# STATES OF JERSEY

# Health, Social Security and Housing Panel Health White Paper Review: "A new health service for Jersey: the way forward" Meeting with the Minister for Health and Social Services

## MONDAY, 18th SEPTEMBER 2012

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

**Witnesses:**
Deputy A.E. Pryke of Trinity (The Minister for Health and Social Services)
Connétable J.M. Refault of St. Peter (Assistant Minister for Health and Social Services)
Mr. R. Jouault (Managing Director, Community and Social Services)
Mr. Director of H.R. (Director of H.R. (Human Resources))
Ms. R. Williams (Director of System Redesign and Delivery)
Mr. A. McLaughlin (Managing Director, General Hospital)
Ms. J. Garbutt (Chief Executive)

**Others present:**
Mr. G. Wilstow (Panel Adviser)
Ms. S. McKee (Scrutiny Officer)

[14:00]

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

As you are aware, we are now podcasting our hearings and so if you can try to make sure that your microphone is angled as close to you as possible so that we can hear you really clearly that would be helpful. We will let everyone get settled down before we start so that we do not have any noises on the tape. This is the final hearing with the Minister regarding the Health White Paper. This is the Health, Social Security and Housing Panel. Welcome, the public. Thank you very much for attending and I refer you to the code of

behaviour and ask you to kindly pay attention to those comments. We will start by introducing ourselves. I am Kristine Moore, Chairman of the panel.

**Deputy J.A. Hilton of St. Helier:**

I am Deputy Jacqui Hilton, Vice Chairman of the panel.

**Deputy J.G. Reed of St. Ouen:**

Deputy James Reed, panel member.

**Managing Director, General Hospital:**

Andrew McLaughlin, I am the Hospital Managing Director.

**Managing Director, Community and Social Services:**

Richard Jouault, Managing Director, Community and Social Services.

**Director of H.R., Health and Social Services:**

Tony Riley, H.R. Director for Health and Social Services.

**Chief Executive, Health and Social Services:**

Julie Garbutt, Chief Executive for Health and Social Services.

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

Deputy Anne Pryke, the Minister for Health and Social Services. Can I say also Deputy Judy Martin, my Assistant Minister, sends her apologies?

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

Constable John Refault, the Assistant Minister.

**Director of System Redesign and Delivery:**

Rachel Williams, Director of System Redesign and Delivery, Health and Social Services.

**Ms. S. McKee:**

Sammy McKee, Scrutiny Officer.

**Mr. G. Wilstow:**

Gerald Wilstow, panel adviser.

**The Deputy of St. Peter:**

Thank you. We will kick off by talking about recruitment because within your White Paper there are plans to recruit a significant number of staff, particularly nurses, and we wonder whether you feel there are any difficulties, Minister, with recruiting and training the full complement of staff that you anticipate.

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

Thank you very much for inviting us, first of all, to the last scrutiny hearing. As you know, we have lodged the proposition and behind that sits an awful lot of work - basically 2 years work of consultation with the Green Paper and the White Paper - and this is a positive step forward for reforming Health and Social Services going forward. It is a very important document. One of the issues you do raise about recruitment is important and we know that we do have to recruit more staff, not just within Health and Social Services but part of working with our third sector is that they will need to recruit staff as well. So we are very much aware that it will be an issue but one that we need to grapple with and deal with.

**The Deputy of St. Peter:**

What efforts are you making to put that in place, Minister?

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

A lot of effort is done, especially with nurses over many different spheres of, very importantly, growing our own nurses; encouraging students, when they leave school or when they wish to come back, to go grow our own; encouraging nurses to come back into the profession, because when they come back into the professional after a few years' gap to have children or whatever they need to do a Back to Nursing course as well as other B-Tech qualifications and with education. I am sure our H.R. Director will give us more detail on those 2.

**Director of H.R.:**

Do you want me to comment on this? I think the first point to emphasise is the work that we have seen thus far are the outline business cases. On their journey to full business cases they will change and they will evolve on a number of levels. Firstly, as the Minister said, quite exactly who will employ and who will deploy the staff in the paper that we have seen thus far may well change and is likely to change as the F.B.C.s come to fruition. Just as importantly perhaps, the journey from O.B.C. (Outline Business Case) to F.B.C. (Full Business Case) is going to be facilitated by recently-appointed, extremely expert and highly qualified and specialist health workforce planner. That work will include comparing, contrasting and challenging our current workforce plans in the O.B.C.s, which are sketches to an extent, into the final, more detailed plans in the F.B.C.s from the perspective of how other jurisdictions are dealing with socio-economic transformational change in health and social care. We would anticipate, for example, that there may well be fewer registered nurses in the final iteration and rather more advanced in-homes practitioners of other kinds which we have seen developed in other jurisdictions over the last few years. Notwithstanding that, it is as challenge. It is always going to be a challenge to quickly and timely and effectively staff large, complex health and social care systems. So we certainly are not complacent. Having said that, there are probably 2 main points on the recruitment challenge for Health and Social Services. One is historically we have had difficulties from time to time, particularly with nursing. Future projections across the modern western world anticipate ongoing challenges and difficulties with nursing recruitment, but as a snapshot right now, this summer, we have had a very good summer. We are not complacent and we are not taken that as a given that it is all going to be rosy in the future, but this year we are recruiting very well. We have worked very closely with S.E.B. (States Employment Board) over the last year or so in developing recruitment and retention initiatives. We continue to work very closely with S.E.B. and with the nursing trade unions and professional bodies to develop a pay and conditions package for Jersey nurses that will make a difference to our ability to recruit. I am not able to go into too much detail because we are in the

throes of negotiations with S.E.B. and with the nursing unions. So to that extent it is a tad *sub judice*, but they are positive. Treasury, Employment Relations at Cyril Le Marquand House, H.S.S.D. (Health and Social Services Department) senior management and the nursing professionals are all working pretty closely together this summer to pull something together.

**The Deputy of St. Peter:**

Thank you for that. Could you tell me, if your summer is being as successful as you say it is, how many vacancies do you now have?

**Director of H.R.:**

At the end of last week we only had 19 vacancies and we had to recruit an additional workforce of about 1,000 nurses. I think we would be considered, in any hospital in any jurisdiction I have ever worked, as very good indeed. But, again, we are not complacent. We have had a really good August and a really good July, but there are more challenges to come.

**Deputy J.A. Hilton:**

Can I just ask you a question around that? You said that currently you are in negotiation with S.E.B. to enhance the package that can offer to new recruits. Are you saying that you have had a good summer recruiting but you have managed to recruit new staff without the new package being in place?

**Director of H.R.:**

The current recruitment is based on the recruitment and retention support that S.E.B. and the Treasury gave us in 2011. We have pulled that through to our 2012 campaigns. Going forward for the future is the issue of pay and conditions for all nurses, not just recruits, but we are working very closely with S.E.B. and the nursing trade unions to put us on a better footing for 2013 and beyond.

**Deputy J.A. Hilton:**

Do you know offhand how many vacancies you were carrying at the start of the year?

**Director of H.R.:**

I believe it was 60.

**The Deputy of St. Ouen:**

In general, where are the new staff coming from?

**Director of H.R.:**

Predominantly the U.K. (United Kingdom), although our Return to Practice Programme is going to generate double figures this year, we think, as well; but predominantly through recruitment in the U.K., from the N.H.S. (National Health Service).

**The Deputy of St. Ouen:**

These would be well-qualified nurses or a complete range?

**Director of H.R.:**

The majority are experienced, qualified registered nurses, with a very small minority of nurses recently qualified from the U.K. nursing schools and colleges.

**Deputy J.A. Hilton:**

Can I just ask you a question around vacancies? You said you thought about 60 at the start of the year. Presumably the health budget is based on a full complement of full-time employees and you must be carrying a lot of spare money, in effect, because you have ...

**Director of H.R.:**

Usually not. The norm in any hospital wherever I have worked is when you have nurse vacancies you cover it by bank and agency. We have our own nurse bank where our own staff and others work additional shifts to cover the additional capacity and nurse agencies will fill in the gap for more specialist posts and quite often they can be more expensive than substantive posts. So the budget is by no means experiencing any largess at the moment.

**Deputy J.A. Hilton:**

So it is not a question of using any spare budget to prop up other services? Your budget for salaries goes on salaries?

**Director of H.R.:**

The nursing budget either goes on substantive nurses in post or on the bank and agency and overtime solutions to cover the vacancies.

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

Support or whatever areas still need to be covered. We cannot say we have not got any nurses. So bank and agency does cost a lot more.

**Deputy J.A. Hilton:**

Before we move off nursing, a lot of the White Paper is around delivering care in the community and presumably that will entail not so much qualified nurses but care assistants. Can I ask how much work is going on between the Health Department and Highlands College in delivering courses, what the dialogue is to encourage local people into the caring profession?

**Director of H.R.:**

We have been talking all spring and summer with Highlands College, with Social Security and with Treasury to pull together plans that are hoped to come to fruition this autumn - if they do not, it will be very early next year - to bring in some new cohorts. That is going to be supported by some vigorous on-Island "raising awareness" promotion. We already did it last week. There was a full-day recruitment fair at the Radisson last week where we had a very large presence and had an awful lot of Islanders come and talk to us about posts, including health care assistants. So those plans are well in train and well developed. Equally, we are talking to potential U.K. academic providers along in partnership with Highlands to develop other programmes for the future. As I mentioned earlier, the workforce plans are likely to evolve and include other advanced healthcare practitioners of different types and different carers than we currently use and there are well-regarded and well-developed

academic programmes in the U.K. that we are looking to engage with for on-Island candidates.

**Deputy J.A. Hilton:**

The final question I have got around this subject is you are talking about the ongoing discussions with the States Employment Board and this will obviously involve additional funding to attract new staff into the Island. Is that allowed for in the business plan, in your figures that you have submitted for the Medium Term Financial Plan, the increase in the package?

**Director of H.R.:**

All of the plans that we are exploring with Treasury and with the States Employment Board have to be contained within the parameters of the current Medium Term Financial Plan. That is a marker in the sand.

**Deputy J.A. Hilton:**

So the answer is yes, or no? It is yes?

**Director of H.R.:**

Yes.

**The Deputy of St. Peter:**

It was mentioned that there has been a recent appointment of a health workforce planner who will work on the full business cases. Could you just tell us whether this appointment has begun work and what stage they are at?

**Director of H.R.:**

She has been with us for a few weeks. She is a very highly regarded lady from the U.K. She is a G.P. (General Practitioner), a hospital doctor by original background, but now she has polished her skills as an expert health workforce planner. So she has been with us a few weeks just coming to grips with the O.B.C.s and, as we launch in the next few weeks into transforming those into F.B.C.s, she will be playing a lead role with all of the senior responsible officers responsible for each business case to revise, update,

adjust and have a really good scrutiny look herself at the present workforce plans.

[14:15]

**The Deputy of St. Peter:**

Thank you. We will move on a little bit. When we visited Guernsey we very much our discussions with the Health Department there who told us that the overlap of private and public sector was a commercial opportunity in their view and we wondered if you shared that view.

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

Regarding the private and public sector? Yes, it is important to us, as you know, that half the population in Jersey have got some type of health insurance. So it is important that we offer it because it not only helps being able to offer it but also helps the income within the hospital and, more importantly I think, it is the type of consultants that we attract and it is a very fine balance. Andrew, the hospital director, has that at his fingertips.

**Managing Director, General Hospital:**

What exactly would you like to know about it?

**The Deputy of St. Peter:**

I guess one issue that has come to light during this review has been the balance of public and private work and whether that can tip sometimes to the detriment of public patients and how that is policed and monitored. It is quite an important issue.

**Managing Director, General Hospital:**

The first thing to say is that the bed base for private practice is separate from the bed base for public patients. We never take public beds for private patients. We sometimes do the reverse and if we are under pressure as a public service we would use our private beds for public patients and we would postpone the private patients, but it does not work the other way round. In

terms of the proportions, we tend to work on a split of 70/30. So if more than 30 per cent of the activity going through theatres for any one consultant is private work then we would be having a conversation, but so far I have not had to have any of those conversations because it has always been below the line. It is very important that we understand on what basis we do private practice here. Under the law as it currently stands and financial instructions we are not allowed to make a profit from our private practice. So where it is a commercial opportunity at the moment in Jersey, because they can charge the market rate for their private practice, we ...

**The Deputy of St. Ouen:**

Do you mean Guernsey?

**Managing Director, General Hospital:**

Sorry, in Guernsey. We can only cost-recover within our service. However, there is a benefit to us in that because we would be apportioning our overheads across a greater amount of activity. So in effect there is a benefit to the public purse in that we are spreading our overheads across more activities, some of which is paid for privately. It is also the case that if a patient was not able to use their private insurance then they would become a public patient. So as a private patient we have full cost recovery of their care. As a public patient we would have to fund their care in its entirety. So not only would it be a pressure on our capacity but it would also mean that we would be spending more money as Health and Social Services treating the population of Jersey. Private practice is a benefit. It is most definitely a commercial opportunity going forward and that is something we are looking to see whether or not there are opportunities in the future to create what are sometimes terms in the jargon new income streams which we could then to cross-subsidise the public service.

**The Deputy of St. Ouen:**

I am just picking up perhaps on private sector involvement. You just spoke about one aspect which is private health insurance, but we also have our G.P.s and other businesses and partners involved in the private sector

delivering services. In fact the major thrust of your White Paper is that you are going to require this group to be involved more in delivering services. We want to get a feel of how that is progressing and what is the scale of possibilities to reduce the delivery of services within the public sector while encouraging development in the private sector. It may be, Minister, you can explain.

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

I am just a bit unclear. Are you talking about the relationship with G.P.s?

**The Deputy of St. Ouen:**

No. We talk about private and public sector involvement in delivering health care. G.P.s are classed as private sector, unless you would put another category on them, in the same way we know we have got a lot of other businesses in the private sector involved in delivering services. I also know that in your White Paper you promote that as an important area of development. It is just to get a feel from you how you see that progressing and to what extent. I mean we have got a flavour of this partnership as identified in the White Paper. I just want to understand how you see it moving forward. Do you see the G.P.s being involved far more in the delivery of service? Take it to the extreme, in Guernsey they take care of accident and emergency, I believe, for the most part.

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

We have emphasised in this 3 years it is more care in the community to be given in the community and obviously working with the G.P.s is important because they provide that primary care. A lot of consultation has gone on with them in the community and some of them have been part of the O.B.C.s, working that up. So it is a partnership. They are in the private sector as such but they also get co-payment because, every time you see a G.P., Social Security pay out, too. One of the parts of the proposition is to look at how we can update all of primary care, including dentists, opticians, pharmacists and G.P.s, because we know that when we went to public consultation people were telling us that the cost of going to a G.P. is high. We know that and we

acknowledge that but everyone needs to be engaged in that and the second part after this 3 years is working that bit up.

**Chief Executive:**

Could I add that? I think what we have said all along in the Green Paper and the White Paper and indeed in the Report and Proposition is that we do not see ourselves as Health and Social Services particularly being always the provider of the services that we have set out as the way forward. We would expect there to be a mixed economy of different providers, including the independent sector, the private sector, the third sector, who all have a part to play. The key criteria of determining which body is ultimately providing services is the quality of the care that can be provided and the value for money they can provide. The decisions will be based on that analysis. Sometimes it may well be that the department itself can offer the best quality and the best value for money. Often it will be other players who will, but that has to be laid out for public security because, at the end of the day, what we are spending is taxpayers' money. So we will always judge it on that basis. I think the issue of the Guernsey model is quite interesting because it is much more of a private model in terms of its delivery and there is far more co-payment of services than there is currently in Jersey, but it has its pros and cons. I think it is quite interesting to look at the idea of an emergency department that is fully staffed by G.P.s. We have taken the choice in Jersey that it is better to have a consultant led and delivered A. and E. (Accident and Emergency) service than it is for other practitioners to provide that service. Andrew, I do not know if you want to say more about why we have arrived at that choice.

**Managing Director, General Hospital:**

It is really leaving people covering off the business that they are specialist in and we are trying not to move away from that. It goes back to Judy's point about maintaining the best possible quality.

**Deputy J.A. Hilton:**

I just wanted to explore the question a little bit more about waiting lists in theatre and the split between public and private. I think you said 70 per cent of the input was public and 30 per cent private and currently I believe that the main theatres operate at over 90 per cent capacity.

**Managing Director, General Hospital:**
Yes.

**Deputy J.A. Hilton:**
Would it be fair to say that currently there is not enough theatre capacity? It would seem to me that public patients are bearing the brunt of the lack of theatre time and maybe it is time for the hospital to look at those percentages and look to change the percentage so that the public patients are taking priority over the private patients.

**Managing Director, General Hospital:**
There are a number of issues there. The first one is, I think, implicit that public waiting times are too long and certainly there are certain specialities where I believe our waiting times are too long. If I take us back to quarter one of 2010, 23 per cent of our patients in Jersey were waiting more than 3 months. That was obviously not within the spirit of what people might expect.

**Deputy J.A. Hilton:**
Can I interrupt you there? Is that 3 months before they get an appointment to see a consultant?

**Managing Director, General Hospital:**
That is 3 months from being referred by a G.P. to being treated. Sorry, I take that back. I am back in my old world again. That is 3 months from being put on the list for surgery to being treated and 23 per cent were waiting longer than 3 months. In the past the proportion waiting more than 3 months has gone up and down. I think it reached an all-time low a few years ago when a lot of money was put into bringing the waiting lists down on the basis that then there would be no limit on how much private practice could be done and I do

not think that is the right way to deal with it either. What I tried to do is work within the existing rules and make it clear to people that there would not be any additional resource in terms of extra payments for bringing public waiting lists down. I expected that to happen as part of people's day job. That is what they are there to do. The waiting list has come down progressively over the last 2 years such that by the beginning of August we were down to 12 per cent of patients waiting more than 3 months. So it had come down from 23 per cent to 12 per cent in just over 2 years with basically no additional money thrown at it. That is around better theatre utilisation. That is around better processing within the hospital altogether to prevent people not being fit for surgery on the day of surgery and on other losses of activity and capacity from the system. There will obviously be bumps around as the figures come down but we are trying to get the figure as close to zero by the end of this year as we possibly can. Within that, the vast bulk of those patients that have long waits are either in trauma orthopaedics or they are in specialist subsets of trauma orthopaedics; so certain things like particular types of specialist hand surgery or shoulder surgery or elbow surgery where we would have to have a visiting consultant come in to perform those operations because we do not have enough activity in Jersey to support the skills of a specialist consultant in those areas. We rely on people coming in. There is an element that we do not have that much capacity for that and that is not really going to change. Even if we had an extra theatre it would not give us the person with the skill set to do it. We are trying to negotiate extra sessions to clear some of those. In terms of the main orthopaedic list, that has come down dramatically in the last few months. We had 2 of our most experienced consultant orthopaedic surgeons retire in the spring of this year and one of them had had an extended period of sickness absence before that which meant we had an orthopaedic waiting list that needed some serious work when we had a new appointment made. That was carried on and we are on track to get that down to zero by the end of the year.

**Deputy J.A. Hilton:**

When you say: "We are on track to get it down to zero by the end of the year," do you mean because there is as waiting time from when the G.P. refers to

the hospital for an appointment, then seeing the consultant and then receiving surgery, if that is what you are waiting for? Could you just explain exactly what you mean by getting it down to zero?

**Managing Director, General Hospital:**
I am seeing a smile from the other end of the table. You could write a degree-level thesis on waiting times, so please stop me if I get boring on it. Within the N.H.S. they introduced a measure of waiting time which was from G.P. referral to first effective treatment and that is sometimes referred to as the 18-week target. That was the first time I was aware of that a waiting time target had been brought in from the patient's perspective. There is a degree that a lot of the waiting time measures we have at the moment are very much around process. So there is a process where you are referred in and you are seen in a first outpatient appointment. You may be referred on for diagnostic investigations or for other follow-up appointments before you are eventually put on the list. However, in a lot of cases that is entirely appropriate because to speed somebody through before they had had a chance to fully consider whether they do want to have that particular surgical intervention done because you are performing against the target is bad in different ways.

**Deputy J.A. Hilton:**
Could I interrupt you there, just for a moment? Could you explain to me, if somebody requires a hip replacement, from the time that the doctor refers them to the hospital for a hip replacement what target are you aiming for at the end of the year that that person will receive surgery from first referral to the hospital?

[14:30]

**Managing Director, General Hospital:**
We do not measure that in that way.

**Deputy J.A. Hilton:**

So we could still be in the situation where public patients are waiting a long time to get in to have surgery? It is not going to be a zero wait, is it?

**Chief Executive:**

No.

**Managing Director, General Hospital:**

No, zero over 3 months was what I was referring to.

**Deputy J.A. Hilton:**

I do not think it is what the general public would understand when you talk about waiting lists.

**Managing Director, General Hospital:**

I do not want anyone to think that I am defending waiting times, even though it sounds as if that is exactly what I am doing. We can deliver waiting times at any level the States of Jersey want the waiting times delivered, but it cannot be done without investment. If you have got 3 months of patients waiting and the waiting list is not going up and it is not going down then you are in a stable situation in terms of balancing capacity and demand. If you then want to clear that 3 month wait you have got 3 months of activity and you will not be able to recruit a permanent appointment to clear that activity because after a number of months you are not going to need that capacity any more. So you would have to bring in temporary capacity, which is very expensive, and you would have to fund the theatre time, the staffing and the prosthetics that would be required to clear that waiting time. The N.H.S. put a huge amount of money into bringing its waiting times down and it did so. We would be delighted to do the same but it would require a very significant investment of money to do it.

**Deputy J.A. Hilton:**

So, as regards smaller waiting lists, at the end of the day it is not going to happen because the money simply is not there?

**Managing Director, General Hospital:**

We are bringing the waiting time down and we are bringing it down within available resources to the best of our ability. That is really the best that we can do.

**Chief Executive:**

For the sake of completeness I think we have to recognise those are maximum waits. The vast majority of people, depending on their clinical presentation, will be treated much more quickly than that. We should not think that this means that everybody waits that length of time. Some patients will, but the vast majority will be seen in far less time.

**The Deputy of St. Peter:**

Intermediate care and the development of that system is a large part of your plan and we are interested to know if you are planning to charge for any of those intermediate care facilities.

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

I think it would be fair enough to say that in the plan there is no mention of charges for that.

**The Deputy of St. Peter:**

But that might happen as the F.B.C.s develop or you have no intention ...

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

Not that we are aware of at this present time but, as we know through our proposition a couple of years ago, if there are any new user-pays charges it would have to come back to the States for debate and approval anyhow.

**The Deputy of St. Peter:**

What about the smaller items, though? If somebody had left hospital and gone home for their step-down treatment post-operative, would they be expected to pay for their own dressings, for example?

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

I know that they go home with a certain amount of dressings. The exact amount, again, Andrew, being Hospital Director because that is very much operational, can tell you what they are discharged with.

**Managing Director, General Hospital:**

I must admit that was not level of detail that I had at my fingertips either, so you will excuse me if I read it out: "When a patient is discharged from hospital they will be given 3 days' supply of dressings if they have a wound that requires dressing. If they need sutures removed they will be given a pack by the hospital and discharged. The F.N.H.C. (Family Nursing and Home Care) will be used to remove the sutures. They will have one free appointment with F.N.H.C. after discharge if it is for the removal of dressing or sutures. If the consultant wishes to review the wound then the patient will attend the hospital dressing clinic until such time as the consultant is happy with the healing process and then the patient will be passed to F.N.H.C. for further dressings if necessary. Any dressings carried out in the hospital in this situation will be free. The patient is issued with a leaflet at pre-admission explaining the procedure and they are advised to join F.N.H.C. if they are going to need ongoing care after discharge."

**The Deputy of St. Ouen:**

Does that mean that the patient will pay but it will not be to your department, it will be to another provider?

**Managing Director, General Hospital:**

F.N.H.C. I would recommend everybody to join F.N.H.C.

**The Deputy of St. Ouen:**

But there will be a charge to the patient?

**Chief Executive:**

In the same way as there already is. It is not a new charge.

**The Deputy of St. Ouen:**

But obviously it is going to be extended because you are choosing to develop that area in the White Paper. So it would follow that the patient is likely to face an additional cost that perhaps would be covered currently in the system of care that we provide?

**Chief Executive:**

I think that level of detail has to be worked up within the F.B.C.s because clearly you can look at a different way of providing that would minimise that happening for patients, but then that is about how you are deploying the resources that are given to us, hopefully, on the back of the Medium Term Financial Plan debate.

**The Deputy of St. Ouen:**

Are you saying in the outline business cases that have been developed so far you have not identified any additional costs that the patient would be likely to face?

**Chief Executive:**

We have made no assumption of that because they do not go to that level of detail. The full business cases will go to that level of detail.

**The Deputy of St. Ouen:**

Sorry to just press you on this because I have not got it clear in my own mind. If you are saying in the White Paper that you are going to transfer more of the services to the G.P.s and other providers then it follows that there is a cost to doing that, a cost that should be at least outlined and identified that you then transfer from your department to the patient. I suppose I am just asking what work has been undertaken to date to support and look at those sorts of implications that are likely to arise from the outline business cases that you have produced.

**Chief Executive:**

We have made no assumption of transferring nay current costs of funding services within the hospital to anywhere else because there is not going to be

a fall-off in patients accessing the hospital. With the demographic growth that we are seeing, as we take patients from the hospital who should not really be there and put them into more appropriate options (whether it is in the home or in intermediate care facilities) those beds will be filled by new patients coming in from the community who need the services of the hospital. So there is no transfer of money from the hospital to anywhere else. The money for the hospital needs to continue funding hospital care. That is why the businesses cases are making bids for new funding, so that we can fund the new services in the community. Now, as part of working up the full details of that, we need to look at where the costs fall. In the main we would attempt to ensure that new costs were not falling on patients unless it was already part of the legitimate policies of the States that those certain things that are user-pays continue to be user-pays. We have said there will be no new user-pays as part of this phase of the investments.

**The Deputy of St. Ouen:**

But Family Nursing and Home Care, when you have that private provider (let us work on the services that we know exist and that you are aiming to improve), you are going to require these private providers to be providing services which currently the patient contributes to. It does not come free.

**Chief Executive:**

Yes.

**The Deputy of St. Ouen:**

So if you are increasing the requirement for the patient to access these services, it follows that the patient will end up paying more.

**Chief Executive:**

Possibly, but then that is the policy.

**The Deputy of St. Ouen:**

But, equally, the other side of the coin is that, for argument's sake, Family Nursing and Home Care, which you mentioned, will require additional funding

themselves to provide and expand the services that they have because it will be shared approach, I presume.

**Chief Executive:**
Yes.

**The Deputy of St. Ouen:**
Has that cost been identified?

**Chief Executive:**
Yes.

**The Deputy of St. Ouen:**
So if that cost has been identified why has no cost been identified which can be directly related to the patient when you know that that cost exists to the patient now?

**Chief Executive:**
Because we have produced an outline business case which gives the global costs. The development of the full business cases will put all of the detail into place.

**The Deputy of St. Ouen:**
When is it likely we will know the additional costs and charges that patients are likely to face if we follow the proposed new roadmap that is being presented to the States?

**Chief Executive:**
We anticipate having full business cases worked up by the end of the year to begin implementation in 2013.

**The Deputy of St. Ouen:**
End of 2012?

**Chief Executive:**

This year, yes.

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

To make that point clear, we know that it will cost more to provide care in the community. So part of what is in the Medium Term Financial Plan are those extra resources to be able to fund a service level agreement or whatever we have with the private sector or third sector.

**The Deputy of St. Ouen:**

Minister, not now, but are you able to for us, within the sums of growth allocated to your department for 2013, 2014 and 2015 can you identify the sums that you plan utilising for support and third sector providers in delivering the services?

**Chief Executive:**

We can identify the funds that we plan to invest in expanding those services.

**The Deputy of St. Ouen:**

Yes, that would be useful to know.

**Chief Executive:**

It is contained within the outline business case paperwork that you have access to.

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

You have got that information there, probably in a different form but it is there.

**The Deputy of St. Ouen:**

If you can just provide in a clearer ...

**Assistant Minister for Health and Social Security:**

If I may, there is a human dimension in this and certain experience elsewhere has shown that where step-down facilities have been used patients recover

far quicker than they do by being kept in an institution. So there is another dynamic in improvement to the patient there and, given that they may well go home and be supported by F.N.H.C., taking them outside the hospital earlier will mean they recover quicker and get back to active life much quicker than they would have done otherwise.

**The Minister for Health and Social Security:**
That is difficult to quantify.

**Assistant Minister for Health and Social Security:**
Absolutely.

**The Deputy of St. Peter:**
Does it concern you, Minister, that already there is general concern about the financial disincentive of accessing the primary care facilities that we have at the moment with regards G.P. costs, for example, and this in effect adds another tier to that; so you are creating another problem before solving the one that is already in existence?

**The Minister for Health and Social Security:**
As we said, we know that we need to provide care in the community. If we did not the hospital would provide because they need to be cared for somewhere and that is the most important thing. As we said and others have told us that, if possible, most people want to be cared for in the community. So we have identified, as we know, the 6 work streams and business cases have been set up for those. Each O.B.C. has got a set sum of money besides which is new money, we hope, to be able to invest in services to provide that care in the community, if it is appropriate in the community.

**The Deputy of St. Peter:**
We have just been told that care in the community is expensive but it is necessary to get people out of the hospital, though, because of the demographics. We will have pretty much a constant number of people in the hospital still because of the rising population.

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

Any care is expensive. Across the board, providing any care, whether you in the community or in the hospital, is going to be expensive and the O.B.C.s identify the main parts that we need to deal with now and have it allocated money alongside that. The next stage will be the full business cases which will go down to the nitty-gritty.

**Assistant Minister for Health and Social Security:**

I think it would be fair to say that no patient will be refused care just because they cannot afford it. They will always get the necessary care they require.

**The Deputy of St. Peter:**

KPMG identified the pattern of charging is a risk to the implementation of new service patterns.

**Chief Executive:**

They did. I hesitate to call into this particular session information from other bodies but I know the panel will be aware that the Consumer Council have been also investigating the issue of charging for G.P. services and carried out their own survey over the summer. They have fed back quite a wide range of information that they have received from that and we take that in the spirit it is intended. Obviously, to an extent, people who fill in questionnaires, whether they are ours from the department or they are the Consumer Council's, have self-selected, but they did have somewhere in the region of 6,000 responses and the messages from that were much more mixed in terms of people's views on what they paid for G.P. services. Quite a strong message coming through that they felt that, although they were quite expensive, they were good value for money and also a message coming through that they felt it was appropriate that there should be some charge for general practice. Now, that is a different view to the one we have heard in our White Paper consultation but it does mean there is a mixed range of views within the public as well and I think we do have to balance it. At the end of the day, if people need carrying for, whether it is in the hospital, in the community, by a G.P., by Family

Nursing and Home Care or whoever, it costs money. That money all comes from taxpayers at the end of the day, whether it is from their pockets as a user-pays or it is through the taxation of pay which then finds its way into the department through the Medium Term Financial Plan process. Finding the balance in terms of what people would like to have some choice over in terms of user-pays against what they expect to have had funded upfront through their taxes is part of the piece of work that we are doing. We will have to keep testing that with the public and with obviously the States Assembly as we go along.

**The Deputy of St. Peter:**

Thank you. We did bring up the issue of demographics in this recent discussion. It was a shame really that the briefing with the Head of Statistics was delayed today because it would have been interesting to see his model, but we are interested to know how you plan to progress your work with regards to the new census figures and what work you have done to date with the information we have had so far in the census.

[14:45]

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

I think it is an important comment to make at this time that, yes, obviously the up-to-date census figures will be important but suffice to say that, with the KPMG modelling, it was based on current usage of the hospital. I think that is an important message that we need to get across because we know that there is an increase in demographics, an increase in the number of people, but we based it on our current use. So we had a realistic figure and I think that is important.

**Assistant Minister for Health and Social Security:**

It is an actual figure rather than a theoretical figure we are working on.

**The Deputy of St. Peter:**

I understand that, thank you, but were some of the assumptions based on the current usage figures or were they based on the demographics given by the previous census? I think, for example, there were comments like we were very medical based or there was a high level of surgical interventions because that was based on the current theatre usage versus the census population of the previous census. Do you see what I mean? How were you basing those assumptions and how true are those statements?

**Chief Executive:**

There are 2 elements to this. There is how you use the numbers to drive forward the planning on what we might need for a new hospital in the future, which Andrew can say more about, and then there is also what numbers have we worked upon to look at developing services in the community. The answers are slightly different for both and Rachel can talk more about the O.B.C.s and the planning going forward. But, Andrew, do you want to just say a few words about how we have modelled the bed usage going forward?

**Managing Director, General Hospital:**

For the modelling for the hospital we need, we started from actual activity and effectively we knew the outcome of the census before it was published because we are seeing it on a day-to-day basis. So we knew there was pressure in certain areas. That was our starting point and the bit that came from the modelling was the projected rate of increase or decrease in certain age groups going forward. Although I have not seen the figures from the census, I would be very surprised if, over the timescale we are talking, that rate of increase or the general ageing of the population and the other splits are going to be significantly different from what we planned on. In general terms, we believe that it is a very robust piece of work that has estimated from current usage going forward what scale of hospital we are going to need and I think that is something that the new census data ... we will feed and rework the figures but we are not anticipating it is going to change.

**Chief Executive:**

The situation with regard to community-based services?

**Director of System Redesign and Delivery:**

I think the question that you are asking (correct me if I am wrong) is around the comparisons that were undertaken and the results that came from that. Is that correct or are you asking about the difference between the 2001 census and the most recent census?

**The Deputy of St. Peter:**

What I am really trying to gauge is how we can read some of the statements that are made within the White Paper and now the Report and Proposition because at some points there are statements such as: "There are a high number of surgical interventions for the population." So what we need to know there is are you basing the current figures in the hospital against the previous census results? Do you see what I mean? That might make a big difference.

**Director of System Redesign and Delivery:**

Yes. So benchmarking of those sorts of figures was one area that KPMG looked at, but it was not the only area. It can give you an indication of the sorts of challenges that might be applicable at any one point in time. You benchmark different jurisdictions or different areas against one another and naturally those are at different time points and with different population levels. Benchmarking is useful because it does not give you the answer. It gives you a pointer to show you where to investigate further. So when KPMG were here and they did exactly that benchmarking they looked at comparator jurisdictions in those different time points. They looked at analysis, this year versus last year versus the year before, to look at trends, but they also tested it out with stakeholders, talked to clinicians, talked to professionals about it. Numbers give you that indication but what brings the life around it is how it feels to people, what it is like to deliver services and the pressures and challenges that come out of that. For example, one of the biggest pressures we found is we do not have 24-hour care. That is not dependent on the number of people we have on the Island. It is a fact and it is one of the biggest pressures.

**The Deputy of St. Peter:**

There are a number of statements that are related to the population and what I am just trying to understand is whether that statistic that was given: “There is a high level of surgical interventions for the population,” is that ...

**Managing Director, Community and Social Services:**

Can I just come in on that? Going back to what the Minister printed out and using current data, that is important because, as the Hospital Director was saying, we were aware a few years ago that the numbers that we were seeing in terms of live births in hospital were returning to rates of 1,000 births a year. Now, we have not seen that for a decade. So in a background of falling fertility rates globally, what does that tell you? It tells you we have got a lot of people of child-bearing age in the Island and, if I were to second-guess what we will see tomorrow, we would expect to see a lot of churn in the working-age population and we would expect to see the ageing population to be relatively static. That is what we would predict. Now, a lot of our work in the community is predicated on that, about the fact that we are fairly certain around the ageing numbers. They were born some time ago and we know where they are and we know who they are. What is interesting about the work tomorrow is about the statistics around people of working age and that has ramifications for us, I do not doubt that, but it is further down the line. We have certainly got time to plan for those changes in projections 10 or 15 years on when those people start requiring services.

**The Deputy of St. Peter:**

I hear what you are saying and that is really helpful, but all I am trying to gauge is how we can trust those statements? If you are working out a percentage based on an old population level and we have more people here now, the figures are wrong. All I need to know is a yes or no.

**Chief Executive:**

Can I just ask for some further clarification? I do not believe we have, anywhere in this documentation, ever said that we have too high a level of

surgical intervention. We have talked about it being over-medicalised. That means we have people being treated in the hospital, largely medical patients not surgical patients, who could be treated much better in the community, in their own home or in a community-based facility. That is what the over-medicalised bit of it was and that is true irrespective of what the numbers say. In terms of surgical interventions, I believe we have the relevant level of surgical interventions. We do not operate on people who do not need to be operated upon, but we know we will need more people having operations in the future, which is why we started to project the number of beds and theatres, et cetera, that we need in the new hospital working on what we see already. What we see already is people coming through our doors from the 100,000 people who live on this Island. Not 90,000 people or 60,000 people, but the 100,000 that we have already got. So I am quite confident that the work that we have underway at the moment with our technical experts will be working with the right numbers to get the right number of beds. Why I made the differentiation earlier about the services in the community was for the point that Richard raised, which is we are fairly confident that what we have said for the first 3 years will be fine because we know those people who are in the elderly population are already with us and we know who they are. Going forward 10, 20 or 30 years will be the effect of the people who are currently middle aged going forward and we have time to plan for that. What I do not think we are likely to find is that the models we are suggesting of care in the community become wrong because our population has increased by more than we thought it had. I think the models are right. Whether we have quite enough of what we want in the community might not be right. We may need to iterate that as we go forward.

**The Deputy of St. Peter:**

I think you may have been misunderstanding what I was trying to say. I thought my question was quite simple. I was not for a second suggesting that too many people were undergoing surgical interventions, but I do not think we are really getting very far on this question. So we will perhaps move on.

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

But I think a point to go back to is that we measured it on current use. We know because they come through the doors and so it is current use.

**The Deputy of St. Peter:**

But all I was trying to suggest was that there were some statements where it appeared that, to work our percentage figures, if you were using the previous census figures, which was all you had when the papers were worked up and that is completely understandable ... but if we are using current figures of people going through the hospital and experiencing interventions and working out those figures balanced against the old census then it would have given you a slightly disjointed perspectives.

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

I think during that time we will know how many people have been born, we will know how many people died and the working age because you are doing it on current usage and also the extra stats that are worked up as you go through, but it is a complicated area.

**Assistant Minister for Health and Social Security:**

I have done this. If you look back at the 1996 census and its predictions in relation to the 2001 census, a credit to our stats unit, they are incredibly accurate around the older population and you can go back and verify that for yourselves.

**Managing Director, General Hospital:**

But with the particular issue you are talking about, at the time those benchmarking activities were performed they were scrutinised by us within the department to see whether we were different from other jurisdictions or not and, if it is any reassurance, the variation of outcomes within the cohort from which the benchmark was taken was far greater than any variance between the average within that cohort and Jersey. If you are saying we had more than the cohort average, that really was just an observation. The reality was that within that cohort that led to that average there was a much greater variation available and it basically comes down to local conditions and the fact

that nobody has perfect data at any one time. So there is always going to be a degree of difference, but we did examine them to see whether or not there was something that said we were different from other places and when we worked through them all we realised that the outcome of the KPMG benchmarking data was a pretty good indication of what we were currently doing.

**The Deputy of St. Peter:**

Thank you. Has the increase in the working age to 67 been taken into account in the demographic figures?

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

I am not too sure about that but I would not think that would make any tremendous difference because they are still there. They are still in the community. They are still needing care, if they do need care. Perhaps they are a bit healthier.

**The Deputy of St. Peter:**

I guess they would be paying taxes and social security.

**Managing Director, Community and Social Services:**

I would expect that allowing people to work longer, as long as they are able to do so, would increase their productivity and their well-being because they would be engaged in a reasonable activity. So how that will affect society as we move through, nobody can predict that but we think it would be a positive effect both in terms of the tax taken but also in terms of their health.

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

Living a healthy lifestyle.

**Mr. G. Wilstow:**

I think the question is whether it is taken into account in calculating the dependency ratio which you used in the White Paper because if it is taken into account that affects the dependency ratio and, as you rightly say, with people

being in employment, (1) it is probably better for their health and well-being, and (2) it impacts on the proportion of the population that is making a direct contribution to the costs of services from their employment as opposed to from their savings. I think that is the question about the dependency ratio.

**The Minister for Health and Social Security:**
Positive, hopefully.

**Mr. G. Wilstow:**
It ought to be.

**The Minister for Health and Social Security:**
It ought to be.

**Chief Executive:**
That will be part of what the statistics unit will be working through on the back of this.

**Mr. G. Wilstow:**
Yes, but I do not think it is clear that that is taken into account in the figures that we have got at the moment. So it should look better.

**Chief Executive:**
Not with the new census data, no. It will improve, yes.

**The Deputy of St. Peter:**
We will move on I think. We wanted to know what discussions there have been with the Minister for Housing and his department about the role of housing services in support of the implementation of the White Paper.

**Assistant Minister for Health and Social Security:**
As the Assistant Minister for Housing, I have not really been very involved with the Housing Department in that. The purpose of Housing at the moment is to look more towards the Strategic Housing Unit but, equally, there is work

that is ongoing all the time particularly between Social Services and Housing with the Assisting Living Unit. That looks at people that have requirements and urgent need for housing for medical conditions and that work is still ongoing. Richard, is that one that you can give some detail on?

**Managing Director, Community and Social Services:**

Certainly we have had meetings with the Minister for Housing and also the Chief Executive of the Development Committee to look at the developments that are being proposed and how we might re-provide for individuals within those community settings and de-stigmatise them in the process by not having them in a Health and Social Services estate, by being rental users in their own right.

**Director of System Redesign and Delivery:**

I was just going to add that representatives from other States departments, particularly Housing, were involved in our working groups and workshops as we developed the outline business cases and will continue to be involved in that as we develop the full business cases this year.

**The Deputy of St. Ouen:**

Has any funding been allocated to home improvements, if you like, with regard to the private individual that is going to be required to be looked after in their home rather than perhaps end up in a hostel setting?

[15:00]

**Assistant Minister for Health and Social Security:**

I can answer that one. Certainly where there is a requirement for some alterations to be made in homes when individuals have become incapacitated in some way that is done on a means-tested basis through Social Security and I have been dealing with one at a parochial level where, if the person does not have the monies, that is provided for through Social Security and the Housing Assistance Unit, but it is both Social Services and Housing working together. Housing will, as a matter of course, where necessary, do some

minor changes to accommodate individuals and that is business as usual, which is a slightly similar question because that work is going on now and there are no changes to that work and the relationship we have between Social Services, Housing and some additional financial support through Social Security.

**The Deputy of St. Ouen:**

I understand what you are saying but presumably for the individual that is not eligible for income support, the normal local resident, they will have to face that additional cost themselves.

**Assistant Minister for Health and Social Security:**

Yes, there is a cut-off. There is a means testing, if you wish. It is quite high. I cannot quite remember the actual figure but it is quite a high figure where, if they have income of more than that figure, they will fund it themselves. If it is less then they are supported or in fact wholly funded by the States, in fact.

**The Deputy of St. Ouen:**

I just want to explore this a little bit further. We are talking about helping people stay in their homes longer. Are we talking about chair lifts, specialist wet rooms, hoists that may or may not be required and encourage the private individual to purchase because of the system that we are proposing?

**Managing Director, Community and Social Services:**

The current system as it stands is there are monies across a number of departments for home adaptations. Certainly within my department there is money within the budget. There is money within Social Security, as the Assistant Minister mentioned. I suppose what we have to be mindful of is that going forward the long-term care benefit in 2014 will probably see a change to that. The idea is to incentivise people to remain in their own home and to provide packages of care to support somebody in their own home. That will require some centralising of budgets, I would imagine. As it currently stands our budgets are set across various departments. I think the Housing Department themselves also have money set aside for, as you say, stair lifts.

**The Deputy of St. Ouen:**

So what new money within the current proposals will meet that additional cost that it is likely the local resident could face in providing for themselves at home rather than accessing the current services?

**Managing Director, Community and Social Services:**

There is new money in the budget surrounding community care.

**The Deputy of St. Ouen:**

There is money? Can you confirm that that is the case, please?

**Managing Director, Community and Social Services:**

Yes.

**The Deputy of St. Ouen:**

That private individuals, regardless of their income will be ...

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

Not regardless of income, no. It will be means tested but there is money for those that cannot afford it. Yes.

**The Deputy of St. Ouen:**

Right, okay. So the average local person who is not on income support and currently enjoying the range of services that is provided through taxation within the hospital environment is likely to be faced with an additional cost because the services will encourage them to be taken care of at home with specialist equipment, if necessary?

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

Not as a statement of fact. I cannot agree with that, James. The reason being, as I have said, if they cannot afford it they will be funded, as Richard says, with across departmental funding to enable them to live assisted in their own homes. The ones that will possibly have to pay something in the future

are those who currently pay anyway and those are the ones who are above a certain income level. So those are the only ones who would see additional funding.

**Managing Director, Community and Social Services:**
There are thresholds that will be for States debate when it comes to orders around long-term care benefit.

**Assistant Minister for Health and Social Services:**
Absolutely.

**Managing Director, Community and Social Services:**
I know there will be some interesting debates about whether capital is taken into account. It will be for the States to debate.

**The Minister for Health and Social Services:**
Also, what you have to put into this is an approving of the housing stock with the lifelong homes and you must not forget that - I bang my drum on that - and how now over 55s the States set down building regulations or whatever, everyone must either have a wet room, access to a lift, have 2 bedrooms so you have carers. Those are online now and are being used. So, in some ways, some of that as we go into the future will not be so much of a problem.

**Assistant Minister for Health and Social Services:**
If I can just support what the Minister just said. Certainly the current Minister for Housing is emphatic that he wants all future States rental tenancy houses to be made ready for people that might need ongoing additional services later on. For example, he is wholly against now the development of one-bedroom units because, potentially, although there will be a number of them for those younger people, but as we move on the potential is, as the Minister just said, that there would be a carer; so to keep them in their own homes or keep them in that environment. Also, we are looking at making sure that wet room compatibilities are put in into new and refurbished properties, widened doorways, lowered switches, raised plugs, all these type of things, for

wheelchair users and the potential to be able to put in chair lifts if required into the wet room. That is part of the Minister for Housing's objective for not only new properties but even for the refurbishment of all properties.

**The Deputy of St. Ouen:**

I hear what you are saying,and that is fine for those who are accommodated within States housing, but we are talking about the overall population and meeting the needs of the overall population, many of whom live within the private sector, either rental or own their own home. I am trying to understand what the implications will be for those individuals and it sounds as though, from what you have just explained, that they just need to be aware that it is going to be an additional cost.

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

For some, but not for all.

**The Deputy of St. Peter:**

Or they will be expected to sell up and move into more suitable accommodation, which is a decision that many people make.

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

Yes, if you are in a 6-bedroom house or 5-bedroom house now and you want to downsize and buy an over 55s in the private sector those will still meet the over 55s criteria. Also, importantly, it is making sure that you have room to take a wheelchair around a bed. That is the fundamental of being able to stay at home or be transferred to hospital.

**The Deputy of St. Peter:**

The practicalities of staying at home in a granite farmhouse are perhaps ...

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

Move downstairs.

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

Rent out the top floor.

**The Minister for Health and Social Services:**
That is a good idea.

**The Deputy of St. Peter:**
Okay, are we happy to move on? So, we will turn now to the hospital and the White Paper is community-focused, as we were just discussing. What services will remain in the hospital and what will be substituted by services in the community?

**The Minister for Health and Social Services:**
I think what is in the hospital will remain in the hospital. There is no talk of moving a certain service, I do not think, that has been in the hospital out of the hospital. What will be the difference is that patients may not come into hospital in the first place because, if you like, if they wish to stay at home then if it is appropriate to stay at home then the facilities and resources can be put in place to enable them to stay at home.

**Assistant Minister for Health and Social Services:**
I think it may be worth, Minister, just reflecting that currently it would appear that there is potential because we have just had a call from the Connétables of the parishes to be able to go out to people's homes, or out to the parishes, rather than have to come into town to the central one and they are starting as a trial over the next few months delivering physiotherapy within the parish hall so people can stay within the parish rather than have to come to town. Now, there is no way of determining whether that is going to develop on from that. I think it is an excellent idea to reduce the travel requirements of people requiring those services and it may be something which will develop in time. It is nice to see somebody is at least having the thoughts to try that.

**The Deputy of St. Ouen:**
Just for me to get my head around some of the things you have just said, I thought that the Green Paper said there are 3 scenarios: one is business as

usual, secondly is hold the money at some unrealistic level, and the third is a new service. We have gone for improvement in service, move more out into the community and so on and so forth but from what the Minister has just said, as far as the hospital seems to be concerned, we are just going to carry on doing the same things we do now. I thought, from what I have read, it was that we were going to look at how our services are provided, knowing some of the challenges that we already face, in accessing consultants and so forth, and really work our way through to make sure that the services are going to provide value for money and meet the needs of the Island. You cannot have it both ways, surely.

**Chief Executive:**

Perhaps I could explain further. If I use an example. If you look at the range of services the hospital probably provides currently I do not think there is any speciality or any service we would say: "That is going to cease completely in the hospital. It is all going to transfer out." One of the examples was physiotherapy and another one might be diabetes. At the moment we have a service where most people who are diagnosed as being diabetic then go to the hospital, they go up to Overdale, they go to the diabetes centre and they get a very good service there but the service is under major pressure and an awful lot of people who are going to the diabetes centre could easily be looked after by their G.P.s in their own practices. So, what the White Paper, what the R. and P. (Report and Proposition) is saying is, if we encourage the development of diabetic services in practices that group of patients who currently go to Overdale for that service could be treated by their G.P.s with support and oversight from the specialists who work in the diabetes centre. That does not mean the diabetes centre will shut and it will not even get any smaller because all those new patients who have been diagnosed with diabetes, but who have complex exacerbations of their disease, they will be going to the diabetic centre. If we do not change the model and have people cared for in the community and by their G.P.s then we are going to have to make the diabetes centre twice as big to get all the new patients in and keep on caring for the people who are there but do not necessarily need to be there or want to be there. So, if that is what we are talking about when we say: "Let

us transfer patients." We are not saying close the whole service down and re-provide it in the community, we are saying: "Let us make sure that service can treat the people who need to go to hospital by making sure the people who would have other choices if we provided them could be seen somewhere else." That is the difference. In a way you do have both options.

**Deputy J.A. Hilton:**

Can you explain a little bit more about what work has been undertaken with the G.P.s in addressing that very thing that you have just explained to us? Because it seemed to me if you have a diabetic who is currently being treated at the diabetes centre they do not pay anything, I presume, I do not know, but I guess that is the way it works. If, as you say, you would like to transfer some of the services into the G.P.s they will have to pay. I am just interested to know what work you have done to speak to the G.P.s about that and how you are going to address this payment issue, because that is the very thing that originally we were told, a long time ago, that people would not have to pay for these services that are going to be transferred out of the hospital to the G.P.s but it would seem to me now they are going to have to pay unless packages are put in place by Health or Social Security out of the Social Security fund to cover the costs.

**Chief Executive:**

It is a very good point. There are 2 elements to this: there is the general fee that we pay when any of us go to see our G.P. and then there is what we want to put in place which is specific services for people with long-term conditions like diabetes and the plan within our proposition is that people would get a number of those appointments for their regulation check-ups and maintenance free because we would be paying the G.P.s to see those patients for that particular condition. What we are not proposing currently is that all G.P. appointments should be free. That is something we can look at as part of the work that we have set out in the proposition; one of the key points in the proposition does say: "We will do further work to identify a new model of primary care." Across those different options there may be an option that says: "Let us make primary care free for everybody." There will be a

massive price tag attached to it but it is a possibility. But we need to do that piece of work and it is a complex and detailed piece of work that will certainly involve our Treasury colleagues but will have to involve our G.P.s because clearly they have a major stake in what this type of service looks like but the specifics of long-term conditions, that is built into the funding that we have already asked for.

**The Deputy of St. Peter:**

Thank you for that answer but I think there was an element of Deputy Hilton's question that was not answered and that was, what work has been carried out so far with the G.P.s?

**Director of System Redesign and Delivery:**

Within the G.P. body there are a whole range of different views, as you would expect. We have 2 G.P.s that have been sitting on our steering group around the Green Paper, the White Paper, Report and Proposition, and going forwards into the future and they have been on our steering group specifically to represent G.P.s really for the last 18 months to 2 years since we started having the steering group meeting. They also represent the P.C.B (Primary Care Body) as well as their G.P. colleagues. We have started having quarterly meetings with G.P.s and we invite all G.P.s and indeed all practice nurses and practice managers as well now to those meetings to keep G.P.s up-to-date on where we are developing with the proposals and with the service models. We have had G.P. representation on each of the outline business case working groups and will continue to have G.P. representation on those working groups as we develop the detailed plans and will continue to check back through the steering group through to the G.P. Body as we go along with that. We know that some G.P.s have some concerns about the outline business cases and some of the service models that are contained within them. We know that we need to continue to talk with them and we know that we need to continue to involve them as we develop those detailed plans but, as we said a couple of times today, the plans that we have at the moment are those outline plans. We have developed them with people, talking to people, trying to take people's views on board but they are outline

plans and now is the point where we are taking them forward into the detailed plans, the detailed implementation plans, that need to be deliverable, that need to work from next year and we will continue doing that with G.P.s as well as with a whole range of other people.

[15:15]

**The Deputy of St. Peter:**
Thank you.

**The Minister for Health and Social Services:**
It is worth mentioning there about the Medical Director's post. We have now appointed a G.P. Medical Director as a result of P.36 back in 2010 and that has been a very positive move. It is also a good link for the G.P.s as well as Social Services.

**The Deputy of St. Ouen:**
Could you just explain what the role entails of this new person?

**Director of System Redesign and Delivery:**
So, the Medical Director for Primary Care and as the Minister says it is one of the results of a proposition from 2010/2011. Part of the role is to ensure working with us that primary care remains sustainable going forward, and by primary care we are not just talking about G.P.s we are also talking about dentists, pharmacists and High Street optometrists. A very essential part of the role is a role called "The Responsible Officer." It basically means the person who looks after the appraisal and the revalidation of G.P.s to ensure and just to give us confidence that they remain fit to practice and can continue to develop and deliver high quality services.

**The Deputy of St. Peter:**
Was this a local appointment?

**Chief Executive:**

No. The G.P.s on the Island were very specific that they felt this needed to be an external appointment; that it could not be one of their own that was undertaking that role and they were involved in the recruitment process in terms of the appointment that was made. I should just point out that the reason that the States did support so strongly the development of this post and the small team that work with Dr. Nick Lyons is because it does allow us to revalidate, and that allows us to continue to ensure that our G.P.s are validated by the G.M.C. (General Medical Council) and able to practice. So it was essential that we did get this appointment made and the R.O. (Responsible Officer) position embedded.

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

It was important because they might not have met their revalidation without it. So it was vital.

**Panel Advisor:**

Can I just follow up a couple of things that you said please? I think there is a concern that I hear around the table that changing the pattern of care will also change where some of the costs fall. Now, obviously the public pays for these services one way or another and the issue is whether it pays for it through some form of taxation or through a direct payment. The issue that I think I have heard being raised is that as the pattern of services is changed then some costs will fall on individuals that previous fell on the State through the hospital system. Am I correct in understanding you to say that as you move to the full business cases you will be identifying where that change in costs is in fact occurring and that in some cases, as in terms of long-term conditions, you have already identified that the States will pay for some of the sessions with G.P.s because you recognise that that is going to impose additional costs on individuals? That is roughly what has been said, is that right?

**Director of System Redesign and Delivery:**

Yes, there is a very detailed set of work that needs to be undertaken now and translating those outline business cases into full business cases and clearly

we would have loved to have been doing that already but we could not circumvent the public consultation; we had to listen to what Islanders said about our outline plans before we could get on with doing the detailed planning. So, yes, doing the really detailed costing and considering the impact of the service models is part of the full business cases and the implementation plan work.

**Panel Advisor:**

Yes, so that will then be available at a subsequent stage for the scrutiny panel to look at. It is an issue, it is a real issue, and work is going to be done. Then the other question I wanted to ask you, Rachel, was in the most recent document, I think it is page 67, there is a section on future funding proposals and that talks about the work continuing to develop a long-term sustainable funding mechanism for health and social services and that looks as though that is going to take a much more strategic look at how costs will be borne across the system as a whole in the longer term future. Do I have that right? If so, could you say something about what that work would involve and over what timescale, because it seems that it is pretty important to do that simultaneously with the roll-out of the new models of care, bearing in mind also the ... I think KPMG are absolutely right that the current way in which you pay for services over here could have disincentive effects in terms of the new models of care. I presume that that statement on page 67 is how you are responding to the risk that KPMG identified.

**Director of System Redesign and Delivery:**

Yes, at the moment there are a number of different funding streams and funding mechanisms for Health and Social Services and if you look at the proposition, which is on page 2 of the Report and Proposition, Proposition B3 refers specifically to this. In order to continue to develop those safe and sustainable and affordable services we want to look at the proposals for sustainable funding mechanisms for Health and Social Services and what we are asking in the proposition is to be able to bring forward those proposals by the end of 2014. In terms of how we are going to do that, we will continue working very closely with our Treasury colleagues in particular but also with

our Social Security colleagues to work up those range of proposals for sustainable funding mechanisms from the medium term financial plan period onwards, so from 2016 onwards.

**Panel Advisor:**
In an ideal world, would you not try and do that kind of work so that the public knew how services would be funded before you changed the service pattern?

**Chief Executive:**
The problem here is in a way we are talking on behalf of the Treasury Department, who are not represented here today. In an ideal world, would it have been good to get it all up front first off? Probably, yes, but we are not in an ideal world.

**Panel Advisor:**
No, I know.

**Chief Executive:**
I think where the Treasury were coming from is that this is a detailed piece of work and there are many nuances in it because not only do we have to understand what we are trying to achieve with primary care and also developments we would like to see in the hospital, not just in terms of its building but its ability to keep functioning during phases 2 and 3 and onwards. Also, the impact of the long-term care fund will probably have on how some of these services are funded but those are 3 very complex pieces of work that all need to be completed in roughly the same timeframe and only by doing all of that will then a sustainable mechanism for funding fall out of it. So, in a way I think what colleagues in the Treasury were able to do is say we will bide the time to do that piece of work because we do feel we can fund this first stage of development which is very focused on developing the missing community-based services while we really do that detailed planning so that when we are coming forward towards the end of this 3-year phase of the medium term financial plan with phase 2, which for us is our middle period of investment, that is when we will be looking for some ... I know it is a big amount of money

we are asking for now but an even bigger amount of money, because that is when we will really drive the changes in primary care and in the hospital. So, in a way, yes, in a perfect world I would have loved to have had it all set out up front. I would have loved to have had the new primary care, I would have loved to have the complete answer to the hospital. We are dealing with a very complex system, as I know you all appreciate and we have had to stage the work that we have been doing.

**Panel Advisor:**
I think that is really helpful.

**The Minister for Health and Social Services:**
I think one thing that is so important is that we acknowledge that we do need that work and it is there in the proposition and I think that is ...

**Panel Advisor:**
Yes, thank you.

**The Deputy of St. Peter:**
When do current hospital services need to be replaced to maintain quality and ensure that they can continue to be provided safely?

**Female Speaker:**
That is a big question. Current hospital services.

**The Deputy of St. Peter:**
Would you like me to repeat it? When do you expect that current hospital services will need to be replaced in order that they can continue to be provided safely?

**Managing Director, General Hospital:**
That is a huge topic. We carry out a continual evaluation of our services to ensure that they are maintained at an appropriate standard. There are some aspects where estates issues mean that we need to carry out works. There

are other areas where we need to introduce new processes and systems. There are some areas where we need to recruit new staff with new skills and that is going on across all of the various services we provide all of the time. So, at any moment, hand on heart, I have to say I believe our services are first of all safe and, secondly, as good as we can make them, but that never means that we cannot make them better and everybody in the hospital and across all of the community and social services are trying to ensure that the care is as good as it possibly can be.

**The Deputy of St. Peter:**

Was your pre-feasibility study and then feasibility study being carried out ... you are obviously continuing to invest in the hospital; we saw the I.C.U. (Intensive Care Unit) open last week, so how much have you spent over the last 5 years on maintenance?

**Managing Director, General Hospital:**

The exact figure I will have to come back to you with. The I.C.U. project itself I think was £2.95 million. The project frankly should have been done many years ago and is not finished yet, so it will not be until the spring of next year that we have completely refurbished the whole of the I.C.U. and high dependency unit facilities in the hospital to bring them up to as close as we can what the standards ... the work we have done there does not mean we do not need to spend money on those services in the future. I would estimate that it would be a maximum of 10 years before those services would need to be completely replaced. So, we are talking about ongoing investment in what are very complicated and expensive services across the hospital indefinitely.

**The Deputy of St. Peter:**

You pre-empt our next question really which is, how much do you anticipate spending over the next 10 years just to keep the hospital as it stands going?

**Managing Director, General Hospital:**

Okay. Well, that suggests that I am not allowed to say how much I would like to spend.

**The Deputy of St. Peter:**

Well, you can give us both answers, if you wish.

**Managing Director, General Hospital:**

Well, put it this way, I put in one bid alone that was more than the entire capital programme for the States for the next 3 years and I put that in this year. So, I am always going to be looking for more investment in the hospital than there is money to cover it, until we get a new hospital. However, I would estimate that the investment required in capital terms in hospital services would fall probably in the bracket of somewhere between £5 million to £8 million per year, would be my best guess for you at this stage. I can go away and refine that. That pretty much equates to what we have spent, I would suggest, over the last 2.5 years which is significantly more, I think, than we have spent for the previous 10 years.

**Deputy J.A. Hilton:**

Can I ask you a question about external inspection in the hospital? Does that currently happen?

**Managing Director, General Hospital:**

Again, another very complex subject. So the answer is yes, but for example our pathology services are subject to external inspection and accreditation, just as they would be in the U.K., our pharmacy services likewise. Some of our other services, like our radiology services, are moving towards the new accreditation that is being brought in across the N.H.S. so they are hopefully going to be one of the first services that is accredited to the new standards. Do we have the Healthcare Commission and the other bodies that look after inspection of facilities in Jersey? Not directly, but in a lot of cases we apply the same standards ourselves and we use every opportunity to get fresh eyes and external assessment of the services we are providing. So, I think it is the regulation of healthcare legislation, which will be going through the States later this year, which will put in place the framework which will lead to an eventual full regulation of healthcare facilities across the whole of the Island.

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

And in the community.

**Deputy J.A. Hilton:**

You have come from the U.K., in your opinion, does the hospital reach a standard that would pass inspection if it happened to be in the U.K. across all of its departments, and if it does not, what departments in your opinion fall short of the standard that the Jersey public would expect?

**Managing Director, General Hospital:**

If there were any departments that I felt fell below the minimum standard I would have shut them. So, I can hand on heart say that all of our services are providing what I regard to be safe care. I think it is a more complex answer to the second part of your question because the regulation, the inspection, the assessment of healthcare facilities in the U.K. is against a set of standards which would not necessarily directly map onto the situation we find ourselves in Jersey. I will give you an example. You have a large number of hospitals that are relatively close together in England and therefore if a service falls below a particular standard in one domain you could, quite legitimately, close that service and the patients will be transferred to the hospital that is 10 miles up the road, or 12 miles up the road, or whatever.

[15:30]

Here you are weighing up the temporary shortcomings you might have identified in a service against the risks that would be certain if you closed that service for an Island where the next alternative would be to wait for a day when the airport was open and fly the patient out to the nearest alternative healthcare facilities. That means you apply a different level of measurement of risk and that is something that the staff that work in the hospital have become very adept at doing and I think it is something that we need to recognise. We are incredibly lucky in Jersey to have staff that can manage a degree of risk that in the U.K. hospital setting would be very alarming for

some staff. They do it because they always had to do it; they are very skilled at doing it and we are very pleased that we have those staff. The obvious measure would be C.N.S.T. (Clinical Negligence Scheme for Trusts). I do not know if you are familiar with that. That is a very complex process whereby you assess risk in a hospital setting. There are 4 levels: 0, 1, 2, and 3 with 3 being the highest. My assessment is that hospital services in Jersey, if we were assessed now and we had an adjustment made because of the differences between the N.H.S. and Jersey, we would be broadly at level 1 and in certain areas we would be up to level 2, such as maternity. What we are intending to do is to bring in external assessors to assess us against the C.N.S.T. standards, even though they are not legally obliged to do so, we are taking every opportunity we can to get external assessment of how safe our services are and what we can do to make them safer still.

**Deputy J.A. Hilton:**

Interesting that you just said that our maternity services you felt would be at level 2, despite the fact that the maternity theatre and the anteroom that is available to consultants, nurses, when we saw it, was very poor indeed.

**Managing Director, General Hospital:**

I remember showing you around it.

**Deputy J.A. Hilton:**

That surprises me a little bit that you said that.

**Managing Director, General Hospital:**

The C.N.S.T. you are mainly talking about risk, you are talking about your systems and processes, you are talking about the evidence base, so do you know what is going on? Can you demonstrate that and have you done something about it? Those are the areas that we are talking about it. So, for example, on the quality of the theatre, which is not used very often, but I agree it is not something that we are very proud of and we have money in the programme to replace it. So, first of all we identified that it was not at the required standard, we bid for funding, States of Jersey approved it as one of

its top capital schemes 18 months ago, the funding was established, the project teams are coming together and work is hopefully going to start before the end of the year on building a new maternity theatre. So, we have a process to identify and deal with risks as they are identified.

**Chief Executive:**
Undoubtedly a new hospital would help a great deal.

**The Deputy of St. Peter:**
I was just going to ask, do you consider that the level of risk could increase in the foreseeable future?

**Managing Director, General Hospital:**
Gosh, the thing that worries me most is winter and it is because the decision to build more capacity should have been presented to the States for a decision a significant time ago, long before hopefully people around the table were sitting here. So, this should have been considered probably 8 to 10 years ago, in my view. Had that taken place at that time then we would now have more capacity in the hospital and the concern I have is that because we are running at virtually 100 per cent occupancy for a lot of the year were we to have a particularly bad winter with a lot of respiratory disease or other issues which would sometimes be in a U.K. hospital compounded by outbreaks of infection such as diarrhoea and vomiting, then you could have a situation where we would run out of beds. Now, it has not happened and staff are very aware of that and they have very good systems and processes to manage those risks but it is something that keeps me awake at night. It does not keep me awake at night, but it is something that I am thinking about when I go to sleep and I am thinking about it when I wake up. But it is something that I think will probably need some form of interim solution to mitigate that risk before a full replacement hospital can be built because the demand on services is increasing year on year and we are full and there is only so much you can do in terms of improving your systems and processes to get patients discharged earlier and we do not really have the community services built up yet to enable us to do that.

**The Deputy of St. Peter:**

Are you working on interim solutions?

**Managing Director, General Hospital:**

Yes.

**The Deputy of St. Peter:**

Are you able to share with us any thoughts on what shape this might take at this point?

**Chief Executive:**

One either has to build more capacity on the site or one has to take more patients out of the hospital and we are looking at both as a potential ...

**Managing Director, General Hospital:**

The nuance on that is that the thing I want most, if I could make a wish, would be more single rooms with ensuite facilities and that gives you greater flexibility in dealing with infected patients coming in from nursing homes, or from their own homes, over the winter period to prevent cross-infection and even if we were to put more beds in I think it is important that we are increasing the proportion of single rooms with ensuite facilities to give us that flexibility.

**The Deputy of St. Peter:**

To play devil's advocate, we have seen in the media over summer that it poses the risk also of people not receiving hydration and simple aspects of their care.

**Managing Director, General Hospital:**

I do not disagree with you, but it is interesting that those hospitals which have moved to more single room facilities such as Tunbridge Wells or to a much higher proportion of single rooms have seen a requirement to employ more nursing staff to ensure that the care of patients is maintained. It is something

which ... it is a constant battle. In a well-run hospital you are constantly looking to find things that are wrong with the care you are delivering so that you can put them right and that is something that is the day job.

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

When we went to Tunbridge Wells that is one of the areas to be looked at. I mean, single rooms, that is the way forward and one of the issues was about, because you are in a single room, how to arrange for a patient who needed extra care or whatever, and it is putting the processes in place for nurses in training and for nurses to understand the risk associated with that and making sure they are in place.

**Managing Director, General Hospital:**

Another very positive thing about that and having the space available is that there is space for relatives, carers, friends, to also spend more time in the hospital and therefore fully participate in the patient's recovery.

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

I just wanted to endorse what Andrew has said about our staff. I think full praise should be given to our staff who are coping at 100 per cent capacity. These staff are working under great pressure and I think we need to acknowledge that and thank them for that.

**The Deputy of St. Peter:**

We do not wish of course to pre-empt the findings of your feasibility studies but we are interested to know if you have any idea of costings of rebuilding the hospital in phases compared with a complete new rebuild. The reason I was going through my notebook is I was trying to find out how much the new wing that we saw at Guernsey's General Hospital, for example, cost. It is something that I have here but I cannot quite see it. I think it is ...

**The Deputy of St. Ouen:**

£140 million is the anticipated cost.

**The Deputy of St. Peter:**

The total, but there was a new wing that we saw, was there not?

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

If I could say that the feasibility study is being worked up at present and it is being overseen by the Minister of the advisory group, who are meeting next week. So, at this moment in time it is not finalised yet, but as soon as it is we are very willing to come to scrutiny in a private hearing and explain it to you.

**The Deputy of St. Peter:**

Thank you. How comfortable are you taking this Report and Proposition to the States without knowing the final cost of the end game in this plan?

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

The end game for the hospital?

**The Deputy of St. Peter:**

Yes.

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

I think it is a mammoth piece of work and it needs to be done in stages. I mean, the feasibility study is the first step and we identify the sites and build it up firstly and then we need to go into more detailed plans. I think the whole thing from start to finish to being built is probably going to take us at least 10 years and that is a long time, but the most important thing is we need to start somewhere and putting this in the proposition is important because it identifies the need to start that work and to make a decision and go forward but that does not stop any capital investment that we need to do in the hospital in the meantime because we still need some funds for the business as usual and that is another matter.

**The Deputy of St. Ouen:**

Just picking up on a general issue that has been raised throughout our review today is that scenario 3 was promoted as a new model for health and social

care and it was to ensure that health and social services were safe, sustainable and affordable and able to meet projected increases in demand. The big issue for the members of the public, and others, is about affordability. It is great to talk about new hospitals at £300 million or £400 million, it is great to talk about: "Okay, we might be able to manage the first phase of the 10-year change within existing resources" but the public know that it is clearly going to require additional funding. Alongside of that to date we seem to hear that rather than necessarily save money by early intervention and transferring services into the community the hospital is going to carry on as is. I am struggling to understand how we are going to satisfy the public's concern, or deal with the public's concern, while at the same time ensuring that the services are delivered as described under scenario 3.

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

If I may, it is not a case of either/or, it is a case of both. We will still need the hospital, we will still need to do the development for the hospital, be it a new or refurbished one on site, even if we deliver all the A, B, Cs. If we can deliver all the A, B, Cs it has potential to make it more affordable because we probably will not need such a large hospital. So, that is why I am saying it is not either/or, it is both. If we get both together we will get the right balance and the right affordability and that is what we are trying to achieve through the pre-feasibility study work we are doing at the moment.

**The Deputy of St. Ouen:**

Would it not be better to describe the route that we are planning to embark on as business as usual plus?

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

No. Business as usual as well.

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

Yes, because if we did not do scenario 3, scenario 1 the costs would just spiral because we would need more people coming into the hospital, increase the care, increase the cost, as well as, as John has just said, but a bigger

hospital at the end. Scenario 3 was cheaper; not significantly so, but when you are talking about 4 or 5 ...

**The Deputy of St. Peter:**

If my memory serves me correctly the difference was about £28 million, which when you are looking at the figures you are talking about it is a drop in the ocean.

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

But on top of that it is providing the care that we should have and more community support; more care in the community which, because of the resources, does not happen as it should do now.

**Chief Executive:**

For 2030, possibly even £40 million that is not spent by going down scenario 3 rather than scenario 1 is the revenue cost. The cost of building a much, much bigger hospital to maintain scenario 1 would also have to be taken into account in terms of the capital costing. So, I think we have to recognise there is a capital and a revenue cost of maintaining scenario 1. The other issue with scenario 1, which is just: "Let us do what we are doing now and do more of it" is that there is a strong possibility we could not staff it, therefore the service model would not work anyway and that was one of the points that we made during the Green Paper consultation. We would hope, with the work that is going on with the ministerial oversight group and the pre-feasibility work that Atkins and Currie & Brown have been doing for us, that before we get to the point of the States debate on 23 October we will be able to put some information into the public domain about the likely way forward for the hospital in terms of costs and sizing. So, I think there will be more information available to States Members because otherwise we do recognise it feels a bit like a black hole in the middle of all the rest of it, so there will be more information made available.

[15:45]

**The Deputy of St. Ouen:**

How are we going to reassure the public as we progress down the path that we are going to achieve the improved health outcomes that are being suggested and spoken about regularly in the White Paper and Green Paper?

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

By getting Members to agree it at the States. It is all there, James, ready for delivery.

**The Deputy of St. Ouen:**

No, I am saying if you are going to ask the public to pay more for an improved service then obviously they are going to want to know that they are going to get it. What I am asking is, how are you going to demonstrate, or will you be able to demonstrate may be a better question, those improved outcomes that you say will result from the new model of healthcare?

**Chief Executive:**

The outline business cases as they translate into full business cases deliver tangible services in the community, on the ground, that people will be able to access. So, I think that over that 2 to 3-year period as we start to roll those services out, more and more people will be able to say: "I now go to my local G.P. and get what I used to get before" or: "I get something different and new" or "I now have somebody coming into my home to provide something that previously I did not get, or I went to the hospital for." So, it will have a tangible output that people will be able to see and feel. If it does not then we should not be doing it.

**The Deputy of St. Ouen:**

But the question is, it would be different ... they will recognise the outcome because they will have the services provided but I am talking about health outcome. How do we ensure that the outcome that is generated from being cared for in your own home, the health outcome, is going to be as good, if not better, than the one that one is used to seeing and receiving within the hospital environment?

**Chief Executive:**

As part of developing the full business cases we will identify a range of metrics, for want of a better word; things that we can monitor like how many times have you had to be admitted this year with an exacerbation of your chronic chest condition? Hopefully if this has worked properly it will be far fewer times than in the previous year where you did not have those community services and a G.P. looking after you. You just got worse and then you were whisked into hospital. So, things like that that you can look for and say: "Well, are those parameters being demonstrated?"

**The Deputy of St. Ouen:**

All right. So, there will be some clear outcomes that we can identify and track?

**Chief Executive:**

Oh, yes.

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

I think there is another element as well, James, picking up one of your earlier questions about the funding for people with assisted living at home. If they were not, and the funding was not available, they would end up in nursing homes and I know where I would rather be and that is not in a nursing home, even if it does cost me money to be at home, because it will be a lot cheaper anyway. So, that is another one of the outcomes of assisting people to live in their own homes.

**The Deputy of St. Peter:**

It is interesting that the Chief Officer raised the question of monitoring conditions and improvements when we are slightly concerned about the funding that is being provided from improving I.T. (Information Technology) systems because surely you need the I.T. systems to be fully integrated between primary and secondary care before you can achieve that.

**Chief Executive:**

Yes, and there is a great deal of work underway on that front, as I know the scrutiny panel members are aware in terms of the development of the server for primary care. We have work underway during next year to put together those 2 systems: our hospital-based system and the primary care system so that G.P.s will be able to get results going backwards and forwards. So, those things are planned. There is no doubt that there needs to be a substantial investment in information technology and in information systems, and in information analysts because the system does need to be able to prove it is doing what it says on the tin and while we can prove a lot more than we used to be able to, and we have a better system in the hospital than we used to have, there is the whole information work stream as part of our transition planning that will allow us to make the case, not just in these first 3 years but in the next 3 years and onwards for further investment in the technology and the people to help us to really demonstrate to the public that their money is being spent wisely.

**The Deputy of St. Peter:**

One aspect we have not touched upon yet today is Telehealth and Telemedicine. There have been some slightly critical reports in medical journals over the summer about these practices and whether they are sufficiently developed yet to be applied across the board in all medical conditions and whether some care should be put in place before sort of willy-nilly using it. What is your view on that?

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

Well, Rachel is the ... but your last point, you should not just put any piece of equipment without making sure that is the right piece of equipment that goes into patients' homes and they know how to use it, and at the end of the day it will benefit them. So, proper assessment needs to be done, but Rachel is our resident teleperson.

**Director of System Redesign and Delivery:**

I absolutely agree. Any technology, the same as any health or social care intervention, will not be applicable in the same way to every condition and will not be necessarily the right solution for every patient, or every service user or every carer. There is an element of choice in there for individuals. There is also an element of making sure that whatever care you put in place for someone it is the right care for them and the right care for their condition. Telehealth and Telecare, where they work well, they are enablers to integrated care that is provided by a whole range of different health and social care professionals. They are not the solution in and of themselves. A piece of technology sitting on its own added onto care is just care with a piece of technology added onto it. It needs to be properly integrated and properly enabled and it needs to be properly developed with a whole range of health and social care professionals to make sure it is the right solution and that it is right for Islanders in totality and on an individual basis. So, I think there is something about looking at what is the right thing to do here and not making sure that we just pluck something from the U.K. or France or Germany or Guernsey, and say: "Well, we will just bring that into Jersey then" because it might not be right. We have to think carefully about what the right solution is for people here. Telehealth, Telecare, the same as any type of care model has its positives and its negatives. I think where we can really take advantage here is that some of those lessons have already been learnt elsewhere so we can take the best of it and make sure that we apply it in the right way.

**The Deputy of St. Ouen:**

Just picking up on a couple of other matters and going back to funding and the costing that is involved around the proposals. One thing I note is that all of the population figures in evidence rely on managing and maintaining an overall population of 97,000 in 2040. We have 100,000 now. I am a bit confused when you say that you have confidence in the scenario and the figures used and the assumptions contained in the population model that KPMG used when we are already 3,000 more in overall population than was identified for 2040 which is 28 years in the future. Maybe you would like to comment on that and what the implications might be.

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

I think what we mentioned earlier is that it is based on our current usage of the services.

**The Deputy of St. Ouen:**

But surely, Minister, current usage, as we already know, is not just based on elderly folk but a range of people accessing the services and ultimately it is overall population and the mix that is there. If overall population has already reached 100,000 and we are growing at 1,000 per year, which has been the case for the last 10 years, my question to you is, how confident can we be that the figures that have been identified to deliver the services which are based on information that is totally out of date can be relied upon?

**Director of System Redesign and Delivery:**

Shall I take that one? You can only do analysis based on information that is available at that time. So, when KPMG did that analysis that was the most up-to-date census data that was available to them and they did that analysis working closely with the stats unit. We understand that the 2011 census information is due to be published at some point in the near future; we have not had that yet so we have not been able to look at the impact of that as yet. We are looking forward to getting the results of that census and then we will be able to consider what the impact is. So, for example, I think the Chief Officer said earlier on, if the census data shows that we have had the largest increase in adolescents and working age adults, for example, then we need to consider at what point that will give us the big service pressure in older age, which is one of the main drivers of the new way forward for health and social services, but until we have had that information on the census data it is quite difficult to be able to second-guess what it is going to say. What we can have confidence in, which is what the Minister has just said, is that the analysis that has been done in terms of the hospital is based on current activity data not on 2001 census data, so we are able to have confidence in the impact on that activity. We are also able therefore to have confidence on the short to medium-term impact, the older adult population. As the Managing Director for Community and Social Services said earlier on, it is the longer term impact

and the results of the census data for 2011 that we will need to look at, but that is the longer term impact and not the short to medium term.

**The Deputy of St. Ouen:**

Exactly, but I would like to remind you that we are looking at a 10-year programme of change, not some short-term fix which perhaps we could have been criticised that we have been following in the past. You speak about the census information has not been available. It has; quite a lot of it has been available for some time, including overall population numbers, in March this year. More recently further information has been produced by the Census Department and it is not just about ageing population; we have natural growth of about 240 a year. Richard spoke earlier about increasing the number of births. We have a working population or a dependency relationship that has not changed since 1931 according to the latest census figures which does not demonstrate the actual changes that are indicated in your White Paper. I think all of these matters ... there might be good reasons behind it, but for the individual that is looking at this is going: "Well, hang on a minute, these are basic bits of information that you need to understand what the demand is going to be in the future and how we are going to fund it."

**Managing Director, Community and Social Services:**

These are very good questions to ask of the Statistics Department when they give their presentation because the issue is not absolute numbers. The issue is about, the word they use is "churn", so if the population increases by 20,000 people and the next year it decreases by 40,000 people, and those are all of working age, there is a significantly different profile going forward 40 years to increase by 20,000 people who remain here to an older age. So, the data that we hear tomorrow will help inform how we set policy around migration and that is exactly how you manage this issue and the key is not the absolute numbers it is about the churn of the working age is the key.

**The Deputy of St. Ouen:**

Just a final comment on that. I do not believe that you should point the finger and say it is the stats unit to sort it out. I just remind ourselves that we have

current migration policies in place which have been totally ignored for the last 3 or 4 years and essentially is a sham, but we have this increase that we need to deal with and it is our responsibility, and obviously the Minister's, to ensure that when the States come to consider this particular document that the appropriate funding is in place, that we can guarantee that we can provide for our population as we wish to in the future. I think that is the general point that needs to be considered.

**The Deputy of St. Peter:**

Just in closing, I think we would just like to ask you whether you would agree that the Report and Proposition that you bring to the States next month provides an equally full and explicit vision of the hospital services and community services for the community.

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

Yes, it does. I have every confidence that it is a step forward and identifies how the services will change in the next 3 years with the funding stream attached but also looks longer than that and as the different points in the proposition go, not only within the community and the hospital services but the wider community from 2016 onwards, how the primary care services will need to change and have sustainable resources attached to it. A lot of work.

**The Deputy of St. Peter:**

Okay. Thank you very much to all of you for attending and taking the time in what one can imagine is a busy week. I close the meeting.

[15:59]