Hospital Policy Review Board – Workshop 3

7/08/18 10am-12pm

Attendees:	**FH team (Part B)**
Connetable Christopher Taylor (CT) – Project Board Chair	Bernard Place (BP)
Deputy Richard Renouf (RR)	Philippa McAndrew (PM)
Deputy Trevor Pointon (TP)	Ray Foster (RF)
Deputy Rowland Huelin (RH)	Richard Glover (RG)
Deputy Carina Alves	
Connetable Richard Buchanan	
Ralph Buchholz – SoJ Officer Support (RB)	

Part A – Board members only

Item	Minute	Action
1. Apologies	None	
2. Approve Minutes and scoping paper from last meeting	CT: Asked for clarification on 'JH' (Jessica Hardwick) from previous meeting. RR: Asked what the thinking behind including cleaners and porters in the survey discussed in the previous meeting. CA: Suggested that they would have a good knowledge of access issues and restrictions. CT: Explained they would understand delivery points and points of access. Agreed that they may not have relevant input on site selection but suggested it would be interesting to see the level of consultation. RB: Suggested that the survey to clinicians was to gauge engagement and was not a technical development or site selection survey. CT: Suggests signing off minutes. All in agreement.	
3. Board discussion	a. Site selection process Urban v Rural RH: Suggested that site selection and design are intertwined before explaining that not having enough of a footprint on a site changes the design. CT: Stated that he sought further information on the weighting of patient safety and design when finding a location. TP: Questioned whether there had been consultation with clinicians on how their departments fit in the floor plans of the new hospital. Also suggested that the decision on site didn't account for provisions of caring in the community. RH: Suggested some of the data being collected was not in depth enough using the example of patients being taken off island for treatment only being recorded from Easter 2014. RR: Assured the board that there was a patient record being planned that was considering many groups.	•

	CA: Asked if there was an assumption that less people would be using the hospital in future despite the growing population. Further questioned if future expansion had been considered. TP: Highlighted that less hospital users was the assumption due to the increased provision for community care. CT pointed out that advances in hospital treatments now meant that stays at hospital were significantly reduced in many cases RB: Highlighted key questions of the Board related to site selection; • To what extent had clinicians been consulted, and how was there input used in the design of the new hospital? • What is the flexibility of future expansion over the next 50 years? • What progress has been made with the provisions for community services? b. <u>Removal of dual site option</u> CT: Highlighted that a trip to Guernsey would be beneficial as that is an example of a dual site hospital. Suggested that this could provide further information on whether a dual site would work and highlighted a desire to speak with politicians and clinicians whilst there. CA: Questioned what the dual site option was. CT: Explained it was with the current site and the Overdale site but highlighted that there were issues of accessibility when getting to outpatients. Explained trip to Guernsey would provide a basis to a decision on the dual site matter. CA: queries why no other dual site options were considered after the proposed one was rejected? RB: Stated that there was a fundamental rejection by clinicians, as noted in the scrutiny report published on September 5th 2014 and so the principal of a dual site was rejected going forwards. c. <u>Current site selection</u> RH: Expressed a desire to look at a hospital on the current site and Parade Gardens. RB: Reminded the board that this was not in the terms of reference. RR: Suggested that a hospital could be built anywhere however reminded the board that this was not what they were here to do. Went on to ask CT what new evidence he had discovered regarding the Waterfront site, as reported in the JEP, and whether that information was discovered in the board meetings.	**RB to arrange site visits for Board**

	CT: Stated that he had found out about further Waterfront site options for the first time, having only previously been shown one site. RR: Suggested that this information had always been available and should have been known about as part of scrutiny. CT: Stated he was previously unaware of the different Waterfront options. Went on to ask RB if the visit around sites could be rearranged for when more board members were available.	

Part B – With FH team members.

Item	1. Introduction	Action
1. Introduction	CT: Asked the percentage breakdown of the footfall arriving at the hospital. JH: Highlighted information from the transport assessment seen in the EIA. Explained that there was a survey on a cross section of all hospital users before handing out a summarising handout. Further highlighted that raw data provided by the survey was available. RB: Highlighted that this information made up part of the planning application and suggested that he could email the raw data from the survey to the board members. JH: Reassured the board that the survey was conducted by an independent company. CT: Highlighted that there was a 45% response rate from the survey which was good. RH: Questioned how many of those attending hospital via ambulance were blue light emergencies as this was most relevant. BP: Suggested that this information could be provided for the next meeting.	**JH to provide detailed raw survey results** **BP to provide blue light data**
2. Site selection process current site Bernard Place & Philippa MacAndrew	Future Hospital Attendees: Philippa MacAndrew (PM) Richard Glover (RB) Bernard Place (BP) Ray Foster (RF) 2. Evolution of current site plans. PM: Started presentation regarding the evolution of the current site. RH: Questioned what percentage of the £626m in 'option C' was inflation?	

	RF: Explained the difficulty in attributing a percentage to inflation, but explained the higher costs of materials and the longer building phases were attributable to the higher figure. BP: Explained how other UK hospitals, specifically Dumfries and Galloway were often quoted to be cheaper but stressed the construction costs in Jersey were far greater and that the proposed build is a general hospital. BCIS (Building Cost Information Service) costs were used to calculate the build costs and this index is used as a standard within the industry. The index is adjusted by location and so in areas of higher cost the index is weighted accordingly. For example the cost base in Dumfries and Galloway using the index is 85, whilst in Jersey the base is set at 125. This means that the cost difference between these two locations is that Jersey has around 40% higher in build costs. RR: Highlighted that previous plans were not suitable due to disruption, cost and extended construction time (11 plus years). CT: Mentioned that In April and May after People Park was discounted, States Members, at the States Members Workshops, suggested the current site was the most politically acceptable. BP: Described how there was an appetite for a one phase build for hospital contractors. Also agreed with CT that the current site provided political alignment. Explained how the site had started as a 'proof of concept'. CT: Asked for clarification on the height of the current 80's block at the hospital. RG: Explained that the 80's block was 39.8m. Went on to explain the urban design and frontage onto Parade Gardens, highlighting that this had been an area highlighted by the inspector in his report. TP: Questioned where A&E was on the new scheme. BP: Highlighted that the innovative way of managing emergency services is through an emergency floor, which was a new way of caring. TP: How will the GP co-op service fit into the new hospital and will it be at a cost to patients? BP stated that the funding model is a separate work stream. RH: Asked what the parking provision was for the new scheme. RG: Explained that Patriotic Street would serve the hospital, explaining that an extra half deck of parking to provide 60 extra spaces would be built. Also explained how the car park is currently being used for commuter parking (approx. 600 spaces) so with management it could serve a purpose just for hospital usage. The use of technology to allocate spaces with hospital appointments can be one way to manage the parking provision. RR: Asked how parking would work with Westaway Court. RG: Explained there was a pedestrian route through the main hospital building to Westaway Court. Expanded by stating there would be some parking at Westaway Court also, as well as patient transport services also having a drop off there. A warden will also be employed to manage the parking allocations.	

	BP stated that the 19 spaces was more than required by patients who would be given spaces based upon need and not convenience. RF stated that the States control most public parking and have the ability to react to changing demand and behaviours. For example short stay parking can be introduced on commuter parking sites or vice versa and parking can be directly linked to appointments CT: Question why Westaway court couldn't be put on the North West corner of the main hospital site. RF: Highlighted that the space would not be big enough. TP: Asked what the services in Westaway would provide. BP: Explained how Westaway would be a centre for long term conditions, which would not benefit being located in an acute hospital. Explained how multiple specialities would be housed in Westaway therefore patients could visit multiple doctors in one visit. A "one stop shop" which reduces unnecessary additional journeys for multiple appointments. TP asked if an X-Ray service would be available. BP: Stated it was part of the respiratory service in main hospital and it was shown that only 8% of those actually required an X Ray There would be no patients going from Westaway court over to hospital requiring an x Ray as these patients would be not at Westaway in first place. As stated Westaway will be dealing with patients with diabetes, heart conditions and that this new service was very different to what has been done in the past. It is a difficult concept to get across to the public. The model is based upon 1000,000 patient visits per year but now over an extended working day and greater efficiencies. TP: Questions whether there would be residents in Westaway Court? BP: Explained there would be no residents, it would instead be purely for ambulatory care. Further suggested that patients would not be walking between sites, instead only visiting the relevant site. TP: Questioned whether patients that became acutely ill would be moved to the main hospital. BP: Suggested this would be the case and that there was provision for emergency transfers to the main hospital. RF: Explained the flexibility in managing car parks, and that this didn't have to be a binary choice across all car parks. RH: Questioned what the political brief given was regarding mental health. BP: Explained the brief was to build a general hospital. Further explained that there was an understanding that people with mental health issues still needed help with physical conditions and that there had to be a suitable link between mental health and the general hospital. Confirmed that there was no intention to include an acute mental health facility on site but that all of the facilities were designed to meet Article 47 which ensured best	

	practice and services for patients with mental health (including dementia) and children services. RF: Highlighted that the strategic case excluded long term mental health facilities. And that this was a separate stream of work with a working budget of £45 million. RH stated that the new hospital was therefore now effectively £520 million RF stated that the OBC had no mental health component in it and they do not sit well side by side. The review of the mental health sites was conducted in a similar way but they have much different requirements and criteria to that of a general hospital. For example Overdale is a good site as many of the facilities are already there, is in a more tranquil setting and the traffic transport issues are different. Metal health is part of a wider P.82 delivery but no decision has yet been made on the site or required detailed funding. TP: Questioned whether GP's had reservations. BP: Explained that Westaway Court was not a primary care centre and that as much outpatient activity as possible would be moved into the community. Explained how patients currently seen by consultants in the hospital would be seen in Westaway. It was not based upon the UK model where some GP's criticised it. For Jersey there are significant patient benefits about moving some services out into the community and Parishes, which also could have a financial benefit to GPs. RG: Continued presentation, explaining the Royal Institute of British Architects (RIBA) stages. CT: Questioned what the delay factor would be moving from stage 3 back to stage 0. RG: Explained that this would be at least two years. RF: Explained how it would likely be longer as the project team already understood a lot about the site when drawing up plans and would not have the same input on a new site. RH stated that P82 appeared to be about buildings and not services and for example questioned whether key worker accommodation had been looked into. RF: Assured the board that it had and gave an example of The Limes to highlight how new accommodation was being provided and that the feedback from Junior doctors was extremely positive when compared to accommodation elsewhere in UK. PM: Handed out engagement consultation document. BP: Touched on the findings of research that had been undertaken that many of the 'letters to the editor' and social media posts are by a smaller number of persistent posters. RH: Suggested that this may be the case however there was an undercurrent of concern. **Future Hospital Team Leave**	
A.O.B	RH: Questioned whether during the period where there are no board meetings whether the board can meet to discuss concerns and evidence.	

	RB: Reminded the board to contact Bernard Place regarding any questions they may have that need answering.	

Attachments

Presentation to Policy Board: Work shop 3