States of Jersey
States Assembly

États de Jersey
Assemblée des États

Future Hospital Review Panel

Our Hospital Project Outline Business Case and Funding Review

Witness: Deputy Chief Minister

Wednesday, 11th August 2021

Panel:

Senator K.L. Moore (Chair)

Deputy M.R. Le Hegarat of St. Helier

Deputy I. Gardiner of St. Helier

Deputy D. Johnson of St. Mary

Panel Advisers:

Mr. M. Clark, Currie and Brown

Ms. H. Pickering, Currie and Brown

Mr. D. Ross, Currie and Brown

Witnesses:

Senator L.J. Farnham, Deputy Chief Minister

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

Mr. S. Hayward, Director, Treasury and Investment Management

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

Ms. J. Poynter, Associate Director, Improvement Innovation, Health and Community Services

Ms. G. Starks, Hospital Project Manager

Mr. R. Hanson, Director, Turner and Townsend

Professor A. Handa, Clinical Director, Our Hospital

Mr. A. Ross, Assistant Director, EY

Mr. R. Barnes, Associate Partner, EY

[10:45]

Senator K.L. Moore (Chair):

We are now live. We are going to start again, apologies for any technical difficulties. I hope everybody is still able to join this public hearing of the Future Hospital Review Panel. We will have to start again, I am afraid, with the introductions but we will try out best to keep this all as brief as we can so we can get on with the question. I hope everyone will be able to stay a little longer so that we maintain our full hour and a half. I am Senator Kristina Moore and the chair of this panel.

Deputy I. Gardiner of St. Helier.

Deputy Inna Gardiner of St. Helier 3 and 4, member of the panel.

Deputy D. Johnson of St. Mary:

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

Deputy M.R. Le Hegarat of St Helier:

Deputy Mary Le Hegarat, District 3 and 4 of St. Helier and also a member of this panel.

Mr. M. Clark:

Hello, Martin Clark, I am a director with Currie Brown.

Ms. H. Pickering:

Helen Pickering, senior director, Currie Brown.

Mr. D. Ross:

Douglas Ross, senior director, Currie and Brown.

Deputy Chief Minister:

Good morning, Senator Lyndon Farnham, chair of the Our Hospital Political Oversight Group.

Director General, Infrastructure, Housing and Environment:

Andy Scate, director general, Infrastructure, Housing and Environment.

Director, Treasury and Investment Management:

Simon Hayward, director, Treasury and Investment Management.

Associate Director, Improvement Innovation, Health and Community Services:

Jo Poynter, associate director, Improvement Innovation, Health and Community Services.

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

Hospital Project Manager:
Gretta Starks, hospital project manager.

Senator K.L. Moore:
Right, thank you all and thank you all for joining us. If we would start. The purpose of this hearing is to go through the outline … apologies, we did not hear that, if you could just repeat your introduction, I think that was Mr. Hanson?

Director, Turner and Townsend:
Ross Hanson, director, Turner and Townsend, Government of Jersey cost consultant.

Senator K.L. Moore:
Are there any other people on the call from the Government side?

Deputy Chief Minister:
There should be, chair, but 2 or 3 key members are still having difficulty accessing the meeting.

Senator K.L. Moore:
Perhaps they can introduce themselves if they come to answer a question, that would be helpful because we do really need to get started. As I was saying, the purpose of this hearing is to gather information for our review and looking at the outline business case as recently published. Initially we would just like a brief explanation, if we could, of how the outline business case was developed by the Government team.

Deputy Chief Minister:
Thank you, first of all the purpose of the outline business case is to primarily set out the case of the new hospital project in line with the appropriate governance. If I could hand over to ...

Senator K.L. Moore:
If I could just stop you there, Senator, if you could perhaps confirm for us that you are content with the governance of the outline business case?

Deputy Chief Minister:

There are definitely still some technical issues but I think we will just have to work through them. The question was: am I content with the governance of the outline business case? The short answer to that is yes.

Senator K.L. Moore:

Thank you. You were handing to somebody who could briefly talk us through the development of it?

Deputy Chief Minister:

Absolutely and I am having difficulty seeing the names. I think Andy ... sorry, I am getting messages other people are joining. We will hand over to Ernst and Young who are with us.

Hospital Project Manager:

Senator, I think both of our colleagues from Ernst and Young are still struggling to turn microphones on, unfortunately, unless they interrupt me now to say that they now have access. I know they can hear some of the discussion but are not able to speak at this point. Ernst and Young are the business case writer and so will be best placed to obviously explain that the process that they went through. In summary, while we are waiting for them to join, this is obviously a business case that has been developed following a strategic outline case and has followed the same principles. So informed by the Public Finance Manual in Jersey and picking up practice from the Green Book and using the 5 case model.

Senator K.L. Moore:

Thank you. When you saying picking up practice from the Treasury Green Book, does that mean following the principles set by it or simply using parts of it?

Hospital Project Manager:

Again, colleagues from EY would be best placed to explain on a case-by-case example exactly which guidance has been used and how they have enabled them to develop the case, but one of the things that they have been very mindful of is that this is a business case being developed in Jersey and it needs to be appropriate for the context here. So informed by the Green Book, informed by other methodologies that we are using on the project such as Prince2 but also mindful of the context that we are delivering in and particularly in the requirements of the Public Finance Manual.

Group Director, Treasury and Exchequer:

Senator, if I might interject and just add to what Gretta has been saying. The Public Finances Manual sets out what is required in a business case and what we have used is the Green Book approach which is the 5 cases business case. From that perspective the O.B.C. (outline business

case) is using a methodology that fulfils the requirements of the Public Finance Manual in Jersey. It is a standard methodology now within the Government of Jersey and we are providing training and familiarisation for staff across the Government of Jersey in this practice. You will be aware, and the advisers will be aware, from discussions that we have been having, it is based on a best practice model that is used in the U.K. (United Kingdom) but, as Gretta has set out, obviously there are some adaptations to the context of Government of Jersey specifically and some of the unique features of that. There are other methodologies but when we look at those the ingredients of the 5 cases and what we have set out in the outline business case prior to that, they cover the same ingredients so there should not be any issue in terms of methodology and the framework that is being used. When we get into a discussion of the detail there may be some areas which are adapted which are unique to the jurisdiction of Jersey, and we can cover that in more detail as we go through the questions.

Senator K.L. Moore:
You mentioned there the 5 case model. Could you outline what aspect of the project each of the cases addresses, please?

Group Director, Treasury and Exchequer:
In the O.B.C. you have a number of sections which cover off the details. So working through from the strategic management, financial, commercial, those are all covered in detail of the business case itself and we set out, first of all, the strategic case for change and then work through the other elements within the O.B.C. to set out the decision-making for each of those sections within the documents and the outline business case. The panel and the advisers have had an opportunity to look at each of those. Preliminary analysis is a strategic case for change, then sets out the criteria for the economic case for change, the commercials and then the financial case as well.

Senator K.L. Moore:
There are comparisons used in the O.B.C. to reach the conclusion that the option chosen, which is of course a new build, is the most appropriate option and one that represents best value for Jersey. Could you explain more about the comparisons that have been used there to achieve that conclusion, please?

Hospital Project Manager:
Senator, this is another question if our colleagues from EY join in they will take over from me and answer in a better technical way. In the strategic outline case a longlisting process took place which identified the full list of options that would be looked at and the outline business case describes for us how that took place. There was a workshop where options were looked at, identified and listed and the evaluation mechanism was discussed, critical successful factors were agreed and during that strategic outline case stage the longlisting took place that identified the 2 options that would be

brought forward to the O.B.C. and the conclusion of the S.O.C. (strategic outline case) recorded that piece of work. So at O.B.C. stage those 2 options were picked up, a piece of work was carried out to review the full longlist and to ensure the correct longlist to review the critical success factors, and again ensure that they remained appropriate and then to carry out the economic analysis in the economic case on the 2 selected options.

Senator K.L. Moore:
Have EY now joined the call?

Deputy Chief Minister:
I believe they are still experiencing challenges, Senator. We are still trying to get them in.

Senator K.L. Moore:
I imagine as the person leading the project and having overall political responsibility, Senator, you should be able to assist with some of these. The previous speaker just spoke of the return to the longlist and the review of that was undertaken in bringing about the outline business case. Our previous report from the site selection identified some governance issues around that. Are you aware that those have now been reviewed by EY in the undertaking of this piece of work?

Deputy Chief Minister:
As I understand it, yes, but before we continue we really do need our advisers in the meeting, Chair. I am afraid I am reluctant to go on without that because it is important we give accurate information to the panel.

Senator K.L. Moore:
Yes, of course. If we could perhaps pause for a couple of minutes. I am struggling to understand why it has taken them 10 minutes to join the meeting.

Associate Partner, EY:
Can you hear me? Hello, it is Richard Barnes from EY, apologises that for some reason we have not been able to access sound or video on the Teams link so we have dialled in now via the telephone connection. I am an associate partner with EY and apologies for the delay.

Senator K.L. Moore:
Okay, thank you, Mr. Barnes. Apologies if there are any issues caused by our side here. Thank you for joining. We were just beginning on the outline business case and the process that you have gone through, particularly touching on the review of previous governance issues that were highlighted by this panel in terms of the longlist. Was that reviewed by yourselves again?

Associate Partner, EY:

This is in the context of the current project or are you asking in the context of the work done at the strategic outline case stage, i.e. the first stage of this process?

Senator K.L. Moore:

We are now looking at the conclusions of this, the new build option, and obviously the work that has gone before this was supposed to have led to this conclusion as well.

Assistant Director, EY:

I am here now if it is easier for me to answer although, apologies, I have literally just arrived and I turned off my computer so I missed about 30 seconds but if you could ask the question again then I think I am probably best placed to answer in the first instance. Sorry, this is Andrew Ross from EY

Senator K.L. Moore:

Thank you, Mr. Ross. So we are simply at the beginning still, trying to identify how the 5 case model has progressed using the Treasury Green Book guidelines and particularly I was just asking about the governance and how or whether this process has revisited the governance issues that were highlighted in the longlist process that got us to this point when you began to develop the outline business case here.

[11:00]

Assistant Director, EY:

Okay, no problem, I can answer that. So the original longlist came from the S.O.C. stage which was originally … well, the S.O.C. process kicked off in February last year, 2020. The longlist option, which is still set out in this O.B.C., was a clinically driven longlist which considered everything from doing nothing or continuing business as usual through to the new build option on … sorry, a new build option, which at the time was site agnostic because site selection was not concluded at that point. But eventually, by the end of the S.O.C. process, became the Overdale new build option. So at the start of the O.B.C. process this year that longlist was reassessed by roughly the same clinical group and was tested again through the clinical governance process and effectively concluded that, again, as the S.O.C. did, that it was the new build option that met the critical success factors of the project. A baseline comparator option, which has developed further as the O.B.C. has progressed, was also taken forward as the baseline comparator, so essentially to be an option of what could happen if the new hospital did not go ahead. That is what has happened at the O.B.C. stage in terms of that list.

Associate Partner, EY:

It is Richard here. Just to contextualise that, because I know there was an earlier question around the 5 case before. The 5 case model effectively is one that uses the same structure at each stage of the business case lifecycle but effectively develops each of those 5 cases proportionate to the stage of the activity you are in. So it is an evolution rather than a new business case. It builds on the S.O.C, and at the S.O.C. stage you would ordinarily have a longlist and you would use the S.O.C. to develop the shortlist and the O.B.C. then takes that shortlist and works out the detail behind that, a value to effectively achieve the preferred option. But, obviously, as part of that, as Andy said, you would check that you were still comfortable that shortlist was appropriate. That is the process that has happened here.

Senator K.L. Moore:

Could we just focus in on the economic case for the time being? It has been identified that there are some items missing from there, in particular the options framework filter. Has that been applied to reach the shortlist?

Assistant Director, EY:

So if I come in initially. The option in terms of what was originally the site agnostic new build option and became the Overdale option has been a clinically driven option, so it has been developed by the Jersey clinical team, not per se by the project team. That option sets forward what the clinical team has worked through as being the best clinical option for a new build hospital.

Senator K.L. Moore:

What comparators were used by the clinical team in order to draw that conclusion? Is that the flawed process that we identified in the site selection report?

Deputy Chief Minister:

Can we go to Ashok, please, for that one?

Clinical Director, Our Hospital:

Thank you, Senator. I am not sure I understand which flawed process you are referring to.

Senator K.L. Moore:

Our adviser report on the site selection process identified there had been governance issues with the finalising of the 2 options. I was asking whether there had been some tightening up of the process in order to progress this.

Deputy Chief Minister:

If I may just come back, Chair, on that. If I recall the Scrutiny report on the site selection process actually gave it a clean bill of health and there were issues and questions raised but I do not certainly ever recall Scrutiny saying the whole process was flawed. I just wanted to make that point clear. Perhaps you could confirm that?

Senator K.L. Moore:

I will happily read from our adviser report that identifies insufficient due diligence undertaken in a rigorous manner to facilitate proper systemic evaluation, which is the purpose for my question.

Deputy Chief Minister:

Understood, thanks. Ashok, perhaps you could address that.

Clinical Director, Our Hospital:

I have to say I am very surprised to hear that because in the over 200 clinical user group meetings we have had when the site selection came down to the 2 options put to the States Assembly last November none of the clinicians in all of those meetings ever suggested that either of those 2 sites was not viable or that there was not sufficient support from the clinicians for either of those 2 sites. Subsequent to the decision of the States Assembly on 17th November we have had 2 rounds of clinical user groups, we have a third one coming up in September and, again, at none of those meetings, including the meetings we had with health worker panels, have any of the clinicians suggested that the solution of Overdale was not a site that any of them disagreed with. They are content with it, and we have not heard anything to the contrary. I hope that reassures the Senator.

Senator K.L. Moore:

Thank you. It appears that those are all subjective points, however, without any evidence base. I am grateful for the answer.

Clinical Director, Our Hospital:

I do not accept that it is not evidence based.

Senator K.L. Moore:

If we can move along with the questioning … well, I think we have probably been over those points in the past and we have not really got anything new since then. If I could return to the current line of questioning in relation to the outline business case and how this has been developed. We were asking about the areas that are missing from the economic case, I had just asked about the options for framework filter, this is how we have got to this discussion. The business-as-usual option, which would be expected as well as the do minimum, why has that not been included in the shortlist.

Assistant Director, EY:

The business-as-usual option, which is akin to what is referred to as the do-nothing option in the S.O.C. was considered at the S.O.C. stage, so effectively a do nothing or a business as usual would have involved essentially continuing with roughly the same level of spend on the existing site, which is currently being proposed. I think it is a £5 million capital spend 2020-23 and then possibly £2 million in 2024 but I would have to absolutely confirm those figures. It was felt clinically and operationally from a hospital perspective that would be insufficient to keep the current estate going and therefore unless there was something else agreed on top of that then the hospital would not be functional in its current form by circa 2026. It was felt that that option could not be taken forward and be a credible option so it was not further developed after that point. What we did do at that point though was essentially asked the question what would we need to do in order to keep the current estate operational into the future? That is where originally the do minimum, which eventually got renamed the baseline comparator, grew from. That is the option that is now presented in the O.B.C. So it was considered it just was not taken forward because it was not felt to be a viable option. The actual viable continuing option would take a lot more than business as usual, which is what is set out in the O.B.C.

Senator K.L. Moore:

Also we have noted the lack of benefit quantifications, such as the societal benefits or a net present strategic outline case value, that would normally be expected in an outline business case. Is there a reason for that?

Associate Partner, EY:

I will pick this up. It would be not unusual at O.B.C. stage to attempt to quantify benefits but that would effectively build on an identification of what the benefits are and then a qualitative assessment of those benefits, so effectively scoring of those benefits for each of the shortlisted options. The intention is very much to quantify benefits as part of the business case lifecycle. When we get to a full business case the project team's intention is to absolutely have a set of quantified benefits. The reason why they are not included in the O.B.C. is a question around the level of maturity of data within Jersey to allow that to be done in a way that is credible and effectively to the point where we could have something that we could stand behind in the business case as an appropriate assessment of those benefits from a quantified perspective. Given we did not have that data the decision was taken not to attempt to quantify those for O.B.C. but to effectively build that work out for the full business case. It is worth saying that a lot of work was done to identify the benefits and then to qualitatively score those. Given the difference between the qualitative scoring of the new build option as compared to the do minimum then the decision-makers … there is enough information in the qualitative scoring of benefits to take an appropriate decision. While the quantification of those would further provide information to decision-makers, I think the project team

is confident that the level of information in the economic case from a qualitative perspective for benefits is sufficient to allow decision-makers effectively to approve a preferred option. But, as I say, in terms of moving forward the project team's intention is to quantify those benefits and that is also important because part of a business case is to be able to then track and monitor that those benefits are actually realised in the delivery of the project itself. That is part of the management case that effectively identifies a need to track and monitor that you realise in the benefits that you set out at the business case stage. That is in terms of savings and benefits from a clinical perspective but also, as you say, broader societal benefits of introducing a new hospital, for example.

Senator K.L. Moore:

Could you just briefly give an example of the data that was lacking in Jersey, please, just so we can have an idea of the data that you were seeking that was not available?

Associate Partner, EY:

Andy, Gretta or Ashok might be best placed to give you a view on that. Maybe Andy to begin with.

Assistant Director, EY:

I think healthcare data. There was a baselining exercise that H.C.S. (Health and Community Services) commenced but were not able to conclude in the time in order to support on the business case, as it was not ready in time. It was just trying to understand and get a baseline for that data. For example, they were going to set up a process around patient surveys which could give a baseline position of results which could then, in the future, be considered against improvements that would hopefully be seen from the scheme in the future. There was not as much baseline data as there might be in the U.K. so work had to be done in order to set that baseline before it could attempt to be quantified in terms of what the hospital would bring in terms of additional benefit.

Senator K.L. Moore:

Thank you. So it states in the proposition that the O.B.C. follows best practice method, referred to as the Green Book or the 5 case model. Given the discussion that we have just had and the identified holes in the economic case, for example, could it be suggested that the economic case does not follow Green Book 2020 guidelines?

Associate Partner, EY:

The brief is a framework for decision-making and it is not unusual to adapt it to those circumstances. I think in this case we set out quite clearly where we have and have not undertaken work that perhaps would be expected at the O.B.C. stage in the business case itself and the rationale for that. I think to the extent it has not followed specific aspects that the Green Book suggests are appropriate at a

particular stage, we have sought to justify why that is the case. I think the implication is transparent in terms of what it does and does not do.

Senator K.L. Moore:

Would it perhaps be more to the point if that was identified clearly where there were certain elements of departure from this standard, understanding of an outline business case, rather than declaring in the proposition that it follows best practice methods.

[11:15]

Assistant Director, EY:

I think on the benefits quantification we do set out all the benefits that are going to be quantified and the work that is being undertaken in order to do that. So I think it is very transparent in terms of acknowledging that there are not quantified benefits at this stage but the work is ongoing and the intention is that that becomes available. I mentioned healthcare particularly earlier but there is also a big workstream ongoing at the moment in relation to facilities management and the future delivery of facilities management for the new hospital. There is quite a lot of information in there that sets out what is not included, why it is not included and also the path forward in order to get that information.

Senator K.L. Moore:

That is a very interesting point, is it not, because facilities management and the ongoing cost of running the hospital, the revenue costs, are very valid and important when trying to take a decision on the economic case?

Assistant Director, EY:

On facilities management in particular you are right, the day-to-day running costs of facilities management are not included but the life cycle of the building is included, which is a very substantial part of maintaining a building over a 60-year period. Part of the facilities management is included but the day-to-day running is subject to a separate business case.

Senator K.L. Moore:

What generally would be the percentage cost in terms of the day-to-day running say of staff in the new hospital?

Assistant Director, EY:

I could not to hand tell you a rough percentage but there is certainly detail that could show that the N.H.S. (National Health Service) does publish data around that. The intention of the facilities

management business case is to look at ways of delivering facilities management better and more efficiently than it has done in the past, but that work has not been concluded yet so I could not say where that will conclude.

Senator K.L. Moore:

Okay, but it will appear in the full business case?

Assistant Director, EY:

Yes, that is absolutely my understanding and intention.

Senator K.L. Moore:

Thank you. If we could just look at page 90 of the outline business case in the re-issued version of P.80, the benefits outlined in table 24 are qualitative with scores allocated. How will the achievement of these benefits be measured, please?

Assistant Director, EY:

It will vary quite possibly from benefit to benefit so, for example, when I talked about baselining earlier healthcare data to try to understand what the position is now, most of the healthcare benefits will fall into that type of area whereby we set a baseline and then improvement against that baseline is monitored into the future when the new hospital is developed. I think that would cover off probably most of the patient ones. I am just looking at the list now myself. How often more wider Jersey society benefits … again there is an exercise ongoing which the design and delivery partner is involved in around that, but it is setting baselines of where we are now, potentially setting targets and then comparing those targets into the future once the new hospital starts delivering or in the case of some of the more immediate economic benefits that is really at construction phrase that those benefits should start to accrue. I think it is on a benefit-by-benefit basis.

Associate Partner, EY:

Just to add to that, I talked about the evolution of the business case and building up different elements at different stages. Part of the role of the management case is to set out the process for both managing and monitoring realisation of benefits and the expectation is that by the time you get to full business case stage there is a very clear process and effectively, as Andy described, methodologies for undertaking that. There is text in the management case currently about benefits realisation but at full business case that will be fully developed and we will set that process out very clearly. That is very important because it is very easy to have business cases that effectively get to a point where a project can start being delivered and being able to then work through how it is achieving those benefits is one of the critical outputs of a good process. Hence why it is a core part of the management case.

Senator K.L. Moore:
Would it then flow that the political decision-making should come with the benefit of the full business case to hand? Perhaps a political question to Senator Farnham.

Deputy Chief Minister:
Thank you. As we go through the process of putting the whole … or seeing the project through to its completion we have to make decisions at the appropriate time. I believe that the outline business case, which is a comprehensive case - and as Andrew has pointed out - that covers the majority of the issues and then committed to fill in any gaps in information as it becomes available. I believe the current outline business case gives more than enough information for the political decisions to be made. It covers the principles, the economic benefits, the clinical benefits, the social benefits. I think it gives enough information on that for us to make a decision and I think while we can put some more detail around aspects of that the overarching principles and benefits are very clear.

Senator K.L. Moore:
Final question on this section is: the project risk register is referenced in the outline business case as being reviewed last in May of last year; is that correct, please?

Clinical Director, Our Hospital:
With your permission, Chair, could we go back to the last question, which you said was a political question for Senator Farnham to answer but in fact it is also a clinical question. It would be very remiss of me if I did not speak up and say that there is sufficient information, and I think you yourself have said that the case for a new hospital has clearly been made. Around 18 months ago that was not the case and I am very glad that this Scrutiny Committee, the States Assembly and the Council of Ministers have all agreed that the case from the clinicians looking after the health of the Island has clearly been made. I think if we are saying we do not have enough information now and want to delay the decision once again, that is something that will be very difficult for the healthcare workers of the Island to understand or indeed accept. On top of that, it will be the case that those people who push that decision will need to take some responsibility when we get to 2026 and we do not have the infrastructure to continue delivering healthcare to the 110,000 who live in Jersey. That is a very important clinical point which clearly has political implications.

Senator K.L. Moore:
It certainly is a political point, thank you, Professor. I think the case was made in 2012 but we will not enter into a debate on that point. My question now is about the risk register, which according to the outline business case was last reviewed in May 2020 and I was looking for confirmation of that point.

Assistant Director, EY:

I can only apologise that a typo has found its way into the O.B.C., it should read May 2021. The risk register being referred to did not exist in that form in May 2020, this is something that has been developed certainly post the start of the proper construction and design work with the D.D.P. (Design and Delivery Partner) so I can only offer my apology but it should read May 2021 not May 2020.

Senator K.L. Moore:

Thank you very much for the confirmation. I will pass on to Deputy Gardiner now. Thank you.

Deputy I. Gardiner:

I will go to the comparison options. The site selection process has undergone scrutiny at the strategic outline case stage, why were the shortlisted sites not included as part of the option appraisal within the economic case of the O.B.C.?

Deputy Chief Minister:

That is a question for Ernst and Young, please.

Assistant Director, EY:

Sorry, was that a question around the 2-site solution? I could not quite hear.

Deputy I. Gardiner:

No, I am asking why the shortlisted sites were not included as part of the option appraisal within the economic case.

Assistant Director, EY:

Sorry, I misunderstood.

Deputy I. Gardiner:

For example, would the shortlisted sites in costs benefit risk quantification not allow a net present sustainable value calculation and have aided in demonstrating that the preferred option delivers the greater value for money, if we would do other comparisons than what was presented to us.

Assistant Director, EY:

It was only the site Overdale which was selected in the site selection process which was included in the O.B.C. and that decision was made in the site selection process, so the O.B.C. just took the outcome off the site selection process, which was the Overdale site.

Deputy I. Gardiner:

No, but we had shortlisted sites. It was 5 and now it has gone down 2 and another was why was the 2 sites option not explored as one of the comparators? How were the comparisons made? Why did you take an option that was not an option? The new hospital clearly needed to be built from 2012 so why were other sites not compared during this process?

Deputy Chief Minister:

I wonder if I might come in at this point, if I may. The outline business case clearly follows the States decision. Previously discussions had been held about the rationale behind staying on the existing site, choosing a single site or a 2-site option. This whole process, the difference between this process and previous iterations is it had to be clinically led from the beginning. Again, if I can just hand over to Ashok just to explain the benefits of a single site over a dual site, which I hope will provide rationale as to why the outline business case only focused on the Overdale site, the single site option. Ashok, would you mind just …

Deputy I. Gardiner:

Just a minute, Senator. Apologies, my first question was why were the shortlisted sites not included as part of the option appraisal.

Clinical Director, Our Hospital:

Maybe I could add to that, Senator. The outline business case only commenced after the States Assembly had made their decision on the site selection on 17th November. It was felt by the project team that it would be inappropriate for us to go back and question the decision of the States Assembly. The States Assembly had given us a decision very clearly on the site selection, we then took that site selection and in our options appraisal for the outline business case we looked at the do nothing and, as Andrew explained earlier to Senator Moore, why do nothing was reconsidered because the clinical case was that we must do something. As you both noted as far back as 2012 that we must have a new hospital. So we were not considering that because the clinical risks of not doing something are considered to be too great by H.C.S. executive and by myself as the external. We were then left in the options appraisal of looking at the option given to us by the States Assembly in a democratic fashion, I understand, and then comparing it with the do minimum. That is why those other options were not considered, because they had been ruled out; not by us in the project team but by the States Assembly.

Deputy I. Gardiner:

I appreciate your answer and understand it, but at the same time as a States Member do minimum was not an option because we knew that we needed a new hospital and it would be helpful to understand that Overdale is the greatest value for money if it had been a comparison for a shortlisted

site. Let us continue. Please explain how the baseline comparator was chosen and used within this document? For example, what comparison options were dismissed from use in the O.B.C. and why was a midrange new build or a more economic option not also included to allow better comparison and for options to put forward?

Deputy Chief Minister:
Thank you, Deputy. Ashok or Andrew, I am not sure who wants to start.

Clinical Director, Our Hospital:
Andrew first.

Assistant Director, EY:
I will go in the first instance. So just building on a question we were asked earlier. The first place you would start when you are developing a long list of options for any capital investment of this nature is with a do-nothing or a business-as-usual option; that was the first option on the list.

[11:30]

However it was felt that continuing to do the business as usual, which was the sort of £5 million per annum rough capital investment I spoke about earlier, would not allow the hospital to continue into the future. The traditional do nothing/business as usual just was not going to deliver a credible option. The other options kind of built on that principle: what do we need to do in order to keep the existing hospital in its current state, which is always your starting point on a capital investment. It is what do you have right now and what could you do with what you have got. Over time, particularly helped when more technical expertise came into the project, that baseline comparator option developed into what is now put forward into the O.B.C. Essentially if a decision was taken not to go ahead with the new hospital what would you have to do at that point? The baseline comparator puts forward a credible, albeit risky, option around continuing to deliver healthcare services from the existing estate. But, as obviously can be seen in the O.B.C., it is not a traditional do-minimum option in the sense that it is not doing little. It is a big option and it would be a substantial change in of itself. So that is where the baseline comparator option has come from and it has developed really over the last 12 months into what it is now. Did you ask a second question on the 2-site?

Deputy I. Gardiner:
I would like to move on because I can see the time. Why was a midrange new build or more economical option not also included to allow a better comparison? For example, we can remove some elements like atriums and it could drive down the price and reduce optimisation of space. More economic options did you consider?

Assistant Director, EY:

So if I start and then I think, Ashok, you could perhaps come in as well. The options were clinically driven. So they were very much driven by clinicians determining what was needed. If I could pass to Ashok to explain why the current option put forward is the best option clinically.

Clinical Director, Our Hospital:

Given that we were working for the new hospital and quizzed, very rightly, by this panel on how could we ensure that the healthcare provision was future proof. So we said that we have to take the same demand and capacity and work to what will the healthcare needs of Jersey be in 2036 and projecting forward with the changes in healthcare, et cetera. If we were going to make a provision we know that business as usual is not going to be enough because the healthcare provision will be significantly under provided if we do not update the estate level and the clinical and operational risk by December 2026. So to make it a reasonable comparator, Senator, we had to look at what would we need to change to the current infrastructure to mirror what we would need but for the healthcare needs of 2036. So a low-end reprovision would not do justice to the provision that is projected to be needed by 2036.

Deputy I. Gardiner:

The question is: how will a central atrium meet clinical requirements? We are talking about how we can create midrange working clinically at the hospital without, for example, the atrium that can maybe be not really necessary and can bring the price down?

Clinical Director, Our Hospital:

One of the things we have learnt through COVID is that you could argue that the current facilities were not fit for purpose and we know that if you cannot even get 2 beds aside in a corridor, the size of the rooms, thinking about infection control is a major problem. So what we need to do in the new hospital, we would be remiss if we did not plan to both the recommendations by HBN on infection control but also changing the flows of public areas, planned elective care, outpatient care, ambulatory care, emergency care and staff pathways. The atrium is part of that because we are thinking about what an external and internal public space is where you can easily have sufficient space to separate out those flows should we need them. In any case, we now know that overcrowding in public areas is a bad idea. Our infection rates go up when we do that. If you are talking about the atrium in the planned new hospital; that is the rationale for it. If you look at high-end and medium to high-end provision across the world, that is what everyone is doing for those reasons.

Deputy I. Gardiner:

Thank you. Please outline why the life cycle expenditure of a new build option is greater than the baseline comparator option?

Clinical Director, Our Hospital:

Andrew is best placed to answer that.

Assistant Director, EY:

Sorry, would I be able to bring in Turner and Townsend, the cost consultants at this time? It was T. and T. who know most about the life cycle specific costs.

Director, Turner and Townsend:

Hi, it is Ross Hanson, from Turner and Townsend, the client's cost consultant so I will take this one. What we have looked at for both options is we have done standard life cycle costing models for the baseline comparator and the new build options. So we have done that in accordance with normal practice and the costing information for each of those schemes. Then that has generated the life cycle costs that are included within the O.B.C. report. Those are driven by the functional requirements for each of the facilities and the assumptions around the elements that go into the buildings and infrastructure in the case of each of the options. Does that answer your question, sorry?

Deputy I. Gardiner:

It does. Before we move to the next section, I would like to check with our consultants if they have follow-up questions about development, techniques of O.B.C., and the comparison options. If you have any follow-up questions please come in.

Ms. H. Pickering:

I do and Martin probably does as well. The explanation around the do nothing, as you call it, not being taken forward to the outline business case, I just want to explore that a bit more. It is quite normal for unacceptable kind of do-nothing options to be carried forward in line with guidance, so that provides a true comparator of the spend to then improve value for money. I mean the way that is dealt with is normally to look at the risk associated with doing nothing and include that within your net present social value calculation. I would just like to understand that a bit better.

Clinical Director, Our Hospital:

If I could step in. Thank you for that question, Helen. Of course, I think you may have heard today already that as far ago as 2012 the States Assembly had accepted the need for a new hospital. That need has become more acute as time has gone on. There are 2 issues really: one is, is it responsible of us in the healthcare to allow the infrastructure to simply fall apart? We are given

significant evidence, there is a risk register within H.C.S., and we made it very clear at a number of these hearings that by December 2026 both the operational daily risks as well as the clinical risks are considered to be so significant that going beyond that without some reprovision is not acceptable and hence, on the basis of that, we decided not to take forward the do nothing as an option because it is not a realistic option in any way, shape or form and that has been accepted by both the States Assembly and by the Scrutiny Panel on more than one occasion.

Ms. H. Pickering:

I think that point is relevant for the strategic case, I am making the point on a qualitative basis. The economic case is to provide value for money and, in pure economic terms, that should have been taken forward for a baseline comparator and quantified accordingly.

Clinical Director, Our Hospital:

Yes, I am really sorry, what you are asking me to do is to put a price on the lives of patients in Jersey. That is what you are asking me to do. What am I prepared to spend or not do for patients' lives to be at risk? It could not be put any more simply than that and, as you will know from the work you are doing at Whipps Cross, that is exactly the same problem at Whipps Cross, where they have not built, they have not built, they have not built and people are suffering.

Ms. H. Pickering:

But it actually helps the argument for a new hospital if you quantify the business as usual.

Clinical Director, Our Hospital:

So I would ask, Helen, could you tell us what number to put on the life or limb of a patient so we can ...

Senator K.L. Moore:

Professor, I am sorry, that is not an appropriate question. It is our job here to be asking the questions of yourselves and our adviser has legitimate and realistic questions, and I am sure the public would like to hear the genuine answers to them please. Martin, I think you put your hand up there. Would you like to go with your question please?

Mr. M. Clark:

If I could come back to this issue of the options. We fully understand the rationale that has been given to us as to why there was one site option only on the shortlist. But I think the question Ms. Gardiner asked about other options and the option framework filter is still pertinent because what we do not see in this O.B.C., that we would expect for a programme I think of this scale, is alternative options for the single site development in terms of the scope of the hospital and the scale of the

hospital. I understand the point in the business case that the care model is outside the scope. But notwithstanding that, it is still I think unusual to have one option only against one baseline and connected to that is the underlying point that has been asked, and I would like to ask again, is that the O.B.C. has a statement ... the O.B.C. as a whole quotes fully compliant with the Green Book. I am not at the moment getting answers as to the elements of it that are not compliant and how those 2 statements come together. Perhaps if I could ask the question again: why were not other options other than the one scope considered please?

Deputy Chief Minister:
I think that is for Andrew at Ernst and Young in the first instance and then perhaps we can come back.

Assistant Director, EY:
This is slightly towards H.C.S. colleagues as well but the functional brief did consider what would be in the new hospital. It was not something I was massively involved in but I know that considered different possible functional outcomes and the inclusion of different areas within the new hospital were considered as part of that. Could it be that that was really the exercise where what the new hospital was going to look like was considered and obviously when that concluded, and by that time obviously site selection had been concluded on Overdale as well, that that is what led to the development of the option that we now have?

Clinical Director, Our Hospital:
If I could add to that. If you like there are 3 options. One is do absolutely nothing, and I think we have articulated why we were not prepared to consider that. It has previously been considered on a number of occasions, as I have already said. The second option is the do minimum, and that is the one that Andrew has worked with us based on the functional brief and based on, as I said earlier, the demand capacity modelling up to 2036. Unless colleagues are suggesting that we should underprovide for 2036 because that would be an unfair comparison. You are saying that you need to put in the new Future Hospital based on is it future-proofed, was a question that Senator Moore has asked me on more than one occasion. We have reassured her and her committee that that is the case. If we did not put in the same modelling and under-provided it would be comparing apples with pears but we needed to compare the similar capacity demand. We did fortunately, or unfortunately, however you look at it, did have a further option which had been considered, which was the Future Hospital project and that was for a provision based up to 2030. It was declined both by Planning and with extreme unhappiness from the clinicians and healthcare workers. The difference between that scheme, and you could use that if that was helpful, Mr. Clark and Ms. Pickering, the Future Hospital project because that is a viable alternative, very fully worked-up with

a business case but there are significant differences between that, that healthcare has moved on in the last 4 years.

[11:45]

We have learnt a lot through what to do with COVID, there has been a political and Island-wide commitment to parity of access for mental health as well as physical health and the Future Hospital did not include that. This is a very different prospect but you did have that other comparison to also have. It was on the basis of the failure of the Future Hospital project that we discounted anything that was a suboptimal provision, which I understand is what you are asking us to have considered, Martin and Helen.

Mr. M. Clark:

Thank you for explaining. Just for the record, I am not asking anybody to consider a suboptimal solution. What we are saying is the business case states that a compliant process was followed, that the guidance to which it is stating is compliant, it sets out a process for considering different scopes of service, different potential solutions, and the business case does not do that. The business case, as I have read it, does not explain why that was not done. I think in our role, as you will understand, we have to ask that question because that is our remit. It is nothing to do with whether there is another option you should have chosen. This is a question around a document stating that a process has been followed and we cannot see evidence that that process was followed.

Clinical Director, Our Hospital:

I understand. That is a very good question and that is why I have answered it to say that other things have been considered. As part of that functional brief there has been a huge process of challenging every single clinical team on what the provision was and the balance between what they would like to have, what we think was reasonable based on benchmarks across healthcare systems both in the U.K. and other parts of northern Europe. That challenge process absolutely has gone on, and again I have reassured Senator Moore and her committee about that at a number of hearings, mainly because that challenge has been undertaken by me, as the external adviser, to challenge them on that. But to go back and say to them: "You think you need, I don't know, 8 operating theatres but we are going to put in the model including 5", that would have been very difficult for the clinicians of Jersey to understand or accept in any way and it would have undermined the clinically-led process that we have been taking. So I hope, Mr. Clark and Ms. Pickering, that tells you why we have stuck to the functional brief. To put in other options that did not meet the requirements of the functional brief would have been disingenuous on my part and I was not prepared to do that and it is about making sure that the clinicians, having had the check and challenge from me, were then said: "This is what we have agreed you need for safe care in 2036"

and that is what we aim to deliver. We are not going to now say: "We could also do something that was slightly different" and that would, I am afraid, have been a suboptimal model, Mr. Clark.

Mr. M. Clark:

Thank you for explaining.

Senator K.L. Moore:

Shall we hand quickly now to Deputy Gardiner before we move on to Deputy Le Hegarat's questions please?

Deputy I. Gardiner:

I think we can move to Deputy Le Hegarat now.

Deputy M.R. Le Hegarat:

I am going to ask questions in relation to the hospital workforce design. The gross floor area of the building has increased from 66.947 m2 at strategic outline case stage to 73.330 m2, an approximate 10 per cent increase. The current area also being approximately 8 per cent above the briefing area. What has driven this increase please?

Deputy Chief Minister:

Would somebody like to answer that please? Are we going to Ross on this particular point?

Hospital Project Manager:

Senator, it just may be helpful to provide a little context on this. The outline business case is based on the concept design and there is an area that is described in the concept design, but I imagine members of the panel may have noticed it was also noted that there has been some work to pick up comments that have been received as part of the review process on the concept design. That has had an impact on area. I know that the panel's advisers have asked for some additional detail on the build-up to the costs in the areas and as they are reviewing that they will notice the impact of some of that work that has gone on to pick up the feedback on the concept design and that has impacted on the overall areas of the building.

Deputy Chief Minister:

I think the question was quite straightforward about the difference in the size of the build.

Hospital Project Manager:

Ashok, in terms of the area, as we know and anticipate and the work that has gone on to ensure that it is the right sized building, are you best to pick up on that?

Clinical Director, Our Hospital:

Sure. I just wondered which comparison you would like me to discuss, if you would not mind just repeating that part of the question please.

Deputy M.R. Le Hegarat:

Basically the strategic outline case showed a square meterage and that has now gone up by 10 per cent. So what I am asking is: what has driven the increase of size of the area?

Clinical Director, Our Hospital:

That is an excellent question. The first thing I would say is that the final size will almost certainly not be determined until we put the planning application in. It is an iterative process that continues to change and at times some things have gone up a bit and other times things have gone down. If I may explain that. So we went through a very extensive clinical engagement programme to get to the initial functional brief and the schedule of accommodation. Of course as time has gone on, the services that have planned to be provided have been repeatedly questioned, in an appropriate way, by members of the public, by clinicians, by our politicians and by you in the Scrutiny Committee. That has been that tightrope between are we future-proofing to make sure there is adequate provision for at least 2036 and hopefully beyond that, and a flexible design to accommodate future changes that are at the moment unpredictable to most people around the world, around what will happen in 2050, for example. At the same time, we have been going through a continuing process of challenging as clinical services change, partly through things like the Jersey Care Model, for example. We have changed some of the outpatient clinic rooms into a suite of rooms for digital consultations, which has meant that some areas have got smaller. But as we refine that, people keep coming up with more. There are also services that currently we do not provide in Jersey that people have aspirations to provide for the future, and the rule we have given them is that as long as they can have a satisfactory business case agreed by H.C.S. we will do that. That is what is going on, is that there is this iterative process. Some things have gone up so when we look at the provision for knowledge of education, the knowledge and education team say we are increasing on-Island training for different types of nurses, mental health nurses, et cetera, so we need an increased provision for that. At the same time, the oncologists tell us that the changes in oncology are such that they now have a partnership with the Royal Marsden Hospital where they will be able to provide more treatment on-Island because they have been able to have M.D.T. (Multidisciplinary teams) consultations, for example, with the patient still in Jersey but the input from clinicians at the Royal Marsden, in the format that we are currently communicating. So those changes have given us some changes within that. But what I would finally say, the final sentence will be that we are also looking back at how we can change the configuration of some of the services to save space so that we can be certain of coming in under budget. An example of that is that we have changed the configuration

of the wards from 26 bed wards to 30, which has substantially removed around 3,500 square metres. So the final number will be there for the planning application. I am sorry that I cannot give you a more definitive answer than that. It is an iterative process driven by the clinicians.

Deputy M.R. Le Hegarat:

Basically you have sort of explained why you have been trying to reduce the areas that have been increased. This will do for a yes or no answer, because I am conscious of time, is that you will continue to drive to ensure that it does not increase any further?

Clinical Director, Our Hospital:

Absolutely. There is no danger of it increasing any further, it will only be going down. The one bit we will not compromise is clinical safety and patient experience.

Deputy M.R. Le Hegarat:

Thank you.

Director, Turner and Townsend:

Can I just make a very quick clarification because I think it is important relative to what is in the O.B.C. document? Where we were at S.O.C. stage was 67,000 square metres, as you have mentioned. The O.B.C. position is at 69,000 so we have not got that 10 per cent increase you mentioned. The 69,000 position incorporates a number of the savings that Ashok has mentioned before that are being worked through. Just for clarity on the O.B.C. position.

Deputy M.R. Le Hegarat:

Thank you. I am just going to move on. It appears no workforce strategy has been produced to support the O.B.C. It would be expected to see this to understand the workforce required to support the new model of care and scale of the hospital and you will be fully aware that this has been something that members of the public, in particular, have made a big point about. As well as the recruitment or training plan for achieving this, what are the plans and timescales to provide this please?

Associate Director, Improvement Innovation, Health and Community Services:

If I come in there. The workforce strategy has started. There is a piece of work being led by our associate director for People Services and the timescale for that is to deliver the strategy quarter 2 next year, is my understanding. But that work has started.

Deputy M.R. Le Hegarat:

I mean obviously that is a concern from the principle that we are building a hospital without actually knowing what sort of workforce we are going to need. Maybe that can be fed back to how quickly that that has escalated. No facilities management arrangements have been included in the O.B.C. as it has been indicated that they will be part of the separate business case. Why is this?

Hospital Project Manager:

My understanding on that is that there is a piece of work that H.C.S. had been doing to look at that facilities management, including for the hospital, and it was important to make sure that that work was carried out in a robust and comprehensive way. So there is a separate business case being developed for that. As colleagues from EY mentioned earlier, we do understand about the life cycle cost and obviously the aim of having a new build that is on a new site, one site, is that hopefully the outcome of that work will be that we can have arrangements that are more efficient and that seek to introduce some benefits. That is absolutely what we are hoping will be the outcome of that, but that is a piece of work that is ongoing and will be a robust piece of work that would inform the O.B.C.

Clinical Director, Our Hospital:

If I can add to that, the consolidation of services on to one primary site will make significant logistic improvements and, of course, we know that it is much easier to look after a new building than it is buildings that are up to 100 years old with lots of bits added on here and there. It is also relevant to the staff workforce plan. I know that Jo Poynter has answered your question around the work that is ongoing. But of course the majority of the staff are already here in the current hospital and other facilities and it will be around both that increased training on-Island that we are going to be providing, and have already started, some recruitment issues. So it is not that we are going to need to staff the hospital from scratch. A large majority of the staff already exist in Jersey. I hope that is helpful to add to Jo's point.

Deputy M.R. Le Hegarat:

Yes, I mean obviously you have identified that and the work is ongoing in relation to this but obviously there will be revenue consequences. So how have these additional costs and design necessities been considered? How have they been considered? Who is considering them?

Clinical Director, Our Hospital:

As I was saying earlier, for any of the areas where the clinical services see that they will need additional services to be provided there is a process within H.C.S. currently where they have to make a clear business case for any capital investment - that will not be the case for the new hospital - but also revenue costs of delivering that service. So that process is ongoing as normal working practice for the H.C.S. executive, and I am sure that Caroline Landon will be able to support that.

[12:00]

The mantra for us is anything that people say needs to be in addition to what you might need for 2036 or beyond 2026 there has to be a business case within H.C.S. for the revenue costs of that.

Deputy M.R. Le Hegarat:

We have talked much about 2036, what consideration has been given to demand modelling beyond 2036 and potential zones for expansion within the design?

Clinical Director, Our Hospital:

That is a good question and of course we have put into the design flexible design throughout the building, so we do not know whether we will need more inpatient beds, more ambulatory care, less operating theatres, more diagnostics or less diagnostics, depending on how healthcare pans out over the next 15 years. So we have deliberately put in a flexible design. So if we, for example, needed to convert office space into beds we can do that. If we need to convert some of our outpatient facilities into more digital ones we can do that. If we need to have less operating theatres and more ambulatory care, we have built areas where you can move admin space, which is currently adjacent to some clinical space into all of that. So that is very much part of the thinking but I would need a really good crystal ball to tell you what is going to happen to healthcare in 2040.

Deputy M.R. Le Hegarat:

Okay, thank you. It is noted that the Jersey Care Model and digital programme is outside of the scope of the O.B.C. As these are highlighted interdependent with O.H.P. and its functional content, how are these interdependencies being monitored and managed please, and by whom are they being managed?

Clinical Director, Our Hospital:

There is a partnership board jointly with primary care and community services and H.C.S., that lead on the governance of that. As far as the interdependencies are concerned, of course that is absolutely the case but the way we have gone in to design the hospital is that it is not completely well into the Jersey Care Model but we know that there are models of healthcare changing across all high and middle income countries - indeed the rest of the world too - but we are focusing on high and middle income countries on the basis that that is the kind of healthcare system that I am sure Islanders will want over the next 30 to 40 years. We know that over that timeline or the life span of the hospital there will probably be between 6 to a dozen different healthcare models, things that change. So we have just built the flexibility so that it can interact with whatever comes up as being a new way of doing healthcare. So it is not completely dependent on the Jersey Care Model per se,

but as far as the Jersey Care Model structure is concerned there is an overarching partnership board with primary care that provides the governance and holds H.C.S. to account on its delivery.

Deputy M.R. Le Hegarat:

The strategic outline case refers to cancer centre being excluded from the functional brief but a specialist centre was being considered and included in the strategic outline case costs. Is this specialist centre still included in the O.B.C. costs?

Clinical Director, Our Hospital:

Yes, it is and depends what you mean by "specialist centre" of course and depends what ... different people mean different things by "cancer centre". So we are not proposing ... currently not in the business case is, for example, provision for radiotherapy on-Island but there is provision for high quality, both inpatient and ambulatory care for oncology, with increased multidisciplinary team working with both the Royal Marsden and the cancer centre at Southampton University hospitals. The clinicians have very much a plan and ambition to deliver more cancer care on-Island with that partnership model with both Southampton and the Royal Marsden.

Deputy M.R. Le Hegarat:

Before I move on, I just want to double check whether Deputy Johnson wants to ask a question at this stage, before I move on to the next question.

The Deputy of St. Mary:

That is kind of you, Deputy. No, if I do have a question it will be after yours regarding private health facilities.

Deputy M.R. Le Hegarat:

The facility includes a private patients' wing. The actual designed area is unclear as it is missing from the table on page 67 of the RIBA stage 2 design report. The O.B.C. reference the private patients' wing is larger than the existing facility on the basis of expected increased demand. The O.B.C. reference the detailed private patients' strategy has been developed but there is no evidence in the O.B.C. to support that the initial capital investment borrowing costs workforce and facilities management costs have been considered to support justification for increasing the private patients' wing. What work has been done to fully support this decision?

Clinical Director, Our Hospital:

If I could start by saying that the private patients' strategy Jo Poynter and Anuschka Muller, the associate medical director, Paul Hughes, are working on still. As far as the justification for it, the reason it is not entirely clear is that the original anticipation was that the private outpatients, as well

as the inpatient facility, might be co-located. As part of the work I was talking about earlier, the interim process of relooking at it and the functionality and changing the pathways of planned outpatients, planned inpatients, ambulatory care, we made the strategic decision to change that and that the outpatients will be co-located on the ground floor with diagnostics and pharmacy, et cetera, to make that a better patient experience and to keep those flows separate. So the actual inpatient facility for private patients will remain at 30 beds. So the anticipation is that we know that a very significant number of patients on-Island have insurance and either do not use it or go off-Island to use it. It is anticipated that there is something like £3 million a year worth of Jersey healthcare going off-Island for private patients. So that, we would hope, would be able to be repatriated if we have a suitable facility on-Island to do that. The same facility also helps us with pandemic and infection outbreak control, as it gives us an additional 30 beds, which are all single en suite rooms, and would allow us to have either a hot area within the hospital or, depending on the numbers of patients, a cold area to allow us to continue with service delivery and healthcare facilities continuity, should we be in the same situation. It looks as if the pandemic is not going away in the world anytime soon. Then the next part of it, is that it is not that it would ... if we find that we have an increased demand from public patients then we have that extra level of flexibility and additional facilities to deliver that demand, both in the short term and in the long term. It is a facility designed to be multipurpose. I think I have answered to this committee before that the capital cost of that part of it are just short of £10 million. We would anticipate with the £3 million a year increased revenue to be able to pay that off in just over 3 years and we would then have that facility for a further 27 years available to Islanders to both use and enjoy, and hopefully continue to get significant revenue income generation from that.

Deputy M.R. Le Hegarat:
I note now that Deputy Johnson would like to ask a question in relation to private patients.

The Deputy of St. Mary:
Thank you for that. I do not want to hijack this part of the discussion. Dr. Handa has given certain information which is helpful but I am concerned that the business case makes overplay of this area. I appreciate that work is ongoing but the clauses like: "Prospective private clients should enjoy a high-quality reception experience where they have access to the private coffee lounge", et cetera, seems to me to not address the main reason why people have private insurance, which is to avoid waiting time. I think following the last public hearing there was some public reaction to the comment made by Caroline Landon that waiting times would not be affected whether you went private or non-private. That I am sure is the main reason why people do engage in private insurance. If it is not being fully utilised I suggest it is because the private insurers do not fully cover the question of consultancy fees. I will not go down that line now but that is something which does need to be addressed. Two points if I may, the first is: do you yet have a private facilities manager in post; there

was not at the time at the last hearing? Secondly, are you in danger of paying too much attention to the needs of private patients given that, like myself, all they want is a quick procedure, and I am not really too fussed about the attendant bells and whistles, which I think Caroline referred to.

Clinical Director, Our Hospital:
Thank you for that question. You are right, there is more than one driver for private practice. You are right: for some people it is waiting times, and we absolutely have every intention, as outlined by Caroline Landon, that the waiting times should be such that that should not be a driver in the future. There is a lot of work going on, on having patient target lists and trying to address that waiting list issue. But there are other drivers for private care and those are the following: some people want to have a convenience of a choice of the individual who looks after them. If you have 5 general surgeons and you want a particular one to look after you, because you prefer their manner or whatever, then you have that choice. Whereas you do not necessarily have that degree of flexibility as a public patient. The second thing that sometimes drives it is convenience. That you may be able to say: "I would like to have my operation on a Saturday because I would like to get back to work on the Monday and I cannot take a day off work to do that." So convenience is another thing. For some it is the hotel facilities and for others, particularly in a smallish community like Jersey, it can be around additional privacy when there might be a particular condition that you do not want necessarily to be in the public domain that you are seen at the hospital, you are having an operation. There is more than one driver. It is clear that we do need some facilities because we are driving patients off the Island to spend Jersey pounds in London or Southampton or even Oxford, and we should avoid doing that. Those are some of the drivers. Yes, there has been a private facilities manager appointed, and they are working very hard on that business case and the details and a management way of addressing the needs for private patients. So I hope, Deputy Johnson, that answers your question.

The Deputy of St. Mary:
Thank you for that. I do have concerns that one reason why people do not have treatment on the Island, although insured, is because of the high level of fees which are paid here, which are not fully covered by the insurance policy. But I will leave that for another day and your new practice manager.

Senator K.L. Moore:
Shall we continue with your section now, which covers the budget envelope, as I am mindful of the time? I think we could go for another 10 minutes to make up for the disruption that we had at the beginning of this session and then we will be sending in further questions by letter.

The Deputy of St. Mary:

My area relates primarily to the budget envelope and, in general terms, could you remind us please how the project for the envelope was decided and who was this set by?

Deputy Chief Minister:
Sorry, I missed that. Could you repeat the question please?

The Deputy of St. Mary:
It relates to the general budget envelope for the project. Who decided on the framework of it and was it set by the Our Hospital Political Oversight Group or individual members of it or how did it come about?

Deputy Chief Minister:
Are we talking about the actual budget of £804.4 million or the funding of it?

[12:15]

The Deputy of St. Mary:
Yes, the envelope as to how it is all encompassed.

Deputy Chief Minister:
Thank you. There is a breakdown of all of the capital costs in the outline business case. They were all compiled by the Our Hospital project team.

Senator K.L. Moore:
I think the question is to you, as chair of that political oversight group, what responsibility you have taken and how it was agreed that this envelope was the right budget envelope for the Island.

Deputy Chief Minister:
It was agreed after a process and a period of time where the project team, based on all of the plans and proposal, compiled the budget working with our design and delivery partner and the estimates. It goes back to the strategic outline case and all of the work that was done around that. I am just trying to think back, and I need some officer help here. We went in with the first figures and I think they were part of the original Overdale site proposition.

Clinical Director, Our Hospital:
The overall figure was informed by the concept designs following the site selection, because of course the costs are going to be informed by that. It was then agreed by the Assembly. As far as

the project officers are concerned, the final budget was set by the Assembly by saying that is what we agreed to.

Deputy Chief Minister:
That was P.123, if I remember, which was debated in 2020.

Clinical Director, Our Hospital:
Indeed.

The Deputy of St. Mary:
Thank you for that. Just moving on from that general point. In regard to some of the questions that have been raised, Minister, how confident or assured are you that the project, with the surrounding detail of the O.B.C., represents the most realistic and cost-effective hospital solution for Jersey's population?

Deputy Chief Minister:
I think, as Professor Handa has explained, the project has been clinically led so we are very keen to ensure that we have the best possible hospital that provides the best clinical solutions and adjacencies. If you look, the original hospital in the O.B.C., the cost categories, the hospital baseline of £604 million, and then your additions to that of contingencies and optimism bias take it up to the £804 million. We hope we do not utilise all of that but, of course, as we said before, and I think in questions from Senator Moore in the Assembly recently, it would be right to highlight the impact on costs of goods and services on the back of Brexit and the pandemic, and the inflationary pressures that are coming our way. One of the reasons why we need to push on with the development is so we do not get too badly impacted by any risk from those issues. But having sort of been through this line by line, the Our Hospital Political Oversight Group are content. But we would be much more content if we did not eat into the optimism bias and the contingencies or did so as little as possible. That is the very firm instruction or request from the oversight group to the project team, to manage the costs very carefully and of course we are ably assisted in that.

The Deputy of St. Mary:
You referred to the items such as contingency and you obviously hope they will not need to be called upon. Are you therefore assured that there will be no question of going beyond that overall total?

Deputy Chief Minister:
Of £804 million?

The Deputy of St. Mary:

Yes.

Deputy Chief Minister:

We have placed a cap on that and we have made it absolutely clear that we would not support any increase in those costs as an oversight group. That is a strict message that has come down from that. If, due to any unforeseen circumstances, that figure were to be exceeded then it would have to go to the States Assembly but there is certainly I think very little appetite for that, including, from myself and the oversight group. The instructions are clear and of course the team are working to that now, and Ashok and the team are finishing the designs. The designs are now ready for the final planning application. We are looking forward to seeing how that comes out and the impact that has on the overall budget.

The Deputy of St. Mary:

Leading on from that, and the question of contingencies: what contingencies are in place should the project in fact fail to be completed by 2026?

Deputy Chief Minister:

I am not sure there are contingencies required as such because if we are talking ... I mean the build is due to be finished by the end of 2025 and then the hospital fully functional by the end of 2026. I cannot see that being exceeded if we stick to the timetable that is planned. But perhaps I could hand over to Ashok who could comment on the operational challenges that might present, which of course will have an impact on the cost.

Senator K.L. Moore:

I think we have heard plenty from the Professor on that point. I am not sure more could be added at this stage, and I am mindful of the time. Can we perhaps stick to the points about the budget envelope at this stage? Senator, if I could just ask a question while I have the microphone, as it were. You have outlined that there is a redline for Ministers and political oversight of £804 million. Do you have a target figure for the project to be delivered?

Deputy Chief Minister:

The target figure, without contingency and optimism bias, is currently £604 million. But that excludes ... I think there is land acquisition on top of that. But for the main works, the preliminaries, the design professional fees, inflation, equipment, contract to contingency, construction services, overhead profits, that kind of thing, the figure in the O.B.C. is £604 million. Then I have not got the figures. There are additions to add on to that, but that is the approximate without contingency or optimism bias added in.

Senator K.L. Moore:

Could you then explain why the borrowing projection is a greater figure than that which the oversight group intends to spend on achieving the project delivery?

Deputy Chief Minister:

To be clear, the oversight group intends to spend no more than £804.5 million. The borrowing is set at £756 million to take into account the money that has already been spent on the project and provided for. The minimum cost I think we can expect it to come in at, as we have just said, is £604 million - it is in the outline business case - and there is almost certainly going to be requirement of contingency and optimism bias, not least because of some of the challenges I outlined earlier. So to be clear, our redline is £804.5 million. That is what we are prepared to support up to that. We very much hope we can come in below that, if at all possible. But that is going to be challenging.

Senator K.L. Moore:

Thank you. I am just trying to run through in my mind what the intention is with regard any additional money that might be therefore borrowed and not used by the project. My understanding of reading the debt strategy briefly is that the Government is proposing a highly speculative approach in terms of investing the money, to use it potentially for repayment purposes down the line. Would that be correct?

Deputy Chief Minister:

I am not sure that I would agree it is highly speculative because the Government is proposing to borrow, over 2 bonds, £756 million and place that money in the Strategic Reserve. The borrowing in the proposition is estimated 2.5 per cent, although because interest rates are currently at historic lows it is likely that if we go to the market sooner rather than later we would get a significantly better rate. The Strategic Reserve over the last decade has been bringing in returns significantly higher than that. By doing it that way you take advantage of an opportunity cost. For example, if you did not do that and decided we are not going to speculate on returns on the Strategic Reserve and you took the money out or presented the money out of the Strategic Reserve you could, of course, then be impacted by loss of potential earnings and an opportunity cost as explained. That is what is being proposed by Treasury. The estimations in the forecast are that, and they are included in the proposition, which you have in front of you, clearly graphs out the forecasts and benchmark set against other options, and that clearly comes out as the most financially beneficial strategy for the taxpayer.

Director, Treasury and Investment Management:

Is it worth me just adding a quick point, Senator Moore? A couple of points. Firstly, the report and proposition, the proposition is asking the Assembly to approve borrowing of up to £756 million, so

as the figures become clearer we will have a clearer picture on how much. Secondly, I would not regard the Strategic Reserve as investment strategy as speculative, and I think that is proven by how significantly the reserve has grown over previous years.

Senator K.L. Moore:

Thank you, Mr Hayward. I am very mindful of the time so we will be sending you our remaining questions in the form of a letter, which might be a simpler way to progress but just before we do sign off, while we are on this topic of the amount of borrowing. There are a couple of differences that we have identified between the outline business case, as it was originally published, and then some of the detail that was in the published version where it appeared in the appendix to P.80. One of those differences is the 2 equal tranches of borrowing that you referred to, Minister. Initially it was 30 years and 40 years but now it is identified as being over 35 years and 40 years. Could you explain for us why that change has occurred please?

Deputy Chief Minister:

Yes, certainly. Can I hand over to Simon please for that?

Director, Treasury and Investment Management:

Firstly, I think we should just confirm that they are just examples, so the intention is predominantly to match the term of the borrowing to the life of the asset but what we also need to do is to consider other debt that the Government has and investor appetite for debt. For example, we already have a bond which matures in 2054, so 33 years from now. Investors will want to see what is known as a debt ladder of maturity so they will not necessarily want to all invest for the same timeframe. So we expect the borrowing to be between 30 and 40 years. You are just picking up some differences in the examples that have been demonstrated.

Senator K.L. Moore:

Thank you. Of course, as I mentioned just then, the debt strategy was published yesterday. That identified that last the debt to G.D.P. (gross domestic product) ratio for the Island was 5.4 per cent and this year it will rise, as a result of this borrowing, to 34.2 per cent. What is the message that the political oversight group has, and indeed the Minister for Treasury and Resources, to the Island about this distinct change in policy to this point in time?

Deputy Chief Minister:

Can I, as chair of the oversight group, comment briefly on the investment in the new hospital? I think the debt strategy question is one for the Minister for Treasury and Resources. That is we need to ... sorry, I had an interruption in the background then.

Senator K.L. Moore:
Cats are very welcome.

Deputy Chief Minister:
Okay, thanks. The oversight group is firmly of the belief this spend of up to £804 million is a necessary and will be a valuable investment for Islanders.

[12:30]

We need a new hospital for all the very good reasons that have been previously rehearsed. I think when you look at the investment in the context of how much money we are going to invest in running the health service over the next 40 years, I mean it provides some context. For example, we are going to spend many billions and billions of pounds in delivering a service, so it is right we have the right asset to deliver that service out of. I think it is also worth mentioning that when we build the hospital we are building and owning potentially a very valuable asset that the land assembly that will go to deliver the hospital campus in future generations, should they decide to remove the hospital again, will be left with a very valuable asset of land. With that in mind, we feel that that does not only justify but makes a very strong case for that investment. I know £804 million is a lot of money but I think we get a very valuable and worthwhile investment out of it, and one that is absolutely necessary. Now given the condition of the existing health estate.

Senator K.L. Moore:
Thank you, Senator. It is interesting that you mention the ongoing running costs of the health service as I think it has been identified today, that figure is completely uncertain at this present moment in time. Therefore do you feel comfortable asking the Assembly to take this major decision with regards the investment in light of the lack of certainty or clarity over the revenue costs to this Government, and subsequent generations, moving forward and mindful of the fact that they will have to deal with the resultant debt of this project?

Deputy Chief Minister:
Yes, I do. We know for sure that we are going to be investing every year many hundreds of millions of pounds in running the healthcare service. The proposed healthcare model, we have always said healthcare models will advise but not dictate what the new hospital lacks because I would expect we will see a number of healthcare models or changes in the models during the life of the existing hospital. I also think, as has been pointed out, that the work ... this is a clinically-led project and we have a clear message from the clinicians and front line health workers that having a single site model will deliver much better logistics and clinical adjacencies and, in the medium to long term, I think will help contribute to delivering a more tightly run healthcare service.

Senator K.L. Moore:

Thank you, Senator, and I would like to take this opportunity to thank everyone who has joined us today for this hearing. It has been very interesting and of course, as I mentioned, we have some remaining questions, which we will be sending to you as quickly as we can. We look forward to receiving the answers but for now I appreciate you have a busy day ahead of you and I thank you all and close this hearing.

Deputy Chief Minister:

Thank you very much.

[12:33]