STATES OF JERSEY

SOCIAL AFFAIRS SCRUTINY PANEL

GP OUT-OF-HOURS REVIEW

MONDAY, 13th NOVEMBER 2006

Panel:
Deputy F.J. Hill BEM of St. Martin (Chairman)
Deputy D.W. Mezbourian of St. Lawrence
Deputy A.E. Pryke of Trinity

Witnesses:
Senator S. Syvret (Minister for Health and Social Services)
Mr. M. Pollard (Chief Executive of Health and Social Services)
Mr. M. Littler (Directorate Manager of Medicine)
Dr. Bryony Perchard
Dr. Steven Perchard

Scrutiny Officer:
Mr. C. Ahier

(**Please note**: All witnesses and Panel Members were given the opportunity to comment upon the accuracy of the transcript. Whilst the transcript remains a verbatim account of proceedings, suggested points of clarification may have been included as footnotes to the main text.)

Deputy F.J. Hill of St. Martin (Chairman):

If we are ready I will begin by welcoming you to our hearing today. If Dr. Perchard does come along she can join us - indeed when she arrives here. I think you know everybody here but just for the sake of the record I will introduce myself, I am Deputy Bob Hill, Chairman of the Social Affairs Panel. To my right I have …

Deputy D.W. Mezbourian of St. Lawrence:

Deputy Mezbourian of St. Lawrence.

Deputy A. Pryke of Trinity:

Good afternoon. Anne Pryke, Deputy of Trinity.

Deputy of St. Martin:

And we have Charlie Ahier who is our administration officer. First, we would like to ask you, Stuart, to introduce yourself and also your 2 colleagues so we have it down for the record.

Senator S. Syvret:
Stuart Syvret, Minister for Health. Mark Littler and Mike Pollard.

Deputy of St. Martin:
You will see a notice in front of you, you have been here before, but can I ask you to keep your voices up so that we can all hear what you have got to say and also it will be very important when we come to the transcription. I also inform you that you are aware of the statutory procedures, et cetera, so with that we will plough straight on. Some of the questions were going to be specific for possibly Dr. Perchard but I think probably we could ask you this, maybe you have some comments. On Friday afternoon we received the 6-monthly review - obviously we will ask her what her thoughts were but possibly we could ask for your comments as well. How you see it progressing, if you have had an opportunity to read it?

Senator S. Syvret:
I have not seen the document yet. I do not know if Mark or Mike have.

Mr. M. Littler:
Yes, it was finalised this Friday. It has only just gone out this Friday. The activity data, it is broadly in line with what our anticipation was, in that there would be a transfer of home visits to surgery visits. That is working out approximately 36 to 40 per cent. In terms of the performance measures in place --

Deputy of St. Martin:
Could I maybe ask you to stop at this moment? At this stage I would just like to welcome Dr. Perchard. We have just started, just got ourselves underway. The first question was being asked; we had delayed, we thought you were here for 12.30 p.m. but what I am -- I know you are Dr. Perchard.

Dr. B. Perchard:
This is the other Dr. Perchard.

Deputy of St. Martin:
That is the other Dr. Perchard.

Dr. S. Perchard:
Steven Perchard. Bryony Perchard.

Dr. B. Perchard:
He is also on the management committee.

Deputy of St. Martin:
If you would like to be part of the interview process you are welcome to but what I will do, I will have to read out the notice to tell you how you are covered by privilege. Also if you are, I would ask you to move over so you are sitting close to a microphone, if you want to sit there maybe. Dr. Steven Perchard, I think it is important to know that you fully understand the conditions upon which you are appearing at this hearing. You will find a printed copy of a statement I am about to read you which is on the table in front of you. Have you been to a hearing before?

Dr. S. Perchard:
No.

Deputy of St. Martin:
The proceedings of the panel are covered by parliamentary privilege through Article 34 of the States of Jersey Law 2005 and the States of Jersey (Powers, Privileges and Immunities) (Scrutiny Panels, PAC and PPC) (Jersey) Regulations 2006. Witnesses are protected from being sued or prosecuted for anything said during the hearings unless they say something which they know to be untrue. This protection is given to a witness to ensure that they can speak freely and openly to the panel when giving evidence without fear of legal action although immunity should obviously not be abused by making unsubstantiated statements about third parties who have no right to reply. The panel would like you to bear this in mind when answering your questions. The proceedings are being recorded and transcriptions will be made available on the Scrutiny website. Just to ask you both please when you do speak, to keep your voices up so it can clearly be recorded. Thank you. We had just started the first question, so maybe it is worth -- I will repeat the question and maybe Mark could come back with a full answer and we will obviously ask for your comments as well. What we are looking for is at the closing stages of the 6-monthly review what observations you have, et cetera, of it. Mark was just giving us his thoughts on it, so maybe you would like to start again or say what you want to say.

Mr. M. Littler:
Because of the lateness we have not had time, both Bryony and myself and the rest of the GP Co-op Steering Group, to analyse all the data and, above all, start planning when the final report will be finished for the Ministry to consider. However, looking at the data there has been our ideas, when we set up the GP co-op we knew that there was going to be a shift from calls or GP visits to visits to the GP surgery. We were not sure, we thought between 25 and 50 per cent. After the first 6-7 months we now know it is approximately 40 per cent. So it was within our broad predictions. Also, we knew that there would be a degree of variation of activity, whether it be GP home visits, visits to the surgery or even telephone calls, and within the report you can see over that review period there is quite a variation. For instance, the appointments vary from as low as 3 per week to --

Deputy of St. Martin:
Can I just ask; are you referring to page 11?

Mr. M. Littler:
Yes, I am. The variation is between 3 and 53 appointments at the GP co-op with an average of 25 per week.

Deputy of Trinity:
Can I just stop you? Just as we are talking about this; can you just explain the graph to us? Because you cannot identify at weekends or bank holidays, they are not easily identifiable.

Mr. M. Littler:
What this is, this is a summary of the statistics that we keep. We keep detailed week-by-week statistics based on various time periods. So what you have got here is just a consolidated list. On your left hand side you have got the week, right from the first week starting 3rd April, right up to the week starting 27th October. Then along the top you have got different time periods; 8.00 a.m. until 12.00 p.m., 12.00 p.m. until 5.30 p.m., 5.30 p.m. to midnight and midnight to 8.00 a.m. This is to enable us to analyse when the activity occurs and, above all, to ensure that we have got the right appropriate manpower covering that. So if there is anything awry that we need to either increase resource there we can analyse on that basis. Likewise, with home visits. So on the left hand side there are the weeks and there are the appointments, i.e. the GP co-op. In the middle you have got home visits. This is where the GP, on the basis of a call from a patient, visits them in their own home. Again, you have got the activity data split into those 4 time periods. Again, to help us to ensure we have got the right resource against the right time period. Above all, we will have to determine whether or not this is the right use of resources when we come for the final report to go to the Minister and the Chief Executive. The other thing that we have got on the right hand side is telephone advice. Now we knew that GPs had telephone calls, we did not know how much and most of those that they do not charge for, but it is interruptions and you can see again that it ranges from one telephone call per week to 62, with an average of 36 per week. So all-in-all within this time period we have got about 100 interactions per week for every week of the GP co-op broken down to appointments, home visits and telephone visits.

Deputy of Trinity:
But it does not say what the activity is during the week and at weekends and bank holidays.

Mr. M. Littler:
We have got that. If you require that we can provide you with a week-by-week account. Then it will tell you from Monday to Friday, Saturday and Sunday and the time periods. This is just the summary sheet.

Deputy of St. Martin:
With the actions per week, particularly the telephone advice, one of the advantage one would say about the co-op that there is one central spot now that one can make a phone call, and would I be right that the 981 figures, is that the total telephone advice that has been given since April to October?

Mr. M. Littler:
Yes.

Deputy of St. Martin:
So we are agreed, so these 981 -- if the co-op was not in place what provision would there be? Would it be normally you and I as a patient would ring up our doctor, because there would be no records kept of that probably in the past?

Mr. M. Littler:
I think it would be best if Dr. Perchard answers that.

Dr. B. Perchard:
In the previous system you would phone your own surgery and whatever arrangements they have put in place you would be able to speak to someone and get some telephone advice. But obviously we do not have any recorded data for that activity.

Deputy of St. Martin:
Is this something that it would be possible to find out or is it just generally felt that because --

Dr. B. Perchard:
Absolutely impossible to find out.

Deputy of St. Martin:
It would be impossible? Obviously by virtue of having your co-op, this is an easier way of recording things, so this is something you saw.

Dr. S. Perchard:
No figures like this would have ever been kept before for any surgery. They would keep a record of the consultations but they would not keep a record of the number of figures.

Deputy of St. Martin:
Is this probably fair to say that we are getting an increase in people phoning, or it seems a fairly consistent number, because they know the co-op exists so they will use that as a means of a safety first really?

Dr. B. Perchard:
Very difficult to say one way or another. I mean logic would probably suggest that because we have improved the availability that it may well be that our number of telephone calls is going up. But I could not possibly respond to that.

Deputy of Trinity:
Do any of your figures surprise you?

Dr. B. Perchard:
No.

Deputy of Trinity:
None at all?

Dr. B. Perchard:
No.

Deputy of Trinity:
I will ask the same question to you, Mark. Do any of the figures surprise you?

Mr. M. Littler:
No. I mean we were at pains when we were setting up the GP co-op, especially setting charges, we needed to have a good idea of the activity in order to ensure, to put it crudely, that Health and Social Services funds were not going into an enterprise to the ultimate benefit of GPs to the detriment of patients. So working with the 2 Dr. Perchards and the group we looked into the activity as best we could on all sorts of activity. It is coming out roughly, as I said, as we thought.

Deputy of Trinity:
But there were no figures beforehand to base it on?

Mr. M. Littler:
No, in the report that we gave to the Scrutiny Panel there were 2 instances where we based our information on. In terms of the report we looked at general activity data from 40 GPs for one week. There was a study during 1st December to 12th December 2002. So the GPs did an activity check then. We also wanted detailed activity data from 3 representative practices for one week of 9th March to 15th March 2005. Also we looked at current tariffs for specific services from 6 GP practices. In terms of the 2 lots of activity data, they are very consistent so we knew from 2 different time periods the activity data was broadly comparable, so we based it on that being the best information that we had and then we did

some sensitivity analysis which you have seen in the report to say: "Okay, how sure are we that this activity data will come to pass?" Fortunately, it largely has.

Deputy of Trinity:
I suggest, just to pick up a minor point, you have got the one visit to the actual Gwyneth Huelin Wing, week 4, which was during the night; did they ring up first to …?

Dr. B. Perchard:
The GPs are able and in a position if, for instance, someone phones before 11 o'clock, before the base is shut. If the GP says: Well, make your way up now" they are able to -- so it is quite likely that may have been 11.15-11.30 something like that. It is discretionary. So rather than be compelled to have a home visit if the GP is still on site they may choose to lock up themselves and see someone. So it is quite likely that that did happen and it was probably around the 11 o'clock mark rather than just before the base shut.

Deputy of St. Martin:
Could I just ask this question, what Deputy Pryke was saying was the fact of close proximity to the cutting-off time; has any consideration been given maybe to extending that cutting-off time to one o'clock rather than midnight or whatever?

Dr. B. Perchard:
We would but obviously that is part of the future analysis. We have just taken on 25 per cent more GPs and we will obviously be collecting the data to extend the service should that be required. However, at this point, I would not presume to answer that question one way or the other.

Deputy of St. Martin:
But you are analysing the situation presumably?

Dr. B. Perchard:
If it looks like the base desperately needs to stay open longer then obviously we will take steps to do that. At this stage there is not demand for it. It does not look like there is going to be but it is something that has come up.

Deputy of St. Martin:
Just one point also that I gather there is no charge paid for anyone ringing up the co-op? There is no charge. If someone rings up for advice would there have been a charge prior to having a co-op? If one rung up their doctors normally would a doctor --

Dr. B. Perchard:

Potentially. It is entirely discretionary. Obviously if someone is to phone up to get a small piece of advice then probably not but if they have phoned up and it involved a large amount of workload and admissions and sorting and it was all done on the telephone they might have chosen to place a charge. But we have taken the decision at this point not to place a charge and obviously if -- there could be circumstances under which charging may be appropriate but we are not doing that at the moment.

Deputy D.W. Mezbourian:
Mark, we are discussing at the moment the performance report which has been produced by the Co-op Management Board and that is dated 3rd April to 3rd October, and that is the prerequisite 6-month performance review, but you have mentioned a couple of times the final report and, for the record, would you explain the difference between this and that?

Mr. M. Littler:
I think this is the performance report which sits within the final management report. Basically, the final report will be developed by the GP Co-op Management Board, that will go to the Chief Executive of Health and Social Services and the Minister of Health and Social Services, basically setting out all the performance data and also the rationale as to why Health and Social Services should continue to jointly fund the GP co-op; within that we will have the GP co-op project agreement so they can see all the elements of the GP co-op. So it is really 2 things; there is the project report and the performance report joined together with a business case to say: "We think this is a good idea, Minister, to continue to support."

Deputy D.W. Mezbourian:
When is that expected?

Mr. M. Littler:
Really, it is expected now. We are behind on that and we are beginning to work on that right now. We were held up in getting the performance management system in place to get some data out of it and then to be able to provide the Minister with the actual performance of the actual GP co-op. Without it, it would be meaningless. So in the next few weeks, certainly before the year is out, we will endeavour to work with Bryony and her team to develop the report for the Minister and the Chief Executive.

Deputy D.W. Mezbourian:
That will be the report on which the Minister makes his final decision?

Mr. M. Littler:
That is right.

Deputy D.W. Mezbourian:

You have said a couple of times that report will say that the system is working but presumably if you find that it is not it would also say the opposite?

Mr. M. Littler:
Absolutely.

Deputy of St. Martin:
Can we just get back to the report; one noticed when reading through it, it says a number of times: "We will not be able to audit this standard until we have the appropriate IT (information technology) infrastructure" and that keeps getting repeated through the report which we had over the weekend.

Dr. B. Perchard:
It is the general theme.

Deputy of St. Martin:
Yes. What are you doing to offset that problem? Because until we had the IT we were all used to using the old pen and paper and keeping records. Are you able to keep a manual record at all?

Dr. B. Perchard:
The national standards by which we would hope to become compliant are very IT driven. They have been written for out-of-hours services that have full complement of information technology support. Therefore, we cannot possibly try to attain those standards until we get there and we will get there but it is very, very difficult to audit something that has been written for a computer program. Essentially lots of the timings and things are automatically logged. In a paper system you do come apart partly because of the time pressures and people are focussed on delivering care. They are not always focussed on logging data in for audit and it is an issue but it is one that we know can be easily resolved. The other thing is that in the first 6 months it has been such a trial, we have to put in places all sorts of systems and protocol-based care and that just does not happen overnight. So, you know, we have to tick something off each month basically and work through it.

Deputy of St. Martin:
I do not mean it as a criticism, it is an observation of style in your report.

Dr. B. Perchard:
It is very difficult to meet those standards without the IT, but even if we were meeting them, proving it is impossible without the IT even if we have lots of paper records.

Deputy of St. Martin:
With this particular - I am not too clever on IT stuff - but is it possible to look at what you are setting up,

you have got off the shelf from another practice in the UK, could it be done?

Dr. B. Perchard:
No.

Deputy of St. Martin:
Just particularly for your …

Dr. B. Perchard:
No, there is a system called Adastra that is used in, now I think, 100 per cent of all out-of-hours systems in the UK. It is also used in Ireland and Holland and parts of France. So certainly we would not look to reinvent the wheel. It is a call handling system and that is where most of the IT comes in.

Deputy D.W. Mezbourian:
Presumably that would be introduced only if it gets the go ahead?

Dr. B. Perchard:
Precisely. You do not want to get the IT until it gets the go ahead, so we are in a trial period and in a trial period there are limitations.

Senator S. Syvret:
On a general point, we are going to be investing very substantially in IT in Health and Social Services in the coming 3 years of £500,000 out of the States.

Deputy of Trinity:
And that includes putting in the Adastra system?

Senator S. Syvret:
It will help. Certainly we are contributing, you know, where this is joint working between Health and Social Services and the Island's GPs. Certainly the IT systems that we want to have in place will enable ready electronic sharing of patient data between GPs and doctors at the hospital who might be treating them.

Deputy D.W. Mezbourian:
Stuart, although you have not had the chance to read this performance report, as Bob has said it does refer in many areas to the lack of IT availability and infrastructure, and so therefore points are not able to be proven as being successful or otherwise. So bearing that in mind, how will you expect to make an assessment when you get the final report?

Senator S. Syvret:
On a variety of grounds. I mean, the paper records themselves, while not as good or as comprehensive as electronic records nevertheless still form an important part of the data. There will be patient satisfaction, patient surveys, feedback from the GPs themselves, our staff in the hospital who have been interfacing with it, one will take into account that whole raft of information before making a final assessment.

Deputy of St. Martin:
If you want to move on to that?

Deputy of Trinity:
Can I just ask one more question about the IT? I mean, we read in the media in the UK, especially with the NHS, that a lot of the IT systems have been way over budget so do you see that as a problem occurring over here?

Senator S. Syvret:
Yes. Certainly that could be a very, very big problem. I have asked Mike and others to make sure that when we start putting in and rolling out IT systems here that are going to take us forward we do not encounter those problems. That we are using proven systems, systems that are known to work, that we are not going to encounter these kind of cost overruns and, in many cases, the failure of the system to deliver what it was supposed to deliver. So I am certainly aware of the issues and I am hoping my offices are taking extra double care to make sure we do not fall into those traps ourselves.

Mr. M. Pollard:
Fools rush in where angels fear to tread; that is our motto.

Deputy of Trinity:
So you say you hope £12 million will be sufficient for what you are aiming to do?

Mr. M. Pollard:
Well, they inform me, the Council of Ministers, is aiming £12.5 to £15 million depending upon the procurement process that we are working on at the moment. Developing specification of service including GP representatives in that process.

Deputy of St. Martin:
A very small amount for GP I should think.

Senator S. Syvret:
One of the points I think that is important to make about the IT investment is that we are being led a lot

by people at the coalface over what it is we should buy, how it should be formatted, what it should do and so on. We have lots of doctors who work with the system, doctors and nurses who will be working with the system at the coalface. So it is not a kind of management top down decision.

Deputy of Trinity:
That is good to hear. Just moving on to the JCRA (Jersey Competition Regulatory Authority) report, which came out a couple of months ago. Wondering what your reaction was to the JCRA report?

Senator S. Syvret:
I was very happy obviously that they finally agreed to everything. Quite whether they had to take 6 months or whatever it was doing it I think is another issue. It has been a real problem, the delays they had and the delays of the issues that they caused. I also think they were being a little too zealous and excessive in their approach. I think really you could see quite readily that GP out-of-hours co-ops are used in a variety of areas up and down the United Kingdom, so it is not as though it was some entirely new issue we were getting into here. It seemed to me really that from a competition point of view the only thing they really had to be worried about was to make sure that the GP co-op could be reigned in if it started to abuse its market power by providing the only out-of-hours GP service in Jersey and then having a captive market and wracking the prices up unreasonably. So it seemed to me the only legitimate interest that the JCRA really had in the issue was that issue. Can we stop market abuse were it to occur? And a lot of the other work they have done, a lot of the delays and a lot of the hassle, it has just been, frankly, a large waste of an awful lot of public money basically.

Deputy D.W. Mezbourian:
What about Dr. Perchard's opinion?

Dr. B. Perchard:
I have found the process of applying for an exemption extremely onerous, probably disproportionate for -- particularly if we look at it from a financial point of view, the turnover of the actual money generated from out-of-hours, and I agree entirely with Stuart, I think it has -- I do think it was appropriate that they looked at it, do not get me wrong, I would never question that at all. I think absolutely and, yes, we had to apply for an exemption and, yes, I think at times it has been a frustrating process. We are very pleased with the outcome obviously. I think all along we have felt that the co-op was never going to be in a position to abuse its position of trust, really, within the community because of our legal agreement with Health, and that if we ever stepped into a position where we would abuse that we would lose our funding at which point the whole thing would become idle anyway so it did seem onerous.

Deputy of Trinity:
Do any of the conditions surprise you?

Dr. B. Perchard:
No.

Deputy of Trinity:
You are very happy with all of the certain conditions they have laid down?

Dr. B. Perchard:
Yes. I mean, they are all fairly reasonable and a lot of it is repeating what we have done already.

Senator S. Syvret:
On a political point of view I found it broadly, largely, inexplicable that they should be devoting so much time and resource to this issue of the GP co-op when, for example, the fuel market in Jersey is rigged and fixed and exploited and has been for decades - the fuel cartels and so on. I mean there are a lot of obviously very important areas that the JCRA could really be getting stuck into in a big way and this kind of issue is, frankly, diversionary and a waste of their time and energy.

Mr. M. Littler:
I think, Chairman, from an officer perspective, we were confident of our case and we were confident of getting a clean bill of health from the JCRA.

Deputy of St. Martin:
They have given you an exemption. Just to pick up on number 5 here. It said that the co-op shall not accept new members except in accordance with JCRA's prior written approval. Soon after this was published you did get a number of people, doctors, practices, et cetera, did apply; do you think it was because as a result of the JCRA or was it just a national process? Would you like to give a comment as to what made them change?

Dr. B. Perchard:
No. I think it is very difficult. I cannot speak for my colleagues as to why their positions changed; we are very pleased their position has changed. It is good for the co-op.

Senator S. Syvret:
The impression I get, and I might be wrong, is that a number of the GPs in the other practices did not have any confidence that it would work, that we would press the button and launch it and make it happen because they had no faith in the States, basically, to work co-operatively and really make the whole exercise happen. The fact that it did work, that we started it and it did work and it was demonstrated to be successful, I think that was probably the significant factor in bringing other practices into it.

Deputy of St. Martin:
What sort of percentage have you arrived at now, because it has certainly gone up? I think you had quite a large tranche come straight after the JCRA report.

Senator S. Syvret:
Nearly all - it may well be all, as far as I am aware.

Mr. M. Littler:
Bar 3. All the GPs.

Senator S. Syvret:
Bar 3.

Dr. B. Perchard:
The police surgeons for obvious reasons do not participate in the out-of-hours service.

Mr. M. Pollard:
Every GP who is registered at the Royal Court is a member.

Deputy of St. Martin:
That obviously excludes?

Mr. M. Littler:
Dr. Mickhael was never in.

Deputy D.W. Mezbourian:
So apart from the 3 police surgeons every other GP is signed up to it?

Dr. B. Perchard:
Yes.

Deputy of St. Martin:
We will move on so you can ask questions about the …

Deputy D.W. Mezbourian:
I would like to refer to a written submission that we have received about the GP co-op, and one GP indicated that the GPs would have little opportunity for sleep were they to work through a night shift and then go straight on to their role as a GP the following day. So would you be able to tell us; in practice, is it the case this will happen?

Dr. B. Perchard:
Well, that position has never changed from before or in the co-op. In the previous out-of-hours system if you had a busy night you would always potentially have to work the next day regardless. So, yes, it can be, as with any night work, that you are busy and up. Our experience is that many of the shifts do enable doctors to get 5 hours of rest, meaning that should they choose to work the next day they would probably be able to do so. Having said that, a large number of GPs have chosen to re-organise and re-structure their working hours such that they do not have to work the next day or if they do it is a half day, to counteract the effect of tiredness. They are doing significantly less nights under this system.

Deputy D.W. Mezbourian:
I think one of the points made in the submission was that obviously because the co-op covers - we are looking at probably now the majority of registered patients in the Island - there would be more chance of being called out while working as a co-operative doctor as opposed to a normal practice over nights.

Dr. B. Perchard:
Certainly, if you were doing the same number of nights that would be quite significant. You know, if I knew that 30 nights a year I was going to be busy -- but it has dropped so significantly that it is quite possible to plan and make arrangements. In practice it is not something that GPs have raised concerns about. They are all pretty content with how it is working.

Deputy D.W. Mezbourian:
What do GPs do, bearing in mind that they may be called out? We have seen that they are called out a number of times during the night. Do you find that they are, in fact, arranging their co-op on-call shifts to coincide with a day off following that?

Dr. B. Perchard:
Generally. Not every practice does the same thing and different doctors sustain different levels of workloads and fatigue, so we do leave it up to individuals. It is not for the co-op management to afford to tell doctors how to structure their working practice, but generally we have found that they are taking either a half day or the day off after a night, therefore reducing the chances of fatigue.

Mr. M. Littler:
Also we are not talking about a lone GP anymore. We are talking about, in parallel, the GP co-op surgery manned by one GP alongside another ready for home visits. So a lot of the extra workload, certainly during the peak time, is covered by the GP co-op surgery. Also, I think there are 2 GPs on this that split the night as well, so it is not from, say, 5 o'clock right the way through to 8.00 a.m. as on previous. We have got 2 GPs covering that and we have got the GP co-op surgery open. So it does take away some of the …

Deputy D.W. Mezbourian:
You appreciate that some of the questions we are asking are in response to comments, as I have said, that we have received from GPs or members of the public?

Dr. S. Perchard:
Can I just say something? From our perspective, from our practice at Health Plus, because we have organised a day off or half day off after on-call the system now is much more robust than it was before because if we are up all night and tired then our patients are protected because we do not have to do a surgery whereas in the old system because it was random, and you still did have busy nights, and you still did have nights when you did not sleep at all, you would still have to do the surgery the next day so that could put patients at risk if you were very tired. Now we have managed to avoid that.

Deputy D.W. Mezbourian:
In your practice?

Dr. S. Perchard:
In our practice. But we cannot legislate for other practices.

Dr. B. Perchard:
But the vast majority of practices have taken a sensible and pragmatic view of it and made provisions within.

Deputy of St. Martin:
How much consultation is there within your groups now, there is the co-op, the overarching --

Dr. B. Perchard:
A huge amount. It has massively improved communication among the profession and we are all talking to each other about what we are doing and the best way to manage it.

Deputy of St. Martin:
It is certainly one of the spin-offs or one of the advantages that has come from the co-op.

Dr. B. Perchard:
It is a huge, huge improvement.

Deputy of Trinity:
How many GPs are now in the …?

Dr. B. Perchard:
80.

Deputy of Trinity:
Do they all take it in turns to do so they all -- do you divide it 365 divided by 80?

Dr. B. Perchard:
What we do, it is a horrible way to do, somehow we managed to produce -- each surgery gets allocated their slots and it is done that way because then it is up to individual surgeries to cover the shifts as per their own internal arrangements with regards a holiday, proportionality, and all the rest of it, so we determine how many shifts a surgery should have covered and then they send us back all that data.

Deputy of Trinity:
That is based on how many doctors in the practice?

Dr. B. Perchard:
Yes.

Deputy of Trinity:
So if a GP did not want to do any nights at all …

Dr. B. Perchard:
He would have to persuade someone else to do it for him. There are one or 2 GPs around who are generally younger with big mortgages who can be persuaded to cover some shifts.

Deputy of Trinity:
So would they sell their …?

Dr. B. Perchard:
They would sell them. And the co-op itself does not get involved in that. That is a private arrangement among individuals.

Deputy of Trinity:
Within each surgery?

Dr. B. Perchard:
Yes.

Deputy of Trinity:

So would the prices differ within the surgeries? You do not know?

Dr. B. Perchard:
Quite probably. We do not police that at all. I mean, it is up to an individual. If you want to persuade someone to work on a Sunday for you then, you know, it is an arrangement between individuals. Certainly, it has meant that for some doctors if at the last minute they have had an arrangement or an invitation or had to do something or been unable to work for any reason through sickness, that it has meant that we now have a much greater pool to draw on to cover those shifts, and it has worked very well.

Mr. M. Littler:
I think the key thing is to ensure that the service is maintained at all times that can meet the need and that patients are charged the appropriate set of hours irrespective of what may be going on in the private arrangements. What the patient sees is a refreshed, delegated GP going out to see them quickly and resolving any difficulties they may have.

Deputy D.W. Mezbourian:
I would like to come back to a submission that we have received from a member of the public expressing concern that over a weekend or bank holiday terminally ill patients whose conditions fluctuate and who may require frequent management change could potentially be seen by as many as 6 different doctors.

Dr. B. Perchard:
Firstly, I would say that we have been in pretty close contact with hospice over the introduction of the GP out-of-hours and we do have plans to sit down and draw up with them a joint protocol for management so that what we provide is consistency. But in the previous system they could have been seen by a minimum of 3 different GPs anyway over the course of a weekend because there are very few practices that have the same person on from Friday night through to Monday morning, or over a bank holiday, the Tuesday morning; very few. You would have had a different person each day anyway and not necessarily from their surgery. So, yes, you can be seen by a number of doctors over the course of a weekend or bank holiday period but particularly if we do bring in joint protocols we will certainly be able to minimise that impact. But it is not a new impact. It did exist before under the previous system and certainly all our feedback from hospice thus far has been broadly positive. I think that they have been pleasantly surprised by it and have certainly not raised with the management board any huge overriding issues or concerns. They have been pretty pleased and are obviously keen to sit down with us and draw up joint protocols which is something that we approached them as to whether they would like to do it, and they have indicated they would, and that is what we will be getting on and doing.

Deputy D.W. Mezbourian:

I would like to refer to what you have just mentioned, which is the joint protocol, and in your report under standard 3, under the performance you say just what you have referred to: "We will be meeting with organisations such as hospice to draw up joint management protocols. This will improve communication and treatment." And the immediate question has to be when, bearing in mind that in the service agreement that was set up between JDOC (Jersey Doctors On Call) and the Minister for Health and Social Services, it does say in there that the 6-monthly performance review will give timetables for improvements, and I do not see any dates for anything in this.

Dr. B. Perchard:

Yes, I think that one of the difficulties has been that we have had -- the management board consists of 5 professionals who have been working very, very hard to ensure that the day-to-day running of the co-op functions and happens. It is a huge task to produce and we have got lists and lists of work that needs to happen away from what the national standards say. And there has been an enormous amount of work that has gone into just make sure that the entire system runs and functions and patients are cared for appropriately. For the vast majority of that we have succeeded. But in addition to that, we have had to deal with a huge amount of workload with things like the Competition Authority that we did not expect and had not put in our timetables, and it has meant that there has been an enormous time pressure, and one can only accomplish so much in the time. It is something that we are addressing but also while it is an extremely important part of what we are doing it is not the biggest part of what we are doing; hospice patients are generally very, very well cared for. It is not a new thing that we are doing. GPs have been looking after their critically ill patients for quite a long time at hospice, so we are confident that these professional people are still able to treat patients professionally but I think in order to go that step further, yes, we would like some joint protocols and certainly we have been talking to them about when would be a good time to meet up to start drawing those up. But they obviously have pressures as well, and it is not always that simple to get everybody round the table.

Deputy D.W. Mezbourian:

Will you be trying to set dates for improvements as identified in this?

Dr. B. Perchard:

Absolutely.

Deputy D.W. Mezbourian:

In your final report?

Dr. B. Perchard:

That is our next task. Our next step is to say we have got this far, this is fantastic. We have got all these GPs on board, we have permission from the Competition Authority, the next step is to start polishing up the service and turning it into a fantastic gold star which is what we all want to do. But to expect to

have achieved that from the outset would be broadly unrealistic really. UK out-of-hours services have been running for about 10 years and they are still not meeting this 100 per cent, so the fact that we have done this well in 6 months we are very pleased with, but it is certainly not the end of the story.

Senator S. Syvret:

It should also be borne in mind that if these issues about protocols and governance working arrangements between different agencies are much, much broader, it is a bigger issue than just the out-of-hours co-op, and that the whole sphere of governance in the way health and social care is delivered in Jersey certainly does need to be taken forward and modernised extensively, and that is going to be part of what we are going to be proposing as something that will be a must do action in the strategic health and social care strategy.

Deputy of St. Martin:

Just on that, it says a red folder procedure or system appears to be working well, et cetera; one of the concerns may well be, it says the red folder is kept in your base: "Doctors are encouraged to put details of any vulnerable patients." So how much supervisional scrutiny is given to ensuring that is done, bearing in mind one would certainly gain this is a manual red folder as opposed to an IT one?

Dr. B. Perchard:

I mean it is in every doctor's interest to ensure that their vulnerable patients are cared for appropriately out of hours and so the GPs are quite highly motivated to enact on that. Essentially we all want to make sure that our patients are looked after well and therefore professionals as part of their, I suppose, daily standard would ensure that they have communicated with colleagues, and it is good handover procedure. So, I mean, while I cannot go out and drag every GP in and make them write down their vulnerable patients they are very motivated to do this. It is happening and it is working.

Deputy of St. Martin:

Whose responsibility is it, at the end of the day, the doctor must put it in, one would hope the doctor says to be encouraged to put it in, but if the doctor does not come back --

Dr. B. Perchard:

Ultimately it is an individual's responsibility and we have set up a system to deal with any complaints or issues that occur and should one happen - and it has not happened - but should one happen we have a process. I mean no system is perfect and we absolutely expect that we are going to come across problems. We do in our day-to-day practice and we would never see the out-of-hours system as being immune from problems. We hope that we have set in place procedures that are robust enough so that should a problem occur we can analyse that and see where we can learn from it to improve it.

Deputy D.W. Mezbourian:

Will you just explain how the red folder system works because it seems to me that each GP has the opportunity to give information about vulnerable patients and this is kept, as we know, in the red folder?

Dr. B. Perchard:
It is kept with our main notes and it is identified as a red folder rather than the others, so it is easily identifiable.

Deputy D.W. Mezbourian:
So from a practical point of view, when a telephone call comes through from a patient does the receptionist then refer to these folders before contacting the GP?

Dr. B. Perchard:
No, the doctor would go and visit --

Deputy D.W. Mezbourian:
The doctor automatically does.

Dr. B. Perchard:
The doctor is there at the base. If there is a problem -- for instance, if I had a patient that I was worried about I would probably phone up the base that evening and explain that I had a patient that I was concerned about and that there was a management plan in the folder which would then mean if a call ever came in for that then the co-op had been pre-warned anyway that we have got a sick person out there that we think may arise as a problem, and if they do then the doctor can go and find the details.

Dr. S. Perchard:
It is only a temporary solution until the IT is in place because that puts it in a much, much more efficient way because when the patient phones up with Adastra, which is the system we are looking at, it flags up immediately that there is a note about this patient regarding their follow-up and their care. These notes are also time limited as well, so when the doctor had initially put the information on there and say: "Well, how long is this note relevant for?" and they might say a month, 3 months, 6 months or forever. So we are looking at just trying to create a system to try and act as a safeguard in the interim before we get the IT. But of course the IT is reliant on the funding and the funding is reliant on getting the okay from all the relevant parties.

Deputy D.W. Mezbourian:
I just want to get this clear in my mind - you have got this means of identifying vulnerable patients; does each GP when a call comes in refer to this list of vulnerable patients?

Dr. B. Perchard:

No, because in some circumstances it is clearly not appropriate. It is all done on clinical need really and if someone is phoning up with their 4 year-old with an ear infection --

Deputy D.W. Mezbourian:
Well, I would not expect them to do that but presumably if they have concerns …

Dr. B. Perchard:
If it is relevant care they can go and refer to the folder.

Deputy D.W. Mezbourian:
To see whether that patient is identified?

Dr. B. Perchard:
Yes. Whether that patient is in there and it has a management plan or anything -- I mean, it is very simple data in there. We just want to know what the problem is and whether there is a specific concern in management.

Deputy of St. Martin:
Could I just ask; have we got a date when we think the IT will really be in - 3 or 4 years?

Senator S. Syvret:
Within 4 years I would certainly hope. I mean, we are talking a period of a couple of years I suspect to get the main components of the Health and Social Services IT systems out. I mean it is a 3 year programme of investment. But it is difficult to put a precise timescale. It will be achieved.

Deputy of St. Martin:
To be fair also it does not mean to say because everything will become IT it is going to become idiot-proof either so … there are very good manual screens have been working for donkey's years so -- but if we are looking to timescale we could be looking 3 or 4 years?

Deputy D.W. Mezbourian:
I am sure I have heard somewhere that you are aiming to do it within 2 years?

Senator S. Syvret:
Yes.

Dr. S. Perchard:
We can get a system up and running for out-of hours a lot quicker than that because it would be independent -- it could be independent of any larger scale system.

Deputy of St. Martin:
I just want to go back on something - I am sorry, it may well have been asked previously but for the public record one question we need to ask - there were other options considered before going down the co-op, could you just tell us what other options were considered or were there any other options considered?

Dr. B. Perchard:
As far as the scope of our investigations, we could have stuck with the previous system, we could have gone to a system where the GPs slowly withdrew from out-of-hours provision, which was a risk, but other than a co-operative there is no other real model out there. I mean Australia and New Zealand, Canada, Ireland, the UK, a lot of Europe have moved towards a co-op type system of having GPs so, broadly speaking, the model was out there slightly different --

Deputy of St. Martin:
There was not a lot of alternative other than going for co-op.

Dr. B. Perchard:
What is happening in Jersey is different to what happens in Guernsey and different to what happens in -- so it has been tinkered for locally but …

Deputy of St. Martin:
But the principle is the same.

Dr. B. Perchard:
It is a broadly accepted international model of delivering.

Deputy of St. Martin:
Could I then move on to a quite important area which (…inaudible) with our time, and look at the funding? At the moment there are arrangements, I think about £86,000 are going. Are you satisfied - maybe I could ask the Minister first - are you satisfied with the way the money is being spent and areas in which there may well be savings or additional expenses along the way.

Senator S. Syvret:
I could not say at this moment whether there will be additional expenditure in this field needed, you know, in the future. But as far as the current spend is concerned I am absolutely satisfied that it represents value for money and a good investment. Not just in terms of the improvement of the out-of-hours service available to the public, and it is an improvement because people can access out-of-hours care much more regularly now at weekends and evenings, and so on, much more easily than was the

case in the past. It is also the case that heath and social care in Jersey does need to modernise in a quite substantial manner, and to be honest there was not really a great deal of communication and co-operative working between the general practice community and Health and Social Services for many years. So this exercise was extremely beneficial in building links between Health and Social Services and GPs and really getting the 2 organisations working together much more than perhaps had been the case in the past.

Deputy of St. Martin:
Some of the questions; one we know from letters in the paper and tittle tattle that goes on, but again for the record purpose we will ask you the questions - the concern that probably £100 for a callout at night was excessive. Would you have an opinion, I am sure -- I see Dr. Perchard having a smile. You have seen the letters in the paper as well? That just maybe some comment on that.

Dr. B. Perchard:
I think that it compares very well to alternative jurisdictions, particularly our nearest neighbours, Guernsey, and I think it is very difficult. I mean, these figures have been cost justified and that cost justification has been accepted by the Competition Authority. They were deemed not to be excessive and ultimately it is difficult. You know, we do have a system where we have payment for a GP.

Senator S. Syvret:
Unlike the UK, for example.

Deputy of St. Martin:
Yes. Again, behind the question may well be the usual thing of, because the States are giving money towards it one would expect, or there is the expectation, maybe the cost to the patient would be reduced because of the input of the money being put in.

Mr. M. Pollard:
It is £86,000 cheaper, is it not?

Deputy of St. Martin:
I know, but I think, again, we are looking at an evidence-based Scrutiny review and we are looking to see where the money has gone to.

Senator S. Syvret:
But in truth, patients do have access to a cheaper service in many respects now. They can attend the surgery in person and there are all these opportunities now to walk in off the street, you know, on Saturdays and Sundays or whenever it may be, and see GPs out of normal working hours at a far lower rate than calling a home visit would be. So, in many respects, the service is, in fact, cheaper to the

public.

Dr. B. Perchard:
Significantly so. The Competition Authority's analysis showed that, conservatively speaking, the cost of out-of-hours care to the population has fallen by, I think, £7,000 in the first 6 months. Now we have brought all of the GPs on, we would expect that overall amount -- and yes, it is an overall amount in that depending on when you access the service it is to a greater or lesser extent more expensive or less expensive. But broadly speaking, Jersey is paying less now for its out of hours than it was paying before.

Deputy of Trinity:
Just picking up that point with the JCRA and how they reached their numbers; they were just looking at the numbers that had been attending GP out of hours rather than the Island-wide numbers?

Dr. B. Perchard:
Absolutely.

Deputy of Trinity:
So sometimes the figures can be a bit distorted slightly?

Dr. B. Perchard:
Well, we can say that within the co-op.

Deputy of Trinity:
Within the co-op, yes, but compare it to on an Island-wide basis because we had quite a few questions to ask how they got that 678 number.

Mr. M. Littler:
Actually, when we went to the JCRA, there were 2 things. There were discussions about the appropriateness or otherwise of the fee set by the GP co-op, and they did certainly compare it with other GP practices that either were not aligned with the GP co-op or were not in the GP co-op at the time, so there was a lot of discussion about setting the appropriate rate from the off. In addition, we said that they should not only look at those rates themselves, but also what is actually happening, in that there has been a significant switch from GP visits to GP -- to patients attending the clinic, approximately 40 per cent. Now, all that was discussed with the JCRA. I have even got the figures of where their graphs and lines were suggested, where the opening rates were, so that was taken into account. It was not just based on GP co-op figures.

Deputy of Trinity:

I am not going down that avenue, but they compared if they had attended in the surgery to the numbers attending GP out of hours, so from that point of view. Just to pick up something that you said -- sorry.

Dr. B. Perchard:
I think it is very difficult because, okay, £100 at 3.00 a.m. in the morning, I am not in any way suggesting that is cheap, but you are getting a professional to come out to your home. And certainly if you compared it, for instance, with getting a plumber out at 3.00 a.m. in the morning or, you know, call-out fees are high and the GP rates come in very favourably compared to other people's call-out fees. And it is difficult and we would always be sensitive to that, but I think certainly the profession feels that the fees have been cost justified and is prepared to --

Deputy of St. Martin:
We are not making a comment; we are asking the questions, you appreciate.

Dr. B. Perchard:
Yes.

Senator S. Syvret:
It should be remembered, of course, that HIE (Health Insurance Exception) clients are exempt the charge in any event.

Deputy of St. Martin:
Do you have any proportion at all of how many are HIE because it could be said that something for nothing is always more open for abuse than if you are going to pay for something. Is there a breakdown?

Senator S. Syvret:
I am sure that data is available, but I do not know. I do not have it off the top of my head. We can get that -- get that information for you, I would have thought.

Deputy of St. Martin:
Yes. Just another thing --

Dr. S. Perchard:
Sorry, can I just -- we must not forget that also it is not obligatory to have that £100 visit at 3.00 a.m. in the morning. You can still get telephone advice first, and obviously the patient does not have to pay for that, and then -- which is an excellent service which is offered to them. And then a decision whether or not a home visit is required can be made secondary to that.

Deputy of St. Martin:
Could I just go a bit more into where the funding is going. We have got £86,000 plus another, I think it is, £38,000 from the doctors' practice, so you are looking at a running cost of £124,000. It would appear that a lot of this or a proportion is going in for administration fees. Where is that money going? Where is that cost?

Dr. B. Perchard:
It pays for a receptionist, yes.

Mr. M. Littler:
I could give you a breakdown. In terms of the Health and Social Services' £86,000 per annum, it can be broken down into the following headings: staff employed by Health and Social Services, £63,000 per annum --

Deputy of Trinity:
That is a receptionist and ...?

Mr. M. Littler:
I can break that £63,000 down into driver support, approximately £18,000, and accounts reconciliation/receptionist, approximately £45,000 per annum.

Deputy of St. Martin:
That is your £63,000?

Mr. M. Littler:
Yes. Facility insurance costs, approximately £6,900 per annum, and that can be -- and also, in addition, you have got general practitioner management fees (this is the GP Co-op Management Board when they do their regular sessions). That is approximately £14,400 per annum.

Deputy of Trinity:
Sorry, can you explain?

Mr. M. Littler:
The GP Co-op Management Board come together on a regular basis to look how the GP co-op is running and they have to do various things like, for instance, audit and overcome any sorts of problems. Basically, that breaks down to 5 GPs at 4 hours per month per person. We also -- car costs of approximately £1,800 per annum. That is lease costs, fuel, maintenance, radio communications. That is the £86,000.

Deputy of St. Martin:
Ordinarily that figure, the car costs, et cetera, would have been met by the GP who would have been doing the normal practice if they were not part of the co-op. Is there any reason why that money should be given by the taxpayer towards the doctors?

Mr. M. Littler:
I think one of the -- the difference is that in order to provide the service and the communications that we needed, we have communications equipment within the car and also hospital equipment within the car. And so it is not only cheaper but it is better for the service to have all that equipment in one car providing the service with the visiting GP.

Mr. M. Pollard:
It is an operational vehicle.

Dr. B. Perchard:
It is used during the day.

Deputy D.W. Mezbourian:
What percentage of visits have actually used the services of the driver? Because I understand from the beginning of this review that it would always be optional for a GP to use that.

Dr. B. Perchard:
It has been one of the most hugely successful parts of the service and has now moved to 100 per cent of the GPs using the driven service. It is invaluable and means that our ability to manage our workload and achieve good target times for getting to patients to avoid undue delay has been enabled. I mean, it is fantastic.

Deputy D.W. Mezbourian:
So all home visits now carried out --

Dr. B. Perchard:
Until 11.00 p.m. at night, and after 11.00 p.m. at night we provide an optional cover for female GPs, which is slightly sexist, we appreciate, but at the moment, in the initial starting of the service that was agreed on safety grounds.

Deputy D.W. Mezbourian:
Are female GPs taking that option up?

Dr. B. Perchard:

Yes, they are using it.

Deputy of St. Martin:
Are they using the specially devised car?

Dr. B. Perchard:
Mm hmm.

Deputy of St. Martin:
Possibly you could enlighten me again. If a GP is on night call, the GP works from the hospital?

Dr. B. Perchard:
Yes.

Deputy of St. Martin:
So they physically go into the Gwyneth Huelin Building and they are there for the night, so all their calls -- they go from there to any call, anywhere in the Island?

Dr. B. Perchard:
If they choose to use the driven service, yes. If they are driving themselves, we do not mind where they are based. If they prefer to be at home and they are driving themselves, then that is fine.

Deputy of St. Martin:
That car would be taken from the Gwyneth Huelin to their home, would it?

Dr. B. Perchard:
No.

Deputy of St. Martin:
They do not use that car?

Dr. S. Perchard:
They would use their own car.

Dr. B. Perchard:
In practice they are not using it overnight because that car then needs to be back at -- for its daytime use by 8.00 a.m. the next morning. And, you know, depending on where their commitments are, it is probably easier for them to use their own vehicle overnight. But they do have the option to do so, and certainly if some of the chaps are sleeping in the hospital and then want to, there is an option. But

generally it is not being taken up simply because the logistics of delivering the car back to ambulance headquarters by 8.00 a.m. in the morning is proving difficult.

Deputy of Trinity:
So the car during the day is used by the ambulance service?

Mr. M. Littler:
Mm hmm.

Deputy of Trinity:
Is it an ambulance service vehicle as such?

Mr. M. Littler:
Yes.

Deputy of Trinity:
I was going to say just an ordinary car, but it is a paramedic car?

Mr. M. Littler:
A lease vehicle.

Dr. B. Perchard:
It is a Ford.

Mr. M. Littler:
Has it got the markings on of an emergency vehicle?

Dr. B. Perchard:
No.

Deputy of Trinity:
So it is just --

Dr. B. Perchard:
We are not quite sure who it is being used by --

Dr. S. Perchard:
Just a black Ford Focus.

Mr. M. Pollard:
It is a pool vehicle.

Dr. B. Perchard:
A paramedic or somebody.

Deputy D.W. Mezbourian:
So do they use the equipment in it as well?

Dr. B. Perchard:
They do not use our equipment in it.

Deputy of Trinity:
So it just sits at the ambulance service during the day?

Dr. B. Perchard:
Yes.

Mr. M. Littler:
This is spare additional equipment that -- you know, other than what is in the ambulances, this is spare equipment that goes within the GP lease car.

Dr. B. Perchard:
But we have things like an automatic defibrillator in it which obviously we cannot put one of those in every GP's car. They cost £4,000. It makes much more sense to put one in one car.

Deputy of St. Martin:
Are there any areas in which you think you can increase the efficiency of the car or are you quite happy with the system you have at the moment?

Dr. B. Perchard:
At the moment.

Deputy of St. Martin:
Good. Are there any other questions we want to ask regarding the funding? We did get it from you anyway but, as I say, we want it on the public record.

Mr. M. Littler:
I think every single item of expenditure and also every major area of activity will be subject to review

and feature in the aforementioned report. I mean, we are duty bound to account for every aspect of public finances within this project.

Deputy of St. Martin:
Again, we are posing the question because it has been asked of us. There is consideration maybe of duplication. Why is it necessary to use Gwyneth Huelin where possibly one could be using someone else's facilities as a base? Maybe that is a question to ask of the Minister.

Senator S. Syvret:
Well, we have that part of the building that was becoming redundant and it was available. And it also just makes more sense clinically for the out-of-hours co-op to be based at the General Hospital in the event of more serious issues arising.

Dr. B. Perchard:
It is a good central point of access and everybody knows where it is. And the hospital is not --

Deputy of St. Martin:
We are asking the questions because it has been posed of us.

Senator S. Syvret:
Yes, we can understand that.

Deputy of St. Martin:
Okay. Also, likewise, the other area again is the administration. Again, doctors have said: "We have paid for our own ambulance staff in our surgeries. We are paying twice." Again, if they are going to be part of the co-op there is no real other answer than saying either they are in the co-op or they are not part of the co-op. There is no way that figure would ever be reduced because obviously ... yes.

Deputy of Trinity:
At one of our hearings a GP commented that he was aware that some patients are being sent from A and E (Accident and Emergency) Department round to the co-op. Is that happening?

Dr. B. Perchard:
No. It happened twice but we are not quite sure who sent them and never really got to the bottom of that. But we think it may have been someone in reception saying: "Well, if you think it is busy you could go round the corner" but it has not happened again and it is certainly not A and E policy or our policy, and we have got an agreement that stipulates that should not happen.

Deputy of Trinity:

So I ask a similar question to you, do you feel that from the A and E Department there has been any impact since the service has ...?

Dr. B. Perchard:
That is what I said to you just now --

Mr. M. Littler:
I can do better than that. You have got a letter from Dr. Brett which I passed on dated 20th July, and I will quote: "Further to your request for formal clarification of the impact of the GP co-op on the Emergency Department, it remains my opinion and that of the other members of the Emergency Department staff that there has been no significant impact attributable to the opening of the GP co-op." That was Dr. Brett.

Deputy of Trinity:
That was a few months ago, though, was it not?

Mr. M. Littler:
Yes, 20th July, yes. And that is still the case.

Senator S. Syvret:
If what you are getting at is; are patients going to Accident and Emergency because they cannot afford or do not want to pay the fee for seeing a GP, then yes, that happens to an extent.

Deputy of St. Martin:
It happened before.

Dr. B. Perchard:
But it happened before, yes.

Senator S. Syvret:
Indeed, yes. This is an ongoing issue and has been for decades.

Deputy of St. Martin:
Okay, I think we have exhausted that. A number of questions we have got simply because people are using Scrutiny as a means of bouncing off questions and it is an ideal opportunity here today for us to ask you them to see if there is any strengths of the rumour that they are putting about or the perception. Could I just ask this, again coming from a GP. They are concerned that you are losing individuality. Again, it is a question that must have been asked before, but one of the downsides, I think, of the co-op is the fact that if, indeed, a patient still would like to see their doctor overnight, does the co-op overrule

that?

Senator S. Syvret:
No, I do not think that could ever necessarily be guaranteed even under the old system. I mean, individual practices would have a rota with a doctor on call and that may well, in fact probably most of the time, would not be your actual GP. And, indeed, some of the practices shared a rota in any event so that there would be even less chance of you seeing your own GP.

Deputy of St. Martin:
Maybe a fairer way of putting it, I will use myself as an example. It does not happen to me, fortunately - I do not see my doctor as often as maybe doctors would like to see me, but say I am not feeling too well and I have a good relationship with my doctor, my doctor has given me that personal attention and I would like a doctor to come out at 2.00 a.m. in the morning for me, does the patient still have that right or does that automatically get crossed now that that option has now closed?

Dr. B. Perchard:
They did not have it before.

Deputy of St. Martin:
Well, again, I am only quoting from what we have had from witnesses who have come to us. They will say: "I have a good relationship with my patient. My patient wants to see me" and the fear is, if the co-op exists, that the patient will no longer have the opportunity of seeing their doctor at night because the only doctor they can get at night is part of the co-op. I am just asking, is that a fact?

Dr. S. Perchard:
Are you saying -- are you asking the question -- are you saying -- let me give you an example. Say from a GP's perspective we may decide, for example, that we have had a very good relationship with a patient who has a terminal illness and we want to provide the care at the end of their life and we may decide that because we know the family of the patient very well we are going to provide that care. And you can still do that within the co-op. You can decide -- you can give your own phone number to the patient and say: "Do not call the co-op, call me if you want that individual care."

Deputy of St. Martin:
I am glad you answered because that was the question we were asked, did it mean that once you become co-op you lose that individuality?

Dr. B. Perchard:
No, absolutely not. If a doctor wishes to provide individual care for their patient, they can continue to do so.

Mr. M. Pollard:
But the onus is with the doctor and not with the patient.

Dr. B. Perchard:
Not the patient, yes.

Deputy of St. Martin:
Yes. Again, we are posing the question because it has been asked of us. Similarly, the question about discretion of fees. Is all discretion lost?

Dr. B. Perchard:
No, no discretion is lost.

Deputy D.W. Mezbourian:
I think you told us that when you came to speak to us earlier, but we wondered whether as things have progressed it had changed?

Dr. B. Perchard:
No, not at all.

Deputy of Trinity:
Have you got any evidence to show that they are using discretion, some GPs are using discretion?

Dr. B. Perchard:
It is very difficult to gather because we would have to go round and ask individual surgeries. So, no. If I had known that you would be interested, I could probably have asked them, but --

Deputy of Trinity:
How about just within your practice?

Dr. B. Perchard:
I would have to ask our practice manager, but yes -- no, in fact, I can think of 2 incidences in which we have waived fees.

Deputy of St. Martin:
We saw in your list of satisfaction, which was very one-sided, nice to see, but are there any sort of --

Dr. B. Perchard:

We did put a negative one in there. We are not afraid. **[Laughter]**

Deputy of St. Martin:
Well, we will have a look at it because we are going to look at the last one, not that we know anything about it. What arrangements are in place, indeed, if a patient does not want to see a particular GP on the co-op? They still have that right?

Dr. B. Perchard:
There are always 2 doctors on call, always. If for any reason they really actively do not want to see one of them, there is always the second doctor. I think the chances and probability of the patient specifically disliking both doctors on call is going to be pretty small. So, you know, we do always have that provision.

Deputy of St. Martin:
There was the one, as we saw, that obviously did not have a lot to say. But they do have a problem with football referees as well and there are certain clubs do not want particular football referees.

Dr. B. Perchard:
You know, no one is perfect.

Deputy of St. Martin:
Okay, the question was posed and we have asked it. Thank you for answering it. Anne, would you like to talk about clinical governance now maybe?

Deputy of Trinity:
Yes. One of the main criteria or the reasons we need to change was to introduce formal governance arrangements. I just want to ask the Minister how far that has gone on.

Senator S. Syvret:
Well, it is obviously much easier to have governance arrangements in place which are being developed and need to be developed on an ongoing basis if you have the out-of-hours service being provided under the umbrella of one organisation as opposed to it being divided up between a variety of different practices where different methodologies, different approaches might be adopted. In more general terms, the governance issue is being driven in Jersey largely by the same issues that are driving it in the United Kingdom. We are having to follow in the wake of a lot of the changes, developments and improvements that are being brought in there. And we will have to meet the same standards. I mean, there is -- I do not think there is any escaping that fact and some people might regard the kind of requirements that the UK are putting in place post Shipman as being perhaps too onerous or too excessive or too bureaucratic, but in reality Jersey, because we are interlinked so closely with the healthcare systems and professionals

within the United Kingdom, we will have no choice other than to meet the same standards.

Deputy of Trinity:
You are talking about the Carson Review and presumably the National Audit Office Review?

Senator S. Syvret:
Yes.

Deputy of Trinity:
So, down to the nitty-gritty, how far have you progressed with that regarding the different points that they have raised and concerns?

Senator S. Syvret:
As far as the governance arrangements within the General Hospital are concerned, they are reasonably good at the moment. Whether they are going to meet the precise detail right now of the requirements being introduced in the United Kingdom I am not sure at this moment, but certainly we are very alive to this issue and we are going to be making sure that we do meet those standards.

Deputy of Trinity:
You say that it is progressing well. Does that apply to the GPs as well or are they a way behind the doctors in the hospital?

Senator S. Syvret:
I would not say the GPs as professionals were behind the doctors in the hospital.

Deputy of Trinity:
No offence meant. **[Laughter]**

Senator S. Syvret:
But I think it is fair to say that the current structure - and the GPs present will disagree with me if I am wrong - but I think it is fair to say that the current structure of the way GPs are working and organised in Jersey, with a variety of different practices, without any really kind of overarching purpose-designed governance structure and systems of accountability, make it harder, I think, to achieve high modern standards of governance within the GP environment in Jersey. Now, I am quite sure GPs are meeting all of the best standards, but we do not have the structure and the oversight needed to be able to give an element of security to the public in terms of those kind of governance arrangements. Doctors within the hospital are working already within a managed environment, you know, with a hierarchy of accountability, oversight from colleagues and organisations, and the organisation generally also has a duty of care to make sure that what is going on within its bounds are meeting with the highest standards,

whereas a lot of that kind of infrastructure is not available to GPs at the moment in Jersey.

Mr. M. Pollard:
One of the important audit -- 2 really very important governance issues from a clinical point of view, one is the questionnaires, and we have seen some of the questionnaires which have been randomly presented, randomly gathered. And the second is actually having a very clear clinical complaints procedure which is integral to the system. And it is rather paradoxical that it is the co-op that has a complaints procedure for clinical complaints, whereas general practice more generally does not. The clinical complaint from a patient sits in a very grey area between a GP, Social Security Department and Health and falls through the net, if you like, between those 3 stools. So paradoxically the standard that operates within the co-op in terms of governance at the minute is higher than in general practice more generally.

Senator S. Syvret:
There is inconsistency of practice and I am sure most, if indeed not all, of the individual GP practices have their own internal complaints procedure, but it is quite possible that the methodology and the approach might differ from practice to practice.

Dr. B. Perchard:
And that is what I would say, is that individual standards within individual practices may be high. I mean, we like to think that our surgery is -- offers a high standard of care, but we have got no benchmark to level -- measure that against and it is not consistent throughout so it is impossible to prove.

Deputy of Trinity:
So if there was a complaint, the complaint would go to ...?

Senator S. Syvret:
Against a GP?

Deputy of Trinity:
Yes.

Dr. B. Perchard:
In a daytime practice?

Deputy of Trinity:
In the daytime practice.

Dr. B. Perchard:
It would go straight to the GP.

Deputy of St. Martin:
But if it is a co-op callout? That is the question I was going to ask.

Senator S. Syvret:
It goes to the Co-op Management Board, I would have thought.

Dr. B. Perchard:
It comes -- and then it goes to us, yes, and then we deal with it jointly with Mark should one happen.

Senator S. Syvret:
And in the daytime situation it would -- the complaint might be made to the GP themselves. They are then, I would have thought, duty bound to share the complaint with their partners in the practice and it will go through whatever procedure they have in place. I mean, ultimately, of course, the public have the right to complain to the GMC (General Medical Council), or whatever, in terms of complaints they may have, if they feel they have not been dealt with adequately at a kind of lower level.

Deputy of Trinity:
So the complaint goes up to the GMC, so you have --

Senator S. Syvret:
Ultimately, in very -- you know, in very extreme cases. I mean, obviously one needs a much, you know, simpler, more grassroots clinical complaints procedure to deal with the generality of issues that may arise.

Mr. M. Pollard:
To be fair, the GPs -- the GP community is sitting down with us and discussing the establishment of a special board called a GP Governance Board. And fundamental to that is a -- 2 documents which are very important. One is a complaints procedure that does meet all of the requirements of patient care, does not allow it to fall between 3 -- complaints ultimately to fall between 3 schools. And, secondly, is to devise a poorly performing doctor procedure; in other words, what do we do, what does the GP and Health and Social Services Department do if a GP's performance dips and needs to be corrected? And those 2 things are missing at the moment and GPs are very keen, with no prompting, of their own volition, are very keen to try and correct that. And we are looking to help them establish that by the middle of next year.

Senator S. Syvret:

And there is no kind of intervention or mechanism that you can use at the moment to kind of require improvements in standards in people's performance or behaviour. I mean, we have the kind of nuclear option of going to court and getting somebody deregistered so they are struck off the register in the Royal Court. I think there might be some more minor powers available to the Employment and Social Security Department in terms of patient subsidy and prescription subsidy, but there is not actually any kind of statutory hierarchy in Jersey at the moment that can actually call GPs in, say, you know: "You are failing for XYZ reasons and this is the programme of improvement we want you to meet" and this kind of thing.

Deputy of Trinity:
That is what I was going to ask. The issue that we brought up at Overdale Review was with nursing homes, the Social Services becoming poacher and gamekeeper all in one, and I just wondered whether the same thing was happening with, kind of, clinical governance for the GPs?

Mr. M. Pollard:
Well, it does not happen with the GP co-op because there is a very clear mechanism for how our department becomes involved. And, writ large, these meetings I am discussing, presenting to you, these conversations that will hopefully find fruition in the middle of next year, they will have an independent process attached to it. I always feel slightly uncomfortable talking about correcting doctors because I have to say that the kind of undertone is there are lots of GPs who are offside in some way and that is most certainly not the case in Jersey. We have got very good GPs here.

Deputy of Trinity:
Yes. We are very lucky and that has been mentioned, but it was the fact of being poacher and gamekeeper, it was on that issue.

Dr. B. Perchard:
On a day-to-day basis we find that most complaints are driven by failure of communication, not the doctor has done something wrong, not the patient has done -- failure of communication. If they are properly dealt with in the practice, usually by a meeting with a group of partners and the patient where everybody is allowed, they are usually immediately resolvable and go away. Where Jersey falls down is it does not have anything between that and the GMC and, you know, the GMC really does not like being referred vast numbers of very -- of complaints that are clearly quite minor. And there needs to be a system put in, in between that.

Deputy of St. Martin:
Are steps in hand to put something in place, as you say?

Senator S. Syvret:

The whole issue of poacher/gamekeeper is, as I think I have said previously, a big issue that the public sector generally in Jersey really has to start to get to grips with. There are so many States areas where they are both service providers and they are the statutory regulators and enforcement agencies in a variety of different areas. And it is going to be difficult to sort that out. We do not want to duplicate another raft of departments whose job it is then to monitor the department that is delivering the service. But on the other hand, at the moment it is true to say that a lot of the inspectors that do inspections within Health and Social Services, they are employed by us, they work for us, yet they are, you know, in some cases having to inspect what we do. And it is not a satisfactory situation and one of the possible solutions I have thought of for this is where people have a policing or an inspection or an enforcing role in terms of activities that are being carried out, perhaps giving to them a kind of statutory right to report directly to the States, to submit reports to the States about their sphere of activities. So if, for example, we were running some really dodgy, rubbishy nursing homes and our inspector, you know, was told: "Do not put that in your report", you know: "We are not having that", you know, by Mike or somebody **[Laughter]**, the inspector would then be able to say: "Well, tough, you know, I am writing it in my report and it is going to the States." I am not aware of anything of that nature ever having occurred in Health and Social Services. Some other departments, but not Health and Social Services, and you can be assured of that. But I do think as a broad principle that it is an issue that we need to think about.

Deputy of Trinity:
Thank you.

Deputy of St. Martin:
Okay, we have covered your points. I think we have just got Deidre to come back --

Deputy of Trinity:
Sorry, just on standard 4, just to pick up, it is: "Audit a random sample of patient contacts ... small percentage ... we achieved good results ... longest time a patient waited for visit was 2 hours for a non-urgent condition." Who assessed that time and when does the time start? When does the clock start, so to speak?

Dr. B. Perchard:
Well, we went in and pulled notes of the clinicians. The management board went in and looked at it, and the time starts from when you take the phone call. Our standard to achieve is that that patient for a non-urgent problem is reviewed within 6 hours for a face to face, so, you know, 2 hours is easily meeting that. But it is from the first contact to seeing the patient.

Deputy of Trinity:
The first contact, right. Thank you.

Deputy D.W. Mezbourian:
I have a couple of questions about the complaints system. On pages 3 and 4 of the report that we have just had, it refers to the complaints system. I think if you turn to page 4, standard 6 under performance, we learn about informal complaints and formal complaints. I would like you to explain what the difference is between the 2.

Dr. B. Perchard:
A formal complaint is somebody who feels aggrieved and writes a letter to the management board or completes the complaints form, thus triggering the formal complaint system. And patients are aware of that; it is in the information leaflet that is available in the surgeries and at the co-op base. Obviously it is not something we necessarily tell to every single patient as a disclaimer as they come through the door: "Here is our complaints procedure", but it is readily available information. But there are informal situations where we hear about someone saying to their GP: "Oh, you know, he was a bit grumpy on Saturday" or: "It was all right but I did not like that aspect." Or, in fact, these 2 informal complaints that we have had have been fed back to me, have been about a patient who did not really understand the fees and wanted to know why she had had that bill and how -- why it was so long from her having seen the GP to receiving the bill. And they are the sort of running feedback that you would receive from a patient in your day-to-day practice that we can, sort of, take on board as part of our criticism but that they do not want to take any further than that. So, essentially, it is up to the patient. They are essentially saying: "I would like to feed this back to you. It is a criticism but, you know, overall okay" or: "Actually, I would like -- this is a formal complaint and I would like it formally addressed and dealt with by a procedure."

Deputy D.W. Mezbourian:
Mike mentioned earlier that, in fact, the co-op has more governance than the GPs outside of it because you do have this formal complaint system. How are patients made aware that there is a formal system of complaint?

Dr. B. Perchard:
We have an information leaflet and it is in that and that is readily available.

Deputy D.W. Mezbourian:
Is that displayed anywhere for them to see?

Dr. B. Perchard:
Well, we have it in all of the -- we found the easiest way is to have it in all of the surgeries and it is available at the co-op base.

Deputy D.W. Mezbourian:

The customer satisfaction questionnaire, we have seen I think 33 attached to the 6-monthly review, one of which was not complimentary. So obviously, you know, as far as we can see it looks very good. The comments that have been given have been first class comments. This one is a minor one, but as it is an anonymous questionnaire can you just explain to us how you go about dealing with comments such as this?

Dr. B. Perchard:
The questionnaire is not designed to be our complaints system. That is why we have a separate complaints system.

Deputy D.W. Mezbourian:
I understand, which is why I asked you about that.

Dr. B. Perchard:
Yes. The questionnaire is another way of flagging up problems with the service that we want as many ways as possible that we can improve so that if patients feel we are really not addressing something we can do that and it gives them, sort of, a prompt to tell us something rather than us sort of, you know, either constantly badgering them or them not feeling able to do so. It is very difficult to act on a questionnaire that says: "The doctor was rude." It might have been that the patient was also -- you know, it is in no way possible to -- but what -- and there is nothing I can do to prevent every single doctor from having a grumpy day or not getting on with a patient or -- but what we are really looking for is criticism about the structure that we are delivering, you know.

Deputy D.W. Mezbourian:
That was my question, really, and I deliberately did not say what the comment was because I was just using that as an example of how do you address these when they are anonymous?

Senator S. Syvret:
Well, I think if it is the -- the general issue coming forward can be addressed if it is anonymous. All the GPs participating in the co-op can be said: "Look, a complaint of bad temper or rudeness has been received. Can all GPs please remember the standards that are expected?"

Deputy D.W. Mezbourian:
That is the answer to my question.

Dr. B. Perchard:
We sent a memo and that is what we did with that. We sent a memo round to all surgeries saying: "Guys, watch your grumpiness."

Senator S. Syvret:
In health and -- in the health and social care sphere, anonymised data is used very often to gather health intelligence, to gather information that can help you remodel and restructure services. It is in many cases standard procedure to make sure this kind of data and feedback is anonymised.

Deputy D.W. Mezbourian:
But that generally, I believe, prompts a very wide response. You know, a formal complaint is the way of identifying a real problem. These give you the opportunity to get a broad comment. You have answered my question. How do you deal with it when you get a broad comment like that, a broad issue? What will you be doing?

Dr. B. Perchard:
We send a memo. We send a memo.

Deputy D.W. Mezbourian:
That is it. That is the answer. Thank you.

Mr. M. Littler:
There is also -- with the GP Co-op Management Board meeting regularly, there is also the opportunity to discuss emerging themes, you know, so that is another area.

Dr. B. Perchard:
For instance, if we got 10 questionnaires saying: "Please be open until midnight" that would -- we could then act on that because we think: "Guys, this is clearly a need."

Deputy D.W. Mezbourian:
The other thing is you can get a negative comment from which you can then create a positive. You can learn from it.

Dr. B. Perchard:
Yes, absolutely.

Deputy D.W. Mezbourian:
I think I have just another question: 33 responses here; is that the total that you have received?

Dr. B. Perchard:
No, we have given out --

Deputy D.W. Mezbourian:

That is just a very ...?

Dr. B. Perchard:
That is what we have had so far. We give out a huge number as well and we just do not get them all back.

Deputy D.W. Mezbourian:
No. The other thing is - I think we probably asked you earlier this year - are they given to patients who receive a home visit or are they just --

Dr. B. Perchard:
Yes. They are in -- there are actually copies of the questionnaires put in the emergency bag that the doctor takes with them.

Deputy D.W. Mezbourian:
Yes. I think I have another couple of questions coming back to the beginning of the co-op set-up itself. The question we have been asked many times, or had drawn to our attention, is the fact that it started on 3rd April, which was the end of the consultation process. The question that has been addressed to us, really, is how can you carry out public consultation, review the comments that you have received in it and have the responses in order to set up the start of this on the same day? Does that make sense?

Senator S. Syvret:
The bulk of the consultation that had taken place was in and collated by them, and the majority of the Island's GPs wanted the co-op to be launched. There did not seem to be any particularly strong or convincing arguments put forward against it. We were happy that we should press the button and launch it, so we did.

Deputy D.W. Mezbourian:
You have mentioned GPs there. What about the public? Did you get any response from them at all during the consultation period?

Mr. M. Littler:
Yes, we did, yes. There were a number of things. Certainly we put out a public notice indicating of what we were doing, a formal notice. Prior to that, the GPs themselves in their practices were saying: "This is what we are doing." We received something like 15, 16 individual letters from members of the public, which we responded to, and all our letters we forwarded to the Social Affairs Scrutiny Panel. So you have got, you know, the formal letters and the responses. Also, at the same time, the GPs themselves were getting feedback from their patients as to say: "Oh, you know, this is either a good idea or not a good idea." We also were working with Social Security to ensure whether this was -- that, you

know, they were happy, was it affecting income streams? We also sent out letters to individual organisations, which we passed on to the Social Affairs Scrutiny Panel. We also sent out a Chief Officer's circular for all States' departments to say: "This is what we are intending to do." And also, this is all -- this was notwithstanding a 9-month run-in beforehand with the GPs themselves and saying: "This is what we are gearing up to." So there was a multitude of different avenues that were, sort of, pursued. Also, the media interest prior to the 3-month period, that came up and I think there were interviews with Bryony and others. There were letters from GPs themselves who had misgivings initially but obviously have come on board. Those were answered. It is a whole host of different approaches.

Senator S. Syvret:
Can I also point out that politically you learn that if you try to wait before introducing a new policy or new initiative until everyone is completely happy with it, then you would never introduce anything. It is absolutely the case. Any change, any new policy, any new development, there is always a particular cohort of stakeholders who are not happy with it. You try to consult, take as many soundings as you can, listen to concerns, modify your plans perhaps, but sooner or later there comes a time when you have got to make the decision and make the change, even though there might still be some people who are not necessarily entirely happy with it.

Mr. M. Pollard:
In this case the proof of the pudding is in the eating. We have fantastic -- we have got 100 per cent buy-in. We have got a good value for money outcome and we have got fantastic consumer feedback.

Dr. B. Perchard:
I think also from a medical point of view we actually had to start the rota. We had to plan for a smooth transition. We had to give a date when we knew we could set this up because you cannot simply have rotas in limbo. It would have been a nightmare and a disaster. You have got a service to cover and you need to plan that start date such that you can make all the necessary arrangements to do so.

Senator S. Syvret:
In truth, if anything, I would like to have -- us being in a position to have been able to start earlier than we did.

Deputy of St. Martin:
Just on that point, and I remember this is a question we asked very early on during the course of the review, one of the concerns one had was that if you did not have a co-op with reduced night work, you may well find difficulty employing sufficient doctors. Given the fact that I think you have about 80 anyway, the turnover cannot be that vast, but have you noticed any difference in the number of people making applications for posts when they have become available?

Dr. B. Perchard:
Well, we have specifically recruited on the condition that the co-op was successful and that the partner that is going to be replacing our retiring partner has absolutely stated that if for any reason the out-of-hours service fails, he will not be coming to Jersey.

Deputy of St. Martin:
But did you find that you got an increased number of applicants simply because you have now got the co-op or would it be unfair to ask, difficult to answer?

Dr. B. Perchard:
I think that that is very difficult to draw conclusions. I can simply take his verbal ...

Senator S. Syvret:
There are a variety of issues which relate to recruitment of GPs into the Island, not least the deal that they now get in the United Kingdom --

Deputy D.W. Mezbourian:
But presumably you see this as a positive for recruitment?

Senator S. Syvret:
Oh, absolutely, yes. Without question, the out-of-hours co-op, this kind of approach to working has been standard practice in the UK for at least a decade now.

Dr. S. Perchard:
I mean, with the new contract GPs in the UK are no longer obliged to provide any out-of-hours care, which is -- obviously because it is such anti-social work is a big plus to them.

Deputy of St. Martin:
Okay. Just to look ahead, we have now got this report which you have just had and there are other reports to come. I think the trial period is coming to an end and then you will sit around the table, make your decision as to whether you intend to continue. Let me ask you the downside question. If indeed you found that you did not want to continue making the subsidy, where would that leave you as far as the co-op?

Senator S. Syvret:
It would be -- it would be extremely difficult, I think. I mean, if I am given information that shows, you know, purely hypothetically, that actually it was not working, it was not meeting patient needs, was not meeting the required standards, there was overcharging and exploiting patients or anything of that

nature, if I had that kind of evidence put before me I would not have any choice other than to pull the plug on it in terms of putting public money into it and using public facilities. But that is just a hypothetical situation.

Deputy of St. Martin:
I am asking the question --

Senator S. Syvret:
All the evidence is actually to the contrary. It actually appears to be working extremely successful. But, I mean, the buck stops with Mike and me as far as what happens with Health and Social Services and with the resources that the States put into it, and if there is something going on that is not working, is not meeting patient needs, is not value for money, then we have got to pull the plug on it.

Deputy of St. Martin:
Just the positive question, would it be fair to say you are quite happy with the way the situation is running at the moment?

Senator S. Syvret:
It would appear to be extremely successful and I am happy with it. I mean, certainly the feedback I have had from the public on it has been -- after the launch and once it has been up and running, has been 100 per cent positive, so I am not aware of any big issues or big problems with it at all.

Deputy of St. Martin:
All right. Deidre, do you have any further questions?

Deputy D.W. Mezbourian:
Just one observation. In the last week, week 27, the Island must have been extremely healthy! **[Laughter]**

Dr. B. Perchard:
I know. It is very variable.

Deputy D.W. Mezbourian:
Yes, only 8 people. Eight people compared to the highest was 138 so something must have happened that week.

Dr. B. Perchard:
It is probably -- I think it is an incomplete week. It must be and, you know -- but we do notice big dips around half-term so, you know, everybody is on holiday.

Deputy of St. Martin:
I think we have finished our side. I always ask the other side is there any questions we have not asked that you felt you would have liked us to ask you, or are there any comments you would like to make?

Senator S. Syvret:
The general comment I would make is that there has clearly been a need for many years for a much greater degree of co-ordination and co-operation between health -- amongst health and social care providers in the Island. And the development and launching of the GP out-of-hours co-op has been a huge stride forward in that sphere. It has been an important first step. Culturally, a lot of GPs were perhaps nervous and reluctant, you know, perhaps for justifiable reasons, from getting too closely involved in working co-operatively with the States. But people like Steven and Bryony in particular, who I would pay tribute to, have done a tremendous amount of work in pulling this initiative together and making it happen, so have the officers in my department, and it would appear to be something that could herald a new era of joint co-operative working amongst all the sectors of healthcare in Jersey.

Dr. B. Perchard:
I think the profession would reiterate that. We are extremely pleased.

Deputy of St. Martin:
Good, okay. With that, can I thank you all for your attendance and declare the meeting closed.