STATES OF JERSEY

Health, Social Service and Housing Scrutiny Panel
Health White Paper Review - Clinical Directors Group

FRIDAY, 13th JULY 2012

Panel:
Deputy K.L. Moore of St. Peter (Chairman)
Deputy J.A. Hilton of St. Helier (Vice Chairman)
Deputy J.G. Reed of St. Ouen

Witnesses:
Consultant, Respiratory Medicine
Consultant Physician
Consultant Histopathologist
Consultant, Paediatrics
Consultant Radiologist
Consultant, Emergency Department
Consultant, Ophthamology

[12:00]

Deputy K.L. Moore of St. Peter (Chairman):

I imagine it must have been quite difficult logistically to clear your diaries at the same time so we very much appreciate that. The public have heard my opening remarks today and I am sure they have not forgotten them. It is merely just to remind everybody to turn your mobile phones to silent; just small housekeeping issues like that. There is also a notice on the table on your side reminding you of the privilege under which you speak today. So, if you want to pass that among yourselves to familiarise yourselves with that please do. Given the numbers as well we will also ask that you do try not to speak over each other and I will try to acknowledge you individually before you speak so that the people taking the recording and transcribing the hearing will know who is speaking at any particular time and it might also assist the public. So, what we will do is start by introducing ourselves formally for the record. So, I am Kristina Moore; I am the Chairman of the panel.

Deputy J.G. Reed of St. Ouen:

Deputy James Reed, Panel Member.

Mr. G. Wistow (Panel Adviser):

Gerald Wistow, Panel Adviser.

Deputy J.A. Hilton of St. Helier:

Deputy Jackie Hilton, Vice Chairman of this panel.

Ms. K. Boydens (Scrutiny Officer):

Kellie Boydens, Scrutiny Officer.

Consultant, Emergency Department:

Nick Payne, A. & E. Consultant.

Consultant Radiologist:

Chris Hare, Radiology Consultant.

Consultant, Paediatrics:

Mark Jones, Paediatric Consultant.

Consultant Histopathologist:

Peter Southall, Consultant Histopathologist.

Consultant Physician:

Mike Richardson, Consultant Physician.

The Deputy of St. Peter:

Excellent. Thank you very much. I would just like to start by making a point that the Minister has made a number of times to us, that doing nothing is not an option and we would like to hear your response and whether you agree with that assertion. Who would like to speak? Mike, perhaps you would like to start.

Consultant Physician:

Well, I would certainly agree with that. I have been here for about 20 years now and the comments I made in the *Evening Post* in 1993 are equally applicable today which was community services needed to be developed in this Island, so from the point of view of community services we are easily a quarter of a century behind the U.K. (United Kingdom). So, something has to happen and the hospital services are ... I

think you can see from the reports we have had, we are seriously under doctored, we have seriously poor estate and we have been seriously under resourced for many years so hopefully we may see some changes in the future.

The Deputy of St. Peter:
Can I take it that you would all agree with Mr. Richardson?

Consultant Radiologist:
Certainly would. What did you write in 1993?

Consultant Physician:
I tried to find it.

The Deputy of St. Peter:
It would be interesting to see that. We have recently been reading a report for the Island-wide strategy for an ageing society; it was written in 2003 and there are many of the themes that we see in the White Paper in this strategy. I do not know if you have a flavour for why this progress has not been seen.

Consultant Physician:
It is financial. We have not had significant resources. I think people feel that because health is such a big chunk of the State's money that it gets plenty of money and there are plenty of things we can do but trying to keep up with changes in health and various other things: regulations, specialisation, demographics, it is impossible to have done it in the budgets that we have had for the past few years and I think everyone would agree we seriously struggle in just trying to provide our modern service.

Consultant, Paediatrics:
Can I add to that?

The Deputy of St. Peter:
Please do, Mark.

Consultant, Paediatrics:
I have been here 6 years and one aspect that was remarkable to me in understanding why the budgets were set as they were set was that there was no real

future planning in terms of budgetary requirements for the hospital. I cannot speak to community services but for the hospital the precedent was the previous year's spending and that has carried on while I have been here, such that we have used the standard of the previous year's spend to allocate monies for the next year and clearly in a growth environment that is completely inadequate and I think that has been the case for many, many years; that there has not been any future thinking about financial requirements for the development of the hospital.

Consultant Histopathologist:
Yes, I have been here 18 years; about the same time as Dr. Richardson and this is the first coherent plan of what is happening now and what we need to do for the future that I have ever seen, I think; it is so comprehensive and the people that have produced are to be congratulated for producing it.

Consultant, Respiratory Medicine:
Sorry we are late.

The Deputy of St. Peter:
Not at all. Please join us. We are just joined now by the medical directors.

Consultant, Ophthalmology:
Richard Downes.

Consultant, Respiratory Medicine:
Andrew Luksza.

Consultant, Ophthalmology:
Clinical Director in Surgery. Sorry, we have just been interviewing for a consultant post.

The Deputy of St. Peter:
Okay. So, do you have that Leo? Richard Downes and Andrew Luksza. Thank you and welcome. Dr. Southall was just saying that this is the first coherent plan for the future.

Consultant Histopathologist:

That is right. I do not think I have ever seen the future of health services in the Island.

The Deputy of St. Ouen:

Just picking up on that, and obviously just sort of focusing perhaps at the moment on the general hospital. Has any discussion or consideration been given to the role of the general hospital in the 21st Century and have you been involved in any of those discussions?

Consultant, Respiratory Medicine:

Yes, I mean, I think in the initial planning there was an acute hospital screen which incorporated particularly oncology and renal services into the future. When the full document was read the hospital was assigned to business as usual with the understanding that it would also be upgraded and developed in parallel with the community services. You cannot have one without the other really.

The Deputy of St. Ouen:

There is a suggestion in the White Paper that if we provide more services within the community it will reduce some of the pressure on the hospital. I just wanted to get a flavour from yourselves whether that is actually the case.

Consultant, Respiratory Medicine:

I think it is true. I think it is a case of whether ... you will not get a smaller hospital; it is just if you invest in community services the size of your next hospital will not be quite as big as it might have been otherwise. I think occupancy in general medicine is almost 100 per cent now anyway whereas the ideal is 85 per cent. So it is arguable that we are under bedded before we start and one could argue that historically we have too few beds to provide the needs for the size of the population we have and clearly there is an anticipation that there will be additional beds or additional capacity when the new hospital is built but given our demography the bubble will not be as big if there is an investment in the community so it is going along in parallel really.

Consultant, Emergency Department:

Yes, I think the pressure on the hospital as it is will not reduce it will just be less pressure on the departments than it would have been and we need that expansion regardless and having it in the community will just make it less bad.

Consultant, Paediatrics:

So, in other words, what is happening here is a reduction of growth but growth will continue in the hospital, so the pressure upon the hospital will not minimise from what we are already experiencing but the growth will be less if community services are better designed.

Consultant, Respiratory Medicine:

I mean, just as examples, none of us want to look after people who are in hospital inappropriately. That does not serve their interests and it is not our daytime business. So, if we have people waiting in nursing home places for weeks that is not ideal for the patient, nor is it ideal for the doctors. Equally in the future if there are better community services; if a person living on their own, perhaps elderly, falls and fractures their wrist, instead of coming into hospital with the attendant risks of contracting M.R.S.A. (Methicillin-Resistant Staphylococcus Aureus) or C. Diff (Clostridium Difficile) they could go to an intermediate care facility, so it is a mixed picture.

Consultant, Ophthalmology:

I think, speaking on behalf of the surgical specialities, there is going to be an increasing requirement for surgery on the Island regardless. The link in with the community is then far more important in relation to reducing, for instance, length of stay for patients after major joint replacement surgery to minimise the utilisation of hospital beds and maximise the efficient utilisation of healthcare resource in total, so moving back to the earlier point we would anticipate that that would result in reducing the size of the otherwise inexorable increase in size of hospital.

Consultant Radiologist:

I think one of the things that you mentioned earlier, and one of the first questions you said was, did we agree with what Anne Pryke had to say and what happens if we do do nothing? If we do nothing the hospital will fall apart because it is already a deteriorating building; you could run a parallel between healthcare and the tube system in London, if you like. It was a fantastic thing when it was built. It was neglected for a long time and then suddenly 10 years ago everybody thought: “Oops, how are we going to get people from A to B?” Healthcare is a very similar issue. You cannot just stop providing the care because everything else will collapse and

you do need the infrastructure and environment to do that, so there is not an option about doing nothing at all.

The Deputy of St. Peter:

Are you confident that the proposed structure of community ... we have touched briefly on the community resources and step up, step down procedures that you would be able to access the patient, say, if they were patients that perhaps you would normally be seeing on a daily ward round, has that been properly thought through how you would access them and how that structure would work?

Consultant, Ophthalmology:

I think at present we have been looking at models in the U.K. and looking at best practice in various areas and of course it is advantageous to us to come in at a slightly later stage when lessons have been learnt but, for instance, we were just interviewing for an orthopaedic consultant appointment this morning. There is a lot of discussion around what happens in some of the district general hospitals whose practice is slightly ahead in the U.K. than ours in relation to this improved interface with the community, so it does not detract from our services, it will enhance them and enable us to do more but we still have more to do. So, because this is all at an early stage obviously things will evolve, practices and procedures will change; they are changing on a year by year by year basis with a general move, again, on the surgical side to limit the length of stay of patients to as small as possible while remaining entirely safe for the patients. We can see quite a lot of potential in interacting more with the community rather than less in relation to facilitating just these changes that you are talking about.

The Deputy of St. Peter:

I think perhaps what I meant is the impact on your workload, whether we will need more doctors to service this.

Consultant, Ophthalmology:

Just on the surgical side there is a move towards far more sub-specialisation. So, to appoint general consultant surgeons they do not really exist anymore so one is likely to need more purely from that point of view. Secondly, it is an ageing population. We are able to do more and more surgically for patients. I am an eye surgeon so cataract surgery is becoming more and more common as patients realise the benefits and the reduction of complications and problems with it. So, I think on the surgical

side there will be an increasing requirement and we will need a commensurate increase in staffing over a period of time to compensate for that. We are always in the department thinking in terms of not just next year or whatever but we have to think in terms of succession planning in very broad terms.

Consultant, Emergency Department:
Step up step down is much less medically intense. If it is elsewhere then you will need medical staff on site where your overall efficiency is much greater, so you are doing more work in the appropriate place.

[12:15]

Deputy J.A. Hilton:
Talking about consultants, I understand I think it is something like 50 per cent of you are retiring in the next 10 years.

Male Speaker:
Such luck.

Deputy J.A. Hilton:
You talk about specialisation and everything else and Jersey being a small community with less than 100,000 people, do you see some time in the future that we may adopt a system whereby we have consultants coming in for one or 2 days a week to do operations, to ...

Consultant, Ophthalmology:
We have that to a small extent at the moment and that perhaps is one of the most useful options for development in the future. It involves a number of factors and creating and improving links with teaching hospitals such as Southampton are one and now with the sort of posts that are being recruited at the moment ... we have a consultant eye surgeon being interviewed for the orthopaedics there, interested in developing links there. Because of this sub-specialisation problem we will need to do something along those lines and we would prefer to bring doctors to see patients rather than take patients to see doctors and that I think is probably going to be an inevitable consequence in part.

Consultant, Emergency Department:

With sub-specialisation there will be plenty that remains here in a more generalist view with sub-specialists and if people demand more because they have read it on the internet then that will have to be shipped in.

Consultant Radiologist:

The other issue with this is that in order for us to get people in from the U.K. we will have to comply with the same standards for running a hospital. So, at the moment you need to have all the governance infrastructure, the I.T. (Information Technology) infrastructure, all the rest of it, to be the same as the people who are sending you their staff because otherwise they are not going to want to send them and their insurance companies will not insure them for working here because it all has to be part of that envelope. It has to be an almost seamless transition between one working environment and the other for the doctors who are visiting to be able to maintain their competence and do things safely. So that just underlines the reason the hospital facility that they come to work in really needs to be as up to date as what they are coming from.

The Deputy of St. Ouen:

I would just like to add to that comment. Apart from the building, and perhaps governance issues that you just highlighted, what are the most significant challenges in developing the hospital services to meet the future needs?

Consultant Radiologist:

Well, to run any hospital system you have to have first of all a safe environment, you then have to be able to put people in it that can do their jobs while maintaining their accreditation with the governing bodies that they ... the governance. So, the General Medical Council who govern us here, that is all part of governance but governance is interlinked with everything, so the other thing is we have to have some form of insurance to allow us to practice and at the moment we will have separate insurance companies: the Medical Protection Society, the Medical Defence Union and so on and so forth, who insure us to work in all aspects of what we do in Jersey. There is a risk in the future that we will require other forms of insurance from other organisations because the way the insurance market is working in the U.K. is changing significantly and there may be some areas which we cannot get insured here any longer. I know we have mentioned it all before but I think Jersey really has to think about moving towards a Crown indemnity programme to allow virtually any of the higher risk specialties to exist at all, particularly Obs and Gynae, and I suspect at

some point in the future A. & E. because they are things that you cannot get rid of; it has to be done here.

The Deputy of St. Peter:

You would prefer a Crown indemnity system as opposed to a large insurance company offering ...

Consultant, Emergency Department:

I think it is less susceptible to vagaries of financial manoeuvres and they are businesses and they want to make money and I think Crown indemnity removes all that.

Consultant Physician:

We may not have the choice.

Consultant, Paediatrics:

The other aspect of what Chris has been speaking about is individual patients, individual doctors, but the other part is that the hospital itself has to be a credible environment. So there will be a growing expectation of outcomes, not just for individual positions, but for the hospital as a whole and so inspections that take place that would be requirements for visiting specialist consultants will have to take place within our hospital environment to see that the hospital is a credible and a creditable hospital. So, outcomes for patients will be matched to those in the U.K. and we will be judged upon those outcomes, so we need the infrastructure in order to be able to demonstrate those outcomes and at the present time, certainly from the I.T., from the informatics point of view, we just do not have the capability.

Consultant, Ophthalmology:

We have spoken about infrastructure and doctors, we also need to talk about nursing staff because there is an ongoing difficulty in recruitment of nursing staff, principally because of the high cost of living on the Island. If there were one way, one thing that would help that, namely to provide some sort of assisted housing with crèche facility I think we would be looking at entirely different numbers of applicants to come to a job which until financial considerations became critical we did not have a problem with recruiting nurses. So, the things we have to always be mindful of are, which are the weakest links within the organisation at any one time? We have to try and predict that and of course it is sometimes a question of predicting the unpredictable but there

are certain factors that we know that are going to be important to maintain all of the other elements because without nursing staff we are not able to do our jobs. Without doctors, they are not able to do a job. Without the infrastructure none of us are able to do the job and the spin off from that is when you have, and continue to have, a strong, happy hospital organisation that can link in with the community in a much more positive way because patients will then see that we are all in it together, we are all working together and no elements have been disadvantaged in order to achieve the outcome which is the best healthcare for the patients on the Island that we can afford.

Consultant, Paediatrics:

I think we do have to think about the rising tide of expectations of patients and their families that more and more ... this is certainly the transformation that we have seen in paediatrics here and in many other environments, is that people no longer are prepared to accept a generalist view and they are increasingly seeking specialist input in consultation and certainly our experience here is that we are not utilising the general practice in an effective and efficient way. I think we very much underutilise general practice here, but part of that is being driven by patients and their families requiring their G.P.s (General Practitioners) to refer to us and that is continuing to lead to the demand on the hospital and their environment to specialist care.

The Deputy of St. Ouen:

One thing that we have not really touched on in all the different challenges in any depth is the issue of recruiting consultants. We keep getting told that we have a problem where 60 per cent of our consultants, and I am not suggesting any of you gentlemen fit the category, will be retiring in 10 years' time. Obviously that causes concern and the first question that you seek to have answered is, why is it the case that we have 60 per cent of our consultants retiring within the next 10 years? Can you just elaborate on some of the issues around ...

Consultant, Ophthalmology:

Historically quite a lot of appointments at consultant level have been doctors, perhaps such as myself, who have been consultants elsewhere. In the N.H.S. (National Health Service) personally I was a consultant for 12 years before I came to Jersey and I think probably half of my colleagues were here, so by very definition we will get to some stage where we are going to have a similar sort of age group that are going to be the bulge at the top. I think there is some confusion in relation to the sort

of difficulty in recruiting consultants. I think the difficulty is in recruiting a consultant like-for-like; in other words replacing one individual with another who does the same when virtually every consultant training programme has altered fundamentally from when I trained certainly to the people that we would be interviewing nowadays. So, obviously if we do not have a structure fit for purpose then consultants are not going to want to come here but if we presume that the environment is conducive to that I do not think we will have a problem attracting consultants; it is just going to be the sub-speciality bit; the fact that doctors will only do perhaps two-thirds in breadth of what we do. That follows on from Mark's point because this is an inevitable element of sub-specialisation; patients say: "Well, are you in front of the eye surgeon?" He says: "Well, actually I do a bit of all of it." They are: "Well, we want to see that" for instance. The advantage of having perhaps more sub-specialist doctors here is that you are going to provide an element of reassurance in relation to that sub-speciality element, but in a lot of cases that can probably be provided by a visiting consultant body as well as the inherent consultant body.

The Deputy of St. Ouen:

I presume the reality is that ultimately we are limited because we only have 100,000 population and any consultant is going to be wanting obviously to exercise his talents perhaps on a far more regular basis than just supporting 100,000 people. So, will that have an impact moving forward on how many consultants will be located on the Island, or how many will be visiting the Island to support the community?

Consultant, Ophthalmology:

It is difficult to project because each discipline is probably different; not only because of the age that you mentioned of the consultants but also some specialities are moving far more towards sub-specialisations. General surgery, for instance, the College of General Surgeons, have said that they have gone too far and they are looking at reining back a little because doctors are saying: "Well, we want a job like the one in Jersey because it is a general job; it is not a specific thing and I am just doing the left hand, big toe, I am going to do far more than that and that is what I want to do." So, I think it is very difficult to answer that question because I do not think our colleges know exactly how we are going to prepare. This question applies to any D.G.H. (District General Hospital) which services a population base of probably 300,000 or less; they are asking exactly the same. It is just geographically we are on a rock in the middle of the water rather than elsewhere.

Consultant Radiologist:

I thought it also adequately explains why most of us have been consultants elsewhere before because we tend to pick people here who are experienced. We very rarely pick somebody who is fresh out of the bag, as it were, because they will not have the experience to deal with the breadth of work that they would be expected to do in a general hospital in a small island. So, it helps if they have lots of experience in doing lots of different things before they come.

The Deputy of St. Ouen:

So, basically you are saying that it is not necessarily the significant issue that some would make us believe?

Consultant, Emergency Department:

We are recruiting at the moment and there are plenty of applicants. People want to come here but I am a generalist, I am an A. & E. doctor.

The Deputy of St. Peter:

So, the recruiting environment is different at the moment for doctors who are quite keen to come here and nurses who are not very keen to come here?

Consultant Radiologist:

I think we benefit significantly from the fact that the N.H.S. is in great turmoil and they are making a huge number of cuts. So, it is a good time to strike while the iron is hot if you want to recruit for the future.

Consultant, Paediatrics: I can only support that. It varies according to specialty and according to those areas which are seen as attractive to young medical students to go into and this varies over the years and some years there will be a development within one specialty which is a greater incentive to remain within that area but this is entirely dependent upon the various differences in terms of what the environment for that specialty is like, whether there is heavy on call, whether there is good financial incentives, these are all variables that are not equal across the board in terms of specialties.

Consultant, Emergency Department:

There is reluctance with nurses because of the financial disincentive. I think they may have been on the same pay.

The Deputy of St. Peter:
And our high cost of living.

Consultant, Ophthalmology:
Perhaps in the future we will need a slightly more flexible approach to our consultant appointments bearing in mind what has been said here. Some years you have an abundance of talent and other years not. If, for instance, you perceive a second appointment coming up a year ahead we are now allowed almost to appoint 2 people to the same one whereas that would be probably so much more cost effective when you take into account losing a good applicant, re-advertising, getting Agency staff in the interim. So, I think there are elements that we can do to very much minimise the concerns in relation to consultant attraction and more importantly perhaps retention.

[12:30]

Deputy J.A. Hilton:
Can I ask you a question about joint services with Guernsey and whether you have been involved in any discussions about increasing the services that maybe you share at the moment. Has that been happening? Do you believe there are services that Jersey and Guernsey could share?

Consultant, Ophthalmology:
In surgery it is very limited. In fact, I think I am the only one who has patients referred from Guernsey on a regular basis for specialist work. It is something that needs to be explored. There seems to have been a certain reluctance to do that probably until recently because it maybe was not necessary or there were conflicting ideas between the various islands. I personally think there could be opportunities for perhaps joint appointments in various sub-specialist areas within surgery.

Deputy J.A. Hilton:
So, whose responsibility would it be within the health hierarchy to push that concept forward? Where would that come from?

Consultant, Respiratory Medicine:
I think we have our examples already. When we were looking at our urology services we spoke to Guernsey and there was talk about a shared appointment. Part of the

problem is that both islands have to have acute cover 24 hours a day so I think the opportunities where we can share appointments and workload becomes necessarily a bit limited but in a specialty where there is lots of elective workload where people have to maintain expertise and given the small numbers of each Island there may be opportunities to share skills. For example, if we had a urologist across both islands who had a particular interest in treating kidney stones; we could use that expertise for the whole population of both islands and vice versa. For specialties such as dermatology, which is largely an elective 9.00 a.m. to 5.00 p.m. specialty, that could be shared but where we have to provide 24-hour services that becomes increasingly difficult.

Consultant Radiologist:

We have explored it. In radiology of course some of our stuff is slightly more portable than everyone else's. Interestingly we used to do all Guernsey's M.R.I. (Magnetic Resonance Imaging) scanning until they bought an M.R.I. scanner about 3 or 4 years ago, so we have a model that works. I think the cardiologist has been doing some of their pacemaker work recently. I think what you have to remember though is of course to fly here and to fly to Southampton is not that different and if Southampton can provide the same service cheaper than we can, which they probably can in terms of size and numbers and all the rest of it then it may be that those types of joint services are not viable financially for them. There are lots of factors at play and not the least of which, for instance, in radiology the guys in Guernsey are really struggling to employ radiographers because it is too expensive for them to live there. So, even though they may have machine capacity, for instance, that I could use if I ran out of space in mine, they may not be able to provide that service unless they have staff to run those machines and our radiographers are very much parallel to the nurses, physios and all the rest of it, they are relatively poorly paid compared to almost all other health professionals and they are also a scarce resource. There are a lot fewer radiographers around than there are nurses. So, recruiting the people to run your basic stuff is difficult in these islands.

The Deputy of St. Peter:

Is that one of the issues relating to radiology not being provided in the islands as well? Because it said earlier that oncology is an increasing business due to higher cancer rates and perhaps ...

Consultant, Ophthalmology:

You mean radiotherapy?

The Deputy of St. Peter:

Radiotherapy. Exactly. I do apologise. Yes, radiotherapy. If we could share facilities between ourselves and Guernsey, for example, and provide services such as that here.

Consultant, Paediatrics:

Well, radiotherapy requires a linear accelerator which is an enormously costly item as a start. Then you require a different specialty group; those who do either clinical oncology, which combines chemotherapy and radiotherapy, or purely radiotherapist consultants. So, you are talking about an extra layer here and really it would not make a great deal of sense to address that without addressing the first principle which is oncology and of itself chemotherapy. I think they are 2 environments: Guernsey and Jersey, have the same issues in terms of numbers. In order to share that requires one individual to come from Guernsey to Jersey or vice versa and of course because the numbers that we are talking about in terms of consultants and/or therapists and so on is low you are sacrificing one to give to the other. The reality of that is that it speaks to very limited services; it is not across the piece and it is certainly not more continuous care. For instance, in paediatrics I can say there would be no point in doing so because there would be no great gain. What you look for is sub-specialist individuals who come from London or from elsewhere to bring in as talent to add extra levels of interest but generalists, who are largely employed in Guernsey and Jersey, like ourselves, the sharing of those skills is really not terribly helpful.

Consultant, Ophthalmology:

I think we have to remember that combining the 2 populations it is still a population base less than that which is probably 95 per cent of the D.G.H. service. If they were not 2 islands then there would be far more potential but I think that the links probably with the mainland are going to be the ones that would be usefully developed rather than necessarily Guernsey other than on an individual case specific basis.

Consultant Physician:

I think from our patients' point of view as well if you are a Jersey resident whether you are in Guernsey or Southampton or anywhere else, you are still not in Jersey

and vice versa. You are as far away from your home, your family, your friends, whether you are in Guernsey or whether you are in Southampton.

Consultant Radiologist:

The logistical issues are always the same. We would love to keep as much as we can on the Island because how many days of fog have we had this year or rain and this, that and the other? There will always be the same issues getting between Jersey and Guernsey as there are getting between Jersey and Southampton and maybe even more.

Consultant, Paediatrics:

It is what patients want. Patients do not want to be spending extended periods of time off Island. I am just thinking particularly about the oncology issue of trying to transfer patients in a more continuous fashion to Southampton for care. The reality is it is a continuous disease process and the patients do not want to spend extended periods of time off Island, quite rightly. So, I think we do have to think about what specialties can we augment with additional specialist input and whether that takes place off Island or here but the expectation is that we have an all-singing, all-dancing hospital that can do most things here. That is the general public's expectation.

Consultant Histopathologist:

In my specialty, pathology, we had correspondence with our colleague in Guernsey, who is a single-handed histopathologist, and they are looking possibly to appoint another histopathologist in Guernsey but we are at very early discussions whether we can have a shared appointment between Jersey and Guernsey because in Jersey our department is getting busier with the number of biopsies and surgical resections that we have to deal with, so we may be at a tipping point where we may enter into an agreement with Guernsey.

Deputy J.A. Hilton:

So it could work in your speciality.

Consultant Histopathologist:

It could be a shared appointment between the 2 islands, yes.

Consultant Radiologist:

We can transfer data and samples and not people. It is a lot more doable than transferring people.

The Deputy of St. Peter:
But you still have the problem of your I.T. system not being quite up to speed.

Consultant, Paediatrics:
Nowhere near up to speed.

The Deputy of St. Peter:
Do you have an end in sight on that issue?

Consultant, Paediatrics:
We have no future, and Andy might want to speak to this, but as far as I understand it we have no future budget for the programmes that were embarked upon to expand I.T. nor do we have a maintenance budget for those that have been put in place.

Consultant, Respiratory Medicine:
No, it is a problem and I think this dates back to the time when the States cut the funding for the original project so we have been having to make do on the basis of not having a fully funded project. So, inevitably it does not run as well as it might do and the teething problems are taking longer to resolve than anyone thought.

Deputy J.A. Hilton:
How much does that rank as a priority, do you think?

Consultant, Respiratory Medicine:
Well, I think alluding back to reassuring the public of the quality of our service it is about having good data and I think therefore I.T. systems are essential in terms of collecting our outcomes. I am confident that we have a safe service and I am confident that we provide a good service but it is being able to demonstrate.

The Deputy of St. Ouen:
Excuse my ignorance, and maybe I should have done some research before, but can you just explain briefly what involvement this group, which is the clinical directors' group, have in determining future health strategy, particularly around services provided within the hospital environment.

Consultant, Respiratory Medicine:

This group is key because this is a group that meets every week and does the operational management but also looks at strategy. So, I think in terms of the hospital business this is a key group, the clinical directors, together with the Managing Director, together with the Operational Manager, are key to deciding future development.

The Deputy of St. Ouen:

May I ask then, and I am not aiming to be critical, but we know and everybody seems to be aware that we have had problems with the hospital over many years and the issues have not been addressed, if this group has been key in helping develop strategy, why do you think that we have not dealt with these matters earlier?

Consultant, Respiratory Medicine:

Because we were not involved; that is the difference. The change in management when Andrew McLaughlin came meant that we have a new structure which involves doctors in management whereby previously they were not.

Consultant, Emergency Department:

It was very clinician light before and now we are much more ... all the clinicians are very much more involved.

The Deputy of St. Ouen:

That is good to hear.

Consultant, Ophthalmology:

We are following N.H.S. practice and probably improving upon it in a lot of respects in relation to the direct input we have collectively with regard to helping the Hospital Director, but also with regard to future developments and strategic ...

The Deputy of St. Ouen:

So how do you balance the demands of this group with your own workload?

Consultant, Ophthalmology:

With difficulty.

Consultant, Emergency Department:
This is my day off.

Consultant, Paediatrics:
Can I just interject? I think there is a point that has been missed here which is that we feed back to the decision-makers. We are maybe in part strategists but we are actually not the decision-makers. We are informers and we can enable people who are making these decisions to make them with the best interests or patients in the hospital in mind but I would challenge this group to say that we are actually those who ultimately make those decisions. I do not believe we are.

Deputy J.A. Hilton:
So, when you meet once a week, which is the clinical directors and the medical directors, you are meeting with your Chief Executive Officer and your Hospital Director?

Consultant, Respiratory Medicine:
Not our Chief Executive Officer. It is hospital-based, so we would have the Managing Director of the hospital and the Operational Manager.

Deputy J.A. Hilton:
All right. Not the Chief Executive Officer?

Consultant, Respiratory Medicine:
No.

Consultant Radiologist:
To be fair to her we have seen a lot more of her recently.

Male Speaker:
Leading up to this meeting.

Consultant Radiologist:
It has been very useful.

Consultant, Respiratory Medicine:
That is not a criticism of her. This is the operational group running the hospital.

Deputy J.A. Hilton:

Of course. So, normal practice would be that generally speaking you would not be talking to the Chief Executive Officer? That is normal practice, is it, in the hospital?

Consultant, Ophthalmology:

It is normal practice to talk to the Hospital Director, in other words the senior management of the hospital. The sort of role in Jersey is slightly different than elsewhere but we talk to the person that is responsible for the managerial decisions in the hospital.

The Deputy of St. Peter:

At what point have you been engaged with the key policy directions that are now in the White Paper? What point did you see, for example, the outline business cases?

Consultant Physician:

Well, we saw the outline business cases on Wednesday evening.

The Deputy of St. Peter:

On Wednesday evening. This Wednesday?

Consultant Physician:

Yes.

Deputy J.A. Hilton:

So, you were not part of pulling the information together, or developing the outline business cases for each of your ...

Consultant Physician:

We were involved with the very high level direction of the White Paper, the Green Paper, the White Paper. That was last year. The list of people that have been involved with the outline business cases is listed within each outline business case but they have not necessarily been involved with the writing of the documents. I think you have to take it that these are outline businesses cases; they are not full business cases. I think we would agree in principle with the directions that they are going in but there is clearly an awful lot more work and discussions to go into the detail and I think particularly Jersey has to recognise that it is a small place and we have to

operate systems as generically and in as leaner fashion as we can, not mimic the N.H.S. which can provide a specific service for different areas; we have to try and be as generic as we can.

Deputy J.A. Hilton:
Were you surprised that you did not see the outline business cases?

Consultant, Paediatrics:
Well, I can speak somewhat differently because I was quite involved with the outline business case for children's health services but that is partly in view of my role, which is partly about children's public health, so I have been involved in this as part of my general work. But I do think that contrasts quite significantly with other services. One of the aspects of this is the outline business cases that I have seen, and certainly the one I am involved in is very specific; it is not about all of the things that are needed to make good health services for children, it is about future direction. But it needs to dovetail very much with what is current; what is here and now, and where those pressures are. That is one of the concerns that has arisen from these outline business cases, is that how exactly do these dovetail current services? Because, without speaking to the hospital service, for instance, or necessarily speaking to primary care and where that is at, at the moment, these are free-floating, they are not necessarily integral to how the future of these particular items might operate. So there is a great deal more work that needs to be done.

Consultant, Emergency Department:
Of course, this document is vastly community orientated, rather than us feeding in directives.

Consultant Radiologist:
But you did hit the nail on the head though when you said, how do you have time to do all this stuff? I think there is an element of fairness in this. I am a radiologist; there is an awful lot of stuff in there that has not very much to do with radiology. I was involved in the oncology outline business case, but that has a lot to do with radiology, but it is not part of the White Paper per se because it is termed business as usual, so a lot of technicalities involved in this in some respects. I think one of the interesting things is that we have now come to a point where the majority of the scut work, if you like, has been done, so to develop the documents. If you had expected us to develop the documents you would probably be waiting a long time. We just do

not have the time to do that. I think what is critical now is that we have come to a point where we have created a structure where we can become involved in analysis and criticism and tidying up of what has happened, and linking it all together. We are in the midst of a process now where we are generating an acute services hospital plan at the same time as all of this and everything informs everything else. It is almost like standing in the middle of a crowd and trying to pick out everybody who is 20 years old, you cannot do that easily, everything has to come together and it takes some time. We have a structure now that we can work with, we know sort of where everything is, we have some detail for what the community wants to do. We have some underlying issues that we know we need to sort out, which is the hospital in terms of structure and the bits we have been over so far. We are a cohesive group that is now in a position to put the whole lot together and to tidy it up and make it work.

The Deputy of St. Peter:

Let us talk about the hospital itself. We have already heard that you have concerns about the fabric of the building, et cetera, and there is still this debate going on about whether it is a new hospital or whether we refurbish what we have at the moment on a rotation basis. I know that the feasibility study has not been carried out, but do you have a view as a group as to which is the right way forward?

Consultant Radiologist:

I think I would love to see a new hospital. One of the things that we are constrained by in terms of efficiency is the building. In my department, for instance, we are regenerating interventional radiology to treat vascular disease. I cannot make efficient use of that service. I could put in a new X-ray room, which will allow us to do this in an existing X-ray room, however, to make the service run efficiently I need a place to decamp the patients to; I need to knock a wall down to build a waiting room, et cetera. I cannot do that where I am now. So we could make large investment in the building that we have in terms of equipment and refurbishing rooms, but we will never make best use of the space we have because of the constraints that we have. We have an old building, which is of historic interest, and it is built out of granite and it is extremely expensive to knock about. So realistically speaking, if you are going to do things properly, you need to have something purpose-built for the way health is now.

Consultant, Opthamology:

I think we would all prefer something purpose built. The difficulty is the timeframe in which that might happen, because we have several reviews of services within the hospital that have already reached a critical situation in relation to infrastructure, or lack of infrastructure. We are really stuck for theatre time and theatre space. So there are some things that really cannot wait for that 5 to 7 to 10-year period, and that is perhaps the biggest factor in favour of staging a development on the site, which will never be as good as the alternative.

Consultant, Emergency Department:
At the present stage, I think we need to see that research and come up with a more accurate ...

Consultant, Respiratory Medicine::
Absolutely, I think we have commissioned a feasibility study so that we are better informed, and I think, as Richard said, this is a balance between trying to get better value for money in a quicker solution or a new build, which is inevitably going to take longer. I think really we will be informed by the feasibility study.

Consultant Physician:
I think a new building, you would be horrified at the size of it, because the hospital we have now is so cramped for space, for office space in order to see patients, theatre space as we have mentioned, to try to do what we do now and build a new hospital, you would be shocked at the size of the hospital we would be expecting to have. The car parks at the side of that as well, we have 2 disabled spaces for the hospital.

Consultant, Paediatrics:
The other thing is, it is the financial climate and a new hospital is an incredibly expensive undertaking, and having seen and worked in other places, I have seen new hospitals being built and sit for 10 years or more because they just could not staff it for lack of funds, and the one particularly I have in mind had to do it department by department, which was incredibly disruptive to the services provided to patients, so they were travelling between an old hospital and a new hospital; a new hospital that was largely just a number of walls and floors and that was it. So it is a decision that is really critical for thinking about future financial planning, not only for the building, but for the staff to inhabit it.

Consultant, Opthamology:

The reason that you have that is because these new hospitals have been funded on a P.F.I. (private finance initiative) basis, and what has happened is there has been a mixture between capital and revenue to cook the books almost, to say the P.F.I. is affordable. I was involved in one when I was in Nottingham and the inordinately complicated measures that the accountants made to prove that the P.F.I. was going to be better confused us all, but there was already money there, it was the last bit of N.H.S. tranche of money that was there to build the unit that we were looking at and sadly we went down the P.F.I. route and as a result, exactly what Mark said, suddenly there is an inordinate shortfall and what goes? It has to be in relation to everything from staff being not reappointed, or sometimes being ... or whatever. So, if capital is separate from revenue, then that should not be a problem. If it is a P.F.I. or something like that one has to learn from the mistakes that have happened in the N.H.S. and try very hard not to repeat those.

Consultant, Respiratory Medicine::
Because money is a problem, there will be a compromise whether it is a new build or a re-provision. That is a fact of life really.

Consultant Histopathologist:
Andrew McLaughlin has put forward a good staged refurbishment plan for the hospital, and he persuaded me with the idea of refurbishing over a period of a number of years, doing stages, costing £30 million to £40 million each, and the work going to local companies.

Consultant Radiologist:
Is it fair to ask you a question, in that we all sit in the silo of the hospital, because we see patients every day and all the rest of it, but you, as politicians, have contact with your voters, your parishioners, whatever, on a daily basis. What do they want? What would they like to see? What are their biggest worries?

The Deputy of St. Ouen:
I think I would turn the question back to you.

Consultant Radiologist:
A true politician's answer.

The Deputy of St. Ouen:

I would basically say, and just point I suppose to documents that people have referred to, the Green Paper and the White Paper, and the question is, has that and will that, will the 2 papers and the consultation that has taken place, informed the public and are they ready for the significant changes that are being proposed. I come back to the issue of funding, and I suppose this is where I would like to know your involvement. You absolutely flag up that the critical issue, which is funding, and the provision of sufficient funding, to provide services. How are you, as we sort of move forward, going to be able to ensure that funding that is brought to the States and to the public to consider is the appropriate amount?

Consultant Physician:

It is never going to be an appropriate amount, is it? We provide a health service and we can always spend as much money as you give us. So there is no such thing as an appropriate amount. You give us whatever you can afford and we can spend it, and we can always justify that.

The Deputy of St. Peter:

But does that not fly in the face of the point where we started in that we have been under-funding hospitals and health resources?

Consultant Physician:

Sure, but what we are talking now is trying to do a quarter of a century catch-up with your local health service. You are trying to catch up on quarter of a century of under-funding and failure to develop services in line with modern practices. What the White Paper is doing is reflecting what the N.H.S. did a quarter of a century ago. So, no matter what we do, we have to just spend what we are given carefully, judiciously, in the best way we possibly can. But there is no way we can take an enormous amount of money and do 25 years of work and produce something that reflects that within 2 or 3 years. I think this is a process that has to be supported, and it has to be supported for a period of years, and it cannot be something that is agreed and then the funding is cut. The way we have lived our professional lives is:"Tighten your belt this year, boys, it is going to be all right next year." Next year they go: "Oh, god, we were wrong, tighten your belt this year, boys, it is going to be all right next year." It has been like that every year to the point where nobody bothers to ask, because you never get. Now, we might be in a position of getting something, but it has to be delivered. I mean we have heard what happened to I.T.; we received half what we thought with I.T. so now we have nothing. You cannot provide us a small proportion

of it, you cannot afford to cut it or change your minds, we have to assume that this is a work in progress for something of the order of 10 years to try to get our services to where they ought to be. This is substantial.

The Deputy of St. Peter:
That becomes a political problem, does it not? This White Paper does provide you 3 stages in each of 3 separate periods of time, but the problem will come in 3 years' time whether there is a political will in the Assembly at that time who will make fresh decisions about funding the next 3-year cycle of reform.

Consultant Radiologist:
That is why we need your help.

The Deputy of St. Peter:
But we may not be here and we cannot promise that we will.

Consultant Radiologist:
I am sure you will be here, Kristina.

Consultant, Paediatrics:
I think, further to the Deputy Reed's question, I do not know that we can be the auditors of healthcare expenditure and ensuring that there is efficient spend. But I do think that principle does need to be part of taking onboard large spend, which is to have auditors of accounts, which is about, not just financial auditors, but auditors and audit of where this money is being spent and whether it is being spent well. So I think, in embarking upon a big financial plan for health, that is an essential part, not only of the strategy in and of itself, but also the monitoring of the spend that goes on. I do not think this group could really account for the spend; we will do what patients ask of us.

[13:00]

Consultant, Respiratory Medicine::
I was just going to say, we have an interest in the fact that the money is used in the most effective way because we are also taxpayers, and so there has to be that sort of compromise and understanding that it is value for money.

Consultant, Opthamology:

Since the clinical director organisation has been up and running, we are privy to far more information than we ever had in relation to budgets. So, on an individual basis, we are able to look at, for instance, the budget for surgery, surgical services, and we can narrow things down and say: "All right, we are doing pretty well here or not so well here; these are areas of over-expenditure, these are areas of under-expenditure." We are getting pretty good at trying to live within our means, provided that we do not have sudden upsets. Because we are a small organisation, the figures we are talking about, it is large, but small in comparison to healthcare figures, we only need, for instance, a patient that will be sent off-Island for a very specialist treatment, which is costing £250,000, one, to make us £250,000 overdrawn so to speak. Those are always going to be difficult ones to answer, but in relation to what control and how we can live within our means, if we know that the capital programme is not going to be funded, then we know there is a big element there that will happen, which we are almost having to rob Peter to pay Paul for from the various budgets to make sure individual bits or areas of the hospital are staying fit for purpose. So it removes that area, and if we know that there is going to be 3 per cent inflation on a year-on-year basis for a 5-year period, it is much easier to work on that basis. We are all realists now; it is "welcome to the real world" in Jersey, 10 years ago you did not have to think about finance, certainly as a hospital doctor, it was just sort of there. That is part of the reason we are in such a state that we are now, because nobody needed to think about it. But I do not think any of us around the table are unaware of the importance of attempting to live within our means, provided we know what the means are and we are able to more or less stick to that.

The Deputy of St. Ouen:

I suppose the point I was making, and I think it was picking up on the point that you made about the I.T., we are, as politicians, going to be required to consider various sums of money that have been put forward by the health service and the Minister regarding how we fund health over the next 3 years or beyond. I suppose it is really my question was more about what confidence can I have when I look at those figures that I can rely upon them and that they are not under-valued or dumbed down to the extent that, you used the example of I.T.

Consultant, Opthamology:

They are the figures that we work on, on a regular basis, and they are as good as we have at the moment. They are not perfect by any means; they are a lot better than

they used to be, and in some areas, for instance Chris' area, his figures are good because he runs his setup sort of semi-independently.

Consultant Radiologist:
I have a fantastic manager who is very good with numbers.

Consultant, Opthamology:
In other areas we are not quite as relaxed.

Consultant, Paediatrics:
I think though that we are talking a little bit at cross-purposes, which is that is Richard is describing the day-to-day running of departments, and we all suffer from the effect of the occasional patient who is a very high-cost unpredictable item. Can I use that word "item" for patient? But what we are talking about here is the future, and the future spend, I would make an analogy to the Olympic spend. We are trying to project for something that we really do not know. How much have previous Olympics cost? Well, we have some idea that they are up and down according to resource. But really here in Jersey, and thinking about this, not only is there the 25-year catch-up that Mike has described, but there is also the unknown element, which is that some of the aspects of moving services from hospital to community are somewhat blue-sky thinking, they are hopes and dreams and wishes and we just do not know, because there are very few examples of secure financial recompense for doing that. In other words, that this is necessarily going to deliver on the financial hopes and aspirations of the States. We hope it will, it seems right, it sounds logical, but we do not know. There are very few precedents to describe substantial savings by doing so. But we are also talking about, the hospital, and the hospital needing to be, not only rebuilt or an entirely new hospital, but also the infrastructure and the way in which we work within the hospital changing. So planning for financial positions in that respect is really quite unknown, and the only way that you can go about it is by doing short-term growth within that area and then auditing it and looking back and saying: "Was that a good use of resource?" You need to do that in growth development terms all the time; that is why the Olympics have sometimes been on-budget and why sometimes they have been grossly over budget, is about when you spend you make sure that you know that you are spending in each increment in the right way.

Consultant Radiologist:

Can I just make one more point; I think what you have to reassure yourself with slightly is that there are a lot of us involved in this and almost the amount of scrutiny that we as clinicians apply to plans that are there should give you some confidence that there are enough questions being asked, there are enough points being raised, that the people who have to put the figures down on paper will have the best information that they can get. So it is a sort of check and balance. We are never going to be able to tell you exactly how much something costs, because I do not know how much the exchange rate is going to change from one minute to the next from the country I buy my gear from. However, I do know that you are going to get the most input from the people who are on the ground to make sure that those who are providing the money and spending the budgets do as well as they can do.

The Deputy of St. Peter:

I am very conscious that we have run a little over time, for which I apologise. Thank you very much for your input today; it has been very interesting to hear from you. If there are any further points that you would like to make and we have not had time to, because it has been very difficult managing so many people in the space of an hour, please feel free, if you have a moment, to jot down your thoughts in an email and we will happily include that in our submissions. We look forward to seeing you all again. Thank you.

[13:07]