States of Jersey
States Assembly

États de Jersey
Assemblée des États

# Health and Social Security Scrutiny Panel

# Quarterly Meeting with the Minister for Health and Social Services

# THURSDAY, 9th JULY 2015

**Panel:**

Deputy R.J. Renouf of St. Ouen (Chairman)

Deputy G.P. Southern of St. Helier (Vice-Chairman)

Deputy T.A. McDonald of St. Saviour

**Witnesses:**

The Minister for Health and Social Services

Deputy P.D. McLinton of St. Saviour (Assistant Minister for Health and Social Services)

Connétable J.M. Refault of St. Peter (Assistant Minister for Health and Social Services)

Director of Finance and Information

Hospital Managing Director

Interim l Director of Children's Services

Director of System Redesign and Delivery

Director of Adult Services

Assistant Director – Policy and Ministerial Support

Head of Healthcare Programmes

[14:00]

**Deputy R.J. Renouf of St. Ouen (Chairman):**

Thank you all for coming in such numbers to talk to us. So this is a regular quarterly meeting with the Minister for Health and Social Services. I will do some introductions first the purposes of the

record. I am Deputy Richard Renouf and I am Chairman of the Health and Social Security Scrutiny Panel.

**The Deputy of St. Ouen:**

Thank you, Linda.

**The Minister for Health and Social Services:**

Can I give 2 sets of apologies as well? First of all the chief executive, not able to join us today unfortunately but she asked that I pass on her apologies, and secondly, Constable Refault, one of my Assistant Ministers who will be here but he is currently at a meeting to do with freedom of information.

**The Deputy of St. Ouen:**

Yes, noted and understood. Thank you, Minister. We propose broadly to follow the order and the question plans which have been provided to you unless of course our discussions take us off in other directions.

**The Minister for Health and Social Services:**

Which they frequently do.

**The Deputy of St. Ouen:**

Yes, Minister, and most interesting and helpful they are. But our question about mental health arises because we had a very helpful review or briefing from your officers on the mental health strategy and we learnt about this training course offered by Mind Jersey and we wondered if that training course has been put to use within the Health Service and you have been trained on it.

**The Minister for Health and Social Services:**

Before I hand over, the mental health first aid course that is being launched by Mind is exactly what it says; it is a first aid course. It is being offered to employers and I had a meeting with the officers of Mind to - which I regularly do anyway - discuss different issues with them. This is more about getting people in the workplace aware of issues around mental health. So the charity is doing it, something we encourage, but just like we would not intervene in St. John's Ambulance providing first aid or ... not on mental health conditions but physical conditions. While we encourage it and we support it we would not interfere in its delivery.

**The Deputy of St. Ouen:**

No, but I was really thinking of your whole department as a workforce and not every ... while you have a mental health ...

**The Minister for Health and Social Services:**

I will hand over in a minute but what you must remember is that our department, it is a big department and we have specialists in mental health. This is about recognising mental health at the lowest level to encourage people then to seek that sort of support. But I will hand over to Chris who knows far more about it than I do.

**Director of Adult Services:**

Yes, thank you. I think you make a very good point and one that has merit because the Minister is right; this is about, if you like, an early intervention in terms of the general public understanding mental health as a primary issue and it is particularly targeted this year at employers and we have done some work with the Jersey Employment Trust because the conference that we are holding later this year is to focus on mental health issues within the workplace. At the moment we are at the very early stages of rolling out what is a nationally recognised course, in fact internationally because it originated in Australia as a concept of course. What it does is it sits alongside a series of other training that we also roll out, so in the main we have targeted our own staff at a slightly higher level of training. But you raised a very good point because there are a significant number of people employed within Health and Social Services who would probably well benefit from that first aid approach. What we have been doing is, over the last 6 years, we have been running a 10-week course that we run at weekends where we invite staff generally to take part and then people get a certificate of attendance on that course. We run that in-house although it is open to other agents of the voluntary and community sector as well who readily take up the opportunity. We have more recently developed a specific series of 6 courses that are targeted at staff who are working at that secondary care level to keep the skill base and knowledge up, and we are also rolling that out for our partner agents and we are piloting this now in September with the Police Department. Then we have a second pilot, which is a multi-agency approach, and we are going to audit from there in terms of how we roll it out. So what Mind Jersey have done, which is really helpful in the scheme of things, is to target that much lower level with a view that the conference in October will hopefully whet people's appetite to take part in one of 3 ... there are 3 modules that they are looking to run. One is a standard module which is 2 days and that is targeted at the full course that is run. There is a specific course that is targeted at younger adults, young people, in understanding of mental health issues that we are looking at trying to roll out in partnership with education. Then the third course is a shortened version, it is a 3-hour course of the standard because what we are aware of is a lot of employers are unlikely to be able to release staff for 2 days. So there is a 3-hour course that is going to be targeted more at employers out there. So as a whole piece it works really well in working in partnership with us but the Minister was right to say that looking at the notion of it being like first aid as a concept, it is Mind Jersey's ... and Mind nationally will run this in the U.K. (United Kingdom) as well to deliver that training.

**The Deputy of St. Ouen:**

Yes, so are you confident that if not now but in the near future your staff across the department would be able to access somebody with some knowledge, somebody who could help them should mental health issues arise at the most basic level?

**Director of Adult Services:**

Yes. I think the aim is to try and empower all employers and , I think, the States across the whole piece are in that same framework. But what this will do is help raise the awareness and understanding that, you know, we know statistically one in 4 of us will experience, within our life, a period of poor mental health and it is about trying to destigmatise that and trying to enable health at the earliest possible point.

**The Deputy of St. Ouen:**

Indeed. Because we are all familiar with first aiders in the work environment but nobody has ever talked about mental health first aid or at least when I was at work, thinking of that.

**The Minister for Health and Social Services:**

No, and that is exactly where we want to eventually get with the community as a whole. Chris mentioned the stigma. You know, if you break a leg then normally people are sympathetic and supportive and want to help. If you have mental health issues they are not as helpful generally, and as Chris said, one in 4 of us will suffer some sort of mental health issue at some time in our lives, and some recurringly unfortunately. So the whole emphasis behind mental health, in my ministry anyway, is that we do get it on a level footing with physical health; that it is just as important. That is why we are doing all this work that we are doing, why we are bringing forward a new Mental Health Law, why we are bringing forward a mental capacity and self-determination law as well.

**The Deputy of St. Ouen:**

So you will support Mind in its efforts to reach out to the community.

**The Minister for Health and Social Services:**

I do support Mind and I regularly meet with Mind with a view to driving our services forward because Government cannot do everything and indeed Mind are in contact with perhaps a lot more people than we are.

**Deputy G.P. Southern:**

Yes, and then have you got your own house set up correctly in the first place?

**The Minister for Health and Social Services:**

We have got ... and again this is taking ...

**The Deputy of St. Ouen:**

Are you sure your own structure will respond appropriately to mental health issues?

**The Minister for Health and Social Services:**

I would like to think that we are but we do have a training programme for our own staff. But also we have an occupational health arrangement as well which many employers do not have.

**The Deputy of St. Ouen:**

Can you briefly describe that?

**The Minister for Health and Social Services:**

The occupational health arrangement, I cannot remember who does it now, is it Axa?

**Hospital Director:**

Axa.

**The Minister for Health and Social Services:**

Yes, okay, and that is not just ... in fact my experience is, I was going to say is not just about physical health. My experience is it is intensively for people suffering from other conditions such as mental health or stress or psychological issues, Axa are there for us to access; all States departments not just health.

**Deputy G.P. Southern:**

Has there been any study or examination of how well Axa responds to issues?

**The Minister for Health and Social Services:**

I am not aware of one.

**Director of Finance and Information:**

The contract with Axa for occupational health is managed by the Chief Minister's Department, by the H.R. (human resources) team, so they may have that covered.

**Deputy G.P. Southern:**

Yes. I am aware of it being the education ...

**Director of Finance and Information:**
Yes, it is a stage one contract.

**Deputy G.P. Southern:**
It is the Chief Minister.

**Director of Finance and Information:**
The Chief Minister's Department manage that contract.

**Deputy G.P. Southern:**
But was there some assessment of how effective Axa is ... have been until now?

**Director of Finance and Information:**
They may have had some assessment work but it will certainly have some statistics on it, but it would be States wide.

**Hospital Director:**
I am not sure of any particular audit but I do know from having accessed it for our staff, when we have had a very difficult time where we wanted debriefing and counselling, they have been incredibly helpful, very responsive and put counselling in place for staff when they have needed it.

**Deputy G.P. Southern:**
That sounds good.

**The Deputy of St. Ouen:**
Thank you, that has been helpful to us.

**Deputy G.P. Southern:**
It has given me another avenue for the review team which is always good fun. Yes, diabetes care in Jersey. We have recently received a submission stating that they have to pay for their strips, their testing strips, the Diabetes Society. How many people pay for what sort of equipment in the Health Service?

**The Minister for Health and Social Services:**
I know we have got 4,000 people diagnosed with diabetes and I think most people pay for their consumables, if I can put it that way.

**Hospital Director:**
They do. They are not ...

**Deputy G.P. Southern:**
Is that common practice? Is that policy that by and large consumables are paid for by us?

**Hospital Director:**
Yes. They get their insulin or their tablets via prescription via their G.P. (General Practitioner), which they do not pay for, but the consumables: the strips, the blood testing, the equipment is a subsidised product, if I am correct, Jason.

**Director of Finance and Information:**
I think so.

**Hospital Director:**
Yes, and that is not just diabetes; it is whenever patients need additional products, we have a subsidised product scheme.

**Deputy G.P. Southern:**
Is that the same as in the U.K. or is there a different regime there?

**Hospital Director:**
If they can get the product on prescription in the U.K. then that is how they would get it, through a prescription route. So, a lot of these are potentially prescribed in the U.K.

**Deputy G.P. Southern:**
Which means that they pay prescription charges on that.

**Hospital Director:**
Yes.

**Deputy G.P. Southern:**
How does that compare with what they pay in figures?

**Hospital Director:**
I have not done a comparison.

**Director of Finance and Information:**

I do not know off the top of my head. I suspect there are differences in different areas so I think the insulin sum that Helen has just talked about, they would probably pay for on the prescription in the U.K. and it is free on prescription here. Other items though I could not tell you line by line what the charge is here that is a prescription charge in the U.K. I do not know off the top of my head.

**The Deputy of St. Ouen:**

The people who are managing long-term conditions, is there a discrepancy because I understand if you need walking aids or wheelchairs, those are provided without charge but other things will need to be paid for; is that the case?

**The Minister for Health and Social Services:**

I do not think you can look at a wheelchair in the same view as you are looking at a testing strip, to be honest with you. But my understanding of wheelchairs anyway is that that is based on that someone needing a wheelchair would be assessed as to whether they would be supported with that or not. That is my understanding. I have to say I have not researched it before I came. But I do not think you can look at testing strips.

**The Deputy of St. Ouen:**

I am not necessarily comparing it with testing strips but people who may need a catheter, I think, have to pay for their catheters. People who are bedridden have to pay for perhaps an air mattress or pads and the like. So, is there a policy on determining what has to be paid for and what can be provided to keep people managing their conditions?

[14:15]

**The Minister for Health and Social Services:**

Basically, as I understand it, I have been involved a little bit with one case with a catheter, although I physically was not involved you understand.

**The Deputy of St. Ouen:**

I understand. Constable Refault has joined us. Welcome, Constable.

**The Minister for Health and Social Services:**

Basically if someone is receiving ... is in nursing care then those sort of issues ... those sort of consumables are paid for as part of their nursing treatment. If they are living in the community they pay for that themselves generally speaking. You know, how far do you go? Do you pay for absolutely everything?

**The Deputy of St. Ouen:**

I know, that is the eternal question.

**Deputy G.P. Southern:**

It is a fair question but if you are moving towards more care in the community then less and less, fewer and fewer are getting nursing care in an institution, then is that bill not going to go up?

**The Minister for Health and Social Services:**

No, because if we get our health strategy right then people will be healthier longer so you are moving the problem to the later years in life, so I do not think it will grow more. So that is about prevention, you know, and that is certainly something that we are concentrating on in our strategies that we will be bringing forward. Indeed I noticed it was put on the question paper for later that one of the reasons why we want to have access to the register of names and addresses is in order that we can invite people to come in for screening. So that is part of our prevention work. The more you get the prevention work right the less you will be paying out in supporting people, or at least you will be putting off in some cases the deterioration of the condition until much later in their lives. Not misuse at that. **[Laughter]**

**The Connétable of St. Peter:**

He has gone to the other side.

**Deputy G.P. Southern:**

He is on the rota for questions 4, 7 and 12. **[Laughter]**

**The Deputy of St. Ouen:**

I do not know if you answer to this because it might be detailed but people who might need oxygen at home, living at home, is an oxygen supply ...

**The Minister for Health and Social Services:**

I could take a guess but I am not going to. I do not know if you know the answer.

**Hospital Director:**

Is the question whether they are paying for it?

**The Deputy of St. Ouen:**

Whether they are paying for it, yes.

**Director of Finance and Information:**

Give Rachel this.

**Director of System Redesign and Delivery:**

These are quite detailed questions. If it helps we can produce a short note for you that details what is funded through Health and Social Services and what individuals pay for themselves at the moment.

**Deputy G.P. Southern:**

That would be useful.

**The Deputy of St. Ouen:**

That would be useful because it is puzzling sometimes.

**Deputy G.P. Southern:**

Is there a line on that list for total revenue coming in?

**Director of Finance and Information:**

It is usually not us that charges for it, so it is not usually the department that charges for these things. It will be on odd occasions but it is often people will go to the pharmacy or an external company to buy these things.

**Deputy T.A. McDonald:**

We go on to prescribing of antibiotics. We understand that a public awareness campaign about antibiotics prescribing was due to take place in April. Has this taken place and if so what were the outcomes?

**The Minister for Health and Social Services:**

Before I ask if you want more detail, I have to say I am relatively encouraged by our figures because the figures published in October 2014 show a 4 per cent increase of antibiotic prescribing by U.K. G.P.s, whereas over the same period ours increased by 0.25 per cent. So I am encouraged that G.P.s are ... I am not saying they were ever irresponsible but they are certainly being more careful. It is one of the indicators used in the G.P. scorecard, their prescribing practice is looked at as part of their annual appraisal. If you want more detail than that I will have to hand you over to my colleague, Helen and Rachel.

**Deputy G.P. Southern:**

Is part of that to do with the fact ... consumers of that, in my head, they had not **[Interruption] ...**

**The Deputy of St. Ouen:**

Sorry, I apologise.

**Deputy G.P. Southern:**

Ten out of 10 for shame.

**The Minister for Health and Social Services:**

It was not 10 last time.

**Deputy G.P. Southern:**

Because we have got more G.P.s per head of population over here than, on average, in the U.K., especially in some parts of the U.K. where Government will not give them the money; find a sheep first. Is it the fact that they are under less stress, I think, than the U.K.?

**Hospital Director:**

Your assumption is if they are under less stress they will prescribe more?

**Deputy G.P. Southern:**

Prescribe more, yes.

**Hospital Director:**

Right.

**Deputy G.P. Southern:**

Sorry, I have got 30 seconds.

**Hospital Director:**

I mean prescribing of antibiotics has been topical across Europe, I mean not just here and not just in the U.K. There was a campaign that was run nationally in the U.K. where we saw it on the news about how they are targeting G.P.s and their prescribing practices. **[Interruption]**

**The Deputy of St. Ouen:**

I apologise.

**Deputy G.P. Southern:**

It is going to be expensive. You will have to sell the house.

**The Connétable of St. Peter:**

Yes, we have a very good charity for today, too.

**The Minister for Health and Social Services:**
It is called “Headway”.

**The Deputy of St. Ouen:**
That is fine, I will do it but it is meant to be on mute. I will switch it off completely.

**Hospital Director:**
As the Minister has already alluded to, the G.P.s in Jersey have been targeted specifically about antibiotic prescribing through their quality initiative framework and they are having their prescribing monitored and, if you like, they gain quality points for correct prescribing. The campaign for the public is about making sure that the public know that when they are prescribed antibiotics they take them as they are supposed to and as they are prescribed. If you do not finish the course or you take them at the wrong times of day you are not doing yourself any favours because then the immunities build up and we get the problem that antibiotics become less effective and that is going to be a global problem; antibiotics resistance.

**Deputy T.A. McDonald:**
M.R.S.A. (Methicillin-resistant Staphylococcus aureus) and so forth.

**Hospital Director:**
Yes, and it will be new bugs that we will not be able to treat in the future.

**The Minister for Health and Social Services:**
It is interesting that - not antibiotic particularly - but medication in the community generally, that in the dump campaign earlier this year 120 black bin bags of unfinished or unused medication was collected. Now, that was not just about antibiotics, that was about all sorts of things including some medicines that had not been in use for years. Over 120 black bags of medicines were returned.

**The Deputy of St. Ouen:**
What legislation requires our G.P.s to report to you and co-operate with you?

**Hospital Director:**
I am going to let Rachel answer about what legislation allows them to report to us but obviously they have professional regulation which is slightly different.

**The Deputy of St. Ouen:**
Yes.

**Director of System Redesign and Delivery:**

Yes. They are professionally regulated by the G.M.C. (General Medical Council). Minister, you will be aware of the performers' list and the various provisions that have been put in place over the last couple of years with regards to G.P.s. It is not so much a legislative requirement, in terms of reporting to us, as a requirement in terms of the G.P.s continuing to demonstrate their fitness to practice, their adherence with good standards and good governance. In order to stay on the performers' list they now have their appraisal and their revalidation in Jersey, which has been a very positive step. Part of them producing the evidence that they need for their appraisals is what is called a J.A.M. (Jersey Activity Monitoring) card. It is the Jersey Activity Monitoring card and each year we agree with the G.P.s what items will go on to that card and they are items of quality interest. So last year, in 2014, we were monitoring trimethoprim prescribing. The aim of that is to raise their awareness and to raise our awareness so that we can see if there are any quality issues or any prescribing issues. The other thing of note is that this is an area that spans Social Security as well as Health and Social Services in that Social Security pay the G.P.s rebate so they have the contractual, if you like, relationship with them and Social Security also employ the prescribing advisers. Helen mentioned the quality points, so from this year each G.P. is encouraged to have a prescribing review with one of the prescribing advisers who can help them to look at their prescribing habits and identify if they are an outlier or where they might need to change.

**The Deputy of St. Ouen:**

What if one doctor was not very responsive to that encouragement?

**Director of System Redesign and Delivery:**

That would be dealt with through the appraisal scheme.

**The Deputy of St. Ouen:**

How do you make them co-operate with an appraisal scheme?

**Director of System Redesign and Delivery:**

They have to. **[Laughter]** In order to stay revalidated, stay on the performers list and stay approved by the G.M.C. they have to undergo appraisal.

**Hospital Director:**

Our new appraisal that has to be demonstrated to the G.M.C.

**The Deputy of St. Ouen:**

They have to demonstrate to the G.M.C. that they are co-operating with you, is that what you are saying?

**Director of System Redesign and Delivery:**

They have to demonstrate that they are meeting the various standards that would be expected which is evidenced through their appraisal and they collect evidence to put into their appraisal. It is exactly the same for hospital doctors, and then a responsible officer will take the appraisal and ... will make the revalidation recommendation to the G.M.C.

**The Minister for Health and Social Services:**

I think the evidence is there that it clearly is working, notwithstanding Deputy Southern said there may be some different issues in the U.K. but 4 per cent increase in prescribing of antibiotics in the U.K., 0.25 in Jersey, I think ...

**Deputy G.P. Southern:**

That is a rate of change and was it from a low level in Jersey and a high level in the U.K. or otherwise?

**The Minister for Health and Social Services:**

I did not ask that question.

**Deputy G.P. Southern:**

It is the important bit.

**Director of System Redesign and Delivery:**

Yes. The other statistic of note is, we talked about resistance, bacterial resistant antibiotics just now. There has been a 50 per cent reduction in the past 5 years in Jersey for 2 particular antibiotics that really should only be used for specific infections and may be bacterial resistant. So it is evidence that the multifaceted approach of appraisals and revalidation, and advice and assistance to G.P.s to help them review their prescribing habits is really having an effect.

**Deputy G.P. Southern:**

Who does the validation, is it somebody independent hopefully?

**Director of System Redesign and Delivery:**

It is the primary care medical director.

**The Minister for Health and Social Services:**

Who is independent.

**Deputy G.P. Southern:**

It is good for you.

**The Minister for Health and Social Services:**

Yes, but lives in the U.K. so he is not ... as I say, he is totally independent, he comes over here and does that work. In the hospital of course there are regular audits, are there not?

**Hospital Director:**

We have weekly audits on antibiotic prescribing and the Consultant Microbiology Systems Chief Pharmacist reviews that. We have an antibiotic prescribing policy and it has got quite clear guidance on when you should prescribe certain antibiotics, how long people are on them for, what route to administration.

**The Deputy of St. Ouen:**

Can you explain to me the role of the primary care governance team and what scope it has?

**The Minister for Health and Social Services:**

That is for Rachel.

**Hospital Director:**

Back to Rachel.

**The Deputy of St. Ouen:**

Clearly a Rachel question.

**Director of System Redesign and Delivery:**

The primary care governance team is the primary care medical director and the primary care manager and their role is to oversee the governance for G.P.s. So it is a bit of a misnomer that it is primary care governance team because it is the G.P. governance team. As the Minister said, the primary care medical director is independent and his role is to recommend revalidation to the G.M.C. for each of the G.P.s in Jersey based on the outcomes of their appraisal. Also to oversee any issues of governance or issues of concern, he oversees complaints, if investigations are required he will either do the investigation himself or if it is of a level of seriousness, that will go to off-Island to be investigated independently. So his role is to oversee and assure the safety and quality of G.P. practice in Jersey.

**The Deputy of St. Ouen:**

Okay. So if you felt at any one time that one G.P. was not co-operating with you fully and there was some possible risk, what action would you take?

**Director of System Redesign and Delivery:**

There are procedures in place that would ... it would start, as with any concern, it would start with an individual conversation and if there were still concerns then evidence would be gathered and it may lead to an investigation. But there are various policies and procedures depending on the level of seriousness of the complaint or the level of seriousness of the concern and the risk that it presents. I have got a flowchart which I can make available to you if you are interested so you can see what would happen in each instance.

**The Minister for Health and Social Services:**

I think it is fair to say, depending on the instances, that there are a number of sanctions that can be implemented from: "You need some further training on this issue" to: "We are going to put somebody to shadow you, to work alongside you, I suppose, on the job training" to: "We are going to suspend you from this job." So it all depends on the nature of the complaint and how serious it is and of course that has to ... because we are talking about people's lives on one hand and we are talking about other people's careers on the other so that has to be done properly. It has to be done robustly and there has to be a method of appeal in there as well, which there is; all that is in place. The G.P. that we have that is independent is a very, very experienced G.P. who is still a practising G.P. in Dorset, as well as a lecturer in providing G.P. services. So he is very experienced, but just as importantly he is independent as well. But he does understand what it is like to work as a G.P. because he is still doing it, albeit it part-time.

[14:30]

**Hospital Director:**

Every doctor has to comply with the code of good practice set by the G.M.C. That is quite a detailed code and if they are in breach of that code the G.M.C. will investigate. One of the things in that code is engagement: engagement with appraisal, engagement with Government's processes. So the G.M.C. ... and they can take referrals from the manager, from another doctor, from a member of the public. So the G.M.C. have a role here as well.

**Deputy G.P. Southern:**

Is there any obligation in the standards for a G.P. or a doctor to maintain their research?

**Hospital Director:**

Yes, it is very clear. For hospital doctors they have to undertake 10 study days a year, well, it is 30 over 3 years. They have to put into that appraisal folder evidence that they have done that. They have time in their timetable to do this and we have a study leave budget to help them achieve it.

**Deputy G.P. Southern:**

That is as easy to do over here as it is in the U.K., is it?

**Hospital Director:**

No, you quite often have to go off-Island to attend conferences.

**The Minister for Health and Social Services:**

Which we pay for, which is why our costs for travel are slightly higher in Health than some other departments.

**Deputy G.P. Southern:**

Yes, I know, my stepson is very upset that he has to go to Belize for 10 days. **[Laughter]**

**The Deputy of St. Ouen:**

The flowchart you spoke about would be helpful to the panel, I think, if we might see it. Thank you.

**Deputy T.A. McDonald:**

Could I just ask before we move on, do the police still have any involvement with intervention with D.D.s (Dangerous Drugs) coming from doctor's surgeries, cars, or anything or is that a thing of the past now?

**Hospital Director:**

To my knowledge the only time we involve the police is if we have concerns about missing drugs or misuse of drugs and then we would automatically tell the police and they would decide whether or not they want to come in and investigate.

**The Minister for Health and Social Services:**

I thought the Chief Pharmacist occasionally, you know, on a regular basis looked at security in that it is part of their licensing for it.

**Hospital Director:**

Yes.

**Deputy T.A. McDonald:**

I am just keeping up to speed. Thank you. Sorry.

**The Deputy of St. Ouen:**

No, that is fine, Deputy. Minister, moving on. Thank you, I noticed you went to Guernsey recently.

**The Minister for Health and Social Services:**

Did I? **[Laughter]**

**The Deputy of St. Ouen:**

Sorry, no, you did not. **[Laughter]** I think it was officers from your department attended a 2-day conference in Guernsey to share knowledge with public health in Guernsey and the Isle of Man, I think, was it?

**Head of Healthcare Programme:**

Yes, it was a number of Islands put forward 2 proposals as part of that.

**The Deputy of St. Ouen:**

Yes, I understand. Thank you, Linda.

**Head of Healthcare Programme:**

Yes, there were quite a number of islands getting into it, it was an inter-island public health conference of 2 days and some of the islands there were the same ones we have just had for the Island Games. So perhaps this time we did a little bit better. **[Laughter]** But, yes, it was incredibly useful because some of the challenges of being on a small island are the same regardless of whether you are in the Falkland Islands or whether you are in Jersey. So from a public health point of view it is very useful to be able to share knowledge and there is always lots of learning that we each gained and also we have then the emailable contacts of having met face-to-face, it is then much easier to email one of those colleagues in another island if there is a particular issue come up to ask what do they do in this particular instance. So, meeting once is then very useful for those contacts.

**The Deputy of St. Ouen:**

Yes, I can well understand that. Were there any particular ways of doing things that you want to investigate further?

**Head of Healthcare Programme:**

What we all had in common was the difficulties in doing things in a small population, and the challenges and the, obviously, good economies that bigger volumes with the larger group of people. Then there are economies of scale there which is often a challenge in a small island with a small population. So there were things that we were able to share there. There were things about alcohol abuse that other islands shared. We learnt that in the western isles of Scotland they have a tremendous problem with alcohol abuse and there is possibly only a couple of thousand people living there and they are very remote, and there is not much to do at the end of the day unfortunately. Then some of the challenges of how the public health teams there are trying to look at that and that was very useful for us in public health thinking about what we can do in Jersey regarding the alcohol abuse problems. So there were lots of learnings and things that we took away from it.

**The Deputy of St. Ouen:**

Are you yet in a position where you are putting forward any proposals directly from that conference?

**Head of Healthcare Programme:**

The Medical Officer for Health I know wants to. In this particular instance of alcohol abuse on these islands they have a high rate of what is called foetal alcohol syndrome which is when children ... it is possibly not recognised until they are a little older and having difficulties at school, that alcohol that mum was abusing, or just having too much of during pregnancy, is then playing out in the child's achievements, both mentally and academically in their schooling. I know that Susan Turnbull wants very much to look and try and explore here whether we do have a problem that we just are not aware of with foetal alcohol syndrome. So I know that was one of the things that she is wanting to explore more.

**The Deputy of St. Ouen:**

Thank you for that.

**The Minister for Health and Social Services:**

There is work going on around alcohol in public health as well. For example, we are working with Guernsey and the Isle of Man on benchmarking and some exercises already are underway. They are not yet ready to release it but there is a certain amount of work comparing what happens on the Isle of Man to what happens in Jersey and what happens in Guernsey to see what we can learn from each other. We are also looking at whether we can work together on regulation of health and social care particularly because they have got to regulate, we have got to regulate and it may be that we can, instead of having 3 departments possibly have one; this is work underway.

I have to say there is a very distinct political will for the 3 islands to work together, and officers as well, but I have to say that I thought it was really not just lip service it was what can we do together, what is useful to do together. There are some things also that we would not do together, you know, it is just not practical. But we are working very closely together; we have got another meeting in the autumn. Politically the officers are regularly now in dialogue with the Isle of Man and with Guernsey.

**The Deputy of St. Ouen:**

Does the Isle of Man and Guernsey have their social care on a statutory basis?

**The Minister for Health and Social Services:**

I do not know the answer to that; I do not know.

**Director of System Redesign and Delivery:**

Yes, they do. Not exactly the same as ours for children but probably similar.

**The Deputy of St. Ouen:**

Adults? Social care or community care?

**Director of Adult Services:**

They would only have it on the basis of Mental Health Law. I understand that there is not community care legislation as there is in the U.K.

**The Deputy of St. Ouen:**

Thank you for that.

**Deputy G.P. Southern:**

We have talked here about that before, have we not?

**Director of Adult Services:**

Yes.

**Deputy G.P. Southern:**

Yes, I can have a look at the answers. Moving on to the topic that I have already introduced to the Minister for Housing, how much joined up thinking goes together between departments on foster carers and adoption issues? In particular I am referring to a specific case I have just come across where it is a housing issue.

**The Minister for Health and Social Services:**

So we are within Jersey, you mean? Between housing and ...

**Deputy G.P. Southern:**

Within Jersey, yes.

**The Minister for Health and Social Services:**

I have to say that I do not know too much about the health side on that yet so I will hand over to Jo in a minute. But when I was Minister for Housing I can remember stepping in, when asked to, to assist one particular family where because of tragic circumstances they were going to foster a whole family but the parents, the people chosen to foster them, did not have the right accommodation and we bent over backwards to get them into the right accommodation.

**Deputy G.P. Southern:**

When you were a Minister, not an officer in a ... what is it called?

**The Minister for Health and Social Services:**

I do not believe that Andium would handle that any differently if they were given the facts. I do not believe that that would be any different today.

**Deputy G.P. Southern:**

What joined up thinking is there?

**Interim Director of Children's Services:**

Joined up work in general in Jersey is good. So, my experience is mostly in the U.K. so I am new to Jersey. But because it is small and people know each other, working together is pretty strong here, I would say. There are some real challenges in relation to housing and fostering in Jersey. On the whole, people do not have an extra bedroom in Jersey, and for fostering very often we need an extra bedroom. We have had negotiations with Housing about re-housing people who are in public housing to increase their house size so that they can foster. I think I know the case you are alluding to and there are complexities when it is connected persons fostering and non-connected persons fostering. So if I can say "connected persons" is where extended family looks after a child who, for whatever reason, cannot be looked after by their parents and we support that arrangement. Whereas a mainstream fostering is just anyone in the public comes forward and says: "You know what, I would like to foster for children in Jersey." There are slightly different legal frameworks for these and slightly different status, I would say. Where it gets complex is where there is a difference in view between either the foster carer or the connected persons and housing about whether there is overcrowding or not. So housing will only be increased if the

family meets the threshold for increased housing. So if children can share a bedroom they do not meet the threshold and there are obviously rules about same sex bedroom sharing but there are not rules about a foster child, connected person foster child, and a birth child of the family sharing rules if they are same sex. So for example, you have got connected persons with 2 children of their own, they foster a connected person who is from their extended family. That child that is connected is, let us say, a girl and could share a room with the birth child in the family. They would not then qualify for increased housing which makes it challenging obviously for us and that would be the same in the U.K. So Jersey is not operating a different system to that which would be operated elsewhere. If, however, it was a different sex child and therefore ... and the age of the children meant that they could not share rooms, then Housing would be working with us to try and find a property. There is often a wait because there is not, you know, an abundance of properties out there just waiting to be moved into, so often families do have to wait. But in terms of the working together and us having a mutual aim which is to secure the best outcomes for children, I would say that that is in place. I have not, in the time I have been here, had conversations with colleagues in Housing about foster carers per se, and following the question that has, I think, been presented by yourself it has prompted me to think I will go and have a conversation and look at the profile of fostering in the housing strategy and its priority groups. I think it is helpful just to signal it. It will not necessarily change the rules but it kind of restates Jersey's commitment.

**Deputy G.P. Southern:**

Put it in the equation.

**Interim Director of Children's Services:**

Absolutely.

**Deputy G.P. Southern:**

I think it may have slipped out of that equation especially when there is a certain amount of social/medical need in being fostered.

**Interim Director of Children's Services:**

Fostered to connected persons.

**The Minister for Health and Social Services:**

It is worth us doing that because as you know there is a category where people, either for medical needs or other needs, can be given priority and it is whether this group might fit it. But Housing are forming a new strategic housing ... the Strategic Housing Group are forming a new housing strategy and this is a good time just to flag up that there may be an issue there, yes, which we will do.

**Deputy G.P. Southern:**

Good. That will do for me.

**The Deputy of St. Ouen:**

But the recent campaign, and it is a continuing campaign, I think, is it that we are seeing more foster carers and more adoptive parents?

**Interim Director of Children's Services:**

I think there is a limit to how many foster carers we will ever have in Jersey, and that will be the same anywhere, in any jurisdiction and there are complexities here. I do not think we have reached our limit yet. I am keen for us to increase our number of mainstream foster carers, specialist foster carers and so on. We are constantly looking at whether our fee structure is competitive. I would say that our campaign this year was lower key than I would like and I would want to, you know, ramp that up a little bit in future years.

**The Deputy of St. Ouen:**

In what way?

[14:45]

**Interim Director of Children's Services:**

Well, I think that we did not have enough of a visible presence so I have noticed on the bin lorries at the moment, or recently, there has been a breast cancer screening campaign. That is where you would see a fostering campaign when you have ramped it up so that as the bin lorries are going around it is in your face every minute. So I do not think we have quite had the visibility and presence, so we are looking at ways that we can increase that and strengthen it. It is the best value for money option for children and it leads to the best outcomes.

**The Deputy of St. Ouen:**

What are the particular difficulties we have in Jersey with regard to encouraging foster carers?

**Interim Director of Children's Services:**

I said there are 3. Housing is one, I have said already the no spare bedrooms, both parents working, the nature of the children we look after; very often we need someone who is at home with the child to really build the attachment that has been damaged in their family of origin, and - I am going to put this very crudely, forgive me - too many rich people and too many poor people and not enough people in the middle.

**The Deputy of St. Ouen:**

That is interesting. Not enough people in the middle?

**Deputy G.P. Southern:**

I will use it. **[Laughter]** It may be my campaign strategy. **[Laughter]**

**The Deputy of St. Ouen:**

Why will the rich people not take this up?

**Interim Director of Children's Services:**

It is not that they will not but there is a population of people that, on the whole, the sociodemographic, that yields the most foster carers. It is not that rich people will not and there are rich people in Jersey who foster for us. But it is about the sociodemographic where you get the best yield and it tends to be lower middle class, poor working class where you have got a spare bedroom and one person wants to stay at home with the children.

**Deputy T.A. McDonald:**

Middle Jersey.

**The Deputy of St. Ouen:**

But is there a way we could try and target the richer classes perhaps?

**Interim Director of Children's Services:**

I mean obviously what we do for targeting purposes here in Jersey is look at our population profile as it is and then work out so what do we need to do then to both increase the numbers who foster and retain those who foster and make sure we have got the right age profiles. So we have got a bit of an ageing profile for foster carers in Jersey and we need to attract ... obviously we need to keep attracting younger people in who will grow with us because you have got foster carers here that have fostered for 30 years which is fantastic; they are experienced, they have looked after a lot of children, made a big difference to children's lives. So I need to be bringing them in when they are in their late 20s early 30s so that we then get another crop who serve children well for the next 30 years.

**The Minister for Health and Social Services:**

I have read a case recently, positively, not ... I was not looking at it for negative reasons, quite the opposite, where one couple had fostered 90 children over many, many years; 90 young people they have helped.

**The Deputy of St. Ouen:**

Credit to them obviously.

**The Minister for Health and Social Services:**

Yes, and some of that would have been done at a time when there was no payment.

**The Deputy of St. Ouen:**

Minister, we wish you and your team well with that.

**The Minister for Health and Social Services:**

Thank you.

**The Deputy of St. Ouen:**

I hope that will generate success.

**Interim Director of Children's Services:**

Thank you. I hope I can be excused now.

**The Deputy of St. Ouen:**

Yes. Thank you very much, Jo.

**Deputy T.A. McDonald:**

Minister, I have not even had a look at the questions. How are the plans for the new hospital progressing?

**The Minister for Health and Social Services:**

I do not even have to look at the answers. **[Laughter]** I could not possibly tell you. I could tell you if I had a definitive answer. We have progressed, as you know, and I cannot remember if it was the last time I appeared in front of the panel or whether in informal discussions elsewhere. We have decided that the hospital will not be on 2 sites so we have moved forward. We are still umming and ahing over - and I am being very upfront and honest - over 2 sites at the moment and those 2 options need to be worked through. We have got the report from Gleeds and I am conscious that you have written to me asking for that report from Gleeds. I am going to pass the letter on to the Minister for Treasury and Resources because the Gleeds report was to Treasury not to myself. I am quite comfortable that it is shared; it will have to be shared at some time so we might as well start ploughing through the 1,400 pages ...

**The Deputy of St. Ouen:**

That is what we like. **[Laughter]**

**The Minister for Health and Social Services:**

... but it is not my report to give you but I cannot see any reason why the Minister for Treasury and Resources would not allow access to it. So we have got it down to 2 sites and I am fairly confident that we will be down to one shortly. The work then needs to be completed, I will not say started. As you will be aware there has been a lot of work going on around the Medium-Term Financial Plan 2 and even if I knew today what site I wanted, I cannot lodge, even if I wanted to unless I can tell you how I am going to pay for it. So Treasury are now working on that now we have got the, I will not say Medium-Term Financial Plan 2 put to bed, but as you know the work is virtually done, it is going to be launched to States Members tomorrow.

**The Deputy of St. Ouen:**

Is it possible to work on that without knowing which site you want to put the hospital on?

**The Minister for Health and Social Services:**

No. What I did say to you is we need to pick a site but I cannot lodge that as an option for the States without putting a resource plan in there and so the 2 have to come together and we are going to be concentrating on that now.

**The Deputy of St. Ouen:**

But for the purposes of the plan which is being lodged tomorrow ...

**The Minister for Health and Social Services:**

The Medium-Term Financial Plan is what it says, the Medium-Term Financial Plan. It does not make provision for the hospital. It acknowledges that the plan, a separate plan for funding of the hospital will be brought forward.

**The Deputy of St. Ouen:**

Right.

**The Minister for Health and Social Services:**

It does not put any figures in there. It is not because we do not want to.

**The Deputy of St. Ouen:**

Can you tell us which 2 sites are under consideration?

**The Minister for Health and Social Services:**

I would rather leave that at the moment, to be honest.

**Deputy G.P. Southern:**

You are not going dib, dib, dib are you, here?

**The Minister for Health and Social Services:**

I did not say anything.

**The Deputy of St. Ouen:**

You have spoken about soon. Is this going to happen before the summer recess?

**The Minister for Health and Social Services:**

It is going to happen in the summer recess because if I have looked at my diary correctly our last sitting is next Tuesday for as long as it takes and I would have hoped to have lodged by then but we will not have. I would have liked to have but you know this will be the biggest project the States has ever undertaken or are likely to undertake and I make no apology for taking a couple of weeks extra, or a couple of months even extra, to get it absolutely right. This is a once in several decades opportunity to get it right for our community and we must get it right. We cannot have some of the problems that we read about in the U.K. where we read about a hospital that has been built very successfully on budget and on time. I was chatting to the chairman of a regional health authority yesterday when he said he still bears the scars of coming to that decision but they came to the right decision. But it takes time and I make no apologies for taking slightly longer than I would have liked but we must get it right. We must get it right, we are going ... you know, this will be the biggest project the States has ever undertaken.

**The Deputy of St. Ouen:**

Certainly we must get it right but many people do remember and still talk about your 100-day promise, Minister.

**The Minister for Health and Social Services:**

My 100-days promise was that I would review the sites. I have done that; did that in 100 days. What I cannot do is tell you which site, because I still do not know, that we are going to ... and I naively made that promise because I did not realise how much work we would have to ... you know, 1,400 pages of Gleeds' information, a transport strategy around the different sites, 23 different sites initially reviewed. So I make no apology for taking longer. Naively I thought we could do it. I would like to have launched it this week; I naively thought that. We are going to be a few weeks beyond that, not many, a few weeks beyond that and if that means we get the right site,

the right funding mechanism in place and deliver the right size hospital for this community, I make no apology for that.

**The Deputy of St. Ouen:**

Does the Gleeds report recommend one site above other sites?

**The Minister for Health and Social Services:**

No, it does not. It scores them and depending on what is most important in your view which site you would pick. So it gives a weighting factor against several factors, so if you thought accessibility was the most important then one site would not score very highly against another. If you thought the opportunity costs of a site was more important than what else you could have done with it, then another site would score better and that site low. There is a whole raft of different things that they have considered, including how quickly can you build clinical adjacencies. By that I mean does the shape of the site allow you to put the right things in the right place? At the moment - and Helen will correct me if I go slightly off key - but at the moment we have got theatres all over the current site, the current general hospital site, therefore several recovery rooms. If you did your work properly - and we will give you this presentation formally when we have chosen what site - but if you do your work properly then you look at having all the theatres adjacent to each other and therefore possibly only one recovery room, and that gives you much better ... well it gives you economies for a start but it also professionally and clinically gives you much better cover because your experts are all in one place. Those are the sort of things we need to achieve. Some sites give you all of those and another site does not give you quite all of those but it gives you other advantages.

**The Deputy of St. Ouen:**

But do you have a process for arriving at a decision, Minister?

**The Minister for Health and Social Services:**

Of course we do.

**The Deputy of St. Ouen:**

Because I can understand there will be so much discussion as to what people prefer but how are you going to arrive at a decision?

**The Minister for Health and Social Services:**

We have a process. Well, we will arrive at a decision fairly soon but it is not what I want, it is what is the consensus of the Council of Ministers so that makes it slightly longer because it is not me being convinced by the reports of Gleeds and the officers as to what I would like. We have got to

discuss that with the Council of Ministers; this will be happening, and a funding mechanism needs to be put in place, and as I say a lot of work has gone into the Medium-Term Financial Plan 2, it is being lodged tomorrow, that box ticked in terms of it is done, there is a lot of work to be done about explaining it, selling it, taking it forward. But I am confident, fairly confident that we will be able to launch soon.

**Deputy G.P. Southern:**

The danger, is it not, is that you follow the advice, the best quality advice, and then it is design your plan. The danger is that it then gets attacked from below by the bean counters who want to pare £30 million off there or whatever.

**The Minister for Health and Social Services:**

I think what ... there is always people that want to ... they think they can do it a bit cheaper or a bit different or whatever. I think what we have got to do, we know what size hospital we need.

**Deputy G.P. Southern:**

Do we, given an interim population ...

**The Minister for Health and Social Services:**

Yes, we do. To achieve that of course we need to, as we are doing, we need to change the way that we deliver services. You know, we were talking earlier about more things being done in the community, more day surgery, which is perfectly clinically safe and what patients want; they do not want to be in hospital for a long time. So all that work is going on now around ... and that is the P.82 work. So we know what size hospital we need. We know today what sort of services we need to provide. Of course that could change tomorrow; technology changes all the time so the plan will have to be flexible. What we do not want ... because it is 6 years from signing the contract to taking the keys, approximately. What we do not want is a hospital that is 6 years old on the day it is finished, if you understand what I am saying. So we need to build in flexibility as well so we take account of modern technology. Once we have got the site determined we know what we want to do with it then it is right - and although you say “bean counters” - it is right that we look at what they call “value engineering” to see whether we can deliver what we want to the right specification, to the right size and more cheaply. So I will give you a really good example of that. When I headed up the Scott Gibaut Homes, the first quote came in for the development of the homes there because it was a listed building as well, so it was quite complicated. It was £1.4 million and we were fortunate enough to stumble upon a chartered engineer who came on the board and said: “Why have you got that sort of roof? That is really expensive.”

[15:00]

"You could have something that looks the same, performs just as well and nobody would know the difference but it is several thousand pounds cheaper." The project then when we went out to tender, after he had valued engineered it and looked at the appropriate finishes and that, came in at £900,000. Now I am not saying we can get that degree of saving in the hospital but it is right that once we pick the site, once we know what we want exactly in terms of what floor is going to hold what and where, that we challenge the materials that finish how it is built and of course we will have to do that. It is not bean counting, it is public money.

**Director of Finance and Information:**
As a bean counter [**Laughter]** I think it is fair to say ...

**Deputy G.P. Southern:**
You have not got your machete with you. The machete-waving bean counter, sorry.

**Director of Finance and Information:**
It is only because I left it in the office. The Minister is right. Any project like this is about value and we value engineer all our capital projects in the way that the Minister has described, but particularly with a project of this nature the value and the cost is not just about the build cost. It is about the life of a new building so you need to look at this over a 60, 80-year period because saving a sum of capital that may appear to be quite significant upfront may have a knock-on consequence over the next 60 years in terms of your revenue costs that may far outweigh something you save. So we are very aware of this and we have done lots of research in the U.K. and looked at other buildings, so we will always aim to value engineer the capital cost down but only in the context of what impact does it have not just in terms of the services that are going to be there and the quality and safety of those services, but also the ongoing revenue costs because otherwise it is just a false economy and we need to get value from the whole project over several generations, not just the cheque that you write to the builders on the day.

**The Minister for Health and Social Services:**
As Jason said, conversely you could spend a little bit more but save huge amounts on revenue of maintenance later so you need to balance all those things.

**Deputy G.P. Southern:**
You keep saying that you know the size of the hospital you want to build. What population is it being built for? Is it 100,800 at the moment?

**The Minister for Health and Social Services:**

You could just look at it on the basis of the number of people known to be in the Island. I prefer to look at it on the basis of the hospital activity and project that forward, which is what I think we ...

**Deputy G.P. Southern:**

On the basis of which population because we keep aiming and we keep missing it time and time again. We have missed it for the last 15 years.

**Hospital Director:**

The current plans, and obviously we upgrade them every time we go in typical business case mode are based on, I think, it was 2012 activity data. It might have been updated to 2013 now. Activity that we had to undertake as a hospital based on the population that was here at the time so we know how much we have to do for that population. But we have changed, we have added on to that what we know is going to happen from the demographic changes, how we know older people access health services more than younger people so we have taken that into account as well as a degree of population growth. So the population growth is almost a smaller measure than some of the other things that we know impact on health more than just straightforward population growth. So there has been quite a complicated calculation. It is all in that 1,400 pages that you will get.

**Deputy G.P. Southern:**

Cannot wait for it.

**The Minister for Health and Social Services:**

You will be pleased to know quite a lot of them are pictures and plans.

**The Deputy of St. Ouen:**

We look forward to that proposition. Thank you for your explanations, Minister.

**Deputy G.P. Southern:**

You will look back on your activities in the next 6 years and say: “Proud of that.”

**The Minister for Health and Social Services:**

Exactly.

**Deputy G.P. Southern:**

I built that.

**The Minister for Health and Social Services:**

Perhaps I will be at the opening, you never know.

**The Connétable of St. Peter:**

In one of the beds even. **[Laughter]**

**Deputy T.A. McDonald:**

I am loath to ask the next question now.

**The Minister for Health and Social Services:**

I am loath to answer it.

**Deputy T.A. McDonald:**

Absolutely. It has recently been announced that funeral directors will take on responsibility for transporting deceased people to the mortuary, taking over the service from the ambulance service. What are the terms and conditions of this?

**The Minister for Health and Social Services:**

I will let my colleague, the Constable of St. Peter answer that, because he led on this. But I mean the philosophy behind it was we want to use our highly skilled staff to save lives and move live people and not, sadly, the deceased, however tragic that is at the time. But the Constable will take over.

**The Connétable of St. Peter:**

I think really to set the scene that Jersey were fairly unique in that we were the only U.K. ambulance service to provide this service. It is historical of course with a small Island you try to make the best use of your resources. Unfortunately as time has moved on we see about 7 sudden deaths per month in Jersey and the problem with a sudden death is not the death itself but the immediate aftermath of that. With a sudden death first of all the police have to be called to determine whether it is foul play or whether it is a medical cause. They have to be there to go through that process. An ambulance is always called as well because is the person dead or are they just deeply unconscious and appear to be dead? So the ambulance service is called as well, particularly in the night time when it is difficult to get a doctor out to pronounce the person is dead and therefore they can be then moved. We have seen occasions where the ambulance service has been held there for up to 5 hours waiting for a G.P. to attend because it is the out-of-hours service and has not been able to come to deal with that, and at the same time there is a police officer been standing there for 5 hours of that same period just to make sure that there had been no tampering with any evidence in that period of time. What we have moved on to now, the

ambulance service, the paramedics have been skilled up to be able to pronounce life extinct and that means now at that point they can leave the site. The police officer also can determine that at the time he is called was there foul play, is there any evidence of foul play and the answer to that he can also give at the site, so it releases the police officer back to his normal duties and releases the paramedics back to their normal duties that we expect them to be doing. What then happens is that the undertaker is called in and they come and take the body to the mortuary of a sudden death. So therefore there has to be a post-mortem to determine the cause of death and that is done at our hospital mortuary. There is a cost to that and I cannot tell you exactly what that cost is because when we first started negotiating - we started this around about 6 months ago I think it was - the first price we had, we were given by one large operator in Jersey, was £250. When the others found out they were all offering different sort of discounts. So basically we are at the point now where the funeral undertakers were expecting to be in the region of £150 to move the body from where it is and to our mortuary. Bearing in mind if there had been a G.P. callout to the home in an out-of-hours service it would probably cost that same money, so from the point of view of the deceased estate, there is probably a neutral cost overall and bearing in mind the Social Security death grant, the last time I dealt with one was about £1,800 and I had one occasion the Parish had a person die intestate with no family so I had to deal with that all. I cannot remember the reasons now, the price went over that and Social Security made a supplementary payment to cover it totally. So people that cannot afford it will be covered effectively, on my experience, by Social Security. The advantage for funeral directors of course is that once they have engaged with the family of the sudden death they are more likely to get the commission for the funeral, so there is an opportunity for them to be more business-like in the way that they charge these elements which then have to show individually on their account sheet going forward. So there is an opportunity there for them as well to deliver a good required service. What we are seeing now is our ambulance crews are ready now to deal with people that are still alive that need their urgent activity and equally the police to be out there doing the job they are doing. To be honest I cannot say, and I did not ask and I should have done, and I apologise to you now, I should have asked, since we have introduced this only a couple of weeks ago, how many times have people been called out, and I cannot give that answer. Not that it is really germane to anything, just to give you an example that is working well, but I have not heard of any where it is not working well.

**The Deputy of St. Ouen:**

Are undertakers engaged on a rota basis to attend?

**The Connétable of St. Peter:**

There will be a call out rota effectively so they all get a fair crack at the whip. We do not want a Ray Bouchard-type issue again coming up, which you know about, Terry. I do not want that coming up with funeral directors. Another good point is that ambulances are equipped to deal ...

the equipment they carry is to carry live people. Dealing with a cadaver, a dead person, is a different type of equipment, particularly like carrying chairs to bring them down very small stairways in blocks of flats. Funeral directors are equipped to do that type of work far better than we are because they are different sensitivities obviously than having to carry a live person down where we need full stretchers, and that is difficult to get down the small stairways. So from that point of view there is an easier job being done - it is easier for funeral directors to do the job, they have the equipment and they are trained to use it. It would also let ambulance staff carry on doing the job that they are trained to do.

**Deputy T.A. McDonald:**

To get it straight in my mind, the paramedics obviously will be able to pronounce life extinct so that is one problem less. Notification of the Bailiff's Chambers or permission to remove the body as such?

**The Connétable of St. Peter:**

That is done by the police officer.

**Deputy T.A. McDonald:**

It is, so that is ...

**The Connétable of St. Peter:**

He is still there. He goes along and says: "I believe there are no suspicious circumstances therefore I am happy to allow the body to be moved."

**Deputy T.A. McDonald:**

That is fine.

**The Connétable of St. Peter:**

It does fall back to the Centeniers in fact but very few make that determination nowadays. They defer to the States Police.

**Deputy T.A. McDonald:**

Yes, and the question they always ask is accident, suicide or murder. What we are really discussing here is private ambulances, because that is what they are called in the U.K. They do the actual removal of the cadaver from whatever the scene, but it was just to get it clear in my mind because obviously it is a major step for paramedics to be able to pronounce life extinct.

**The Deputy of St. Ouen:**

Thank you, Connétable. Thank you, Deputy. I will ask Deputy Southern to ask the next question.

**Deputy G.P. Southern:**

The question is: have you worked out the necessary protocols in conjunction with the Department of Social Security over long-term care? I think what we are talking about there is 6 categories or 4.

**The Minister for Health and Social Services:**

I will pass you over in a minute but what I will say is that the method of assessment has been streamlined in order to try and speed things up ... not "try", has succeeded in speeding things up but are you going to talk about that, Chris?

**Director of Adult Services:**

Happy to. I think the quick answer is yes. We have been talking. We have protocols in place for how we are working together. I think we may have mentioned before, and it was a very steep learning curve for ourselves and our colleagues in Social Security as we hit this time last year, we had just celebrated the anniversary and we, over the last 12 months, have been able to improve significantly that joint-working process. The good news to report from a process perspective is that at the beginning of this month within our adult services we have been able to go live with the integrated electronic record system, called "Face". We have used Face for a long time in some of our service areas but we have now got a cloud-based system that will automatically populate the data that is required with Social Security. That will improve the whole process because of the automation because over the last 12 months we have had to be doing some element of that manually, which has added weight to the demand of time and such for the social workers doing the assessments. So we did 2 things earlier this year in agreeing a simplified version of the assessment that was required for the majority of cases, so we have been using what was called the overview assessment, which is a comprehensive assessment, and we deliberately did that because we wanted to be sure that we captured all of the assessed needs in processing a care package for people. There is an element within the system called the "needs assessment" which is a slightly simplified version, which captures enough for the mainstay of the work, so the majority of our work is older adults in regards to residential and nursing care requirements. Behind that we have a number of adults across the piece where there is much more complex need. We continue to use the full assessment where it is more complex but we have given the professional and clinical judgment of that to the social worker to determine, but we have given permission to use the simpler version, which actually speeds the process up.

[15:15]

The second element as well is we were required within the law that was set by Social Security to have professional validation of the assessments in place, but we have now also got agreement that because we have got people operating well and to a good standard that we have agreed self-authorisation, and again that has increased -- the process has taken out a layer of bureaucracy that we had that delayed again the assessments going through for the resource allocation, which would then allocate the money to a care package. What we have in place now, and we have been working on this over the last 4 weeks, and we complete this on 16th July is that we have undertaken a joint Lean evaluation of the whole process, so we have done the work within Social Security from the Lean perspective. We have connected that to a Lean review within community and social services and we are bringing all of that together on the 16th. What that is telling us already is we need to improve some of the process at the front end to manage the referrals coming through and improve some of the back end, which is about commissioning the care packages in order to release the resource in the middle to focus more ... in essence, it is about getting a social worker's time released to focus on the assessment and putting together the care plan. So we are anticipating that with the 3 elements that we have done, which will include the Lean, that that will then give us over the next 3 months a true reflection on what the actual additional pressures are, because there are additional pressures because today we have to assess everybody whereas a year ago we did not assess people who were self-funding. So everybody who ... nobody will self-fund for ever today, they can access States funding to cover. So the demand has increased but we have done some significant work to establish what that real pressure is. So we went through a big hiatus early on, huge pressure across the teams in both Social Security and ourselves and it feels as though it started just to filter down a little bit. We do still have a waiting list and currently our unallocated cases sits at 62 referrals, but what I can assure you of is in managing any unallocated cases, and the longest that has been waiting for assessment - and do not sigh too hard until I tell you the whole story - is 6 months. Now that is a long time for waiting except because we have had a lot of referrals of people who are self-funding already people are already in existing care packages, so people are safe and well. It is the bit of getting through the process to transfer the payment. But because people have made the referral that people know that the money is backdated to the date of the referral. So a significant number of people are happy to wait for that assessment process because what we always have to do is prioritise those people who are out in the community without a care package whose needs have changed and we have to manage that process quickly and well and we monitor all of our stats. At the moment we are achieving really good outcomes in terms of those priorities for completion of the assessment of the process through the resource allocation system.

**The Deputy of St. Ouen:**

That is good to learn that progress.

**Deputy G.P. Southern:**

Can I take you on to a different area of long-term care in the community? Terms and conditions of the companies that are bidding for care in the community in looking after people, are you aware that in some cases travel time is not paid, there are spaces in the middle of the day where empty space, no time is allowed to get from, say, St. Helier to St. Clement on the schedules and that people are seriously questioning the terms and conditions as happened in the U.K. in many cases. It appears to repeating itself here.

**The Minister for Health and Social Services:**

Terms and conditions must be entirely a matter between the employer and the employee. The sort of things that we would be wanting to ensure take place is they do pay the minimum wage or the appropriate wage but no less than the minimum wage, that is their practice at the moment, and that staff are appropriately qualified, appropriately supervised and appropriately checked for C.R.B. (Criminal Records Bureau) or whatever it is called these days, because I cannot keep up with the letters. Other matters of employment issues in terms of when they are paid, whether they get travel payment, whether they get paid meal breaks or not, is entirely a matter between the employee and the employer.

**Deputy G.P. Southern:**

If one of those have, say, no time to get between St. Helier and St. Clement ends up with a half hour visit which is no good to anybody, are you satisfied that that might happen?

**The Minister for Health and Social Services:**

That is a different question. If you are asking me is the person who has been contracted not delivering that which they have been asked to contract, i.e. if they have been contracted for an hour's contact time but they have not allowed for that hour's contact time - and I just made that figure up - then that is something again that needs to be looked at by our regulator. But employment conditions, the conditions under which staff are employed, subject to the ones that I have raised at the beginning, has to be a matter between the employer and the employee.

**Deputy G.P. Southern:**

Okay, no comment.

**The Connétable of St. Peter:**

I made an erroneous statement earlier on. We were talking about the sudden deaths. I was asked are the funeral directors on a rota and I said yes. The first question that is asked of the deceased family: "Do you have a preference?" Only if they do not have a preference are the funeral directors appointed on a rota basis.

**The Deputy of St. Ouen:**

Yes, I see.

**The Connétable of St. Peter:**

Just to correct that answer.

**The Deputy of St. Ouen:**

Thank you, I understand. Assuming their family is there.

**The Minister for Health and Social Services:**

Yes. Jersey is quite traditional and many of us have a preferred funeral director.

**The Deputy of St. Ouen:**

You are right. There are 2 big questions, and I am very conscious we are running out of time, so, Minister, if I was to ask you about departmental savings, can we ... I would also like to ask you something about the names and addresses register. So in just a few minutes could you perhaps take us through the chart that has been given?

**The Minister for Health and Social Services:**

On departmental savings?

**The Deputy of St. Ouen:**

On departmental savings. Just to understand the chart you have in front of you.

**The Minister for Health and Social Services:**

I will ask my bean counter, as you put it, to take us through.

**The Deputy of St. Ouen:**

We are interested in the traffic lights.

**The Minister for Health and Social Services:**

The only thing I would like to say before we go through it is that ... I ask Jason to go through it, it is not negating ministerial responsibility. The changes in service because that is what most of it is, the efficiencies that we are trying to achieve, has been approved by myself as Minister on advice that I have approved it but I will ask Jason to take us through the actual progress.

**Director of Finance and Information:**

I think you were going to ask about the traffic light colours. They are quite simply to give a headline indication of whether the particular line is on track or given to cause for concern in terms of deliverability this year, so there is a combination red, amber, green. The greens are areas where we think we are absolutely on track delivering savings. The ambers are ones where we have a concern ... we are doing okay but we have got a concern. The reds are ones where we are particularly concerned about whether we are going to deliver, particularly to the level that we have targeted. That is not to say that the red is necessarily bad. There are some that you will see there where the red is just reflecting what the reality of what is happening and it does not mean we are going to take some drastic action to extract money or savings where there are not savings to be had. It just reflects where we are today against our original plan.

**Deputy G.P. Southern:**

So what will you do if your plan does not work out? The red lights end up red in whatever.

**Director of Finance and Information:**

We deliberately took the approach at the beginning of the year to slightly over-programme our targeted savings, recognising that we were not likely to be 100 per cent successful against everything identified because life is that you never are with these things. There is always an element of best laid plans do not come to fruition. So we have over-programmed to a degree so we could afford for some of the issues or some of the plans that we have put in place not to deliver to the full extent that we planned. So some elements of red lights there are fine. There will be other areas where we manage to achieve savings that we did not initially plan, so there will be some lines that we can add on to this that were not there in the initial plan. Perhaps the easiest one I can give you is around insurance arrangements for our locum consultants. Historically where we have brought locums into the Island to cover for absences through sickness or leave or vacancies we have had to put specific and separate insurance arrangements in place for each and every doctor. We have now managed to negotiate with our insurers to put a block arrangement in place for all locums that come to the Island, which provides better value for money so we are making one payment to our insurers to cover all locums. That has generated a saving that was not initially planned. So that will go towards covering some of the ones that might not deliver to the full extent that we anticipated in the first place.

**The Deputy of St. Ouen:**

Can I just look at what seems to be the largest target there, which is the U.K. contract saving, the second entry? So does this mean that you were seeking to reduce payments made to U.K. hospitals by virtue of contracts with them?

**Director of Finance and Information:**

It reflects a range of ambitions to reduce the level expended in the U.K.

**The Deputy of St. Ouen:**

I had understood we had renegotiated those contracts recently.

**Director of Finance and Information:**

Some. We have renegotiated 2 contracts, which I am sure Helen can talk about in more detail if you wanted. They are generating some particular benefits. Some of which have financial implications, some of which do not. Some of which just make life better for the patients that travel to the U.K. We are looking to do more. We have not been able to extract any of those savings to date, not least because they have been offset by increases in costs in terms of the referrals to the U.K. and other areas. So it is not ... where there is a red or a zero in the achieved column it is not simply that we have not achieved what we set out to achieve. In some cases we may have made some achievement but it has been offset by some other pressure in the system that has meant we have not been able to extract the budget. So it is no good me saying to Helen: "I am going to take out £100,000 of budget in this area because you have made this saving" if all I am doing is reflecting the fact that there is another cost pressure that Helen has to deal with.

**The Minister for Health and Social Services:**

It does depend on how you look at it because if we were to take that £100,000 out and then suddenly we had more patients that need to have that procedure carried out in the U.K. and it costs us more than we planned we cannot say no.

**The Deputy of St. Ouen:**

No, I do understand.

**Hospital Director:**

The pressures around this, we have seen more emergency transfers to the U.K. in the last 12 months than previously. We have seen pretty static numbers going in a planned fashion but the prices have gone up from the U.K. The element about contracts is where we think we will make the biggest gains. We have just this last week appointed a new individual who is going to come and do that contract work for us, so we think this will start to accelerate now. We have done a contract with Oxford and a contract with Cambridge that have been really successful, so we guarantee the price, we guarantee the patient's care and their pathway and we want to now spread that out to some of the other hospitals that we send significant numbers of patients to. We want to also challenge some of the doctors about returning patients and keeping them on Island

for their follow-up care rather than sending them back to the U.K., so we are looking at reducing the numbers travelling as well.

**Deputy G.P. Southern:**

The other areas that interest me is vacancy management which is the classic pull up of appointing somebody and so you are going to have to ... is that what is happening?

**Director of Finance and Information:**

Each and every vacancy that we have is reviewed by either Helen or Helen's equivalent in the community or the Chief Executive. I think it is fair to say there is no delay in any vacancy appointment for any purely financial reason. Every appointment that needs to take place does take place and they are only delayed or stopped with Helen or Helen's counterpart's approval. There are natural gaps in recruitment between somebody starting and we have managed to take advantage of some of that. There are some areas where we have targeted particular savings; particularly around administrative areas and some of the support services, where we have pieces of work underway to review the processes to try and make then more efficient and effective.

[15:30]

So where there has been an opportunity to get ahead of the game on that, we have taken that opportunity. We are particularly targeting some of the support services so I can speak personally in the finance team that we have rearranged how we do some work to extract some savings and recruit staff at a lower level than we would otherwise have done. So there is a whole combination of things in there but there is no kind of a blanket delay on recruitment in any size, shape or form. In fact, often, delaying recruitment incurs a cost rather than savings so we are acutely aware of that. Particularly for nursing posts, social care posts and so on; what we are trying to do is make the recruitment process quicker because that avoids agency and bank costs, which tend to be more expensive than filling the post.

**Deputy G.P. Southern:**

The line of rephasing of P.82/2012, which has been delivered; what is that rephasing about? Is that rephasing of services, rephasing of staffing at all?

**Finance and Information Director:**

That is rephasing of the implementation of some of the services. So probably the easiest example is where we might have planned to start something in January, and it may now be started in July, which means we will have a 6-month cost in 2015 rather than a 12-month cost. If you wanted to look at it scheme-by-scheme, I am sure Rachel could probably talk about it.

**The Deputy of St. Ouen:**

The difficulty is we have run up against 3.30 p.m.

**The Minister for Health and Social Services:**

That is about management capacity as well. We have got a lot going on at the moment so it is not just about money. Although I would say - and I know you want to move on, Chairman - 23 of the new services that we wanted to introduce under P.82 have now been introduced.

**The Deputy of St. Ouen:**

Yes. I mean that is a large discussion and we unfortunately have not got time. Minister, we have reached 3.30 p.m. did you want to ...

**The Minister for Health and Social Services:**

I will give you a few moments.

**The Deputy of St. Ouen:**

You are very kind.

**The Minister for Health and Social Services:**

But I am not always very kind. If you want to talk to me about names and addresses.

**The Deputy of St. Ouen:**

Okay, the names and addresses register; because we are going to be discussing that in the States, are we not? I am sure, and everyone would see the benefits of using data to capture the cancer risks and to alert people to what is available, but the proposition also talks about what may happen in due course and other uses in due course. So can I ask what must be done to enable what you want to happen in due course?

**The Minister for Health and Social Services:**

I will pass over in a minute for the more technical in depth; but this is something I am particularly keen on because this is about, as you rightly said ... well you did not use the words, but this is about ensuring that we are able to screen our community to help prevent some of the diseases that are either preventable or treatable if we get them early. Can I start by saying what this is not about? This is not about sharing medical information. That misnomer seems to have got out there that we are going to share peoples' medical information; we are not. What this is about is getting the name, the address, the date of birth and the gender of individuals in the Island. You may think: "Well, you have got a lot of that." And we have. We have got about 70 per cent of the population engaged with us. Now it may be questionable whether we have got the right name and address,

but we have got a name certainly and a date of birth and gender for about 70 per cent of the population. What we have not got is any information about the other 30 per cent. So when we are inviting people for screening, either bowel screening or to come in for breast screening, we are missing 30 per cent of the population. Now there is no compulsion here. We can only invite people to come, but we would like to invite everybody - at the right time - to come and have an appropriate screening. If they do not want to do it, they say no, but at least that way we have invited ... everyone has had the opportunity to come in. If you want more detail I will hand you over to Linda, but I will be speaking very firmly in favour of this and talking about sharing names and addresses. Now I think the Scrutiny Panel for - not necessarily this panel - but a panel were asking about the security of that data. Well we have got 70 per cent of the populations' data secure; why would we treat the other 30 ... was it this panel?

**The Deputy of St. Ouen:**

Yes, I do not necessarily want to go into that again. One possibility is that it might be used for medical research. That is within the definition of medical purposes. Is there any possibility in the future that the population of the Island could receive correspondence from validated, recognised, research hospitals asking them to take part in research projects; is that the thinking?

**Head of Healthcare Programmes:**

The answer is no.

**The Minister for Health and Social Services:**

No. Because we are not sure.

**Head of Healthcare Programmes:**

Because the wording "medical purposes" comes from the Data Protection Law that the Information Commissioners have recommended. That term was used and as part of the Data Protection Law "medical purposes" includes medical research, but there is no intention to do that and there will be no passing on to a third party for commercial purposes. There is no plan to do that. You asked about the "in due course", another function. As the Minister has explained, the primary purpose is around our cancer screening programmes. But one of the other things that we could use ... we could take a feed, an electronic feed from the names and addresses register of that information and we could use it to update the names and addresses that we have in the hospital system. One of the reasons that would be useful is that there are many times when people are sent an appointment for an outpatient appointment and people do not turn up. So there are numerous appointments that are wasted and often we find out later that it is because the letter has gone to an outdated address. So the person never even knew that they had an appointment and obviously the doctor's time is wasted and somebody else could have that appointment, et cetera.

**The Deputy of St. Ouen:**

It is very frustrating.

**Head of Healthcare Programmes:**

What is needed in order and why it says “in time “one could use that is because the TrakCare system that is used in the hospital is a patient administration system. So it is all of the patients who have ever been treated in the hospital. So you may have been on holiday here 10 years ago and had sunburn and went into the A. and E. (Accident and Emergency) Department and your details would be on there. So you can see if ... for like the cancer screening, you cannot use that otherwise you would be writing to invite people who are not here. So in terms of being able to use it to update, to ensure the addresses on that system are correct and updated from the updated names and addresses register, the bit of work that would need to be done first is you would need to archive off some of the information in the patient administration system. So you may have for argument’s sake - and I do not know the number - say it is 200,000 names and details of people; there would need to be a bit of work to put a field against some of those who are not here so that they are still there in that system but they are archived, if you like. So if it was somebody that lived in Jersey and then they came back, one could retrieve their information. But once you have done that piece of work, there would be ... and that technology was enabled to do that, then there would be no reason why you could not ensure that as people go around the different departments in the States of Jersey and that information is updated, that that updated name and address could be shared with the hospital to minimise the appointments. Is that fair to say, Helen?

**Hospital Director:**

Absolutely, yes. It is a big problem for us.

**The Minister for Health and Social Services:**

Emphasis on name and address. We are the recipient of updated information; we are not going to be giving it out.

**Head of Healthcare Programmes:**

But the primary reason is for the cancer screening programmes and you heard the colleague earlier mention we have to do imaginative things to try and ... so the refuse truck of the Parish of St. Helier volunteered to paint it pink and put adverts on it to tell women about breast screening and cervical cancer screening. We have put things on the railings down at the steam clock. We have put an advert on the back of the LibertyBus because people think ... when you talk to people anecdotally they think: “Well you must know that I am here” and of course we do not. So if they have not been in ... if they have not engaged with us, we do not know that they are here and as the Minister said, it is your choice whether you want to take up the offer of bowel cancer screening

when you reach the age of 60. But you cannot be given the choice if nobody writes to you in the first place and invites you. That is all we wanted; to be able to access those names and addresses, date of birth and gender because when we have those things, we know that many women who have reached in this calendar year their 60th birthday year, they are the people we can say: "Hey, would you like to come for ... you are eligible for bowel cancer screening; would you like to come?" Women 50 to 69, to write to them and invite them for breast cancer screening, and women between 25 and 64, to invite them for cervical cancer screening. So gender, date of birth, name and address are vital to be able to do that. I think the names and addresses register, as you know was made for the Control of Housing and Work Law, so this is getting in some added value.

**Deputy G.P. Southern:**

What confidence do you have that the population register is sufficiently accurate for your needs?

**Head of Healthcare Programmes:**

Okay, well that is why we have waited until now when the register actually came into being in 2012. So we were advised to give it some time so that as it gets used more and more it becomes more accurate in terms of names and addresses.

**Deputy G.P. Southern:**

Have you spoken to the Statistics Department? Have you spoken to Duncan in the Statistics Department? Because he thinks that ...

**The Deputy of St. Ouen:**

The Chief Statistician?

**Deputy G.P. Southern:**

The Chief Statistician, yes.

**Head of Healthcare Programmes:**

Yes.

**Deputy G.P. Southern:**

He is very sceptical about the accuracy of the population register and has said ... put out a message to all States Members last week I think it was, with his latest bit of data: "This data is really ropey", in effect. "We cannot trust the estimates they are making of this particular area and much longer. Give me the population register and I will have it pristine and ready for use properly and accurate within 2 or 3 years."

**Head of Healthcare Programmes:**

Okay, well it is a lot better than what we have got, which is nothing other than advertising and people coming forward themselves. So it would give us ... remember we are sending a letter of invitation, so at the very worst it is going to be a letter that goes to somebody who is not here because perhaps they have left, and the names and addresses register is not as up to date. But certainly I know that the Chief Minister's office with the ... want the programme and want to increase its use so it is not used at the moment by the Income Tax office, for example. I do not believe it is used yet by the Vehicle Licensing Centres. The more that it is used, obviously the more accurate it will become.

**Deputy G.P. Southern:**

There is an issue there; provided that you bring proper regulation, I mean, clear about your intentions, that is fine, but beware of mission creep is the word with any data source, we tend to: "Why do we not we just do this with it?"

**The Deputy of St. Ouen:**

That is for the States to decide.

**Finance and Information Director:**

It might just be worth saying; we do have very clear policies that are approved on what we do and do not do with our data.

**The Minister for Health and Social Services:**

Do not forget, apart from gender, the information we are asking for; a lot of it is available in the phone book anyway.

**Head of Healthcare Programmes:**

Apart from date of birth. We cannot put the date of birth and gender in the phone book so yes ...

**The Deputy of St. Ouen:**

Okay, well I hope it enhances the cancer screening campaign and thank you, Minister, and thank you for your whole team. It has been a useful afternoon for us.

**The Minister for Health and Social Services:**

Thank you for your time.

[15:42]