Office of the Comptroller and Auditor General

Decision Making: Selecting a Site for the Future Hospital (March 2012 - February 2016)

23 November 2017

JERSEY AUDIT OFFICE

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Introduction

1.1 Making the right decisions in the right way is key to securing value for money. Decisions on major capital projects are an example of such decisions and inevitably draw significant public and political interest. I previously reported on arrangements for decision making about a major capital project in my September 2013 report *Management of Major Property Transactions: Learning from the proposed acquisition of Lime Grove House*. I made a series of recommendations for improvement in the management of future projects.

1.2 In October 2012, the States Assembly debated and adopted P.82/2012, a proposition on healthcare reform, including requirements for future hospital capacity. The Assembly required the Council of Ministers to bring forward proposals for investment in hospital services, including detailed plans for a new hospital on either the existing General Hospital site or a new site.

1.3 The proposed Future Hospital is the biggest capital project ever undertaken by the States of Jersey (the States). To give an indication of scale, the cost of the Future Hospital as a proportion of Jersey's economic activity is similar to that of High Speed 2 as a proportion of the UK's. The scale of the project and the public attention that such a project receives reinforce the importance of making the decision on where to build the Future Hospital in the right way.

1.4 Consideration of where to build a Future Hospital commenced in 2012. In July 2013, Ministers endorsed a proposed development based on the General Hospital site but set a 'phase 1' maximum capital funding package of £250 million. Officers subsequently developed a 'refined' dual site option and in October 2013 the Council of Ministers agreed to progress this option. In December 2013, the States Assembly agreed the annual budget for 2014, including for capital expenditure of £10.2 million in 2014 and subsequent years on planning and creating new hospital services.

1.5 In July 2014 a 'Peer Review of Reform of Health and Social Services':

- highlighted the risks of building on an operational hospital site;
- concluded that at ten years, the dual site option would take too long;
- highlighted the need to reconsider the size requirements for the hospital; and
- emphasised the importance of viewing the project in the context of a wider programme of healthcare reform.

The review recommended reconsidering the implications of the dual site approach in terms of risk and mitigations. Subsequently, in September 2014, a report of the Health, Social Security and Housing Scrutiny Panel questioned the dual site option.

1.6 Following the General Election held in October 2014, a new Council of Ministers was formed, including a new Minister for Health and Social Services

who was publicly opposed to the dual site option. Against this backdrop further work was undertaken, including reconsidering some of the original options. In July 2015, the Project Board identified and the Ministerial Oversight Group approved a new site option – the People's Park. In August 2015, the new site was evaluated by the States' advisors and in October 2015 Ministers endorsed it as the preferred site.

1.7 Plans were developed for public consultation on five potential sites in 2016. In February 2016, prior to commencement of consultation, the Council of Ministers withdrew People's Park as one of the options and decided not to proceed with the public consultation process. Subsequently the Council of Ministers identified part of the existing General Hospital site and adjacent land as the preferred site for the Future Hospital.

1.8 Between 2012 and 2016, the project proceeded in two main phases: a 'pre-feasibility stage' and a 'feasibility stage'. I consider the scope of these stages in theory and practice later in this report. A timeline and associated arrangements are summarised in Exhibit 1.

Exhibit 1: Timeline for decision making on Future Hospital

Political groups	Officer groups	Key advisors	Key activities and decisions	Cumulative expenditure	Estimated Capital cost at period end
Pre-feasibility stage					
May 2012 – February 2013					
Ministerial Oversight Group (MOG) MOG Pre-Feasibility Sub-Group (from Dec 2012)	Project Board	Technical Advisor	Preparation of long list of 24 sites Identification of short list of 11 sites against industry standard criteria Preparation of a Strategic Outline Case preferring development on the existing General Hospital site	£243,000	£462m
February 2013 – July 2013					
MOG	Project Board	Technical Advisor Design Champion (from June 2013)	Affordability issues raised, leading to a proposal to develop a more detailed concept for a £250m 'first phase'. Engagement of a Design Champion to support the process.	£369,000	£250m in 'first phase'

Feasibility stage					
July 2013 – October 2015					
MOG Ministerial Oversight Hospital Feasibility Sub-Group (October 2013 to February 2014)	Project Board	Design Champion Lead Advisor	Financial constraints drive 'refinement' of preferred option to 'dual site' solution. Following Scrutiny Report, option of 'dual site' reconsidered. Evaluation of alternative sites. Agreement to proceed to public consultation. Introduction of People's Park for consideration and evaluation by Lead Advisor. MOG and subsequently Council of Ministers agree People's Park as preferred site.	£4,300,000	£435m 'funding envelope'
October 2015 – February 2016					
MOG	Project Board	Lead Advisor	Agreement to include People's Park in public consultation. Withdrawal of People's Park from and cancellation of public consultation.	£5,500,000	£435m 'funding envelope'

1.9 After the decision not to proceed with the People's Park option, Ministers agreed to develop the General Hospital site. To September 2017, reported cumulative expenditure on the Future Hospital project had reached £18,900,000. In P.107/2017, as lodged au Greffe on 31 October 2017, the States Assembly has been asked to approve capital expenditure on the Future Hospital of up to £466 million.

Objectives and scope of the review

1.10 The review evaluates the effectiveness of decision making within the States, focussing on one key decision – the choice of site for the Future Hospital. The review:

- evaluates the effectiveness of decision making processes relating to the identification of the location for the Future Hospital; and
- identifies areas for improvement that can be applied by the States more widely. My recommendations are therefore predominantly directed towards future major projects undertaken by the States although many are also relevant to the Future Hospital project as it progresses.

1.11 The review covers the period up to 23 February 2016 when the People's Park option was withdrawn from the shortlist. The review does not cover the period after 23 February 2016. However, where officers have provided evidence of subsequent improvements in arrangements, I have evaluated the information provided and, as appropriate, reflected it in this report.

1.12 The review does not extend to:

- whether to build the Future Hospital or not;
- validating the size or clinical requirements for the Future Hospital;
- the options for financing or procuring the Future Hospital; or
- a detailed review of the development of the wider Acute Service Strategy, including the role of clinicians in the development of the Strategy.

1.13 In undertaking my work, I obtained advice from PricewaterhouseCoopers on good practice in decision making in the context of clinical development. That advice is reflected in this report but the conclusions reached and recommendations made are mine.

1.14 The remainder of this report does not provide a detailed chronology of the site selection process. Instead, to emphasise the key findings and their applicability to decision making more generally, it evaluates the effectiveness of arrangements for decision making in key areas (see Exhibit 2).

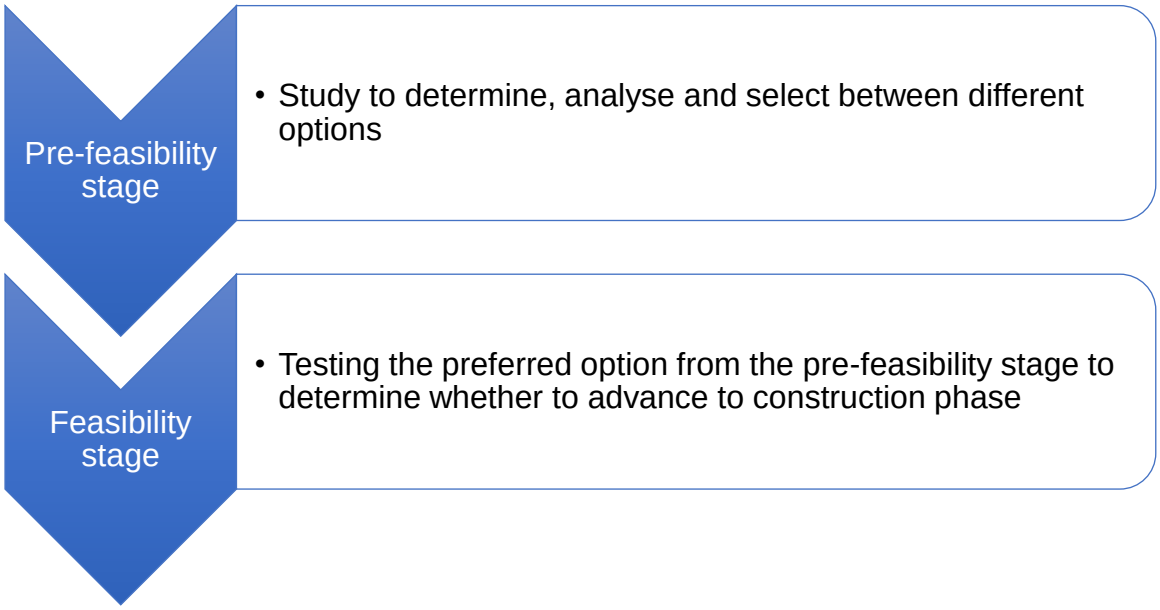
Exhibit 2: Aspects of decision making reviewed

Decision making stages
Decision making arrangements: Ministers
Decision making arrangements: Officers
Risk management
Criteria and evaluation against criteria
Consultation and communication
Expertise to support decision making
Recording decision making

Decision making stages

2.1 Effective decision making requires clarity throughout the process of the decision to be made. For major projects, there are conventionally both pre-feasibility and feasibility stages (see Exhibit 3). The different stages provide clarity for decision makers about the nature of the task in hand. Inherent in the feasibility stage is the possibility that the preferred option from the pre-feasibility stage is rejected and that there is a return to the pre-feasibility stage.

Exhibit 3: Pre-feasibility and feasibility stages



2.2 As described above, the States adopted a two-stage approach with the pre-feasibility stage identifying a solution based on the existing General Hospital site before moving into feasibility stage. However, during the feasibility stage there were in turn two new preferred options: a dual site development in 2013 and the People's Park in 2015. But there was no return from the feasibility to the pre-feasibility stage.

2.3 I am concerned that the decision making process was confused. Returning to a pre-feasibility stage would have explicitly reflected the point reached in decision making. It would have helped to increase focus on the task in hand and provided a clear distinction between identifying a preferred site by the application of agreed criteria and testing the validity of that preference.

Recommendation for future major projects

R1 In managing major projects identify the overall process at the outset and follow that process unless there is an overriding, documented reason not to do so.

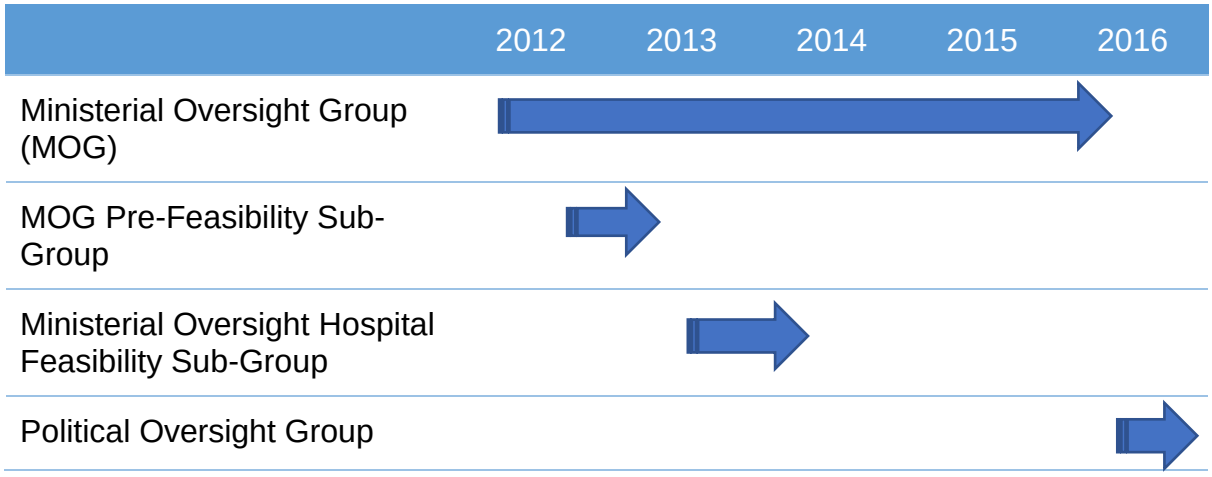
Decision making arrangements: Ministers

3.1 The nature of the decision was one that was not delegated to officers or indeed entrusted to an individual Minister. The States Assembly had specifically charged the Council of Ministers with bringing forward proposals. In addition, the nature and the scale of the project meant that different Ministers had a direct interest:

- the Minister for Health and Social Services, as health services were to be provided by the Future Hospital and because of the wider links to P.82/2012;
- the Minister responsible for Jersey Property Holdings (initially the Minister for Treasury and Resources and subsequently the Minister for Infrastructure), as the lead for delivery of the capital programme;
- the Minister for Treasury and Resources, given the substantial funding implications of a project of this scale; and
- the Minister for Planning and Environment (subsequently the Minister for the Environment), given the need for planning permission for the Future Hospital.

3.2 In these circumstances it was appropriate for structures outside the Council of Ministers to be put in place for Ministers to receive and consider information. It was important for officers to support Ministers in putting in place effective governance arrangements. The arrangements at different stages of the project are summarised in Exhibit 4 and the membership of the different groups is detailed in Appendix 1.

Exhibit 4: Ministerial arrangements for the Future Hospital 2012 – 2016



Pre-feasibility stage

3.3 The wording of P.82/2012 was high level: it required the Council of Ministers to:

- co-ordinate the work of all relevant Ministers;
- bring forward proposals for investment in hospital services; and

- bring forward proposals for a new hospital, either on the site of the existing General Hospital or a new site.

3.4 What was required at that stage was clarity on the processes that the Council of Ministers would follow to implement P.82/2012 and how and when it would report back to the States Assembly. However, I have not identified any document that sets out those arrangements nor have I identified clear and unambiguous advice from officers recommending appropriate arrangements.

3.5 The result was ambiguity. In October 2013, the Council of Ministers agreed that it was appropriate to pursue the dual site option and included funding in the 2014 budget. Initially officers argued that in agreeing funding, the States Assembly had implicitly agreed the dual site solution. Subsequently, following a Scrutiny Panel report in September 2014, officers accepted that no such agreement had been provided.

3.6 In April 2012, the Council of Ministers requested that the already established Ministerial Oversight Group (MOG) was tasked with providing political direction to, and scrutiny of, the transformation of the Health and Social Services system, as subsequently set out in P.82/2012. I am concerned that:

- MOG comprised a substantial proportion of the membership of the Council of Ministers with other members frequently in attendance. Establishment of a group of this size meant that the potential benefits of a small focused group were not secured and blurred the distinction between the respective roles of the Council of Ministers and MOG; and
- what should be reported by MOG to the Council of Ministers and when was not specified in the Terms of Reference or elsewhere.

3.7 In October 2012, in light of the timetable to which the Council of Ministers was then working to identify a site (March 2013), the Council of Ministers resolved that 'the existing Ministerial Oversight Group should not lead the further work to be undertaken and that a Steering Group should be formed …'. The Council of Ministers decided that the Steering Group should include the Chief Minister, the Minister for Health and Social Services and unspecified others. But that was not what happened: a group met for the first time in December 2012 but it was described as a 'MOG Sub-Group'.

3.8 I am concerned that the arrangements put in place hindered effective decision making:

- the Sub-Group had no Terms of Reference setting out its functions; and
- crucially, its relationship with MOG was not defined: the minutes of the meeting of MOG in June 2013 recorded that MOG was unable to endorse a recommendation for a preferred site in the absence of a report from the MOG Sub-Group. But there is no documentary evidence that such a duty was ever placed on the MOG Sub-Group.

Feasibility stage to February 2016

3.9 In July 2013, as the project moved into the feasibility stage, Terms of Reference were developed for a Ministerial Oversight Hospital Feasibility Sub-Group that was to serve as a point of reference on making key political and policy decisions and provide reports on progress to MOG. The Ministerial representation comprised the Minister for Health and Social Services and the Minister for Treasury and Resources.

3.10 I have highlighted key events in the feasibility stage that may have contributed to slower progress: responding to the report of the Health, Social Security and Housing Scrutiny Panel, responding to the peer review and the September 2014 General Election. There was also an absence of a consensus within the Council of Ministers that the Future Hospital was required and key decisions were deferred. As late as June 2015, the Chief Executive wrote to the Council of Ministers acknowledging that the Ministers who did not sit on MOG were not well sighted of the need for a new hospital or the site option appraisal that had been undertaken.

3.11 Political leadership is vital for major projects. I am concerned that for the period of nearly four years covered by this review effective arrangements for political oversight of site selection were not in place. In my view officers should have done more in this period to promote improved arrangements.

Subsequent developments

3.12 Improvements in arrangements were secured in May 2016, after the period covered by my detailed work. MOG was dissolved and a new, smaller Political Oversight Group was established. Its Terms of Reference clearly set out that it was to report to and advise the Council of Ministers. In particular, it was charged with holding monthly meetings and reporting to the Council of Ministers:

- setting out for the Council of Ministers the site options to be considered; and
- advising the Council of Ministers about the political risks associated with the delivery of the Future Hospital programme and the potential implications for the wider social, economic and political environment.

3.13 I welcome the arrangements that have now been put in place.

Recommendation for future major projects

R2 For all major projects, establish at the outset clear and effective arrangements for political oversight, including:

- compact and focused groups established for political oversight; and
- Terms of Reference for such groups that include responsibilities for reporting.

Decision making arrangements: Officers

4.1 Just as at ministerial level, there is a need for clear structures and accountability at officer level. In establishing those structures, officers can draw on widely-accepted standards for project management, such as PRINCE 2, that provide for a project board and assigned roles for different members of that board. But in doing so they cannot detract from the statutory responsibility of individual Accounting Officers for funds voted by the States Assembly. The Accounting Officer and project management arrangements for the Future Hospital are summarised in Exhibit 5 and the membership of the different groups is detailed in Appendix 2.

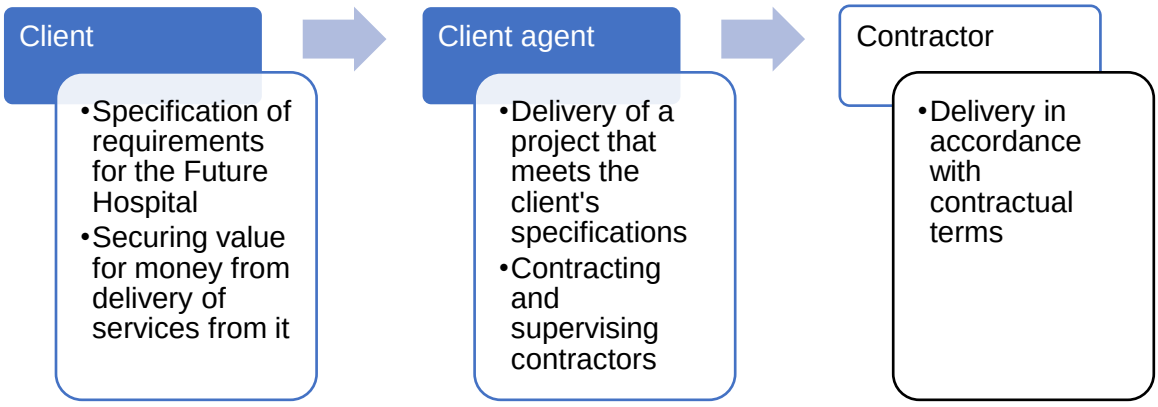
Exhibit 5: Accounting Officer and project management arrangements 2012 - 2016

Notes: (1) Named as Project Director in draft Outline Programme and Terms of Reference
(2) Date of appointment of Project Director (Delivery) not documented

4.2 The Accounting Officer role is a key feature of the Public Finances (Jersey) Law 2005. It places personal responsibility for the propriety and value for money of public expenditure on designated Accounting Officers, usually chief officers. As a capital project, the Accounting Officer role for the Future Hospital did not rest with the Chief Officer for Health and Social Services but with the Chief Officer responsible for Jersey Property Holdings. This meant that the Accounting Officer role was held by the Treasurer of the States until January 2016 and, following the transfer of Jersey Property Holdings to the Department for Infrastructure, by the Chief Officer of that department from 2016.

4.3 The Accounting Officer framework does not reflect the respective roles of two chief officers – the Chief Officer for Health and Social Services as 'client' and the Chief Officer responsible for Jersey Project Holdings as the 'client agent' (see Exhibit 6). In my view both have important roles. The current statutory framework does not reflect that complex joint and inter-related responsibility.

Exhibit 6: Roles of different chief officers



4.4 Despite the statutory allocation of responsibilities, there was a clear benefit of the 'client' chief officer assuming a leadership role and for key officers, drawing on their different knowledge, skills and expertise, to work together to provide leadership for this very substantial project.

4.5 The Future Hospital is part of a wider vision for transformation of health and social services set out in P.82/2012 that involves changes in the mode of delivery and increased delivery of healthcare outside the acute hospital environment. The Chief Officer for Health and Social Services is responsible for this wider vision and delivery of P.82/2012 is dependent on a number of individual projects, including the Future Hospital project for which the site is a key factor. Successful delivery of the Future Hospital project is also in significant part dependent on delivery of other projects. Yet it was clear from my discussions that leadership for hospital site selection was seen to be the responsibility of the Accounting Officer for Jersey Property Holdings.

4.6 Effective delivery of change depends upon the relationship of individual projects to wider programmes and the range of projects and programmes across an organisation (see Exhibit 7). Effective management at programme and portfolio level maximises the chance of success of individual projects.

Exhibit 7: Project, Programme and Portfolio management

	What does it mean?	What does good management involve?
Project	A series of tasks that aims to produce a specific product, service, or benefit within a defined timeline.	Working with stakeholders to ensure that projects are completed on time, within budget, meet the established requirements and realise project benefits.
Programme	A group of related projects that all contribute to the same business objective or benefit.	Identifying and addressing cross-project dependencies, risks, issues, requirements and solutions. Co-ordinating with individual project managers to achieve these insights and deliver the overall programme.
Portfolio	All the projects an organisation is running in order to meet its main strategic objectives.	Setting priorities based on the organisation's agreed objectives. Choosing programmes and projects based on what will provide optimal value, the level of risk involved and available resources. Evaluating whether projects are being executed well, how they could be improved and whether the organisation is experiencing the expected benefits.

4.7 The States do not have an established corporate framework or dedicated resource for effective programme management and there is no established culture of managing at programme or portfolio level. This increases the risk that projects do not deliver the objectives of a programme or wider organisational objectives.

4.8 There were, however, programme management arrangements in place for the P.82/2012 programme. An officer level Transition Steering Group oversaw the programme, attended by leads for each 'workstream'. The Group discussed the interdependencies between and risks associated with individual workstreams. Interdependencies were also reflected in the risk register for the programme and in Outline Business Cases for each workstream. However, at pre-feasibility stage in particular, the Future Hospital project was insufficiently connected to the wider change programme (see Case study 1).

Case study 1

The pre-feasibility stage of the Future Hospital project was intended to agree on a site by September 2012 'within the context of the proposed model of health and social care being set out within the White Paper'.

Draft governance arrangements reflected this through:

- at political level, MOG overseeing site selection as part of wider transformation of Health and Social Services; and
- at officer level, the Transition Steering Group. comprising the leads for each P.82/2012 workstream.

However:

- the Project Boards did not routinely consider updates on the progress of - or the impact of delays to - other initiatives; and
- the Transition Steering Group did not have a standing item on the progress of the Future Hospital. The operational connection between the Future Hospital project and the wider change agenda relied on people moving between groups rather than more formal mechanisms for information exchange.

Crucially, site selection proceeded in the absence of strategic plans which would inform how Acute services fitted alongside, for example, evolving plans for Mental Health, Primary Care and 'Out of Hospital' services. In August 2013 the impact that this gap in strategic planning posed to site selection was recorded in the Future Hospital project risk register as 'an inadequate service brief had resulted in the wrong facility being specified'. The risk register recorded development of an Acute Service Strategy as mitigation. By February 2016 the size requirements for the Future Hospital had fallen significantly, informed by both the Acute Service Strategy and a decision to work to more restricted floor area standards.

In the absence of a robust specification for the Future Hospital, it is difficult to see how the preferred site options adopted in February, July and October 2013 were justified. The consequence of planning in the absence of comprehensive service delivery plans and area schedules was that People's Park, subsequently identified in 2015 as the preferred site, was not even considered in 2013 as it could not accommodate the size of hospital then envisaged.

Pre-feasibility stage

4.9 The Pre-feasibility Spatial Assessment Process was originally planned to last for six months but ran from April 2012 to June 2013. A Project Board was supported by a Project Team.

4.10 Draft Terms of Reference and an Outline Programme were developed for the initial six-month stage. I have not been able to identify who drafted these and therefore whether they had the requisite knowledge and authority. In any event, they remained in draft.

4.11 In key respects those draft Terms of Reference:

- were overambitious. They envisaged the appointment of a technical advisor in May 2012 to obtain relevant information and make informed judgements on data quality and robustness to feed into the business need for the hospital site decision. The work of the Technical Advisor was intended to be completed in time to be reflected in the draft Medium Term Financial Plan due to be debated by the States Assembly in September 2012. Even if good quality information had been available the timetable would have been challenging. As it turned out the data was not of sufficient quality. The original 13-week contract with the Technical Advisor was extended and ran for over a year; and
- did not explicitly recognise the importance of ensuring a mechanism to involve clinicians and hospital managers in the process leading up to site selection. While the draft Terms of Reference provided for a senior clinician to be the 'Senior Clinical User' on the Project Board, expectations and responsibilities of this role were not defined. As a result, the opportunity, at an early stage, to understand the views of people with knowledge of the existing patterns of service delivery and who would work within the Future Hospital was not taken.

4.12 In any event, the draft Terms of References were not followed in practice:

- during the pre-feasibility stage, the Chief Officer of Health and Social Services chaired the Project Board as planned. However, without reference to any new arrangements, in July 2013 the Treasurer of the States assumed that role. Although the Chief Officer of Health and Social Services was not the Accounting Officer for the expenditure on the Future Hospital, she was, as discussed above, the client:
    - leading on delivery of the ambitious transformation plans in P.82/2012 of which the Future Hospital project was part; and
    - responsible for the ongoing expenditure on the Future Hospital when operational.

  There is a compelling case for her, as client, to have continued to lead the Project Board and the reasons why this did not happen are unclear; and
- the clinician appointed as 'Senior Clinical User' attended only two out of the 11 Project Board meetings held between April 2012 and July 2013 and no contribution is minuted. As a result, there was only limited direct input at Project Board level from a senior clinician at a formative stage in the project. In my view, the Board should have been done more to secure such crucial early clinical engagement.

Feasibility stage to February 2016

4.13 The Future Hospital Feasibility Project was launched in July 2013. But it was not until September 2014, after an Internal Audit report, that Terms of Reference for the Project Board were drafted and adopted. A delay in adoption of Terms of Reference increases the risk that neither the Project Board nor its individual members were clear as to their roles and responsibilities and that in turn increases the risk of non-delivery of a project.

4.14 The 2014 Terms of Reference draw on two separate sources to describe the roles of individual members of the Board – the project management approach, PRINCE 2, and draft Financial Direction 7.1 on the Control of Major Projects. But the roles are not fully described in one place and, coming as they do from two separate sources, there is an increased risk of confusion and lack of a common understanding of respective roles. Even the titles used in the Terms of Reference are not consistently used in practice, increasing the risk of confusion: the Chief Officer of Health and Social Services is described in the Terms of Reference as both the Senior Responsible Owner (Brief) and the Client Sponsor.

4.15 A Project Board alone is necessary but not sufficient for the delivery of a major project. It needs to be supported by dedicated staff with appropriate skills and sufficient authority. In November 2013, at the stage when the dual site option was being progressed, a Project Director (Health Brief) was appointed with wide ranging responsibilities for:

- managing and overseeing the development and maintenance of the Acute Service Strategy and planning for the Future Hospital;
- managing and coordinating the input of Health and Social Services into Future Hospital Development; and
- coordinating engagement and involvement of clinicians, other Health and Social Services Department staff and stakeholders to inform development of the project.

4.16 In my view, more robust arrangements for the management of the Future Hospital project, including embedding it in the wider P.82/2012 programme, should have been established earlier.

Subsequent developments

4.17 The Health and Social Security Scrutiny Sub-Panel in November 2016 recognised the weaknesses in programme management within Health and Social Services and recommended the establishment of a Programme Management Office. Management accepted this recommendation and recruitment for key posts is now in progress.

Recommendations for future major projects

R3 Assign a clear client responsibility for major capital projects to the Chief Officers of service departments, including through leadership of Project Boards.

R4 Develop existing Accounting Officer arrangements for capital expenditure to reflect the respective and inter-related roles of the ‘client’ and ‘client agent’.

R5 Implement effective arrangements for portfolio and programme management consistently across the States.

R6 Ensure that clear, documented Terms of Reference, with unambiguous allocation of responsibilities and appropriate representation of all interested parties including service providers, are established and followed for Project Boards for major projects.

R7 Allocate clear corporate responsibilities for challenging the Terms of Reference for major projects, including the realism of proposed timescales.

Risk management

5.1 Identification, evaluation, mitigation and monitoring of risk are key tools of management and of particular importance in the context of major projects. Best practice would involve the establishment, maintenance and active use of a risk register as a key activity of the Project Board with escalation of risks as appropriate to the Corporate Management Board and to Ministerial groups as appropriate.

5.2 In my recent report on *Risk Management*, I have identified the steps that the States have taken since 2014 to introduce corporate processes for risk management. But I also identified that risk management is not yet consistently embedded across the States.

Pre-feasibility stage

5.3 There is no documentary evidence that the risk register or equivalent document was considered by the Project Board. Although risk was reflected in some of its deliberations, no overarching view of risks faced by the project, the effectiveness of mitigation in place and the scale and significance of residual risks was available.

Feasibility stage to February 2016

5.4 The Terms of Reference for the Project Board, put in place more than a year after its inception, refer explicitly to risk and assign specific roles in relation to risk to three members of the Project Board. However, the Terms of Reference for MOG did not refer directly to risk.

5.5 In April 2014 the Project Board received and endorsed a risk register developed by the Project Team. Review of the risk register was subsequently a standing item for the Project Board. The register was sophisticated: it categorised and scored risk, it colour coded risks based on scores assigned, it identified the workstreams to which risks related, it identified controls in place and proposed and it identified risk owners. The risk register saw changes in the scoring of risks: significantly the residual risk of the preferred site not being politically acceptable, resulting in delays to the project, increased from low to high over the period from March 2014 to August 2015.

5.6 However:

- the version of the risk register considered by the Project Board did not identify timescales for mitigating action or review dates;
- despite triggers within the risk register for reporting risks to MOG, MOG minutes do not demonstrate that the most serious risks that should have been referred to it were routinely reported or that discussion of those risks took place; and

- there is little documented evidence that either political or officer groups used the risk register effectively to support the site decision making process. In particular, significant increases in risk scores did not trigger minuted discussions on the effectiveness of existing controls or new mitigation required.

Recommendation for future major projects

R8 In the management of major projects, implement the recommendations from my report on *Risk Management* published in September 2017.

Criteria and evaluation against criteria

6.1 Choosing between alternatives – in this case different sites – is rarely straightforward. For a major decision it involves firstly establishing appropriate criteria against which to make a decision, assigning relative weights to them and applying them consistently. Relevant criteria may include:

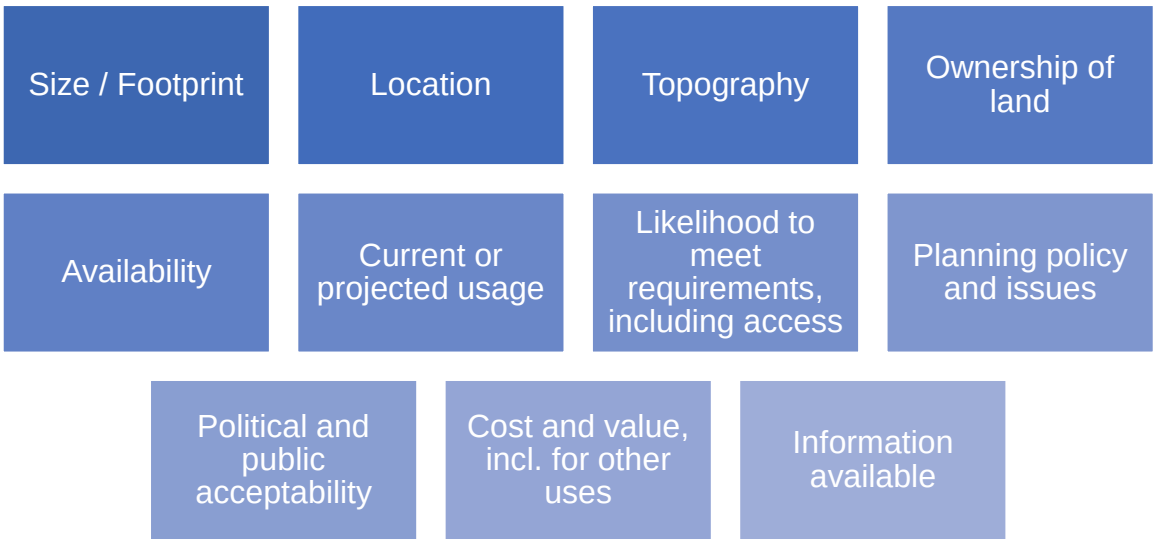
- financial impact;
- functional suitability;
- timescale; and
- risk.

6.2 The process of setting criteria means that decision making is structured and demonstrably objective.

Pre-feasibility stage

6.3 The initial identification of sites in March 2012 used five criteria relating to assumptions on size requirements, on accessibility and on absence of restrictions on development of a site within a five year period. As a result, 24 sites were identified. However, the identification of 24 sites predated the adoption of criteria for evaluation of sites in April 2012 (see Exhibit 8) and when the criteria were applied the initial 24 sites were reduced to 11.

Exhibit 8: Criteria adopted for initial site evaluation – April 2012



6.4 I am concerned, not only that initial site identification was undertaken in the absence of detailed criteria, but that when more comprehensive criteria were developed and applied it was:

- without an agreed Acute Service Strategy that would drive the requirement for and size of the Future Hospital;
- in the absence of such a Strategy, without sufficient focus on how the options performed in light of potential changes in demand for acute healthcare provision and future changes in models of delivery of healthcare;
- without external advice from those with experience and expertise in design of new or substantially redeveloped hospitals; and
- crucially, without effective input from clinicians.

6.5 When external consultants were appointed in May 2012, they adopted a 'five case' model based on the UK Treasury's Green Book and applied industry standard criteria. However, industry standard criteria were applied in the absence of:

- sufficient understanding and ownership of the relative importance of different criteria in the context of decision making in Jersey;
- any guidance on what would be considered affordable: such clarity was essential to allow unambiguous application of the criteria;
- sufficient quality of information on key areas, such as service activity and delivery models;
- input from clinicians; and
- clarity about the willingness to consider departures from planning policies in the context of a major infrastructure project.

Feasibility stage to February 2016

6.6 The absence of buy-in to the criteria underpinning the decision making process contributed to the decision in July 2013 to 'refine' the pre-feasibility stage decision and instead develop a 'dual site' option. This appears to have been driven by the imposition of a cost cap that was not clearly reflected in the criteria used at the pre-feasibility stage. Although there was reference to 'affordability' in the criteria, it was difficult to apply this criterion as there was:

- no ceiling on capital expenditure specified; and
- no statement of an acceptable return on investment – the value of future revenue savings that would justify higher capital expenditure.

6.7 Following the Scrutiny Panel Report in September 2014, the States' advisors used a structured approach to compare the dual site option against the single site options considered to date. Applying industry standard criteria, as expected they concluded that the dual site option performed poorly against single site options.

6.8 However, the Project Board was uncomfortable with relying on the analysis as:

- service plans and therefore department sizes had moved on since 2013 but the revised plans had not been reflected in the criteria applied; and

- there was still no clear guidance on affordability.

6.9 Partially as a result of the absence of clear criteria at the outset, the requirements of MOG shifted. The advisors were requested to undertake a new analysis, the design of which was revised five times between November and December 2014. The States agreed expenditure of over £600,000 to cover abortive costs and the costs of the new analysis.

6.10 But even at that stage:

- the weighting of criteria was driven by the advisors in agreement with the two Project Directors and, despite acceptance by officers in Health and Social Services, might not adequately have reflected the priority of decision makers. For example, minimisation of short-term disruption to services during the construction of the Future Hospital contributed only 0.6% to the overall benefit score; and
- there was limited involvement of clinicians and operational staff, a matter that I discuss later in this report.

6.11 Even in this phase, the minutes of MOG and notes of the Project Board record exclusion of sites without explicit reference to criteria. They refer instead to the views of Ministers or officers or statements that sites were 'unlikely' to be viable on grounds of cost or planning considerations. Crucially, the decision not to pursue the Waterfront option from February 2016 was not adequately documented by reference to the criteria set, a repetition of the situation in September 2012 (see Case study 2). I recognise that decisions may be made that depart from previously agreed criteria for essentially political reasons. In such circumstances it is even more important that the decision to depart from criteria and the reasons for the decision are documented clearly.

Case study 2

The Esplanade Car Park was longlisted as a potential site in May 2012 and ranked second out of four best performing sites by the Technical Advisor in July 2012. However, in August 2012 MOG raised concerns that no alternative site for the Jersey International Finance Centre could be identified or costed during the shortlisting process and a meaningful financial analysis could not therefore be performed. MOG agreed that the recommended site should not be progressed.

The Zephyrus/Crosslands/Les Jardins de la Mer site was shortlisted in 2012 and 2014, proposed for public consultation but not subsequently progressed. In April 2015, prior to consideration of the People's Park option, it was appraised by the Lead Advisor as the best performing option. No unanimous view on the site was expressed by MOG.

In both 2012 and 2015, despite the ranking of the sites following evaluation, the Waterfront sites were excluded from further consideration. For both sites the Future Hospital website records reasons for rejection as:

- a constrained site compromised hospital design;
- flood prevention measures would be required; and
- redevelopment would not comply with the Island Plan.

Recommendations for future major projects

R9 At the outset of a project determine an appropriate evaluation model and consistently apply it unless there is an overriding, documented reason for change.

R10 When undertaking an option appraisal:

- secure informed agreement to unambiguous, weighted criteria at the outset;
- document any changes to the criteria and the reasons for them; and
- apply the criteria consistently.

R11 When undertaking an option appraisal, clearly document the reasons for decisions by reference to the agreed criteria or by explicitly recording the departure from agreed criteria and the reasons for the departure.

Consultation and communication

7.1 The decision about the siting of the Future Hospital was by its nature contentious. There were many interested parties both within Health and Social Services and outside. It was therefore important to determine both the nature and timing of two distinct but related activities:

- consultation - actively seeking views that would inform the decision making process; and
- communication - explaining the current thinking or decisions reached and the reasons for them.

7.2 Consultation and communication may involve different groups including:

- the service providers, delivering services from the existing and proposed hospital;
- service users;
- other stakeholders; and
- the wider public.

7.3 Consultation and communication are important parts of wider project planning. Consultation and communication can improve the transparency of decision making and enhance ownership of the decisions reached. Such ownership is vital to the ongoing success of substantial capital projects. For these reasons consultation is mandated at various stages in health planning in the UK.

7.4 In the context of siting an acute hospital, failure to manage clinical consultation processes adequately creates the risk that:

- well-respected operational clinicians are not sufficiently engaged and do not therefore become active ambassadors for proposed changes; and
- clinical adjacencies and flows are misjudged leading to a hospital design that does not support clinical flow with a knock-on impact to cost, efficiency and safety.

7.5 Below I summarise best practice in consultation and communication.

Best practice in consultation and communication

- Formally adopting a clear narrative of the reasons for a decision and putting that narrative at the centre of a communications strategy.
- Engaging with clinicians to develop a clinical narrative to reflect best practice clinical outcomes and patient experience throughout the strategic business case. This entails establishing a series of clinically led workstreams (for example in emergency care, elective care, specialist care, maternity, paediatrics and clinical support and diagnostics) which form the basis for the activity and size modelling of a hospital.
- Developing workshops and similar events that actively include clinicians, seek views and tackle thorny questions (such as service location and consolidation) as part of site selection.
- Seeking patient input in a considered fashion at the right time with appropriate clinical support.

Pre-feasibility stage

7.6 At the pre-feasibility stage there was no overarching and explicit plan for consultation and communication. The Terms of Reference did not set out any requirements for consultation or communication with any groups.

7.7 However, elements of consultation and communication did take place (see Exhibit 9).

Exhibit 9: Consultation and communication in the pre-feasibility stage

Date	Activity	Parties	Observations
May 2012 – July 2013	Discussion on spatial requirements	Hospital managers Clinical Directors and Service Leads	No consultation on site preferences
February 2013	Consultation with focus groups	HSSD staff Community and voluntary sector Members of the public	Only designed to test perceptions. No consultation on specific sites. In April 2013 consultants reported little consensus on the need for a new hospital and recommended 'active engagement' but by that date the General Hospital site had been selected.
February 2013	Briefing	Clinical Directors Senior nurses	Asked for 'in principle' confirmation that a viable hospital could be maintained during the site development process. Took place after MOG had endorsed the General Hospital site.
July 2013	Facilitated workshops	Hospital managers Clinicians	Discussion of safety and sustainability of the dual site option. Concerns expressed that the single site option was not being pursued.

7.8 I am concerned that:

- communication and consultation was ad hoc and not driven by an overarching plan;
- there was a lack of early, effective consultation with operational clinicians, despite their knowledge and the need to secure their buy-in to the site selection; and
- elements of consultation were completed too late to inform decision making.

Feasibility stage to February 2016

7.9 There was effective communication on the wider P.82/2012 programme. However, there were weaknesses in planning for consultation and communication on the Future Hospital site selection:

- the planned role of consultation shifted over time. Both MOG and the Project Board at different times suggested both public consultation over a range of options (as opposed to a preferred site) and communication of the reasons for a preferred site;
- an overarching communications and consultation plan was not established at the start of the feasibility stage. My review of minutes and other project documentation shows that different approaches were adopted at different stages of the process (see Exhibit 10); and
- no decision on the timing and nature of public consultation (if any) was made before the commencement of the feasibility stage of the project.

Exhibit 10: Plans for communications and consultation during the feasibility stage

Date	Communications	Consultation
July 2013	Draft Communication Plan developed with support from the Communications Unit in the Chief Minister's Department. Used in meetings with stakeholders exploring the benefits and risks of the preferred dual site option.	
September 2015		Ministers commented on a draft introduction to public consultation, including statements that stopped short of clarifying what weight was to be given to public views.
November 2015	Consultants were appointed to evaluate public sentiment following the identification of	

Date	Communications	Consultation
	People's Park as the preferred option. Clear statement by a consultant that the campaign should be focused on the preferred option.	
February 2016		Following consultants briefing on key principles of effective consultation, MOG agreed: • to extend the consultation period from eight to 12 weeks; and • to continue consultation on five sites even though some failed against key criteria, on the grounds that the public had already been advised that the consultation would cover five sites. Despite the decision, there was continuing discussion on whether all five sites should remain in the consultation.
February 2016		Curtailment of the consultation process following the Council of Ministers' decision to withdraw the People's Park as a potential site and preferred option.

7.10 When, in September 2014, MOG agreed to reconsider other sites, detailed plans were only available for the dual site option. To develop similar detailed plans for three alternative sites, in 2015 there was significant consultation with Clinical Directors to optimise clinical adjacencies and patient flows. Following the introduction of People's Park as an option, the Medical Director participated in a consultation exercise to evaluate the benefits and risks of all five potential sites.

7.11 Where external advice was received on consultation, it was not always followed:

- in May 2015, external advisors recommended considering wider consultation on benefits and risk scores for the various site options, engaging with a wider group of stakeholders, such as charities and patient groups. They said that such consultation would secure wider buy in to the preferred site and reduce the risk of subsequent challenge. MOG did not make a clear decision on this recommendation;
- in June 2015, the same advisors recommended to the Project Board a 'risks and benefits' workshop with a wide range of stakeholders to consider

the four site options then under consideration. The Project Board expressed concerns about how representative the list of potential stakeholders was and whether consulting more widely ran the risk of contradicting the previous scoring exercise. The Project Board decided not to proceed with the proposal and instead to recommend to Ministers that focus groups with stakeholders were conducted once affordability was understood. Such focus groups had not been arranged by February 2016, when the decision was made to remove People's Park from consideration.

7.12 A key element of the consultation process was the public consultation on the five shortlisted sites, planned for early 2016 but curtailed following the decision not to proceed with the People's Park option. In January 2017, external consultants reported on the States' management of the public consultation on the site options for the Future Hospital. Their key findings and my evaluation of those are set out in Exhibit 11.

Exhibit 11: Consultants' findings on consultation and evaluation of implications

Consultants' findings	My evaluation of the implications
It was evident that at the MOG meeting in February 2016 not all Ministers were bought into the consultation process, weakening the basis for external consultation.	The risk of failing to secure political consensus on the consultation process would have been reduced if there had been much earlier consideration of the nature and timing of consultation and communication.
Concern about cancelling the public consultation process following the decision to remove the People's Park as a potential site when a legitimate expectation had been raised by the States.	Early discussion and debate at Ministerial level leading to an agreed communications and consultation strategy would have reduced the risk of withdrawal of the potential site before the conclusion of the consultation process.
Conflict between Ministers over site options	An early focus on agreeing criteria for decision making and the weighting for those criteria, and securing buy-in to those criteria, would have reduced the risk of conflict at this stage.
The Project Team asserted that the General Hospital site option that was identified as preferred in August 2016 was not causing undue public concern and that clinicians were pragmatic about the risks associated with the option. However, interviews with hospital staff identified significant concerns.	This reinforces my concerns expressed elsewhere in this report that engagement with clinicians was ineffective. A conclusion that clinicians were being pragmatic about the new preferred option was not a strong endorsement but rather a recognition that development of the Future Hospital at the new preferred site was better than no Future Hospital.

Source: Consultation Institute Assessment of the Engagement Strategy for Jersey Hospital 2016 (January 2017)

7.13 Consultation and communication, crucially including with service providers, are an integral part of any major project, especially one designed to change service delivery. In my view, there was insufficient early focus on consultation and communication about site selection and, in particular, on engagement with and involvement of operational clinicians as the key service providers. Such service providers will operate the services from a new asset and their early engagement and ownership of the ultimate decision is vital in ensuring that the benefits from the new asset are realised.

Subsequent developments

7.14 Following the decision to proceed with development on the General Hospital site, there has been a focus on communication about delivery of services from the preferred site, including:

- appointment of a Client Project Advisor with expertise and experience in developing new hospitals, to support clinicians in producing a high quality health brief and in the detail of the hospital design;
- engagement with clinicians on the standards for the modularised interim facilities proposed for use during the construction phase of the Future Hospital;
- direct briefings delivered by a team from Wales involved in a similar project; and
- support for the Project Director (Health Brief) by two Clinical Consultants from the General Hospital with experience of major capital projects in the UK. Each is assigned a day per week to help colleagues to understand implications of transition arrangements and maximise Future Hospital opportunities.

Recommendations for future major projects

R12 For major projects at the outset establish and secure agreement to well defined plans for both communication and consultation:

- reflecting best practice; and
- covering service providers, service users, other stakeholders and the wider public as appropriate.

R13 Ensure that communication and consultation plans:

- focus on early, continuing and meaningful engagement with service providers, service users, other stakeholders and the wider public, including key milestones over the life of a project; and
- place sufficient focus on continuing and meaningful consultation with service providers.

R14 Ensure that all communication and consultation is undertaken in the context of communication and consultation plans, clearly specifying the purpose of engagement and, in the context of consultation, in sufficient time to influence decisions.

Expertise to support decision making

8.1 Identifying the requirements for a Future Hospital and determining where to build it was not something that the States had done before. They did not have the in-house expertise to support the necessary decisions and inevitably would have to identify, procure and manage external experts to support the decision making process. Such experts would contribute up-to-date knowledge in the design of acute services and an insight into the impact on services of developments in medicine, technology and workforce models that move beyond traditional doctor and nurse roles.

8.2 But, as I identified in my 2016 report on the *Use of Consultants*, securing best value from the use of consultants is not straightforward. It requires identification of the information that will be available to consultants on which to base their work, clear specification of work to be undertaken, effective procurement and strong management of consultants through to final delivery.

8.3 In the context of the Future Hospital, the States recorded over £2.6 million as spent on consultants in the feasibility stage alone up to February 2016. While much of that expenditure was entirely appropriate to support high quality decision making, I am concerned that there were abortive costs and additional time taken as a result of weaknesses in the arrangements established. In the context of the UK and its devolved administrations, there is a statutory obligation to report such abortive costs to legislature as public funds have not been applied for their intended purpose.

Pre-feasibility stage

8.4 The draft Terms of Reference for the pre-feasibility stage of the project included appointment of technical advisors as an early key deliverable. An Invitation to Tender for the role was issued in April 2012 for consultants to support the project by:

- developing and verifying the statement of business need;
- establishing a nominal blueprint for the Future Hospital capacity;
- establishing assessment criteria;
- identifying suitable potential sites to take forward to detailed option appraisal;
- identifying constraints, opportunities and costs associated with the shortlisted sites;
- undertaking the option appraisal assessment; and
- recommending a preferred option, including preparing a supporting business case and funding submission.

8.5 Following a procurement process, consultants were appointed in May 2012 to commence work in June 2012.

8.6 The States' expectations of the Technical Advisor appointed in May 2012 were wide-ranging and dependent on building blocks being in place on which the Technical Advisor could build. The successful firm specifically stated that its tender was on the assumption that sufficient high quality information was available to convert strategic care pathways into function, accommodation and area requirements for the Future Hospital. But this was simply not the case: there was inadequate high quality data and no service plans.

8.7 As early as July 2012 the Technical Advisor identified information weaknesses. On 9 July 2012 a contract variation was issued for the Technical Advisor to produce and cost a development strategy for general and acute services at an additional cost of £36,000 to be delivered in final form by 27 July 2012, some 18 days later. In my view, given the information then available, it was entirely unrealistic for such a fundamental strategy to be delivered for such a comparatively low fee and in such a short timescale. Indeed, the final output was not a comprehensive strategy but a report highlighting 'areas where investment was needed in the short and medium term'.

Feasibility stage to February 2016

8.8 In July 2013 a Design Champion was appointed to refine the proposal emerging from the pre-feasibility stage in light of the affordability constraint. Normal competitive tendering requirements were waived for this appointment. Whilst there are circumstances where it is appropriate to make appointments without competitive tendering, I am not convinced that in this case the rationale was clearly documented before the appointment was made.

8.9 A lead advisor was appointed in June 2014 for the purpose of taking the preferred dual site option through the feasibility stage of the project. However, in August 2014 the requirement changed with the decision to assess the dual site option alongside alternatives. The advisor reported that the robust service plan information was not available to support the process and made proposals for undertaking the necessary clinical engagement to deliver a service plan. As a result, change orders totaling £752,000 were issued that altered the services to be provided by the lead advisor:

- £525,000 to cover the cost of development of an acute services plan; and
- £227,000 to cover the costs of abortive work and the impact that the resultant nine month delay would have on the project as a whole.

8.10 This experience demonstrates that key information that should have been available when the Future Hospital project commenced was not available. Its non-availability had both cost and time implications.

8.11 In March 2015 consultants were commissioned to review the work done to date on patient activity and service plans that was an essential underpinning of decision on hospital size and specification. I am concerned that they found the work undertaken up to that date, some three years into the project, to be 'un-assurable'.

8.12 The consultants then began a further assessment of patient activity based on new assumptions about patient length of stay and occupancy rates. They undertook benchmarking against UK metrics on inpatient beds, operating theatres and outpatient clinic capacity and found space savings opportunities in all three areas. However, reliable comparable data for other island communities could not be found.

8.13 I discussed above the approach to consultation and communication. I am concerned that the need for effective external advice in this area was not identified early enough in the process and, when it was engaged, the basic premise for engagement, such as the role of consultation in the process, had not been agreed upon. Earlier professional advice in this area may have helped to avoid the withdrawal in February 2016 of the planned public consultation.

Subsequent developments

8.14 Subsequently, HSSD has commissioned further external expertise relevant to the development of the Future Hospital. It recognised that its current Informatics Strategy did not provide a sufficient basis for Information and Communications Technology (ICT) planning for the Future Hospital. In response, in September 2016, it engaged a consultant to set out a vision for how the Future Hospital can best exploit the potential of new ICT in meeting the needs of the Acute Service Strategy. The consultant's work led to an ICT Strategic Brief finalised in July 2017, setting out the opportunities that ICT investment can offer in ensuring that the right information is available at the right time to support earlier and better decision making. Work is ongoing to establish which ICT capabilities are most relevant to the Future Hospital for further definition and analysis.

Recommendations for future major projects

R15 For major projects, develop at the outset a plan for the nature, extent and timing of engagement of external advisors focusing on both current patterns of and potential changes in patterns of service delivery and monitor delivery against that plan.

R16 Prior to seeking to engage external advisors, identify and verify the extent to which information necessary to support their work is or is not available.

R17 In managing major projects, implement the recommendations of my October 2016 report on *Use of Consultants*.

Recording decision making

9.1 Good decision making requires that the decisions reached are promptly, consistently and unambiguously recorded and communicated to interested parties. Doing so:

- underpins accountability;
- reduces the risk of confusion, delay and additional expenditure;
- in the context of Ministerial government, provides clarity on the role of officers as civil servants and the role of politicians; and
- strengthens the 'corporate memory' and reduces dependence on individuals.

9.2 Good record keeping is even more important in the context of a large, complex project with multiple decision makers at both political and officer level.

9.3 I am concerned that high standards of record keeping were not consistently observed:

- the reasons for including or not including sites in the long list of 11 established in May 2012 are not clearly recorded for all sites. When a member of the public questioned the decision making process in 2016, it was not possible to provide an answer solely by reference to the records maintained by the Project Team;
- decisions to defer consideration of issues were not consistently recorded explicitly; and
- whilst minutes of the Project Board, MOG and other groups involved in the project are maintained and for the most part record the discussions in some detail, there are instances where it is difficult to identify the decisions made. Case study 3 gives examples of minutes that record deliberations but do not give rise to a clear record of the action agreed. Failure to record agreed action increases the risk of dispute about what was decided and makes it harder for groups to monitor whether agreed action has subsequently happened or not.

Case study 3

In many cases minutes do not clearly record what has been decided:

'It was suggested that there should be a further interim step of individual briefings to allow Ministers to have a full understanding of the sites.' (MOG, December 2012)

'[The Chief Executive] suggested that it may be beneficial to have an independent analysis of the proposed cost, as undertaken for the Energy from Waste project, as this could help develop a broader acceptance of the level of cost both politically and with the broader public.' (Project Board sub-group, March 2013)

'[It was] suggested that because the decision had been taken about a phased development and the budget, there was not much to consult about [and] communication rather than consultation would be appropriate.' (MOG, June 2013)

'[The Chief Officer, Health and Social Services] stated that [the Chief Executive] had mentioned at a debrief, that the Project construction timescale should be looked at as being too long. [The Chief Executive] stated that the ten year timeframe for the new Hospital would politically be seen as unacceptable, and that a quicker solution would be needed. This may bring 'new build' back into play.' (Project Board, December 2014)

Recommendations for future major projects

R18 Establish clear standards for recording decisions of Ministerial and other groups established to oversee projects, including decisions to defer consideration.

R19 Communicate, provide training on and monitor implementation of standards for recording decisions of Ministerial and other groups established to oversee projects.

Conclusion

10.1 High quality decision making is a pre-requisite for securing value for money. The choice of site for the Future Hospital was one of the biggest decisions that the States have faced in recent years. It is both complex and contentious. I therefore selected that decision as a focus for my work.

10.2 The decision was complex and I therefore placed boundaries on my work. In particular, I have not:

- reviewed in detail events after February 2016 when the People's Park was withdrawn from consideration as a site for the Future Hospital. I have, however, reflected on certain improvements in arrangements since February 2016 that I have identified;
- reviewed the decision as whether to build the Future Hospital as opposed to the decision on its location;
- validated the size or clinical requirements for the Future Hospital;
- reviewed the options for financing or procuring the Future Hospital; or
- reviewed the development of the wider Acute Service Strategy, including the role of clinicians in the development of the Strategy.

10.3 Although the States will not have to make a directly comparable decision in the near future, they have other major decisions to make regularly. Although the detail of decision making differs, the principles of good decision making remain unchanged. Learning from the experience of deciding on the site for the Future Hospital is therefore both important and timely. I believe that the findings and conclusions from this review that relate to the effectiveness of decision making are of much wider applicability across the States. Indeed, some of the findings could equally be applicable to previous major decisions, including the Energy from Waste plant. Many of the findings echo those from my report on the *Management of Major Property Transactions* published in September 2013.

10.4 There were weaknesses in the decision making process for the selection of the site for the Future Hospital during the period covered by this review.

10.5 Firstly, I have identified the need for clear structures, roles and responsibilities to facilitate effective decision making. I am concerned that elements of structures, roles and responsibilities may not have been developed adequately to reflect the requirements of Ministerial government.

10.6 In particular, I have highlighted:

- the need for clarity on the overall decision making process;
- the importance of clearly articulated and unambiguous roles for Ministerial groups accompanied by clear reporting lines;
- the importance of effective leadership of major projects by client departments;
- the need to develop effective programme management arrangements and integration of project management into those wider arrangements; and

- the importance of clearly articulated and unambiguous roles for the Project Board and its members, consistently applied.

10.7 I have a significant concern about the accountability arrangements for capital expenditure. The existing statutory framework meant that the legal responsibility for capital expenditure and therefore site selection for the Future Hospital project rested solely with the Chief Officer responsible for Jersey Property Holdings – initially the Treasurer of the States and subsequently the Chief Officer of the Department for Infrastructure. At no time did any legal responsibility rest with the Chief Officer of the Health and Social Services Department as 'client' despite their responsibility for specification of the requirement for a new asset and for the costs of delivering services from that asset once it is built.

10.8 This framework would allow Health and Social Services to stand back from elements of the site decision process. It encourages silo working and can be a barrier to effective decision making. Both the 'client' department (responsible for service policy and delivery) and the 'client agent' department (responsible for delivery of a capital project on behalf of the client) have important and inter-related roles and in my view the statutory accountabilities should reflect that inter-relationship.

10.9 Secondly, I have highlighted the need for the use of the right resources, tools and approaches to support effective decision making, in particular:

- the engagement of the right people, including informed professionals involved in service delivery, in the decision making process from the outset;
- effective risk management as an integral part of project management;
- identification of appropriate criteria for decision making from the outset and their consistent application;
- early consideration of consultation and communication, including clarity about the nature and role of consultation, and integration of consultation and communication into overall project planning; and
- early, sustained and meaningful engagement, including meaningful consultation, with service providers who are key ambassadors for a new asset and pivotal to the successful delivery of services from that asset.

10.10 Thirdly, I have highlighted some basic operational imperatives that help to secure the delivery of good decisions in a timely manner but which were not consistently demonstrated:

- identification of relevant professional support requirements at the outset to minimise the need for subsequent variations to advice with consequent cost and time implications;
- being clear that key information necessary to make a decision is in place and robust before the engagement of external advisors. In the context of the Future Hospital I am surprised that consultants were engaged to advise on site selection without an Acute Service Strategy, an essential underpinning for the specification of the Future Hospital, being in place; and

- maintaining high quality records so that there is no ambiguity about what has been decided.

10.11 The overall effect of these weaknesses is that:

- it was difficult for the States to justify that the sites proposed in the period covered by this review were an optimal solution for Jersey based on objective and agreed criteria;
- there have been additional costs and delays; and
- it is more difficult to justify all of the costs incurred.

10.12 By actively learning from one experience and applying the lessons more widely the States can move towards being a 'learning organisation'. This is an important shift in culture to secure value from all experiences, even when things have not gone as well as hoped for.

10.13 But the Future Hospital project is ongoing. There is evidence of improved arrangements in some areas subsequent to the period covered by this review. In particular, I welcome the establishment of a smaller and more focused Ministerial group to drive forward the project.

10.14 However, it is important that the key lessons from this work are taken forward over the rest of the project. In particular, there should be a focus on:

- the lead role of Health and Social Services as 'client' for the Future Hospital project;
- effective programme management;
- effective and meaningful consultation with clinicians and other stakeholders at appropriate times; and
- ensuring that sufficient advice has been sought and taken into account in hospital design on potential changes in medicine, technology and workforce models.

10.15 Doing so will facilitate securing value for money and the delivery of the wider objectives of P.82/2012.

10.16 Given the scale and significance of the Future Hospital project, I shall keep this area under review and consider whether further detailed work on my part is necessary.

Recommendation for the Future Hospital project and P.82/2012 programme

R20 Consider the recommendations from this review and where relevant apply them to:

- the remainder of the Future Hospital project; and
- the wider management of the implementation of P.82/2012.

Appendix 1

Membership of Ministerial groups

Group	Membership from Terms of Reference
Ministerial Oversight Group (MOG)	Chief Minister Minister for Health and Social Services Minister for Social Security (previously Employment and Social Security) Minister for Treasury and Resources Representatives from the Comité des Connétables
MOG Pre-Feasibility Sub-Group (December 2012 to February 2013)[1]	Chief Minister Assistant Chief Minister Minister for Health and Social Services Minister for Treasury and Resources Minister for Planning and Environment Minister for Transport and Technical Services Assistant Minister, Health and Social Services
Ministerial Oversight Hospital Feasibility Sub-Group (October 2013 to February 2014)	Chief Minister (attendance optional) Minister for Health and Social Services Minister for Treasury and Resources Other Ministers as determined and required
Political Oversight Group (May 2016)	Assistant Chief Minister Minister for Health and Social Services Minister for Infrastructure Assistant Minister, Health and Social Services Assistant Minister, Treasury and Resources

[1] In the absence of Terms of Reference, attendance is as recorded in the Sub-Group's minutes

Appendix 2

Membership of officer groups

Group	Membership from Terms of Reference	Role
Pre-feasibility Spatial Assessment Project Board (From April 2012)[1]	Chief Officer, HSSD (Chair)	Project Executive
	Treasurer of the States	Project 'Treasurer'
	Hospital Managing Director, HSSD	Project Director
	Director of System Redesign and Delivery, HSSD	Senior User
	Chair, Clinical Directors Group, HSSD	Senior Clinical User
	Assistant Director, Finance and Strategy, Jersey Property Holdings	Senior Supplier
Future Hospital Feasibility Project Board (From July 2013)[2]	Chief Officer, Transport and Technical Services (Chair)	Project Sponsor
	Chief Officer, HSSD	Senior Responsible Owner (Brief)
	Hospital Managing Director, HSSD	Senior User
	Director, Jersey Property Holdings	Senior Supplier
	Treasurer of the States	'Independent'

[1] Membership from Terms of Reference dated March 2012
[2] Membership from Terms of Reference dated November 2014

Appendix 3

Summary of recommendations

Recommendations for future major projects:

Decision making stages

R1 In managing major projects identify the overall process at the outset and follow that process unless there is an overriding, documented reason not to do so.

Decision making arrangements: Ministers

R2 For all major projects, establish at the outset clear and effective arrangements for political oversight, including:

- compact and focused groups established for political oversight; and
- Terms of Reference for such groups that include responsibilities for reporting

Decision making arrangements: Officers

R3 Assign a clear client responsibility for major capital projects to the Chief Officers of service departments, including through leadership of Project Boards.

R4 Develop existing Accounting Officer arrangements for capital expenditure to reflect the respective and inter-related roles of the 'client' and 'client agent'.

R5 Implement effective arrangements for portfolio and programme management consistently across the States.

R6 Ensure that clear, documented Terms of Reference, with unambiguous allocation of responsibilities and appropriate representation of all interested parties including service providers, are established and followed for Project Boards for major projects.

R7 Allocate clear corporate responsibilities for challenging the Terms of Reference for major projects, including the realism of proposed timescales.

Risk management

R8 In the management of major projects, implement the recommendations from my report on *Risk Management* published in September 2017.

Criteria and evaluation against criteria

R9 At the outset of a project determine an appropriate evaluation model and consistently apply it unless there is an overriding, documented reason for change.

R10 When undertaking an option appraisal:

- secure informed agreement to unambiguous, weighted criteria at the outset;
- document any changes to the criteria and the reasons for them; and
- apply the criteria consistently.

R11 When undertaking an option appraisal, clearly document the reasons for decisions by reference to the agreed criteria or by explicitly recording the departure from agreed criteria and the reasons for the departure.

Consultation and communication

R12 For major projects at the outset establish and secure agreement to well defined plans for both communication and consultation:

- reflecting best practice; and
- covering service providers, service users, other stakeholders and the wider public as appropriate.

R13 Ensure that communication and consultation plans:

- focus on early, continuing and meaningful engagement with service providers, service users, other stakeholders and the wider public, including key milestones over the life of a project; and
- place sufficient focus on continuing and meaningful consultation with service providers.

R14 Ensure that all communication and consultation is undertaken in the context of communication and consultation plans, clearly specifying the purpose of engagement and, in the context of consultation, in sufficient time to influence decisions.

Expertise to support decision making

R15 For major projects, develop at the outset a plan for the nature, extent and timing of engagement of external advisors focusing on both current patterns of and potential changes in patterns of service delivery and monitor delivery against that plan.

R16 Prior to seeking to engage external advisors, identify and verify the extent to which information necessary to support their work is or is not available.

R17 In managing major projects, implement the recommendations of my October 2016 report on *Use of Consultants*.

Recording decision making

R18 Establish clear standards for recording decisions of Ministerial and other groups established to oversee projects, including decisions to defer consideration.

R19 Communicate, provide training on and monitor implementation of standards for recording decisions of Ministerial and other groups established to oversee projects.

Recommendation for the Future Hospital project and P.82/2012 programme

R20 Consider the recommendations from this review and where relevant apply them to:

- the remainder of the Future Hospital project; and
- the wider management of the implementation of P.82/2012.

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