre-OBC funding -** Delay in funding for the project impacts on the programme. | Options for maximising funding available ahead of agreement of main funding progressed to enable early activities which will de-risk the project such as land assembly to take place. | 2 | 5 | **10** | Cost of delay including Consultant fees, inflation, de-mobilisation and re-mobilisation costs. |
| OBC5 | **New variant of Covid-19 -** New variants of covid-19 may result in delays and cost impacts. Travel restrictions and social distancing due to covid-19 will impact access to the island for key workers or may result in a reduced number of key workers accessing the Island.<br>There may be cost premiums from supply chains. | Alternative ways of working such as Virtual Meetings and Workshops being used where possible. Many members of the team are based in Jersey, which mitigates risk, and strategy to encourage local recruitment and procurement is also supporting this risk. Vaccine role out and general progress on pandemic also helping. | 2 | 5 | **10** | Capital cost. |
| OBC6 | **Funding full project -** Failure to put in place sufficient funding required for the project up until FBC stage. | Affordability and funding to be considered as part of OBC decision by SOSG/POG and in the Assembly in Sept 2021. | 4 | 5 | **20** | Cost of a 3,6,12 month delay. |
| OBC7 | **Project Delay due to political process –** The political decision making process results in delays that impact on the Our Hospital project process timeline. | Governance team established to support political decision making process. | 4 | 5 | **20** | Cost of a 3,6,12 month delay. |
| OBC8 | **Planning -**<br>Risk around planning not being achieved or being delayed. This could be due to one or several of the following:<br><br>- Objections and appeals to planning processes extend for longer than current programme forecasts.<br>- Failure to demonstrate appropriate compliance with planning policies. | A Planning Strategy has been developed in consultation with the DDP Planning Consultant in order to maintain critical timeline.<br>The project team have a regular meeting with GoJ Development Control in order to regularly consult on all matters in relation to planning in order to obtain early feedback. | 4 | 5 | **20** | Cost of a 3,6,12 month delay. |
| OBC9 | **Financial management and control -** Loss of key financial and project management staff and ability to replace in the short term impacts overall financial management and control surrounding the project | Risk monitored through regular discussions. Team assembled and in place. | 2 | 2 | **4** | Additional consulting costs. |

| | | | | | | |
|---|---|---|---|---|---|---|
| OBC10 | **Senior staff capacity –** Capacity of key officers to deliver multiple projects across Government simultaneously and to align interdependencies with other projects. | Monitor and prioritise OHP activity given the strategic importance of the project, and the impact of competing priorities. Analyse proximity of interdependent projects. | 3 | 4 | **12** | Additional consulting costs. |
| OBC11 | **Economic & external factors -** Risk around Economic & other impacts which are beyond the control of the Project. These could include but may not be limited to:<br>- Potential Brexit Impact on exchange rate and supply chain of materials, many of which will come from EU regardless of origin of build partner. A weak pound could mean that the hospital becomes more expensive.<br>- Economic issues leading to Jersey being less attractive to EU or UK labour.<br>- Client changes to the brief<br>- Unknown ground conditions and services. | Close monitoring of economic and external factors informs development of procurement strategy.<br>Client brief established prior to design starting.<br>Surveys have taken place where possible. | 3 | 4 | **12** | Variety of exceptional risks such as high inflation in global economy and shortage of supplies due to large-scale demand through to trade tariffs with new trading agreements |
| OBC12 | **Achievement of Timetable / Programme -** Challenging Project Timetable and complexity of interdependencies. | Regular review, revision and communication.<br>Ensure the appropriate process is complied with, without impacting overall delivery. | 3 | 3 | **9** | Cost of a 1,3,6 month delay |
| OBC13 | **Supplier Performance -** Delays to the overall project caused by supplier performance through lack of coordination of workstreams within the overall programme of works. | Strong supplier management in place<br>Areas of concern raised and followed up with to mitigate impact as far as possible. | 2 | 3 | **6** | Additional costs passed to GoJ. |
| OBC14 | **DDP Affordability limit -** Affordability limit is not achieved by DDP resulting in an element of the costs being passed through to GoJ<br>(e.g. Pain that would be part of the agreement of the contract) | During pre-construction stage, strong value management and market testing to ensure affordability limit maintained. Procurement and contracting strategy for works contract is for a target cost contract with a pain/gain mechanism that incentives the DDP and the client to work together to avoid cost overruns. | 4 | 4 | **16** | Additional costs passed to GoJ. |

| | | | | | | |
|---|---|---|---|---|---|---|
| OBC15 | **Re-provision of Service -** Catch-all risk around the decant risk which results in some or all services not being able to decant on time which results in a project delay. This could be driven by:<br>- Inability to find suitable site locations for services provided at Overdale<br>- The proposal to relocate certain services to Le Quennevais fails<br>- Inability to relocate the playground at People's Park | Appropriate locations and necessary approvals in place aiming to avoid any impact to the programme. | 2 | 3 | **6** | Cost of a 1,3,6 month delay. |
| OBC16 | **Highways –** Risk of increased requirements for changes to wider highways network as design is develop, leading to additional cost and programme implications. | Progress travel surveys and studies where possible to inform design. | 3 | 4 | **12** | Cost of a 1,3,6 month delay. |
| OBC17 | **Economic Benefits to Jersey -** Approach to ensuring maximum economic benefits to Jersey unsuccessful due to failure of procurement strategy. | To put in place an appropriate Procurement Strategy and regularly monitor to ensure outcomes are being delivered. | 2 | 3 | **6** | Not costed - reputational risk |
| OBC18 | **Contractor or Supply chain insolvency** – Delay and/or cost increase caused by contractor and supply chain insolvency. | Appropriate and rigorous financial checks during procurement and as part of supplier management. | 1 | 5 | **5** | Cost of a 1,3,6 month delay |
| OBC19 | **DDP/GoJ Interfaces –** Interface & scope gaps between DDP and GoJ. | Develop interface schedule, check that schedules of inclusions and exclusions generated by DDP are aligned with GoJ position, and conduct technical review. | 2 | 2 | **4** | Possible items identified. |

### 4.11.3 Baseline Comparator Project Risk Register

As part of the development of the Baseline Comparator Option, a GoJ Baseline Comparator Risks Register has been produced. This has been developed by MACE, T&T and EY and has been scored on a likelihood/impact basis and where possible have been quantified.

The Baseline Comparator Risk Register was tested with OBC Project Team on 19th May 2021.

The table below summarises these risks.

**Table 28: Baseline Comparator Risk Register**

The following risks have been identified in relation to the Baseline Comparator Option:

| No. | Risks | Mitigating Actions to reduce risk | Mitigated Likelihood Score | Mitigated Impact Score | Mitigated Risk Score | Approach to Quantification |
|---|---|---|---|---|---|---|
| DM1 | **Decant** – Lack of available suitable sites for decanting the services while the build takes place at the existing site. | A decant plan would be developed, and GoJ sites would be used where possible. However the level of decant required is high and the strategy would be complex. | 3 | 5 | **15** | 3, 6, 12 month delay and associated increased costs as a result.<br>If a decant site cannot be identified, more services may need to move off-Island. |
| DM2 | **Affordability risk -** The risk that the eventual cost of the Baseline Comparator scheme is unaffordable to the GoJ as a result of the complexity of the build and the inflation effect of the programme. | A phasing plan would be developed, aiming to achieve the project as efficiently a possibly, but due to the complexity this risk would remain. | 4 | 5 | **20** | Quantified through appropriate Optimism Bias |
| DM3 | **Service Disruption –** Service Disruption during the Baseline Comparator Programme.<br>- Length of construction programme and decant/phasing required could cause significant disruption to the delivery of clinical services during the build process. | Careful planning and engagement with users would take place to mitigate the impact to services as far as possible during the construction programme. | 4 | 4 | **16** | Services delivered off island |
| DM4 | **Existing Estate -** The condition of the Jersey General Hospital declines significantly whilst phased refurb is underway.<br>Critical plant that is past life expectancy to be maintained as unable to upgrade the facility all at once.<br>Wider estate earmarked for relocation into the proposed OHP requires significant refurb. | Surveys and maintenance plans would be used to understand and plan for essential maintenance. | 5 | 4 | **20** | Additional spend required on elements of the existing estate which are re-developed later in the programme of works |
| DM5 | **Jersey Care Model –** Significant disruption to the delivery of the proposed Jersey Care Model. | Alternative plans would be developed to enabled services to be provided. | 5 | 4 | **20** | Services delivered off island |
| DM6 | **Planning -** Risk that the Planning Application for the proposed Baseline Comparator could be rejected resulting in the scheme not being able to progress. | Early and ongoing engagement would take place with the GoJ Planning Department, and to obtain pre-planning application advice to best inform the requirements of the planning application. | 3 | 5 | **15** | Delay to programme |

| | | | | | | |
|---|---|---|---|---|---|---|
| DM7 | **Safety -** Continuing clinical safety risks. This could be driven by:<br>- operating from the existing site whilst a phased re-development is taking place<br>- infection control will become more difficult during the build phase<br>- challenges with hot/cold site working in the event of a recurrence of the covid-19 pandemic. | Consultation would take place to develop plans to best manage and mitigate this risk. | 2 | 3 | **6** | Increased maintenance costs |
| DM8 | **Multiple Site Working –** Ongoing additional costs from working on multiple sites for HCS e.g. Sterile services, stores, etc. | Explore the option to reduce the number of multiple sites as far as possible. Explore the option to share facilities between sites if possible and with no impact to the service provision. | 3 | 3 | **9** | Lack of efficiency. |
| DM9 | **Delivery risks -** Delivery risks similar to those present for the New Build option (client change, programme delays through consultant design, contractor performance, client governance, unknown conditions, asbestos, etc.) | Mitigations would be developed similar to the approach for the New Build Option. | 3 | 3 | **4** | Project team and capital cost increases + 3,6,12 month delays |
| DM10 | **Scope Gaps -** Scope gaps in works required to deliver the project | An interfaces schedule would be developed, check that schedules of inclusions and exclusions generated by supply chain are aligned with GoJ position, and conduct technical review. | 2 | 2 | **4** | Schedule of possible items |

### 4.11.4 Risk conclusion

A number of detailed processes have been put in place to manage risk on the project, which are described in the Management Case.

For the purposes of this OBC, the OBC Project Risk Register and the Baseline Comparator Risk Register both detail the specific risks which sits with the Government of Jersey, the mitigations for these risks and a qualitative risk assessment. Certainty and confidence has been established in relation to these risks through a full quantified risk appraisal.

The quantified risk totals shown above for both the Baseline Comparator Option and the New Build Option have both directly informed the allowance included in each Option for Client Contingency.

## 4.12 NPC Analysis

This section provides an economic Net Present Costs (NPC) appraisal of the Preferred Option with a comparator against the baseline Baseline Comparator Option. The economic appraisal focuses on estimating the NPC of future costs, in keeping with HMT Green Book guidance.

### 4.12.1 NPC Assumptions

The following key assumptions have been quantified on a whole life cost basis using a number of key assumptions and principles as follows:

- The economic life of the new hospital is estimated at 60 years
- The total appraisal period for the new build option is 67 years (2019 – 2085) which includes the pre-construction and construction periods (up to 2025). The Baseline Comparator has been aligned to this profile however it should be noted that the Baseline Comparator Construction period extends to 2028
- The following cost categories are included in the NPC assessment:
    - Construction Costs (including Pre-Construction, Professional Fees and Land Assembly)
    - Lifecycle – 60 year profile for the new build option, Baseline Comparator is a shorter lifecycle due to the longer construction period
    - Overdale Shuttle Bus service – new build option only
- Benefits – a number of benefits are currently being costed by the GoJ and the DDP. These will be included in the NPC analysis for FBC
- The price base date for indexation is 1st January 2021 with inflation applied beyond this point
- Inflation is applied as follows:
    - Construction Costs – mid-point BCIS inflation indices with a Jersey Factor
    - Lifecycle Costs – Jersey Standard Inflation of 3.0%
    - Shuttle Bus Costs – Jersey Standard Inflation of 3.0%
- The economic appraisal focuses on expected future real resource costs for the States of Jersey; therefore, it excludes loan interest charges
- Deflator Rate (to remove the impact of non-variable inflation) – 3.00% based on the Jersey General Inflation Rate
- Discount Rates
    - Years 1-30 – 3.5%
    - Years 31-75 – 3.0%

### 4.12.2 NPC Calculations

Based on the assumptions set out above, The Net Present Cost of the capital and revenue costs for each option is set out below and indicates that New Build Option offers the lower Net Present Cost (£745.4m) compared to other the Baseline Comparator Option (£764.5m).

**Table 29: NPC Results**

| | Baseline Comparator Option | New Build Option |
|---|---|---|
| NPC | £764.5m | £745.4m |
| Rank | 2 | 1 |

### 4.12.3 NPC per Benefit Point

In making value based decisions, the Green Book Guidance recognises the value and usefulness of monetising qualitative scores to establish a clearer basis for understanding the relationship between project cost and the evaluated benefits.

This is achieved by using the Net Present Costs and the Weighted Benefit Scores resulting from the non-financial benefits appraisal to calculate an NPC per Benefit Point. The lower the cost per benefit point, the more cost effective the option is. This analysis of the cost and benefit associated with each option is set out below:

**Table 30: NPC per Weighted Benefit Point**

| | Baseline Comparator Option | New Build Option |
|---|---|---|
| NPC | £764.5m | £745.4m |
| Weighted Benefit Score | 1.9 | 4.2 |
| NPC per Weighted Benefit Point | £402.4m | £177.5m |
| Rank | 2 | 1 |

The analysis above shows that the New Build Option has a significantly lower NPC per Weighted Benefit score (£177.5m) compared to the Baseline Comparator Option (£402.4m).

### 4.12.4 NPC Conclusion

The NPC analysis set out above shows that the New Build Option represents the best Value for Money both in terms of NPC and NPC per Weighted Benefit Points. The New Build Option is also cheaper in terms of the initial capital spend.

The detailed cost analysis undertaken in relation to the Baseline Comparator Option shows this option to be more expensive, riskier and delivering far fewer benefits compared to the New Build Option.

## 4.13 Sensitivities

Sensitivities have been performed in line with Green Book best practice in order to test the conclusions outlined above in relation to the selection of the New Build Option as the Preferred Option. These sensitivities are indicative and only carried out to demonstrate the impact that changes would have on the NPC ranking of options.

Three sensitivity tests have been undertaken on the Capital Cost and NPC analysis as set out above:

- Sensitivity 1 – a 10% Capital Cost increase on the New Build Option
- Sensitivity 2 – a 50% increase in the Weighted Benefit Score in relation to the Baseline Comparator Option
- Sensitivity 3 – a combination scenario in which the impact of both Sensitivity 1 & 2 are combined

### 4.13.1 Sensitivity 1 - 10% increase in capital costs of the New Build option

The impact on the NPC ranking of a capital cost increase of 10% on the New Build Option is shown in the table below. It is assumed for the purpose of this test that there is no change in the capital cost of the Baseline Comparator Option.

**Table 31: NPC and NPC per Benefit Point Ranking - Capital costs for 10% increase**

| | Baseline Comparator Option | New Build Option |
|---|---|---|
| Weighted Benefit Score | 1.9 | 4.2 |
| NPC per Weighted Benefit Point | £402.4m | £193.3m |
| Rank | 2 | 1 |

It should also be noted that the New Build total capital cost currently includes Optimism Bias and Client Contingency. Therefore, in reality in the event of a 10% increase in the cost of the New Build Option, there would be sufficient contingency to absorb that increase.

As set out in the table above, a 10% increase on the New Build capital cost would not change the ranking between the options for NPC per Weighted Benefit Point.

### 4.13.2 Sensitivity 2 - 50% increase in Baseline Comparator Option Weighted Benefit Score

This sensitivity assumes tests the impact on the NPC per Weighted Benefit Point if the Baseline Comparator Option was to score 50% higher on the options benefit scores. Therefore, in this scenario the Baseline Comparator Option Benefit Score increases from 1.9 to 2.85.

The Capital Cost and NPC of both options will not change under this scenario.

The updated NPC per Weighted Benefit Point is shown below.

**Table 32: NPC and NPC per Weighted Benefit Point ranking – 50% increase in Baseline Comparator Weighted Benefit Score**

| | Baseline Comparator Option | New Build Option |
|---|---|---|
| Weighted Benefit Score | 2.85 | 4.2 |
| NPC per Weighted Benefit Point | £268.2m | £177.5m |
| Rank | 2 | 1 |

As set out in the table above, a 50% increase in the Weighted Benefit score of the Baseline Comparator Option would not affect the ranking of the options in NPC per Weighted Benefit terms with the New Build Option still delivering a significantly higher NPC per Weighted Benefit Point.

### 4.13.3 Sensitivity 3 – Combination Sensitivity

This sensitivity combines the impact of bother Sensitivity 1 and 2 above and therefore assumes 1:

- 10% increase in the capital cost of the New Build Option, and
- 50% increase in the Weighted Benefit Score of the Baseline Comparator Option.

The updated NPC and NPC per Weighted Benefit Point analysis is shown below.

**Table 33: NPC and NPC per Weighted Benefit Point ranking – 50% increase in Baseline Comparator Weighted Benefit Score**

| | Baseline Comparator Option | New Build Option |
|---|---|---|
| Weighted Benefit Score | 2.85 | 4.2 |
| NPC per Weighted Benefit Point | £268.2m | £193.3m |
| Rank | 2 | 1 |

As set out in the table above, the combination sensitivity would not change the ranking of the Options on the NPC per Weighted Benefit Point.

## 4.14 Conclusion

The Our Hospital Project New Build option at Overdale represents an exciting and ambitious scheme which can help deliver a meaningful change to the delivery of health services in Jersey and deliver a hospital which is fit for purpose today and in the future.

This OBC is reconfirming the New Build Option at Overdale as the Preferred Option for re-developing the healthcare estate in Jersey, for the following key reasons:

- The New Build Option is the only option that achieves the CSF
- The New Build Option is cheaper is absolute terms and NPC terms than the Baseline Comparator Option
- The New Build Option delivers greater benefits to patients, staff, HCS and the wider community

As set out above, the New Build Option will deliver significantly more benefits to all stakeholder, scoring 4.2 against the Baseline Comparator 1.9 out of 5 for the weighted benefit score. Work is underway to quantify and/or monetise these benefits where possible, particularly around the clinical and social benefits that the hospital will bring which is expected to further reinforce the case for the New Build option.

The Our Hospital Project offers an opportunity to modernise not just the healthcare facilities in Jersey, but to be a key enabler of change for the wider Jersey healthcare system. The new hospital will provide a facility which conforms to the highest standard of clinical care, both now and into the future and will be a centrepiece that the Island can be proud of.

In contrast, the Baseline Comparator Option will not be able to achieve these benefits. The facilities in their current state, and even following significant refurbishment, will remain restricted by the functional layout and quality of the building structures. This prevents the current hospital ever being able to deliver any improvements to adjacencies or co-location of mental health services, thereby not meeting the expectations of patients, staff or the wider community.

The Baseline Comparator option also does not deliver a sustainable solution for the delivery of healthcare services at the existing Jersey General Hospital site – and represents a more expensive option in both absolute terms and in NPC terms due to the significant refurbishment that would be required. On top of this, the Baseline Comparator option carries substantial risk both in terms of the condition of the existing facilities and the ability to attract and retain the best possible clinical staff for the Island.

In addition, any deferral of a decision to invest in the hospital at this stage could potentially have a significant impact in the future. This is because of the expected pressure on the construction industry due to the pipeline of hospital developments in the UK and the high construction inflation rates in Jersey.

# 5. THE FINANCIAL CASE

## 5.1 Introduction

### 5.1.1 Purpose of the Financial Case

As detailed in the Economic Case, a Preferred Options (i.e. the New Build Option) has now been selected and this Financial Case sets out the financial implications of delivering that Preferred Option. This involves setting out the up-front Capital Cost, the whole life financing implications of those capital costs and the whole life Lifecycle and Shuttle Bus service associated with the Preferred Option.

A detailed Proposition is being developed which will be presented to the States Assembly for debate in September 2021 and will include a request for approval to fund the Our Hospital Capital Costs set out within this OBC. The Proposition will set out the options that have been considered in relation to funding the Our Hospital Project and the GoJ Treasury recommendation. For the purposes of the Our Hospital OBC, a series of funding assumptions have been made by the GoJ Treasury but the ultimate decision on funding will be made by the States Assembly when the Proposition is debated in September 2021.

### 5.1.2 Work undertaken at the SOC Stage and updates to the Case in this OBC

**SOC Stage**

During the development of the SOC, the following high-level work was undertaken on the Financial Case:

- Initial view on the potential funding solution for the proposed Our Hospital Scheme alongside some indicative funding assumptions.
- Setting out the capital cost of the proposed scheme at the time and revenue implications, including ongoing financing costs, of delivering the scheme.

**OBC Stage**

The OBC builds on the analysis undertaken at SOC stage and provides more detail on the capital and funding costs and proposed funding for the scheme. The main updates provided are listed below:

- Details the current funding position of the project and sets out the interim funding solution.
- Details the work that is currently being undertaken to establish a debt strategy for the Our Hospital Project ahead of this being completed in July. The Proposition which develops from this will be debated to the States in September 2021
- Sets out the current assumptions around the quantum and cost of the required debt as best estimated at the time of this OBC.
- Updates the capital and revenue cost analysis for the Preferred Option with the updated information as set out in the Economic Case

## 5.2 Proposed Funding Solution

This section sets out the proposed funding solution for the Our Hospital Project including both the capital and revenue requirements.

### 5.2.1 Interim funding solution

Funding for the Our Hospital Project for the calendar years 2019 and 2020 was approved in the Government Plan (P137/2018 and P71/2019) with total spend in these years being:

- 2019 – £0.5m
- 2020 – £10.6m

A further £20m was approved in the Government Plan (P130/2020) to cover the period of 1st January 2021 – 30th June 2021. At the time of approval, it was anticipated that the Our Hospital OBC and Island wide Proposition for the balance of the project would be approved by the 30th June 2021 and new funding would be in place from 1st July 2021. However, there has now been a delay the timeline for the Proposition with funding now anticipated to be in place from October 2021.

Matters changed and developed as work on the project has been carried out in recent months and the financial impacts are:

- Decant costs previously planned post June of £1.317m
- Site acquisition to be procured earlier than planned of £7.766m
- Further earlier site acquisitions £8.084m
- The costs of the period between July and September £17.796m.

As an interim measure, an additional £11.167m was approved on 9th March by Ministerial Decision (MD-TR-2021-0020) which increased the total budget for 2021 to £31.167m. This allocated budget is to fund the project team expenditure, early works and the early site acquisition and decant costs to June 2021.

Further to this, an additional funding requirement of £17.796m has been identified in order to continue funding the project until October 2021. This budget increase was supported by the Political Oversight Group (POG) as a result of the Proposition being debated in September and has been approved in principle by the Council of Ministers (COM). This additional funding has been identified from reductions and deferrals of existing capital projects and is required to fund additional early site acquisitions.

From October 2021 onwards, it is currently assumed that the project will be funded with the request set out in the Proposition which is being debated at the States Assembly in September 2021. That Proposition will include the additional 2021 funding outlined above which will be re-allocated back to reserves following draw down of the proposed capital funding solution.

### 5.2.2 Our Hospital Capital funding solution

The Government of Jersey Treasury and Exchequer department have completed an exercise to understand the cumulative financing requirement for Government through to 2026/27. A significant part of the financial requirement over the period of the next Government Plan is the Our Hospital Capital cost. Whilst the Our Hospital Project forms part of Jersey's longer-term debt strategy; the wider debt strategy will be brought forward for States Members to consider at a later date.

The Proposition will, when completed, set out in detail the options that have been considered in relation to funding the Our Hospital Project and the GoJ Treasury recommendation. For the purposes of the Our Hospital OBC, the following assumptions have been made but the ultimate decision on funding will be made by the States Assembly when the Proposition is debated in September 2021:

- £800m could be funded via at least two separate public rated Sterling Bonds:
    - Bond A is likely to have a tenor of 40 years with a value of £400m
    - Bond B is likely to have a tenor of 30 years with a value of £400m
- Subject to expert independent advice, it is likely that both Bonds will be issued at the same time (currently assumed to be Q4 2021) and will be deposited into the Strategic Reserve. Draw-downs to fund the Our Hospital capital costs will then be made from the Strategic Reserve as required during the construction phase.
- The exact timing of the borrowing will be driven by market conditions and in the event a decision is taken to delay the funding by a number of months, the GoJ expects to have the option to

utilise any unspent balance approved within the Rolling Credit Facility (RCF) which was put in place in May 2020 to mitigate the risks of the Covid-19 pandemic.

- The Strategic Reserve is assumed to grow at RPI (currently assumed to be 3.00%) + 2.0% per annum

### 5.2.3 Our Hospital Revenue funding solution

There are two principle financial implications as a result of the Our Hospital Project funding solution:

- The annual financing charge associated with the debt – this is required annually from the year of debt execution until maturity
- The ultimate repayment of that debt

It is anticipated that the returns on the Strategic Reserve over the full life of the bonds will be sufficient to meet both the annual financing costs and grow the value of the investments to a sufficient level to meet investor capital repayments as they fall due. Specific approval will need to be sought for the annual coupon payments to be made from the Strategic Reserve.

A separate business case is also being developed in relation to the approach to delivery of Facilities Management services at the new hospital post opening. This is out-with the scope of the Our Hospital OBC and therefore no funding of Facilities Management or Utility costs are assumed in the this OBC. In addition to this, the Our Hospital Business sets out an estimated 60 year Lifecycle programme to maintain the new hospital post opening. A firmer position on these costs will be developed by the work being done on the Facilities Management Business Case and an updated position will be presented at FBC stage. In addition to this, work is being undertaken by HCS to understand the workforce implications of moving to the new hospital. An update will be provided when this work has completed.

Work is underway to develop the Workforce Strategy for the new hospital. It is anticipated that the efficiency of the building will generally lead to efficiencies in the way staff can work in the space. However the increase in single occupancy inpatient rooms may lead to changes in the staffing requirements for wards. These considerations will be addressed in the workforce strategy.

### 5.2.4 Proposed funding assumptions

For the purposes of estimating the financial impact of the proposed Our Hospital project for the purpose of the OBC financial case, the following assumptions have been assumed:

**Table 34: Capital costs for New Build Option**

| Financing Charges | Bond A | Bond B |
|---|---|---|
| Bond tenure | 40 years | 30 years |
| Bond Quantum | £400m | £400m |
| Bond Drawdown Charge | 0.3% | 0.3% |
| Bond Annual Charge | 2.5% | 2.5% |

The two proposed bonds could be drawn down in full ahead of the commencement of the construction programme and will be deposited into the Strategic Reserve. Drawdowns from the Strategic Reserve will be made over the course of the construction programme (currently assumed to be 4 years). Therefore, the

fully drawn down Bond will be able to earn an investment return on the unspent amount during the construction programme. A high level assumption has been made that this would attract a return of RPI (3.0%) + 2.0% during that period.

## 5.3 Our Hospital Project financial impact

### 5.3.1 Initial capital costs

As outlined in the Economic Case, the capital costs for a New Build option comprise of the following components:

- Capital Costs, including:
  - Main Works (including demolition)
  - Preliminaries
  - Design & Professional Fees
  - Inflation
  - Equipment
  - Contractor Contingency
  - PCSA Costs
  - Overhead and Profit
  - Re-provision of Services form Overdale
  - Decant & Migration
- Other costs, including:
  - Optimism Bias
  - Client Contingency
  - GoJ Team Costs
  - Land Acquisition/Re-provision Costs

These are detailed with their profile in the table below for the New Build Option.

**Table 35: Phased Capital costs for New Build Option**

| Cost Categories (£m) | Total | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|---|---|---|---|---|
| Main Works | **311.7** | - | - | - | 20.4 | 68.0 | 138.9 | 83.7 | 0.7 |
| Preliminaries | **53.4** | - | - | - | 13.0 | 12.3 | 12.3 | 12.3 | 3.5 |
| Design and Professional Fees | **33.6** | - | - | - | 10.3 | 11.2 | 6.8 | 5.4 | - |
| Inflation | **34.6** | - | - | - | 2.3 | 7.5 | 15.4 | 9.3 | 0.1 |
| Equipment | **56.3** | - | - | - | - | 33.8 | 22.5 | - | - |
| Contractor Contingency | **35.8** | - | - | - | 2.3 | 7.8 | 16.0 | 9.6 | 0.1 |
| PCSA Costs | **34.2** | - | 6.2 | 21.8 | 6.2 | - | - | - | - |
| Overhead and Profit | **44.7** | - | - | - | 4.4 | 10.1 | 18.2 | 11.5 | 0.4 |
| Re-provision of Services from Overdale | **14.6** | - | - | - | 1.0 | 3.2 | 6.5 | 3.9 | 0.0 |
| Decant & Migration | **0.6** | - | - | - | - | - | - | - | 0.6 |
| **Sub Total – Construction Costs** | **619.5** | **-** | **6.2** | **21.8** | **59.8** | **153.9** | **236.6** | **135.7** | **5.4** |
| Optimism Bias | **38.1** | - | - | - | 3.5 | 8.4 | 15.8 | 10.0 | 0.4 |
| **Total Capital Costs Incl. Risk** | **657.6** | **-** | **6.2** | **21.8** | **63.3** | **162.3** | **252.4** | **145.7** | **5.9** |
| Client Contingency | **73.1** | - | - | 1.7 | 6.6 | 14.7 | 30.3 | 19.2 | 0.8 |
| GoJ Team Costs | **39.5** | 0.5 | 4.4 | 9.4 | 6.3 | 4.8 | 4.7 | 4.7 | 4.7 |
| Land Acquisition / Re-provision Costs | **34.3** | - | - | 25.5 | 8.8 | - | - | - | - |
| **Total Costs incl. Other Costs** | **804.5** | **0.5** | **10.6** | **58.4** | **85.0** | **181.7** | **287.4** | **169.6** | **11.3** |

The total forecast costs for the new build are the current estimates, including contingency and risk allowances. It has been noted that work will continue during the next stage to refine the costs, and that there is a particular challenge around the preliminaries that has been discussed in the Economic Case.

### 5.3.2 Indicative Funding example

For illustrative purposes only, an indicative funding example has been set out below based on estimated bond charges and funding requirement. The final funding requirement will be agreed via the Proposition that will be debated in the States Assembly in September 2021.

Funding has already been provided for the Design & Delivery Partner Pre-construction and Government Team Costs for 2019 (£0.5m), 2020 (£10.6m) and up to 30 June 2021 (£20m). These costs are therefore excluded from the total funding requirement in the indicative example set out below, however, the expectation is that the full £800m will be raised via two Bond issues.

The remaining capital construction costs are assumed to be funded through the two Bond issues detailed above. It is assumed that the Bonds would be issued in Q4 2021 and therefore interest would be earned on the balance of the bond during construction. The financing cost assumptions are shown in the table below.

**Table 36: Example Financing charges**

| Financing Charges | Bond A | Bond B |
|---|---|---|
| Bond Quantum | £400m | £400m |
| Bond tenure | 40 years | 30 years |
| Bond Drawdown Charge | 0.3% | 0.3% |
| Bond Annual Charge | 2.5% | 2.5% |

The total financing costs over the 40-year period are set out in the table below.

**Table 37: Financing costs**

| Source (£m) | New Build Option |
|---|---|
| Bond Drawdown Charge (A+B) | 2.3 |
| Total Bond Interest (A+B) | 680.1 |
| Interest Earned on Bond during construction (A+B) | (102.3) |
| | |
| **Total (excluding Bond Repayment)** | **611.2** |
| Bond Repayment (A+B) | 773.4 |
| | |
| **Total (including Bond Repayment)** | **1,384.6** |
| | |
| Average annual financing charge (Bond interest) | 17.0 |
| Average annual financing charge (if Bond repaid annually) | 36.3 |

### 5.3.3 Operational Revenue costs

Table 38 below outlines the incremental operational costs in relation to Lifecycle and the provision of a Shuttle Bus service which would be incurred as a result of the New Build Option from 2027 through to 2085. The costs shown are indexed by the Jersey standard inflation rate of 3%.

This OBC is not seeking approval at this stage for the funding of the Lifecycle and Shuttle Bus service costs.

In addition to the New Build Option Capital Costs, funding has already been approved for a programme of urgent capital works at the existing Jersey General Hospital. This equates to £5m per annum for 4 years (FY20 – FY23), £20m in total, with work already commenced on urgent backlog maintenance requirements. In addition to this, £2m has now been included in the Government plan for FY24 and the required investment in FY25 will be assessed as part of the next Government Plan. The approved £22m will be incurred in addition to the cost set out in the New Build Option. As these costs would also be incurred under the Baseline Comparator Option, no differential costs are included in the analysis se out below.

**Table 38: Revenue impacts – New Build Option Additional Lifecycle and Shuttle Bus revenue costs (indexed)**

| Cost Categories (£m) | Total | Year | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 | 2029 | 2030 | 2031-2055 | 2056-2085 |
| Lifecycle | **914.5** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **0.8** | **0.9** | **116.5** | **796.3** |
| Shuttle Bus | **179.0** | - | - | - | - | - | - | 1.1 | 1.2 | 1.2 | 1.2 | 46.7 | 127.6 |
| **Total** | **1,093.5** | **-** | **-** | **-** | **-** | **-** | **-** | **1.1** | **1.2** | **2.0** | **2.1** | **163.2** | **923.8** |

## 5.4 Annual Revenue Impact

Table 39 below sets out the annual revenue impact in 2027 (unindexed and indexed) of the New build Option. The example below shows the impact of setting aside a flat bond principle repayment annually in order to ensure funds are available to meet the liabilities when they fall due.

The average annual cost of the bond interest is £19.3m p.a. over a 30-year (Bond A) and 40-year (Bond B) tenor, at which point the bond would need to be either repaid or refinanced. The payment of the annual bond coupon is a new cost to Government and a funding source will need to be identified.

There is an additional annual charge of circa £24.3m (New Build Option) p.a. in 2027, rising to £43.6m (New Build Option) in unindexed terms if annual bond reserve payments are made. Therefore, funding for this additional spend will need to be identified as the Project progresses, which could include additional income streams from operational efficiencies or otherwise.

The additional spend for Year 1 of the new hospital is detailed in the table below. Indexation is applied at the Jersey standard inflation rate of 3% in the Indexed column:

**Table 39: Year 1 Annual Revenue Cost (2027) for New Build Option**

| Year 1 Annual Revenue Cost (Ye 31 December 2027) £m | Overdale | |
|---|---|---|
| | Unindexed | Indexed |
| | | |
| Shuttle Bus | 1.0 | 1.1 |
| Lifecycle (average annual over 60 years) | 4.0 | 15.5 |
| Bond Interest Charge (A+B) | 19.3 | 19.3 |
| **Year 1 Annual Revenue Charge 2027** | **24.3** | **36.0** |
| | | |
| Annual Cost of Bond Repayment if repaid annually (A+B)* | 19.3 | 19.3 |
| **Adjusted Year 1 Additional Revenue Requirement** | **43.6** | **55.3** |

The Lifecycle costs shown in the table above represent the spend required on the New Build Option when it has been delivered (i.e. from 2027 onwards). However, this does not represent a completely new cost to the GoJ as Lifecycle spend is currently incurred on the JGH and a similar on-going Lifecycle Programme would be required under the Baseline Comparator Option.

## 5.5 Capitalisation of Costs & Balance Sheet Treatment

All property and land purchases will be made by Jersey Property Holdings which is an arm of the Department for Infrastructure Housing and Environment (IHE).

All asset purchases (land & buildings or newly built assets) would initially be capitalised at cost but there would be a re-valuation exercise undertaken on a cyclical basis. This re-valuation would be performed using the Standardised Model Equivalent which often leads to the asset being downwardly valued. This cyclical external re-valuation exercise is undertaken every five years and in the third year of that cycle, an additional internal revaluation is undertaken which can also lead to movements in the valuation.

The GoJ uses a Capital Accounting Manual which provides guidance on the application of depreciation. The guidelines for buildings is anything up to 75 years but it could equally be matched to the 60 year lifecycle profile. The actual depreciation charge would map to the IHE Balance Sheet which would incur the annual impact.

The budget for the current site acquisitions currently sits with HCS. The GoJ is typically paying Market Value/CPO valuation for these properties but is then demolishing the buildings which will lead to a write down on some sites. GoJ Finance advice is that a cross-company capitalisation can be done which will transfer these assets from HCS to the JPH balance sheet. JPH will be responsible for write down.

## 5.6 Projected Cash Flow

The table below sets out the expected additional annual revenue associated with the funding, lifecycle and shuttle bus costs. As noted previously, the impact of Facilities Management costs and Utilities are not within the scope of this OBC.

The numbers shown below are pre the impact of any potential efficiency savings which are currently under review (section 4.9 in the Economic Case). The GoJ also currently spend c. £5m per annum (2020-2023) and c. £2m per annum (2024) on maintaining the existing JGH. This spending will not be required beyond 2026 when the new hospital opens and the GJH is able to close. The effect of this analysis is not shown in the table below as the GoJ does not have any committed spend on the GJH beyond 2024.

**Table 40: Annual Revenue Cost (2021 - 2030) for New Build Option**

| Cost Categories (£m) | Total | Year | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 | 2029 | 2030 |
| Lifecycle | **1.7** | - | - | - | - | - | - | - | - | 0.8 | 0.9 |
| Shuttle Bus | **4.8** | - | - | - | - | - | - | 1.1 | 1.2 | 1.2 | 1.2 |
| **Total operating costs** | **6.4** | - | - | - | - | - | - | 1.1 | 1.2 | 2.0 | 2.1 |
| Bond drawdown charge (A+B) | **2.3** | 2.3 | - | - | - | - | - | - | - | - | - |
| Bond yield (A+B) | **193.3** | 19.3 | 19.3 | 19.3 | 19.3 | 19.3 | 19.3 | 19.3 | 19.3 | 19.3 | 19.3 |
| Interest earned during construction (A+B) | **(102.3)** | (36.7) | (32.5) | (23.4) | (9.0) | (0.6) | - | **-** | **-** | **-** | **-** |
| Bond repayment (A+B) | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** |
| **Total costs** | **99.8** | **(15.1)** | **(13.2)** | **(4.1)** | **10.3** | **18.8** | **19.3** | **20.5** | **20.5** | **21.4** | **21.4** |

## 5.7 Efficiency savings

Section 4.9 of the Economic Case sets out a series of potential efficiency savings which are being developed and the progress to date on incorporating efficiencies.

Further work will continue to be carried out during the development of the FBC and an update will be provided at that time.

## 5.8 Affordability

The financial analysis currently performed on the New Build Option shows the revenue impact of the financing charges, lifecycle and shuttle bus costs. The impact of Facilities Management and Utilities along

with potential clinical, operational and financial benefits is excluded for the analysis set out above. Work on benefits will continue during FBC stage.

Based on the information set out above, the GoJ will need to fund on-going financing, lifecycle and shuttle bus costs in-line with the analysis set out above.

The decision to fund the on-going revenue costs associated with the scheme will be made by the States Assembly and therefore the scheme will be affordable if the States Assembly agrees to fund it.

## 5.9 Accounting & tax treatment

### 5.9.1 Accounting Treatment

As noted above at section 5.5, the new asset will be capitalised on the JPH Balance Sheet which sits under the Department for Infrastructure Housing and Environment (IHE).

### 5.9.2 Tax Treatment

The Government of Jersey pays input tax (General Sales Tax (GST)) on the suppliers of goods and services used for the delivery of government services. Therefore, GST will be paid on Construction related invoiced for the Our Hospital Project. Each quarter the Government submits a GST return where any GST collected from our customers (output tax) is offset against the input tax paid. The Governments input tax is greater that its output tax and it is therefore entitled to receive a GST repayment.

Any GST payable (input tax) on supplies purchased for the delivery of Our Hospital will be included in the Governments GST return and reclaimed within 3 months.

Stamp Duty has been incurred in relation to the land/property acquisitions associated with the delivery of the Project. This tax charge is included within the total acquisition cost paid already/still under negotiation of £34.3m.

# 6. THE COMMERCIAL CASE

## 6.1 Introduction

### 6.1.1 Purpose of the Commercial Case

This Commercial Case details the procurement strategy and process which led to the appointment for the pre-construction stage of the ROK FCC Joint Venture “ROK/FCC JV” as the Design and Delivery Partner “DDP”. This process was set out in detail in the Strategic Outline Case in Autumn 2020 and is therefore summarised at a higher level in this OBC. Building on the SOC, a summary of the DDP’s two-stage procurement strategy and contract position are also set out.

In addition to this, a number of commercial opportunities and land transactions associated with the proposed new hospital are set out in detail.

This commercial case also sets out the key design work undertaken to date by the DDP.

### 6.1.2 Work undertaken at the SOC Stage and updates to the Case in this OBC

**SOC Stage**

The Commercial Case was significantly more advanced than would be expected of a typical SOC, reflecting that there was already an agreed procurement strategy for the main Contractor which had been executed, and therefore that the Design and Delivery Partner had already been appointed. At SOC stage, the Case summarised:

- The proposed commercial structure of the new hospital development, alongside supporting procurement and contracting information
- Indicative scope for the design informed by the functional brief
- Information pertaining to the various land transactions that would be required for the Overdale site development
- Early identification of any further commercial opportunities

**OBC Stage**

Given the significant early development of the Commercial Case there has been limited change at OBC, but additional information has been included on:

- DDP Concept Design (RIBA 2) which was shared in May 2021 (section 6.13)
- The DDP’s Procurement Strategy for their supply chain which has been reviewed by the GoJ team (section 6.8)
- Further exploration of commercial opportunities, including vacated sites and initial proposals with regards to Private Patient strategy (sections 6.10 and 6.12)
- Land transactions associated with sites adjacent to Overdale, which are currently ongoing (section 6.11)

Other sections of the Commercial Case have been reviewed and updated where required but remain substantively the same as with the SOC and are included for reference.

## 6.2 Procurement Summary

Implementation of the Preferred Option will be a significant exercise for the GoJ and the project team. Being one of the largest construction projects ever undertaken by the GoJ, its scale and the complexity of an acute General Hospital involves significant inherent delivery risk.

Identifying a commercial approach suitable for the delivery of such a major development programme is therefore critical to the success of the project.

The Commercial Case sets out the strategy the GoJ established and the options that were considered in relation to the delivery of the proposed Our Hospital Scheme. When assessing the appropriate procurement strategy, much consideration was given to the specific procurement environment of Jersey. This has created parameters that are unique to Jersey and this project. The GoJ procurement strategy ultimately led to the selection of a “Design & Delivery Partner” model for the Project.

Following an extensive procurement exercise in the first half of 2020, ROK/FCC JV was appointed for the pre-construction stage as the Design & Delivery Partner, charged with, principally, the design, and delivery of the preconstruction stage. The process also provides an opportunity to proceed with ROK/FCC JV for the main works stage, and the potential option for provision of facilities management services once the hospital is complete. The sections below (**ref. 6.3 - 6.6**) set out a summary of the strategy and the process which led to this appointment.

## 6.3 Summary of Our Hospital procurement options

The following section provides a detailed overview of the procurement strategy that was developed by the GoJ ahead of the commencement of the procurement process. It sets out details on the aims of the procurement, and the tending and contracting strategies that were considered in developing a procurement approach to achieved them.

For the delivery of the Our Hospital project, GoJ developed a procurement strategy that aimed to:

1. Maintains the existing timeline and provide certainty of dates for completion and occupation
2. Gives best price certainty before construction commences
3. Permits valuation of changes at fair and economic rates and prices
4. Permits some Contractor-led design input into overall design, whilst allowing control of the performance/quality specifications of important elements in the Project to be controlled
5. Facilitates a relatively high, but not prestigious, standard of design and construction
6. Provides minimum contractual links, reducing the opportunity for disputes by having single point responsibility
7. Passes maximum, but controllable, risks to Contractor.

*The Procurement Strategy adopted also:*

1. *Allows the Contractor to manage the final stages of design development; and*
2. *Makes the Contractor responsible for the design.*

This is a comparatively common-place approach where there is no division between, design and fabrication, but also inextricably to cost and programme.

### 6.3.1 Contract strategy options

The main types of procurement routes appropriate in relation to a project’s size, complexity and value are summarised below:

1. **Traditional:** Design by the employer's consultants is completed before the contractors are invited to tender for, then carry out construction;
2. **Design and Build:** Detailed design and construction are both undertaken by a single Contractor in return for a lump sum price. Where a design is largely prepared before the Contractor is appointed, the strategy is called 'develop and construct'.
3. **Novation**: Consultants are appointed to design the Project to a certain stage, including securing any planning permission. Tenders are then invited from Contractors to develop and complete the design and construction of the building. This may be undertaken by the Contractor's own design team, or if design continuity is important, it may be stipulated that the design team originally appointed be transferred (in the case of external design consultants) to the Contractor, for completion of the design under the responsibility of the Contractor. This process is commonly known as 'novation';
4. **Construction Management:** Design by the employer's consultants and construction overlap. A fee-earning construction manager defines and manages the works package. All contracts for work packages are between the employer and the works package Contractors. The final cost of the Project may only be accurately forecast when all work packages have been let;
5. **Management Contracting:** Design by the employer's consultants and construction overlap. A management Contractor is appointed early to let elements of work progressively by works package Contractors (called 'work packages'). As with construction management, the final cost of the works can only be accurately forecast when the last package has been let; and
6. **Design and Manage:** This is similar to management contracting, with the Contractor also being responsible for either the detailed technical design or managing the detailed technical design process.

### 6.3.2 Tendering strategy options

In addition to the contract strategy options set out above at 6.3.1, GoJ also considered the following tendering strategies which would be linked to the decision made in relation to the contract options.

Tender strategies can broadly be classified as either single-stage or two-stage. Both procedures can be based on competition or negotiation. The two options set out below were considered by GoJ during the development of the commercial strategy.

#### Single-Stage Tendering

Single-stage tendering is the more traditional route, used when all the information necessary to calculate a realistic price is available when tendering commences:

- An invitation to tender is issued to prospective suppliers, following acceptable completion of a pre-qualification questionnaire. The invitation to tender will include information describing the goods or services required in sufficient detail to enable prospective suppliers to prepare an accurate tender.
- Tenders are prepared and returned by prospective suppliers (this may involve questions and answers and a mid-tender review meeting to clarify the Client's requirements).
- Submitted tenders are then assessed and compared (this may involve further interviews).
- The preferred tenderer is selected, and negotiations opened.
- Subject to the outcome of those negotiations the preferred tenderer may then be appointed.

#### Two-Stage Tendering

Two-stage tendering is a procedure typically used to achieve an early appointment of a Contractor to a lump-sum contract. For the first-stage, the objective is to competitively appoint, on the basis of limited information, a preferred Contractor for further negotiation.

The first-stage competition is typically based on deliverables including a construction programme and method statement, detailed preliminaries pricing, and overheads and profit. The first-stage may also include the competitive tendering of some work packages, together with lump sums for pre-construction services, design fees, risk margins for work that will not be tendered in the second-stage, and so on. The first-stage usually concludes with the appointment of a Preferred Contractor (or a Preferred Bidder) on the basis of a Pre-Construction Services Agreement (PCSA).

The second-stage, which is typically managed as a negotiation between the Employer and the preferred Contractor relies upon competition between second tier Contractors (sub-contractors) for Work Packages. The second-stage is concluded with the agreement of a lump-sum contract sum, typically based upon the competitive tender of between 70% and 80% of the value of Work Packages.

Two-stage tendering is adopted for a number of reasons, including:

- Achieving early appointment of the Main Contractor ahead of the completion of design, and potentially a quicker start on site.
- Securing the involvement of a contractor for pre-contract services on a competitive basis, to obtain input on buildability, sequencing and sub-contractor selection.
- Retaining greater client involvement in the pre-selection and appointment of sub-contractors.
- Motivating the design and construction team to drive out cost and to drive in value by fixing on outcomes and making the contractor responsible for securing these end-to-end.
- Transferring a greater degree of design and other construction risk to the contractor as scope, risk and price are refined during stage one therefore risks are either removed or mitigates and more accurately assessed and priced.

### 6.3.3 Determining the preferred procurement strategy

A workshop was held with GoJ and their legal advisers, Shepherd and Wedderburn, in November 2019, to determine the most appropriate contracting and tendering options for the Our Hospital programme. The detailed analysis undertaken can be summarised as follows:

**Contracting strategy**

- **Traditional:** this option is weak in meeting the requirements of time certainty, contractual responsibilities, risk allocation and buildability. Under this route GoJ would retain the risk of errors or omission in the design documentation. This provides less cost certainty even post contract award.
- **Construction management, management contracting and design and manage** are deemed to be less preferable for the Our Hospital project as the volume of risk retained by the client is high generally higher.
- The **Design and Build** option is considered to give the required certainty both on programme and cost grounds. When combined with a two-stage tendering approach the Project Team believe this will enable contractor input into buildability during the 1st stage and remove the barriers to entry the market may consider when compared to a single stage approach.

**Tender strategy**

The two-stage design and build route would be appropriate on the following grounds:

- **Low barrier to entry**. The market is currently nervous of the large costs associated with tendering large healthcare projects of this nature with the potential for no cost recovery due to recent projects in the UK which have proven problematic for contractors who have encountered significant issues with construction, resulting in delays and additional costs. Under a two-stage approach, GoJ are able to competitively tender with minimal costs to the contractor in areas such as:

    - Overheads and Profit
    - Preliminaries
    - Risk
    - Pre-Construction Services
- The competitively tendered Pre-Construction Services Agreement (PCSA) will need to be specific to ensure that the client gets maximum benefit from the earlier involvement of a Contractor. Agreement of a fee for the PCSA responds to the market's concern over abortive costs and also gives a strong signal to the market that the project is funded and will move forwards.
- **Early Contractor input.** In order to benefit from the construction market's real time knowledge of projects of this nature it is important to get this engagement early in the process. Through this approach the Contractor can develop the design and assist the Government of Jersey in delivery of practical and economic solutions (avoiding challenge later in the process which may result in abortive work and delay). This approach provides greater certainty about the technical deliverability of the proposed solution and of Programme timescales, resulting in lower capital costs (less risk to price). It also means that there will be a higher level of cost certainty by OBC stage leading to cheaper supplier prices (less risk to price).
- **Maintaining the project programme.**
- **Achieving cost certainty.** Design and Build enables a fixed price lump sum to be reached.

**Conclusion**

Following the detailed workshop outlined above, a decision was taken to progress to market using a two-stage design and build route.

### 6.3.4 Routes to market for the procurement of a Design & Delivery Partner

The following procurement options were considered by GoJ for the procurement of the Design & Delivery Partner. These options are set out in the table below along with supporting rationale as to why the decision was made to take an option forward or not.

**Table 41: Options for the procurement of a Design & Delivery Partner**

| Option | | Comment |
|---|---|---|
| 1 | Engage the previous (Future Hospital) project Design & Delivery Partner | Due to the development of Jersey Care Model, questions have been raised regarding the scope and suitability of the previous contract and desire to maximise competition. Therefore, this option has not been taken forward. |
| 2 | Source the Design & Delivery Partner via a framework | Some suitable construction frameworks exist but are with a limited number of suppliers. There is a desire to maximise competition and a request by ministers to explore the potential within the French market. Therefore, this option has not been taken forward. |
| 3 | Run a competition limited to Jersey-based suppliers | Concerns have been raised about capacity and capability in the Jersey market and the desire to maximise competition. Therefore, this option has not been taken forward. |
| 4 | Run an open competition available to Jersey-based and overseas suppliers. | This option maximises competition and enables the potential of the whole market to be explored with stronger incentives on suppliers to offer fair prices to secure the work. Therefore, this option has been taken forward. |

While Jersey does not sit within the European Union as a public sector body it applies the principle of transparent procurement practices in accordance within the boundaries of its own laws and financial regulations. While Jersey is not subject to the EU Procurement Directives or UK Public Contract Regulations it does consider EU and UK procurement policy and procedures as best practice despite not being bound by EU or UK law.

The UK Cabinet Office policy is to procure using the OJEU Open Procedure by default and use the other available procurement procedures by exception. This good practice is also promulgated by GoJ. There are two options for complex procurement:

- **Competitive Procedure with Negotiation** - used where it is possible to specify minimum requirements that need to be improved via negotiation with bidders.
- **Competitive Dialogue** - used where multiple solutions must be discussed with bidders before a formal tendering process can commence.

Of these options a competitive procedure with negotiation type process was deemed to be the most appropriate for the procurement of the Design & Delivery Partner. Competitive dialogue is most often used for transformation change situations requiring the development of innovation solutions. It is also less flexible and typically can be a more expensive and drawn out process.

A competitive procedure with negotiation type process provided the right balance in exploring and adapting supplier proposals and the need for efficiency and effectiveness. Both procedures ran the risk of slowing things up unnecessarily and incurring high costs on both sides. This risk has been mitigated via extensive initial soft-market engagement, with competent and experienced contractors, with a demonstrable track record and thorough detailed planning and control.

## 6.4 Conclusion of the Our Hospital procurement strategy

Having concluded on the preferred contracting and tendering approach, GoJ proceeded to procure a (multi-disciplinary) design and build delivery partner to provide the full suite of delivery services and works

with options for the provision of other services e.g. specialist designers and facilities management. The details of this process are summarised in the next section

## 6.5 Design & Delivery Partner Procurement Process

Having concluded on Design & Delivery Partner model, the GoJ undertook a process to procure a Design & Delivery Partner to deliver the Our Hospital Project.

### 6.5.1 Service requirements

The services required from the Design & Delivery Partner are:

- Stage 1A: Undertake feasibility studies on multiple sites to be identified by the Employer
- Stage 1B: Complete the Pre Construction Services to fully design the 'Our Hospital' project, ready to commence the development phase
- Contribute to the Business Cases for the delivery of the Project (including capital and operational expenditure)
- Review / survey the current built estate capabilities, as impacted by the project
- Produce a brief for the new build estate including the Employer's Requirements document for any new buildings or refurbishments
- Undertake building and site options appraisals
- Contribute to and support to the site evaluation and procurement options process
- Develop an outline design and buildings scope for the preferred option
- Develop a cost plan with controls and assurance to move to a firm price commitment
- Full and coordinated design to including all disciplines, equipment design and integration, incl. ICT and AV
- Develop a strategy for obtaining planning permission and other (statutory) permissions
- Investigate and develop methodologies for the required demolitions / site enabling and subsequent construction activities
- Produce a sustainability strategy and a quality assurance strategy, to include design
- Develop a soft landings strategy, including business change and staff training requirements, commissioning, handover, migration, aftercare and post occupation evaluation strategy
- Identify the option for facilities management and operation
- Take part in the communications and engagement process
- Be the principal Designer and Contractor.

### 6.5.2 Procurement Law

Jersey does not sit within the European Union but as a public sector body it applies the principle of transparent procurement practices in accordance within the boundaries of its own laws and financial regulations. Jersey is not subject to the EU Procurement Directives or UK Public Contract Regulations. GoJ aligns to EU and UK procurement policy and procedures as best practice whilst not bound by EU or UK law.

The Public Finance Manual covers the purchasing of goods and services. Competitive tendering via the Channel Islands procurement portal is the normal route to market for contracts valued over £100,000.

As a general principle, GoJ is transparent and treats all bids equally without discrimination. Bidders for the Our Hospital Project were given the same opportunity, based on the same information and criteria, and bids were evaluated fairly.

### 6.5.3 Early Market Engagement

Early market engagement can lead to increased competition, promote innovation and improve value for money in contracts by ensuring potential suppliers have sufficient time to appropriately influence, understand and prepare to make an offer against the contract requirements.

The GoJ undertook constructive engagement with the market to help promote the opportunity, shape the procurement process and develop the requirements, including obtaining advice from those with practical hospital delivery experience and discussing areas of complexity and risk. In particular, GoJ has explored:

- Local supply chains in Jersey together with opportunities for the services to be provided by off island suppliers but in joint ventures with local suppliers
- Opportunities for the services to be provided by off-Island suppliers with a strong emphasis on knowledge transfer to GoJ employees
- Where the specialist skills are and how best to reach the breadth of market required
- Pre-procurement promotion and consultation
- Establishing a communications channel to enable suppliers to enquire about opportunities and how to be considered for them
- Test the proposed procurement process and timescales.

The outcome of the process was that GoJ was able to attract two strong bidding consortiums to formally engage in a detailed procurement exercise:

A summary of the Design & Delivery Partner Procurement Process is set out below

## 6.6 Summary of Design & Delivery Partner Procurement Process

The objective of the procurement process was to secure a Design & Delivery Partner responsible for the design and construction of the new hospital facility.

In 2019 GoJ, via the project team, undertook extensive pre-tender soft market engagement to raise supplier awareness and enable the collation of feedback, a Prior Information Notice (PIN) was then issued 28th November 2019 which commenced the formal tender process.

Subsequently a Selection Questionnaire was issued to identify a suitable shortlist of potential Design & Delivery Partners, possessing the pre-existing organisational competence and demonstrable experience in delivery and construction of comparable schemes. This resulted in three organisations being taken forward to tender for the Our Hospital project:

- **ROK FCC JV Ltd:** FCC Construccion SA (Spain) – 80% and ROK Group Holdings Limited (Jersey) – 20%
- **Anonymous Bidder 2**
- **Anonymous Bidder 2**

The unsuccessful bidders are listed as Anonymous above due to the Government of Jersey respecting that the information they provided when involved in the bidding process was in confidence and commercially sensitive.

Anonymous Bidder 3 was initially engaged in the process but did not response to several requests made by GoJ during the ITT process and formally withdrew from the process on 28th January 2020 during the Workshop phase.

The outcome of the process therefore was that the GoJ was able to attract two strong bidding consortiums to formally engage in a detailed procurement exercise.

After the shortlisting of potential Design & Delivery Partners, an Invitation to Tender (ITT) stage was conducted to select a Design & Delivery Partner for the Our Hospital Scheme, consisting of two distinct phases:

- An initial workshop phase over 6 weeks to discuss the commercial and quality aspect of the tender, completed at the end of February 2020.

- A tender phased from 2nd March 2020 to 11th March 2020 during which the bidders lodged firm offers (tenders).

The ITT was initially issued to all tenderers on 2nd March 2020, an updated ITT was issued on 13th March 2020 following the completion of the workshop phase.

Following a review of the tenders received from Bidder 1 and Bidder 2, the project team recommended Bidder 2 as the Preferred Bidder. The recommendation was based on a scoring matrix weighted 70% for Quality and 30% for Commercial aspects, with both submissions being score independently by an evaluation panel.

The procurement process had been due to formally conclude by the end of March 2020. However, towards the end of the month, the Covid-19 pandemic had started to manifest itself fully in both Jersey and internationally. It was unclear at that stage of what the potential impacts would be on the remaining Bidders, GoJ and in particular HCS.

These impacts included practical ones in relation to how a DDP could operate including level of interaction and interface possible with the OHP team, but also the way in which clinical care might be dispensed in the future.

GoJ chose to undertake an additional risk assessment exercise on the bidders to determine the resilience and ability of the Design & Delivery Partner bidders and their supply chains as a result of Covid-19. EY were asked by GoJ to prepare a risk analysis report which highlighted some matters for review. The short- and long-term impacts of Covid-19 on the project and closeness of the scoring from the initially completed tender, resulted in an extension to the procurement process; Invitation to Tender clarification stage. The extension aimed to clarify arising matters and impacts on the Bidder's offers through a series of clarification workshops, which resulted in the Commercial score being re-evaluated and the original Quality score remaining the same. Following completion of this exercise, the GoJ implemented ongoing financial monitoring of the Design & Delivery Partner which will continue throughout the duration of the Programme.

Following this extension to the procurement process, Bidder 2 was still awarded the highest score and it was noted that nothing had been highlighted throughout the clarification process that would preclude them from being appointed as Preferred Bidder. Thus the project team recommended Bidder 2 (ROK/FCC JV) as the Preferred Bidder on 26th May 2020 as a result of the tender process.

## 6.7 Key contractual information

### 6.7.1 Form of contract

As part of development of the contracting strategy consideration was also given as to the appropriate form of contract to use for the project. The NEC3 suite of Standard Forms of Contract is an industry and market accepted suite of contracts and deemed to be best suited to GoJ. The NEC provides a focus on the project management of risk, and early identification and collaborative resolution of risk issues. This together with strategic amendments to the NEC suite including a market security package (performance bond, retention, parent company guarantee) offers GoJ the control of and recourse to the contractor required for a project of this size and nature. However, in some instances the Standard Contract

Conditions were amended to reflect Jersey Law and the risks that the client wished to transfer to the Contractor.

### 6.7.2 DDP Contract

The DDP has been contracted using a standard form contract, the NEC Preconstruction Services Contract (commencing with an Option A 'fixed price' form, then progressing to an Option C 'target cost' form) for the pre-construction phase (the PCSA), with an agreement between the parties that the NEC Engineering and Construction Contract form would be used for the build phase (the Works Contract).

A number of amendments have been proposed to both the PCSA and the Works Contract which are largely to align with Jersey law. These were reviewed as part of the process of the DDP appointment and include for example and amended to reflect that The Freedom of Information (FOI) of Jersey Law 2011 provides public access to recorded information held by public authorities and therefore the Our Hospital Project is subject to FOI requests.

The ROK/FCC JV Pre Construction Services Agreement ("PCSA") Contract was signed on the 23rd July 2020. The PCSA contract is now expected to run until c. mid-2022. Following satisfactory completion of the PCSA stage the arrangement enables the project to proceed through entering into NEC3 Option C Target Cost Contract with the DDP for the main works. The Contract also sets out the mechanism for payment, which follows construction industry standard processes for 'interim' payment through a monthly payment cycle.

The target cost within that contract would be subject to a pain/gain share between the DDP and the GoJ which incentivises both parties to manage cost and risk and seek efficiencies, by providing a share in any gain/pain on the target. The share agreed is summarised in the table below:

**Table 42: Contractual pain/gain share**

| Share Range | Share Percentage |
|---|---|
| **Gain** | **Gain** |
| 95% to 100% of the Target Cost | 50% Contractor / 50% Employer |
| 90% to 95% of the Target Cost | 25% Contractor / 75% Employer |
| 0% to 90% of the Target Cost | 100% Employer |
| **Pain** | **Pain** |
| 100% to 105% of the Target Cost | 50% Contractor / 50% Employer |
| 105% to 110% of the Target Cost | 75% Contractor / 25% Employer |
| Above 110% of the Target Cost | 100% Contractor |

110% of the Target Cost is the sum above which the Contractor takes the whole risk of cost escalation

## 6.8 DDP Supply Chain Procurement Strategy (Stage 2 Procurement)

The SOC set out the principle of adopting a two stage procurement approach to drive greater value for money in the tendering of construction packages. Whilst the DDP will be responsible for tendering the sub-contact packages, in line with the strategy below, there is a requirement for GoJ to pre-approve the

letting of each package and also approve the appointment of successful bidder following a robust tender evaluation.

The DDP was responsible for developing a strategy for this procurement, which has been reviewed with the GoJ team. The strategy produced by the DDP is summarised below:

### 6.8.1 Overarching strategy

The DDP Supply Chain Procurement Strategy sets out the plan to deliver the GoJ objectives with the intended outcome of delivering best value for the OH Project and the GoJ. This strategy will evolve as the project develops and progresses and further revisions of the strategy will be issued to reflect this.

The overarching strategy is to achieve maximum value by promoting a high-performance, collaborative culture throughout the supply chain, which underpins resilient delivery, mitigates risk and maximises the impact of the supply chain in legacy activities.

### 6.8.2 Objectives

The DDP have worked with the GoJ to identify appropriate objectives for this procurement. The Objectives for the two-stage procurement are outlined below:

- **Quality (design/specification)** - The design and specification of a quality clinical facility that supports the health, safety and wellbeing of patients, staff, public and the workforce. The project should improve the quality of the hospital facilities and delivery of healthcare services through design excellence. All procurement should support the achievement of this objective where applicable.

- **Quality (implementation)** -To achieve a quality product, it is important to select sub-contractors with the required skills and expertise, and a track record of having delivered comparable projects. This will be supplemented by exercising control over the selection of sub-contractors. Methodologies will be requested as part of the tender evaluation to ensure that the selected sub-contractors have the right level of experience.

- **Programme Certainty** - Programme certainty is a key objective for the procurement strategy to ensure the overall project timeline is delivered.

- **Best Value** - Best Value and its demonstration is a top priority for GoJ. Best Value must be considered specific to each procurement to ensure the appropriate balance of factors that must be considered. Best Value for OHP and GoJ does not mean lowest price and must consider quality, risk, programme, cost and social value.

- **Cost Certainty** - The NEC3 Option C Target cost contract has been selected for the project which therefore means that the contract is structured to support a controlled share of risk. Unlike a fixed price contract this provides a target, with a mechanism for sharing ‘gain’ and ‘pain’ and a guaranteed maximum price. As the design develops and certainty in the procurement can be achieved it is important to obtain cost certainty through procurement. The strategy for doing this is defined through the packaging strategy.

- **Risk Transfer** -The right level of risk transfer is desirable in the context of placing risk with the party who is best placed to manage the risk. The risk management approach will be considered on a package-by-package basis to ensure that it is appropriate and proportionate. A risk and opportunity register is in place and this will be continually reviewed and updated to ensure that it clearly identifies the risk ownership. Risk will only be transferred where it represents value for money.

- **Transparency (visibility/involvement)** -Full visibility of and involvement in the procurement process by GoJ and the OH team is required to ensure that only sub-contractors with the requisite capabilities and track record are selected, and that the tender process results in the optimum price/risk transfer for the contract/package of work involved.

- **Competition** - All construction work, whether of a general or specialist nature, is to be competitively tendered, generally to a minimum of three companies.

- **Local Opportunities** – the "Jersey First" approach is designed to ensure that where possible, works/services which can be procured in Jersey, they should first be tendered to the local supply chain. The Jersey First approach is the key objective for the procurement of Workstream 2 (WS2 the re-provision and decant from the existing Overdale hospital site). If local supply chain is unable to meet the requirements to tender, then partnering opportunities with off-island supply chain will be explored.

### 6.8.3 Construction Workstreams

The DDP have developed procurement strategies to strategy cover the overall programme of works/all workstreams and details their plans for achieving the objectives. As the project and design develops the strategy will be updated to reflect the works package procurement requirements specific to each of the four construction workstreams (WS) the DDP is using:

- Demolition of Overdale Hospital Buildings
- The re-provision and decant from the existing Overdale hospital site
- Provision of a new hospital with associated local highway works
- Highways works, including associated demolition works.

### 6.8.4 Governance for the 2 stage procurements

The DDP Commercial Director has overall responsibility for the two-stage procurement strategy and is supported by the DDP Procurement Director who has day-to-day operational accountability for the implementation of the procurement plan.

The DDP will work in collaboration with the GoJ client team and their consultants to ensure open, collaborative and transparent procurements. This includes the Procurement and Local Economy Workstream meetings, reviewing and agreeing the strategy and agreement of the best value approach to each procurement action. A procurement toolkit which integrates the following project controls for procurement is updated regularly:

- Actions tracker
- Supply Chain Database
- Tenderer Tracker
- Tender Event Schedule
- Procurement Log

The procurement processes, procedures and forms are contained within the overall DDP Commercial Management System (CMS).

### 6.8.5 Tendering Strategy Options

The following Tendering Strategy Options will be considered for each work package:

- Single stage tender – a single competitive action where a tender document is issued to the supply chain seeking a competitive price and quality submission to deliver the works package.

- Two stage competitive - an initial stage of competitive action to the supply chain where a tender document is issued based on limited information. The second stage would then involve the open book tendering of the sub-contract works package.
- Negotiated - A preferred contractor is selected without any tender process and the works package is negotiated on an open book basis. This option will only be utilised in exceptional circumstances where there is a specific project need to procure quickly or negotiation gives a clear benefit to the project. Agreement will be sought with the employer before choosing negotiation.

The following tendering options were confirmed by the DDP as generally not applicable for these packages:

- Frameworks
- Partnering
- Serial tendering

ROKFCC JV have proposed utilising FCCI, a company that is part of the FCC group and which provides Mechanical and Engineering (M&E) Services, to provide the Mechanical and Electrical services for the project. The Procurement Strategy sets out more information about this proposal, and how it is intended to fulfil the stated procurement objectives.

### 6.8.6 DDP Contract Strategy Options

There are three procurement routes which will be considered. The route chosen by the DDP will depend on the circumstances of the specific procurement at the time.

1. Traditional: with quantities/re-measurable - taking the design to RIBA Stage 4 (excluding CDP elements), preparing bills of quantities, and then issuing a tender enquiry to the supply chain on that basis
2. Traditional: fixed price lump sum - taking the design to RIBA Stage 4 (excluding CDP elements), and then issuing a tender enquiry on the basis of drawings and specification to the supply chain on that basis
3. Target cost - issuing a tender enquiry on the basis of drawings and specification to the supply chain to obtain a target cost price with a defined share range. This would most likely be undertaken at an early design stage.

### 6.8.7 Tender Process

A detailed package tender report will be produced for each trade package for the main scheme, setting out tenders received, any clarifications, and any operational or commercial issues. As part of the evaluation of tenders and preparation of the report the DDP will ensure the required due diligence is undertaken to obtain compliant tenders.

As part of the procurement strategy, the following key steps will be undertaken on each of the three procurement route options set out above:

- **Expression of Interest** – identify initial interest from the supply chain and to gain feedback on key issues to be considered when procuring.

- **Pre-Qualification Questionnaire** - to accept a sub-contractor onto the project sub-contractor database through assessing their safety record, capacity, capability, experience, stability and resilience.

- **Soft Market Testing** – on the sub-contractor market will be undertaken from June through to August to support cost planning activity in advance of the planning application.
- **Full Market Testing** – undertaken from October through to December with analysis and reporting complete by the end of February to support the FBC cost plan submission.
- **Early Contractor Involvement** – from the supply chain, providing insight from their own expertise. The OHP will likely benefit from early sub-contractor involvement where possible.
- **Evaluation** - Tenders will be assessed on a Most Economically Advantageous Tender (MEAT) basis using a cost and quality split.

### 6.8.8 Contract Form

To minimise risk created by mixing different forms of contract it is the DDP's preference to contract using the NEC3 2013 suite of contracts. This ensures alignment with the DDP's contract with GoJ. NEC3 compliant subcontracts will be proactively managed to deliver success for all and will include clear obligations and incentivisation.

### 6.8.9 Risk Management

The DDP's project risk management plan for the two stage procurement strategy sets out the approach to managing risk on the project, the applicable tolerances and strategies for responding to risk. The procurement of all works packages will consider the appropriate and proportionate allocation of risk. Work package specific risk registers will be developed to support this

Strategic level risks have also been identified through the SWOT analysis, gap analysis and the overview of the tendering and procurement strategies.

### 6.8.10 Best Value

The DDP approach to best value takes three strands:

- Driving value through the design.
- Selecting the correct procurement route to secure best value in the market.
- Ensuring the best value tender in the market through MEAT evaluation.

### 6.8.11 Conclusion of the DDP Supply Chain Procurement Strategy

This section has summarised the approach the DDP is taking to procure the sub-contractors required to deliver OHP. This procurement is underway and will continue through the remainder of the pre-construction stage.

## 6.9 Personnel

The Our Hospital Project will not have any implications for the Terms and Conditions of Employment for any GoJ or HCS employees. There will be no TUPE implications and all employees will remain in current position with current employers.

There will be a change in working location for a large proportion of HCS employees who will now have their main place of work at the Overdale Site as opposed to the JGH or other HCS sites at which they are currently based. However, this change in location is not considered to be significant as both sites are within the St Helier area and as noted in section 4.8 (Revenue Costs) in the OBC GoJ is exploring the

possibility of implementing a shuttle bus service from St Helier to the new Overdale site to minimise the impact of this change.

## 6.10 Opportunities in relation to the Our Hospital Programme

GoJ is seeking to explore potential opportunities as part of the Our Hospital programme, which could provide either a commercial or social benefit to the Island. The opportunities identified to date are detailed below.

### 6.10.1 Potential Vacant Sites

As part of the development of the OBC, work has been undertaken by the HCS Estates team to identify sites owned by HCS which are already vacant or are expected to become vacant following the planned opening of the new hospital in 2026. An HCS Estate Planning working group has reviewed all sites across the HCS estate and assessed the current healthcare services delivered and the expected impact of the OHP.

This review has produced the following indicative list of sites which could theoretically become vacant, or are already vacant, following the opening of the new hospital.

**Table 43: Indicative list of potentially Vacant Sites**

| Site | Notes |
|---|---|
| General Hospital - Blk A, B, C, E, F, G | Blk C is a Grade 1 listed building which would need to be considered in terms of any redevelopment. This may limit the ability to use it for other purposes. |
| General Hospital - Sir Peter Crill House - Blk D | |
| **St Saviours – North**<br>• Clinique Pinel<br>• Rosewood House | A draft future planning strategy document has been prepared which sets out planning considerations in relation to the site.<br><br>Rosewood House is currently earmarked for the re-location of Aviemore and therefore may not be available for disposal. |
| **St Saviours – South**<br>• Maison du Lac<br>• Orchard House<br>• Valerie Band House<br>• Crafty Corner | |

| | |
|---|---|
| • Gardeners Workshop<br>• Queens House<br>• Engineers Workshops<br>• Engineers Admin<br>• Swimming Pool<br>• Nurses Home<br>• Dolls House<br>• Marina Court & Cottages<br>• Valley Close | |
| Five Oaks CSSD | Only the CSSD will become vacant, not the Central Laundry and Hospitals' Central Stores. |
| Maison Le Pape | To be considered as a standalone opportunity and a joint opportunity including Westaway Court |
| 14 Gloucester Street (health clinic and 5 flats) | |
| St Elmo (5 Edward Place) | Currently vacant |
| Westaway Court | To be considered as a standalone opportunity and a joint opportunity including Maison Le Pape |
| Further Opportunities | As part of the land assembly strategy it is possible that the acquisition strategy will lead to some opportunities to dispose of land which is not essential for OHP but was acquired as part of a wider plot. |

In addition to the sites listed above, there may be opportunities in the future to dispose or re-provision certain elements of land which have been assembled to deliver the New Build Option.

The decision on the future usage of the sites listed above is out-with the scope of the Our Hospital Project and has not yet been determined. Therefore, for the purposes of the Our Hospital OBC, no firm position in terms of the future usage of any of the sites listed above is being assumed. This is a prudent position, that understates the benefits of the New Build Option.

There are a number of options which could be considered with regard to the future usage of these sites:

- Seek to dispose of some or all of the sites on a commercial basis and realise a capital receipt
- Re-provision of some or all of the sites to support delivery of GoJ priorities, for example market rental, social or affordable housing.
- Re-provision of some or all of the sites for use by other Government of Jersey Departments

### 6.10.2 Units 9 & 10 St Peter's Technical Park

The St Peter's site currently delivers Jersey General Hospital's catering facilities. Under the proposed Our hospital scheme, this site would be vacated, and the service moved into the new hospital, however the site is only in its third year of a 21 year lease. The site is rented at a cost of circa £313k per annum (circa £6.6m over the 21 year lease before factoring in rental reviews which occur every 3 years). Additional costs for the site include insurance premium and a proportion of the service charge.

The lease allows the site to be sublet if approved by the Landlord and therefore the GoJ may explore opportunities to sublet the site to avoid a stranded cost.

The lease provides no detail on the process or costs associated with a termination.

## 6.11 Land transactions associated with the project

Various land and buildings close to or adjacent to the Overdale site were identified as necessary to enable the Our Hospital Scheme. This has been acknowledged by the agreement of the States Assembly to the Compulsory Purchase Plan.

The process to engage and negotiate with owners of the properties listed above has been undertaken by the GoJ Real Estate Advisor, D2 Real Estate ("D2RE"). The following process has been undertaken:

- D2RE reviewed all sites that had been identified as potential required purchases during the Site Evaluation Process
- D2RE undertook discussions with the owners to understand the willingness to sell in relation to each site. Where possible, working with Covid-19 restrictions, D2RE visited each site and engaged directly with owners.
- D2RE performed a desktop valuation exercise on each identified site
- Following confirmation of Overdale as the preferred site, D2RE firmed up valuations by making visits and engaged directly with owners, where possible.
- All sites are currently being progressed on a negotiated sale basis

At the time of this OBC, a number of sites/properties have already been successfully purchased by GoJ with a number of others still being negotiated. The current total estimated costs of the sites/properties is £34.3m (this includes sites that have already been purchased and those still in negotiation, and includes costs associated with CPO should this be required).

## 6.12 Private Patients

The Government of Jersey have set out to improve and transform the private patient service offering in Jersey.

### 6.12.1 Current Private Patients services

The available Private Patient facilities within Jersey General Hospital encompasses inpatient medical, surgical and day case surgery, as well as various outpatient services that provide access to:

- Intensive Care
- Pathology
- Radiology

- Physiotherapy
- Endoscopy
- Audiology
- Clinical Investigations; and
- Maternity Services

The currently Private patients operational model has a number of limiting factors to enable growth within the service, the limiting factors are:

- Sorel ward bed capacity is limited to 16 private beds
- The pandemic has meant private activity stopped and the beds were re-purposed
- Private theatre capacity is limited within the current public/private timetable
- The current staffing model for Nurses and Consultants couldn't support an increase

### 6.12.2 Our Hospital Private Patients strategy

Private patient services are in the process of developing the Our Hospital private patient strategy. A number of key strategic design principles have been agreed for the strategy:

- Maximisation of centralised distribution and storage facilities with appropriate top up systems to support the ward
- Nurses based outside patient rooms at local touchdown bases rather than staff bases
- The provision of rooms for isolation of patients where required
- Separation of goods/FM flows from patient flows
- High spec single room accommodation.

Private patient services have identified a range of considerations to prepare the foundations of the service to enable growth and expand into the new hospital:

- Creating the foundation to improve the private patient provision
- Standardising a consistent platform in line with the private patient branding
- Enhance the service in remaining current and expanding designed for future growth
- Developing strategies and increasing the provision
- Establishing new pathways to provide patient choice
- Delivering and maintaining a service which is affordable, high quality and flexible to meet the need of the patients
- Development of a strategic plan focused on small/short term projects without an overarching strategy.

The Our Hospital project aims to provide a full suite of clinical services for private patients in Jersey, which should create a new Private Patient offering in a very different setting to that of the main public Hospital. It is proposed that private patients attend a dedicated Private patient's department within the hospital for the following services:

- Outpatient;
- Day Surgery;
- Endoscopic Procedures;
- Elective Surgery; and
- Inpatient Stays.

Private patients should enter the department through a separate entrance with an exclusive pathway for shared specialist areas where appropriate. Prospective private patients or visitors should enjoy a high quality reception experience where they have access to the private coffee lounge and seated waiting area.

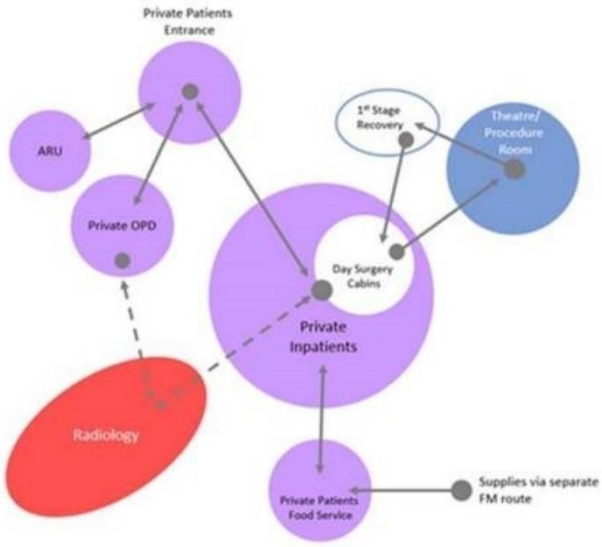
Patients attending for outpatient appointments should have access to private consulting rooms from the reception area.

The private service should provide patients with an efficient experience of examination, appropriate diagnostic investigations and then consultation to review results and prescribe medications or discuss further treatment regimes. A small percentage of these patients should require:

- specialist and high dependency care skills and knowledge;
- frequent and intensive attendance by nurses;
- frequent attendance by specialist doctors; and
- require acute input from therapists.

The following diagram outlines the anticipated construct of the Private Patient flows:

**Figure 8: Private Patient flow diagram:**




## 6.12.3 Private Patient Financial analysis

Private health care in Jersey currently generates approx. £10 million net income annually, from users with private medical insurance or self-pay to access predominantly essential healthcare provision or treatment.

- There are an estimated 25,000 insured lives in Jersey
- Estimated £20m Gross Written Premium (GWP)

Overall private activity and income reduced by £1.6m during 2020 due to the impact of the global pandemic COVID-19.

The GoJ is making a substantial investment into the Private Patient unit in the proposed Our Hospital Scheme which will result in a larger unit which can deliver more services. A detailed exercise is currently underway to understand the additional income and operating costs associated with the larger Private Patient unit and the corresponding additional contribution to HCS which will be generated from the Unit. This will also help to define and quantify some of the wider benefits of the Private Patient offer, for

example potential benefits for staff recruitment and retention, and reduction on the demand for public provision.

This costing exercise was not completed in time to be included in this OBC and therefore an update will be provided when in the FBC.

## 6.13 Our Hospital Technical Design and Build Information

### 6.13.1 RIBA Plan of Work

The Our Hospital Project is being delivered using the Royal Institute of British Architects ("RIBA") Plan of work. The RIBA plan has continuously evolved since its first publication in 1963 and is viewed as the gold standard for designing and constructing buildings. The current 2020 update describes the RIBA processes as follows:

- 0 – Strategic Definition
- 1 – Preparation and Briefing
- 2 – Concept Design
- 3 – Spatial Coordination
- 4 – Technical Design
- 5 – Manufacturing and Construction
- 6 – Handover
- 7 – Use

For the main hospital RIBA2 Stage (Concept Design) has completed, and work on RIBA3 Stage is underway.

### 6.13.2 Construction Risk Register

The Management Case sets out the plans for managing and controlling risks for Our Hospital Project.

### 6.13.3 Decant of Departmental Services

Following the decision to recommend Overdale as the preferred site, Overdale departmental services need to be relocated before the decommissioning and demolition works of the Overdale estate can be completed, in order to allow for preparation of the site for the construction of the new OHP.

The existing services at Overdale were identified and quantified, these can be grouped into five main areas:

- Clinical services provided by HCS
- Services that support these clinical services
- Storage for HCS services
- Children and Young People Education and Skill's services
- Meals on Wheels

Some of the services will be provided from the new hospital, so will be moved back to the hospital site once it is operational, and therefore require temporary relocation, until the hospital is built. However, some of the services are not within the scope of the main hospital and will not therefore be relocated to the main hospital site.

The following sequential selection criteria for substitute sites was produced to identified alternative locations for the existing services:

- Available and achievable within the project timeline
- Suitably sized building to accommodate all HCS services from Overdale
- Minimising compromises to patient, staff and public safety or experience
- Location with appropriate facilities and public transport

A list of potential sites were evaluated against the site evaluation criteria. Any sites that could clearly not achieve the first two criteria were excluded from further evaluation. Sites visits and inspections were carried out on sites that had the potential of meeting the initial criteria, and the former Les Quennevais School site was selected.

Design has commenced, and a Planning Application is due to be submitted shortly.

### 6.13.4 Planning Application

Full detail on the planning application is included in the Management Case at section 7.8.

### 6.13.5 Social Value

The Social Value work undertaken to date is set out in section 4.10.5 (Future quantification of benefits) in the Economic Case.

### 6.13.6 Equipment Strategy

The Our Hospital Project equipment strategy has been developed to:

- Ensure that the approach is clinically led
- Provide best value
- Provide flexibility, choice and is future proofed
- Ensure a smooth transition into the new hospital

All equipment (furniture, fixtures and medical equipment) for the Our Hospital project will be contained within the project affordability limit. A comprehensive review of the existing assets will also be undertaken and where practical, the existing asset base will be utilised.

The DDP has employed the services of an equipment adviser (MJ Medical) to assist the clinical teams with the identification of suitable equipment. As the project design develops, the equipment content will be refined and aligned to the requirements of a wide-ranging spectrum of project stakeholders.

An Equipment Committee (EC) will be formed to be responsible for the implementation of this strategy and provide clear governance and approval as the project develops. This will include a dedicated procurement manager who will be appointed at the appropriate stage in the project. The EC will ensure that all existing maintenance and support contracts for the key items of medical equipment are identified. The EC will also propose the best value solution for the ongoing maintenance and support for the key items of medical equipment.

To achieve best value the DDP will support in the specification and procurement of the medical equipment. The DDP will also investigate the opportunity to lease the medical equipment wherever possible and where it adds value to the Our Hospital project.

### 6.13.7 Facilities Management Strategy

A separate Facilities Management Business Case is currently being developed. The scope of this FM Business Case will include:

- All Hard and Soft FM activities ( non-clinical support facilities )
- All spend associated with resources (employed and contracted), materials, contracts for services and minor works/lifecycle replacement
- FM Provision at all HCS Core Assets including Decant facility.

Upon completion of the FM Business Case a detailed strategy for delivering FM services at the new Hospital will be developed alongside detailed cost information.

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### 6.13.8 Healthcare Planner input into design

MJ Medical were initially appointed as the GoJ Healthcare Planner to support with the development of the Jersey Care Model. Following the inception of the Our Hospital Project in 2019, they then supported with the development of the Functional Brief which was used to help inform the site evaluation process which was detailed in the SOC in 2020.

Upon appointment of the DDP in 2020, MJ Medical were retained by the DDP due to their in-depth knowledge of healthcare in Jersey. Since this time, MJ Medical supported on the further development of the Functional Brief for the proposed new hospital which set out in section 4.6 of the Economic Case.

Post completion of the Functional Brief exercise, MJ Medical have continued to work closely with the DDP to provide support as the RIBA Stage 2 design has progressed. They will continue providing this role for the remainder of the Project with a particular focus on developing the equipment strategy as part of RIBA Stage 3.

### 6.13.9 Build Scheme information

The RIBA Stage 2 Concept Design Report (“RIBA 2 Report”) for the Our Hospital Project was completed by the DDP in May 2021. The purpose of the Stage 2 report in to “*prepare outline proposals which reflect a series of relevant project and design strategies and establish the clear direction and content of the project.*” Feedback on the RIBA 2 Concept Design has been collated and are informing the design and planning for the delivery of the scheme.

The next step in the design process is the RIBA Stage 3a Development Design stage which will enable the scheme to be submitted as a Full Planning Application in late 2021.

A summary presentation of the Our Hospital Project Concept Design is included at Appendix G.

# 7. THE MANAGEMENT CASE

## 7.1 Introduction

### 7.1.1 Purpose of the Management Case

This section of the OBC addresses the 'achievability' of the preferred way forward. The Management Case sets out the reporting structure, management arrangements and details of the team in place to deliver the programme.

The Management Case section of this OBC has been produced in line with UK HM Treasury Green Book Guidance and also the principles of PRINCE2.

### 7.1.2 Work undertaken at the SOC Stage and updates to the Case in this OBC

**SOC Stage**

The Management Case at SOC stage already covered the key areas outlined below due to the stage of development of the programme:

- Overarching project management approach, including stakeholder and change management
- The outline programme timeline and milestones
- Summarised approach to risk and benefit management, including contingency plans and post-project evaluation

**OBC Stage**

The project is now being delivered as a live capital project and has the processes and systems in place to enable this. To reflect the progress made during the period to OBC, the following additional information or updates have been made to the Management Case:

- Construction programme has been updated to reflect the information prepared as part of the RIBA 2 design process
- Project management approach has been updated to reflect the latest Project Manual
- Costs have been updated to reflect the latest cost information

Other sections of the Management Case have been reviewed and updated where required but remain substantively the same as with the SOC and are included for reference.

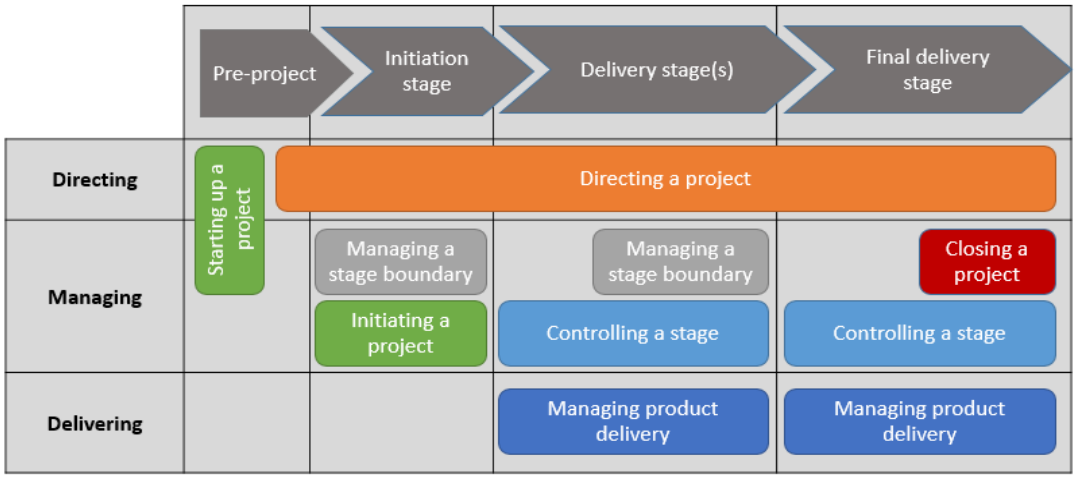
## 7.2 Stage of project and Project Plan

The new hospital is targeted to be constructed and clinically commissioned by 2026. As part of Concept Design the Design and Delivery Partner reviewed proposed construction logistics and summarised the challenges and opportunities with achieving this. This will be further developed during the pre-construction stage.

The DDP has produced a detailed Programme for the pre-construction stage of the project. The programme provides a detailed schedule of activities for the project delivery of PCSA Phase 1B which is due to be completed July 2022. It includes the key milestones for various project areas and workstreams, including any project sign-offs and approvals.

The plans for delivering the project have been informed by PRINCE2 methodology and HM Treasury Green Book Five Case Model. The PRINCE2 methodology is summarised as follows:

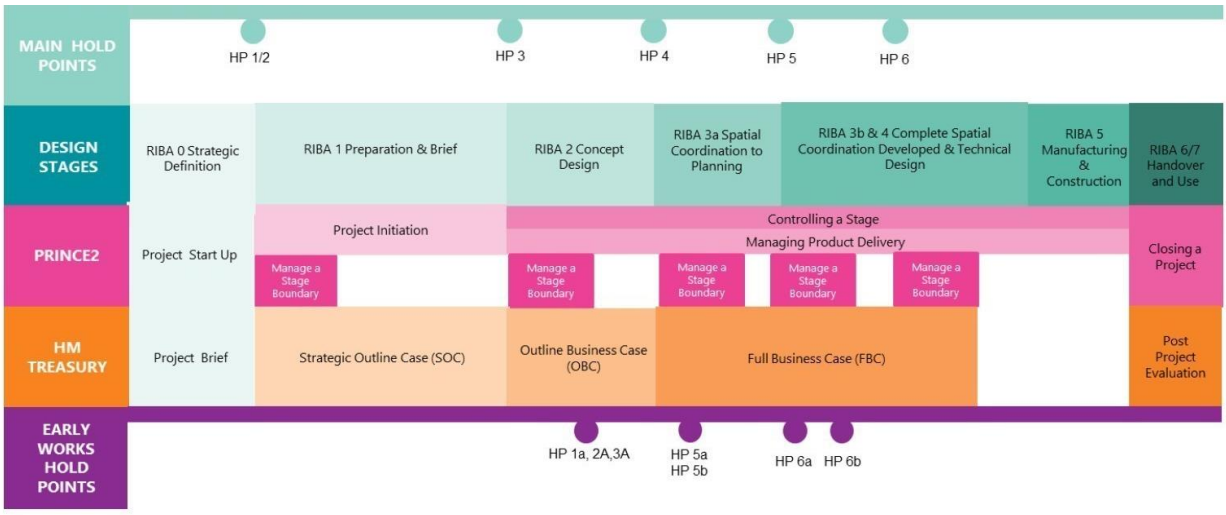
**Figure 9: PRINCE2 methodology**




In accordance with PRINCE2 and the Project Manual, 'pre-project' stage commenced with the mandate provided by the Chief Minister's report R.54/2019 – New Hospital Project: Next Steps, published in May 2019. This mandate is included in the Project Manual at Appendix F. During this stage, the project team was assembled, governance arrangements were agreed, funding agreed for this stage of the project and the project product description (draft functional brief) was developed.

The project is now in the stage PRINCE2 defines as 'delivery stage' and a number of stages have been identified to manage the pre-construction period. Hold Points have been adopted to act as stop-go gateways when significant decisions are required for the project to continue. At each Hold Point the PRINCE2 Managing a Stage Boundary process will be followed. At each hold point SOSG and POG will be asked to confirm continued business justification and that the project is/will deliver its expected benefit. It is currently working towards Hold Point 4 (OBC). A diagram how the various schedule and gateways align can be found below:

**Figure 10: Programme Map**




The early works packages (the demolition and relocation of the services currently located at Overdale) also use hold points.

**Table 44: Upcoming Hold Points**

| Hold Point | Summary of Key Deliverables |
|---|---|
| Hold Point 4 | • Concept Design<br>• Outline Business Case |
| Hold Point 5 | • Detailed design<br>• Planning application submitted for Our Hospital |
| Hold Point 6 | • Build contract signed<br>• Determination of Planning application |

The Project Manual sets out the controls and governance for the project and is updated for each Hold Point.

### 7.2.1 Contract Management plan

As has been discussed in the Commercial Case, the Contract between the Design & Delivery Partner and the Government of Jersey is in the form of a Pre-Construction Services Agreement with amended Conditions of Contract. Once the project is ready to progress into the construction stage, the form of Contract will revert to the Engineering and Construction Contract (ECC) NEC3 Option C Target Cost Contract which offers a robust, tried and tested approach to contract management.

The Design and Delivery Partner is obliged to produce a programme for acceptance, and to update and resubmit it following the cycle set out in the contract.

Contract Administration Software (CEMAR) has been selected to aid the administration of the contract, and is used for all contractual notices, ensuring there is a clear record of both the communications, and the dates/timescales related to them. In addition to the Design and Delivery Partner, other interim and external appointments have been made to the project team in line with the resourcing strategy for the project and whose contracts require management. This management will be undertaken by Government of Jersey.

A supplier performance management process has been established for the project. This includes a standard form of KPIs for Supplier Management. Currently the plan is for:

- Quarterly reviews take place with the DDP
- Bi-annual reviews take place with other major suppliers

### 7.2.2 Post-Project Evaluation

Upon successful completion of the Our Hospital Project, a two-stage project evaluation report will be produced.

The first stage report will be completed within three months of practical completion and provide an initial assessment of the project performance including:

- Scheme performance
- User satisfaction
- Contractor performance
- Consultant's performance

A second stage report will assess the value for money performance of the project.

Both stage reports must be approved by the Senior Responsible Officer, presented to the Sponsoring States Body and copied to the States Treasurer and Principal Accountable Officer or their delegates.

A budget will need to be established for the post-project evaluation.

### 7.2.3 Programme

By maintaining delivery of the project within the revised timeline this will mitigate several financial and front line service issues. If the new hospital was delayed the following could result:

- Delays to the construction of a new hospital are likely to lead to increase in the costs/m2 because of the current high trend in construction inflation rates in Jersey (8.00% per annum as per GoJ Technical Advisor).
- The UK Government is committed to a major investment in infrastructure, including health infrastructure (40 new or refurbished hospitals) which is likely to put pressures on the construction industry in the UK and further drive construction inflation and market appetite for the scheme in Jersey.
- Credibility could be lost in the construction supply market should the project fail to progress to construction and may reduce the likelihood of bidders in any future new build procurement.

There are also advantages in moving forward with the new build programme and maintaining the speed of that delivery, providing higher assurance of a sustainable solution being put in place. This includes:

- Reducing the likelihood of other capital interventions into the current hospital which should then reduce disruption to patients and staff.
- Improving the current layout and clinical adjacencies than the existing site can never allow and provide the benefits sooner for patients
- Speeding up the construction of the new hospital should have a positive impact on the recruitment and retention of staff.
- Enabling the delivery of the Jersey Care Model in the time required.

## 7.3 Project Management arrangements

The Government of Jersey has established a Project Management Office (PMO) that will assist with the oversight, management, assurance, and governance compliance for the Our Hospital Project. The Project Management Office is responsible for ensuring the project is delivered:

- In line with the HM Treasury Green Book guidance as required and principles of PRINCE2.
- In accordance with the Government of Jersey Public Finances Manual (PFM).
- With a robust set of processes in place, which were originally set out in the Project Brief, and have now been developed to form the Project Manual
- On time and in line with agreed budget.
- In a transparent and accountable manner.
- With an appropriate level of engagement, review, Senior Officer and political oversight in line with the project governance structure.
- In accordance with the Project Mandate.

### 7.3.1 Project Approvals

The Project Manual summarises the approvals that are required for the project, informed by guidance such as the Jersey Finance Manual, and by best practice. Papers for items for approval are submitted to SOSG and POG in advance of the scheduled meetings. Decisions are made at the meeting and minuted. Items are progressed for POG approval only once SOSG approval is obtained. The OBC approval process as per the Project Manual is set out below.

**Table 45: OBC Approval requirements**

| OBC Approvals | Date |
|---|---|
| Senior Officer Steering Group (SOSG) | 10/06/2021 |
| Political Oversight Group (POG) | 16/06/2021 |

## 7.4 Project Reporting and monitoring

The reporting and monitoring methods are tailored for the Our Hospital Project whilst following PRINCE2.

A number of reports which vary in frequency and audience are produced throughout the project to ensure the project board and team members are kept up to date with the latest developments.

The reporting and approval requirements for each type of report during the OHP is shown below:

*A Approves R Receives*

**Table 46: Reporting and approval requirements**

| | DEVELOPMENT DIRECTOR | SOSG | POG |
|---|---|---|---|
| Weekly Report | A | R | |
| Monthly Highlight Report | A | R | |
| Monthly POG | A | A | R |

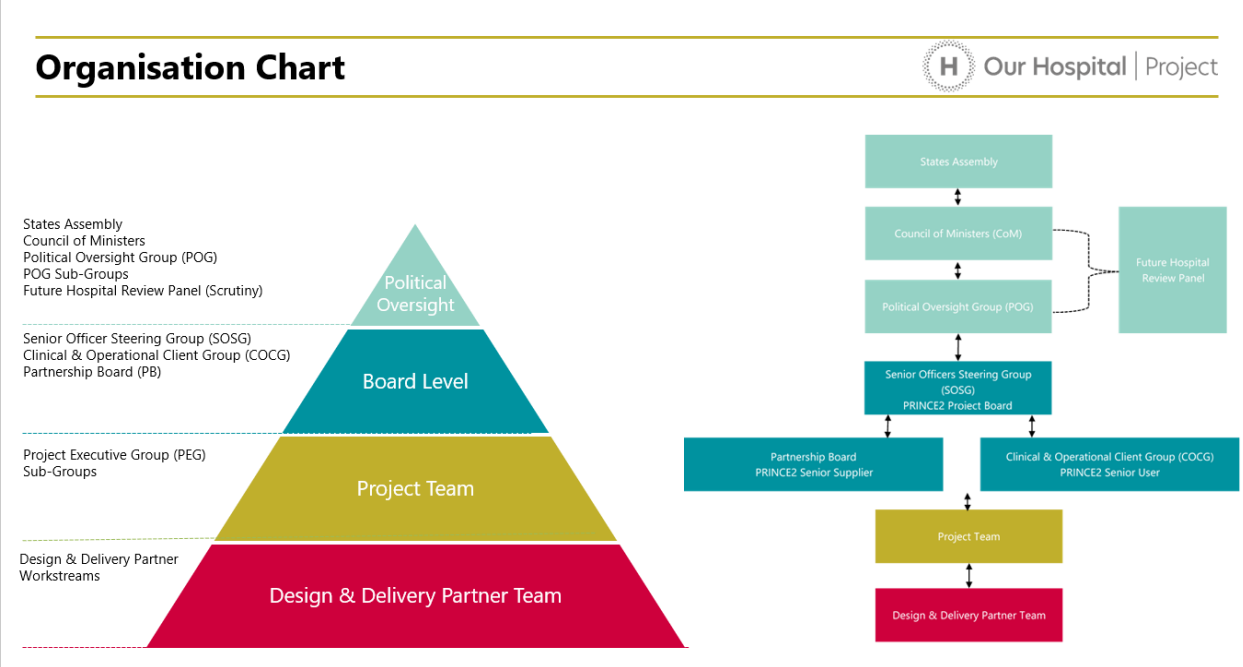
| | | | |
|---|---|---|---|
| Checkpoint Reports | R | | |
| Hold Point End Stage and Next Stage Reports | A | A | A |
| Health Check Report | A | R | |
| Lessons Report | A | R | |

## 7.5 Outline roles and responsibilities

### 7.5.1 Programme governance structure

The Programme governance and reporting structure has been developed to follow the principles set out in the HM Treasury Green Book and PRINCE2. The diagram below outlines the framework that supports the governance, monitoring and successful delivery of the Programme.

**Figure 11: Our Hospital Governance Structure**




The groups are summarised below, and more information can be found in the Project Manual.

***States Assembly***

The States Assembly.  Will make decisions for Our Hospital Project as required eg the Proposition that was debated on Site Selection.

***Council of Ministers***

The  Council of Ministers. Will make decisions for Our Hospital Project within its remit and make recommendations to the States Assembly.

***FHRP (Future Hospital Review Panel)***

The FHRP that was established to provide assurance and scrutiny for the States Assembly on the project to provide a new hospital.

***Political Oversight Group (POG)***

The group that was established to provide political scrutiny and oversight to the delivery of a new hospital as well as making decisions and taking recommendations to CoM, who they take direction from. They also lead on communications outside the project team.

POG is chaired by the Deputy Chief Minister and Minister for Economic Development, Tourism, Sport and Culture.

***Senior Officer Steering Group (SOSG)***

The Officer Group that was established to act as the PRINCE2 Project Board for the project. Accountable for the success of the Our Hospital project on behalf of POG. It makes decisions within its authority levels on the approach to be taken to deliver the project. It ensures coordination of the project into other government programmes and departments.

SOSG is chaired by the Chief Executive and Head of the Public Service and attended by the SRO who is the Accountable Officer for the project.

***Clinical and Operational Client Group (COCG)***

The group established to act as the PRINCE2 Senior User specifying the clinical and operational requirements for a new hospital for Jersey

COCG is chaired by the SRO, the Director General for Health and Community Services.

***Partnership Board***

The group established to act as the PRINCE2 Senior Supplier responsible for  delivery of the for a new hospital for Jersey.

Partnership Board is chaired by the Director General for Infrastructure, Housing and Environment (IHE).

***Project Executive Group***

A coordination group for the project team to enable them to communicate plans for delivering day-to-day tasks on the project.

***OHP Project Team***

The team members responsible for delivering the project as directed by the Board and Political level groups.

### 7.5.2 Individual roles and responsibilities

The roles and responsibilities of the key senior officers within the Our Hospital programme are as follows:

**Project Executive**

The Chief Executive and Head of the Public Service will act as Project Executive and is a member of SOSG. The Project Executive is ultimately responsible for the project. It is the role of the Project

Executive ensure that the project is focused throughout its life on meeting its objectives and delivering Our Hospital, realising the forecast benefits and delivering Value for Money.

**Senior Responsible Officer (SRO)**

The Director General, Health and Community Services for GoJ will act as the Senior Responsible Officer (SRO) during project start-up and initiation and to the end of the Pre-Construction Services Agreement (PCSA). At the end of the PCSA period, the SRO will move to the Director General of Infrastructure, Housing and Environment. The SRO is a member of SOSG and responsible for approving the issue of documents to SOSG and for approving payments for costs that have been authorised by SOSG. The Director General of Health and Community Services will also be the Accountable Officer for the project as defined in the Jersey Public Finances Manual.

**Development Director**

Due to the size, scale and complexity of the Project, a Development Director role has been established. The role of the Development Director is to act as the day-to-day agent on behalf of the SRO for the successful delivery of the programme. Key responsibilities include co-ordinating all elements of the project, shaping the overall programme of work to deliver the agreed objectives and providing an overall monitoring and assurance role across the project.

## 7.6 Use of specialist advisers

To ensure the necessary skills and capabilities have been leveraged to maximise the potential of delivery of a successful project, specialist advisers have been recruited or procured to support the project. Details are set out in the table below:

**Table 47: Specialist advisers**

| Specialist Area | Adviser |
|---|---|
| Communication and Engagement | Complete Insight Media Training |
| Project Management Office | Mace |
| NEC Contract Legal Support | Shepherd & Wedderburn |
| Property Agent | D2RE |
| Financial and Commercial Advisors | EY |
| Cost Consultants and Buyer | Turner and Townsend (+Tillyards) |
| Clinical Director | Vivek Consulting Services |
| Development Director | Plan RB |
| Financial and Commercial Services | PWC |

| | |
|---|---|
| Design and Delivery Partner | RokFCC JV |
| NEC Supervisor and Design Adviser | Mott MacDonald |

## 7.7 Government Team Project Budget

The 2021 Government Team Project budget is being continuously reviewed and updated to reflect monthly actuals.

In addition, the specialist knowledge brought into the team has provided greater insight and certainty into the realistic cost estimates and project roles needed, to ensure delivery of a successful project. It has been recognised that expertise and contracts to deliver major developments come at a premium when compared to the UK.

The project is at a point where the majority of the procurement of the client team is complete and experts are on board, which affords greater assurance of the forecast budget required in 2021 and beyond.

The latest estimate for the Government of Jersey Team costs is as follows:

- 2019 £0.5m
- 2020 £4.4m
- 2021 £9.4m
- 2022 £6.3m
- 2023 £4.8m
- 2024 £4.7m
- 2025 £4.7m
- 2026 £4.7m
- **Total** **£39.5m**

The forecast reflects the main specialist services procured through a competitive process, which demonstrate value for money and quality services.

## 7.8 Project Delivery – Planning Application

The Design & Delivery Partner has recommended GoJ make a Detailed Planning Application for the main hospital rather than one in Outline followed by a subsequent reserved matters submission. The reason is four-fold:

- Supplementary Planning Guidance (SPG) which is out for consultation requires detailed information to be provided.
- Outline permission requires subsequent ‘reserved matters’ submissions. Each of these can be challenged and therefore the detailed permission removes this risk of repeated delays to the project.
- The detailed design allows more time to conclude our final requirements.
- Detailed permission will overall be achieved quicker than outline permission and help speed up the construction programme.

The Planning Application will be submitted to the Government of Jersey Development Control Section. Pre-application consultation has started, with formal pre-application advice due to be provided by the GoJ Development Control in June. The OHP planning strategy is set out in the Concept Design (RIBA 2) report.

The original timeline to achieve Outline planning was to March 2021. The plan is now to submit a Detailed Planning Application by winter of 2021. The revised timeline reduces the planning process from two submissions being Outline Planning and reserved matters to one Detailed Planning Application. As provided above, two applications could lead to delays in the project, which could then impact on the operational readiness of the building scheduled for 2026.

It is currently expected two additional planning applications will be required to deliver the project at Overdale.

- A change of use application for the site selected to relocate the services currently provided on the Overdale Site.
- An application for demolition, to enable the site to be clear for construction, de-risking the programme.

## 7.9 Benefits Management

The Our Hospital Project is committed to realising significant benefit from the new hospital and intends to direct significant clinical and management resource to achieving this.

A Benefits Register been created which will captures all of the benefits identified in the Strategic Case. This Register is based on the Benefit Register Template as set out in the Green Book Guidance 2020. This Benefits Register is included at Appendix E.

A draft Benefits Register has already been prepared and identifies the following for each benefit:

- Benefit Number
- Benefit Category and class
- A description of the Benefit;
- Service feature
- Potential costs (where a benefit can be quantified)
- Activities required
- Responsible Officer
- Performance measure
- Target improvement
- Full-year value (where a benefit can be quantified)
- Timescale

At Full Business Case (FBC) stage a more detailed benefit register and plan will be developed which will cover all benefits, Cash Releasing and non-Cash Releasing, and detail the plan for measuring those benefits as the project progresses.

In addition to this, Construction Stage benefits are being managed by the DDP and are captured in the KPI's which have been developed. The KPI's will continue to be developed during the pre-construction phase of the project and will be set out in more detail at FBC stage.

## 7.10 Change Management

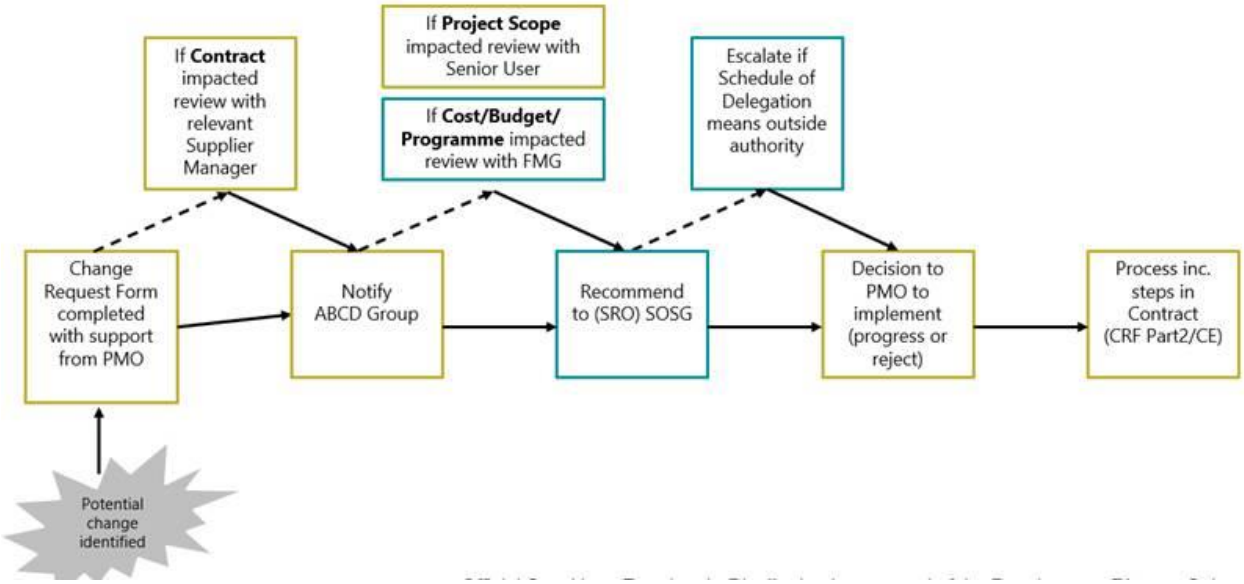
As set out in the flow chart below, the change process identifies how, and by whom, the project's products and baselines (costs, programme and scope) will be controlled and changed. Changes to any of the contracts or baselines on the project are managed following the process set out in the Change Flow Chart.

Changes that require changes to costs/budget or programme are reviewed by a Financial Management Group (FMG) which has been established with a remit including management of project change. The SRO, who is the Accountable Officer, is a member of FMG.

Changes the require derogation to the Scope (the Employer's Requirements, which include the Functional Brief) need approval from Senior User (COCG/SRO). Where the change exceed the delegated authority levels of the governance structure the change is reassigned to the relevant level of authority.

The Jersey Public Finance Manual, and the HCS Scheme of Delegation which sets out authority limits for change, have informed the development of the project change process.

**Figure 12: Change process**




All identified changes are managed through the change control process set out in the Project Manual, which is informed by the requirements of PRINCE2 and the Jersey Public Finance Manual.

Any changes will be raised through a Change Request Form (CRF) and added to the Change Log by the PMO. The CRF will be reviewed by the relevant Contract Supplier Managers, and then submitted to the Financial Management Group who act as the Change Authority for consideration. The Change Authority will escalate the change if the change is outside the scope of their delegated authority.

## 7.11 Following assessment of the change the outcome will be recorded and reported back to the PMO and Contract Supplier Manager for implementation. Risk Management

Strong risk management is key to the effective governance and management of the Our Hospital project. The project's risk management process has been established in accordance with the Government of Jersey Risk Management Guidance which applies to all Government Bodies as defined in Article 1 of Public Finances (Jersey) Law 2019 and has been designed to align with ISO Standard 31000:2018 for risk management and PRINCE2.

The key principles of the Risk Management approach will ensure it:

- Aligns with project objectives.
- Fits the context (internal/external environment).
- Engages stakeholders.
- Provides clear guidance.
- Informs decision making.

- Facilitates continual improvement.
- Creates a supportive culture.
- Achieves measurable value.

The following elements have been addressed:

**Communication and Consultation**

Ensuring relevant stakeholders understanding risk, the basis on which decisions are made, and the reasons why particular actions are required.

**Scope, Context and Criteria**

Tailoring the risk process, enabling effective risk assessment and appropriate risk treatment. This has involved putting in a place a process that works across the full project structure, from the POG, to SOSG, to the Project Team.

**Assessment**

Establishing a suitable process to enable risk identification, analysis and evaluation. Risk assessment will be conducted systematically, iteratively and collaboratively, drawing on the knowledge and views of stakeholders.

**Treatment**

Selecting and implement options for addressing risk and through an iterative process:

- The formulation and selection of options
- Planning and implementing
- Assessment of the effectiveness of that treatment
- Deciding whether the remaining risk is acceptable
- If not acceptable, taking further treatment

**Monitoring and Review**

Ongoing monitoring and periodic review of the risk process and its outcomes will be a planned part of the risk process and will take place in all stages. Monitoring and review includes planning, gathering and analysing information, recording results and providing feedback. The results of monitoring and review will be incorporated within health check and lessons learnt processes.

**Recording and Reporting**

The risk process and its outcomes are documented and reported through risk registers which are owned and updated by identified members of the different project and governance groups.

**Escalation**

Risks should be managed by the party best placed to manage the risk and at the most appropriate level in the organisation. Risks may need to be escalated – either within or between the levels of hierarchy. The Manual sets out the mechanism that is used for escalation of risks.

**Project Level Risk Management**

The Design and Delivery Partner are responsible for managing project level risks. Regular workshops are held, at least monthly, and all members of the Project Team participate. The log is updated regularly and is recirculated at least monthly. The OHP Team review the log following the risk workshops, to identify

new and emerging risks to escalate to the Board and Political levels of the project. The full process for managing risk with the Design and Delivery Partner is detailed in the Contract and the PEP.

**Board and Political Level Risk Management**

There are currently risk registers held for the Senior Officer Steering Group and Political Oversight Group, managed by the Government of Jersey's Director of Risk and Audit. These are reviewed at SOSG and POG meetings, and through specific risk workshops.

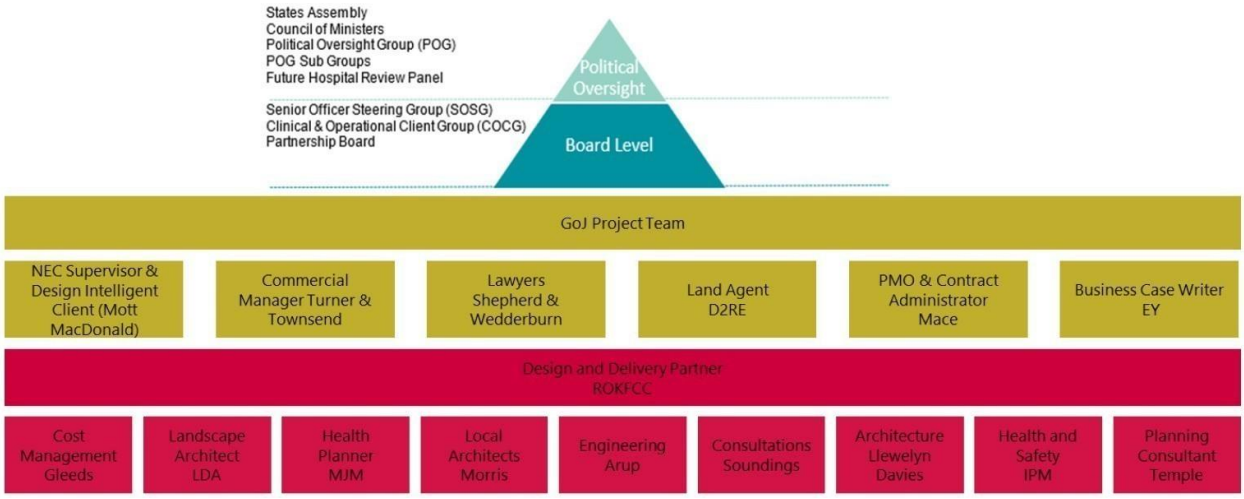
**Reporting**

The PMO are currently reporting on risk in the weekly reports and monthly Highlight reports, whilst the Design and Delivery Partner are reporting via their monthly Checkpoint reports. The risk log is shared with the full team monthly as part of the drumbeat of meetings and reports.

## 7.12 Advisor Team

Given the complex nature of the scheme, the GoJ has procured a number of specialist advisors to provide external advice on the project as set out in the below diagram. This includes advice on build, health and safety and estate issues with the advice evidenced throughout the business case as appropriate.

**Figure 13: OHP Team Organisation Structure**




## 7.13 Engagement and Communications Approach

The OHP Public Engagement and Communications Strategy outlines the public engagement and consultation approach that is being undertaken as part of the pre-planning application process for Our Hospital Project.

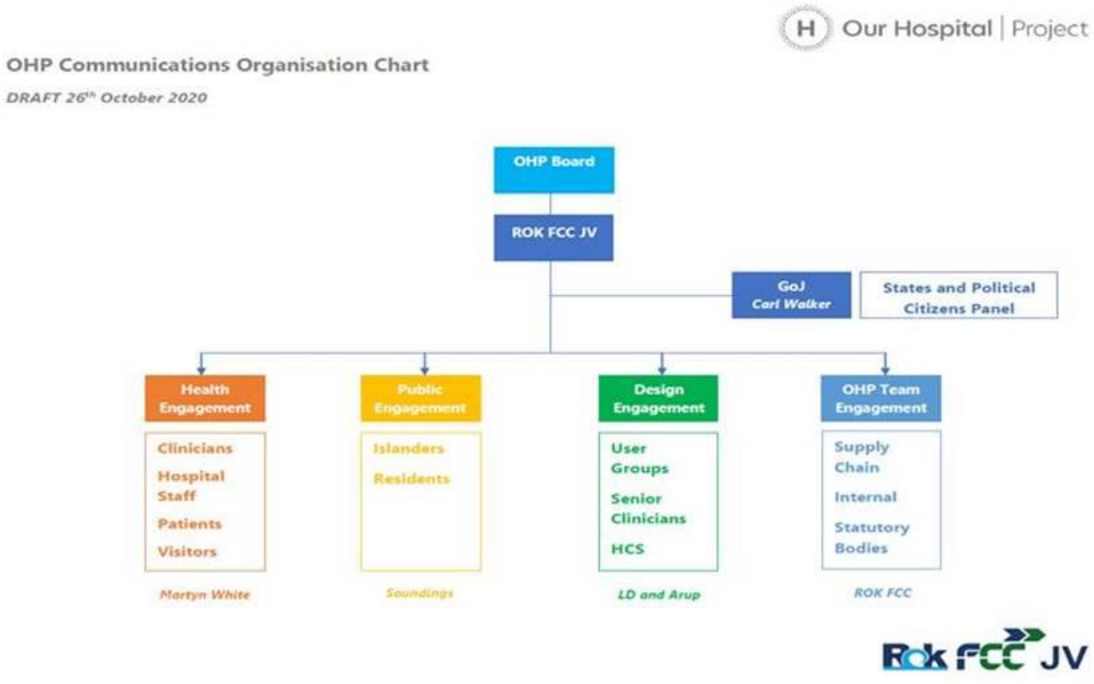
To ensure all public consultation is carried out impartially, transparently and thoroughly is a prerequisite of a properly conducted planning process for a project of this significance, Soundings have been appointed as an independent consultant. Soundings will ensure that all opinions and thoughts as regards the design of the hospital, and allied early works, such as the Overdale access arrangements, are logged and properly considered by the design team at each stage of the scheme's evolution. Soundings will be responsible for producing the Statement of Community Consultation, which will accompany the planning application documents for consideration on determining the planning application, describing the consultation process and its impact on the final design outcomes.

The Engagement and Communications Approach for Our Hospital project will be to keep audiences informed with clear, consistent and informative messages, ensure that they respond positively to opportunities to engage, and seek to build supports, advocates and champions for the project and for the selected site. The core elements of the approach are:

- Clear, agreed project **objectives** to which communications objectives can align
- **Segmented audiences**, backed by insights into their known positions, who influences them and who they influence
- A clear, compelling and evolving **narrative**, based on facts, consistently applied, but adapted to segmented audiences, which dovetails with and adapts to the new healthcare model narrative
- A **multi-channel approach**, using face-to-face, focus group, public events, media, social media, staff and stakeholder engagement, and advertising, tailored to the segmented audiences
- The promotion and use of **Citizens' Panels** as an integral part of community engagement, and as focus groups to inform decision-making across a range of hospital requirements and site evaluation issues
- A **rhythm of significant bursts of engagement and communications** related to achievable project milestones, with a continuous flow of bite-sized chunks of dependable factual information between major milestones
- Building a group of **third-party advocates and champions**, who have influence and trust among wider audiences, to speak in support of the project and encourage islanders to join in their support
- Establishing **core project spokespeople** among POG, who are identifiably the faces/voices of the new hospital, backed by trusted medical professionals, who can be deployed to explain the urgent case for a new hospital, and authoritative specialists, who can explain technical issues
- **Measurement and evaluation** of the inputs, outputs, outtakes and outcomes of communication activity to assess its effectiveness and adapt the approach in the light of what the evaluation is telling us.

DDP is responsible for the OHP Engagement and Communications Strategy.

The strategy will be co-ordinated in partnership with different teams involved in the project, each leading specific areas of responsibility. The DDP Communications organisation chart below demonstrates this:



The below table demonstrates the various communication channels for each of the stakeholders. This is anticipated to continuously evolve throughout the project.

**Table 48: Communication channels for stakeholders**

| Stakeholder Group | Lead | Audience | Channel | Frequency |
|---|---|---|---|---|
| Political | GoJ<br>ROK FCC | POG<br><br>States Members | Briefings<br>Meetings<br>Reports | High |
| Health | OHP Project Team<br>Soundings | Health Workers Panel<br>Clinicians and JCM<br>Hospital staff<br>Patients<br>Visitors | Meetings and workshops<br>Newsletters<br>Email<br>Notice boards<br>Digital Screens | High |
| Public Engagement | Soundings | All Islanders | Virtual Exhibition<br>Flyers/adverts/posters<br>Newsletters<br>Residents/ Community Liaison Group<br>Workshops and meetings<br>Web site | At each design development stages: 4 key stages: –<br>— site evaluation<br>— concept design<br>— final design<br>— planning application |
| Overdale Neighbours | Soundings | Overdale neighbours | Residents Liaison Forum<br>Newsletters<br>Leaflet drops<br>Hotline No.<br>Meetings<br>Web | High |
| User Groups and Panels | LD and Arup | Citizens' Panel<br>Senior Clinicians<br>Users<br>Jersey Architects' Commission | Workshops | Medium |
| Social Value Partners | ROK FCC | GoJ Colleagues<br>Charity Partners<br>Voluntary Sector<br>Education<br>Business Groups | Meetings<br>Workshops<br>Events | Medium |

| | | | | |
|---|---|---|---|---|
| | | Employment and skills | | |
| Supply Chain | ROK FCC | OHP sub-contractors | Press releases<br>Communications<br>Protocols<br>Emails<br>Meetings | Medium |
| Land-owners | GoJ<br>D2RE | Land-owners | Meetings<br>Letters<br>Telephone Calls | As Required |

## 7.14 Learning and continuous improvement

Throughout the project, the PMO will co-ordinate a lesson learned review following each Hold Point and at the close of the project to ensure as many lessons as possible are captured. These will be recorded within a Lessons Log held by the PMO and recommendations following reviews will be distributed.

A Lessons Learned report will be produced during the project close down, detailing lessons which should be applied to future stages or projects and sent to the Project Board for approval.

## 7.15 Conclusion

A comprehensive system of processes and controls has been put in place and is being used to manage the project. Regular periods of review are set out, enabling feedback to be received and improvements put in place.

## Appendix A – Appendix list

- Appendix B – Abbreviations
- Appendix C – Policy Publication links
- Appendix D – OHP New Risk Template
- Appendix E – Benefits Register
- Appendix F – OHP Project Manual
- Appendix G – OHP Concept Report Summary

## Appendix B – Abbreviations

| Abbreviation | Full name |
|---|---|
| AV | Audio Visual |
| Client | Government of Jersey |
| CAS | Community Alarm Service |
| CCC | Combined Control Centre |
| COCG | Clinical and Operational Client Group |
| COO | Chief Operating Officer |
| DG | Delivery Group |
| DDP | Design & Delivery Partner |
| ED | Emergency Department |
| EY | Ernst & Young LLP or the Commercial & Financial Advisor |
| FBC | Full Business Case |
| FTS | Fleet and Technical Services |
| GoJ | Government of Jersey |
| Green Book | The UK Her Majesty's Treasury Green Book Guidance on the development of Capital Business Cases |
| HBN | Health Building Notes |
| HCS | Health & Community Services |
| HSI | Health & Safety Inspectorate |
| IM&T | Information and Communications Technology |

| Abbreviation | Full name |
|---|---|
| ITT | Invitation to Tender |
| JCM | Jersey Care Model |
| MJM | MJ Medical or the Health Care Planner |
| NMSC | Non-melanoma skin cancer |
| NEC | New Engineering Contract |
| NPC | Net Present Cost |
| OBC | Outline Business Case |
| PCCG | Planning and Construction Client Group |
| PCSA | Pre-Construction Services Agreement |
| PEP | Project Execution Plan |
| PFM | Public Finances Manual |
| PICU | Psychiatric Intensive Care Unit |
| PIN | Prior Information Notice |
| POG | Political Oversight Group |
| PTS | Patient Transport Services |
| PwC | Price Waterhouse Coopers or the Health Care Advisor |
| SME | Subject Matter Expert |
| SOC | Strategic Outline Case |
| SOSG | Senior Officer Steering Group |
| SPG | Supplementary Planning Guidance |

| Abbreviation | Full name |
|---|---|
| SRO | Senior Responsible Officer |
| T&T | Turner & Townsend or the Cost Consultant |
| UK | United Kingdom of Great Britain & Northern Ireland |
| VfM | Value for Money |
| WTE | Whole Time Equivalent |

## Appendix C – Policy/Publications reviewed - links

- Imagine Jersey 2035 (2008) - https://statesassembly.gov.je/scrutinyreviewresearches/2008/s-18058-20518-11122008.pdf
- Island Plan 2011
- St Helier Development and Regeneration Strategy (2008) - R StHelierRegeneration 2020080417.pdf (gov.je)
- Strategic Plan 2015-2018 (2015) - Strategic Plan 2015-18 (hwa.uk.com)
- P.82/2012 Health and Social Services: A New Way Forward and its amendment - Health and Social Services: A New Way Forward (P.82/2012) – amendment (gov.je)
- The States of Jersey Hospital Pre-Feasibility Spatial Assessment Brief (2013) - Microsoft Word - Refined Concept Addendum SOC_Report_131003_Updated (hwa.uk.com)
- Acute Service Strategy 2015-2024 (2016) - Health and Social Services: Acute Service Strategy 2015 – 2024 (gov.je)
- Health and Social Services Department Business Plan (2017) - POE-1-Appendix-19.pdf (hwa.uk.com)
- A Mental Health Strategy for Jersey 2016-2020 (2015) - POE-1-Appendix-20.pdf (hwa.uk.com)
- Out of Hospital and Long-Term Conditions OBC 2016 - A Proposed New System for Health and Social Services (hwa.uk.com)
- A Sustainable Primary Care Strategy for Jersey 2015-16 (2016) - r.1-2016.pdf (gov.je)
- Jersey Carer's Strategy (2017) - CN34-Jersey_Carers_Strategy_2017.pdf (hwa.uk.com)
- HSSD Informatics Strategy 2013-2018 (2013) - Word Document Template (gov.je)
- Disability Strategy for Jersey (2017) - R Disability Strategy For Jersey Standard Version 20170525 DS.pdf (gov.je)
- Future Jersey 2017-2037 (2017) - https://www.gov.je/SiteCollectionDocuments/Government and administration/FUTURE JERSEY_SPREADS 12072017.pdf
- Digital Health and Care Strategy (2017) - Digital Health and Care Strategy by Digital Jersey Hub - Flipsnack
- One Health and Community Services (2018) - ID One HCS - Playing Our Part Within One Government (full document) 181203 LD.pdf
- Common Strategic Policy 2018 to 2022
- Health and Wellbeing Framework for Jersey (2020) - r.21-2020.pdf (gov.je)

## Appendix D – OHP New Risk Template

https://statesassembly.gov.je/SiteCollectionDocuments/States%20Assembly/Appendix-D-OHP-New-Risk-Template.xltx

## Appendix E – Benefits Register Template

https://statesassembly.gov.je/SiteCollectionDocuments/States%20Assembly/Appendix-E-Benefits-Register-Template.xltx

## Appendix F – OHP Project Manual

https://statesassembly.gov.je/SiteCollectionDocuments/States%20Assembly/Appendix%20F%20-%20OHP%20Project%20Manual.pdf

## Appendix G –OHP Concept Report Summary

https://statesassembly.gov.je/SiteCollectionDocuments/States%20Assembly/Appendix%20G%20-%20OHP%20Concept%20Report%20Summary.pdf

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Re-Issue Note

This report was re-issued on 16th August 2021 to fix the Appendices links to various documents in Apprendices C, D, E and F.