

# *Assurance Report*

## *Future Hospital Project*

<b>Version number:</b>	v1.0
<b>Status:</b>	Final
<b>Date of Issue to Scrutiny Panel:</b>	8 <sup>th</sup> November 2017
<b>Chair of Scrutiny Panel:</b>	Simon Bree
<b>Client:</b>	States of Jersey
<b>Review dates:</b>	31 October to 3 November 2017

---

**Review Team Leader:**  
Matthew Symes, Concerto Partners LLP

**Review Team Members:**  
Jane Austin, Concerto Partners LLP  
Bill Yardley, Concerto Partners LLP

The authors acknowledge that this report is based upon a Cabinet Office document “Gateway Review 2 V4.0 (High Risk Delivery)” dated June 2008.

## Executive Summary

The Review Team has followed the UK Government's process for conducting assurance reviews, tuned by the Terms of Reference provided by the Scrutiny Panel.

The Review Team found good practice within the Future Hospital Project (FHP) and within the wider Health Transformation programme. Motivated people, albeit under-resourced, are working collaboratively to achieve a significant health system transformation in line with the objectives set out in P.82/2012 of which the FHP is a major component part.

The FHP's Outline Business Case (OBC) has five main elements in line with UK Treasury guidelines, mostly matching good practice. The project has submitted the OBC to the States Assembly for approval, so there is no time to take on board our comments, none of which are show-stoppers.

Our chief concern with the OBC is with its presentation and overarching flow. The OBC does not present a compelling story, starting with the drivers for change and leading the reader to a natural conclusion. An executive summary would help, linking the drivers for change, the whole health and social care transformation and the hospital's place within it, its Target Operating Model (TOM) and the number of beds. The OBC does not describe the TOM, raising a potential risk of future contingency fund drawdown if scope or layout changes become necessary. There are also inconsistencies in the dates and data presented in the different sections of the OBC and the accompanying appendices. Whilst not material, these are confusing.

In terms of the long-term project objectives, namely to deliver a new hospital within a budget of £466 million by mid-2025, we rate the project as **Amber-Green**, meaning that successful delivery appears probable. In terms of the short-term objectives, measured over six months, we classify this phase of the project as **Amber-Red**, which means that successful delivery of the project in that period is in doubt with major risks or issues apparent in a number of key areas.

The immediate risks at this time are:

- Delay to the OBC approval, potentially magnified by the political "purdah" period.
- Failure to obtain Planning Permission within the next few months.
- Failure to appoint a main contractor for the construction works in a similar timescale.

Despite some concerns in the detail and weaknesses in the over-arching narrative, our view is that the OBC is fit for purpose and presents a sound enough basis for decision-making by the States of Jersey.

## 1. Introduction & Terms of Reference

- 1.1. This report presents the findings of a review carried out by Concerto Partners LLP of the Outline Business Case for Jersey's Future Hospital Project (FHP) and its underlying assumptions.
- 1.2. The main requirement in our Terms of Reference is for an examination of the robustness of the Outline Business Case (OBC), with particular reference to the five supporting constituent cases (Strategic, Economic, Commercial, Financial and Management).
- 1.3. We would like to thank everyone interviewed for their openness and transparency. We would also like to thank the Officials supporting this review for their efficient help.
- 1.4. Appendix A lists those interviewed as part of this review.

## 2. Strategic Case

- 2.1. P.82/2012 - Health and Social Care: A New Way Forward set out a far-reaching and ambitious agenda for whole system reform and transformation across health and social care. It provides clear direction for the Island and, following its approval, an assurance that funding will be made available through the MTFP process to support its implementation.
- 2.2. P.82 is underpinned by a series of Health and Social Care strategies which together describe how the principal objectives will be delivered across the whole health and social care landscape.
- 2.3. The Future Hospital Project forms part of the Acute Services Strategy and the strategic case for a new district general hospital remains compelling on a number of levels. The inefficient design and aging fabric of the existing hospital has over time resulted in:
  - Poor clinical adjacencies;
  - Sub-optimal space standards;
  - Lack of flexibility;
  - Poor separation of clinical and non-clinical flows;
  - Poor gender separation, and lack of privacy and dignity;
  - Poor supporting mechanical and engineering infrastructure.
- 2.4. Failure to address these issues will compromise safe and effective care delivery in the future and the driver for change is clear.
- 2.5. The existing hospital also faces a growing capacity problem which will worsen in coming years. Population growth and a changing demographic profile increase demands on health and social care services.
- 2.6. Delivery of a new hospital is just one part of the overarching programme of system reform and transformation and its success is predicated on all P.82 health and social care

strategies coming together. The Review Team found that these strategies closely align, and we saw good evidence of strong collaborative, integrated, patient-centred working.

- 2.7. Considerable progress has been made with health and social care transformation in the period 2015-17 and we saw early evidence of the positive outcomes resulting from these service re-design initiatives. We discuss these more fully later in this report.
- 2.8. The Service Re-design and Transformation agenda has strong leadership and highly focused, committed and capable management teams. The potential for change and improvement is gaining traction and clinical engagement is gathering momentum. However, we found that the resources delivering the transformation are thinly spread, discussed more fully in the Management Case. It is important not to underestimate both the scale and pace of the transformational challenge ahead, and the capacity required to sustain it.
- 2.9. Our conclusion is that the strategic case for the FHP remains sound. The case for a new hospital, as a key component of the whole service redesign and transformation agenda for health and social care on the Island, is compelling.

### 3. Economic Case

- 3.1. The economic case in the Outline Business Case identifies four options:
  - Option 1 – Do Nothing
  - Option 2 – Do Minimum
  - Option 3 – New Hospital Build on existing site plus refurbishment of Westaway Court
  - Option 4 – New Hospital Build on existing site and a new build on the site of Westaway Court.
- 3.2. The economic appraisal assesses the extent to which each option satisfies the following criteria:
  - Represents a sound strategic fit and meets the strategic objectives
  - Fulfils the business need
  - Delivers the required/expected benefits
  - Is both deliverable and affordable.
- 3.3. The appraisal concludes that Option 4 is the preferred scheme.
- 3.4. The Review Team notes the lack of an over-arching document describing the Target Operating Model (TOM) for the new Hospital and Westaway Court. This document should compare the current “*as is*” with the future “*to be*” operating models.
- 3.5. The TOM should describe the full range of services, including all support services and business/administrative functions. It should provide clarity on those that will be re-provided in other community and primary care settings, and how they will operate in future.

- 3.6. There is general understanding of the main assumptions supporting the new builds and the location/relocation of the main services, but there is some uncertainty about what the future target operating model will look like. Without this clarity there is a risk of late changes of scope and layout.

**Recommendation 1: A Target Operating Model should be developed for the Future Hospital, covering all its services.** *Essential – First draft by January 2018*

### Population

- 3.7. As part of our brief for this assurance review we assessed the population projections within the OBC and determined how these might affect future demand for acute services.
- 3.8. The OBC's data for estimating changes (i.e. growth) in Jersey's resident population comes from a range of sources, including:
- Census 2011
  - Births, Marriages and Deaths Registrar
  - Population Office data under the Control of Housing and Work (2012) Law
  - Statistics compiled by the SoJ Statistics Unit
  - Data on pre-school and school-age children from the Department of Health and Social Services and the Department of Education.
- 3.9. The SoJ Statistics Unit keeps the population estimates under constant review and we understand that the unit is re-examining the population forecasting in the light of the Brexit decision.
- 3.10. Two factors affect population growth, namely net +inward migration and natural growth (births – deaths). In the OBC an analysis of the last 10 years shows that, on average, inward net migration has accounted for roughly 75% of the Island's growth.
- 3.11. The sensitivity analyses within the OBC relating to total population and annual net migration have an uncertainty range of approximately +/- 400.
- 3.12. The population forecasts in the OBC assume a net migration of +700/year for the four options, a figure that is consistent with social security planning assumptions. In recent years, net migration has been higher (for example +1300 in 2016). The sensitivity testing addresses this by modelling a range of different net migration levels (+325, +700, +1000 and +1500).
- 3.13. The OBC's population projections show an ageing demographic profile with a high proportion of older residents (65yrs+ and 80yrs+). These age groups show an increased prevalence of long-term conditions such as chronic pulmonary obstructive disease, cardiovascular disease and diabetes as well as multiple morbidities, cancers, joint replacements and ophthalmic conditions. As such, the older age groups tend to be the heaviest users of the Island's healthcare services and have increasing levels of dependency. The number of residents in each age group between 2016 to 2065, and the incidence of disease within each age group, informs the model's future demand for acute services.

- 3.14. The OBC extrapolates demand in the future from the current incidence of certain diseases within the population. It does not, however, reflect potential increases in the prevalence of certain diseases that are known to be on the rise.
- 3.15. The prevalence of disease in a population is influenced by many different factors including genetics, lifestyle choices/behaviours (e.g. diet, alcohol consumption), education and public awareness, other environmental factors such as pollution and socio-economic circumstances. Whilst these interactions are complex to measure and notoriously difficult to model, there may be some merit in further sensitivity testing to see how increases in the prevalence of certain conditions might impact future demand. This exercise could focus on those conditions that consume a high proportion of hospital resources.
- 3.16. We understand that the Public Health Division of the Statistics Unit has analysed recent trends and may be able to assist with this exercise.

**Recommendation 2: Further sensitivity testing should be undertaken to see how recent trends in the prevalence of certain diseases might impact future demand.**  
*Recommended*

- 3.17. The Review Team concludes that the approach adopted to assess population growth over the lifetime of the FH is well understood and that the methodology is appropriate and the data sources are reliable.

### Capacity

- 3.18. The future hospital will open in 2025 and 66 additional beds will be available, with Samares reverting to its original function as a 24 bedded rehab unit. The table below reflects the figures used by EY in the OBC modelling exercises:

**TABLE 1 – Current and Future Bed Capacity** (source OBC & appendices and HSSD data)

Type of Beds (excluding Special Care Baby Unit)	Number of Beds <sup>(1)</sup>	
	Current JGH ("as is")	Future Hospital ("to be")
Adult	148	212
Private	24 <sup>(2)</sup>	24
Samares	23 <sup>(3)</sup>	
Other	41	39
<b>Hospital Total</b>	<b>236</b>	<b>275</b>
Rehabilitation and Reablement		27
<b>Total Beds</b>	<b>236</b>	<b>302</b>

(1) There are some minor discrepancies between the information about the number of beds provided to us by HSSD and the information in the OBC appendices and how they are categorised.

(2) Some supporting documents refer to a private bed complement of 22. We understand that with the appointment of new consultants, there is the potential to offer new private procedures.

(3) Four Samares beds are currently closed. These rehabilitation beds are predominantly used as adult beds to relieve pressure within JGH.

- 3.19. The OBC's demand/capacity modelling utilises a variety of different drivers, including:

- Hospital Activity levels (episodes, attendances etc.)

- Population estimates
  - Demographic profiling by age bands
  - Case mix (types of conditions) and average lengths of stay
  - Resource/Space Utilisation (number of hrs/day, days/week)
  - Bed occupancy rates.
- 3.20. The success of the new hospital - with the capacity to meet the demands of a growing and aging population - is predicated on the delivery of several ambitious service “interventions” designed to prevent unnecessary/inappropriate attendance at hospital, avoid unnecessary admissions and expedite timely discharge.
- 3.21. The OBC includes a range of these service re-design initiatives (“interventions”) designed to deliver non-financial benefits by reducing the demand on:
- inpatient beds
  - theatre and day case sessions
  - hospital outpatient clinics.
- 3.22. Using a +700 net migration annual growth rate, the options appraisal assumes that these service interventions will, in totality, avoid the need for some 120 inpatient beds, which allows for bringing back into use four currently out of action Samares beds (see EY Intervention Modelling Report set out in Appendix 9 of the OBC).
- 3.23. The OBC presents a series of population/demand sensitivity tests, covering a range of net migration level. The findings for adult inpatient beds are summarised in Table 2 overleaf. Figures in red (-) denote a shortfall in the number of adult beds (i.e. demand exceeds capacity). Figures in black (+) denote spare capacity (headroom).

**TABLE 2 – Sensitivity Testing of the demand for Adult Inpatient Beds at different levels of Inward Migration**

<b>Option 1 - DO NOTHING</b>		
Net inward migration	2026	2046
+325	-34.3 beds	-144.7beds
+700	-36.5 beds	-154.6 beds
+1000	-38.3 beds	-162.5 beds
+1500	-41.2 beds	-175.5 beds

<b>Option 2 - DO MINIMUM</b>		
Net inward migration	2026	2046
+325	-46.7 beds	-129.2 beds
+700	-48.7 beds	-138.3 beds
+1000	-50.3 beds	-145.4 beds
+1500	-52.9 beds	-157.4 beds

<b>Option 3/4 - New Builds and/or Refurbishment</b>		
Net inward migration	2026 (first year of opening)	2046 (20 years after opening)
+325	+76.9 beds	+6.9 beds spare capacity
+700	+75.2 beds	-0.4 beds
+1000	+74.0 beds	-6.3 beds
+1500	+71.8 beds	-16.0 beds

*Source: Collated by the Review Team from data presented in EY demand and Capacity Modelling Methodology and Outcomes paper, Appendix 4 of the OBC*

*Note – this table concentrates on Adult Inpatient Beds only to present a simple inter-year sensitivity comparison, and does not include Rehab, Private and Speciality beds.*

- 3.24. The Review Team saw evidence demonstrating that the current programme of service re-design activities are working and already releasing valuable hospital resources (e.g. the recently commissioned MCAP Report in 2017 undertaken by The Oak Group and the latest reviews to assess the impact of step-down services, rehabilitation/reablement services and improvements in discharge planning).
- 3.25. We were given access to an additional modelling tool to allow us to assess the “tipping” point should these service interventions not fully deliver their intended outcomes. We found that a 50% shortfall would lead to a bed deficit in 2036. However, we recognise that the interventions included in the demand and capacity model are conservative. Other service initiatives now underway and not included in the OBC might mitigate this risk. Further opportunities may reduce the pressure on hospital services e.g. introduction of new technologies, integrated care records, new surgical procedures and new drug regimes.
- 3.26. As an extreme scenario that illustrates this dependency, the OBC’s demand/capacity modelling work indicates that the existing hospital would run out of beds by 2018 if these interventions do not achieve any of their anticipated outcomes.

### Flexibility

3.27. Those interviewed said that the new hospital, its design and size would provide sufficient flexibility to allow the service to respond to future changes in demand and new ways of working. For example, the single-room pod design, the configuration of the bedrooms, improvements in work flow and opportunities in relation to the Medical Day Ward all offer physical and process options that could cope with or divert demand. There is also some limited potential to expand on the site.

### Impact Assessments

3.28. The Review Team notes that the OBC makes no reference to an Equality Impact Assessment (EQIA).

3.29. Whenever there are any proposed service reconfigurations, the NHS in England is legally required to undertake an EQIA to ensure that the planned changes do not disadvantage any groups of individuals that share what are referred to as “protected characteristics” (i.e. age, disability, gender, pregnancy/maternity, race, religion/belief, sexual orientation, marital status). The results of the EQIA are included in all public sector business cases. We understand that there is no such requirement within the States of Jersey, but the HSSD has recognised the added value of an EQIA. We understand that the project team intend to carry out such an assessment.

3.30. Similarly, the OBC makes no explicit reference to a Health Impact Assessment (HIA). An HIA is a specific test to identify any unintended health consequences that may result from policy changes and/or service reconfigurations. Typically, it contains a clear analysis of whether the health outcomes of the population (or certain sections of it) will be compromised by the proposed changes. We understand that an HIA has now been completed for the FH Project and the report will be submitted to the Project Board for formal approval.

3.31. Our conclusion is that the Economic case is based on sound principles and analysis.

## 4. Commercial Case

4.1. The main hospital procurement strategy consists of a 2-stage design and build process, with novation of the design teams to the contractor once appointed. The contract is a target cost incentivised arrangement with a maximum guaranteed price cap.

4.2. The chosen form of contract is NEC3, modified by over 40 pages of “Z-clause” amendments. These largely cover unique Jersey-specific clarifications. Some cater for matters that are now in the NEC4, the latest version of the contract.

4.3. The Project Board has approved this strategy, based on a thorough analysis of the options. The Review Team support the strategy despite its complexity. It is well understood by the core Department for Infrastructure team and Gleeds but potentially less so by lay people,

including senior officials and politicians approving and scrutinising the project as it moves forward.

**Recommendation 3: The Project Team should raise awareness of the 2-stage target cost NEC3 procurement approach among senior decision-makers, the scrutiny panel and key stakeholders. Critical – Do Now**

- 4.4. The procurement process for the new hospital is well advanced with the stage 1 contractor bids due back in about one month's time. The Review Team are reassured that the Department for Infrastructure core team and Gleeds recognise the importance of maintaining competitive tension all the way through to the appointment of a contractor for stage 1 and the issue of a Pre Contract Service Agreement.
- 4.5. Gleeds and officials from the Department of Infrastructure are managing the relocation works. Local contractors and professional service providers are delivering these projects, with Gleeds coordinating them into the delivery schedule.
- 4.6. The successful timely purchase of a number of properties, including hotels, residential and commercial premises on Kensington Place will provide the full site footprint for the new hospital. The OBC reflects current valuation estimates and negotiations are ongoing with landlords. We heard that good progress is being made. At the present time there are no significant concerns that the purchases cannot be achieved within the valuations in the OBC and in a timely manner to allow the full site for the new hospital to be made available. Compulsory purchase is available to the Department for Infrastructure as a fall-back and has political support, as a last resort.
- 4.7. Gleeds are playing a critical role on the delivery of the project. The Review Team understand that they are contracted through to the end of the project, with hold points in their contract, the next being before the end of 2017. The Department for Infrastructure continue to monitor their performance.
- 4.8. The timely procurement of equipment is a key aspect of the project. A strategy is in place and as the project progresses this will be worked up into detailed plans and requirements.
- 4.9. Our conclusion is that the commercial case covers all the main elements that would be expected and matches the requirements of the project.

## 5. Financial Case

- 5.1. The Review Team's commentary of the financial case concentrates on the capital cost forecasts of the project and the associated programme. We have not considered the funding aspects of the project.

### Capital Costs

- 5.2. In the Strategic Outline Business Case the total estimated project cost was £466m. That remains the case for the OBC's preferred option. The constituent costs have developed

between the SOC and the OBC, as shown in the table below which reconciles the previous estimate, commonly known as CRO25, with the estimated cost at OBC stage.

**TABLE 3 – Cost Reconciliation** (source Gleeds analysis of SOC v OBC costs, Oct 2017)

Description	Total Cost (£) CR025	Total Cost (£) OBC Option 4	Diff	Comments
<b>FEASIBILITY COST SUMMARY</b>				
1 Departmental Works Costs (Department HPCG Costs)	124,333,568	113,300,366	-11,033,202	Reduction to main hospital area
2 Site Specific Works Costs (On Costs)	47,444,003	51,191,254	3,747,251	Value Management items identified Design development has informed the abnormals cost allowances
<b>3 Sub Total</b>	<b>171,777,571</b>	<b>164,491,620</b>	<b>-7,285,951</b>	
4 Provisional UK geographical location adjustment	41,226,617	39,477,989	-1,748,628	Continues to be applied at 24%
<b>5 Works Cost Total</b>	<b>213,004,188</b>	<b>203,969,609</b>	<b>-9,034,579</b>	
6 Consultant and Design Team Fees	31,950,628	35,627,519	3,676,891	Additional client fees identified and included at OBC stage
7 Site Specific Non-Works Costs				
7.1 Land	9,527,500	10,486,800	959,300	Land valuation has been refreshed by clients advisors
7.2 Other	4,505,000	4,505,000	0	Unchanged
7.3 % for art	1,065,021	1,019,848	-45,173	% driven
7.4 Off Site Transport Improvements	322,400	664,020	341,620	Additional highways works identified by design team
8 Equipment costs (Group 2 [Supply only], 3 & 4),	18,650,035	18,650,035	0	Unchanged
<b>9 Project Cost Total</b>	<b>279,024,773</b>	<b>274,922,832</b>	<b>-4,101,941</b>	
10 Contingency (Planning Contingency)				
10.1 Design development risk (inc within HPCG)				
10.2 Construction risk & Employer change and other risk	33,482,973	19,244,598	-14,238,375	Previously applied at 12% within CR025. Now 5% of this allowance is included in Item 1 above (Departmental Works Cost) to account for design development. 7% allowance included here.
<b>11 Sub Total</b>	<b>312,507,745</b>	<b>294,167,430</b>	<b>-18,340,316</b>	
12 Optimism bias	40,626,007	38,241,766	-2,384,241	Reduction to 12% captured in the Value Management items included in Item 1 above
13 Sub Total	353,133,752	332,409,196		
14 Inflation	68,751,739	53,083,713	-15,668,026	BCIS TPI applied (post Brexit this has shown a decline)
<b>15 MAIN HOSPITAL FORECAST OUTTURN COST</b>	<b>421,885,491</b>	<b>385,492,908</b>	<b>-36,392,583</b>	
<b>16 RELOCATION WORKS COSTS</b>	<b>39,932,327</b>	<b>76,180,322</b>	<b>36,247,995</b>	ES01 Area increased ES03 & 8 merged and scope of works increased ES04 additional floor added ES06 lease and fit out costs advised - above previous allowances ES07 scope and area increased ES09 design development detailing plant relocation work required ES10 The Limes refurbishment added into scope Pneumatic tube link works extended Multi Storey Car Park added into scope
17 INFLATION ON RELOCATION WORKS COSTS	4,092,597	4,189,642	97,045	BCIS TPI applied (post Brexit this has shown a decline)
<b>18 RELOCATION WORKS OUTTURN COST</b>	<b>44,024,924</b>	<b>80,369,964</b>	<b>36,345,040</b>	
<b>19 FORECAST TOTAL OUTTURN COST</b>	<b>465,910,416</b>	<b>465,862,872</b>	<b>-47,543</b>	

5.3. Our view is that the £466m estimated cost for the project appears safe and is a reasonable budget for the project at OBC stage. This is based largely on our analysis of Gleeds' work

and our understanding of their approach to developing the cost model for the Main Hospital building, which accounts for £386m of the £466m proposed budget. We have not undertaken a forensic check on Gleeds work but the following points are worthy of note in supporting our judgement:

- The detailed costs follow a standard industry approach involving the Health Premises Cost Guides (HPCG).
- Significant “abnormals” (a term Gleeds use to identify and provide cost estimates for items not included in the standard HPCG data) are costed at a conservative level.
- Given the challenging nature of the site and the likelihood of a longer build programme, £5.9m has been included in the costing to cover time-related site preliminary costs
- The size, scale and value of the project would normally attract an economy of scale adjustment to the detailed costs. In the previous estimate this was included at 0.89, reducing the estimate by about 12%. This has been set at 1.00 in the OBC, which is conservative.
- Detailed value engineering work has identified a net -£7m of savings in capital cost which have been approved by the Project Board. Further opportunities are available for later consideration.
- Substantial allowances have been included for Inflation (£57m) and a Jersey “location factor” (£39m), which caters for the effects of working in Jersey rather than on the UK mainland.
- The final estimates have been benchmarked against comparable UK hospital costs, adjusted for the Jersey location, using data from the Royal Institution of Chartered Surveyors Building Cost Information Service. The benchmarking indicates the hospital costs are in the expected range.
- The OBC includes substantial contingency allowances for “Optimism Bias” and for risk at £38m and £19m respectively, with a further 5% allowance for design risk embedded in the construction cost build up.

5.4. Table 4 overleaf shows the distribution of the various contingency allowances within the OBC (shown in the yellow highlighted boxes).

**TABLE 4 – Contingency Allowances within the OBC** (Source, Gleeds analysis October 2017)

Cost description	CR025 £m	OBC/current £m
Works Cost Total	213	197.25
<i>Works Contingency – Main Scheme</i>	£0	9.71
Fees, equipment and other costs	66.02	70.95
<b>Project Cost Total</b>	<b>279.02</b>	<b>277.91</b>
Contingency, Risk ( <i>Client Contingency</i> )	33.48	19.25
Optimism Bias	40.62	35.25
Inflation	68.75	53.08
<b>Main hospital Forecast Outturn Cost</b>	<b>421.88</b>	<b>385.49</b>
Relocation Works Costs	36.3	69.97
Works Contingency – Relocation Schemes	1.51	2.59
Client Contingency – Relocation Schemes	2.12	3.62
Inflation on relocation works costs	4.09	4.19
<b>Relocation works outturn Costs</b>	<b>44.02</b>	<b>80.37</b>
Forecast Total Outturn Cost	465.9	465.86
<b>Total Contingencies</b>	<b>77.73</b>	<b>70.42</b>

- 5.5. The Review Team understands that the bidders' proposals due in early December 2017 will include indicative budgets for the new hospital. This will represent another check on the robustness of the OBC budget.
- 5.6. The Relocation costs, including enabling works, amount to £80m and show an increase from £44m at the previous stage. The following table provides a reconciliation.

**TABLE 5 – Relocation Costs Reconciliation** (Source Gleeds analysis October 2017)

9th October 2017				
<u>EXISTING JERSEY GENERAL - ONE PHASE</u>				
<u>RELOCATION WORKS</u>				
<u>SUMMARY</u>				
	£ OBC	£ CR025	Difference	Comments
ES-1 Creation of Catering CPU				Allowance substituted by known leased building and scope defined
ES-2 Relocation Medical Secretaries/Consultants				
ES-3				
ES-4 Construction of the Temporary Block				increased size of the Temporary Clinic block to house more critical services adjacent to the interim hospital during construction; this facility has been designed to be re-used after the opening of the Future Hospital.
ES-5 Off Site Transfers				Medical records storage, brief developed
ES-6 Relocation of Corporate Functions -Lease costs		<b>REDACTED</b>		education facilities and offices required during the construction period to house HSSD staff decanted from Peter Crill House.
ES-7 Transfer of Clinics 2- Remodelled Westaway Court				Westaway Court to include the Pathology Lab, reduces the cost of the Future Hospital; as the Pathology Lab will remain permanently at Westaway Court connected to the hospital by a pneumatic tube.
ES-8 Transfer of Clinics 1 - Catering Refurbishment				Briefing developed and requirement established
ES-8 Reorganisation First Floor Parade, Granite and 1960s wings				Complex plant relocations defined and detailed including investigative works
ES-9 Re-siting of Critical Plant and Systems				changes in the funding assumptions for housing junior doctors at the limes, which is a one off capital cost rather than an ongoing revenue cost.
ES-10 Transfer of Staff Accommodation				
Post Occupancy Granite Block Refurbishment				
Additional 2 decks on MSCP				addition of the scope for modifications to Patriotic Street car park; not included in the previous estimate as no decision on funding had been made at that time.
<b>RELOCATION WORKS TO SOA SUMMARY</b>	<hr/>			
<b>INFLATION ON SCHEMES TO SOA SUMMARY</b>	<hr/>			
<b>TOTAL RELOCATION COSTS</b>	<u>£80,369,964</u>	<u>£44,024,924</u>	<u>£36,345,039</u>	

5.7. The increase in the Relocation costs is largely due to:

- the inclusion of the Pathology Lab in Westaway Court, which has created a saving in the estimated cost of the main hospital building,
- the inclusion of the cost of staff accommodation and work to the Patriotic Street car park which were not previously funded from the FH budget, and
- costs associated with more general scope changes and design developments.

- 5.8. The scope changes and design development element illustrate the importance of robust change control and management of risk and Optimism Bias (OB) monies at the next stage, following the appointment of the contractor, potentially as early as January 2018. Gleeds presented to the Review Team a possible approach to the delegation and management of risk monies and OB and we believe it is important that this is subject to the formal Approvals Process before the end of 2017.

**Recommendation 4: The Project Team should agree with the Project Board the arrangements for managing contingency funds for risks and optimism bias. Essential: Do by end of January 2018**

- 5.9. The Review Team are satisfied that there is no double-counting of costs within the OBC resulting from the transfer of the Pathology service to Westaway Court. We also understand that the FHP application for Planning Permission will not include the Pathology Laboratory; rather, Westaway Court's Planning application will.
- 5.10. As part of this review we considered the management of risk. We found that a good process is in place. The risk log identifies a high number of acute service risks which suggests the potential for client change and confirms the need to have a robust arrangement for the management of risk and OB funding in place as soon as possible.

#### Revenue costs

- 5.11. The revenue cost elements analyses in the Finance Case are broadly as we would expect, although we have not undertaken a detailed forensic analysis. The Finance Case element of the OBC goes into substantial detail on the revenue costs of the preferred scheme (Option 4). Based on a 60 year life, timed from the completion of the new hospital, the preferred scheme shows a £13.3Bn saving over the 60 years when compared to Option1, the do nothing scheme (see Figure 73 in the OBC).
- 5.12. The major element of the running costs of the future hospital are the clinical and non-clinical costs, which over the 60 year life significantly outweigh the capital costs. The revenue costs also contain, as we would expect, hard and soft facilities management costs and lifecycle costs. The detailed analysis in the Finance Case section of the OBC then comes together in Figure 83 of the OBC, which indicates a total capital and revenue cost for the preferred option of £61.1Bn over the 60 year life.

#### Programme

- 5.13. In the Review Team's judgement the construction programme is realistic for an OBC at this stage, to open the new hospital in 2024, followed by the opening of the Granite Block in 2025. This judgment is based on a planned construction period of nearly 3.5 years + 1 year for commissioning and occupation of the new building.
- 5.14. In examining the Appendix 23 of the OBC we were advised that the construction programme and phasing had a September 2017 baseline. This was inconsistent with other sections of the OBC.

- 5.15. We saw evidence that the dates for key critical path activity, including planning approval, contractor appointment and Westaway Court are already slipping against the timetable established in September 2017.
- 5.16. Several short-term activities, due for completion by the end of January 2018, are on the critical path for the project. These include:
- OBC approval
  - Planning approval
  - Contractor appointment for the first stage of the main Hospital build contract.
- 5.17. An independent planning inspector has been appointed and will open a five-day public inquiry in early November 2017. His terms of reference steer against revisiting the decision already taken over the choice of site. The Planning Department have adopted a neutral rather than supportive stance as the project breaches the Jersey strategic planning guidelines. We heard that the influential Jersey Architectural Commission have moved from a critical point of view more towards acceptance. There is a tight timescale for the planning submission to be approved by the Environment Minister following a recommendation from the inspector.
- 5.18. We formed the view that small delays in these approval and appointment activities may be manageable and recoverable in later phases. However, they are all significant, have a degree of complexity and are outside the direct control of the project team. A delay of more than two months could have more serious consequences for the programme as an election purdah period is due to start in Spring 2018 and decisions of this magnitude would probably have to await the appointment of new Ministers.

**Recommendation 5: The project team should keep up to date the detailed critical path plan for the activities leading up to the commencement of the purdah period. Essential – Do by January 2018**

- 5.19. The rebuilding of Westaway Court is either close to or on the critical path for the FHP project. This is a substantial project in its own right, with a value approaching £30m. Design work is ongoing and the first of two planning applications, for the demolition of the existing building, are about to be submitted.
- 5.20. The redevelopment of Westaway Court, its commissioning and the relocation of key hospital functions, among other things Pathology, is crucial to enable a start on site to be made on the new hospital building. Given our lack of confidence in the programme at Appendix 23 of the OBC referred to above, and the current slippage, we consider more needs to be done to provide comfort that Westaway Court will not become project critical.

**Recommendation 6: The project team should develop further the plan for Westaway Court, identifying options to protect the overarching FHP critical path. Essential – Do by January 2018**

### Costs to date

- 5.21. The costs to date are £15.1m. This nearly all relates to fees, mainly to Gleeds and their sub consultants, but also to other consultants for the planning submission process. The fees total £13.3m and the remaining £1.8m is attributable to States of Jersey costs, for example directly hiring staff to work on the project.
- 5.22. The costs to date become abortive costs if Planning Permission is not granted for the preferred site. The design solution is almost wholly site-specific and starting again on a new site would require a new design solution.
- 5.23. If Planning Permission is granted but if the OBC is not approved, the project will become delayed. The cost impact of such a delay would be of the order of low £ millions if the delay is measured in single weeks, but any larger delay will be exacerbated by the purdah period and the ensuing cost impact will more likely be measured in £10 million multiples.

### Financial case – conclusion

- 5.24. Taking all of the above into consideration, our view is that the cost forecasts include contingency allowance that look reasonable at this stage of the project in relation to the risks. Our conclusion is that the Financial Case is based on sound principles.

## 6. Management Case

- 6.1. The project governance arrangements are in place and are working effectively. The project team has strengthened the overarching governance in the last six months, with the addition of senior advisors at project board level.
- 6.2. We are pleased to see evidence of the Project Board being aware of cost-time-quality - scope trade-offs and taking decisions in that light. The Board has become familiar with the concept of Value Engineering and maintains a long list of options in which the cost-time-quality-scope trade-offs are explicit. This understanding represents a line of defence against inadvertent cost rises or delays.
- 6.3. Terms of reference are in place for all the main governance groups.
- 6.4. We saw evidence of structured engagement processes with the FHP's stakeholder groups, which will help mitigate the risks of future unexpected scope changes.

## Resources

- 6.5. It is important that the “intelligent client unit” works effectively and our primary concern is one of capacity. The core project team is under-resourced. There are too few suitably experienced in-house project resources, at all levels. Consequently there is a strong reliance on Gleeds, whose people demonstrate high capability. We are aware that the project team are considering the resource profile for the next phase of work but are constrained from making any appointments until the OBC has been approved. As such, this represents a continuity risk.
- 6.6. Once signed, the contract will contain numerous client obligations, many of which will involve the sign-off of critical requirements specifications and design decisions, often within very tight timescales. These tasks require specialist domain knowledge, some of which will be specific to Jersey. Dedicated resources - with the skills, knowledge and capacity to fulfil these functions - will need to be in place. One approach is to backfill key roles so that clinical, administrative and support staff can be released from their “day jobs” at critical times throughout the lifecycle of the project.
- 6.7. The new hospital is just one part of an ambitious programme of change and transformation across health and social care. The success of the programme depends on:
- (i) significant service re-design and process re-engineering, and
  - (ii) the extent to which these new ways of working can be embedded within the hospital and the wider community.

To drive this work will require specialist change managers as well as change champions within the hospital and the partner organisations.

**Recommendation 7: The HSSD should provide assurance that there is sufficient capacity (in place, or planned) to deliver the transformation agenda. Essential – Do by January 2018**

### Project and Programme Dependencies

- 6.8. The FHP construction schedule contains numerous project-specific dependencies (e.g. approvals, planning, funding, and relocations). There is also widespread recognition that the success of the future hospital depends on key initiatives in the community and primary care settings. There are many other critical inter-dependencies that require management attention too e.g. the provision of ICT.
- 6.9. The new hospital will be ‘*paper light*’ and the design assumes that there will no longer be a Health Records department onsite. This scenario assumes that the development and implementation of the electronic patient record, and all its associated systems, will be fully operational for the opening of the new hospital. It also assumes that the Jersey integrated care record will be in place across health and social care.

6.10. We understand that ICT delivery plans are on track, but it is important that all the inter-dependencies between the FHP and the wider transformation programme are properly identified and tracked.

**Recommendation 8: All inter-dependencies between the FHP and the wider transformation should be identified. Essential – Do by March 2018**

6.11. As a relatively minor point, the Review Team sees an opportunity to improve document management and control. Documents are date-stamped but not subject to effective configuration management and version control.

6.12. Our conclusion is that the Management Case is sound.

## 7. Risks

7.1. In addition to the risks identified in the FHP risk register, this review highlights some different risk perspectives that are of concern:

- Dependencies. The capabilities that the FHP will provide will contribute to transformation activities across the wider Jersey Health and Social Care economy. Likewise, the FHP depends on those wider transformation activities to optimise its efficiency and effectiveness. The Review Team has two concerns in relation to this. First that those interdependencies are not clearly expressed or understood. Second that future funding cuts in the wider transformational activities may undermine the ability of the FHP to operate as planned.
- Changes to scope and requirements. Despite the project team's initial stakeholder engagement work, the high incidence of acute clinical/service risks presented in the risk register suggests a potential for future contingency consumption when stakeholders engage more fully. This raises a supplementary question about the extent of the culture change programme necessary to embed new ways of integrated working, custom and practice, particularly in the acute and social care community.
- Project resources. As noted above, the core team is too thinly-resourced and is over-dependent on external support. This creates a continuity risk and misses an opportunity for wider knowledge and skills transfer.

## 8. Conclusion

8.1. Our overarching conclusion is that the OBC provides the States of Jersey with a sound enough basis for decision making. The five elements of the OBC match good practice, albeit containing some issues, but none of these are showstoppers.

8.2. We rate the project as Amber-Green because the project has sufficient contingency, in terms of time and cost allowances, to cope with the various risks that face it.

**APPENDIX A**

**Interviewees**

<b>Name</b>	<b>Role</b>
Ray Foster	Director of Estates, Jersey Property Holdings, Dfl
Bernard Place	FH Project Director – Health Brief, HSSD
Helen O’Shea	Managing Director, JGH, HSSD
Mike Penny	Director, Gleeds Management Services - Lead Technical Advisers
Robin Whitby	Construction Advisor, Dfl
Sarah Howard	Assistant Finance Director, HSSD
John Rogers	SRO Chief Officer – Department for Infrastructure
Julie Garbutt	Chief Executive – Health & Social Services
Andy Ross	EY, Financial Assurance and Evaluation
Rachel Williams	Director – System Redesign & Delivery, HSSD
Tom Brader	Costs, Gleeds Management Services
Becky Sherrington	Head of Nursing & Governance, HSSD
Bronwen Whittaker	Deputy Director – System Redesign & Delivery, HSSD
Mark Plenty	Procurement, Gleeds Management Services
Jason Turner	Deputy CEO/Director – Finance & Information Services, HSSD
Richard Glover	Manager, Planning Performance, Dfl
Jessica Hardwick	Project Manager, Transport and Civil, Dfl