

# A Review of The Our Hospital Project

**Advice to the Assembly about whether  
changes can be made to deliver a more  
affordable and appropriate alternative**

**Minister of Infrastructure Housing and Environment  
Government of Jersey  
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## **Foreword from the Minister for Infrastructure**

As the saying goes, a week is a long time in politics. And over the past nine months every week seems to have produced another layer of instability. War in Eastern Europe, a fuel and energy crisis, the potential for recession and higher inflation now set the scene.

In terms of infrastructure, this means that large-scale capital projects across the globe face greater uncertainty. The cost of materials has risen sharply as markets compete for the same supplies, with long lead times as a result of severely disrupted supply chains.

The cost of energy is rising, and there are shortages of labour as a result of Covid-19 and Brexit. Against this backdrop, contractors internationally are naturally more wary about under-pricing contracts and taking on greater risk. And in order to safeguard themselves against fluctuations in their direct costs, fixed prices may be a thing of the past as project prices rise.

Jersey's situation is no different.

When the funding model for the Our Hospital (OH) project was first revealed, Jersey was hoping for an average return on its £1bn strategic reserve fund of 4.6% (2% above the Fiscal Policy Panel's long-term RPI assumption) over a 40 year period, and borrowing costs to be fixed at 2.5% for the duration.

The financial markets environment has changed considerably, and a return to stability may not be achieved any time soon. The strategic reserve will not reach its target this year and the cost of borrowing is considerably higher. The change in circumstances provides part of the backdrop to this review and, perhaps unavoidably, frames some of the fundamental thinking, particularly the need for a more robust approach to risk management in the volatile economic climate we now face. However, the situation is not without opportunity.

Recognising the amount of information and knowledge accumulated during the OH process, it was decided that the review work could be undertaken by our existing experienced local team, with the assistance and oversight of a Principal Expert Advisor; in this case, Mr Alan Moore OBE TD DL BSc (Hons) FRICS.

Until retirement in September 2021, Mr Moore was the Director of Strategic Capital Development within the Western Health & Social Care Trust and in this capacity was the Senior Responsible Owner responsible for the

successful delivery of a £1Bn capital investment programme within health in the West of Northern Ireland.

His responsibilities included the delivery of the South West Hospital at Enniskillen, the new Omagh Hospital and Primary Care Complex at Omagh, The North West Cancer Centre and the phased re-development of the Altnagelvin Area Hospital at Londonderry

Having assembled a small team and drafted an appropriate Terms of Reference which ruled out a return to site selection, a number of options were considered and a comprehensive consultation process began with 20 stakeholder meetings involving over 60 individuals in total.

Accepting that the current hospital may be required to stay in service for slightly longer than anticipated, the hospital's maintenance team were consulted and assurances were given that all required resources would be made available to keep the existing hospital buildings safe, without unnecessary bureaucratic process.

With regard to the review, the focus has, first and foremost, been to ensure that the conclusion would lead to the best possible facilities for both patients and health-care staff, in all areas.

In the process, every effort has also been made to combine this focus with an emphasis on some form of project phasing (possibly dual site or 'hybrid' model) to spread the financial risk over a longer period and deliver better value for money to the taxpayer, whilst recognising the urgent need to progress as quickly as possible.

In addition, devising a scheme where buildings could be designed to a scale more compatible with their surroundings, requiring less impact on the existing environment, and offering better project access to local construction firms and associated building trades. Finally, to allow for future, cost effective expansion, using modern methods of construction.

The resulting recommendations are unlikely to please everyone, but have been reached after careful consideration of the evidence presented and have set out the roadmap for our best chance of achieving the high quality future hospital facilities which the Island needs, but in a way that is both affordable and achievable in the shortest possible timescales.

It is time to put aside the public discord of the past and progress at pace, alongside a constructive dialogue with Health-care workers, Clinicians, Scrutiny, Assembly members and all Islanders, including neighbours and interest groups.

Finally, I should like to offer my sincere thanks to the Principal Expert Advisor, those Government of Jersey officers directly involved in the production of this Review (and those supporting its delivery in the background), the stakeholders who have provided evidence that led to its conclusions, and the individuals providing quality assurance for their constructive feedback.

## **Executive Summary**

In accordance with its terms of reference, and the Chief Minister's 100-day plan, this Review has been established to consider whether any changes can be made to the hospital project to deliver a more affordable and appropriate alternative. In short, within the constraints of 100-day review period and the need for further detailed design and cost assessments, the conclusion of the Review is 'yes':

- A prudent risk management approach can be taken to deliver a more affordable project through a different financing model, and by spreading commitment to spend over a longer period, rather than progressing a single large-scale and high-cost scheme with cost estimates for construction outside the forecasts within the Outline Business Case.
- Services can be broken over two or more sites to deliver a more appropriate service provision – to ensure that given our island context, the broad range of services delivered by Jersey's Health and Community Services continue to be delivered safely on-island but do not have the same degree of environmental or infrastructure impacts as a single-site scheme.

### **Existing Facilities and Their Maintenance**

The Review recognised the absolute necessity to ensure that the existing Jersey General Hospital site infrastructure at Gloucester Street remains safe whilst the various developments are constructed. To this end, additional funding should be made readily available to utilise in the event that it is required since it is recognised that there is a significant and increasing backlog to address. If necessary, further surveys (such as the six-facet survey) should be funded to ensure that those areas that pose most risk are prioritised and have not changed since the previous survey. Currently, £5m per annum of funding for capital maintenance of the existing health and care estate is available as part of the Government Plan. It was further agreed that a working group should be formed to identify interim solutions that could improve current working conditions and patient outcomes.

It should be noted that the ambitious target for delivery of the whole of the services provided in the Functional Brief by 2026 was under pressure: preliminary construction programmes for delivery of the whole of the current Overdale proposals indicated completion beyond that date. This would only

have been confirmed at Main Contract Award. Additional provision for the maintenance of services of the Jersey General Hospital is therefore also likely to have been required for this scenario.

### **Measures being undertaken to improve and transform Jersey's health service (provided by Minister for Health and Social Services, Karen Wilson)**

Changes in the delivery of modern healthcare over the last forty years have meant that the current hospital is no longer able to respond to the increasing demands placed upon it nor does it meet patients' expectations for privacy and dignity or meet the requirements of clinical staff to enhance the quality of the care they provide. Despite efforts to maintain the hospital environment through a programme of upgrade and maintenance, we have reached a point where we can no longer sustain this at the current hospital.

As part of the above, we mirror health economies across the world who are redefining and redesigning their hospitals in response to developments in clinical practice and moving towards increasing some aspects of care in the community.

New hospital facilities therefore must be capable of meeting changes to care over time and delivering services, support developments in new health technologies, and provide an environment in which to attract staff. They need to offer flexibility, support integrated care delivery, be fit for purpose, and meet the expectations of patients and clinicians engaged in delivering person centred care. Critical to their success is the expertise to deliver such specialist facilities.

### **Affordability of the Current Scheme**

In the first instance, the Review considered the affordability of the current project in light of recent global events that have considerably altered the financial climate and fractured international supply chains.

The Government of Jersey's Chief Economic Adviser has provided the following information on the global economic context:



*The latest forecast from the International Monetary Fund (IMF) is for global growth of 3.2% this year and 2.9% next, much lower than the 6.1% seen in 2021. By any comparison, this is a significant drop off from the global growth position. Whilst circa 3% growth might appear strong in a normal national context, in a global context anything below 3% is very low, and as such these figures need to be interpreted as a particularly problematic global economic outlook.*

*The key risks to the global outlook relate to supply-chain disruption due to the ongoing war in Ukraine and bounce back from the pandemic. The war has disrupted the global economy due to international tensions with Russia and led to higher global commodity prices for key Russian and Ukrainian exports such as oil, gas and grain. Imposed sanctions have also had an impact on the economies imposing them, mainly in places of needing to source alternative supply-chains.*

*Commodity price increases and lingering supply-demand imbalances have led to increased 2022 inflation projections. The IMF in their most recent 6 monthly report (June 2022) forecast 6.6% in advanced economies and 9.5% in emerging market and developing economies. The most recently published figure for RPI inflation rate in Jerseys is 10.4% at September 2022<sup>1</sup>.*

*Much of this has led to increased interest rates in most developed countries, with anticipation of higher interest rates to come. Borrowing for investment will therefore be significantly more expensive now that it was just a few months ago and it is likely that these interest rate rises will be the new norm. Market projections for 2023 are above 4% and long term borrowing in the UK (Gilt Yields) are still above 3.6% despite recently falling (following the new government in the UK).*

*The most recent Fiscal Policy Panel report suggests that evidence from the labour market and businesses shows that the economy has been recovering well from the Covid-19 pandemic. The construction sector faces a shortfall of workers and materials. Currently, it appears that Jersey's labour market has been resilient to the global shocks and the economy overall remains in a good position to weather them, however these shocks represent a short-term risk to the economic recovery as does the lack of spare capacity for large projects and programmes.*

*In this context, it has concluded that the scheme in its current form and delivery model is unachievable within the original £620 million envelope established to*

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<sup>1</sup> [Retail prices index \(inflation\) \(gov.ie\)](https://www.gov.uk/retail-prices-index)

fund the contracted elements of the project. Current estimates are now between £70 million and £115 million in excess of that figure.

Affordability should also be considered in the context of changes to markets and the global economic environment, and the associated pressures this will no doubt place upon government finances. It would no longer seem prudent to expend such a large sum on one project in such uncertain times.

Further, in the current arrangement, there is little flexibility in the timing of the commitment to commence main works and so this could be required when costs are at their most volatile and least affordable. The project could be delayed until more stable times, but the risk could return mid-project with the same consequence. It could be argued that current effects are transitory; however, it may also be the case that the previous environment of sustained, low interest rates was also transitory. In any circumstance, it is unlikely that the mechanism described in the Funding Proposition would remain the preferred choice and alternatives would be explored.

Finally, as could be interpreted from the economic analysis above, there is an increasing suggestion that there may be a global recession in the short to medium term. Infrastructure projects, including investment in healthcare facilities are a proven means of stimulating areas of the local economy but to do so, they need to be accessible to those businesses. The current model places the procurement control within one off-island and one on-island contractor rather than maximising the supply base. The current proposal does not target expenditure to those areas of the island economy that could be most in need, delivering best value for money and therefore contributes to it being unaffordable.

In line with the conclusion that the current scheme at Overdale is unaffordable, it was similarly concluded that a relocation of the proposal, a 'lift and shift' of design and functional delivery elements of the scheme, to the existing hospital site at Gloucester Street was also unaffordable, and completely unachievable from a space planning perspective.

## **Review Methodology and Options Appraisal**

In reaching these conclusions, the Review team undertook a review of documentation, took into consideration evidence from key stakeholders through interviews and in writing (over sixty stakeholders were consulted), and

undertook visits to various healthcare facilities elsewhere in Northern Ireland, some for similar population sizes.

The facilities in Northern Ireland were selected since they had been delivered by the Lead Advisor and consequently, the Review team was able to understand how these had been affected, the standards to which they had been designed and the consequent outcomes that they had achieved. Further, one of the hospitals was in a remote location and so had some similarities with Jersey's healthcare requirements. Despite Jersey's higher GDP, the island has not been able to deliver healthcare facilities to similar standards and so the Review team hoped to understand how Government of Jersey might be able to learn from the example of Northern Ireland Healthcare Trusts.

It is important to note that this Review has been substantially completed within 100 days, during which time it is very challenging to collect any new evidence to support the Review outcome. In contrast, this Review has sought to review existing sources of evidence and discussed these with stakeholders – often those that had produced the evidence in the first instance. It is imperative to note that this Review cannot replace a detailed business case approach and quantitative analysis of options, which will need to be undertaken in due course.

Subsequent to its conclusions about the current scheme and the option to relocate the existing functional brief to the Gloucester Street site, the Review team undertook an options appraisal on additional options, to establish whether any of these could deliver a more affordable and appropriate alternative.

In line with the terms of reference, the Review has not sought to reopen the site assessment process to an extensive list of locations across the Island. This is because this approach would create a significant delay in progress and almost certainly would not enable the delivery of a new hospital within the required timescale. The Review options were therefore limited to permutations around the existing Jersey General Hospital site and nearby sites in Government of Jersey ownership and the Overdale site, as designated as a site for a new hospital for Jersey in the Bridging Island Plan 2022-2025<sup>2</sup>. As a result, the options assessed were:

1. Develop Overdale as a single hospital site with a significant reduction in designed space allocation.

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<sup>2</sup> [Bridging Island Plan 2022 to 2025 \(gov.je\)](https://www.gov.je/Bridging-Island-Plan-2022-to-2025)

2. Redevelop the existing hospital site at Gloucester Street in a phased manner, with a similar reduction in designed space allocation to Option 1, whilst maintaining existing hospital services as work proceeds.
3. Redevelop the existing hospital site at Gloucester Street and the adjacent Kensington Place site in a phased manner, with a similar reduction in designed space allocation to Option 1, whilst maintaining existing hospital services as work proceeds
4. A hybrid phased option, developing hospital facilities over both Overdale and Gloucester St/Kensington Place, ensuring the most advantageous division of services whilst continuing to deliver safe clinical services and minimising any potential impacts (emergency, ambulatory, intermediate care, rehabilitation, etc).

All of the options above are able to deliver safe clinical and operational services.

It should be noted that option 4 is not the same as the previous dual site solution since that only explored the refurbishment and redevelopment of the existing Jersey General Hospital site over many phases rather than new build developments of adjacent sites that avoid complex works on an existing, operational site and associated enabling works.

## **Criteria For Assessment**

The criteria for options appraisal were based upon critical success factors outlined in HM Treasury Green Book guidance on appraisal and evaluation of policies, projects and programmes<sup>3</sup>. The criteria can be grouped as:

- Deliverability/Achievability
- Affordability
- Suitability
- Social Value
- Operations
- Capacity and Capability
- Innovation
- Strategic fit and meets business needs
- Potential value for money
- Supplier capacity and capability

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<sup>3</sup> [The Green Book: appraisal and evaluation in central government - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/publications/the-green-book) P31-32

- Potential affordability
- Potential achievability

## Conclusions

When weighing up the available evidence, the Review considered the adoption of a phased option delivered over two or more sites, Overdale and Gloucester Street/Kensington Place, would provide the best opportunity to make the scheme more affordable and appropriate. Whilst it must be recognised that this approach will not use all the material that has been developed to date, a substantial portion can be modified and adapted as well as the work that was developed as part of the Future Hospital proposals.

Part of the consideration of taking this approach is because there is currently significant cost uncertainty – the larger the scheme, the more uncertainty there is – not for the known elements of the work, but for inflation and risk contingencies. This Review does not therefore give precise figures in relation to the extent of saving that can be achieved but does provide some indicative estimations, at today's prices.

It is considered that a multi-site phased approach, broken up into smaller packages of work, presents a prudent risk management approach to deliver a more affordable project through a different financing model. In addition, it is considered that by spreading then commitment to spend over a longer period, and executing some elements of construction in the shortest time possible, this would create an environment where some health facilities could be replaced and momentum gathered to deliver the project. This view is in contrast to the single large-scale and high-cost scheme with cost estimates for construction outside the forecasts within the Outline Business Case, making it unaffordable within current approvals.

In addition to being affordable, to be appropriate, the right services must be delivered in the right place. Consequently, the Review recommends that further, comprehensive consultation should take place with all stakeholders, but especially healthcare staff and clinicians, before determining the locations of the different services. Some adjacency of service are absolutely essential and these will provide a 'critical mass' of departments that should stay together. Whilst the majority of clinicians consulted as part of the Review work to date have articulated a strong preference for a single-site solution, it is recognised that changes to project affordability as a result the global economic environment and the overall community perspective mean that the project context has changed

and an appropriate risk management approach is prudent. Furthermore, that there is an overriding need to deliver modern healthcare facilities for Jersey and that a hybrid or multi-site option is workable and a considerably more favourable solution than a potential further prolonged delay to identify an alternative affordable single site option.

Additional work will be required to further refine the functional brief agreed as part of the Our Hospital project; an outline of a possible division of delivery location for services that is liable to change following consultation could be:

- Phase A
  - Elective in-patient and day surgery (public and private)
  - Ambulatory care and outpatients
  - The possibility of including some kind of primary care services should not be discounted (could be either phase).
  - Intermediate care services, including rehabilitation
  
- Phase B
  - Urgent Treatment Centre, Emergency and in-patient services and associated diagnostics
  - Intensive Treatment Unit
  - Women's and Children's services
  - Knowledge and Education Centre (could be either phase)

The Review also found that mental health services could be established at a separate standalone location, which could be on the Overdale site, although further work would need to be undertaken to validate this possibility.

The Review reached this conclusion for the following reasons:

1. It was recognised that all previous scheme iterations relied on a single highly concentrated site solution, which brought all services onto a single relatively confined location. The need for appropriately sized sites capable of supporting the scale of services provided was reinforced during the fact-finding trip to visit various hospital facilities in Northern Ireland. Any variation of the currently planned scheme would therefore benefit from the larger initial footprint for services provided by two larger sites rather than just one, whilst still enabling room for future expansion, disposals of sites or use for other strategic priorities.

2. Dividing the services over distinct and separate sites provides an appropriate response to public feedback to reduce the environmental impact of the current scheme on the lands adjacent to Overdale whilst still providing world class health facilities. The associated cost saving is estimated to be circa £50 million at today's prices taken from acquisitions to date and estimates for the access works. All cost savings described in this report are estimates informed by evidence provided by project cost consultants and the experience of the Principal Expert Adviser. Further work will need to be undertaken to fully validate these estimates as part of the business case process. It is also recognised that for some, the environmental impacts are outweighed by the benefits of healthcare facilities all in one location.
3. Separating the scheme into smaller constituent elements will interest a larger number of contractors rather than only the very largest of contractors. Through distributing and phasing the scheme into smaller elements, it allows for a procurement approach that will enable a greater local contractor interest and for them to have a larger stake, in any partnership with larger, off-island firms that are more experienced in the delivery of health care facilities. It should be recognised that a programme of works does bring added complexity and possibly risk, but it could be argued that this is offset by increased diversity of supply chain (i.e., no single point of failure). This approach has also been adopted for other capital projects and has proved successful, i.e., the Sewage Treatment Works.
4. There will also be increased benefits for the local economy and increased social value through training initiatives, upskilling islanders to maintain the infrastructure that is being delivered. Indeed, evidence presented from the local construction industry expressed frustration that the scale of the current project precluded many of the local contracting industry from fully participating and that phased smaller contracts permitted better value for money and lower tenders to be achieved. In addition, stakeholders also noted that although smaller, those phased contracts were likely to remain of sufficient size and scale to attract international construction interest. The new government also intends to play a greater and more inclusive role in island wide construction planning, and it is anticipated that, in future, there may be significant opportunity to

programme other projects more accurately in order to provide a more consistent overall development profile.

5. In turn, this could drive more competitive bids and leave a higher percentage of the overall project spend circulating within the Jersey economy. This could have the potential for a 5-10% capital cost reduction with savings estimated to be circa £30-60 million at today's prices and engender greater buy-in and commitment. These figures are estimates but were tested with project advisors during stakeholder meetings from their experience of competitive bids. However, reliance on a greater number of contractors could increase the risk of slippage along the project's critical path; conversely it also spreads the risk across a larger number of organisations, potentially increasing resilience.
6. Revisiting the scheme requirement allows consideration of future digital healthcare services delivery (such as remote monitoring and online consultations) to be incorporated into any revised proposal and thus future space requirements. This would have a beneficial effect on the future efficiency of Jersey's health service and provide the potential for a 2.5-5% cost capital cost reduction savings estimated to be circa £15-30 million at today's prices. These space reductions were tested with Digital Specialists within OHP Advisor organisations and are commensurate with savings seen on schemes in Northern Ireland. In line with the discussion on page 23, any investment in digital schemes should be balanced with a number of considerations, such as potential space reduction, clinical benefit, and geographic context. Smaller facilities within the hybrid model described above also allows for the increased potential for lower cost off-island modular construction for some buildings. Whilst historically, these solutions were not robust, they are now designed to the same standards and with the same life expectancy as in-situ construction. This type of approach could still optimise involvement for local contractors and mitigate against inflationary pressures if the local construction industry remains strong and demand continues to outstrip supply, as currently. This could have the potential for a 2.5-5% cost capital cost reduction savings estimated to be circa £15-30 million at today's prices. These are estimated from savings in overall programme time for preliminaries.
7. Evidence presented by clinicians arising from experience of the delivery of mental health services suggested that the Functional Brief in relation



to Mental Health should be reviewed. It may be more appropriate that acute mental health services are co-located with other services. This is a significant amendment from the current Functional Brief and needs careful exploration. Delivery of this separate project should be at pace.

8. In addition to the above and in line with HM Treasury best practice, any revised proposal and associated business case should also reflect and offset the market values of health care facilities no longer required against the proposed scheme. Whilst this could reduce the capital cost of the proposals going forward, the realisation of any capital receipts would be dependent on political decisions regarding the future alternative uses of sites currently part of the health estate, for example the Gloucester Street General Hospital. Estimated value circa £15-20 million at today's prices on the basis of recent land transactions for affordable housing.
9. Crucially, the phased or hybrid model allows the delivery of future health care facilities to be risk managed. In other words, phasing the various elements provides an opportunity to take the development forward within the realm of current affordability and to carefully balance investment in the current estate with investment in the construction of new facilities when the market conditions are more favourable. This also allows for the scheme to progress within and beyond the mandate of the current Government as and when funding is secured. A phased solution can also better harness improvements in digital healthcare and every evolving healthcare equipment.

Being mindful of past delays and the age and deteriorating condition of the existing hospital facility, the Review recognised that the hybrid phased option, if accepted, should be progressed at pace and within clearly defined timescales in order to retain public confidence. It is acknowledged that the project will have to work hard to ensure clinicians also understand and can accept the reasons that previous proposals are no longer affordable and that this phased approach is the solution that is most achievable. The project team needs to ensure that all work undertaken to date is exploited to minimise any rework by clinicians. Ministers have provided clear direction to the Review that construction of new facilities must commence within the current electoral term.

## **Phasing Opportunities**

Although subject to availability and profiling of capital funding, relevant approvals and favourable tendering conditions, the Review would suggest the following phased development programme as a target to be followed:

- Phase 1 – Development of services at Overdale to be commenced on site within 24 months with a 36month construction programme to completion.
- Phase 2A – Development of phase 2 services at Kensington Place to be commenced on site within 36 months with a 36-month construction programme to completion
- Phase 2B - Development of remaining services in part of the current Hospital Site at Gloucester Street adjacent to Kensington Place, following completion of Phase 1 and 2A. This final phase to be commenced on-site within 72 months, with a 24 month construction programme to completion
- A review of the requirements for Mental Health facilities to be commenced immediately and proposals on site within 36 months with a 24-month construction programme to completion

Within these timelines, it may be possible to commence enabling works, subject to planning permission, on each of the phases twelve months in advance of the main schemes.

## **Other Considerations**

It is recognised that within a phased hybrid option, there may be a degree of duplication in some clinical infrastructure which will have revenue implications, for example diagnostics facilities. There may also be increased staffing requirements, depending on the division of any services. However, the duplication of same may be appropriate in comparison to the potential costs savings that could be achieved and, in many cases, there may already be duplication of equipment. Any such comparison would need to be considered as part of a detailed options appraisal as part of the business case process. However, it should be noted that there may be a compelling argument and benefits for providing such duplication to ensure additional flexibility and resilience that would also be assessed against cost in any business case. This the direction of travel for some Health Authorities in the UK and indeed in Northern Ireland. It is possible to also provide resilience on a single site although there would be less mitigation if the whole site suffered an issue, i.e., fire or emergency event.

Appropriate resourcing of current healthcare facilities is recognised to be a global issue, also noted in Northern Ireland. Additional staffing would therefore seem to add to an existing issue. However, there is a reasonable timeframe to fully understand the reasons for current recruitment and retention issues and put in place strategies to attract staff. This is beyond the scope of this review and the hospital project itself, however it is anticipated that new, fit-for-purpose healthcare, knowledge and education facilities, will assist with this existing issue and help to mitigate the risk arising from any additional staffing requirement.

Following a recent visit to the redevelopment works at the former Les Quennevais School, the Minister for Infrastructure and Minister for Health and Social Services consider that there may be an opportunity to retain these facilities as a point of delivery for health and care in the longer term. This could be considered as part of Strategic Proposal 4 of the Bridging Island Plan regarding a west of Island planning framework and masterplan for Les Quennevais and adjacent areas and will be discussed with the Minister for Environment and the Connétable of St Brelade.

In addition, the Review team considers that it could be prudent to undertake a separate review in relation to the Island's mental health facilities requirements, to fully understand where they might best be located, whilst ensuring the right range of services are available to Islanders and fit as part of a holistic programme of healthcare facilities redevelopment.

As will be appreciated, the Review has been undertaken in a very constrained timeline: it is hoped these recommendations offer a roadmap to progressing the critically needed and long overdue healthcare facilities for the Island.

Should the Review recommendations be accepted, it is essential that a further, more detailed analysis is undertaken with respect to clinical risk, cost and planning assumptions before any final decisions are ratified.

## **Next Steps**

The next steps that would take approximately three to six months would be:

1. Further consultation with stakeholders, especially healthcare staff on the services that should be provided in any hybrid or phased solution
2. Ensure sufficient funding to minimise clinical and operational risk at JGH

3. Commission review of requirements for mental health facilities to be commenced immediately
4. Ensure an appropriately sized political oversight group is in place that meets regularly and can make effective, timely decisions, in line with the Comptroller and Auditor General's 2017 report on Decision Making: Selecting a Site for the Future Hospital<sup>4</sup>
5. A mandate is prepared, providing an initial project plan, including potential resourcing and timelines.
6. Feasibility studies to convert current designs and proposals into initial proof of concept designs and costings
7. Report and Proposition in the States Assembly for phased or hybrid solution at Overdale and Gloucester Street
8. Development of business case
9. Identify and secure funding of project through States Assembly and Government Plan processes.

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<sup>4</sup> [Jersey Audit Office](#)

# Section 1: Introduction and Scope of Report

## Introduction

The construction of new health care facilities is one of the most important tasks faced by the incoming government owing to the condition of the existing facilities and the clinical need and has been a subject of public and political interest for some time. The complexity of the approach, requirements, timescale for delivery, cost and financing has meant that the project has seen a number of iterations, none of which has achieved the construction milestone of a modern, affordable, value for money, fit for purpose, and efficient hospital for Jersey providing appropriate and modern healthcare services.

The case for new hospital facilities that are appropriate to the island of Jersey has been established and accepted by the public. As such, the Chief Minister has outlined the requirement for a review that will allow the Government of Jersey to make properly informed decisions about the future of the project. The aim is to provide evidence-based recommendations for the future of the project and to consider whether there may be options to deliver a more affordable and appropriate alternative – it will not seek to re-run or critique decision-making of the project to date. The Review scope seeks to expand on and explore the concepts of affordability and appropriateness.

## Review Scope

The Review has:

- Assessed the affordability of the current project in light of recent global events that have considerably altered the financial climate and fractured international supply chains.
- Considered the state of the existing hospital and associated health and care facilities, including an assessment of the measures required to ensure that they remain fit for purpose pending the delivery of new health and care facilities.
- Considered measures currently being undertaken to improve and transform Jersey's health service during this period.
- Examined various options from a scope, operational efficiency, cost, programme and local economic impacts perspective, including, but not limited to:
  - a scheme at Overdale;
  - a scheme on the existing Gloucester Street site, utilising adjacent sites, such as Kensington Place;

- opportunities for a longer-term phased development at Overdale or Gloucester Street, and;
- the opportunity to use secondary sites to complement the delivery of health and care from a primary hospital location.

A new site assessment process is not part of the Review, as this would not enable the delivery of a new hospital within the required timescale.

Care has been taken to ensure that the development incorporates provision of delivery space for an appropriate range of health and care service for Jersey, contributes to a 'whole system' of healthcare, addresses future care needs, is aligned to evidence-based models of care and includes opportunities to exploit innovation and digital methods of care delivery.

The Review has sought to identify where opportunities to reduce cost or increase and add value might arise. Areas of focus include, but are not limited to:

- Reducing construction costs – for example by reviewing scope, size of development or alternative delivery techniques such as Modern Methods of Construction/modular build (without compromising on quality of build or clinical risk factors).
- Reducing associated infrastructure costs – for example, by reducing the requirement for transport measures and road improvements
- Reducing overall cost – for example by disposing of land not required for health facilities or delivering value by enabling other strategic objectives of the Government of Jersey
- Phasing of activity – breaking the construction into phases over a longer period of delivery may be an appropriate risk management response. In other words, whilst a phased build might appear to cost more on paper, due to inflationary changes as time passes, real terms adjusted costs may be comparable. The key mitigation opportunity arising from phasing is therefore the distribution of costs over a longer time. This could make delivery more affordable for Government finances at any given point, particularly in an uncertain global economic environment, when compared to a single-phased approach that may require commitment of significant resources at a stroke. Phasing may also enable more flexibility in the timing of large expenditure, permitting optimal funding arrangements.
- Procurement approach – for example providing greater opportunity to tender smaller work packages to the local construction industry, getting the best

agreements in place with contractors regarding their overheads and profit, and identifying a partner or partners that will leave a lasting legacy in Jersey in terms of social value – leaving professionally-trained and knowledgeable local residents with transferable skills that can benefit the island in future projects once the health care facilities have been delivered.

- Digital health – for example, optimising the use of remote consultations to reduce the need for clinical floor space or exploiting telehealth internet of things devices connected to central analytics and software could achieve efficiencies and opportunities to reduce scale, whilst potentially improving clinical outcomes and achieving efficiencies. However, Jersey’s small geography means that accessibility to its health and care services is excellent, and remote consultations for those without mobility challenges may not prove to be as successfully adopted on a Jersey-only basis as they might be on a greater geographic scale. Remote consultations may be more successful if they can be offered to island residents appropriately from off-island, but necessary controls would need to be put in place from a clinical governance perspective and a significant culture shift with respect to health and care services consumption within Islanders will be required. Telehealth is also of benefit for peer-to-peer communication.

At the same time, the digital environment continues to evolve and, and investment in digital health technologies must carefully balance benefit, cost, and other interdependencies, such as implications for the hardware/software framework to enable delivery, as well as clinical governance, regulation, licensing costs and data protection/permissions access. Notwithstanding, these are barriers to delivery which are challenging but can be overcome. In addition, opportunities for progress in this should be exploited as the world moves towards a more digital delivery environment. Indeed, Jersey should be aspiring to achieve high-standards of digitally embedded healthcare, as expressed in the Digital Health Strategy that was developed in partnership with Digital Jersey in 2016<sup>5</sup>, and ambitions to achieve the highest level of digital health care maturity – HIMSS7<sup>6</sup>. However, the ability to deliver such ambitions has been slower than anticipated, and greater focus will be required in setting out a roadmap for an achievable delivery plan with appropriate levels of investment and culture change management. It might be that a dedicated digital health team needs to be established, most likely with an external partner with a proven track record in order to achieve digital ambitions.

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<sup>5</sup> [Digital Strategy: Health and Care in Jersey | Digital Jersey](#)

<sup>6</sup> Healthcare Information and Management Systems Society - <https://www.himssanalytics.org/emram>

## Process

The Review has been informed by:

- A review of key project documents and sources of challenge and/or scrutiny, pertaining to various iterations of the project
- Evidence from a range of stakeholders
- Visits to completed hospital projects elsewhere in the British Isles.

An appraisal of the options outlined above has been undertaken, using criteria based upon critical success factors outlined in HM Treasury Green Book guidance on appraisal and evaluation of policies, projects and programmes. The criteria were:

- Potential deliverability/achievability, to consider
  - Time
  - Scale and phasing, local involvement and engagement
- Potential affordability, to consider
  - Capital cost
  - Global economic circumstances and risks
  - Financing options
- Suitability – strategic fit and meets business needs, to consider
  - Scope and functional brief
  - Clinical and operational need
  - Clinical and operational risk
- Social value and potential value for money, to consider
  - Local economic impacts
  - Social, economic and environmental costs, including proportionality of ancillary infrastructure
  - Benefits and risks
- Operations
  - Operational costs, including revenue and staffing costs
- Supplier capacity and capability, to consider
  - Procurement and team assembly
  - Local involvement
- Innovation
  - Opportunities for taking advantage of digital health care
  - Modern Methods of Construction

Whilst a reasonable assessment of each option has been undertaken for each criterion, based upon the evidence considered, including expert evidence from officers and advisers with extensive professional experience such as commercial



and cost consultants, designers, engineers and quantity surveyors, the options appraisal will not be based on fully weighted quantitative measures. Such analysis would normally be undertaken to formulate a detailed business case.

However, this Review does provide an evidence-based appraisal of options, relative to one another, to identify opportunities to reduce cost and add value, and present a new direction of travel and associated phased action plan for decision makers to consider.

Stakeholders were selected on the basis of their knowledge and experience. They have not been asked to declare any conflicts of interest since they are not able to make decisions and their evidence will be shared widely and subject to public scrutiny.

It is important to note that following this Review, if decision makers change the mandate of the Our Hospital project, this report does not replace the processes required as part of Government of Jersey governance frameworks.

The Review has been led by the Minister for Infrastructure and supported by a Principal Expert Adviser, Mr Alan Moore OBE TD DL BSc (Hons) FRICS, who has extensive experience of large-scale capital projects in health and care.

The Review and advice provided by expert adviser(s) will be presented to the States Assembly by the Minister.

## **The Review Team**

The Review Lead is the Minister for Infrastructure, Deputy Tom Binet.

Deputy Binet is supported by:

- The Minister for Health and Social Services, Deputy Karen Wilson
- The Assistant Minister for Health and Social Services, Deputy Rose Binet

The Principal Expert Adviser to the Review is Alan Moore OBE TD DL BSc (Hons) FRICS.

The Review team has been supported by Government of Jersey officers:

- Information relating to current and previous iterations of the hospital project has been provided by the Acting Our Hospital Project Director.
- Operational advice has been provided by to the Review by the Associate Managing Director of Health and Community Services.

Additional quality assurance has been provided by subject matter experts:

- Clinical assurance has been provided by the Medical Director of Health and Community Services, Patrick Armstrong.
- Insight into local industry has been provided by former Director General for Growth, Housing and Environment, John Rogers.
- Insight into digital health has been provided by the Chief Executive Officer of Digital Jersey, Tony Moretta.
- Further independent challenge has been provided by Dr Graham Root.

These individuals have not contributed directly to the content of the Review or influenced its outcomes but have provided critical friend challenge ahead of publication. They have reviewed the content for factual accuracy within their field of knowledge and identified areas where more or less focus should be required to produce a rounder, more coherent publication.

The Minister for Infrastructure would like to express his thanks to all of the Review team and expert quality assurance support for their input into this Review.

## **Section 2: Background to OHP Proposals and Emerging Delivery and Affordability Risks**

### **Introduction**

The current Jersey General Hospital in St Helier is tired and deteriorating. Previous projects have looked at delivering a new hospital for Jersey, most recently the Future Hospital Project, which preceded the current Our Hospital Project.

The Our Hospital Project (**OHP**) was initiated in 2019, which is the latest in a series of iterations to progress new hospital facilities spanning over 10 years.

To meet the clinical needs of the Island through OHP, the new hospital was anticipated to be deliverable by 2026, when costs to maintain the deteriorating hospital estate escalate sharply, could start to impact the delivery of care and mean greater expenditure on facilities that are due to be replaced.

Subsequent to the States Assembly receiving the OHP mandate, a number of specialist external States of Jersey employees were appointed, and professional services engagements put in place to support a public procurement exercise to identify and select a Design Delivery Partner (**DDP**), progress site selection, assist with OBC completion and submission of the Planning Application.

The DDP was appointed in July 2020 to support in these activities as part of a Pre-Construction Services Agreement (**PCSA**). This means that no build contracts were entered into, but the DDP would support the Government of Jersey to deliver a Technical Design and would be the preferred partner at the point of entering into construction contracts.

Overdale was endorsed as the preferred site for a new hospital by the States Assembly in November 2020 and the Assembly approved a funding model for the project in October 2021 on the basis of an Outline Business Case (**OBC**) produced in the Spring and Summer of that year.

In parallel, other key actions were progressed in relation to planning, land acquisition and other pre-contract award requirements. Following a Public Inquiry, conditional planning permission for the Overdale site was approved by the former Minister for the Environment in May 2022 following recommendation from Planning Inspector. The Government of Jersey is

continuing to pursue the Planning Obligation Agreement for the Overdale site, which will provide a constructive baseline from which to work. This means that whatever the agreed direction of travel, the project will have an approved planning permission, and the reduction in scale of any future proposed development at Overdale can be balanced against it, as well as allowing the demolition and clearing of the site for any enabling works once any relevant conditions are discharged.

Discussions between the Government of Jersey and the DDP about ongoing affordability within the current uncertain economic climate have been on-going over several months. Regrettably, the DDP and expert cost consultants have recently advised that the current scheme is not likely to be deliverable within the budgets approved by the States Assembly. The current cost plan is estimating that costs will be £70 million to £115 million in excess of the figures provided in the OBC. As a result, Government of Jersey has recently taken steps to bring to a conclusion the PCSA contract by mutual agreement. This was on completion of Royal Institute of British Architects (**RIBA**) Stage 3 Spatial Coordination in September 2022. Completion at the end of a RIBA Stage means that there is a package of work that can be used to specify and brief any future project. It also could be continued from this stage in the future, if desirable.

As a result of the changes to the global economic context and its likely impacts on the affordability of the current scheme, the Government of Jersey has initiated a review led by the Minister of Infrastructure Housing and Environment and supported by an expert adviser, with support from OHP team members to consider options and provide advice to the Assembly as to whether changes can be made to the hospital project to deliver a more affordable and appropriate alternative.

## Section 3: Stakeholder Interviews and Submissions – What We Heard

Over twenty interviews have been held with the Review team with over sixty stakeholders who have been instrumental in developing previous or current proposals or healthcare schemes elsewhere. Summaries of information that was discussed at these interviews are provided in Appendix C. Some of the key messages are provided in this section:

- Cost estimates for the schemes have significantly increased since the OBC and this can be linked to global economic circumstances and the disruption of supply chains
- Cost estimates provided in the OBC are likely to be exceeded without alterations to the Functional Brief although one interviewee considered that it was still possible to deliver the currently constituted scheme within this envelope although they are not involved in the scheme and it was subject to certain conditions.
- There are various mechanisms that could be used to fund the current scheme; if the funding were required imminently, it is unlikely to be the funding mechanism presented in the OBC since financial markets are currently volatile and the short-term outlook for interest rates and investment returns is challenging. Longer term it is anticipated that this mechanism might become possible again.
- It could be beneficial to have flexibility in timing for raising funds that would be possible in a phased approach rather than for one large project. This is true for a one site or multi-site proposal.
- A risk-based approach has been adopted to manage existing hospital buildings since a new hospital has been expected for the last ten years. “Doing nothing is not an option”.
- A number of works are essential to deliver services safely and so have been undertaken or planned to be undertaken. Further, the Review supports forming a working group to deliver small, short-term projects that would improve current working conditions and patient outcomes, i.e., ‘quick wins’.
- Increased budgets are likely to be required to manage operational risks in those departments where new hospital facilities will not be delivered by 2026 although this may have been necessary even with the existing scheme.

- Phased solutions may permit whole buildings to be delivered earlier and healthcare service benefits to flow sooner. On a more constrained site, this will be less possible.
- Senior clinicians and managers in HCS were extensively consulted on the current brief for the hospital and the departmental and room layouts.
- They confirmed that they were challenged during the consultation process and not all requests were necessarily incorporated
- The majority would like to see the current proposals move forward but reluctantly acknowledge that global events necessitate a review of the current scheme and requirement to consider alternative, more affordable solutions
- There are different options that could deliver a scheme that achieves new, fit for purpose healthcare facilities that could meet clinicians' and users' requirements
- Further detailed work on the impact of each option is required to fully understand any potential clinical and operational risks and likely impacts and mitigate these although some can be inferred
- Jersey has specific recruitment challenges with some staff attracted to the Island because of the 'Our Hospital Project'
- Education and learning is central to developing and maintaining high quality and safe health care in addition to maintaining recruitment and retention. It is vitally important that Education is given significant prominence in any project.
- Many health workers and clinicians expressed concern that they would need to further input into proposals for healthcare facilities. There was frustration that they had made significant contributions to previous proposals and there was little appetite to start again.
- The importance of communication with all healthcare staff and islanders over different channels and locations was emphasised.
- Opportunities to modernise and upgrade electronic systems and technological platforms are available and should be explored further. Digital Health Specialists confirm that for example in outpatients, these could lead up to a one third reduction in patient presentations and up to a twenty percent space savings.

- Non-delivery of these digital aspirations is a considerable risk. A dedicated digital health team needs to be established most likely with an external partner with a proven track record in order to achieve digital ambitions.
- From the ambulance and patient transport services perspective, all potential sites are viable options however the factors that need careful consideration are access and egress to the site, traffic flows and safety of the crews. Evidence was provided to the Public Inquiry of the importance of these aspects and the challenges in mitigating these risks with one-way systems or hurry-signals/traffic lights.
- If a dual or multi-site solution were being explored, then distance to and from sites, as well as additional journeys an out of town option would generate, needs to be considered.
- Consideration also needs to be given to the amount of space that is available on any site for the segregation and manoeuvring of emergency vehicles adjacent the healthcare buildings. Out of town options have provided more opportunities for this than urban settings, owing to additional availability of space.
- A development of this scale presents clear constraints, challenges, and infrastructure needs as well as opportunities (and opportunity cost) in relation to sites released
- Any development also has to follow due regulatory process. As experience in this project shows, there is no straightforward site from an infrastructure or planning point of view. Each site has its unique challenges which will need to be overcome before development proceeds.
- Ancillary infrastructure is normally proportionate to the scale of any development proposal; consequently, there may be potential to reduce planned mitigations if the impacts are lower, such as for transport infrastructure.
- The Minister for Environment may decide that Planning Inquiries are not necessary where development is on an existing hospital site (and the proposed development is of a similar or smaller scale) or where a Planning Permission is already in place.

- There are milestones and overall timelines that are typically required for any large construction project, and will be applicable to proposals for new hospital facilities whether at Overdale or Gloucester Street or a hybrid scheme.
- Time needs to be allowed for political decision making, such as Decisions in the States Assembly. If required, also for any revised project mandate and funding.
- The fastest solution to deliver would be the developed solution for Overdale.
- The slowest solution to deliver would be a redevelopment at Gloucester Street, using only land currently within public ownership.
- The current commercial model with a DDP was agreed at a different time with a different market outlook.
- The project has been a clinically led one, with the design team responding to the clinical user requirements and the contractor looking at the logistical approach and supply chain.
- The shape of the team will depend on the type of scheme and the chosen approach. However, there should be a Senior Responsible Owner assigned and the Project Director role should be filled by an employee of the Government of Jersey.
- Given the nature of the project, it is always likely that a blend of local and off-island skills and knowledge will be required; the larger the scheme, the more likely that there will be a larger requirement from off-island resources.
- Conversely, a smaller or phased solution will enable larger involvement and buy-in from local contractors and construction professionals where there is capacity.
- Members of the Jersey Construction Council were in favour of increased opportunities to become involved in the design and construction of new healthcare facilities that would also support increased training and educational opportunities for those seeking careers in the construction industry.
- Any project of this size needs a Government client team function, to oversee and control the work of the contractors or consultants. GoJ does not carry this level of capacity in house and therefore there is a need for client functions to also be understood and funded, to ensure GoJ interests are protected.
- The new government also intends to play a greater and more inclusive role in island wide construction planning, and it is anticipated that, in future, there may



be significant opportunity to programme other projects more accurately in order to provide a more consistent overall development profile, helping to balance supply and demand in the construction market and consequent pricing.

- The Public Finance Manual does require all procurement to deliver Value for Money; this is normally demonstrated through a tender process.
- GoJ can and sometimes does request to use UK Government contractual frameworks and this is appropriate and possible in certain circumstances. However, this does not normally obviate a tender process.

In the following sections of the report, further information is provided regarding the current condition of healthcare facilities and the steps that have been agreed to manage extant and emerging risks as well as measures that are currently being taken to improve and transform Jersey's health service.

## **Section 4: The State of The Existing Hospital Including an Assessment of the Measures Required to Ensure That They Remain Fit for Purpose**

The Review heard that a large proportion of the existing hospital infrastructure is ageing and reaching operational failure. This has long been recognised and the reason that there have been several iterations of hospital project seeking to replace it. Not only has the ageing infrastructure not been replaced, maintenance spend has been minimised to avoid abortive cost.

In 2019, a master condition survey (six facet survey) was undertaken that identified £83 million to upgrade as far as is possible existing infrastructure. The department is assigned an annual budget of £5 million which is managed on a risk prioritisation basis, balancing against clinical requirements and accessibility to operational areas.

There are a number of areas where there is a single point of failure, and it remains challenging to manage these risks. These are in mechanical /electrical services, the building fabric, including water and fire compliance which presents a daily challenge to infection prevention and control. Managing these risks also contributes to current operational costs.

The Review heard directly about the additional health and safety measures and constraints associated with construction works on live healthcare sites and that this can lead to increased pricing or a reluctance to undertake works when other opportunities might be available. They are also factors in any redevelopment of the existing Jersey General Hospital site.

It is absolutely imperative that existing Jersey General Hospital site infrastructure at Gloucester Street remains safe whilst the various developments are constructed. To this end, additional funding should be (and is currently being) made readily available to utilise in the event that it is required.

It was further agreed that a working group should be formed to identify interim solutions that could improve current working conditions and patient outcomes.

## **Section 5: Measures Currently Being Undertaken to Improve and Transform Jersey's Health Service**

Provided by Minister for Health and Social Services, Karen Wilson:

The general direction of travel in health economies internationally is ensuring hospital-based care is of high quality and focused on delivering specialist care and treatment. Alongside this, developments in primary care and in the community are supporting the delivery of person-centred care, focusing on early intervention, prevention and self-care.

The original intention behind the JCM was to make progress towards a more community based/primary care focused model of service but is currently paused following concerns raised by the public about the delivery of such an approach for Jersey.

In this context the new hospital facilities need to be flexible enough to deliver health and care services in the context of any future healthcare model. The healthcare model will inform the brief for new healthcare facilities and will be constantly evolving.

## **Section 6: Identification and Examination of Options to Permit Both Future Affordability and Delivery of Appropriately Provisioned Hospital Solution**

The Review, in considering the current proposal to build the new hospital as currently configured at Overdale, has concluded that this is unachievable within the original £620 million envelope established to fund the contracted elements of the project. The current cost plan is estimating that costs will be £70 million to £115 million in excess of the figures provided in the OBC. This scenario is as a result of global economic circumstances.

It would be possible to return to the States Assembly for a larger capital bid, however given current global economic circumstances, there would remain a risk that an even larger sum would be required and there would have to be significant contingencies. Seeking any approval of a new funding envelope is likely to take in the order of three months. Since the current contractual relationship with the DDP is predicated on one large construction contract, with rapid site delivery, the current PCSA with the DDP has been brought to a conclusion at the end of RIBA3.

It was similarly concluded that a relocation of the Overdale proposal as currently configured to the existing hospital site at Gloucester Street was similarly unaffordable since any benefits achieved from reduced ancillary works will be equivalent to the costs of working within a constrained town centre setting. There would also be increased clinical and operational risks from development of an existing hospital site. These can be significantly mitigated but will continue to impact services users and providers as well as increase cost. There will also be additional design costs and larger abortive costs from the current expenditure to date. From a practical perspective, it is also going to be more challenging to mitigate environmental challenges of any designs since even with a reduced scope, volumetric requirements would still be larger than the Future Hospital proposals that twice were not able to secure a successful Planning determination. It is therefore concluded that relocation of the currently configured proposals to Gloucester Street would not be affordable and are unachievable from a space planning perspective.

Both of these options have therefore been discounted from further consideration.

## **Further Options for Consideration:**

The Review has identified the following further options for consideration with a view to increasing affordability and still achieving the new modern healthcare facilities for Jersey. In line with the terms of reference, the Review has not sought to reopen the site assessment process to an extensive list of sites across the Island. This is because this approach would create a significant delay in progress and almost certainly would not enable the delivery of a new hospital within the required timescale. The review options were therefore limited to permutations around the existing Jersey General Hospital site including nearby sites in Government of Jersey ownership and the Overdale site, as designated as a site for a new hospital for Jersey in the Bridging Island Plan 2022-2025<sup>7</sup>.

In considering the options it was determined that two variants of a reduced scheme at Overdale should be explored. All of the options below are able to deliver safe clinical and operational services.

**Option 1A: A reduced scope hospital at Overdale** – Develop Overdale as the sole Hospital site with a significant reduction in designed space allocation.

**Option 1B: A reduced scope hospital at Overdale** – Develop Overdale as the sole Hospital site with a significant reduction in designed space allocation and in a phased manner.

**Option 2: Gloucester Street with a scope reduced from the current scheme** – Redevelop the existing hospital site at Gloucester Street with a similar reduction in designed space allocation as Option 1, and in a phased manner, whilst maintaining existing hospital services as work proceeds.

**Option 3: Gloucester Street and Kensington Place with a scope reduced from the current scheme** – To redevelop the existing hospital site at Gloucester Street and the adjacent Kensington place site with a similar reduction in designed space allocation as Option 1, and in a phased manner, whilst maintaining existing hospital services as work proceeds.

**Option 4: A multi-site scheme, delivered across Overdale and Gloucester Street/Kensington Place sites** – A hybrid, phased option developing hospital services over more than one site with a similar reduction in designed space

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<sup>7</sup> [Bridging Island Plan 2022 to 2025 \(gov.je\)](https://www.gov.je/BridgingIslandPlan2022to2025)

allocation as Option 1. This would most likely be Overdale and Gloucester St/Kensington Place. Grouping of services (that could be combined) could be:

- Emergency and In-patient services with associated diagnostics, Intensive Treatment Unit,
- Intermediate Care Beds and Rehabilitation
- Urgent Treatment Centre, Ambulatory care and Outpatients (and possibly GP services)
- Elective In-patient and Day Surgery
- Mental Health services would also be established at Overdale or at a separate standalone location in line with best clinical practice

The Review has identified and appraised options in line with the criteria derived from HM Treasury Green Book critical success factors outlined on page 12. Within the constraints of these criteria, the Review considered a number of other important factors that should be taken into account:

A. In terms of Strategic Fit, it is important to design a facility that:

1. Delivers an advantageous solution in terms of hospital design and functionality both now and into the future, embracing opportunities for modernisation of clinical practice where appropriate.
2. Does not compromise on clinical safety.

B. In terms of potential value for money and supplier capacity and capability, ensure the best value team assembly and opportunities for Islanders, permitting where possible any benefits of greater market competition and past project design expenditure are retained. It must be noted that previous false starts on the project will have damaged the Island's reputation in the supplier market, and care should be taken to appropriately engage local and international markets to identify the widest pool of potential suppliers and achieve the best value for money, within the procurement parameters set out in the Public Finances Manual.

C. In terms of potential achievability, timely hospital delivery and commissioning within affordability constraints. Ministers have provided clear direction to the Review that construction of new facilities should commence within the current electoral term. This means that some options are likely to perform less well against the achievability criterion, given that the overall

programme is likely to be elongated as design completion will take a greater amount of time, and that, dependent on the procurement approach, further tender activity may be required that would mean that construction would be less likely to commence within the current electoral term.

- D. There is no contemplation of not working to healthcare planning standards or designs that have not been demonstrated to be clinically or operationally safe, generally codified through Health Building Notes (**HBN**) and Health Technical Memoranda (**HTM**). All options require a reduction to the currently drawn proposals to achieve affordability and a hybrid solution necessitates a division of services between sites. Whilst the Review has heard from health workers and senior operational managers and clinicians, there is no overriding consensus on those areas or departments that should be reduced or removed from current proposals or the optimal division between sites. Further consultations with healthcare workers and senior clinicians is therefore essential and will take at least one month.
  
- E. Work could be undertaken to identify opportunities and maximise advancements in digital health care services that have taken place since the writing of the Functional Brief and as a consequence of Covid. Investment in these technologies needs to be appraised with a cost/benefit approach, and further consultation is required with clinical and operational teams in HCS to establish the extent to which these could be incorporated into any revised Functional Brief and associated design proposals. Notwithstanding, review participants agreed that these could contribute to a 2.5 to 5% capital cost reduction, estimated to be circa £15 to £30 million at today's prices. However, in order to realise these kinds of savings, these figures will need to be validated alongside an achievable plan to realise Jersey' digital strategy ambitions, with a dedicated team where appropriate.
  
- F. Evidence presented by clinicians arising from experience of the delivery of mental health services suggested that the Functional Brief in relation to Mental Health should be reviewed. It may be more appropriate that acute mental health services are co-located with other similar services. This is a

significant amendment from the current Functional Brief and should be addressed by a separate project team and come forward as a separate programme of works.

A high-level narrative bringing out the key differences between the performance of options against each criterion follows. A RAG-rated summary of how options performed relative to each other can be found in the table on page 51.

## **Application of Critical Success Factors to Options**

### **Option 1A: A Reduced Scope Hospital At Overdale**

Develop Overdale as the sole hospital site with a significant reduction in designed space allocation and no phasing.

<p>Deliverability/ Achievability</p>	<p>Allows for advantages in relation to earlier completion estimated to be within 5-6 years given extant planning permissions, albeit these are likely to be subject to a revised planning application to an existing consent.</p> <p>Even descoped, the scale of the project is likely to remain an issue to some of the stakeholders interviewed that remains a challenge to deliverability. These views also reflected those aired at the Public Inquiry for the new hospital at Overdale, still available on the planning portal.</p>
<p>Affordability</p>	<p>The reduction in floor space will have some impact on cost but with little opportunity to eliminate costs associated the extent of neighbouring purchase/compulsory purchase and ancillary infrastructure requirements associated with a single concentrated site. These are estimated at £50 million at today's prices. These could be offset by the financial benefit from the sale of the Jersey General Hospital site in due course.</p> <p>This scheme remains substantial and considered to be in excess of £500 million at today's prices, there may be reduced opportunities for Island-based contractors to tender for this work without reliance on International Contractors. This in turn has the effect of reducing market competition that could achieve a 5 to 10% capital cost reduction although it is recognised that diversification could increase cost and risk, if not suitably managed.</p>



	<p>Funding would be committed on any appointment, limiting potential for disaggregation or mitigation if financial conditions are unfavourable.</p> <p>Benefit will be derived from some of the work previously undertaken, particularly in relation to topographical and services surveys at Overdale and departmental briefing, planning and layouts.</p>
Suitability	<p>The most significant opportunities with respect to rationalising scope for a single-site development could include, but are not limited to, reduced clinical space due to digital health initiatives, reduced provision for facilities management, or retaining kitchen, sterile stores and other ancillary services off the main site.</p> <p>This will allow a re-design with a reduced footprint but only if modernised clinical practice is embraced with a consequential reduction in clinical space requirement</p> <p>Careful consideration will however need to be given to ensure that the specified remain compliant with best clinical practice and appropriate in relation to required clinical adjacencies. This can only be achieved following intense clinical consultation, over a period of at least four weeks.</p>
Social Value	<p>Neighbourhood impacts from intensity of development on a single site Being delivered in one phase, there is little scope to remove ancillary infrastructure (especially proposed access arrangements) that representations have suggested are unacceptable. These views also reflected those aired at the Public Inquiry for the new hospital at Overdale, still available on the planning portal.</p>
Key risks	<p>The delivery of healthcare facilities will continue to be provided at Jersey General Hospital or the former Les Quennevais School whilst work proceeds.</p>

## Option 1B: A Reduced Scope Hospital At Overdale Delivered In A Phased Manner

Develop Overdale as the sole Hospital site with a significant reduction in designed space allocation and in a phased manner.

<p>Deliverability/ Achievability</p>	<p>Allows for advantages in relation to earlier completion estimated to be within 6-7 years given extant planning permissions, albeit these are likely to be subject to a revised planning application to an existing consent.</p> <p>One site will be more constrained than two, meaning any subsequent phases will be harder to achieve than facilities across separate sites.</p> <p>Even descoped, the scale of the project is likely to remain an issue to some of the stakeholders interviewed that remains a challenge to deliverability. These views also reflected those aired at the Public Inquiry for the new hospital at Overdale, still available on the planning portal.</p>
<p>Affordability</p>	<p>The reduction in floor space will have some impact on cost. With further time permitted for design, there may be an opportunity to eliminate costs associated the extent of neighbouring purchase/compulsory purchase and ancillary infrastructure requirements associated with a single concentrated site. These are estimated at £50 million at today's prices. These could be offset by the financial benefit from the sale of the Jersey General hospital site in due course.</p> <p>Current designs would need to be amended to enable the scheme to be phased although each portion would remain significant at £250 million and overall, in excess of £500 million at today's prices. Local contractor could become more significant partners at this scale, which could in turn have the effect of reducing market competition that could achieve a 5 to 10% capital cost reduction.</p> <p>Funding would be committed on any appointment that would be in a phased manner enabling mitigation if financial conditions are unfavourable.</p>

	<p>Benefit will be derived from some of the work previously undertaken, particularly in relation to topographical and services surveys at Overdale and departmental briefing, planning and layouts.</p>
Suitability	<p>The most significant opportunities with respect to rationalising scope for a single-site development could include, but are not limited to, reduced clinical space due to digital health initiatives, reduced provision for facilities management, or retaining kitchen, sterile stores and other ancillary services off the main site.</p> <p>This will allow a re-design with a reduced footprint but only if modernised clinical practice is embraced with a consequential reduction in clinical space requirement</p> <p>Careful consideration will however need to be given to ensure that the specified remain compliant with best clinical practice and appropriate in relation to required clinical adjacencies. This can only be achieved following intense clinical consultation, over a period of at least four weeks.</p>
Social Value	<p>Neighbourhood impacts from intensity of development on a single site</p>
Key risks	<p>The delivery of healthcare facilities will continue to be provided at Jersey General Hospital or the former Les Quennevais School whilst work proceeds. Following the first phase, subsequent phases will need to be constructed on a more constrained site with potential for disrupting healthcare facilities. It is highly likely there will be a need for separate energy centres and plant rooms that will be spatially inefficient and less cost effective, further constraining the site.</p> <p>There is increased risk in and therefore less potential for overlapping the phasing, if there are separate contracting teams working on a relatively constrained site.</p> <p>Further design considerations and impact assessments do not establish a scheme with reduced ancillary infrastructure or reduced neighbouring purchase/compulsory purchase associated with a single concentrated site. These are estimated at £50 million at today's prices.</p>

## Option 2: Gloucester Street With A Scope Reduced From The Current Scheme

Redevelop the existing hospital site at Gloucester Street with a similar reduction in designed space allocation as Option 1, and in a phased manner, whilst maintaining existing hospital services as work proceeds.

<p>Deliverability Achievability</p>	<p>Requires new planning consents that are likely to include the requirement for Planning Inquiry with consequential time delays compared to other options.</p> <p>It has a number of disadvantages in relation to earlier completion particularly with a work phasing to allow services to continue in adjacent areas and a requirement for new planning application. Completion through this option is estimated to take 7-8 years and is at risk of not commencing within one electoral term, a requirement for any feasible option.</p> <p>Even descoped, the scale of the project is likely to remain an issue to some of the stakeholders interviewed that remains a challenge to deliverability. These views also reflected those aired at the Public Inquiry for the new hospital at Gloucester Street, still available on the planning portal.</p>
<p>Affordability</p>	<p>The reduction in floor space will have some impact on cost but with little opportunity to eliminate costs relating to the environmental impact on the buildings adjacent to Gloucester St and reduced the extent of neighbouring purchase/ compulsory purchase given that all services remain on a very constrained town centre site.</p> <p>The scheme remains substantial and considered to be in excess of £500 million at today's prices, there may be reduced opportunities for Island based contractors to tender for this work without reliance on International Contractors. This in turn has the effect of reducing market competition. Some benefits will be derived from some of the design development work previously undertaken, in relation to individual department and room requirements.</p> <p>Funding would be committed on any appointment, limiting potential for disaggregation or mitigation if financial conditions are unfavourable.</p>

Suitability	<p>The most significant opportunities with respect to rationalising scope for a single-site development could include, but are not limited to, reduced clinical space due to digital health initiatives, reduced provision for facilities management, or retaining kitchen, sterile stores and other ancillary services off the main site.</p> <p>Allow for a re-design with a reduced footprint but with functionality constraints given the scale of building still to be undertaken. Also modernised clinical practice will need to be embraced to allow a consequential reduction in clinical space requirement.</p> <p>Careful consideration will however need to be given to ensure that the specified remain compliant with best clinical practice and appropriate in relation to required clinical adjacencies. This can only be achieved following intense clinical consultation, over a period of at least four weeks.</p>
Social Value	Neighborhood impacts from intensity of development on a single site
Key risks	<p>Does not allow for the continued use of Gloucester St Hospital for the delivery of acute services whilst work proceeds and a reduced or alternative service provision must be put in place whilst work proceeds on a phased basis.</p> <p>Increased risk from the likely requirement for a Planning Inquiry process</p> <p>Healthcare workers and clinicians have not supported previous iterations of hospital project at Gloucester Street</p>

### Option 3: Gloucester Street And Kensington Place With A Scope Reduced From The Current Scheme

To redevelop the existing hospital site at Gloucester Street and the adjacent Kensington Place site with a similar reduction in designed space allocation as Option 1, and in a phased manner, whilst maintaining existing hospital services as work proceeds.

<p>Achievability/ Deliverability</p>	<p>Requires new planning consents with consequential time delays.</p> <p>It has a number of disadvantages in relation to earlier completion particularly with a sequential work phasing to allow services to continue in adjacent areas and a requirement for new planning application. Completion through this option is estimated to take 6 -7 years and is at risk of not commencing within one electoral term, a requirement for any feasible option.</p> <p>Even descoped, the scale of the project is likely to remain an issue to some of the stakeholders interviewed that remains a challenge to deliverability. These views also reflected those aired at the Public Inquiry for the new hospital at Gloucester Street, still available on the planning portal.</p>
<p>Affordability</p>	<p>The reduction in floor space will have some impact on cost but with little opportunity to reduce the extent of neighbouring purchase/ compulsory purchase given that all services remain on a constrained town centre site.</p> <p>The scheme remains substantial and considered to be in excess of £500 million at today's prices, there may be reduced opportunities for Island based contractors to tender for this work without reliance on International Contractors. This in turn has the effect of reducing market competition. Some benefits will be derived from some of the previous design development work previously undertaken, but only in relation to individual department and room requirements.</p> <p>Funding would be committed on any appointment, limiting potential for disaggregation or mitigation if financial conditions are unfavourable.</p>
<p>Suitability</p>	<p>The most significant opportunities with respect to rationalising scope for a single-site development could include, but are not limited to, reduced clinical space due to digital health initiatives,</p>

	<p>reduced provision for facilities management, or retaining kitchen, sterile stores and other ancillary services off the main site.</p> <p>Allow for a re-design with a reduced footprint but with functionality constraints given the scale of building still to be undertaken. Also modernised clinical practice will need to be embraced to allow a consequential reduction in clinical space requirement</p> <p>Careful consideration will however need to be given to ensure that the specified remain compliant with best clinical practice and appropriate in relation to required clinical adjacencies. This can only be achieved following intense clinical consultation, over a period of at least four weeks.</p>
Social Value	<p>Neighborhood impacts from intensity of development on a single site</p>
Key risks	<p>Does not allow for the total use of Jersey General Hospital for the delivery of acute services whilst work proceeds albeit the use of Kensington Place allows for phasing and a reduced or alternative service provision must be put in place whilst work proceeds.</p> <p>Increased risk from the likely requirement for a Planning Inquiry process.</p> <p>Healthcare workers and clinicians have not supported previous iterations of hospital project at Gloucester Street</p>

#### Option 4: A Multi-Site Scheme, Delivered Across Overdale And Gloucester Street/Kensington Place Sites

A hybrid, phased option developing hospital services over more than one site with a similar reduction in designed space allocation as Option 1. This would most likely be Overdale and Gloucester St/Kensington Place. Grouping of services (that could be combined) could be:

- Emergency and In-patient services with associated diagnostics, Intensive Treatment Unit,
- Intermediate Care Beds and Rehabilitation
- Urgent Treatment Centre, Ambulatory care and Outpatients (and possibly GP services)
- Elective In-patient and Day Surgery
- Mental Health services would also be established at Overdale or at a separate standalone location in line with best clinical practice.

<p>Deliverability/ Achievability</p>	<p>A revised planning application to an existing consent will be required for Overdale and a new application for Gloucester Road/Kensington Place. However, the scale of the new facilities could be conceived to be consistent with surroundings and minimise impacts and may not necessitate a Public Inquiry.</p> <p>Allows for advantages in relation to earlier phased completion with Mental Health facilities estimated to be completed within 3 years if desirable, Overdale and Kensington Place within 5-6 years and the remaining phase of the scheme at Gloucester Road within 8 years</p> <p>Less intensive development of two larger sites allows for greater expansion to both sites and provides areas where future construction using Modern Methods would be viable enabling more future flexibility (and potentially less requirement for future-proofing from day one)</p> <p>The scale of the project would be more in keeping with other capital projects and so may prove more acceptable, increasing the deliverability and achievability of the scheme.</p>
<p>Affordability</p>	<p>The reduction in floor space will have some impact on costs but this option also creates a substantial opportunity to eliminate costs associated with the extent of neighbouring purchase/ compulsory</p>



	<p>purchase and ancillary infrastructure requirements, associated with a single, concentrated site.</p> <p>The scheme can be broken into separate phases valued between £50 and £200 million at today’s prices, there may be greater opportunities for greater market competition and a reduced cost achieving a total of 5 to 10% capital cost reduction.</p> <p>It is likely that there would be an increase in Operational and Staffing Costs within a hybrid model. This would arise from duplication of some services across the different sites. This is however an existing issue, outside the scope of the review and may be mitigated somewhat by the new and fit-for-purpose healthcare, knowledge and education facilities.</p> <p>Benefits will continue to be derived from some of the previous design development work previously undertaken, particularly in relation to topographical and services surveys at Overdale and Gloucester Street and previously agreed department and room design details.</p> <p>Funding would be committed on any appointment that would be in a phased manner enabling mitigation if financial conditions are unfavourable.</p>
Suitability	<p>Distributes services with a consequential impact on patient flow and staff efficiency. This option allows a re-design of clinical space with a reduced cost footprint but only if modernised clinical practice is embraced with a consequential reduction in clinical space requirement.</p> <p>There will be a degree of duplication in some infrastructure, particularly diagnostics facilities and operational support services, however in many instances, this equipment is already duplicated (duty and standby), it may be appropriate and provide resilience, in comparison to the potential costs savings that could be achieved.</p> <p>Careful consideration will however need to be given to ensure that the specified services identified for each site remain compliant with best clinical practice and appropriate in relation to required clinical adjacencies.</p>

	<p>A multi-site phased solution provides much greater flexibility in the future to have such a facility to move services into and out of in order to allow multiple projects to occur simultaneously.</p> <p>Less intensive development permits future areas for expansion.</p>
Social Value	<p>Reduced long-term neighborhood impacts owing to reduced intensity of development over separate sites; temporary impacts over a larger area and impacting more neighbours arising from multiple sites.</p>
Key risks	<p>Allows for the continued use of the Jersey General Hospital for the delivery of acute services whilst work at other, possibly adjacent sites proceeds, with work commencing in existing, operational hospital buildings only following decant to the other locations.</p> <p>Any multi-site option may increase clinical operational risk to an extent by having specialities and equipment dispersed over a greater number of locations. This risk must be mitigated through Operational Policies.</p> <p>Healthcare workers and clinicians did not previously support the dual site solution. However, the hybrid solution is not the same (i.e. complete new build rather than combined with refurbishment/redevelopment of JGH site). Further, Covid has changed healthcare requirements and digital healthcare solutions are evolving that would further support this model.</p>

**Summary of Options Appraisal – Relative comparison of options – all options can deliver clinically and operationally safe healthcare facilities**

**It should be noted that the current Overdale Scheme and that scheme transposed to Gloucester Street are unaffordable and the latter, also unachievable. Therefore a detailed analysis has not been prepared for these schemes.**

	<b>OPTION 1a</b>	<b>OPTION 1b</b>	<b>OPTION 2</b>	<b>OPTION 3</b>	<b>OPTION 4</b>
<b>LOCATION</b>	Overdale	Overdale	JGH	JGH and Kensington Place	Overdale, Kensington Place and JGH
<b>SCOPE</b>	Reduced scope	Reduced scope	Reduced scope	Reduced scope	Reduced scope
<b>PHASING</b>	Main building single award	Phased	Phased (by necessity)	Phased (by necessity)	Phased (by necessity)
<b>DESIGN</b>	Maximise use of existing designs allowing for some redesign	Maximise use of existing design and allowing for greater redesign	Increased time allocated for design (by necessity)	Increased time allocated for design (by necessity)	Increased time allocated for design (by necessity)
<b>Deliverability/Achievability</b>					
o Time	24 months to design completion - limited approvals required from States Assembly - may require amended (reduced) planning application - limited time required for redesign	28 months to design completion - some approvals from States Assembly - may require amended (reduced) planning application - reasonable time required for redesign to enable phased solution	40 months to design completion - new approvals from States Assembly - new planning application and public inquiry - significant time required for redesign	40 months to design completion - new approvals from States Assembly - new planning application and public inquiry - significant time required for redesign	24 – 36 months to design completion - new approvals from States Assembly - will require amended (reduced) planning application - limited time required for redesign

o Local involvement and engagement	Representations and experience suggest that one healthcare facilities project and predominantly one building does not resonate with the public and it is hard to get buy-in	Representations and experience suggest that there might be more buy in to deliver healthcare facilities in a phased manner.	Representations and experience suggest that one healthcare facilities project and predominantly one building does not resonate with the public and it is hard to get buy-in	Representations and experience suggest that one healthcare facilities project and predominantly one building does not resonate with the public and it is hard to get buy-in	Representations and experience suggest that it might be more achievable to deliver several smaller healthcare facilities in a phased manner over more than one site.
<b>Affordability</b>					
o Capital Cost	Current cost exceeds OBC approved level	Smaller development will reduce the cost below OBC	Smaller development will reduce the cost below OBC	Smaller development will reduce the cost below OBC	Smaller development will reduce the cost below OBC
o Global economic circumstances and risks	On appointment of the main works contract, the island is committed to full project costs with limited scope for mitigation. There will be a price premium for contracting partners to take inflationary risks at this time (even assuming that they are willing to do so).	Phased solution would mean smaller commitment at each of the phases reducing risk in current global economic circumstances. There will be potential for reduced price premium for inflationary risks for later phases.	On appointment of the main works contract, the island is committed to full project costs with limited scope for mitigation. There will be a price premium for contracting partners to take inflationary risks at this time (even assuming that they are willing to do so).	On appointment of the main works contract, the island is committed to full project costs with limited scope for mitigation. There will be a price premium for contracting partners to take inflationary risks at this time (even assuming that they are willing to do so).	Phased solution would mean smaller commitment at each of the phases reducing risk in current global economic circumstances. There will be potential for reduced price premium for inflationary risks for later phases.
O Financing options	Financing options likely to be different to OBC owing to global economic circumstances. It is still achievable to provide funding but this would	Increased potential to mitigate impact on reserves owing to phased nature of spend	Financing options likely to be different to OBC owing to global economic circumstances. It is still achievable to provide funding but this would	Financing options likely to be different to OBC owing to global economic circumstances. It is still achievable to provide funding but this would	Increased potential to mitigate impact on reserves owing to phased nature and potential reduced extent of spend

	have increased impact on reserves		have increased impact on reserves	have increased impact on reserves	
<b>Suitability</b>					
o Scope and functional brief	Current Functional Brief could be delivered in part. Opportunity to reflect more current healthcare requirements including learning from Covid	Current Functional Brief could be delivered in part but over longer period. Opportunity to reflect more current healthcare requirements including learning from Covid.	Current Functional Brief could be delivered in part but may not achieve all adjacencies Opportunity to reflect more current healthcare requirements including learning from Covid	Current Functional Brief could be delivered in part but over longer period. Opportunity to reflect more current healthcare requirements including learning from Covid.	Current Functional Brief could be delivered in part but may not achieve all adjacencies Opportunity to reflect more current healthcare requirements including learning from Covid
o Clinical and operational need	Could be met by prioritising services most in need of modern facilities	Could be met by prioritising services most in need of modern facilities but over a longer timeframe	Phasing would be determined by existing location rather than need and over a longer timeframe	Phasing would be determined by existing location rather than need and over a longer timeframe	Could be met by prioritising services most in need of modern facilities but over a longer timeframe
o Clinical and operational risk	New facilities would be to guidelines and standards. Reduced requirement for works adjacent to or within operational areas Less resilience from separation of sites but single site provides greater resilience for staffing Ancillary infrastructure does mitigate operational risk in relation to highway infrastructure.	New facilities would be to guidelines and standards. Some requirement for works adjacent to operational areas. Where viable, prioritisation should be given to those services currently operating at most clinical risk. In the longer term, less resilience from separation of sites but greater resilience of staffing	New facilities meet current guidelines and standards. Increased requirement for works adjacent or within operational areas. In the longer term, less resilience from separation of sites but greater resilience for staffing. Ancillary infrastructure does mitigate operational risk in relation to highway	New facilities meet current guidelines and standards. Increased requirement for works adjacent or within operational areas. In the longer term, less resilience from separation of sites but greater resilience for staffing. Ancillary infrastructure does mitigate operational risk in relation to highway	New facilities would meet current guidelines and standards. Some requirement for works adjacent to operational areas. Where viable prioritisation should be given to those services currently operating at most clinical risk. In the longer term, more resilience from separation of sites but less resilience for staffing

		(albeit less in the shorter term) Ancillary infrastructure does mitigate operational risk in relation to highway infrastructure.	infrastructure (current highways) although less area for drop off and emergency bays.	infrastructure (current highways) although less area for drop off and emergency bays.	(albeit less in the shorter term). Ancillary infrastructure must be fit-for-purpose and enable safe access and egress of emergency services. Increased space should enable appropriate drop off and emergency bays.
<b>Social Value</b>					
o Local economic impacts	Large off-island contractors more likely to use off-island supply chains, reducing economic benefit to the island. There will always be some requirement for off-island expertise.	Increased potential for increased proportion of island supply chains and economic benefits There will always be some requirement for off-island expertise	Large off-island contractors more likely to use off-island supply chains, reducing economic benefit to the island. There will always be some requirement for off-island expertise.	Large off-island contractors more likely to use off-island supply chains, reducing economic benefit to the island. There will always be some requirement for off-island expertise.	Largest potential for increased proportion of island supply chains to be used bringing economic benefits where there is capacity. There will always be some requirement for off-island expertise
o Social, economic and environmental costs, including proportionality of ancillary infrastructure	Islanders have made representations that the social and environmental costs of all healthcare infrastructure on one site are significant, including the ancillary infrastructure	Islanders have made representations that the social and environmental costs of all healthcare infrastructure on one site are significant, including the ancillary infrastructure.	Islanders have made representations that the social and environmental costs of all healthcare infrastructure on one site are significant, including the ancillary infrastructure	Islanders have made representations that the social and environmental costs of all healthcare infrastructure on one site are significant, including the ancillary infrastructure. This might be reduced by further optimisation of designs	Separating services over more than one site and in smaller buildings should permit a reduction in environmental impact, including ancillary infrastructure, albeit it will need two sets and areas.

<p>O Benefits and risks</p>	<p>Significant benefit of new healthcare facilities in one location delivered in shortest timeline with extant planning permissions. It may be difficult to attract a supply chain again owing to long history of the project but could be mitigated by demonstration of determination of government to ensure physical works start in this administration.</p>	<p>Significant benefit of new healthcare facilities in one location delivered in shortest timeline with extant planning permissions. It may be easier to attract a supply chain given the long history of the project since it would be for a different scale and could be mitigated by demonstration of determination of government to ensure physical works start in this administration.</p>	<p>Significant benefit of new healthcare facilities in one location although delivered over a longer timeframe. Planning risk from no extant planning permission. Risk arising from undertaking significant enabling works within, and adjacent to, operational healthcare site. It may be difficult to attract a supply chain again owing to long history of the project but could be mitigated by demonstration of determination of government to ensure physical works start in this administration.</p>	<p>Significant benefit of new healthcare facilities in one location although delivered over a longer timeframe. Planning risk from no extant planning permission. Risk arising from undertaking significant enabling works within, and adjacent to, operational healthcare site. It may be difficult to attract a supply chain again owing to long history of the project but could be mitigated by demonstration of determination of government to ensure physical works start in this administration.</p>	<p>Significant benefit of new healthcare facilities over several locations with some extant planning permissions, although delivered over a longer timeframe, some prioritised services will be realised earlier. Any amendments need to be carefully considered in the context of the Bridging Island Plan and extant permissions. It may be easier to attract a supply chain given the long history of the project since it would be for a different scale and could be mitigated by demonstration of determination of government to ensure physical works start in this administration.</p>
<p><b>Operations</b></p>					

<p>o Operational costs, including revenue and staffing costs</p>	<p>Operational costs are likely to be lower for one site but will be larger than existing owing to the ventilation and heating standards for modern healthcare facilities.</p>	<p>Operational costs are likely to be lower for one site but will increase owing to phasing and larger than existing owing to the ventilation and heating standards for modern healthcare facilities.</p>	<p>Operational costs are likely to be lower for one site but will increase owing to phasing and larger than existing owing to the ventilation and heating standards for modern healthcare facilities</p>	<p>Operational costs are likely to be lower for one site but will increase owing to phasing and larger than existing owing to the ventilation and heating standards for modern healthcare facilities</p>	<p>Operational costs are likely to be higher over more than one site and will be larger than existing owing to the ventilation and heating standards for modern healthcare facilities.</p>
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**Capacity And Capability**

<p>o Procurement and team assembly</p>	<p>It is very likely that a large proportion of the work would be undertaken by larger external contractors and building professionals owing to the capacity, capability and experience of local organisations. There is increased risk because the project will be reliant on one strong relationship. The benefit is these suppliers are experienced in delivering large healthcare facilities. There is an increased mismatch between island control and the supplier.</p>	<p>If a larger proportion of the works are phased, it is likely that a greater proportion of island contractors and building professionals could have the capacity to undertake the works. Phasing would enable suppliers to gain new capabilities and educational opportunities. There would remain a requirement for some off-island expertise. The capacity of island contractors to deliver the works needs to be explored in the context of a larger public construction works programme. There may need to a</p>	<p>Owing to the interlinked and complex work that would be required to build on JGH with many enabling works, it is more likely that greater volume of external contractors and building professionals would be required to undertake the works. There is increased risk because the project will be reliant on one strong relationship. The benefit is these suppliers are experienced in delivering large healthcare facilities. There is however an increased mismatch</p>	<p>Owing to the interlinked and complex work that would be required to build on JGH with many enabling works, it is more likely that greater volume of external contractors and building professionals would be required to undertake the works. There is increased risk because the project will be reliant on one strong relationship. The benefit is these suppliers are experienced in delivering large healthcare facilities. There is however an increased mismatch</p>	<p>If a larger proportion of the works are phased, it is likely that a greater proportion of island contractors and building professionals could have the capacity to undertake the works. Phasing would enable suppliers to gain new capabilities and educational opportunities. There would remain a requirement for some off-island expertise. The capacity of island contractors to deliver the works needs to be explored in the context of a larger public construction works programme.</p>
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		larger client team to reflect the increased complexity of the supply chain.	between island control and the supplier.	between island control and the supplier.	There may need to a larger client team to reflect the increased complexity of the supply chain.
O Local involvement	Limited involvement means less potential for island supply chain to increase capacity and capability from working on a large capital project and there will be less buy in from this community	Increased involvement means more potential for island supply chain to grow capacity and capability from working on a large capital project and increased potential for buy in from this community	Limited involvement means less potential for island supply chain to increase capacity and capability from working on a large capital project and there will be less buy in from this community	Limited involvement means less potential for island supply chain to increase capacity and capability from working on a large capital project and there will be less buy in from this community	Largest possibility for involvement of island supply chain leading to a greater potential for island supply chain to increase capacity and capability from working on a large capital project and increased potential for buy in from this community
<b>Innovation</b>					
o Opportunities for taking advantage of digital health care,	To maximise benefit from existing proposals, limited time for redesign to increase digital health provision.	Depending on phasing, could enable incorporation of increased digital health provision	Necessity to restart design would permit full incorporation of digital health provision.	Necessity to restart design would permit full incorporation of digital health provision.	Digital solution could address spatial separation of facilities. Could enable incorporation of increased digital health provision.
O MMC (Modern Methods of Construction)	Current design has not been developed to embrace MMC	Smaller development phasing and redesign may complement MMC.	New design may allow MMC. Town centre site will place constraints on level of MMC use.	New design may allow MMC. Town centre site will place constraints on level of MMC use.	Smaller development and new design may allow MMC

## Section 7: Conclusions

When weighing up the available evidence, the Review considered the adoption of a phased option delivered over two or more sites, Overdale and Gloucester Street/Kensington Place, would provide the best opportunity to make the scheme more affordable and appropriate. However, it is challenging in the current uncertain financial climate to give precise figures in relation to the extent of saving that can be achieved.

In addition to being more affordable, to be appropriate, the right services must be delivered in the right place. Consequently, the Review recommends that further, comprehensive consultation should take place with all stakeholders, but especially healthcare staff and clinicians before determining the locations of the different services. Some adjacency of service are absolutely essential and these will provide a 'critical mass' of departments that should stay together.

Additional work will be required to further refine the functional brief agreed as part of the Our Hospital project; an outline of a possible division of delivery location for services that is liable to change following consultation could be:

- Phase A
  - Elective in-patient and day surgery (public and private)
  - Ambulatory care and outpatients
  - The possibility of including some kind of primary care services should not be discounted (could be either phase).
  - Intermediate care services, including rehabilitation
  
- Phase B
  - Urgent Treatment Centre, Emergency and in-patient services and associated diagnostics
  - Intensive Treatment Unit
  - Women's and Children's services
  - Knowledge and Education Centre (could be either phase)

The Review also found that mental health services could be established at a separate standalone location, which could be on the Overdale site, although further work would need to be undertaken to validate this possibility.

Being mindful of past delays and the age and deteriorating condition of the existing hospital facility, the Review recognised that the hybrid phased option, if accepted, should be

progressed at pace and within clearly defined timescales in order to retain public confidence. Ministers have provided clear direction to the Review that construction of new facilities should commence within the current electoral term.

## **Phasing Opportunities**

Although subject to availability and profiling of capital funding, relevant approvals and favourable tendering conditions, the Review would suggest the following phased development programme as a target to be followed:

- Phase 1 – Development of services at Overdale to be commenced on site within 24 months with a 36month construction programme to completion.
- Phase 2A – Development of phase 2 services at Kensington Place to be commenced on site within 36 months with a 36-month construction programme to completion
- Phase 2B – Development of remaining services in part of the current Hospital Site at Gloucester Street adjacent to Kensington Place, following completion of Phase 1 and 2A. This final phase to be commenced on-site within 72 months, with a 24 month construction programme to completion
- A review of the requirements for Mental Health facilities to be commenced immediately and proposals on site within 36 months with a 24-month construction programme to completion

Within these timelines, it may be possible to commence enabling works, subject to planning permission, on each of the phases twelve months in advance of the main schemes.

## **Other Considerations**

It is recognised that within a phased hybrid option, there may be a degree of duplication in some clinical infrastructure which will have revenue implications, for example diagnostics facilities. There will also be increased staffing requirements, depending on the division of any services. However, the duplication of same may be appropriate in comparison to the potential costs savings that could be achieved and in many circumstances, equipment may already be duplicated. Any such comparison would need to be considered as part of a detailed options appraisal as part of the business case process. However, it should be noted that there may be a compelling argument for providing such duplication to ensure additional flexibility and resilience. This the direction of travel for some Health Authorities in the UK and indeed in Northern Ireland.

Appropriate resourcing of current healthcare facilities is recognised to be a global issue, also noted in Northern Ireland. Additional staffing would therefore seem to add to an existing issue. However, there is a reasonable timeframe to fully understand the reasons for current recruitment and retention issues and put in place strategies to attract staff. This is beyond the scope of this review and the hospital project itself, however it is anticipated that new, fit-for-purpose healthcare, knowledge and education facilities, will assist with this existing issue and help to mitigate the risk arising from any additional staffing requirement.

As will be appreciated, the Review has been undertaken in a very constrained timeline. There was a restricted timescale to carry out the Review, but it is hoped these recommendations offer a roadmap to progressing the critically needed and long overdue healthcare facilities for the Island.

Should the Review recommendations be accepted, it is essential that a further, more detailed analysis is undertaken with respect to clinical risk, cost and planning assumptions before any final decisions are ratified.

## **Next Steps**

The next steps that would take approximately three to six months would be:

1. Further consultation with stakeholders, especially healthcare staff on the services that should be provided in any hybrid or phased solution
2. Ensure sufficient funding to minimise clinical and operational risk at JGH
3. Commission review of requirements for mental health facilities to be commenced immediately
4. Ensure an appropriately sized political oversight group is in place that meets regularly and can make effective, timely decisions, in line with the Comptroller and Auditor General's 2017 report on Decision Making: Selecting a Site for the Future Hospital<sup>8</sup>
5. A mandate is prepared, providing an initial project plan, including potential resourcing and timelines.
6. Feasibility studies to convert current designs and proposals into initial proof of concept designs and costings
7. Report and Proposition in the States Assembly for phased or hybrid solution at Overdale and Gloucester Street
8. Development of business case

Identify and secure funding of project through States Assembly and Government Plan processes.

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<sup>8</sup> [Jersey Audit Office](#)

## Acknowledgements

The Ministers and Review group would wish to acknowledge with thanks those who provided assistance in the production of this report

## **Appendices**

- Appendix 1: Stakeholders Interviewed and Evidence Taken as Part of The Review
- Appendix 2: List of Hospitals Visited as Part of The Review and Summary Report Regarding Same
- Appendix 3: The Current Condition Of The Jersey General Hospital And Working On An Operational Healthcare Site
- Appendix 4: Further Information From Our Hospital Project Team And Advisors
- Appendix 5: Applying £804million Overall Capital Costs

## Appendix 1: Stakeholders Interviewed and Evidence Taken as Part of The Review

Those interviewed and written submissions received to be listed:

Subject	Stakeholders
Costs& funding models	Treasurer of the States OHP Head of Finance Business Partnering Director of Treasury & Investment Management Head of Treasury and Investment Management Group Director – Strategic Finance
Costs modelling& confidence in current cost plans	Acting Project Director T&T Cost Consultant
Existing health estate& redevelopment vs refurbishment	HCS Head of Estates
User perspective – Functional brief – evidence base for size and scope& relation to whole models of care& opportunities for scope reduction/delivery off main site& digital strategy	DG HCS OHP Clinical Director Associate Managing Director HCS Medical Director Consultant Cardiologist Consultant Gastroenterologist and Hepatologist Director of Mental Health and Adult Social Care Members of the Clinical and Operational Client Group Members of the Health Workers Panel (11 members)
Islander perspective	Members of the OHP Citizens’ Panel (4 members)
Interpreting the functional brief – needs to scale and comparisons to other hospital builds	Representatives of Llewelyn Davies, OHP Project Architect
Suitability and impact on emergency blue light support& patient transport and logistics around ½ sites etc	Chief Ambulance Officer
Infrastructure requirements – strategic level	DG IHE MACE Project Management Office
Phasing of building at Gloucester St	DG IHE Representatives from J3

Regulation and ancillary infrastructure	DG IHE Group Director Regulation Head of Transport and Infrastructure Head of Liquid Waste
POSH perspective	Connétable and Chief Executive of St Helier
Process – design/planning/programme & Procurement and contracts	Acting Project Director Head of Procurement MACE Project Management Office
Local industry perspective	Managing Director SFE Ltd
Team Assembly	Acting Project Director
Representatives from Jersey Federation of Contractors	Our Hospital Sub-Committee with representatives from Camerons, Jersey Electricity Company, Rowney Sharman, Buesnel Architects, Aston Services Ltd, Normans, 4safety and Geomarine Ltd
Contractor perspective of deliverability and affordability of a new hospital in Jersey	Representatives of RokFCC
Phasing of building at Gloucester St	Future Hospital Technical Lead (M&E)
Contractor perspective of deliverability and affordability of a new hospital in Jersey	Representatives of Laing O'Rourke
Digital Health	Chief Clinical Information Officer
Advisors to the Future Hospital Scrutiny Panel	Representatives from K2 Consultancy, Archus and Currie & Brown
Digital Health	Representatives from Mott Macdonald, OHP Technical Advisors and NEC Site Supervisors
Innovation and digital	Director of Improvement and Innovation

Written submissions:

Email from Laing O'Rourke

Note from IHE Regulation



## **Appendix 2: List of Hospitals Visited as Part of The Review and Summary Report Regarding Same**

### **1. Overview Of Northern Ireland Hospital Visit**

As part of the Government 100-day review of the Our Hospital Project a small group of officers and HCS staff (HCS Medical Director, Associate Managing Director and OHP Acting Project Director) travelled to Northern Ireland to support the Minister for Infrastructure, Tom Binet, who is leading the 100-day review. The group visited a number of best-in-class hospitals that had been delivered as capital projects by teams working to the Principal Expert Adviser. In addition, those hospitals were set up to serve similar population sizes to Jersey's facilities.

### **2. Healthcare Facilities**

All the hospitals visited formed part of the Western Health and Social Care Trust in Northern Ireland:

1. Altnagelvin Hospital Londonderry
2. Northwest Cross-Border Cancer Centre, Londonderry
3. Grangewood Acute Psychiatric Hospital, Londonderry
4. Omagh Hospital and Primary Care Complex, Co Tyrone
5. South West Acute Hospital, Enniskillen

#### **Altnagelvin Hospital**

Altnagelvin is an acute hospital which offers a range of services, including a 24-hour Accident and Emergency Department and is one of Northern Ireland's five designated cancer units. It has 472 inpatient beds and 36 day case beds.

The hospital is currently undergoing a major redevelopment programme, consisting of a phased development with a number of new build extensions already delivered on the site with several phases still planned. The Cancer Centre and north wing ward block being two of the more recent developments. Refurbishment of existing buildings, including the central tower block, has also been undertaken although to deliver less clinically intense activities.

The main hospital building consists of a 12 storey tower block with a number of adjoining new extensions accommodating the outpatient's department, day case unit, medical imaging, theatres, surgical wards, maternity ward, oncology unit, physiotherapy department. There are also separate buildings such as the Renal Unit, Breast Screening Unit, laboratories, and the pharmacy building. All of the main buildings are linked by two main corridors, with segregation achieved on different levels; underground supports the delivery of goods, ground floor level is for visitor traffic and the first floor is utilised for patient transfer

across site. Demonstrating that although a mix of buildings, old and new are in existence, it is still possible to segregate flows and maintain dignity of patients.

The phased redevelopment of the site was possible owing to its out of town location, being originally surrounded by green open areas.

Altnagelvin has been a well-established site for delivering systemic anti-cancer treatment (**SACT**) for over a decade. However, with the recent establishment of a brand new state-of-the-art Cancer Centre on-site, the Trust is now in a privileged position to enable a catchment area consisting of approximately 500,000 residents to avail of both Chemotherapy and Radiotherapy Services closer to home. This is to residents both within Northern Ireland and the Republic of Ireland. Radiotherapy treatments have been provided since 2016 and are delivered five days a week, Monday to Friday.

### **Grangewood**

Grangewood is an acute mental health inpatient unit situated in the central aspect of Gransha Park, an estate on the outskirts of Derry, where each building located on this site is surrounded by significant green open areas.

The new crisis unit provides inpatient acute mental health care, alongside a 24 hour, seven days a week crisis response and home treatment service. Flexibility of care is provided within patients own homes or at the new unit as an inpatient.

Grangewood is a modern, patient-centred facility with 30 beds and single ensuite facilities for service users. There is also a fully operational day care facility providing therapeutic activities, assessment, and many single and group activities such as physical health classes, pottery, art, social, education and employment. There is flexibility within the unit to flex up to 39 beds as required. The unit is 3,500 sqm and was built at a cost of £10.8m and opened in 2012

### **The Omagh Hospital And Primary Care Complex:**

This facility offers Primary Care alongside Ambulatory Care in a unit that opened in June 2017. This development replaced an acute hospital following a reconfiguration of services across the area and at the outset was not a welcomed development due to the loss of the community's local hospital.

Most of the local GP practices moved into the centre and now work alongside each other providing routine and out of hours GP access. They are co-located to the nurse led Minor injuries walk in centre, providing 24 hour access. Major traumas and emergencies are not treated on this site and would be taken to Altnagelvin or South-West Acute Hospital (SWAH). Also adjacent is a Nurse Led cardiac care service, a protocol followed service that assesses

and triages patients with suspected cardiac problems, referring only those patients with a true cardiac concern to the main hospital centre.

A large number of varied Outpatients Clinics are delivered onsite, with a dedicated Women's Health centre and sexual health clinic. In addition, there is also a Mental Health outpatient service and a 16 station renal dialysis satellite unit.

Three theatres provide a range of day case surgery, adjacent to an endoscopy unit, with 22 recovery beds for patients' recuperation. Transfer rates (into the main hospital site) as a result of failed day cases or intraoperative complications are monitored and are low.

There are two inpatient wards providing 40 single ensuite bedrooms, delivering Palliative Care and Rehabilitation. The rehabilitation beds have strict admission criteria with the routine length of stay being 14 days.

This was a £110m development built in 2017 at a design size of 20,285 sqm.

### **The South West Acute Hospital (SWAH):**

This relatively new hospital is situated in Enniskillen and was opened in June 2012, with patients transferring from the old Erne Hospital. There are up to 210 inpatient beds with 22 day case beds, serving a population of a similar size to Jersey.

This was a Private Finance Initiative (**PFI**) build which was constructed over 3 years, delivering 67,376 sqm of space at a construction cost of £230m. The team future proofed the size by adding additional capacity at the outset which was to remain mothballed until required. This was done to save significant future costs that would arise because of the PFI funding method.

Contained within are all the services that you would expect to find in a general acute hospital and is a similar size with a similar feel to the current proposals for the new hospital at Overdale. Complementary to the healthcare services are an education centre, lecture theatre, some key worker accommodation, an energy centre and a creche. The Trust is experiencing similar challenges recruiting staff at all levels, but especially Medical and Nursing staff and have advised that on reflection they should have increased the number of key worker residential units that formed part of the scheme.

### **3. Modern Methods Of Construction (MMC)**

The McAvoy Group visit was to their factory in Lisburn, on the outskirts of Belfast. The team met their Chief Executive Officer, the Head of Design & Technical Services, the Modular Hire

& Sales Director, along with other members of the team who provided an overview of the company, the projects that they had delivered and supported by a factory walkabout.

The group delivers modern methods of construction, building prefabricated units within a factory setting and then transporting and assembling on site. They have provided many healthcare facilities, both permanent and temporary, purchased and leased, to a number of UK health providers.

Within the factory, at the time of our visit, we saw a ward being constructed that was destined for the Good Hope Hospital in Birmingham as temporary bed facilities to assist with their elective post-Covid backlog completed to HBN/HTM standards. They were able to provide a number of case studies that had been delivered within short time frames to meet demand, some of which can be found on their website, including the Northumbria Specialist Emergency Care Hospital and Kingston Hospital, Mental Health Assessment Unit.

Their primary areas of focus are education, commercial and healthcare.

#### 4. Objectives Of The Visit And Observations

The aims and objectives of the visit was to inspect a number of recently built hospitals and healthcare extensions and gain insight into a modern method of construction. Against the following objectives, the team made these observations from the visit, particularly relevant to future healthcare in Jersey:

Objectives		Observations
1.	To understand the healthcare standards to which equivalent projects are delivered in Northern Ireland	<ul style="list-style-type: none"> <li>Health Building Notes (HBN) and Health Technical Memoranda (HTM) were utilised as the starting point for all new build design, as is the case in the current design</li> </ul>
2.	To compare spaces and adjacencies that have been built to modern healthcare standards to current spaces used to deliver healthcare in Jersey	<ul style="list-style-type: none"> <li>The new builds were 100% side rooms. Staff reported that this had been significant in minimising the impact of Covid and almost eliminating the spread of infection. Jersey has designed 74% side rooms in general wards</li> <li>Clinical adjacencies in the purpose-built facilities were more easily achieved</li> <li>Clinical adjacencies (once complete) and routing of patients in emergencies were key considerations in relation to any improvement works.</li> </ul>

		<ul style="list-style-type: none"> <li>• Dedicated staff bases were created to support each 8 beds.</li> <li>• Omagh provided primary care and ambulatory care services with only a small number of inpatient beds (which were not acute) on a standalone site. A number of services were Nurse led: minor injuries and illness, adjacent to the Cardiac Care Nurses who delivered a nurse led, pathway driven, assessment service.</li> </ul>
3.	To understand the process that is followed to deliver and monitor the success of projects in Northern Ireland and outcomes delivered through projects	<ul style="list-style-type: none"> <li>• A Construction and Procurement Delivery Office act as a Project Management Office and Intelligent Client for capital projects. They have their own processes but also follow the RIBA Plan of Work.</li> <li>• There was a significant reconfiguration of services across the region visited that resulted in their current hospital care model. This, at the outset had been met with resistance.</li> <li>• Robust data was collated regarding transfer rates between hospitals to monitor the quality of care.</li> <li>• Emergency transfers from Omagh would be to Altnagelvin or SWAH that were 32 miles away with protocols in place.</li> <li>• Staff satisfaction was reported to have increased following the move into new facilities, despite some cross site working</li> </ul>
4.	To determine if there are any elements of the planning and design that healthcare service professionals and facilities managers would do differently	<ul style="list-style-type: none"> <li>• Ensure that storage and staff support (rest rooms, changing, toilets and training space) were not well provided for in one hospital.</li> <li>• Ceiling hoists were not routinely or widely installed, and this had created higher risks for patients and additional work for staff.</li> <li>• Ensure there is adequate ambulance drop off space to relevant areas of the healthcare facility from the outset</li> <li>• Build in more IT infrastructure than you think you need from the outset as it cannot easily be retrofitted once the hospital is operational</li> </ul>
5.	To establish the benefits and	<ul style="list-style-type: none"> <li>• Changes at Altnagelvin were necessary owing to the fire risk associated with evacuations from their existing post</li> </ul>

	<p>disbenefits that have arisen from the new healthcare facilities and how these compared to original objectives and constraints</p>	<p>war tower block, in which all of the wards had previously been located. External fire evacuation routes have been retrofitted, with most acute clinical services being relocated from the tower, especially above the fifth storey.</p> <ul style="list-style-type: none"> <li>● The extensions to Altnagelvin were possible owing to large areas of open space surrounding the hospital. The optimal solution was a new build, but this could not be financed.</li> <li>● All new spaces were light and airy with courtyards and significant glazing, providing high levels and quality of light to clinical and patient areas.</li> </ul>
6.	<p>To discuss with hospital staff and managers the benefits and disbenefits that they have experienced from the delivery of new healthcare facilities</p>	<ul style="list-style-type: none"> <li>● One hospital was not easily divided into hot and cold areas and so was difficult to use through Covid</li> <li>● Another hospital was able to create a hospital within a hospital and was therefore better placed to be able to manage through the pandemic.</li> <li>● The trust was challenged with medical and nursing recruitment which had led to a dedicated programme to recruit overseas that had been successful in increasing recruitment and retention.</li> <li>● Investment in the Human Resource team to assist with recruitment and retention had been secured as an invest to save initiative and it continues to demonstrate it is a cost neutral team.</li> <li>● Staff residential accommodation was a limiting factor at all hospitals, but more so at Enniskillen, which was impacting on recruitment and retention.</li> <li>● The rehabilitation ward had access to outside space, was routinely used for stays of 14 days only and Patients with no rehab potential are not transferred there.</li> <li>● Build in future capacity where able at the outset, even if it is shelled until required</li> </ul>
7.	<p>To discuss digital healthcare with practitioners and the extents to which this</p>	<ul style="list-style-type: none"> <li>● There was a significant IM&amp;T digital investment in all facilities, but particularly in the South West Acute trust, being paperless from the outset with everywhere being swipe access only. Single rooms had the technological</li> </ul>

	has been adopted in Northern Ireland and the benefits that this might bring to patients, clinicians	<ul style="list-style-type: none"> <li>• capability to maximise patient safety by motion sensors, with up to 13 sensors in each room, activating low level lighting to aid the patients' path to their bathroom facility.</li> <li>• The 'hospital at home' concept was in place and anticipated to increase further through technological advances such as remote monitoring. A virtual ward was utilised identifying the patients being cared for in the community.</li> <li>• The use of "Robo Doc" assists in seeking a medical view from Omagh Hospital when required, rather than defaulting to transfer of patient to the larger centre.</li> <li>• Telemedicine was used across a number of services, including Haematology &amp; Oncology, and is seen as key to reducing the number of outpatient appointments across services.</li> </ul>
8.	To discover the team of construction professionals that are involved in healthcare projects in other jurisdictions, including client team	<ul style="list-style-type: none"> <li>• Established in Northern Ireland was a team to oversee and manage all the capital builds schemes comprising of, but not limited to; a Director for Capital Development, Project Leads for each workstream, a Senior Nurse (with additional significant input from the Infection Prevention &amp; Control team to avoid aspergillus/legionella), a Finance representative, a Quantity Surveyor, and a Communication Lead.</li> </ul>
9.	To explore the typical unit costs of delivering services in Northern Ireland compared to current estimates for designs	<ul style="list-style-type: none"> <li>• The South West Acute Trust in Enniskillen was built by FCC as a PFI; this required it to be significantly future proofed since any significant alterations would not be value for money</li> <li>• Current overall unit rate estimates from the Design and Delivery Partner are significantly in excess of those paid for Northern Ireland facilities, even allowing for costs arising from Jersey's location and increased cost of living.</li> </ul>
10.	To determine the typical timeframes for stages of healthcare projects in Northern Ireland	<ul style="list-style-type: none"> <li>• Generally, design was taken to RIBA Stage 4 and the main contract appointed following a tender process.</li> <li>• Changes to service transformation and location of delivery has attracted significant public and media attention in</li> </ul>

		Northern Ireland and does need to be carefully considered and executed to not impact on timeframes.
11.	To consider the Modern Methods of Construction that were available and used to deliver healthcare services	<ul style="list-style-type: none"> <li>• These were viewed in the factory environment. At the time of the visit a modular inpatient facility was being built in preparation for shipping to Birmingham. This was to create additional bed capacity for the Trust to assist with managing their elective backlog.</li> <li>• Further examples were demonstrated through presentation of completed schemes that included both modular schools and other health facilities.</li> </ul>
12.	To consider the relative merits and disadvantages of development on greenfield, brownfield and operational healthcare sites	<ul style="list-style-type: none"> <li>• The mental health facility was surrounded by significant green space with large internal courtyards and secure outside space that was not overlooked</li> <li>• Altnagelvin demonstrated that it was possible to build upon an existing site, however they had the benefit of space around the site, with it not being a constrained site. Their challenge was clinical adjacencies and the linking of all clinical services together to ensure safe and segregated patient transfer</li> <li>• South West Acute &amp; Omagh Hospitals were built on clean sites and in one phase. This allowed the South West Acute hospital to transfer all the patients from the closing hospital into the new hospital in one day, 3 weeks after completion</li> </ul>
13.	To discuss relative revenue and operating costs of new facilities compared to old	<ul style="list-style-type: none"> <li>• It was noted that revenue and operating costs would normally be submitted as part of Business Cases</li> <li>• Generally, revenue and operating costs are higher owing to the mechanical and electrical servicing provided in modern healthcare facilities and also owing to increased staffing costs from single patient rooms</li> </ul>
14.	To establish connections with officers seeking to deliver and operate healthcare services	<ul style="list-style-type: none"> <li>• The team met those responsible for project managing / delivering all the recent new and refurbished buildings referred to within this brief</li> <li>• A number of Senior Nurses and Managers escorted us around all the sites</li> </ul>



		<ul style="list-style-type: none"> <li>• Senior Consultant Medical staff made themselves available to us to share their journeys and experiences of change management</li> <li>• We have access to the Trusts Chief Executive and all key staff should we need to draw on their experience at any point in the future</li> <li>• All design layouts have been shared</li> <li>• All the staff we met, Clinicians and Managers, advised us to “Be brave and embrace change”.</li> </ul>
15.	To understand the typical and preferred procurement methods used to engage volumetric suppliers	<ul style="list-style-type: none"> <li>• They believe projects are most successful when delivered through frameworks (such as UK Government Crown Services Frameworks) rather than through competitive tender, especially since in Northern Ireland, the latter can often now just be on price (rather than price and quality).</li> </ul>
16.	To discover the feasibility and efficiency of hybrid construction (combinations of on-site and off-site construction)	<ul style="list-style-type: none"> <li>• They have also delivered schemes where they have combined traditional and hybrid components which is typical for schools</li> </ul>
17.	To understand the services normally provided by modular suppliers (i.e., Main contractor providing all of the services or subcontractor, employed by a main contractor)	<ul style="list-style-type: none"> <li>• They can provide volumetric, modular solutions as well as acting as the main contractor.</li> <li>• Typically the main contractor would be responsible for groundworks and other attendances, but McAvoy can be flexible regarding the services that are delivered</li> <li>• McAvoy and their subcontractors are normally responsible for all mechanical and electrical services, i.e., main risers as well as local distribution</li> <li>• They have a mature supply chain, but they would also be able to tender subcontracts.</li> </ul>
18.	To understand any additional challenges that might be of concern owing to	<ul style="list-style-type: none"> <li>• No specific concerns since McAvoy have delivered modules to various parts of the UK and Northern Ireland</li> </ul>

Jersey's location and infrastructure	
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**3. Conclusions From Visit**

To conclude, the visit was deemed to be exceptionally valuable by all who attended. It demonstrated differing models of care delivery, in a geographically challenged environment where there were a number of similarities to Jersey. The team had the opportunity to meet a number of clinical and managerial staff who were happy to share not just the positive aspects of each build, but also what they would do differently if they were to do it again, which was very welcome.

It has developed a network of like-minded individuals who, if Our Hospital Team needed to, we could reach out and use as a critical friend, all of whom seemed very open to being accessed as required.

## **Appendix 3: The Current Condition Of The Jersey General Hospital And Working On An Operational Healthcare Site**

### **2.1 Introduction**

This Appendix provides the context and challenges of the existing hospital infrastructure. It also presents the risks of construction works adjacent to and within the existing hospital boundaries.

### **2.2 Health Care Improvements – (Backlog Maintenance Programme)**

Following the political decision in 2019 to cease the Future Hospital project, the requirement for essential infrastructure and compliance upgrades at the general and acute Hospital became of high importance. A revised Business Case supported the continued requirement for funding to support a Health managed programme of upgrade works of which funding was approved for £5million in the previous Government plan for 2020 and for the years 2021-2024, dropping to £2,595 in 2025. This revised the previous 2016 – 2019 Government plan's allocation of funding that consisted of £4.0m per annum split between Health £2.85m and Jersey Property Holdings £1.15m.

Funding sought, is therefore based on requirements from the previous programmes, robust feasibility studies and detailed specialist consultations. A revised programme of works is developed and aligned to any other works that may be required within the Hospital to address capacity and improvements.

A prioritised programme of works that address the most urgent requirements, first in a manner that is deliverable within the working environment, will be produced annually to confirm the following years work programme.

An updated Six Facet Survey was undertaken in the first quarter 2019. The output of the report will further inform the programme of works for 2021-2025.

The HCS Estates team controls the development and management of the annual upgrade works programme with support from local and UK companies providing programme and project management resources.

Project Management services to support the delivery of the proposed works programme have been established. With a works package over the period totalling up to £27.595 million. There may be some synergy in combining support for the Hospital upgrade works programme with other similar HCS work streams, such as the annual Capital (medical) Equipment replacement programme, which are the subject of separate Business Case submissions.

### **2.3 Role of HCS Estates**

The respective delivery roles for HCS (as client) and IHE (as the body with responsibility for public property) have been clearly established and set out within the programme governance framework. An SRO (HCS Estates Manger) has been established and a working group set up to ensure appropriate decision making and recording processes are maintained. Senior representatives of both HCS and IHE will need to be standing members of the decision making body.

The programme is fluid; responding to changing needs such as Covid-19 and funding availability. The governance process establishes clear guidelines on variations to both individual projects and the programme as a whole.

A structured Risk Management process has been adopted at a programme level that reports activities from individual projects. Project control is managed on Concerto, a system that can provide the necessary functionality to deliver an integrated process.

The upgrade works programme will not, in itself, provide a step change to the delivery of healthcare services. Its absence, or structural underfunding, will, however, perpetuate and accelerate a decline in acceptable quality of service provision, ultimately increasing the clinical risk to patients.

Pressure on existing facilities is growing and will continue to place demands on services and infrastructure as the resident population ages and their demand for healthcare increases. Delivery of an upgrade works programme is intrinsically linked to the changes in operation of the Hospital during the period that a new Hospital is being procured and commissioned. A clear direction on the new Hospital project is a key dependency for the creation of an efficient and effective programme of upgrade and maintenance works.

At present, there is a published timeline of 2026 for the new Hospital project deliverables, so to obtain maximal impact from funding in 2020-2025 a programme for this year and future years has been developed and even adapted to work around the COVID-19 pandemic that addresses high priority items that would be required in any event. This was achievable due to the in depth detail of the master works programme. There was flexibility in the programme to switch between patient and non-patient facing activities.

There is a physical constraint in relation to the delivery of maintenance works packages. Many functions within the Hospital are already operating at near capacity and the ability to close areas for remedial work requires a high degree of advanced planning. The site is constrained and only able to hold a limited number of 'compounds' for building works. The Hospital is a complex set of buildings that operate on a 24/7 basis for scheduled and

unscheduled events, so works to clinical services, in particular, need to be managed carefully and with appropriate safeguards in place.

Delivering an upgrade works programme of a significant scale will require increased capacity and capability to support the in house team. External support was provided for the current scheme of works (OHP and the failed Future Hospital programme).

A number of medium and large companies in Jersey have experience of working in the Hospital environment, but the current high level of demand for building services, particularly in mechanical and electrical trades, means that capacity may be a constraining factor. It is a well-known fact that construction companies can make financial profit outside of the healthcare environment with less risk and scrutiny on their day-to-day activities.

**Site Summary by Block:**

Block A. Parade Building. (1987)	Gross floor area = 11,472 m <sup>2</sup>
Block B. 1960 Wing Building. (1960)	Gross floor area = 4,028 m <sup>2</sup>
Block C. Granite & Gatehouse Building. (1860 & 1877)	Gross floor area = 4,852 m <sup>2</sup>
Block D. Peter Crill House Building. (1950)	Gross floor area = 4,121 m <sup>2</sup>
Block E. Gwyneth Huelin Wing Building. (1979)	Gross floor area = 9,354 m <sup>2</sup>
Block F. Pathology/Pharmacy/Kitchen. (1983)	Gross floor area = 3,194 m <sup>2</sup>
Block G. Engineering Building. (1980)	Gross floor area = 1,541 m <sup>2</sup>
	<b><u>Gross floor area = 38,557m<sup>2</sup></u></b>

**2.4 Six Facet Condition Survey – Spend Profile**

Referring to table 2, Six Facet Condition survey spend profile, you can see that the annual cumulative spend requirement, across the entire profile, heavily outweighs the GoJ Capital allocation of funding made available.

Year 0 (2019) meant that upon completion of planned works, to the sum of £2.85m, there was still a large deficit in deliverables or improvements required in complying with the Six Facet survey. A shortfall of cr£31.5m.

This trend carries on throughout the revised GoJ Capital allocation and therefore the HCS Estates team are continually unable to achieve the volume of backlog maintenance required to create any inroads, albeit what has been delivered has been of benefit to mitigate key risks to date. The Capital allocation is not the only issue, the lack of decant facilities and on island specialists is another key contributing factor.

Table 2: Six Facet Spend Profile:

			2019	2020	2021	2022	2023	2024	2025	2026
			Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7
		<b>Blk A</b>	£5,907,161.35	£107,784.95	£61,728.63	£184,701.55	£249,317.36	£62,636.45	£557,864.92	£2,795,233.04
		<b>Blk B</b>	£2,083,239.58	£41,109.77	£0.00	£5,410.94	£68,991.47	£0.00	£144,130.41	£163,796.51
		<b>Blk C GH</b>	£40,348.63	£701.67	£228.37	£228.37	£1,245.23	£3,040.44	£2,172.00	£228.37
		<b>Blk C</b>	£2,329,118.07	£906,394.29	£80,275.98	£2,187.40	£331,029.40	£14,833.30	£324,233.83	£205,077.18
		<b>Blk D</b>	£1,539,708.43	£187,063.07	£76,112.21	£128,927.95	£1,095,327.22	£6,934.79	£128,820.66	£192,802.42
		<b>Blk E</b>	£6,218,435.67	£217,256.61	£480,041.82	£110,490.92	£397,301.99	£0.00	£351,255.47	£113,465.87
		<b>Blk F</b>	£3,523,601.38	£147,190.63	£28,520.00	£72,247.31	£933,604.86	£35,650.00	£32,024.14	£82,996.86
		<b>Blk G</b>	£1,505,769.85	£283,524.92	£6,894.74	£7,157.49	£246,074.74	£11,507.81	£58,387.82	£38,623.77
<b>Works cost</b>	<b>£54,871,514.40</b>	<b>Total</b>	<b>£23,147,382.96</b>	<b>£1,891,025.90</b>	<b>£733,801.75</b>	<b>£511,351.93</b>	<b>£3,322,892.28</b>	<b>£134,602.79</b>	<b>£1,598,889.25</b>	<b>£3,592,224.02</b>
<b>Additional costs</b>	<b>£283,310.00</b>		<b>£283,310.00</b>	<b>£0.00</b>	<b>£0.00</b>	<b>£0.00</b>	<b>£0.00</b>	<b>£0.00</b>	<b>£0.00</b>	<b>£0.00</b>
(inc. Jersey %)										
<b>SUB TOTAL</b>	<b>£55,154,824.40</b>		<b>£23,430,692.96</b>	<b>£1,891,025.90</b>	<b>£733,801.75</b>	<b>£511,351.93</b>	<b>£3,322,892.28</b>	<b>£134,602.79</b>	<b>£1,598,889.25</b>	<b>£3,592,224.02</b>
<b>PRELIMINARIES (20%)</b>	<b>£11,030,964.12</b>		<b>£4,686,138.40</b>	<b>£378,205.00</b>	<b>£146,760.20</b>	<b>£102,270.20</b>	<b>£664,578.46</b>	<b>£26,920.56</b>	<b>£319,777.80</b>	<b>£718,444.80</b>
<b>CONTINGENCY/RISK (12%)</b>	<b>£6,618,578.48</b>		<b>£2,811,683.04</b>	<b>£226,923.00</b>	<b>£88,056.12</b>	<b>£61,362.12</b>	<b>£398,747.07</b>	<b>£16,152.33</b>	<b>£191,866.68</b>	<b>£431,066.88</b>
<b>PROFESSIONAL FEES (14.52%)</b>	<b>£8,006,085.00</b>		<b>£3,402,136.48</b>	<b>£274,576.83</b>	<b>£106,547.91</b>	<b>£74,248.17</b>	<b>£482,483.96</b>	<b>£19,544.33</b>	<b>£232,158.68</b>	<b>£521,590.92</b>
<b>OVERALL COST</b>	<b>£80,810,452.00</b>		<b>£34,330,650.88</b>	<b>£2,770,730.73</b>	<b>£1,075,165.98</b>	<b>£749,232.42</b>	<b>£4,868,701.77</b>	<b>£197,220.00</b>	<b>£2,342,692.41</b>	<b>£5,263,326.62</b>
<b>Cumulative Costs</b>			<b>Year 0</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>	<b>Year 4</b>	<b>Year 5</b>	<b>Year 6</b>	<b>Year 7</b>
			£34,330,651	£37,101,382	£38,176,548	£38,925,780	£43,794,482	£43,991,702	£46,334,394	£51,597,721
<b>Capital Backlog Maintenance Fund</b>			<b>Year 0</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>	<b>Year 4</b>	<b>Year 5</b>	<b>Year 6</b>	<b>Year 7</b>
			£2,850,000.00	£5,000,000.00	£5,000,000.00	£5,000,000.00	£5,000,000.00	£5,000,000.00	£2,595,000.00	tbc

			2027	2028	2029	2030	2031	2032	2033
			Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Year 14
		Blk A	£107,784.95	£2,599,136.18	£1,147,290.72	£236,723.15	£1,042,473.53	£314,029.55	£2,155,597.32
		Blk B	£0.00	£1,165,716.56	£231,756.45	£130,751.08	£74,671.06	£130,838.45	£328,121.11
		Blk C GH	£701.67	£1,245.23	£3,040.44	£2,041.35	£228.37	£228.37	£3,641.25
		Blk C	£35,370.13	£1,105,107.14	£24,954.32	£125,244.52	£152,425.16	£0.00	£530,223.41
		Blk D	£16,472.08	£48,187.74	£85,608.26	£108,304.27	£225,258.00	£23,276.70	£1,227,864.17
		Blk E	£10,695.00	£1,874,939.73	£257,628.09	£114,661.25	£80,290.00	£13,020.00	£1,417,142.23
		Blk F	£0.00	£399,326.34	£303,369.54	£77,912.86	£31,434.71	£84,546.50	£805,910.52
		Blk G	£36,376.49	£563,019.05	£12,393.17	£164,553.44	£8,605.60	£7,157.49	£292,048.78
<b>Works cost</b>	<b>£54,871,514.40</b>	<b>Total</b>	<b>£207,400.31</b>	<b>£7,756,677.98</b>	<b>£2,066,041.00</b>	<b>£960,191.92</b>	<b>£1,615,386.44</b>	<b>£573,097.06</b>	<b>£6,760,548.80</b>
<b>Additional costs</b>	<b>£283,310.00</b>		£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
<b>(inc. Jersey %)</b>									
<b>SUB TOTAL</b>	<b>£55,154,824.40</b>		<b>£207,400.31</b>	<b>£7,756,677.98</b>	<b>£2,066,041.00</b>	<b>£960,191.92</b>	<b>£1,615,386.44</b>	<b>£573,097.06</b>	<b>£6,760,548.80</b>
<b>PRELIMINARIES (20%)</b>	<b>£11,030,964.12</b>		£41,480.06	£1,551,335.60	£413,208.20	£192,038.38	£323,077.29	£114,619.41	£1,352,109.76
<b>CONTINGENCY/RISK (12%)</b>	<b>£6,618,578.48</b>		£24,888.04	£930,801.36	£247,924.92	£115,223.03	£193,846.37	£68,771.65	£811,265.86
<b>PROFESSIONAL FEES (14.52%)</b>	<b>£8,006,085.00</b>		£30,114.53	£1,126,269.64	£299,575.95	£139,227.83	£234,231.03	£83,099.07	£980,279.58
<b>OVERALL COST</b>	<b>£80,810,452.00</b>		<b>£303,882.94</b>	<b>£11,365,084.57</b>	<b>£3,026,750.06</b>	<b>£1,406,681.16</b>	<b>£2,366,541.14</b>	<b>£839,587.19</b>	<b>£9,904,203.99</b>
<b>Cumulative Costs</b>			<b>Year 8</b>	<b>Year 9</b>	<b>Year 10</b>	<b>Year 11</b>	<b>Year 12</b>	<b>Year 13</b>	<b>Year 14</b>
			£51,901,604	£63,266,688	£66,293,438	£67,700,120	£70,066,661	£70,906,248	£80,810,452
<b>Capital Backlog Maintenance Fund</b>			<b>Year 8</b>						
			tbc						

## **2.5 Risk Management & Compliance Issues**

### **2.5.1 Asbestos**

The Hospital still has areas of known Asbestos that is managed via Asbestos Management Plans (AMP's). Each Block has its own bespoke Plan and that is reviewed and updated every six months by an external specialist. Known Asbestos is encapsulated and/or removed during refurbishments. Daily management is carried out by the Estates team and prior to any new building work a detailed Refurbishment & Demolition Survey must be commissioned and contractors issued with the relevant Asbestos Management Plans.

Licensed removal of Asbestos is carried out under contract and to strict air monitored legislation.

### **2.5.2 Fire**

Under The Fire Precautions (Jersey) Law 1977, the hospital site is officially a "Certificated Premises" meaning that HCS are legally bound to ensure the premises, and those using it, remain safe from the effects of fire. It must be remembered that Jersey Fire & Rescue Service have the power to enforce temporary or permanent closure of all, or parts of, the premises, if they assess the risk to occupants, in relation to fire, is too great. It must be remembered that in the event of a fire on the site, the Fire Service can only muster an immediate turnout of 2 fire appliances (9 firefighters) to an incident, with the potential to increase that headcount to maybe a maximum of 30 to 40 personnel over a protracted period. In the UK most hospital facilities, of a comparable size to Jersey, would probably attract an attendance of 10 to 20 appliances initially, with the ability to increase this considerably over a relatively short period of time. We should therefore be ensuring that the fire safety measures are satisfactory enough to counter this limitation in firefighting response.

The "risk" from fire within the hospital premises can be assessed from two perspectives – management and material.

The management of fire safety is, generally speaking very good. Policies exist to ensure the reporting and investigation of fire safety incidents and the training of staff ensures that we mitigate the possibilities of a fire starting and that our actions in the event of a fire on the premises are robust enough to ensure the safety of everybody therein. Emergency evacuation remains a challenge however, as the physical layout of the buildings and departments within restricts HCS from always adhering to modern healthcare horizontal evacuation strategies.



The material fire safety within the premises remains the greatest risk by far. The site is a collection of buildings that have evolved in a piecemeal fashion since the original “Granite Block” building, constructed over 150 years ago. Without the obvious existence of a premises fire sprinkler system, the biggest risk to the hospital is fire and smoke spread, due to inadequate internal fire compartmentation. Although every effort is made to enhance this fire compartmentation through scheduled backlog maintenance and capital build projects, an ongoing audit of fire doors (over 500 to date) has shown that the majority so far assessed require urgent remedial works or complete replacement. Decades of internal construction have riddled the partition walls (that act as fire/smoke breaks) between wards and departments with penetrations that no longer afford adequate fire separation; many of the old fire/smoke dampers used throughout the heating and ventilation systems are now in urgent need of replacement, either due to maintenance reasons or because they no longer comply with modern standards. This increases the risk of fire spread through compartmentation lines to adjoining floors or buildings and would have catastrophic impact on maintaining continuity to live clinical services. Whether the risk is managed via internal building teams or future capital developments on the site, fire safety has to be a key fundamental in any design package.

### **2.5.3 Water Safety**

Control of legionella is managed by a software programme called Zeta Management System, in place with a dedicated person overseeing all activities that reports to a Water management board.

Water quality management systems are in place and these include daily flushing routines, which consists of running taps for two minutes to each affected outlet, temperature monitoring and infrastructure upgrades i.e. replacing taps, temperature monitoring valves (TMV's) and filters.

Some areas of the hospital are managed with Chlorine dioxide (ClO<sub>2</sub>) as both a disinfectant and an oxidant in water. Its selective reactivity makes chlorine dioxide a powerful oxidizing agent useful in many water treating applications for which chlorine and other oxidizing agents are unsuitable. Chlorine dioxide is currently added, via a mechanically measured dosage, into cold water storage tanks serving Blocks E & F. The HCS maintenance teams are currently looking at implementing the same technologies into the cold water supplies for Blocks A, B & C.

#### **2.5.4 Mechanical Services**

Antiquated plant and equipment are located across all blocks of the Hospital with some key infrastructure now some 30+ years old resulting in risk being managed on a daily basis. As there is limited opportunity to decant departments or blocks at a time, the ongoing management of plant and its replacement programme is challenging. Working around critical services and patients adds to the growing risk of plant failure and disruption to operations.

New installations of air handling plant have had to be installed external to plant rooms due to the old plant having to remain live until the new plant has been commissioned, decreasing its live expectancy due to our saline island environment.

Medical gas infrastructure lacks resilience in having adequate shut of valves, which impacts on the ability to isolate blocks in the event of maintenance works or more extreme circumstances.

Foul drainage is a site wide issue at the Hospital with many of the underground runs being below standard or at point of failure. Many of the runs are located under live clinical departments and replacement works are unfeasible due to the impact to services. Backed-up foul sewage due to snagged waste is becoming a common reactive task to clear.

Medium temperature hot water (**MTHW**) infrastructure has been elevated to high risk and is on high alert for failure. Considerable mitigation has been applied to the risk with full replacement not deemed economical with a new hospital earmarked for 2026, delay in that timeline will require a review and a potential million pound plus project, impacting all areas of the hospital.

Compliance around storage of medical gas bottles is not met due to the physical lack of space on site.

Ventilation compliance is another area that is far from adequate outside of key critical services. Inpatient bays and single bedrooms along with supporting staff administration areas are all naturally ventilated which is a concern when looking at spread of infection and the ever growing concerns with our warming climate. Windows next to construction sites have had to be kept closed and sealed due to dust and noise issues.

As with modern health design comes Health Technical Memorandum (**HTM**) compliance. Current health projects are using best endeavours to comply with modern standards but working within existing parameters severely impedes the ability to deliver without derogations away from best practice, unfortunately, a

common trend we are seeing at the Hospital. Examples of this is the installation of new mechanical and electrical (**M&E**) services in ceiling voids, current voids are too small versus modern standards, therefore impacting on maintenance or restricting access.

### **2.5.5 Electrical Infrastructure**

With the exception of the refurbished areas of the hospital, the majority of the Electrical services have exceeded design life and are considered to not meet satisfactory standard and are needing major replacements.

Consideration will have to be given to any future largescale site development and a full understanding of existing services will need to be fully understood so that design consideration can be costed from the offset to manage any phased site redevelopment. The site must have resilience and comply with current HTM documentation.

### **2.5.6 Building Fabric**

Clinical buildings are generally well maintained but the fabric is nearing end of its intended life. Numerous windows have blown and aluminium panels offer poor insulation levels, flat roof areas are ageing and deteriorated requiring repair. Ceiling tiles with some infection control issues need to be replaced but cannot due to the lack of decant space available.

Despite cosmetic improvements and refurbishment of support areas, the footprint is still significantly below the size and configuration that meet the functional requirements of modern inpatient wards recommended by current UK Health Building Notes.

The increasing emphasis on infection prevention and control requires larger bed spacing, reduction of 6 bed bays to maximum 4 bed bays, more single rooms and pressurized lobbies to isolation rooms. This would also improve flexibility of use, segregation of sexes, privacy, dignity and security of vulnerable patients to satisfy Capacity and Self Determination (Jersey) Regulations.

The inpatient zones equally fail to meet these standards; however, it would be unrealistic to try and refurbish the current facility to achieve the requirements outlined above.

With many ongoing construction projects spread across multiple blocks there is the need to manage the H&S Risks around noise pollution and resulting patient upset and complaints. Projects have to include agreed stoppage times for breakfast, lunch and dinner, if late night working is required to carry out isolations or shutdowns this has to be planned in advance with a wide buy-in

from both clinical and non-clinical managers but is not a cost effective way to deliver planned works.

With any construction project comes dust, the additional resources and materials required to ensure clinical areas are kept ultra clean is a factor when costing, as to avoid infection risk and unwanted illness such as Aspergillus, a respiratory infection caused by concrete dust.

## **2.6 Estates Maintenance/Running Costs**

HCS Estates services are primarily delivered through an insourced model consisting of ten Civil Servants and sixty-five Manual Workers covering the Mechanical, Electrical, Building, Refuse and Gardening teams. With only a small number of services provided by external suppliers, most of which are very specialist, specific services including statutory inspections or specialist equipment.

With a modest £10m annual budget for the entire Health Estates Department, the non-staffing maintenance and material costs sits at just over £5m p/a. Within that sum there is a medical equipment service portfolio of over 150 contracts totalling £1.7m.

With ever-growing risks across the entire estate, not just the Hospital, the budget is seen as insufficient and is forecast to be overspent again this year. Mainly due to unplanned reactive maintenance.

## **2.7 Operational Systems**

Maintenance on HCS assets – Buildings, plant, medical equipment, patient handling equipment etc., is managed through a Computerised Maintenance Management System (**CMMS**). The CMMS uses a database which centralises asset information to facilitate, and record, planned and reactive maintenance operations.

The effectiveness of the CMMS is reliant on the accuracy of the information recorded in the asset register database. Information includes manufacturer, model nr, serial nr, description, purchase date, asset nr and forecast replacement date. The information from the asset registers is also used in the procurement of third-party specialist support contracts.

Planned maintenance is the approach to minimise equipment downtime and to ensure equipment is performing as designed. Planned maintenance schedules are based on a combination of legislation, regulation, manufacturer information and best practice.

Reactive maintenance is unplanned equipment faults/failures which are managed through the helpdesk and online portal. All calls are prioritised on several factors including Health and Safety, impact to staff and/or patients, equipment criticality and type of fault/failure.

All assets have an expected design life and though there may be options for this to be extended through refurbishment or increased maintenance, it will eventually reach a stage where it is no longer economically viable.

Assets exceeding design life are likely to require additional maintenance that will increase costs and demand on resources to maintain equipment serviceability. There will also be an increased risk of failure.

Scheduled and recorded maintenance for 2022 shows that out of 8902 planned maintenance activities, 5404 are for Jersey General Hospital.

So far this year, there have been over 8700 reactive maintenance requests of which more than 5500 are for the Hospital. As well as equipment faults/failures, a number of these requests are for remedial works following ward relocations, office moves and temporary relocations or change of use. Works include moving/installing whiteboards, moving furniture, installing/removing shelving, additional power points and data points etc. A phased approach is likely to increase this further which will impact the planned maintenance schedule due to lack of resource.

## **2.8 Contractors & Tender Inflation**

As the local construction industry sees a boom in inflation around material prices, procurement lead times and general activity, HCS projects are seeing the impact to labour availability and cost inflation that is reflected in tender pricing and limited contractors willing to commit to health projects, especially M&E services.

## **2.9 Infection, Prevention & Control (IPaC)**

With any construction project delivered by Engineers or Contractors they are required to follow HCS' IPaC Policy.

Key controls such as adequately sealing areas where there will be dust production from sawing, drilling etc. Not having dust mats to remove dust from work boots. It is also important to manage the footfall of contractors throughout a healthcare facility as dust, dirt, and potential microorganisms walked through a department will increase the risk of infection. Carefully planned access routes

to have a separate entry and exit for contractors near to where they are working is favoured. Public wayfinding signage must be continually revised to suit any refurbishment works as to not cause any confusion or disruption to patient services.

Potential microorganisms falling from ceiling tiles is another risk, therefore if two or more ceiling tiles are removed or moved then the housekeepers are required to do a terminal clean and HPV of the area, if possible, this can be challenging if major works are being undertaken. Any building work has the risk of Aspergillus in the dust.

The impact of invasive infection and the devastating consequences in vulnerable groups is well documented.

It is much more complicated to mitigate the risk factors during hospital construction work than it is on a general building site. This can be challenging for outside contractors undertaking work within healthcare settings as they do not necessarily understand the risks and therefore may not always be vigilant in complying with the mitigation measure in place.

Maintaining IPaC standards and getting buy-in from staff and patients during construction projects within a functioning hospital is extremely challenging.

### **3. Conclusion**

There is a clear acknowledgment from all that a new Hospital is urgently required for the Island. How we get there and where it may finally be sited is a decision that needs to be carefully considered, any further unplanned delay in achieving that goal, will undoubtedly impact on the existing hospital buildings by increasing risk, clinical services provided, its staff and ultimately its patients safety.

## **Appendix 4: Further Information From Our Hospital Project Team And Advisors**

### **Section 1: How Much & How to Pay for It?**

The following is a summary of information that was discussed with the Review panel to set out the financial context and various cost scenarios. A summary of possible financing issues was then discussed. In summary, the context and overall cost scenario table (that are not estimates of outturn costs) has been produced together with the funding issues.

### **Context**

A1. The cost estimates have been produced to enable comparison between scenarios. They are not and should not be interpreted as accurate out-turn costs at this stage; much further analysis would be required to produce these. Assumptions have been made in order to simplify the analyses.

A2. The existing cost consultants have worked on various scenarios using aspects of both Overdale and Gloucester Street including a costing for the Future Hospital site scheme.

A3. The Review is seeking to understand the balance between the cost of the schemes and the amount of time to deliver the scheme

A4. No analysis has been undertaken in relation to the benefits of proposals and consequently the overall value for money of each of the options.

A5. Cost is only one aspect of any Business Case undertaken using the HM Treasury Green Book Guidance.

Table 1: Total Construction and Client Team Costs including client contingency for comparison purposes by OHP Cost Consultant

Ref	Scenario	Area (m2)	Works Total, A (£m)	Contract Costs, B (£m)	Construction Works Sub-total, excl. Fees & Equipment (A+B), C (£m)	Project Costs, D (£m)	Total Construction and Client Cost (C+D) (£m)	Start on Site	Operational	Overall Duration (Years)
1.00	<b>Overdale - Current Approved Business Case</b>	66,948	312	134	446	218	664	Jan-23	Jan-27	4
1.10	Overdale - Continue	69,389	322	182	505	268	772	Jan-24	Jan-28	5
1.20	Overdale - Continue (as designed, tendered)	69,389	314	147	461	221	682	Jul-24	Jul-28	6
2.00	Overdale Reduced – Reduce area to 55,000	55,000	271	145	416	226	642	Apr-25	Oct-28	6
2.10	Overdale Reduced 2 – Reduce area to achieve £725m AFL	42,707	220	112	332	201	533	Jul-25	Jan-29	6
3.00	Dual Site - Overdale Light and Gloucester Street Refurb	57,466	381	131	512	280	792	Feb-26	Aug-31	9
3.10	Dual Site - Overdale and Gloucester Street (Rebuild on Kensington Place)	69,389	337	154	491	284	775	Jul-24	Dec-28	6
3.11	Dual Site - Overdale and Gloucester Street (Rebuild on Kensington Place) - Reduced Size	60,508	289	131	420	260	680	Jul-24	Dec-28	6
3.12	Dual Site - Overdale and Gloucester Street (Rebuild on Kensington Place) - Reduced Size and Efficiency	59,867	275	124	398	247	646	Jul-24	Dec-28	6
4.00	Gloucester Street - Refurb current Hospital for next 15 years	36,695	125	81	206	220	426	Dec-25	May-31	9
4.10	Gloucester Street - Comprehensive refurb (back to shell)	36,695	194	145	338	294	633	Oct-25	Mar-34	12
5.00	Gloucester Street - Rebuild on existing footprint	69,389	449	284	733	515	1,248	Oct-25	Apr-36	14
5.10	Gloucester Street – (Rebuild with Kensington Place)	69,389	296	196	492	388	880	Apr-26	Oct-31	9
6.00	Future Hospital Scheme	57,825	279	106	385	251	636	Jan-27	Dec-30	8

- **Works Total:** Demolition; Hospital; Energy Centre; Mental Health Centre; Knowledge Centre; Car Park; External Works; Highway Alterations and Other
- **Contract Costs:** Contract Preliminaries; Contractor Overheads & Profit; Contractor Risk
- **Project Costs:** Fees excluding PCSA; Equipment; Decant; Client Contingency



Whilst the works, contract and project costs are reasonably reliable since they are based on historic rates paid, the other project costs are more uncertain and include Optimism Bias and Inflation. These are not provided in the table above, nor is the current PCSA fee or land acquisitions or disposals. No analysis has been undertaken in relation to the benefits of proposals and consequently the overall value for money of each of the options.

Table 2: Operational Costs

Ref	Scenario	Area (m2)	Operational Cost for 30 Yrs (£m)
<b>1.00</b>	<b>Overdale - Current Approved Business Case</b>	66,948	855
1.10	Overdale - Continue (as designed)	69,389	886
1.20	Overdale - Continue (tendered)	69,389	886
2.00	Overdale Reduced – Reduce area to 55,000	55,000	702
2.10	Overdale Reduced 2 – Reduce area to achieve £725m AFL	42,707	535
3.00	Dual Site - Overdale Light and Gloucester Street Refurb	57,466	864
3.10	Dual Site - Overdale and Gloucester Street (Rebuild on Kensington Place)	69,389	1,024
3.11	Dual Site - Overdale and Gloucester Street (Rebuild on Kensington Place) - Reduced Size	60,508	892
3.12	Dual Site - Overdale and Gloucester Street (Rebuild on Kensington Place) - Reduced Size and Efficiency	59,867	883
4.00	Gloucester Street - Refurb current Hospital for next 15 years	36,695	1,256
4.10	Gloucester Street - Comprehensive refurb (back to shell)	36,695	552
5.00	Gloucester Street - Rebuild on existing footprint	69,389	886
5.10	Gloucester Street – (Rebuild with Kensington Place)	69,389	886
6.00	Future Hospital Scheme	57,825	738

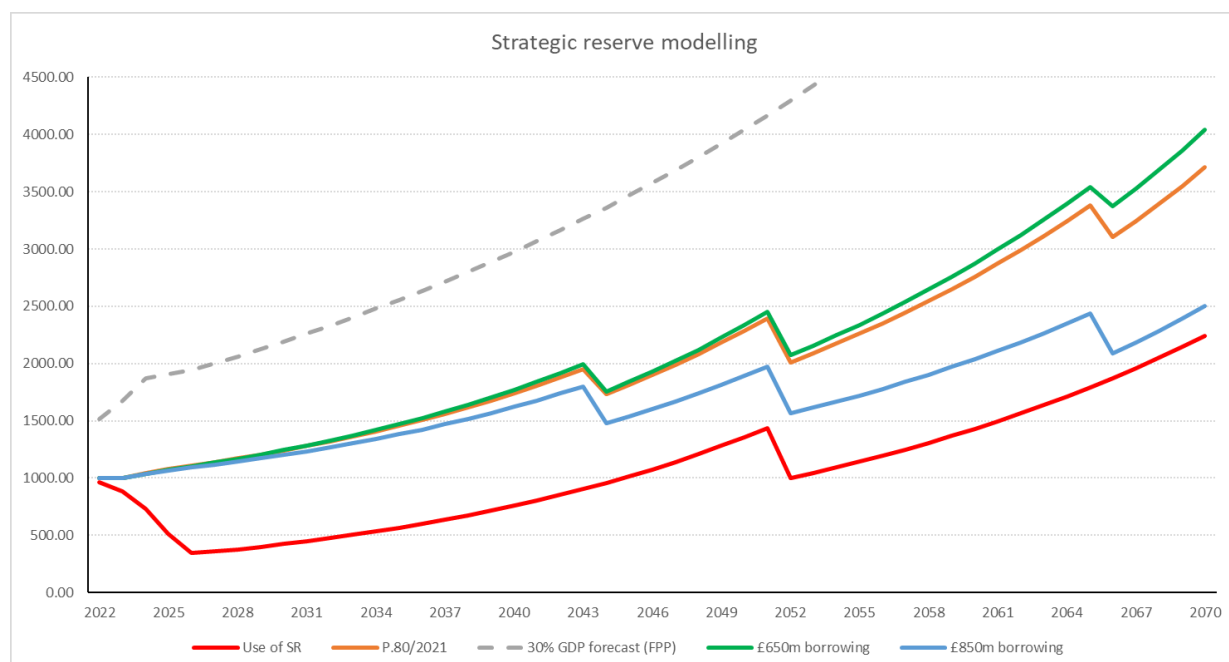
## Funding for Hospital Projects

A6. When funding any large capital project there are three main options available to Government: **taxation, use of reserves or borrowing.**

A7. Despite changes in the underlying financial markets environment, the broad principles of P.80/2021 still apply today - the Strategic Reserve pays the annual financing costs and ultimately repays the debt.

A8. P.80/2021 proposed that the most likely debt funding solution would be the issuance of two public rated Sterling bonds in equal amounts of £378 million with two different long-term maturities (35 & 40 years).

A9. The new proposed approach to borrowing would utilise a more flexible



solution that is more closely matched to any OH spending profile. This would involve shorter-term debt being replaced by longer-term funding as the project progresses.

A10. The financial modelling is sensitive to future interest rates and clearly if borrowing costs exceed forecast investment returns (4.6% p.a.) for an extended period of time the value of the Strategic Reserve will be eroded.

A11. The chart above shows the future value of the Strategic Reserve Fund based on various borrowing levels and using current assumptions for interest rates and investment return.

A12. The chart demonstrates that borrowing at the level approved in P.80/2021, and up to £850 million, can still be supported through the new proposed funding solution and leads to a better long-term outcome than solely using reserves

A13. It is notable that all the scenarios do not grow the Strategic Reserve to the Fiscal Policy Panel's desired minimum of 30% of GDP.

### **Other Considerations**

A14. There are differing issues that arise related to the types of land use and requirements between Overdale, Dual site and Gloucester Street

A15. The sunk costs for the scenarios will vary depending on the amount of the existing RIBA 3 work can be used for the scheme. However, increasing borrowing above £850million forecasts the potential for a lower long-term value for the Strategic Reserve

A16. In all the scenarios the time value of money has been represented within the inflation estimation and an estimate has been made on discounted cashflows

A17. The societal benefits of each scheme will not be equivalent since they do not deliver the same clinical outcomes.

A18. There is a possibility that specific parts of the hospital might have the capability to be funded by alternative methods such as sponsorship, building branding, foundation monies or bequests

A19. The risks and costs of maintaining the existing services at the hospital are not considered in these analyses and will be impacted by the period of time any new project will take

A20. The overall balance sheet of the Island of Jersey is strong with £8.1bn of net asset. The funding decision needs to be tested against this backdrop and within the constraints on public finances by the S&P rating and the requirements of the Fiscal Policy Panel.

## **Section 2: Why?**

B1. A large proportion of the existing hospital infrastructure is reaching operational failure. In 2019, a master conditions survey was conducted that identified an £83M spend required for maintenance, this built upon the survey that was undertaken in 2014. The department is assigned a budget of £5M which is managed annually on a risk prioritisation basis, whilst balancing against clinical requirements and accessibility of estate. Additional funding was required to keep the infrastructure safe and operational until the new hospital is ready.

B2. In preparation for the Future Hospital Project, maintenance was restricted to several departments in anticipation of moving which has now subsequently created a backlog of maintenance works required.

B3. There can be no guarantee there will not be a major failure or something of significance between now and a new hospital. Key risks faced by the existing site are in mechanical / electrical services, the building fabric, including water & fire compliance which has an impact on existing budget and presents a daily challenge to infection prevention & control. Actions to address and mitigate these risks are in place.

B4. The department faces procurement challenges when tendering projects in excess of £100k as a full open tender bid is required taking approx. three months to complete. A £5M budget allocation roughly translates to around 20 projects a year. Managing 20, three-month tenders is difficult and time consuming. This issue is currently being addressed with Treasury officers.

B5. The existing Health Estates team are severely stretched supporting the ongoing maintenance projects, including key infrastructure improvement. The estates team primarily are a maintenance team. Additional resources would be required to maintain the safety and ongoing status quo of existing sites.

B6. The facilities team are unopposed to a split/hybrid solution and noted as with the Future Hospital Project a Hybrid solution has previously been a topic for conversation however has concerns with how the clinical staffing would be managed across two sites as staffing needs to be supported unless there is likely to be an investment in the growth of the equity of staff.

B7. Engineering, Non-Clinical Admin, Key Worker accommodation, Outpatients Services and Mental health could all be accommodated offsite, however, having these all on one site especially for clinical travel between sites would be more easily managed.

B8. There would need to be special measures undertaken when building next to a live hospital. In the case of the preferred option, no redevelopment of live hospital services would be necessary, reducing the need for mitigating activity.

B9. A robust decant strategy would be needed when making way for demolition. It is vital that the scheduling of work is correct, as the first new acute clinical block will be the resilience to manage a standalone block while then having to tap into future redevelopment on the same site.

B10. A revised strategy would be required identifying a holistic plan of the offsite/on-site model including every stage of the redevelopment/redesign including satellite sites.

### **Section 3: What 1 (Clinical)**

C1. The overriding desire for all those who were consulted from Health and Community Services was to maintain the proposals as they currently stand if this was possible given current global economic circumstances.

C2. Parties interviewed confirmed that they have been involved in the design process, helping to specify their clinical spaces but also having their requests robustly challenged.

C3. All but one stakeholder suggested that the design team have got it right and that we do not need to return to the drawing board, but most acknowledged there were opportunities to explore further. The stakeholder who was not satisfied with current designs confirmed that their involvement was relatively recent.

C4. There is an acceptance that the landscape has changed since the inception of the project, coupled with an unquestionable realisation that something is required and required at pace. It was stated from the lead reviewer at the outset that to do nothing was not an option. All spoken to were asked to give their views on other options proposed within the given timeframe.

C5. If the scheme cannot progress in the way it is designed then there was acceptance that a reduced or phased version of the current scheme could be explored, failing that, an acceptance that a hybrid scheme could work, which in essence means some services on the Overdale site and some services on Kensington Place or the existing Jersey General Hospital site.

C6. There was wide acceptance that the Mental Health provision does not need to be co-located, but an acceptance that something new is required. It was felt that as long as it was fit for purpose and in an acceptable location, that this may be an opportunity to review requirements along with location. This is likely to be an increased rather than decreased scope.

C7. There was a suggestion that hot (acute) and cold (elective) sites could be created by having two sites, but there needs to be further engagement regarding what could go on which site measured against the available footprint of each site. Given the limited timeframe of the Review, it was not possible to properly and robustly determine the services that would be best placed on each site.

C8. Undoubtedly there is more work to do to understand how the use of digital technology can be embraced and utilised to reduce the reliance physical healthcare buildings, with further opportunities to modernise current service delivery models, which is felt to be stifled due to the limitations of the existing estate.

C9. There remains further work required to determine the model of care for the future; we need a hospital to be a place that Islanders need to stay when they are sick, and it was highlighted throughout the meetings that there is further work to be undertaken in the community that not only prevents hospital admission but pulls patients out of hospital and into their own homes or care settings as soon as they cease requiring medical intervention. This will be key to right sizing the bed requirements of any new build.

C10. Likewise, outpatient services do not necessarily need always to be delivered within a clinical or hospital setting.

C11. It was highlighted that adopting a hybrid model there would be an impact on staffing, equipment and running costs, which was acknowledged and aside from the build costs for this, further work needs to be undertaken to assess the true revenue costs of any split site model. This is not something that can be accurately estimated until the detail is understood regarding site size and where clinical services will be located. From a resourcing perspective the current workforce has a number of single-handed practitioners who, if working in a dual site model, may experience logistical problems, especially in relation to emergencies, if they occurred on a site that they weren't already situated. These might be overcome by appropriate operational policies and careful planning.

C12. Concern was expressed, as was the case within the Future Hospital project, that to build alongside or within an existing hospital whilst still delivering care was felt to be an unworkable solution, however, there is already planning permission approval to build flats on Kensington Place, so this would proceed if it were not to be replaced with a medical facility, without the ability to fully influence noise and disruption. This happens in hospital sites the world over and although the site in Altnagelvin was not constrained to the same extent, there are numerous examples of how this happens all over UK cities. It is acknowledged that this may have an impact on staff morale which is a concern and there may be consequences to patient care and the impact on recovery that would need to be carefully monitored. This would be to a greater extent for proposals requiring enabling works within operational settings, such as for the Future Hospital Project but would be to a lesser extent for new builds on adjacent sites.

C13. Staff morale, although not the only consideration, it is an important one, as without healthcare workers we are unable to maintain service delivery. There are already challenges in recruiting and retaining staff, however, this is not peculiar to Jersey. Affordable housing is one of the reasons cited for this. Although the provision of staff accommodation is does not feature within the current scheme, there may be an opportunity to do so in future iterations.

C14. There was overriding support to get on and do something, given the time already invested in all the previous schemes, that wherever we build we should try and use what we can from the current briefings and designs given the high level of clinical involvement to get us to this point, but that we need to do something quickly.

C15. It was suggested that a happy working environment translates into positive staff morale, that in turn delivers good quality healthcare, which was evident on the visit to Northern Ireland.

C16. Concerns were also expressed regarding any further extensions to the programme for the delivery of new health facilities since the current hospital is not fit-for-purpose: new health facilities are very likely to contribute to improved clinical outcomes.

C.17 It was suggested and agreed that in the interim, if there are any quick wins that could improve conditions for staff and users, these should be adopted



where it would be good value to so. A further suggestion was to form a small working group to put into effect any proposals.

C.18 Communication and engagement was particularly discussed at the Health Workers Panel and that it was essential. It was suggested that it needs to be multi-channel and multi-site (including desk drops and walking the departments), meetings perhaps scheduled at various times and repeated so all are able to attend. It was thought a Teams Channel for the panel would be helpful. Meetings need to be arranged at least 8 weeks in advanced.

C.19 From the ambulance and patient transport services perspective, all potential sites are viable options however the factors that need careful consideration are access and egress to the site, traffic flows and safety of the crews. Evidence was provided to the Public Inquiry of the importance of these aspects and the challenges in mitigating these risks with one-way systems or hurry-signals/traffic lights.

C.20 If a dual or multi-site solution were being explored, then distance to and from sites, as well as additional journeys an out of town option would generate, needs to be considered.

C.21 Consideration also needs to be given to the amount of space that is available on any site for the segregation and manoeuvring of emergency vehicles adjacent the healthcare buildings. Out of town options have provided more opportunities for this than urban settings, owing to additional availability of space.

The summary is based on feedback, not only within the stakeholder engagement sessions listed below, but also in existing forums including the Clinical & Operational Client Group (**COCG**), the Senior Leadership Meeting (**SLT**) and meetings with the Associate Medical Directors:

- Health & Community Service's (HCS) Chief Clinical Information Officer (Digital Health)
- Consultant Cardiologist, Our Hospital Project Clinical Director, HCS Director General, HCS Medical Director (Clinical Design)
- Chief Ambulance Officer (Government of Jersey/Emergency Transport & Patient Logistics)
- Director of Innovation, Improvement & Modernisation in HCS (Health Improvement and Modernisation)

- Consultant in Gastroenterology (Clinical Needs & Design)
- Director of Mental Health Services in HCS (Mental Health)
- Health Worker Panel and Citizen Panel members
- Architects and Designers from Llewelyn Davies/Interpreting the functional brief)
- Consultants from Mott MacDonald/Digital Health & IM&T)

#### **Section 4: What 2 (Infrastructure)**

D.1 The Review heard from stakeholders in relation to the likely ancillary infrastructure requirements, land assembly and planning considerations that any proposal requires.

D.2 Ancillary infrastructure is generally proportionate to the scheme that is submitted to the planning department and related to the impacts that there might be. Normally ancillary infrastructure relates to transport and drainage, but any planning application would also consider matters of waste.

D.3 In terms of drainage, any development at the Overdale site will require the connection of foul sewage into the existing foul sewer network. Surface water currently flows into a combined sewer (foul and surface water) as does the remainder of surface water in this neighbourhood. Consequently, the surface water would need to flow into a new surface water trunk sewer between St Aubin's Inner Road and St Aubin's Bay. On-site surface water disposal is not considered feasible. Some attenuation of flows is likely to be necessary.

D.4 For the Jersey General Hospital and Kensington Place sites a connection will be required of foul sewage into the existing foul sewer network; it is anticipated that the foul sewer network has adequate capacity. Surface water will require the construction of a new surface water trunk sewer connecting into an existing surface water tunnel in Gloucester Street; this may require the attenuation of surface water on site, to manage the downstream flows so as not to exceed the existing capacity. Due to the depth of the existing sewer, and other existing utilities, it is not considered feasible to upsize this sewer or construct an additional sewer and outfall.

D.5 For the satellite sites at the former Les Quennevais School and St Saviour's Hospital the capacity of the existing sewer network at both sites is severely

limited; for any scheme that significantly increased flows, substantial improvement to the foul sewer network at either site is likely to be required.

D.6 For transport and highways, all developments need to demonstrate how they deliver better active travel in line with the Sustainable Transport Policy and also the Carbon Neutral Strategy. In addition, any development needs to tie into the existing highway network and not create new issues because of any change or increase in journeys, by car, on foot or by bike.

D.7 There is already a hospital at Gloucester Street. It is located on the principal town highway network and so limited wider change would be required, although local changes would be required to amend and improve vehicular access, especially for operational vehicles. However, further measures would be required to improve sustainable travel. There is public car parking in the vicinity of this location although its operation should be reviewed in the light of any new proposals.

D.8 The current road access to Overdale is secondary and residential in nature. Current proposals divert all traffic from the existing JGH site and so it is proposed to adapt and increase the capacity of the access via Westmount Road. Traffic management is proposed to minimise traffic impact to the north. Car parking will also need to be provided for hospital users and for some hospital staff. An active travel and bus service level enhancement have been proposed to meet the requirements of the Sustainable Transport Policy. If there are fewer trips to the site owing to different services being offered, then the proposals could be revisited.

D.9 The former Les Quennevais School is located within a secondary settlement to the West of the island within a residential area. It relies upon the current road network serving this part of the island which has limited highway capacity for significant development over the current former school use and now community health use. The site is served by a local bus service and is well placed to access the cycle network.

D.10 Existing healthcare facilities in St Saviour are in a more remote rural location in the east of the island and ranks lower in spatial planning in terms of its connectivity and accessibility. Highway capacity is limited due to its remote location, its reliance on one main road and junctions that are already at capacity during peak traffic hours. Modest development should not require considerable enhancement of bus services or active travel. Depending on the scale of development proposed, the site is likely to require facilities for car parking.

D.11 For many travellers, the need to interchange buses and the extra time involved will be a deterrent to bus use at the Overdale and St Saviours sites, reducing the attractiveness of this mode. Comfortable and convenient taxi-cab access needs to be a consideration for all three sites.

D.12 From a property perspective, a new full hospital proposal at either Overdale or Gloucester Street will require land acquisition over and above that already owned by the Government of Jersey although it will also lead to the disposal of property.

D.13 Active land acquisition has already taken place for the Overdale site, and most of the land is now assembled for the Our Hospital Proposal. Parish of St Helier land (including the Jersey Bowling Club) and a small parcel in private ownership remain to be acquired. The acquisitions were required owing to designs for the new access and car park as well as the scale of the current proposals. If these acquisitions are not required for healthcare facilities, the properties can be resold either to previous owners or on the property market.

D.14 Depending on the scale of any scheme at Overdale, the following land could be used for other purposes or disposed: Jersey General Hospital, Five Oaks (CSSD), Maison Le Pape, 14 Gloucester Street, Westaway Court and St Elmo.

D.15 Land acquisitions were required for previous proposals at the Jersey General Hospital to reduce the scale of proposals. However, this site was still not large enough for a single proposal, with catering, outpatients and mental, and community health facilities located on other sites. Consequently, to support the current Functional Brief, further land acquisition is likely to be necessary beyond that on Kensington Place that was previously identified. Again, depending on the scale of any scheme at Gloucester Street there may be an opportunity use land at Overdale for different purposes or dispose of it.

D.16 Both the former Les Quennevais School and St Saviours are heavily constrained sites. Either in the case of Les Quennevais by the surrounding residential area, or in the case of St Saviours by the countryside. Land acquisition around St Saviour would be more straightforward and arguably cheaper, whereas Les Quennevais has multiple ownerships in higher value residential use surrounding it.

D.17 For all options, provision of key worker accommodation, outside of the scope of the Our Hospital Project, needs to be advanced to assist with resourcing any new facility.

D.18 By the same token a new approach to site development will reset the island wide public site use puzzle to meet the competing property demands of education, residential, amenity, infrastructure and blue light services.

D.19 For any development proposal anywhere in the island which requires planning permission, there is a formal statutory process to go through. The main differences in sites, are that Overdale has a planning permission for a new hospital development currently not implemented, and Les Quennevais has planning permission for conversion for health use, which has been implemented. Gloucester street has not received planning permission for a new hospital redevelopment, and any proposal would need to recommence the planning process to achieve consent. St Saviours has planning permission for a revised Mental Health facility, currently being implemented.

D.20 All previous hospital projects have come forward as one large development, the size and importance of which has been deemed to be a development of island wide significance and has therefore been called to a Public Inquiry directly by the Minister for Environment on three occasions, relating to three specific proposals. Each of those proposals has been assessed by way of Public Inquiry, and an independent inspector has on each occasion provided the Minister with a report and recommendation, which has led to a Ministerial planning decision.

D.21 This process has resulted in two previous refusals of outline planning permission on the Gloucester Street site, and one approval of planning permission on the Overdale site (subject to Planning Obligation Agreement).

D.22 Jersey has a plan led system by virtue of the Planning and Building Law 2002 as amended, and the current Bridging Island Plan 2022 is the extant development plan against which to assess development proposals. There is a variety of sub-ordinate legislation governing process for both Island Plan and Public Inquiries.

D.23 A proposal takes circa 6 to 9 months to go through the formal planning process once submitted.

D.24 Due to the scale of the facilities proposed, Visual Impact is an issue for proposals seeking to deliver all services on one principal site. This has manifested as a key part of all public inquiries, either within the tighter urban grain setting of St Helier, or on the more open higher geographic setting of Overdale.

D.25 Visual impact has been referenced twice as a reason for refusal for the Gloucester Street site. It remains a key issue for Overdale site due to its elevated nature.

D.26 Development at St Saviours will be subject to a wider visual impact challenge due to the remote rural location. Whilst Les Quennevais is within a developed area. Impact on both sites would be dependent on scale of development proposed.

D.27 Heritage impact on buildings and their settings are therefore common across both sites, and arguably more challenging on the Gloucester Street site.

D.28 The Overdale site has several listed buildings either within the development site itself that would need to be demolished, or in the vicinity. The access road also includes an historic muster point for the Battle of Jersey.

D.29 The current hospital includes a Grade 1 listed building, and the wider site has several listed buildings in the vicinity or potentially within the site boundary (depending on how this is assembled). The site is also opposite the Jersey Opera House a Grade 2 listed building.

D.30 Any site at St Saviour is likely to be on the northern side of north of Route de la Hougue Bie and the Grade 1 listed building at Queens House and arguably within the setting of this building.

D.31 Les Quennevais is sited within a modern residential area and has no immediate heritage constraints.

D.32 A variety of other material considerations are common to both main sites would be as follows:

- Waste arisings and management, and contaminated land
- Traffic impact
- Noise and construction impacts
- Active travel
- Height, daylight and privacy/shadowing
- Street scape and Design Quality and wider architectural assessments
- Accessibility
- Community engagement
- Need

## **Section 5: How and Where?**

E1. Outline durations for single site proposals to be developed at Overdale and Jersey General Hospital could be:

### **Overdale**

- Re-brief and decision making: 3 to 6 months
- OBC and Re-design (to RIBA Stage 03): 9 to 12 months
- Planning Permission Amendment or Application: 3 to 6 months
- RIBA Stage 04 Technical Design: 9 to 12 months

### **Gloucester Street**

- Re-brief and decision making: 3 to 6 months
- OBC and Re-design (RIBA Stage 01 to Stage 03): 18 to 24 months
- Planning Application: 6 months
- RIBA Stage 04 Technical Design: 9 to 12 months

E2. The above timelines assume that State Assembly approvals happen alongside the above. There may also be some efficiencies and overlapping of other tasks.

E3. If the delivery were phased it could allow some programme efficiencies for the first phase due to the reduction in scale. It would reduce the initial capital commitment, lowering the monthly cash profile and mean that risk could be spread across several separate delivery partners and contracts. It would also open up more on-Island opportunities from the scheme due to the respective scale. On this point, there should also be wider consideration to the Island programme and how demand can be aggregated to support decisions and buying.

E4. However, there would be an overall cost premium to deal with wider inefficiencies of design and delivery, as well as a longer exposure to market conditions and inflation, especially if current global market conditions continue.

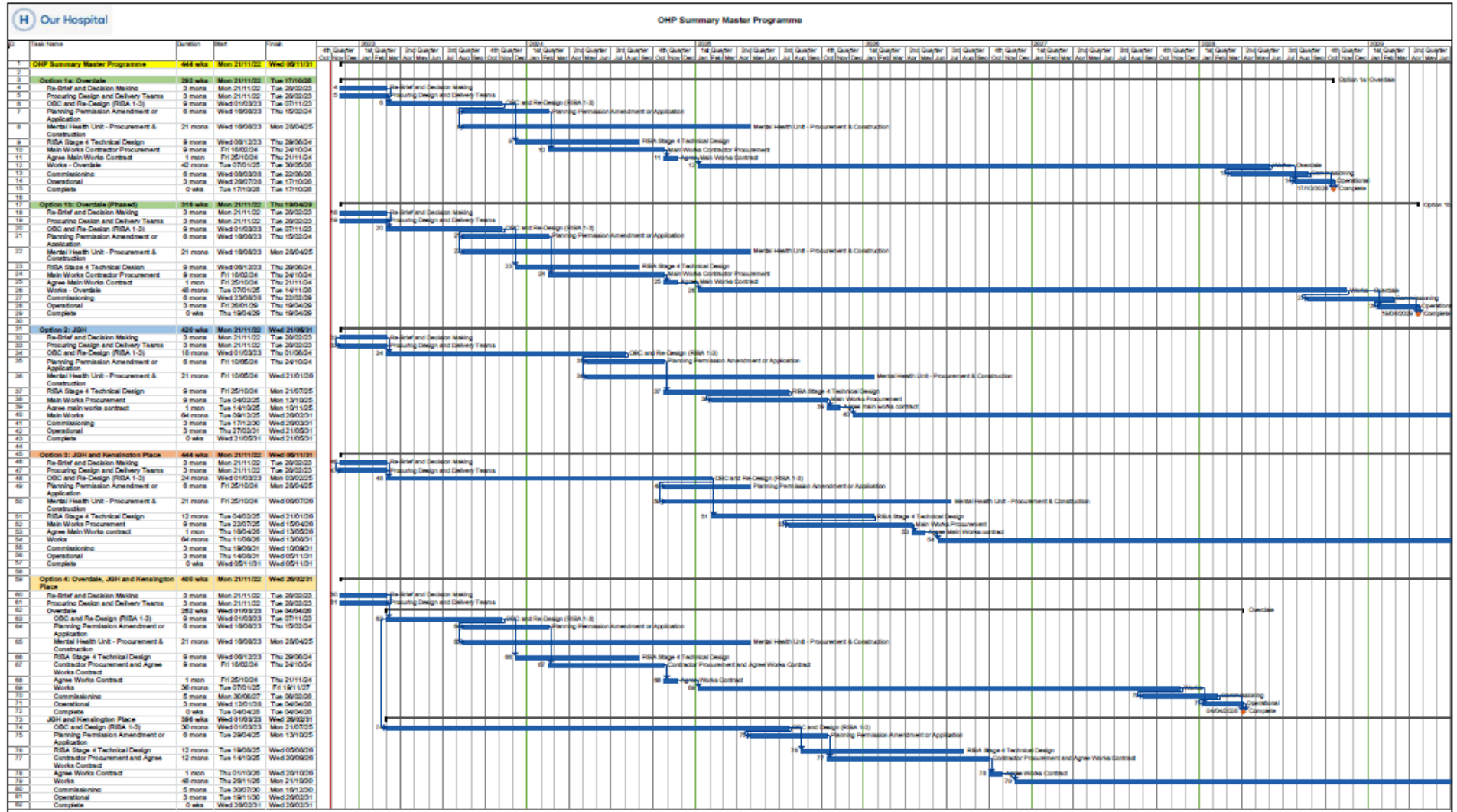
E5. On an open site, clinical adjacencies and priorities can be optimal; for an existing site, the healthcare provision within the new build will be dictated by the services that are decanted to accommodate the next phase.

E6. A phased delivery of a two-site option, with the added potential for the early delivery of a Mental Health (MH) facility, could offer some of the aforementioned benefits. It may also support the on-Island opportunities with MH and allow the reuse of some of the information developed thus far for a reduced Overdale facility.

E7. The programme for a phased delivery of a two-site solution could see an accelerated approach to the MH facility, with the ability to commence works on site within a 12-to-18-month window. A reduced Overdale facility could follow a 24-to-30-month duration to commence works on site (with the potential for some enabling works ahead of this), with a further facilities at Kensington Place or Gloucester Road to be developed to follow on from this.



Table 1: Summary Programme



Stakeholders interviewed for this section include:

- Project Management Office Advisor to Our Hospital Project
- Director General Infrastructure Housing and Environment
- Representatives of Design and Delivery Partner for Future Hospital scheme at Gloucester St
- Representatives of Design and Delivery Partner for Our Hospital scheme at Overdale
- Other potential Design and Delivery Partners

### **Section 6: Who?**

F1. The scheme has been a clinically led one. The building is ultimately for the health service and Islanders, and it needs to be able to function for health requirements and those delivering services from this floorspace. However, with the change of market conditions, it is more important than ever to ensure we have the most efficient design we can, to optimise how we not only build but also maintain. Time should be taken to not only develop this, but then robustly test and challenge it using structured engagement alongside digital tools, so that a truly optimised scheme is realised. This is likely to continue to require involvement of healthcare design specialists.

F2. A commercial or delivery model is normally informed by the objectives of a project, programme, or organisation, as well as self-acknowledgement around the type of client the organisation is. Some of these objectives may include risk; certainty; integration with supply chain; design ownership; social value; and capital vs operational expenditure.

F3. A typical delivery model would look at the timing of the contractor engagement; the design responsibility they take on; and any wider non-construction considerations (operations, for instance). It is likely this would be a one-off procurement exercise. A framework approach was discussed, but this would require procurement as well, and may not be attractive due to the lack of wider projects of this scale.

F4. Representations from larger off-island contractors with experience in healthcare suggest that they would continue to be interested in the one site, solution; there would be less interest in a phased solution. One representation confirmed that they thought it remained achievable within the figures provided in the Outline Business Case. Representations were not sought nor received from off-island specialist healthcare contractors who may normally act as sub-

contractors to the larger contractors. Their interest in tendering therefore needs to be tested in the next stage.

F5. Representations from local contractors suggested that they would be interested in having a larger role in any partnership arrangement that may be enabled by a phased solution. However, they also recognised the capacity of the local market and the likelihood that some off-island healthcare specialist involvement would be required.

F6. A variation on these approaches would be something like a local alliance. This could see local businesses combining in a formal contractual agreement to support delivery. The management of this, and associated terms, will be critical. Given the specialisms of healthcare facilities, this may pose challenges from a local capacity, capability, and experience perspective. However, it is something that there are examples of and may suit a scheme that is delivered in smaller parts, with the non-clinical spaces being an opportunity to exploit this approach.

F7. In terms of how any model is then delivered, it would need to follow the GoJ procurement guidance to deliver Value for Money, transparency and probity.

F8. The shape of the wider team will depend on the type of scheme and the chosen approach. However, from the previous work done in design, management, and controls, it is clear wider skillsets are needed to supplement local ones, with specific experience of delivering complex schemes.

F9. Any project of this size also needs a government client team function, to oversee the work of the contractors or consultants. GoJ does not carry this level of capacity in house and therefore there is a need for client functions to also be understood and funded, to ensure GoJ interests are protected. This would include suitable finance, commercial and governance roles. The exact composition of this will vary with the chosen commercial / delivery model although recent recommendations for the Senior Responsible Owner to be DG IHE and that the Project Director role must be fulfilled by an employee of the Government of Jersey has been adopted.

F10. A typical client team will be supported by a professional team. This will be led by a Project Manager, supported by a Cost Manager. For large and complex schemes, it will also include a Programme Management Office. In terms of the Design Team (architect, civil and structural engineer, mechanical/electrical

engineer, and specialists), these can sit under the client or Project Manager, or can sit under the building contractor.

F11. Jersey and other Crown dependencies can only utilise UK Government frameworks if named from December 2020. Many of the relevant frameworks to this project / programme were let prior to then and are not able to be called off. That been said, they are used as a benchmark to negotiate and utilise some of the best practice from those frameworks through GoJ tender processes. It is also worth noting that Jersey suppliers rarely feature on UK Government frameworks.

Stakeholders interviewed for this section include:

- Head of Procurement, Government of Jersey
- Project Management Office Advisor to Our Hospital Project, Mace Ltd
- Director General Infrastructure Housing and Environment, Government of Jersey
- Representatives of Design and Delivery Partner for Future Hospital scheme at Gloucester St
- Representatives of Design and Delivery Partner for Our Hospital scheme at Overdale
- Other potential Design and Delivery Partners
- Representatives of the Our Hospital Committee of the Jersey Construction Council
- Representatives of the Jersey Construction Industry

## **Appendix 5: Applying £804million Overall Capital Costs Indicative Construction Cost and Space Reduction Comparator Model applied to Options 1-4**

### **Step 1: Factoring Cost/M2 For Each Option**

**Original construction cost projection for OHP at Overdale  
66000m2@ £million = £12182/m2 (base reference cost)**

**Considering cost per m2 construction costs:**

1. Applying a 2.5% reduction on £12182 to reflect potential utilisation of increased modular construction applicable to options 1,2,3 & 4 leaves a revised base reference cost of £11877/m2 (revised base cost) **(Note 1)**
2. Applying a 7.5% reduction on the revised base reference cost applicable on the green field/Brown field elements on options 3 & 4 leaves where phasing is applicable and a wider tendering base and more competitive tenders could be achieved, a construction cost of £10986/m2 can be applied **(Note 2)**
3. Applying a 5% reduction on the revised base reference cost applicable on the town centre refurb elements on options 2-4 leaves where phasing is applicable and a wider tendering base and more competitive tenders could be achieved, a construction cost of £11283/m2 can be applied **(Note 3)**
4. Applying a 2.5% reduction on the revised base reference cost applicable on the Overdale 1b (phased construction option) where phasing is applicable and a wider tendering base and more competitive tenders could be achieved, albeit with greater risks associated with occupation and operation of part of the site whilst construction proceeds on the remaining phase. then a construction cost of £11580/m2 can be applied **(Note 8)**
5. When considering the Hybrid 2 site Option 4 costs, a potential capital cost reduction of £50m **(Note 4)** can be applied should the enhanced road construction (£30m) and adjacent land acquisitions (£20m) become unnecessary through lower site traffic density at Overdale.

## Step 2: Factoring Space Requirements For Each Option

Space requirement for original OHP proposals was 66000m<sup>2</sup> (base spatial requirement)

### Considering spatial requirements for Options 1-4:

1. For Option 1, a 10% spatial reduction on the original Overdale proposals can be assumed through greater use of E Health/Telemedicine and consequential space reduced space requirements together with removal of elements of scheme which could be provided elsewhere such as kitchens, clinical stores etc. This would result in an option 1 space requirement of 59400m<sup>2</sup> (Note 5)
2. For Options 2 & 3, a 7.5% spatial reduction can be assumed through greater use of E Health/Telemedicine and consequential space reduced space requirements together with removal of elements of scheme which could be provided elsewhere such as kitchens, clinical stores etc is assumed. This is less than the percentage reduction in Option 1 due to inefficiencies resulting from confined town centre site utilisation. This would result in an option 2 & 3 space requirement of 61050m<sup>2</sup> (Note 6)
3. For Option 4, a 5% spatial reduction can be assumed on the Overdale element of the proposals (50% of base spatial requirement) can be assumed through greater use of E-Health/Telemedicine and consequential space reduced space requirements together with removal of elements of scheme which could be provided elsewhere such as kitchens, clinical stores etc. This is less than the percentage reduction in Option 1 due to inefficiencies resulting from some duplication of facilities at both sites. This would result in a space requirement of 31350m<sup>2</sup> (Note 7) for the Overdale element of the Scheme.

The spatial reduction for the Gloucester Road/Kensington place element of Option 4 would be 7.5% as per 2 above and result in a space requirement of 30525m<sup>2</sup> (Note 8) for the Gloucester Road/ Kensington Place element of the Scheme. Combining the spatial requirement of both the Overdale and Gloucester Road/Kensington Place elements of Option gives a total special requirement of £61875 (Note 9)

### **Modelling Cost And Space For Option 1A**

£11877/m<sup>2</sup> (revised base cost) (Note 1) x 59400 m<sup>2</sup> (Note 5) = circa £705.5 million

**Option 1A cost £705.5 million**

### **Modelling Cost And Space For Option 1B**

£11580/m<sup>2</sup> (revised base cost) (Note1) x 59400 m<sup>2</sup> (Note5) = circa £705.5 million

**Option 1B cost £687.85 million**

### **Modelling Cost And Space For Option 2**

£11283/m<sup>2</sup> (Note 3) x 61050m<sup>2</sup> (Note 6) = circa £688.8 million

**Option 2 cost £688.8 million**

### **Modelling Cost And Space For Option 3** (assumes site 50% Gloucester St and 50% Kensington Place)

£11283/m<sup>2</sup> (Note 3) x 30525m<sup>2</sup> (Note 6) = circa £344.4 million

£10986/m<sup>2</sup> (Note 2) x 30525m<sup>2</sup> (Note 6) = circa £335.3 million

**Option 3 cost £679.7million**

### **Modelling Cost And Space For Option 4** (assumes site 50% Overdale & 25% Gloucester St and 25% Kensington Place)

Overdale element

£10986/m<sup>2</sup> (Note 2) x 31350m<sup>2</sup> (Note 7) = circa £344.41 million

Gloucester Road/Kensington Place elements

£11283/m<sup>2</sup> (Note 3) x 15262.5m<sup>2</sup> (Note6) = circa £172.21 million

£10986/m<sup>2</sup> (Note 2) x 15262.5m<sup>2</sup> (Note6) = circa £167.67 million

Sub-total of both elements of Option 4 = circa £684.29 million

Less road and surplus land costs at Overdale (Note4) = circa £50 million

Construction costs Option 4 = circa £634.29 million

**Option 4 Cost £634.29million**

## Summary

**Option 4 has been found to have lowest in capital cost from £635 million and a potential saving of up to £170 million on the basis of the costs in the Outline Business Case (Summer 2021)**

**Option 3 has been found to present the second lowest in capital cost from £680 million and a potential saving of up to £125 million on the basis of the costs in the Outline Business Case (Summer 2021)**

**Option 1b has been found to present the third lowest in capital cost from £685 million and a potential saving of up to £120 million on the basis of the costs in the Outline Business Case (Summer 2021)**

**Option 2 has been found to present the fourth lowest in capital cost from £690 million and a potential saving of up to £115 million on the basis of the costs in the Outline Business Case (Summer 2021)**

**Option 1a has been found to present the fifth lowest in capital cost from £705 million and a potential saving of up to £100 million on the basis of the costs in the Outline Business Case (Summer 2021)**

## Notes:

1. This construction cost and space comparator model has been developed with “as now” costs and ignores inflation since Summer 2021.
2. The model attempts to factor in greater tender efficiencies through modular construction and has been applied to all options.
3. The model attempts to factor in greater tender efficiencies through phased completion where options allow and this has been applied to options 2,3 and 4. For the purposes of the exercise and given its relatively small capital cost, the phasing of the mental health facilities has been ignored but would be possible in any event.



4. The model also ignores the potential advantages of phased tendering as and when market conditions prove favourable and the capacity to restrict borrowing to individual phases.
5. The model attempts to factor in spatial reduction through greater use of E Health / Telemedicine and consequential space reduced space requirements together with removal of elements of scheme which could be provided elsewhere such as kitchens, clinical stores etc is assumed. The degree of space reduction reflects greater efficiencies in option 1 but
6. with reduced efficiencies in option 2 &3 and particularly option 4 which has built-in inefficiencies due to duplication requirements of the Hybrid 2 site option.
7. Option 4 creates the potential for a further £50 million cost reduction if the road and additional land requirements can be removed due to a lower density site.

All of the assumptions laid out in the above model are subjective and should be validated by a further detailed analysis prior to ratification of the selection of the option going forward.

