Health, Social Security & Housing Sub-Panel
Full Business Cases Review Hearing

FRIDAY, 22nd FEBRUARY 2013

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

Witness:
Medical Officer for Health

[12:00]

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

I remind the public about our code of behaviour; if they will be kind enough to observe that. We will kick off with introductions. You have also got a note there about privilege, if you would like to take a moment there to read that. So I am Kristina Moore, Chairman of the Panel.

The Deputy of St. Peter:

Well, thank you very much for coming in to talk to us today, Dr. Turnbull.

Medical Officer for Health:

It is a pleasure.

The Deputy of St. Peter:

We will start briefly, if you could outline your involvement in the full business case process, please?

Medical Officer for Health:

I should probably start at the beginning, so I am probably, apart from the project leads, the most involved person throughout the whole process right from the beginning, going right back to the point where there was a tendering exercise to select the organisation that would come and do the 6-month project and then, after KPMG was selected, working with the 2 clinical advisers; one was a very experienced G.P. (general practitioner), Dr. Rod Queenborough, and Dr. Jose Westgeest, who was a hospital clinician who advises KPMG.

The Deputy of St. Peter:

Sorry, can I just stop there. Were they already involved in Jersey or were they from outside of the Island?

Medical Officer for Health:

No. They were part of the KPMG Team, so they were the people with expertise of similar types of work in the past who came to visit all of the practices in the Island. So I accompanied Dr. Queenborough at about 4 of the practices, just while he listened to their perspective on healthcare in Jersey at the moment, their perspective on what had happened before in terms of the need for change, some reflections on what had happened with New Directions, so just basically going round finding out what could be learned from all of the practices in the Island. Dr. Westgeest did the same thing with the hospital clinicians, so there was from the ground up, alongside all the statistical analysis, so my Health Intelligence Department provided a lot of the data about patterns of disease and mortality in the Island. They took evidence from, obviously, the statistics unit on the demography and all of the hospital activity data, so lots of different sources of information, but talking to clinicians was probably the most important part of it.

The Deputy of St. Peter:

So are you surprised by the clinicians' recent letter?

Medical Officer for Health:

Yes. I am, I am surprised, but in a sense it is a small number of people who are, perhaps, to put it in one sense, coming slightly late to the party, who perhaps did not engage as much with the process at its earlier stages, so after the KPMG 6-month piece of work was the steering group that led through the process that led to the Green Paper, and then the consultation and the various events around the Green Paper consultation in 2011. There were G.P.s involved at that stage through the steering group; in fact, there were 7 doctors on that steering group throughout the Green Paper stage and the White Paper stage. So it has all been going on for a number of years now, but just to reflect on why some people perhaps did not engage as much as they could have done. Just a reminder probably: some of my colleagues have not been here long enough to

remember this, but the New Directions process that had been going on from between about 2004 and 2007, was a very similar huge piece of work that took a lot of time and a lot of programme developments, workstreams, et cetera, scenarios even. There were many striking similarities. They did not particularly highlight the need for a new hospital, it was looking at ways of keeping things sustainable through more self-care or prevention, better management of chronic diseases; all of those things were in New Directions. But then there was a costing exercise, and the price tag that came up was seen as likely to be politically unacceptable, and it hit the buffers, but I think there was also an element of not as much confidence in the then Minister for Health and also in the then Chief Executive. So compared with the more effective and people with more credibility that we have had in post for the last few years, I think we have taken a different approach by bringing in external advisers who shone a different light on the system and have come up, not very surprisingly, with quite similar conclusions. It is not right what Dr. Minihane said, that it is to do with what the King's Fund came up with, because the King's Fund reported after we had our piece of work done. So the timing does not support his case.

The Deputy of St. Ouen:

Can I ask you what your current involvement is?

Medical Officer for Health:

I am still on the steering group, the Transition Steering Group, as it is now called, but I am also senior responsible owner for 2 of the workstreams, so I am the Corporate Director who is ultimately accountable in the lead on the Healthy Lifestyles workstream and the Children's workstream. So I have been that ever since they were ... once the Green Paper consultation came back and when Scenario 3 was decided on, then there was a process to decide which were the areas for the highest priority to work up as O.B.C. (Outline Business Case) workstreams. The criteria that were taken into account was things that you could do in the first 3 years, things that you could do ahead of having the whole funding system of primary care reviewed and possibly changed, et cetera, and things where there were the most sort of pressing health issues that needed something different from what is already happening as business as usual. So not just a case of expanding what is already happening, and in some cases under pressure, like we heard in the earlier hearing, but looking at new ways of doing things. So alcohol just is one issue; the statistics on alcohol in this Island are truly shocking in terms of the mortality rate, the years of life lost, premature mortality, the amount of work lost, the amount of crime and disorder, everything about alcohol. The amount of emergency detoxification that has to be done for people whose alcohol dependence has reached a point where they are a medical emergency. So looking at all of that, I personally made a bid to a Steering Group to say we need to have alcohol as one of these initial pieces of work to dovetail into all the other work that is going on in an alcohol strategy and a revision of the licensing and all, but do something about recognising people with harmful

drinking. There is no point in going out and recognising people if you have got nothing to offer them. So having a seamless pathway where people would be able to get help and able to have, if they need it, detoxification in the community. We only have to look at the figures to see that the number of people having treatment for dependence in the community is less than half of what you would expect it to be for a population of this size, but if you amplify that by a population of this size with the amount of alcohol problems we have got, it is woefully low. So there is a big need out there. That is just one example.

The Deputy of St. Peter:

We also have a very high prevalence of cancer and that is not really in the first workstreams in the 3 years.

Medical Officer for Health:

No. There is lots of work already underway on the cancer front. But just to use cancer as an example, if we look at the ageing population, we have seen all the figures, so we know in a way the problem is a success story, because better treatment is helping people to live longer lives and so on. But if you live longer, because of how cancer develops, and it is to do with mutations and cells, if you live long enough, most of us will get some sort of cancer. So therein is another issue that is going to cause pressure on the health services. But the other thing that has not particularly been mentioned as a reason to be concerned about the ageing demographic, is the effect of the Baby Boomer generation. We are probably all in it; Kristina is a bit too young, but if you look at that bulge of the population that is playing through and, as we all live longer and hopefully stay well, we will be the people who will be doubling the number of over-65s by 2040. But even by 2021, there is going to be a third as many more over 65s as there currently are.

The Deputy of St. Peter:

I would just like to backtrack slightly. You did mention that there were 7 doctors on the Steering Group throughout the process. I think we had only really been aware of the 2 primary care group leads, Dr. Venn and Dr. Perchard. Were the other doctors from acute services or ...?

Medical Officer for Health:

Yes. Well, there was obviously myself, 2 medical directors, so Mr. Siodlak and Dr. Luska, Dr. Carolyn Coverley, who is the Consultant Psychiatrist for Children, so community and social services and, more recently, Dr. Nick Lyons, who is the new Primary Care Medical Director.

The Deputy of St. Peter:

Thank you.

The Deputy of St. Ouen:
I would just like to explore a little bit about some of the comments you just made regarding this case of alcohol abuse. Where can I find robust and reliable data to support your comments?

Medical Officer for Health:
We have a report in the Health Intelligence Unit that has been used on a number of occasions when we have been asked questions by the media, but it is also in a draft alcohol strategy that is in the "about to go to the Council of Ministers" phase, but it is waiting to dovetail into the updated Licensing Law and the Economic Development Department is leading on the Licensing Law and they have been asked to revise some of the aspects of that.

The Deputy of St. Ouen:
Well, is it based on real-time information?

Medical Officer for Health:
Yes. Absolutely, what people are dying of, what the conditions are that people are being admitted to the hospital with. There is a way of calculating and comparing data called alcohol-attributable hospital admissions, so you look at all of the causes of admission to hospital. Those are based on very good scientific evidence, an accepted international method of saying: "If you have this many head injuries, 70 per cent of them will be connected to alcohol." So the figure for the number of alcohol-attributed admissions is a factor of 0.7, or something, for a head injury, and it might be different for a collapse due to drunkenness. So lots of different things that are connected with alcohol are scored and our rate for that is the second-highest compared with all of the English regions, so people dying of cirrhosis of the liver, for instance, is twice as high as the English average in Jersey.

The Deputy of St. Ouen:
Right. That is real-time information that ...

Medical Officer for Health:
That is real people dying in the Island.

The Deputy of St. Ouen:
On an annual basis?

Medical Officer for Health:
As recently as this week, yes.

The Deputy of St. Ouen:

So we can look back and compare one year's results with another?

Medical Officer for Health:

Yes. We have got all that data.

The Deputy of St. Ouen:

Sorry, I just want to explore this a little bit more: you talk about statistical information and then calculations. Why do you need to undertake calculations when we are basing all of our knowledge solely on 100,000 people?

Medical Officer for Health:

That is just one example where you use a scoring method to calculate the impact on a hospital of alcohol overall on a whole range of medical conditions. There is no other simple way of doing that, especially if you want to compare with other places but, in terms of the actual number of deaths and the number of admissions due to different causes, those are things that we do directly count and measure and look at trends. If you look at our health profile that we published just a few months ago, the most recent one is data up to 2010, that has got all of that sort of data in it.

The Deputy of St. Ouen:

I am pleased you have raised that because you quite rightly point out that this is a health profile for 2 years ago, or nearly 3 years ago.

Medical Officer for Health:

That is right. That is the comparative data, but we have got all of the most recent data for up to even the end of the most recent year within our Health Intelligence Department.

The Deputy of St. Ouen:

Right. So for argument's sake, let us just focus on children for a minute and the development services for the 1 to 5s, if I asked you to tell me how many children are in the 0 to 5 on the Island, are you able to give me proper, robust information that is not calculated or utilising 2011 census figures?

Medical Officer for Health:

We have a child health system within the Public Health Department and that has on it all of the children born in the Island, all of the children coming into the Island who need immunisation, health visitor services, et cetera. So we have got very exact figures. There may be one or 2 who, for some very rare reasons, do not become noticed by the system, but we believe that is incredibly

rare, we believe we have got all of the children on the system. It is through that that we know that we have got a higher immunisation rate than anywhere else.

The Deputy of St. Ouen:

That is really encouraging because, on another particular view we have undertaken as regards respite, the department was not able to tell us how many young people had special needs, and yet you are telling me that you are able to identify each individual that makes up a particular group.

[12:15]

Medical Officer for Health:

Each child. That is right.

The Deputy of St. Ouen:

So if you can identify each child, why is it not possible to identify at an early age those children that will need and continue to need special or additional care throughout their lives?

Medical Officer for Health:

Well, part of the children's workstream is of those children who are in the under 5 age group to identify families that are particularly vulnerable and offer them some additional ... a programme is mentioned in the White Paper, but it would not necessarily be that programme, but there are lots of different things that can be done to support vulnerable families, and it is the health visitors who are in the front line of being linked up with when the children are needing their immunisations and sort of advising on childcare and feeding and so on, who are more than aware where the vulnerable families are. Some of the vulnerable families are already getting that sort of support, but there is not enough of it and the new workstream is acknowledging if you could cover all of the vulnerable families, the amount of trouble that you could head off by early intervention into the future by giving people better chances right from the very start is one of the aims of that work stream.

The Deputy of St. Ouen:

Sorry just one last question, Chairman. Are you saying (and I might not have got this straight) that we can identify accurately all the children in each year 0 to 5, but currently we cannot identify which category they may fit into or whether they would be classed as vulnerable? Yet, as you rightly say, all these children and the families are being seen by the Health Department and various other practitioners and so they must be aware of this, clearly.

Medical Officer for Health:

It is a personal judgement based on what you know about a child and their family whether they are vulnerable, it is not something that will come up as their name, address, date of birth, post code, immunisation status and so on; you cannot tell it from the basic data that we keep on a computer, it is not a clinical database.

The Deputy of St. Ouen:

But if I have got a daughter, which I have, who is obviously a grown up now, that was a Rubella baby and she has a heart complaint, 70 per cent hearing loss and blind in one eye. That was known from day 1. I am asking you are we able to currently identify all children who have and will require special needs? Are you telling me that we can, but there is another group which would be classed as vulnerable (whatever that means) that we are going to identify in the future?

Medical Officer for Health:

I think at the moment the public health system and the child health system has got basic data about all of the children: who they are, where they live, when they were born, what immunisations they have had, what child health checks they have had. There are other organisations, so the health visitors under Family Nursing have a certain amount of contact with families and there will also be families that are in contact with Children's Services because of past history or existing problems, or even when a mother is pregnant sometimes it is apparent that there is going to be a problem, for instance that the mother is a drug user or something in that category. So there are other mechanisms beyond public health surveillance that identify who are the vulnerable families and it is from that evidence that it is apparent that the small amount of support for vulnerable families is not exactly the tip of the iceberg, but it is certainly not covering all the recognisable need at the moment, and there is more that could be done by having more investment in that type of service.

The Deputy of St. Peter:

Is this not the question of empowerment, though, giving those front line people who are visiting these families the time and the power to report back and say: "Here is a vulnerable family."

Medical Officer for Health:

They do, but the thing is there is not the resource to bring the extra team of people to wrap around that family without this new bit of investment that has been very sensibly voted through the States as something where a case has been made, it will be done, it will be starting.

The Deputy of St. Peter:

How do you see that new service opening out vis-à-vis the existing one? There is obviously a home-grown charity who operates and provides early intervention services to families. Do you see this work stream like in collaboration with them or a different ...?

Medical Officer for Health:

The stage it is at at the moment is that the full business case involves a number of service investigations; you must have heard that or seen that. But it is very much work in progress and the service specifications have been worked up by what started off ... I wish I had brought the list with me, but the number of people who were invited to the initial workshop for the working up of full business case and the service workstreams, was probably about 50 or 60 people, and it ended up being a much smaller number of people who did engage with it and put some time into it. Not all of the people who have been saying they do not quite like what has come out of the system took the opportunity to come and take part in it.

The Deputy of St. Peter:

Why do you think that happened, though? Why did we have such drop-off?

Medical Officer for Health:

Well, it is difficult to know. I think possibly it is backtracked to the urgency of getting all these things happening, the figures from the very beginning, from the first Green Paper and then the white Paper showed that it is only going to be 2 and 3 years really unless the battleship starts turning round and things are done differently to prevent problems occurring. It is not so the much the case with vulnerable families and children, but other parts of it, to do what you can to keep people well, keep people in other places when they do not need the hospital. But the timescale of it was necessarily short in order to, having got proposition 82 voted through and then the M.T.F.P. (Medium Term Financial Plan) and the money behind it, to be able to start spending it in 2013, because the money is there so it is a terrible shame not to be ready to get on and deliver it, the process to get service specifications worked up was inevitably quite truncated. There is an awful lot of detail to ...

The Deputy of St. Peter:

Not necessarily. There is no urgency to spend the money. Would you not say that it is more correct to get it right and have everybody on board than to rush out and spend money?

Medical Officer for Health:

To get it right. Yes. I think that is what has really come through the process, because I think the people who were involved in the workshops and the people such as project leads, for instance, my

2 workstreams, Andrew Heaven is my Head of Health Improvement, he was the project lead and is the project lead for those 2 workstreams. He has been working all hours and all days on all of these things trying to keep up the pace with all of the different workshops and all the different interim reports in between them all. It has been a massively intense process for people whose job it has been to do this, but then to ask other people externally to give that much time for such an intense process, with numerous workshops, et cetera, is a big ask, is it not?

The Deputy of St. Peter:

We can help you a little bit though on that issue of the drop-off that was experienced in the workshops, and we have conducted a survey, we are still receiving responses, and so we could share some of that with you. Because it comes down to a discussion we had in our previous hearing, where you were sitting as a member of the public so you would have heard, and a feeling of isolation perhaps related to the language and the vocabulary that was used and seemed to be a sort of anglicised, U.K.-centric process. There seems to be a lot of similar feedback that has put people off. Can you understand where that might come from?

Medical Officer for Health:

I suppose, yes, that is understandable, if people are in Jersey, the concept of the word "commissioning" was mentioned earlier. People do not really understand what that is or why it is sensible to have it, because it has become, in the U.K. context, just for instance, a bit of a dirty word because the health reforms over in England are all about passing money over to what they call clinical commissioning groups, which is consortia of G.P.s who will then make decisions about how the money is spent on behalf of patients. It has caused all sorts of disarray because G.P.s just do not have the sort of background or the skills to manage that process through and to steward the public money in an effective value-for-money safe sort of way. So it is not a great story over the water. What commissioning is is making sure that you are spending the money that you have got wisely on the right things for the right people in the right place.

Deputy J.A. Hilton:

As far as the early intervention and full business case goes, have any service level agreements been awarded to any third sector ...

Medical Officer for Health:

No.

Deputy J.A. Hilton:

Because you are not that far yet.

Medical Officer for Health:

Not that far, we have slowed the pace because of the feedback that has been coming in. As was discussed earlier, people are now looking at the service specs as they are again to see which of them might be ready to roll as they are, which is seen as not too complex, fairly simple and perhaps no-brainers. That kind of thing.

Deputy J.A. Hilton:

I asked that question because I am sure I recall seeing an advertisement several months ago of midwives, and it must have been additional midwives, and I assumed that ...

Medical Officer for Health:

No, it would not have been that one. What happened last year was also alluded to earlier, there was an extra sum of money that the Minister for Treasury identified to start doing some things a bit earlier than they would have been done, but because that was a one-off piece of money, the only things that could be done were things that did not involve recruiting new substantive staff. Because if you did not have certainty that you could then sustain them and keep them going, you could not possibly recruit new people. So the things that were done were scaling up of some things that could happen without bringing in extra staff, so coming up with a system that would provide a step-up intermediate care type of facility could be done on a temporary basis. We could scale that up, do it for a while and in theory you could stop doing it again but, in fact, it has been such a success that nobody would let that happen. Also, end of life care, doing more with family nursing to help people to be supported for terminal care in their homes was something you could do more of, even on a temporary basis with goodwill with our partner organisations. So it has been that kind of thing that was done upfront. Community midwifery is already happening in one practice, Cleveland Clinic is already running that model to very good effect and, in due course, it would be good to see that expanding out.

Deputy J.A. Hilton:

Where was the step-up care being given?

Medical Officer for Health:

I do not know the exact details of how that is done, but I think it has been a case of using some of the Health and Social Services care home type settings in a slightly different way. So they would not normally be used for that purpose, it has been possible to provide people with care who either were just too unwell to stay at home but did not need acute hospital care, and could be looked after in a different setting by the G.P.s with an arrangement made to make that happen, or people who were in hospital who did not need acute hospital care any more but who were not really ready to go home, either because they were not ready to go home or there was nobody at home to give

them any sort of support and it would just be too difficult. So it has met that half-way house, and it has proved the concept, it has proved that if you have that it is really effective. That is the kind of thing you can do on a temporary basis, but it is certainly in the plans to make sure that that is rolled out and sustainable in the next set of services specs, et cetera.

Deputy J.A. Hilton:

Thank you.

The Deputy of St. Ouen:

The department kindly provided us with a number of slide presentations which I think they have used previously, and one in particular focused on the commissioning cycle.

Medical Officer for Health:

Right. I have not seen that one.

The Deputy of St. Ouen:

As owner of 2 of the F.B.C.s, namely Children's and Alcohol, what confidence can you give us that all the relevant analysis has taken place to allow for the identification of appropriate services that will ultimately be specified and then put out to tender?

Medical Officer for Health:

It is as well-developed as it can be because the O.B.C. (Outline Business Case) process, in terms of determining the numbers of people in need of the alcohol intervention type of approach is one aspect, and the number of vulnerable families has been quantified both from what is known locally and what is known from evidence from other places. So that is the sort of needs assessment end of it. You are saying what is the actual need in the population, so even before that, it was the need in the population that got those particular workstreams accepted as priority areas for development and investment.

The Deputy of St. Ouen:

I hear exactly what you are saying but, for instance, part of the process includes analysis of providers, so if I said to you: "Right. Can you provide me a list of all providers that support the children's F.B.C.s that you are responsible for?" would you be able to provide me with a comprehensive and complete list?

Medical Officer for Health:

I do not think so because I have not been involved in that level of detail. I think that is probably at the next stage, because what is happening is if you develop a service specification, part of the

decision in the first place is you decide what you want to be delivered, you determine what the evidence says is needed and then you put that out and say who is available.

The Deputy of St. Ouen:
This is the information that we have been provided from the department and it is quite clear it starts with a process, which is an analysis, then it moves to the plan, which is the next step, which is the commissioning and service specification, service design.

[12:30]

Then it moves on to how you do it, implementation. Then finally the last section is: "Right, how do you make sure that what we have got is hitting the mark and is delivering the improvements that we are looking for?"

Medical Officer for Health:
That is right.

The Deputy of St. Ouen:
So again my question to you is: if you are saying that you and your group have not had or cannot consider all of that basic information, how then are you able to move on to the next step of determining where the gaps are in the services and who is most likely to be able to provide it; whether it is the Health Department or indeed the voluntary and community sector?

Medical Officer for Health:
The way we have started about it is to analyse what the need is and where the pressures are, what is the health issue that you are trying to address and tackle and make better and then to work out what a service would look like with all the parameters for what outcomes you would expect, what sort of standard of clinical governance you would expect, what quality. It is all about getting value for money for the bit of money that we would be investing in a particular thing. Once that is developed, once you say: "This is what we want. This is what we are prepared to pay for it" then you get expressions of interest from people and organisations who believe they could provide it. It is at that point that all the range of possibilities, be it statutory organisations, voluntary and community organisations et cetera, who look at the service spec and think: "Yes. We could do that." So it is a very inclusive thing that means that things are available for anybody who is in a position to provide that service to say: "We wish to engage with this and become part of the tendering process."

The Deputy of St. Peter:

I can see where you are coming from there, but earlier we were talking about chicken and egg, and if you take what you have just said from the perspective of the service provider, rather than you saying: "Here is what we would like. Come forward if you think you can" they may feel that: "But here we are, we are doing this, or something akin to that, so would you not like to come and talk to us and find out more about what we are doing?" Has that not gone on in your gap analysis?

Medical Officer for Health:

That is what has been going on all the while, there have been all of these consultations and engagement events and meetings with the different organisations to find out as much as possible, but I do not know of anybody who has been left out altogether; tell me if they have. But all of these ...

The Deputy of St. Peter:

One of our survey results: "Do you feel your input to the full business cases will make a difference?" under "children", it says: "83 per cent of respondents said no."

Medical Officer for Health:

Is that people who are engaged in the process or people who did not come to the party? That would be interesting to find out and cross-refer that.

The Deputy of St. Peter:

That is one of the reasons why we conducted this survey because we wanted to find out why there was a such a drop off in numbers of people who began attending and felt disenfranchised and did not continue attending because they did not feel that they were being listened to.

Medical Officer for Health:

That is a very surprising statistic because of all of the things, having gone through this laborious and intensive process over a number of years to take on board all of the views and then get a political engagement through the proposition being voted through by the States, and getting the money voted for it, for the first time in quite a long period of time there is new money to start doing something entirely different. If people do not think that that is going to come to fruition and be delivered more than in the past when there has never been money behind new initiatives in this way, it is very surprising to me.

The Deputy of St. Ouen:

I do not think anybody needs convincing that we would like to see improved and better, more efficient health service on the Island, and you are right to say that some money has been

allocated, but there is no guarantee that future funding will be provided to the level that has already been identified for phases 2 and 3, so there is still a piece of work that goes on to work out how both the hospital, that is £400 million or £500 million, and the ongoing requirements to meet for this new redesigned health service, will be provided for. Those are commitments that have been made and both the States and the public are well aware of them. But I would just like to come back to commissioning because I personally would like to really understand the process that you have gone through, because I maybe have missed a point somewhere, because this is another paper that was provided by the department to us which is all about understanding commissioning, and it spells out the steps that will be undertaken to achieve certain providers at different issues. The first one says: "Understand the health and social care needs of the Island" I think which you clearly say.

Medical Officer for Health:

That is right. That is our job in Public Health, we provide that.

The Deputy of St. Ouen:

Then it says: "Identifiying what services are currently provided, where and by whom." That is very clear, because obviously if you do not know that, well, how do you move on? Then it says: "Understanding where the gaps are." It then says: "Agreeing where things could be done differently or better" then: "Identifying the outcomes that we need to achieve" then, and only then: "Developing service specifications, tendering for services, monitoring the delivery of services and then supporting service providers to enable them to deliver the outcome." So there are some clear steps that have been outlined in the process which is in plain English and everyone can understand it. If I asked you as the owner of 2 of the F.B.C.s, to provide this panel with evidence that these particular steps have been followed so that we could all have some confidence that the work (and there is no doubt that there is a significant amount of work being undertaken by the Health Department) has been carried out, that you would be able to do so?

Medical Officer for Health:

Yes. As part of all of this process in terms of seeing what is already being provided, it has been from that process that we are aware that ... just taking one example, we know that Brighter Futures does a lot of very good work with some vulnerable families, but we know that they are not either geared up or equipped to cover the whole Island. We also know that there are a lot of good things happening in health visiting through Family Nursing. We know that there are lots of good things happening through the hospital, and some families having support through the hospital side of things, Children's Services. Lots of different things are happening but, nonetheless, there are some vulnerable families who are not getting support, and it is a case of, having determined that there is a gap and there is a need, then to work out: "Okay, what do we then want?" What would

look like a good service that could be equitable for all families with vulnerable children, not just some who turn up in one camp and some who turn up in another, and to come up with something that is more comprehensive with less likelihood of vulnerable families and children ...

The Deputy of St. Ouen:

Just to explore the comment you have just made that Brighter Futures are not extending services to cover the whole line ...

Medical Officer for Health:

I did not say that all. What they do at the moment was obviously part of the stock-take, if you like, of what is currently happening in the Island, which refers to one of the steps in the process about understanding what is out there at the moment. So that has been very much part of the process. But there have been no assumptions made about who could do things differently or more of or whatever, that is for the next stage.

The Deputy of St. Peter:

Going back to our fabulous survey, there are a couple of really interesting points perhaps to raise with you that might help assist this point. This is going out to everybody who has taken part and decided to respond to our survey so far: "How would you rate your overall satisfaction with the process with the full business cases to date?" 53.8 per cent said they were somewhat dissatisfied with 23.1 per cent saying they were somewhat satisfied, and nobody answering that they were very satisfied. Another really important one to flag: "Following the full business case process to date, how likely is it that you are going to continue working with Health and Social Services?" 33.3 per cent said: "Very likely" 33.3 per cent said: "Somewhat likely" but 13.3 per cent said: "Very unlikely."

Medical Officer for Health:

It is interesting. My own sort of feel for the period of 3 months when all the full business case workshops were going on, was one of concern that it was so intense that the people who are most involved in it would possibly feel almost a sense of burn-out through being so involved in so many different meetings about diverse things. Just to use one example of that ... the elephant in the room is always the funding of G.P.s and the fact that G.P.s, in order to keep their businesses running, have to keep seeing patients, and there is no other way of a G.P. playing their part in the practice by not being there and seeing patients in surgery or in their homes. So to expect G.P.s to come to meetings when they would otherwise be earning money for their practice, is something that is very difficult to make them do. It has turned out that there was only one G.P. who was prepared to come to the workshops and that one G.P. went to all of the workshops and, in a matter of a few weeks, found that that was far too much to cope with. Nobody could cope with that, it was

far too much. It was very noble of her to try to do that and to put time aside and cancel every other commitment to do it, but it was almost destined to go wrong. Because that is just too much for somebody to be expected to do. So there was a problem. The other G.P.s out there, I spoke to many of them; we had a Jersey Medical Society Symposium all about surgical issues, in November, and lots of the G.P.s were there. I just took the opportunity to express my concerns to a number of them that this process was going ahead and there were so many opportunities in it for G.P.s to influence it, and I was really concerned that there were not enough G.P.s; well, there was one G.P. who was trying to spread herself so thinly and do so much. They were all saying: "We would absolutely love to do it, but we have just got this problem; we cannot leave the practices because of the fact that we are expected to do our share of the work in the practice. There is not any other way of saying somebody can leave and put time into these processes. But they were concerned as well that something was sort of moving ahead in a way that they did not really understand, but nor did they have the physical ability to separate themselves from their practices to take part in it. I can see why some people would be expressing ...

The Deputy of St. Peter:
What was done to address that issue?

Medical Officer for Health:
What was done to address it? Well, there have been all the way through meetings in the evenings, Tuesday evening meetings to invite all the G.P.s to come and have ... it goes further back than that, there have always been primary care engagement meetings where G.P.s have come together, and there would be presentations to keep them fully up to date with everything that was happening. Sometimes there would be a good turnout, if it was something that had possibly immediate implications for how they might be paid, it had a better turnout than when it did not, but it is one of these things that it was not just at that point that it was clear that we needed to offer the G.P.s the opportunity to come in in the evening. But that was scaled up a bit more, and it has been scaled up even more than that. Rachel Williams and Tara Murphy, who was working with her at the time, has been out and running events in the hospital where people could call in at lunchtimes to get latest updates. But they have also been visiting all the practices, going to practice meetings and updating the G.P.s at their own practice meetings on where it had got to and taking feedback. So I cannot imagine that more could have been done, unless you had said: "Well, let us take a year to do it and let us put these workshops on some evenings, weekends", and that sort of thing. It is hard to see how you could do it and then, faced with that balance between the urgency of getting these things started, because the gaps are still there. The vulnerable families are still out there not getting support that they could do with having, and the money is waiting there to pay for it once the service model is agreed. The people who are hazardous drinkers are still hazardous drinkers and developing liver disease and possibly dying

early, who could be getting upstream help to head it off. The money is there once the service spec is agreed; once we roll it out, people can physically start getting help and support that is not in the current system. So it is frustrating to try and get the balance right.

The Deputy of St. Ouen:
I hear what you are saying but it does seem rather strange that previously you told us that this process could be traced back to 2004, 2007 with New Directions.

Medical Officer for Health:
New Directions was a different thing, it was a different administration.

The Deputy of St. Ouen:
Then obviously the process was restarted back in 2010 and for even a member of the public it is clear that the G.P.s play a significant part in the health services provided on this Island. So to suggest that it is somehow rushed and that they have not been allowed time, I am just wondering why was that not taken into account at the very beginning and why was it not made clear about some of the impacts and the issues identified by the department itself (because obviously they are the professionals) the sort of issues that the G.P.s would have to consider moving forward? Because even down to funding, they say the issue of funding still is unresolved, and it will not be resolved for another 2 years.

[12:45]

It seems ridiculous that we are basing a new redesigned health service on something that is going to support far more clearly the community, we hope, and yet we are almost falling at the first hurdle.

Medical Officer for Health:
Well, if it is falling, it is the last rather than the first because the process has been, as you say, over a period of more than 3 years now. G.P.s have been very involved throughout. Nobody is any doubt about the principle of whether these are the right things to be doing, or the general principle that change is needed. The devil is now in the detail, and the detail came with the F.B.C. process and the inevitable intensity of trying to work up 30, approximately, service specifications for detailed things, and that is where I think people have felt that it was not possible, from a G.P. perspective, to engage at the detailed stage and they are feeling anxious about that.

The Deputy of St. Peter:

We are not just talking about the G.P.s, we are talking about stakeholders who have taken part, and there are a significant number of stakeholders from the voluntary and community sector, as well as the commissions. But you heard our earlier hearing and there was still some concern about the community aspect and what was the right level for Jersey, and I think the Medical Director pointed out that it is a small easily manageable geographical space, therefore it makes sense to have some services in a central location and you do not need to be as spread out as, say, Norfolk. It is an obvious practical position. I think we just need to move on, but I think the yes or no answer is: are you aware of concern about the full business cases within the voluntary and community sector?

Medical Officer for Health:

Not directly, because they have not come to me directly about it. In fact, the detail of what you told me was a surprise to me. The people who did give up their time to take part in it and fully engage in it will not be those people who are concerned about it. They may have been concerned about the impact it had on their other commitments, because it was a huge amount of work that people were being asked to do, and the G.P. who took part in most of those pieces of work is one example of where it obviously was not sustainable for one person to try to cover all of that. So it may be that other people who felt intensely pressurised because of having ... it was a really big ask, what was asked of people, but it was that balance between the urgency of getting something ready to make it start happening against the urgency of getting it right.

The Deputy of St. Ouen:

Can I just move a little bit outside of the role of being owner of 2 of the F.B.C.s to your day job, which is you are Medical ...

Medical Officer for Health:

Officer of Health.

The Deputy of St. Ouen:

Officer of Health. Thank you. what role do you see yourself fulfilling as Medical Officer of Health with regard to communicating with all of those, whether they are in the private or public sector, that are involved in, obviously, delivering medical services?

Medical Officer for Health:

Just to say at a slightly higher level what my role is in this as Medical Officer of Health, and my biggest concern is for the population of the Island and whether we have got a safe and sustainable health system. On the current trajectory we have not, so it is very obvious from a public health

point of view that we need something different to be happening. So that is the top level. On the issues that are pressing needs to have investment in, I, as you know, frequently speak on the subject of the impact of alcohol on the Island, not so much on the children's side of things, so I am not a paediatrician and I am not a Children's Services expert, I am a public health expert so my connection with that as a professional is more remote. I am the Corporate Director with an interest in it, but I am not involved in any way in delivering the services. In terms of the actual communication with individual stakeholders, I could not possibly do that as an individual because this is just one ... well, it has been a lot of work, but it is one small component of my total workload. So the project lead, Andrew Heaven, has been very involved with all of the stakeholders, because he has been physically running the workshops and facilitating them and writing up all of the outcomes and feeding them back and re-writing things. So he is intimately connected with all of the stakeholders who have been initially invited and then those who did engage in the process. So it is a level thing; it would be lovely to do everything, but it is simply not possible to speak to every single person. Yes.

The Deputy of St. Ouen:
In your role as Medical Officer of Health, is it part of your duty to communicate with a range of health providers on the Island?

Medical Officer for Health:
No. My duty is to, number 1, run the Public Health Department, number 2, be an effective Corporate Director in Health and Social Services and play my full role as that and, number 3, be the Chief Medical Adviser to the States of Jersey. If I was concerned about this process being a wrong process or a dangerous process or an unsafe process or not the right process, I would have been saying that at a very early stage.

The Deputy of St. Ouen:
Right. Thank you.

Medical Officer for Health:
I could not imagine a more robust, effective process to reach where we are today from where we were 2 and a bit years ago, than has been the case, and I am glad to have been involved in it, I am proud to have been involved in it. So really, from the top level, while I cannot possibly talk to individuals ... if individuals want to talk to me my door is very open, and I do talk to people who want to talk to me all the time about all sorts of things. So it is that way round, it is top level, it is taking the population's needs and priorities and pushing to get the right things into the workstreams then taking high-level responsibility for them, but being prepared to flag up if I feel that something is not right.

The Deputy of St. Ouen:

Right. So can I ask you, how do you currently monitor the outcome of the various health services provided on the Island?

Medical Officer for Health:

Well, at the very top level we look at death rates and disease rates and compare ourselves with other relevant jurisdictions or parts of them. So for instance, cancer rates, we look at cancer survival rates compared with the south-west region of England and we find that our survival rates for all of the range of cancers is either as good as or better than the rates in the south-west of England. That is a bit of a blunt instrument, but it does tend to suggest that our detection of cancer and the treatment that people are getting when they get it is as good, if not better. If you look at the treatment for skin cancer, for instance, our death rates and survival rates for skin cancer are very much better than the south-west region of England, even though our actual rates of that type of cancer are much higher. So sunshine, skin cancer, but detected early, treated effectively, much lower death rate. So that is just one example, but it is things like that that show us our outcomes across a whole range of medical conditions.

The Deputy of St. Ouen:

I heard somebody the other day talking about dementia, this was on the radio, and they could not identify or talk about real numbers, they used and continued to refer to comparators with regard to using a U.K. model and perhaps linking to our 2011 census. Were they misleading us in believing that that was the case or is there far more robust information that you as the Medical Health Officer can rely upon to be able to turn round to the public and the States and say: "Right, this is the picture now with regards ..." whatever the service may be: "this is what is proposed and I can assure you that if this service is delivered in this manner we will be able to not only see better outcomes, but be able to properly identify them."

Medical Officer for Health:

Yes. Things like death rates due to certain conditions and hospital admissions due to certain admissions are things that we have the data on. What we have not got at the moment is data on all of the diagnosis in primary care. We will have that, the G.P. central server, which is due to go live later this year, is all on track to do so, and it is going to be the first time ever that we are going to have access to anonymised data about medical conditions across the whole population. So I am excited about that. It has been something that has been again a few years in the pipeline to get that happening. That is through the good offices of Social Security funding and supporting the development of it through the Health Insurance Fund and we are going to have access to data about things that do not always come to hospital attention. Because dementia is not a cause for admission to acute hospital, it is a need for long-term care, quite often, but it is not something that

will figure in the acute hospital statistics, and it is not necessarily a cause of death, because when people who have dementia die, it is often a different cause of death that is recorded on the death certificate. So that is a very good example of something that we have not got fantastic data on the whole picture at the moment, we have just got some snap shots of what happens in terms of long-term care. But we now have much better data, once we have got access to that, and it will not be data about individual people with names, it will be data that I will have access to in terms of total numbers, age ranges, possibly even what areas of the Island people live in, in case there are any differences between different parts of the Island and ...

The Deputy of St. Ouen:

We will have similar comprehensive data flowing from the hospital itself.

Medical Officer for Health:

That is right. Yes. So it is all as good as it can be or as good as it is at the moment, but there are developments in the immediate offing that are going to make things much better.

Deputy J.A. Hilton:

Can I just ask you a question about that: you just mentioned about you will be developing or you will be receiving data that you can pinpoint to certain places in the Island.

Medical Officer for Health:

Yes. If we have got post codes, so long as we are here, we do not want people's names unless the screening programme want to call people in, but if it as about disease patterns, anonymised data is what we deal with.

Deputy J.A. Hilton:

Is there any evidence to suggest that the rate of cancer is higher within a certain radius of the old Bellozanne incinerator?

Medical Officer for Health:

No. That was a States question this week, was it not?

Deputy J.A. Hilton:

Oh, was it?

Medical Officer for Health:

Yes. I am sure there was a question this week on that subject, but basically we have mapped cancer data, we did not have complete data for post codes, so we had about 50 per cent of the

post code data. What it showed us is that the vast majority of cancer diagnoses are where most people live, so town, a cluster over at Quennevais, a bit of a cluster out towards St. Clement but, really, it only showed us what commonsense will tell you. Where your cancer is diagnosed as well, where you live at the time of your diagnosis, does not tell you anything about where you have worked all your working life or if you have moved from somewhere else where you have spent most of your time, possibly, exposed. So we tried to do it but because of small numbers and because most people live in certain places in the Island, it does not tell us anything very useful, which is ...

Deputy J.A. Hilton:

Can you tell me as an exercise have any of the employees of Transport and Technical Services who have worked at Bellozanne been tested on a regular basis and are you receiving data from that?

Medical Officer for Health:

I really do not know what the occupational health issues are in terms of what T.T.S. (Transport and Technical Services) does for the staff, I really do not know, but it has never been brought to my attention or raised as a concern.

Deputy J.A. Hilton:

Thank you.

The Deputy of St. Peter:

Do you have any further questions?

The Deputy of St. Ouen:

One last one, and it is regarding the Jersey strategic needs assessment, and we understand that is being developed at the moment. Can you just explain briefly what that is and whether it differs from the health profile for Jersey that you mentioned earlier?

Medical Officer for Health:

It is a bit of a title that has got many parts underneath it. It is to do with part of the Public Health Department's function is to understand the health of the population, so the health profile is the beginning part of that. But what we know about health is not everything: there will be data from the Housing Department, data from the Education Department, data from other parts of the state which, using the term "health determinants" we know there are things about education and things about housing, things about crime and disorder, that can tell you something about the health of your population. So our intention is to have a programme of not just looking at the health data but

wrapping round more needs assessment. We have had a vacancy on the Health Intelligence Team, but we have recruited somebody who has got relevant skills to start being the project lead on a programme of strategic needs assessment that will feed into the other things that are going on in the Island. But you cannot do everything at once, you could not possibly do that level of analysis for each range of conditions all in one go, but what we can do is start to have a system for pulling together not just health data and the health profile, but having what is ... if you look over the water in England, they have some quite good ideas, and one of them is that public health directors are part of local authorities as much as they are part of the health service. In fact, when I was Director of Public Health in Bournemouth before I came here to work in Jersey, I was jointly appointed between Bournemouth Borough Council and the primary care trust, which meant I was on the executive board of the local authority, which meant that every week I would be at a meeting with other local authority directors who would be bringing forward their reports on housing, transport, leisure, education, all of those things. I had the ability to influence all of those things at that table. We are not necessarily there at the moment in Jersey, although I am sure if I went knocking at anybody's door, they probably would be very happy to have a dialogue. But if we start sharing data and collating data together, I think it will move in that direction of working more collaboratively across States departments.

The Deputy of St. Ouen:

It is a high-level document, basically.

Medical Officer for Health:

It is a programme of work, it is not a thing.

The Deputy of St. Ouen:

Obviously this programme of work is in a report ...

Medical Officer for Health:

That is right, yes. Heath profile.

The Deputy of St. Ouen:

So presumably there will be an end report.

Medical Officer for Health:

It will become part of a public health report on the health of the Island.

The Deputy of St. Ouen:

When can we expect to see the first one?

Medical Officer for Health:

The first version of that, probably next year, given all the work that we are doing at the moment. We are only a few people so there is a limit to what we can do all at once.

The Deputy of St. Ouen:

It has mentioned in a proposition and designed to support the F.B.C.'s process.

Medical Officer for Health:

Let us say we have built out the capacity to be able to have extra workforce to start on the programme and to start having the dialogue with other departments. Watch this space.

The Deputy of St. Ouen:

Thank you.

The Deputy of St. Peter:

We look forward to receiving that and thank you very much for your time for today's meeting.

Medical Officer for Health:

Thank you very much.

[13:01]