States of Jersey
States Assembly

États de Jersey
Assemblée des États

Health and Social Security Scrutiny Panel

Quarterly Meeting with the Minister for Health and Social Services

THURSDAY, 11th FEBRUARY 2016

Panel:

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

Deputy T.A. McDonald of St. Saviour

Witnesses:

Senator A.K.F. Green, The Minister for Health and Social Services

Deputy P.D. McLinton of St. Saviour, The Assistant Minister for Health and Social Services

Hospital Director

Medical Officer of Health

Director of System redesign and Delivery

Ministerial Support

Director, Services for Older People

[10:01]

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

Welcome, Minister.

The Minister for Health and Social Services:

Good morning, thank you.

Deputy G.P. Southern:

And first of all my apology on behalf of my Chairman, who has another meeting.

The Minister for Health and Social Services:

Yes, can I add 2 apologies as well. My chief executive, Julie Garbutt, and Assistant Minister, John Refault, they are both attending a Council of Ministers'/Corporate Management Board meeting.

Deputy G.P. Southern:

We are honoured then.

The Minister for Health and Social Services:

You can just see how important scrutiny is to me.

Deputy G.P. Southern:

Thank you, if we can do the normal things. I will just point out to you, you know what the rules are. The rules of a witness when you are giving evidence here. I welcome you to the quarterly meeting of the Health and Social Security Panel. I am sure we have got a lot to discuss. If you could just introduce yourselves.

The Minister for Health and Social Services:

Okay, we will start with me. Senator Andrew Green, and I am the Minister for Health and Social Services.

Deputy G.P. Southern:

All right then. We do appear to be the star turn of the moment this week. We will start with the hospital site, if you would like to tell us what the situation is there and, in particular, if you could fill us in on the costings, please?

The Minister for Health and Social Services:

On the costings they will be in round figures, but I am sure they will be good enough. I do not think I am going to tell you anything, Chairman, that you do not already know. As you know, we have looked at 40 sites, they have been rejected for a number of different reasons, either because the infrastructure was not available or you could not shoehorn the hospital in there or it would have been too high for that part of the Island. A whole host of different reasons. It has got shortlisted down to about 9 of the original shortlist and then more criteria was added to that and now we are down to 4. The dual site which had been chosen before I became Minister, and in fact it was part of my election campaign to review it. The dual site is not up for consultation but I have left it in the information so that people can do a comparison. The dual site was estimated to have been under £300 million, it would have provided a facility on the current hospital site and a new facility up at Overdale. So a repurpose of the current site and a new facility at Overdale. However, when the true costs were understood, not only the state of the current building but also the building cost inflation that had happened in the intervening period, it would have been in excess of £500 million

and that would have given you the second most expensive option if it had been on the table and clinically a less acceptable hospital because it does not take the brain of Britain to work out we are a small hospital compared to the U.K. (United Kingdom). It is big in Jersey, it is the biggest project we have ever done but it is a small hospital. In terms of the dual site, if you have consultants running clinics up at Overdale and you have a medical emergency down in the general hospital, they would all just pile in and help each other out, they would have to come down the hill. So clinically, and for a load of other clinical reasons, it was not the best option. So despite the criticism I get, the dual site does not work. What has been the challenge is coming back with something that does work. We have now have 4 sites on the table: the current site, that is a 12 year building plan, if it were to happen. Clinically it does not give you the best outcomes but, for example ... I mean we use jargon like clinical adjacency. What we mean is if you can imagine that certain things are best if they are situated close to each other, or indeed some things are best if they are situated away from other things, if you were to take the current site, we have maternity theatre, we have general theatres and we have day surgeries, all of those have their own recovery rooms at the moment and your top expert consultant anaesthetist, and we have many good anaesthetists, cannot be in 3 places at once. If you had all those in one place with one recovery room and the other theatres adjacent to that - it is just one example, one that I remember very clearly - then your main man [consultant] can keep an eye on everything that is happening that day. But those of us that have done up old buildings know that even if we were to overcome the clinical problems that you would be revisiting the refurbishment of that hospital much earlier than you would be in a new build. For my sins I have done up a 18th century cottage and a friend in a similar circumstance put a bulldozer through theirs and rebuilt it. I am still working on mine, they are enjoying the luxury of it without having to go back and redo things because old buildings constantly - no matter how well you do it - need working. It is in my presentation that you will see tonight and you may have seen at the States building as well, on the adjacencies of the building as well. If you were to look at examples in the U.K. where piecemeal development had gone on, that is not a good way to build a hospital. We know that is not right. But the current site is an option, but not the best outcome, and it is circa £600 million and 12 years building. So that means people, for example, coming in for dialysis, chronically ill people visiting the hospital will be coming into a building site for 12 years to not get the best outcome. I think that sums up that one. So let us look, the Waterfront gives you a good hospital, no doubt about that. The challenge there for me is the parking because ... just to give you an idea of the site that we are talking about, it would be as high as the Radisson. It would run from the Radisson to Le Fregate and right back to the road where the cinema and the restaurants are. There are very challenging technical things about providing underground carparking. It can be done but not enough so patients will have to walk from Patriotic Street to the hospital. There was a big drop in points for that. But it was a good hospital and that is the sort of choices that people are having to make. Overdale gives you a long thin hospital, it does not give you all the clinical adjacencies that you would like because of the

longness of the building and access is really, really difficult. We knew that when we started. I wanted Overdale, I thought we could overcome the transport difficulties. Some could be improved but it will be doing some major roadworks and that might mean widening roads where the cemeteries are, for example. But it is not clinically the best outcome and that is circa £420, 430 million, I cannot remember the exact price.

Hospital Managing Director:
It is 427, you were about right.

The Minister for Health and Social Services:
£430 million. Then we have the Waterfront which is a flat site, easy to develop ... sorry, People's Park. Flat site, easy to develop, parking can be provided underground there easily as well, public parking. It is the quickest built, 6 years. Overdale is ... it is about 6 years for Waterfront, Overdale and the People's Park, they are all about the same. It is the cheapest built. Let us be clear, because there seems to be some confusion, what we call the compensatory space, I think that is a bit confusing to say that. I think the land swap that could be available on the table to provide another park or parks has been costed in to that scheme.

Deputy G.P. Southern:
What are those costs?

The Minister for Health and Social Services:
Those costs are around £400 million, £444 million.

Deputy G.P. Southern:
What portion of that 444 is ...?

The Minister for Health and Social Services:
Sorry?

Deputy G.P. Southern:
What proportion of the 444 is, do you believe, compensatory?

The Minister for Health and Social Services:
I do not know the answer to that to be honest. I have been told, I cannot remember. I can remember what the price was for one of the hotels which would be part of the compensatory space but it would not be fair to announce that publicly when you are discussing that with the owner, who is a willing seller. So I could come back to you on a confidential basis on that one.

Deputy G.P. Southern:

That includes a patch down at Gas Place?

The Minister for Health and Social Services:

Well, I think it is a bit more than a patch, it includes extending the park from the current order of the park through to St. Saviour Road.

Deputy G.P. Southern:

Has that got building permission on it?

The Minister for Health and Social Services:

Not yet, but of course it will have probably by the time we get around to talking to the owner. As I understand it, the owner is a willing seller but, of course, if it has got building permission that sets the value of the land and it is on that basis that the estimated cost to us has been worked out on.

Deputy G.P. Southern:

It is worked out as ...?

The Minister for Health and Social Services:

As a building site, a site with building permission, although permission has not been given yet.

Deputy G.P. Southern:

So that is quite significant, is it not?

The Minister for Health and Social Services:

Yes, I mean you have to allow for that because since they have put in for planning permission there has been an inquiry in public, or a public inquiry, I am never quite sure ... they are slightly different but they mean the same thing to us. The Minister for Planning is compromised because he is the one that said no to the first one so there has been an appeal and that report needs to come back and another Minister - because the Minister for Planning cannot - needs to make the decision. I am pleased to say that was meant to be me but because I would be compromised as well now as a potential buyer, I am pleased to say I do not have to make that decision.

Deputy G.P. Southern:

Coming back ... I think I have been through this with members of the public but I did not ask this question, I think it is fairly central, is you appeared to have spent something like £2 million and you

still have not decided what ... you could have come with one site and said: “that is the best site, here are the reasons.” That has not happened.

The Minister for Health and Social Services:

No, I could have done.

Deputy G.P. Southern:

Can you tell me something about why that has not happened?

The Minister for Health and Social Services:

I absolutely justify the £2 million just on the basis had we proceeded with the 2 sector hospital instead of spending £270 million we would have spent in excess of £500 million to get a second rate hospital. So I think the £2 million is more than justified. Even if it was not for that, £2 million in a £400 million plus project is ... it is a lot of money but as a percentage of the scheme, it is quite low and considerably lower than you would expect to see. The U.K. would spend considerably more than that in determining the outcomes. So we have looked at the pros and cons of different sites. You know, this is a hospital for the people of Jersey and there are compromises to be made. We want to do this hospital with the people not enforce it on the people, which is why we have gone out to the consultation.

Deputy G.P. Southern:

Would you like to explore some of those compromises?

The Minister for Health and Social Services:

Well, I have explained them to you. You have speed of build on some sites, which you would not have if you renovated the current hospital. You have better clinical outcomes.

Deputy G.P. Southern:

That is important. That is where the build is important because the hospital is crumbling.

The Minister for Health and Social Services:

Yes, absolutely. The hospital is in dire need ...

Deputy G.P. Southern:

It is not fit for purpose.

The Minister for Health and Social Services:
It is not fit for purpose as we saw in the 6-facet inspection recently where they looked at 6 facets of all of our buildings, you saw that as States Members, our presentation. Without exception the buildings are either ... need replacing within 3 years or are not suitable for use today.

[10:15]

Apart from the administration block and the porter's gate lodge at the entrance to the carpark. While I have used that as a point of comedy in some of my presentations, that is because they are not clinical areas, that is why they are just about serviceable as they stand.

Deputy G.P. Southern:
Sure. Carry on.

The Minister for Health and Social Services:
So the access obviously is improved on some sites compared to others, clinical adjacency, that important work flow is improved on ... well the best clinical adjacency, whether we like it or not, is on the People's Park. You get acceptable ones in the Waterfront and you get workable but not as good at Overdale. So accessible, the rest of it, it is all ...

Deputy G.P. Southern:
What about the non-clinical arguments around that? The States does not own People's Park.

The Minister for Health and Social Services:
No, that is true. The parish own People's Park but that is not unusual for big important schemes to be developed on land or to be earmarked to be developed on land that other people own and discussions have to take place as to what that value might be, what the compensation may be if there is a different space to be provided or whatever. I think it would have been wrong to have built ... to have just said: "We are going to build not the best hospital we can build but we could have built the best hospital. But we are going to do this to the people not ask the people." We could build the best hospital, we could build a good hospital. People have to make those decisions on the compromises ...

Deputy G.P. Southern:
Are you saying that the hospital on People's Park is the best hospital?

The Minister for Health and Social Services:
It is clinically the best, yes.

Deputy G.P. Southern:

But what if the people of St. Helier decide that they do not want to sell it?

The Minister for Health and Social Services:

That is a discussion we would have to have with the people of St. Helier. We have a meeting tonight, as far as discussions with the Constables. But I am hoping that people will listen to the facts and if it is just too much for the people of Jersey, if it is just that step too far and they are prepared to compromise, that is fine. We have a workable scheme on the other sites.

Deputy G.P. Southern:

Workable or good?

The Minister for Health and Social Services:

No, workable. Varied from workable to good.

Deputy G.P. Southern:

Okay. The non-clinical arguments around the Waterfront site?

The Minister for Health and Social Services:

How do you mean, non-clinical?

Deputy G.P. Southern:

You mentioned ... you are saying the best one is on People's Park, the ...

The Minister for Health and Social Services:

Yes, clinical adjacency is what I want to achieve for the hospital. So I do not know what you mean by non-clinical ... apart from anything ...

Deputy G.P. Southern:

Is there not ...

The Minister for Health and Social Services:

Access? We talked about access. Access is difficult at the Waterfront but can be done. People will have to come from Patriotic Street. Access is not bad from People's Park because you could put underground carparking, public underground carparking, but it is not much further from Patriotic Street than some of the current buildings. Access at Overdale I think will be challenging and will take out a number of fields to provide carparking because the experience we have gained

from places like Milton Keynes, Addenbrookes, and I cannot remember the name in France where they built out of town. It does not matter how many free buses you put on, the majority of people are going to turn up in their car. So it is not just the patients turning up in their car, but the staff as well. They need to have somewhere to park.

Deputy G.P. Southern:

Is the Waterfront not due to have a financial centre there?

The Minister for Health and Social Services:

It is having a financial centre, this is to the side of that.

Deputy G.P. Southern:

To the side of it, and there is not a parking problem with a massive finance centre?

The Minister for Health and Social Services:

They have underground carparking, but the carparking there at the moment is full. They are putting more carparking there as part of the finance centre. If you are going to put a hospital there you cannot ignore that because people will need somewhere to park. I am talking about elderly and disabled and mums with babies.

Deputy G.P. Southern:

That is insolvable?

The Minister for Health and Social Services:

I am not saying it is insolvable, nothing is insolvable but we have not costed other than the basic parking, we have not costed ... so we can compare sites like with like, we have not costed parking.

Deputy G.P. Southern:

Has there been a debate at the Council of Ministers around value of the Waterfront site? Is there a foregone assumed profit from doing something else there?

The Minister for Health and Social Services:

In our calculations the loss ... the value of the loss from what you might have been able to get had you not developed it as a hospital, that has been included in the cost.

Deputy G.P. Southern:

Has been?

The Minister for Health and Social Services:
Has been included in the cost.

Deputy G.P. Southern:
Okay, so the numbers include a foregone profit?

The Minister for Health and Social Services:
Yes. If you were to develop on the People's Park, so there is a cost for the replacement park, if you were to develop on the Waterfront there is an opportunity loss and that has all be costed in.

Deputy G.P. Southern:
I was wondering what the phrase was "opportunity loss". That is the one, magic money that you do not have ... have not seen yet.

The Minister for Health and Social Services:
Yes, but it has been costed.

Deputy G.P. Southern:
That has been costed, okay. There is some picture of what we are comparing there. Would you like to move on? In case you are wondering, that rehearsal was 20 minutes.

Deputy T.A. McDonald:
We will take the pressure off now and start talking about waiting lists. I will try to be gentle. It is very much a matter of huge public concern, waiting lists and so on. First of all, could we ask you to provide an update on bed closures?

The Minister for Health and Social Services:
Yes, okay. I will hand over in a minute but this is something I take a great interest in and I hope you will be pleased to hear that we do not have any ... we have one bed that has closed but that is due to renovation of that particular area, every other bed in the hospital is open.

Deputy T.A. McDonald:
Obviously the hospital is no longer on any sort of alert ...

The Minister for Health and Social Services:
No, we are not. But Helen could take you through that if you wanted to.

Hospital Managing Director:

Yes, certainly. The one bed that is closed is on Samarès Ward, while we are doing some works up there to expand Samarès Ward. That is due to finish about end of March, April time. The hospital is on green alert, if you can have a green alert so we have shifted considerably from the new year position. So flow through the hospital is good.

Deputy G.P. Southern:

What was the problem with ... the new year position?

Hospital Managing Director:

It was multi-factoral really, it was the fact that you are coming up to Christmas and the flow of the patients tends to slow down a bit, you are families that are away, you have got nursing and residential homes that are preparing for Christmas. We had some staff sickness which was key, so some of the people that helped move the patients out of the hospital had gone off sick the week before Christmas and that had a knock on effect. Also we had an increase in admissions. So as soon as we had gone through the 4 day bank holidays we had a higher level of admissions on those next 2 days than we had ever seen. So we had a lot of patients trying to come into the hospital.

Deputy T.A. McDonald:

Was there any reason so that subsequently ...

Hospital Managing Director:

There was nothing specific, it was not any particular bug or anything like that. We always know there will be more and that is predictable but it was higher than we had ever seen before. So there was nothing specific. It was just poorly people.

Deputy G.P. Southern:

What is the trend in terms of flu? Are we expecting a flu outbreak this winter or is it ... what is the prediction?

Hospital Managing Director:

I am going to pass that to my colleague.

Medical Officer of Health:

Well the traditional answer to that is the flu season extend so the end of March. So until the end of March we cannot sure that there is not going to be flu epidemic. Probably at this time of the year, there has not been sign of it, there is less likely to be but there is certainly quite a lot of flu like

illness bubbling around in general practice, so it has the potential to escalate. It is something that we definitely are vigilant about until April Fool's Day and we can say that is probably the end of the risk, but we cannot be complacent until then.

Deputy T.A. McDonald:

If it was to hit us next week or next fortnight, are we sufficiently prepared to cope with it?

Hospital Managing Director:

It could be flu, it could be any of the other winter vomiting type illnesses. We are as prepared as we can be. In terms of flu, we vaccinate our staff leading up to the winter period and we have had the best vaccination programme this year that we have ever had, so we have more staff vaccinated than ever before. If flu hits and if we have more admissions staying in the hospital, then we would do as we plan every year, and that is isolate where possible and if necessary we will have to look at taking down routine and elective surgery. That would be what every hospital would look at doing. Hopefully we will not need to do that.

The Minister for Health and Social Services:

You might like to talk to the Medical Officer of Health about our very robust plans in the event of a pandemic.

Medical Officer of Health:

Yes, as Helen has alluded to there is a plan for normal winter escalation but we have an even more elaborate plan which we put into action. In 2009 was the last time we had a flu pandemic, you have to be able to recognise different phases of pandemic and have anti-virals ready for distribution in the event of needing to contain the spread like we did in 2009 until a vaccine is available and then use the vaccine too. That successfully absolutely flattened the spread of the infection. A new pandemic is something that will happen again at some point. So you have to be ready for the eventually that that would happen. There is a new flu virus strain bubbling around in south-east Asia but there always is. The thing is in the new world where it is possible to have more testing available in many more parts of the world and also to transmit information from where a positive result has been found to everywhere else very quickly, we hear about these things quite regularly. The World Health Organisation is always ready to respond to any upsurge of human transmission of bird flu virus, which is still probably the main threat. I suppose the point to make is that it has not gone away and when it happens we are as ready for it as we will ever be.

Deputy G.P. Southern:

There is a new vaccine available, is there?

Medical Officer of Health:

When a pandemic flu strain is declared. So that will be a new strain that has never been seen before. The W.H.O. (World Health Organisation) then declares a pandemic and starts work on preparing the specific vaccine to that specific virus, which takes a period of around 6 months. So if you remember the pandemic in 2009 was declared in early May and it was early November when we got our first supplies. We had an advance purchase agreement with the vaccine manufacturers so instead of little Jersey being at the back of the queue, we were up at the front of the queue with the other jurisdictions with the same agreement. So that means we were able to hold the line throughout the summer and take the community with us to all do what we could among ourselves. You will remember the "Catch it, Bin it" campaign and the 48 hour rule that we engaged children and families in schools in that if people had been to pandemic affected countries such as England, when they came back to Jersey they did not go back to school for 48 hours so as not to start spreading possible infection if they were incubating it when they came back. So all of those things ... we were only really able to convince people that it was worth doing fairly inconvenient things because we knew we had the vaccine coming. There was a big surge of infection shooting up in the 2 weeks before the vaccine was ready for distribution, and then we vaccinated around 13,000 children in the space of 5 days and it flatlined after that. Had we not done all we did we were heading for about 22,000 cases of flu in the following month to 6 weeks, which would have been Apocalypse Now for Jersey.

Deputy G.P. Southern:

We are equally as prepared this time round or this year?

Medical Officer of Health:

Yes, we have the anti-viral stocked up. We are on the point, probably within the next week of signing the latest advance purchase agreement to make sure that in the event of needing to do exactly what we did ... that it is all ... all the ducks are in a row, it is all ...

Deputy G.P. Southern:

What is the cost of that? Is that in the budget?

Medical Officer of Health:

There is money available and I cannot remember what the exact amount is but it is like an insurance policy to have the advance purchase agreement. You pay a certain amount per year, but in the event of needing the supplies, that would be a much bigger sum of money and on the previous occasion we did that we went to central Treasury and made the case that the potential impact of the pandemic would be for Jersey as a whole, and not just an issue for the health department.

Deputy G.P. Southern:
It would be a contingency?

Medical Officer of Health:
Entirely and the Emergencies Council takes a view on it obviously. Among all of the risks in the world it is still the highest risk of catastrophe that is ... it will happen again and being as prepared as you can is the best thing you can do.

Deputy G.P. Southern:
Do you know how much it cost last time?

Medical Officer of Health:
Not off the top of my head, I can easily find out.

The Minister for Health and Social Services:
I vaguely remember us debating it in the States, but I cannot remember the figure. It is a lot of money.

Medical Officer of Health:
But you compare that with the cost of 22,000 people ill in a period of month, which would have overwhelmed the hospital within a week or less.

Deputy T.A. McDonald:
It is nice to hear obviously the hospital staff taking on the vaccination, what has the public uptake been like? Their response to it this year?

Medical Officer of Health:
Well, we have data back from the GPs suggesting that the take up of high risk people, with high risk conditions is about what we would normally expect, which is about two-thirds.

[10:30]

It would be better if it was a better than that but that is an individual decision to get the vaccine.

Deputy T.A. McDonald:
It is, yes. Two-thirds is ...

Medical Officer of Health:

Yes, it has been par for the course for countries like Jersey, but I would always like it to be better than that.

Director, System Redesign & Delivery:

I think we have also investigated different delivery mechanisms in terms of nasal flu vaccine for school children.

Medical Officer of Health:

The school programme, the new programme for the reception of year one, year 2 and going up to year 3 next year, is the nasal vaccine which is very popular with children. They like it, it just causes a little tickle. We got 75% uptake with that. So when children are protected it protects them from being ill and off school. It also protects their families and potentially even the wider community. The children are not ... children are typically known as super spreaders of viruses. So whenever ... if you look back at the 2009 pandemic, it was spread within schools that then seeded the rest of communities, which is why were so vigilant about schools here. So by protecting the children, we are protecting them primarily but we are also protecting everybody else. We have a very, very good programme starting off and already protecting the first 3 years of children at school.

Deputy T.A. McDonald:

It might be a silly question but obviously there are quite a number of people who have a real fear of having injections, or needles, et cetera, would I be right in assuming that obviously the nasal method would not be as effective on adults?

Medical Officer of Health:

At the moment it is not licensed for adult use. In terms of the clinical trials and the effect of those trials and so on to prove that it works have not reached the stage where it is approved yet for adults. As soon as it was it would be a potential option, but it does come at a slightly higher cost than the injection, but if there was a world where some people were not having injections for a fear of injections, they may wish to, I do not know, pay the extra cost to have a nasal vaccine as an alternative. But it is not a possibility at the moment because it is not a licensed product. These are all things that could be considered in the future.

Deputy T.A. McDonald:

That is it. Children are obviously getting caught seeing as they are high risk ...

Medical Officer of Health:

The vaccine is fully effective in children by the nasal route, so it is a wonderful thing to be able to do.

Deputy G.P. Southern:

The problem is there is probably 65 year-old men who do not seem so vulnerable like me. But moving on, can I take us on to the issue of vacancies, in particular nursing vacancies. When we spoke to you last I think we had the May figures where we saw that there was 101 vacancies on a head count of, let us call it, 1,000, about 10 per cent. At the time you said it was cyclical, seasonal, this is when we ... a lot of those 100 would have job offers we are waiting to fill, we are advertising for and that the magic market of 5 per cent vacancy is something that is a universally critical issue. We have just got the latest figures for January 2016 and I see that nurses and midwives are showing 187 vacancies on a head count of 1,000. So we are up to one in 6 vacancies, so things have got worse rather than better since we last spoke about it.

The Minister for Health and Social Services:

I will let Helen answer that one. I suspect what you are looking for does not exist. There is no policy of not filling vacancies.

Deputy G.P. Southern:

I never said that.

The Minister for Health and Social Services:

No, I am just making sure you did not think that.

Deputy G.P. Southern:

I only got these this morning and quite frankly I was shocked the number has gone up and I was expecting it to have gone down, and we wondered what the explanation is of that?

The Minister for Health and Social Services:

We want it to go down but I will let Helen explain.

Hospital Managing Director:

I am afraid you are one step ahead of me because you have the figures and I do not have. Without seeing the figures and without seeing what is making them up ... I would to check whether or not in the figures that you have ... yes, that has just been added to me. What I would want to check is whether or not in those figures we have accounted for people who we have recruited who are still waiting to arrive. So ... and I cannot answer this with any accuracy without going back and

having a look at those figures, which I will happily do, but we would sometimes report the number as whatever it is, 187 on this paper, but we might have appointed 80 people that are awaiting to start. But I would have to check that.

Deputy G.P. Southern:
But would the same not apply for the last figures?

Hospital Managing Director:
It could have done but I am just wondering if we have the same like for like figures. I do not know.

Deputy G.P. Southern:
Are you aware of changing the method by which you count vacancies?

Hospital Managing Director:
No, I am aware that we count it in 2 ways and I am not sure whether you have like for like figures or not. It might be. If it has gone up then it is quite surprising because the hospital is not feeling that at the moment. We have a whole piece of workforce planning going on with an external company that are part of the future hospital and the whole of the P82 healthcare planners, looking at our workforce now, what it needs to look like in 5 years and then what it needs to look like in 10 years.

Deputy G.P. Southern:
Is this part of the modernisation programme?

Hospital Managing Director:
It is part of our reform programme, the modernisation programme is something slightly different, it is looking at pay scales, which is why I hesitated there. The early work that I have seen coming out of that is looking at around the 5 to 5.2 per cent vacancy in the nursing staff that I have at the hospital, which is still higher than we would like but has not gone up significantly. I would like to offer that we come back to you with some clarity over these because I am not sure whether the figures you have here are exactly the same as the figures you got last time.

Ministerial Support:
I can place a bit of context around this because H.R. (human resources) have provided those figures as requested I think for your recruitment and retention report, that was the context of this and I did not realise that you were going to focus ... obviously you can focus on what you like but I did not realise you were going to focus on this because our H.R. director is on leave - on prearranged leave - otherwise I would have invited him to come along and he could give you an

explanation. But I can go back ... if you have particular questions on these figures I will make sure we answer on that. So I apologise for that.

Deputy G.P. Southern:

As far as you are aware we are not ... when I saw the figures that was just alarm bells, it is one in 6 positions not filled. Even if you are waiting for them to be filled that is still a remarkably high figure, if that figure is accurate.

Hospital Managing Director:

It is not an unusual figure in healthcare. In the hospitals I have worked at before you would expect ... it varies significantly by staff groups but a 5 per cent vacancy is ...

Deputy G.P. Southern:

Well, 5 per cent is the magic marker that ...

Hospital Managing Director:

This is 5.6 on here, is it not?

Deputy G.P. Southern:

... we are reluctant to step into if it was 17 per cent. That would crisis, would it not? That would make recruitment very hard.

Hospital Managing Director:

If it was how many?

Deputy G.P. Southern:

Seventeen per cent, which that is, approximately, one in 6.

Hospital Managing Director:

I am not sure where you are reading that. I have 5.6 per cent nurses and midwives on here.

Deputy G.P. Southern:

I have 187 vacancies on 1,046 headcount.

Hospital Managing Director:

Okay, well I am reading along the line. Yes, 17 per cent would worry me. I am not sure that I am reading the same. What I would say about these figures, these are the whole of H.S.S.D (Health and Social Services Department) so these are not necessarily all focused in the hospital. That still

does not make it a good figure but we know that we have had some difficulty recruiting into some of our community posts. But from a hospital point of view, I have not got any beds closed.

Deputy G.P. Southern:

You have some difficulty recruiting into community posts?

Hospital Managing Director:

Some of the community posts, particularly around social work, which is not nursing, but Susan is not here unfortunately today to be able to give you an update specifically on community posts.

Director, System Redesign & Delivery:

The other thing we need to look at as we look further into these figures is whether those ... the headcount has increased for the P82 programmes that are due to start this year but have not yet started. So the numbers of what has been reported there as available posts might be more than the number of actual posts at the moment if they have been inflated by the P82 posts for services that have not yet started.

Director of Services for Older People:

I can give you an example in my area. We have P82 money for funding for community services for old people with mental health problems and that is going to increase our staffing ratios by about 25 people. We are in the implementation phrase now of pairing the job descriptions and the recruitment drive and such like with an aim to start getting people into posts by July of next year. Now, if those 25, and I have not seen the figures, are included within this, these are new posts coming in but they would probably be shown because they are beginning to be ... they will be flagged up on our full-time equivalent numbers. So I would guess they would be there along with, for example, increased numbers that are going into our children's service following the business for the increased numbers that are required there. So if those 2 numbers are in those it would make a significant difference in there. But I think it is something we probably need to look at and come back to you with ...

Hospital Managing Director:

In the same principle, I have additional posts going into the emergency department on the back of this year's increase in headcount and I have additional posts going in to support the new Samarès beds when they are completed. So another reason why I would like to go back and check what these figures are.

Deputy T.A. McDonald:

It is just again public perception. If people read, hear or see that 5 per cent is critical to a hospital, anything above 5 per cent ...

The Minister for Health and Social Services:

The operational evidence is not that we are back to that level, so we need to go back and do justice to it and give you the correct ...

Deputy T.A. McDonald:

Exactly.

The Minister for Health and Social Services:

I am not saying that these figures are not correct but they need to be seen in the context of what is going on.

Deputy T.A. McDonald:

Yes, because it obviously of major public concern and we will wait for the figures. Thank you.

Deputy G.P. Southern:

Far more interesting possibly, or far more brief, tell me about the progress with the health charge, Minister.

The Minister for Health and Social Services:

I am waiting for my colleague in Treasury to some work on that and I have, last night, seen that I have been invited to a meeting to discuss it. So nothing has been agreed, it is being looked at at the moment. I think we are working on the basis that we know there will be some areas that a health charge will need to be made. But we want to only do it where it is necessary and keep it as low as possible and that is why it is taking longer than it might have done. It is a matter for Treasury but obviously I have a view and I have been invited to discuss that with Treasury and Social Security.

Deputy G.P. Southern:

In terms of your position as the champion of the health service, where do you see charges being most likely to be placed, on medical grounds? Ignore the Minister for Treasury ...

The Minister for Health and Social Services:

But I see happening, there may be one or 2 areas where you would bring in a user pays, maybe I am not sure about that yet and I am not going to say where because I am not sure that we would.

How I see it working is personally, and this a private view, not one the Minister for Treasury shares - he has never said no and he has never said yes - but I see it working somewhat similar to the long-term care scheme myself. That seems to be the fairest way where it is based on total income and those who most make the biggest contribution. But that is a private view, not one of the Council of Ministers and indeed not one of the Minister for Treasury and Resources.

Deputy G.P. Southern:

But so far, and we are now well into February, there has been no discussion with you and the Minister for Treasury and Resources to say ...

The Minister for Health and Social Services:

No, that is correct. I have been invited to a meeting now but there has been no discussion. Do not forget that it was not envisaged that any charge would come in until towards the end of the medium term financial plan, but we are coming to the States in, I think it is, June or July, I cannot remember exactly, with the detail of the medium term financial plan so it will have to be worked out by then.

Deputy G.P. Southern:

Indeed, it will. I am suggesting the States should be seeing something of what is being proposed early April.

The Minister for Health and Social Services:

I shall express your view to the Minister for Treasury and Resources. I have to say, I share it.

Deputy T.A. McDonald:

Ditto. Yes, I think we all do.

Deputy G.P. Southern:

It is supposed to be in long-term planning but it is one year at a time. Never mind.

Deputy T.A. McDonald:

I will give you an easier one now. Prescription charges, can we discuss those? Are they likely to be reintroduced?

The Minister for Health and Social Services:

I think realistically it is a possibility but it would never be done in isolation so there are discussions going on with Social Security at the moment and I do not know if any of my colleagues would like to speak about it, but to say that it would never happen would be untrue. To say it might happen is

probably where we are. It is in discussion. You would not bring a prescription charge in in Health and not one in the community. So that has to be looked at, and it may be we decide that there are better ways of doing it. I do not know, but it is being looked at at the moment.

[10:45]

Deputy T.A. McDonald:
Yes, and obviously discussions are taking place.

The Minister for Health and Social Services:
There are some advantages to charges ... there are disadvantages as well, obviously the administration and the picking up of that but there are some advantages as we see really quite unsafe and inappropriate stockpiling of stuff sometimes when people make a small charge they might think about whether that is the right thing to do. Some things are being prescribed that people frankly could buy cheaper off the shelf themselves that do not require a prescription, but they get it on prescription because it is free. So those things do need to be looked at, and are being looked at.

Deputy G.P. Southern:
By whom?

The Minister for Health and Social Services:
Well, there is an officer working group with Social Security.

Deputy G.P. Southern:
At officer level?

The Minister for Health and Social Services:
Yes.

Deputy G.P. Southern:
Okay, and is that being looked at in isolation from other charges, for want of a better phrase?

The Minister for Health and Social Services:
It is a workstream on its own but you cannot do it without considering all the other things that are going on. So when the workstream has looked at it they will look at that against the other charges, because there is only one source of income, is there not, and that all needs to be weighed up. So

there is a separate workstream but then it will be looked at in the context of the other work that is going on.

Deputy G.P. Southern:

To what extent ... as soon as I start talking about charges on health I get this U-shaped graph in front of me which has got children at one end, big users of medical care, and elderly people at the other end, big users. Is it partly your thinking that some protection should be built in for those big users, the chronically ill, the elderly, children?

The Minister for Health and Social Services:

Yes, it is not set in stone but it is certainly part of the thinking. That also applies to access to different services all being looked at at the moment. A lot of that is around Social Security but it is being looked at at the moment, yes.

Deputy G.P. Southern:

But it is no good Social Security going on their own, they are talking to you on this, unlike the Minister for Treasury and Resource who has finally invited you ...

The Minister for Health and Social Services:

Did I say that?

Deputy G.P. Southern:

No, I said that.

The Minister for Health and Social Services:

I have a very close working relationship with the Minister for Social Security.

Deputy T.A. McDonald:

We are not really talking about ... it is mainly acute services we should be discussing. But talking about therapists and the current waiting list for assessment.

The Minister for Health and Social Services:

Ian will take you through that. Obviously this is something that we are particularly pleased that it is up and running and I know you will want to talk about how long it takes for people to access it. We are in a better position than we were but, however, Ian will take you through the details.

Director, Services for Older People:

Jersey Talking Therapies has now started last year, sorry the end of 2014, and since then there has been 16 people appointed to work with that. There are 2 steps of psychological therapies, psychological and wellbeing therapy, mainly aimed at people with what we describe as common mental health conditions. That is often anxiety and depression. Step 2 is looking at counselling and some form of short intervention cognitive behaviour therapy which would normally last between one to 8 weeks, and that can be guided self help, it can be using therapy, it can be using group work and such like. So it is a structured therapy for people who have milder symptoms that can be treated with counselling and quite straightforward cognitive behaviour therapy. There are 8 people working within that service and the wait for initial assessment for that service at this moment in time is 4 weeks. What is described at step 3, which is the next step up, step 1 being primary care, G.P. (general practitioner) who would not touch psychological therapy. So step 3, which is another 8 therapists being appointed for that area. We have had some equipment retention issues there so there have been fluctuations with people coming, possibly not settling in Jersey, leaving or people seeking appointment elsewhere and such like. So we have not had those numbers in constantly throughout which would have made a difference as far as the waiting lists are concerned. But there is a 5 week wait for initial assessment into step 3. Step 3 could be therapeutic interventions using more detailed cognitive behaviour therapy or cognitive analytical therapy, both of which are evidence-based practices for the more moderate mental health problems. J.T.T. (Jersey Talking Therapies) do not provide urgent or emergency services. Any urgent or emergency services for mental health care would go to the mental health teams, which would be the adult team, the older adult team or the child and adolescent mental health services and the urgent emergency would normally go through an A. and E. (Accident and Emergency) route or such like for a rapid response from those teams. Following the initial assessment there is then a wait to engage into treatment. It is purely on the numbers of referrals. Since last year the demand for the service was 1,839 referrals, one year, for the new Jersey Talking Therapy Services. So it is ... the waiting list is almost there now because of the recognition of problems that people have perhaps been suffering silently with who now have access and are going into ... or accessing services. The intention was that J.T.T. would move towards self-referral where you would not have to go via a G.P. or another secondary care provider and so you could have open access referrals into J.T.T. and there is good evidence as why that is useful because the earlier you can start seeing people the better the outcomes. That has been put on hold at the moment because we will not be able to open more doors into accessing services. It is one of these, I think, often when you get new services what you get is a significant number of people coming through the door as they come in and start getting the support and the need they get so that the demand goes down. We are really not going to be able to see how that bell curve works until we get to sort of year 2 and year 3. What I would say is if we compare our practices and when we are able to compare with U.K. equivalent of I.A.P.T. (Improving Access to Psychological Therapies) services,

which is the term used for similar services in the N.H.S. (National Health Service), we are in the sort of higher quartile of outcome benefits in the success and treatment. So there is a very good news story within J.T.T. but the numbers of people that access it so rapidly have made the time of accessing the service longer than we would want it.

Deputy T.A. McDonald:

They were obviously, the numbers, greater, I presume, than what you anticipated?

Director, Services for Older People:

Yes. I think it is significantly greater. What we know with psychological wellbeing there are a number of factors that cause people to have concerns about their health and wellbeing, worried, is one of the key things. We look at what we call a stress vulnerability model within mental health services where certain people have high levels of vulnerability for certain conditions and stress can trigger those. We know when we go through national, international recession and concern people get more worried, more concerned and it adds to more psychological distress and such like. So there are significant sort of social and environmental factors that impact on people's wellbeing and mental health. I think generally it is an extremely good news story but it is going to take a little while for the bell curve to come down and for it to iron out, and I think it would be inappropriate to start looking at more resource now because we need to get to what the actual bottom line is.

Deputy G.P. Southern:

You talked about 1,000 referrals. Where are those referrals coming from?

Director, Services for Older People:

The majority ... it is 1,800 referrals, the majority, over 1,000 of them, are coming from the G.P.s. The second most highest referral come from mental health services. So what will happen within mental health, someone might go in because it is perceived initially as urgent and they will have a short intervention with mental health and then it is more appropriate to go to the J.T.T. services. They can also come from our social worker colleagues from hospital ...

Deputy G.P. Southern:

But as you are saying, at the moment there is that gap between that emergency support and moving on to ...

The Minister for Health and Social Services:

Before we had Talking Therapies, you would have waited up to 9 months, this is much, much quicker. To pick up on what Ian was saying initially with a new service you pick up a lot of legacy

stuff, and rightly so. It is an issue that needs to be dealt with and once those legacy things are stabilised there they will be in an even better position.

Director, Services for Older People:

Can I just clarify, Chairman, the question you asked there about the emergency services? Were you asking whether or not ...?

Deputy G.P. Southern:

There is still a gap between getting the emergency help and then moving on to some more ...

Director, Services for Older People:

Jersey Talking Therapies, and to some degree psychological therapies will not be providing ... there is never an intention for them to provide emergency services. They will not be providing it. Our urgent and emergency care for people with mental health problems is of a good standard. In fact our standard for emergency care for adult mental health would be that someone would ... a liaison mental health professional would attend A. and E. within probably about 30 minutes. So once someone at A. and E. has identified that there is a significant mental health concern, that may have borne out with physical health conditions, there is a standard which I think we reach a vast majority of the time. So access to emergency mental health care is of a good standard but J.T.T. would not be providing that, there would not be direct access ... sort of that type of rapid response.

Deputy G.P. Southern:

I know it is early days but can we just turn our attention to something which is relatively long term and that is the results of the disability survey, disability strategy. The number coming through in that survey, is that a concern to you? How are you adjusting your thinking in health to cater for this?

The Minister for Health and Social Services:

It was no surprise to me as someone who works voluntarily within the disability sector for something like 30 years now, so to be honest with you ... and you are right, it was a survey not a strategy. So we understand now because of the survey the makeup of the disabled people in our community. In terms of the new hospital, because I think that was of interest to you, their disability does not affect their access to services, it might affect their physical access getting to and from the building, and that will be catered for with such things as more people with dementia being brought very often by their husband or their wife without the support of other people. Where do they put them while they park the car and things like that. All those sort of things. Obviously it helps to inform us as to how much space we need, what drop off arrangements we need and all those sort

of things that we had a feel for before but we have a greater understanding. But a lot of the information informs of work that will be going on in the community rather than in the new hospital. I do not know if it is appropriate to hand over to you, Helen, on that?

Hospital Managing Director:

Certainly from a new hospital perspective, the new building standards that any hospital would be built to would cater for people with wheelchair requirements. So you would not just have disabled toilets, everything would be accessible to people with disability. We would also have better facilities for people with sight impairment and hearing impairment. You would build hearing loops into reception areas that we do not currently have as we would wish. In terms of dementia friendly, that is another key area that every new hospital would be built to a dementia friendly standard. That is all to do with how you distinguish between colours of doors and walls and toilet seats and ... this is going more towards the mental health side, but you would also make sure that all the hospital would be suitable for people that might be at risk of self-harm so that you would not necessarily segregate them into particular areas that we do at the moment, you would have everything designed in such a way that it is safe for everybody.

Director, Services for Older People:

I think it is worthy of note, the future hospital team are working closely with their colleagues in mental health services to ensure that we cater people who have dementia. What we know within the adults of the General Hospital, about 25 per cent at any one time will have a cognitive impairment. So it is making sure that the environment is suited and suitable for people who have mental health problems and such like. So there is some good joined up working there as you would expect and the commitment to ensure that wherever and whenever it is built it will be built to those standards.

Director, System Redesign & Delivery:

It is also important to continue listening to the views of Islanders. We gave presentations on Monday this week to the Disability Partnership Forum and we give regular presentations to them. This week we talked to them about the future hospital and about the sustainable primary care strategy, and I think we made the point quite strongly that it is important that we carry on listening to their views.

[11:00]

We have a representative from the voluntary sector who also represents patients, service users, carers, families on each of the working groups and each of the boards for P82, because it is so important to keep on listening to the views of Islanders. That individual is also the chair of the

Disability Partnership Forum and is rightfully very vocal with making their views known, which is hugely valuable to us.

Deputy G.P. Southern:

We have heard it. Can I take us on to another issue that I keep getting unsatisfactory answers from, but I will try it again? How has the size of the new hospital been determined?

The Minister for Health and Social Services:

You have referred to it in the States as the population target. I reminded you it was a policy not a target, or not one that we have to hit. We are obviously ...

Deputy G.P. Southern:

I have got pictures of Robin Hood all over the place, and William Tell.

The Minister for Health and Social Services:

Normally you get complimented if you hit a target, on this occasion not. Obviously we are aware of the ageing population and we are also aware that people in the ageing population and the people that are heading, like myself, toward the ageing population have indicated in the consultation that was done last time on P82 that wherever possible, wherever appropriate, wherever safe, they would prefer to be treated in their own home. So we know we need a bigger hospital than we have now, not just a modern hospital, we need a bigger hospital. But it is not as big as it might have been had we gone ahead with just lifting up current practice and plonking it straight into the new one, that would need to be considerably bigger. So what we are doing is planning for that appropriate care in the community, because that is what the community said they want, planning for, as far as we can tell, changes in treatment, technology and all the rest of it and building a hospital that will have more beds than the current beds. Helen will go into the detail on that if you want to. But within that, of course, you would be stupid, unwise, to build a new hospital without some contingency or expansion. That is obviously there as well.

Deputy G.P. Southern:

It is obviously there as well.

The Minister for Health and Social Services:

I would have to be, it would be unwise ... all of the plans, every one of the sites is capable in some form of some addition if it is needed in 40 years' time or whenever, when we are all pushing daisies up or dandelions or whatever it is that you push up.

Deputy G.P. Southern:

The starting question is what population is it designed to cater for now?

The Minister for Health and Social Services:

I cannot give you a straight answer to that, you know I cannot.

Deputy G.P. Southern:

That is okay.

The Minister for Health and Social Services:

But I know there has been work around population ...

Deputy G.P. Southern:

I am sure there has, it is obviously.

Hospital Managing Director:

It has been based on the stats from the States population data and what the forecast is. But as the Minister has said, from the hospital perspective the actual population growth is not the biggest issue. It is the ageing population and their use of healthcare going forwards. We know that as people over 65 use X amount of healthcare, as you get over 80 that triples. So as we are looking at the ageing population it is that that is going to drive the demand far more than any population growth. So what we have been doing is exactly as the Minister said, we are saying: "What do we need now for 100,000 population that we have with the ageing profile that we have and how will that increase and change over the years. We have got quite a sophisticated modelling tool that we have used by specialty and then added to that, I mean, it is quite complex because then ...

Deputy G.P. Southern:

The models have come from who?

Hospital Managing Director:

We have had 4 different models so that we can check that they are all telling us the same answer. There was the early one that KPMG worked on back in 2010, there was one just as I was arriving ... and I have now forgotten the name of the company, but there was another one that was done about 2012 that looked at the same profile. I think it was Atkins that led it. We have done an internal one that looks at exactly what activity we are doing now, what we expect the demand to be and interventions that we think we will do as a hospital around productivity and efficiency and reducing the length of stay, those sorts of things. Lastly, we have had EY have a look at all of that modelling to double check it against national and international benchmarks to make sure that we

have got a credible model. So we have had it looked at in 4 different ways. That modelling is showing us what we should expect an acute hospital to be able to cope with for the future. P82 is critical because we are assuming, and I think rightly so, that P82 initiatives will deliver and keep some of our patients healthy in the community using less hospital time.

Deputy G.P. Southern:
But the basis for this is projections for the population, is it not?

Hospital Managing Director:
That is one of the elements, the other element is the ageing population and changes in healthcare.

Deputy G.P. Southern:
Sure. How that ties into ...

Hospital Managing Director:
Yes.

Deputy G.P. Southern:
But the fact that we have got a range of options for population growth in and of itself is significant, and it is a wide range. The question is, what is your starting point in terms of your growth, your figures in terms of overall population growth? I accept what you are saying that the ageing population has a bigger impact but nonetheless it is a bigger impact on a rising population or not?

Hospital Managing Director:
Yes, the actual figures used, which I am not going to try and quote because I will probably get them wrong, are in the documents that I believe we have just released to scrutiny, the 1,100 page document that brings everybody up to date with all of the modelling work that we have done. It is spelt out very clearly and know exactly what figures we used.

Ms. K. Boydens:
Is that the Gleeds?

Hospital Managing Director:
Yes.

Ms. K. Boydens:
Okay. They still need to sign the confidentiality agreement

Deputy T. McDonald:

It is imminent.

Deputy G.P. Southern:

This man knows more about it than me. I need to you to help me carry it across. So I will take it back to the Minister. On what those figures are, can you hit them?

The Minister for Health and Social Services:

Do you mean can we provide appropriate healthcare for the population as we understand it will be or can we hit a population target?

Deputy G.P. Southern:

Population target.

The Minister for Health and Social Services:

There is not a target. The policy around controlling population is a policy around economic activity, keeping people in work, keeping people economically active about income for Treasury in order to fund things like healthcare. So there is not a population target for us to hit in Health, what we need to do is to ensure is that we have appropriate services for the right sort of community. I do not think ...

Deputy G.P. Southern:

You deny that there has been a target but there has been for the last few years which is around 325 net immigration and we have managed 700.

The Minister for Health and Social Services:

We could spend all day talking about whether it is a target or not. It is not a target, it is not something that we are aiming for ...

Deputy G.P. Southern:

We have not been aiming for for the last few years on the interim ...

The Minister for Health and Social Services:

We have not been aiming on any target. What we are saying is that there is a policy of ensuring that those that come into the Island are those that are economically active, that make the right contributions to community, so there is a social element to that as well. But my job as Minister for Health and Social Services is to ensure that I have a health service that is fit for purpose for the community as it is. It is not my job to drive up the population. Although I do cause some of the

increase in population because we very often have to bring in very specialist skills, orthopaedic surgeons, anaesthetists and such like. Sometimes we strike lucky and we get a very good person who has got lots of experience in the U.K. but while locally brought in ... but we do not have a target.

Deputy G.P. Southern:
Okay, that is the same answer as I usually get.

The Minister for Health and Social Services:
Sorry, because that is what it is.

Deputy G.P. Southern:
In the process of selecting sites or deciding on the size of the hospital, has there been a change in the size of the hospital?

The Minister for Health and Social Services:
Yes. Yes, a change down which has reflected the work that was done around ... well the work that was planned to be done around P82 and also the consultation that was done for P82 from the public. Had we continued to provide services as we are providing it, Helen can go into the detail in a minute, what we do today and the way that we do it then we would need a bigger hospital than we are planning for.

Hospital Managing Director:
Yes, if you wish to take the straight line from today without changing any models of care you would probably be building a 400 bedded hospital. We are planning to build just under 300 bedded hospital. So we are expecting those 100 beds to be taken up by changing the way that we work. We have also changed the size of the hospital over the last couple of years by looking at international standards for hospital sizing, so rather than just accepting the U.K. standards we have looked internationally, we have looked to Australia, we have looked all around the world, and we have decided that we are working that out where appropriate, so not every single clinical area but where appropriate, at a 15 per cent less than the U.K. standard size. So that has changed the ultimate size of the hospital as well.

Deputy G.P. Southern:
I take it that you understand that to be a safe practice. Is there differences in the level of care being produced by those small units in the quality of care?

Hospital Managing Director:
No, so for example ...

Deputy G.P. Southern:
For a range of services?

Hospital Managing Director:
Yes, intensive care we would not want to see any reduction in size. So that one would not have a 15 per cent applied to it. Circulating space, you could lose 15 per cent and it would still be at the same standard as the U.S. (United States) or at the same standard as Australia.

Deputy G.P. Southern:
The U.S. is remarkably expensive.

Hospital Managing Director:
It is.

Deputy G.P. Southern:
It delivers badly a health service, that is not a model I would say we should be going close to.

Hospital Managing Director:
That is about care models as opposed to size of hospital. Australia has smaller sizing, Europe has smaller sizing, the U.K. is the most generous. Another area, if you take a single room and with an ensuite bathroom, you would not want to see the actual ensuite bathroom reduced in size because you need it accessible for somebody in a wheelchair, you need people to be able to get in there and help patients when they are in that room. But the bedroom itself can be reduced in size and still have enough room for all the equipment and for managing the patient. So it has had a sensible view taken in terms of what is clinically appropriate and what is not.

Deputy G.P. Southern:
Okay.

The Minister for Health and Social Services:
I think it is worth saying, Chairman, that the space allocated to ... in our calculation to patients would be considerably higher than that that we had today.

Hospital Managing Director:
About 60 per cent higher.

The Minister for Health and Social Services:

It is balancing those things, because it is that work ... and maybe this is what people are trying to get at, it is that working looking at the size of the hospital which allowed us then to bring back that other option of looking at the People's Park.

Deputy G.P. Southern:

Yes, okay, I heard that bit as well. That was just on the grapevine. It got thrown back in there at one stage.

The Minister for Health and Social Services:

I just thought I would confirm it for you.

Deputy T.A. McDonald:

I am avoiding the sugar tax for the moment.

Deputy G.P. Southern:

Oh no, we will get to it, do not worry about that.

Deputy T.A. McDonald:

I like to keep a bit of excitement brewing. The closures of the Limes. Obviously a great matter again of public interest, in relation to that decision to close it, will there be a reliance on private companies to provide the same service?

The Minister for Health and Social Services:

I cannot deny that. If we are not providing the service somebody has it. I have never hidden that. The fact is that you need to look at, when you are looking at services, what you can do and what other people can do. Let us get back to why the Limes closed. The Limes closed for a number of reasons. First of all I want to stress that the care provided there, and I do not think anyone said otherwise, that the care provided there by the staff was first class. There is no criticism of any of the staff whatsoever. I do not think anyone has implied that anyway. It is not discussions I have had. But the environment in which they were cared for was less than desirable because it was designed as a residential home, so a home for the walking wounded if you like, it was not designed as a nursing home where everybody is in wheelchairs.

[11:15]

A very simple example of that is single doors into bedrooms where you can barely get a wheelchair in. You could not push wheelchairs along the corridor and pass each other. Now sometimes things come to your attention and you cannot unknow what you know. It was brought to my attention, all of those issues, and also the issues about the great difficulty in being able to, in the event of an emergency, evacuate that building. So we had to look at whether we were prepared to spend considerable sums of money to virtually knock down the whole of the inside and reshape, and you would have to move all the patients out to do it, you could not do it around them. So the patients would have had to have moved whatever we did. In 18 months, 2 years' time the patients might have been able to move back. We had that ... we were faced with that scenario and the Director can take you through the detail in a minute, but the decision I took was I was not prepared to compromise on standards we are trying to achieve. Others can achieve those standards. There is no cost to the individual now because with the long-term care scheme ... we were getting the money from Social Security to look after those people, well that money went with them to wherever they have gone. I am not sure where we are in terms of numbers in there, I think it is about 8 at the moment, maybe the Director could …

Director, Services for Older People:
In the Limes at the moment.

The Minister for Health and Social Security:
In the Limes at the moment.

Director, Services for Older People:
Twelve, I think.

The Minister for Health and Social Security:
Twelve, okay, but that is where we are. The Limes will be closed at the end of April.

Deputy G.P. Southern:
I understand an argument that says it was not appropriate for nursing care but it was designed for the walking wounded.

The Minister for Health and Social Security:
Yes.

Deputy G.P. Southern:
But we still have walking wounded, is there no demand for residential care that is similar to that but …

The Minister for Health and Social Security:

There is plenty of supply of residential care in the community. The challenge might have been in the past that people just could not afford to pay for it, they now get that support from the long-term care scheme and rightly so. Of course, we are putting a lot more support ourselves within supporting people in their own homes, keeping them out of residential or nursing homes as long as possible.

Director, Services for Older People:

The question, Chair, was looking at, are we dependent on the independent sector to provide?

Deputy G.P. Southern:

Yes.

Director, Services for Older People:

The answer is, yes, and we always have been. If we think about the beds now within the independent sector for residential and nursing care over the age of 65, there are 987 beds in the community within the independent sector. The independent sector, that includes Parish homes, private or for profit and also not-for-profit charitable homes. There is 987 of which there are 256 nursing beds. When we look at the nursing bed numbers and the residential bed numbers within the independent sector, it has been significantly high for a period of time. If we go back to the KPMG figures in 2011, you will recall that they identified the number of residential beds and the number of nursing beds in Jersey, they commented that for residential beds we probably have twice as many residential beds than the equivalent population in the U.K. One of the things that P82 is doing is moving to provide much better domiciliary care services. What we want to do is to be able to offer people the opportunity to stay in their own home and not move into residential care. To be clear, so that residential care is the walking-wounded and people that are mobile, people that can get about, people that may use a Zimmer frame but do not use big hefty chairs, they have less care needs, they do not have to have a nurse on duty all the time, their physical care can be provided with minimal support, where nursing needs is quite different. All of the people in the Limes, when the decision was decided to close the Limes, were dependent on support for their mobility, whether that be through hoists, whether that be through wheelchairs and such like. We need to be clear I think as well, the Minister has touched on the issue about sort of the emergency situation, we had a number of reports on the Limes and following that looked at what we can do or if it is possible to change it from a residential to a nursing home, to maintain it. There is a report in 2014, a final report, that specifically said the doors are very narrow, the corridors are narrow and they do not support emergency evacuation using mattress sleeves or what we call skids. You cannot get people through the door in an emergency. The top level does

not have a sprinkler system, did not have to have initially, but it is good practice now. We looked at the whole option of what we could do to bring the Limes up to safe standards in nursing care. As the Minister said, short of knocking it down and rebuilding it, we are limited in what we can do within the kind of environment. The question the Chair asked about residential care; can it be used for residential care? Yes, it can. It can be compliant for residential care. We do not need residential care. There are significant numbers of residential care beds out there. I am hoping our colleagues within the independent sector are going to start using some of their residential beds and transfer them to nursing beds. The new modern residential and nursing homes within Jersey are designed to be appropriate for nursing care and some of the rooms are used for nursing care and some of them are used for residential care, depending on demand. The hope is, as we move forward in partnership with the independent sector, they will reduce the number of residential beds they provide and increase the number of nursing beds they provide. Recently it has been suggested that there are not nursing beds in Jersey for people to access and I think 2 things I would like to point out, the number of nursing beds during February this year almost mirrors what they were in 2014 and 2015 of the nursing beds available. We are normally talking about 2 to 4 beds at any one time. That is a moving feast on a regular basis. If you think there are 280 beds in total in nursing beds with Health and Social Services and the independent sector, those numbers change on a daily basis. Access to nursing beds is not emergency access. You would not phone up, it is not like booking a hotel room where you phone up in the morning and you are going to nursing in the afternoon. The assessments that have to be carried out are assessments often within Health and Social Services but also within the home that are looking to provide accommodation for someone. There is often a waiting list and in fact going back to 2011 KPMG identified a waiting list of 46 days for nursing beds. That is significantly less now than it was then and in fact our beds have increased by 21 per cent in today's numbers for nursing beds than they were in 2011 across the sector while our population increase with over-65s increased by 18 per cent. The need to close the Limes I think there is another facet and I think the key one is risk and managing risk and making sure we provide a safe environment for the people we care for. But it was calculating what is out there for the people of Jersey to keep them as safe as possible in the environment we require.

The Minister for Health and Social Security:

The only thing I would like to add to what Ian said is that we know that there is significant new supply coming online shortly as well. I am much more comfortable about the private sector providing residential and nursing care than I might have been because we now regulate them, so that we can ensure that standards are appropriate and maintained. You might even argue that in some areas they are better than what we currently have but we are working on that.

Deputy T.A. McDonald:

But it is about regulation because everybody knows that they are safe.

The Minister for Health and Social Security:

Yes, yes.

Deputy G.P. Southern:

To what extent are the number of nursing beds available dependent on recruitment, the number of nurses available to staff those beds? Yes, we know it is a problem inside the acute services but in the community, is that becoming apparent?

Director, Services for Older People:

Yes. Recruitment I think is a challenge and, to be quite honest, I think my colleagues would probably say since the Francis report in the U.K. when hospitals used to use lots of bank and agency staff, that has changed significantly. Lots of nurses are now employed on a full-time basis and are not as flexible as where they were. The option for them to have full-time employment is there, so that is a challenge. That said Cheval Roc, as the Minister alluded to, is coming online and is waiting for registration and it is a piece of work that is happening at the moment. But they are staffed for opening the beds and they are looking to open them now, so they have full staff complement and ready to go. The difference between residential and nursing is having a qualified nurse on duty, depending on the number of beds and so that is something that our colleagues in the independent sector will look at. It is a challenge but it is doable.

The Minister for Health and Social Security:

But we do work very closely in Health and Social Services with the private care sector in providing, for example, continuous professional development and training in our nurse education centre.

Deputy G.P. Southern:

Do you want the final one?

Deputy T.A. McDonald:

What are we going to make the final one? Go on, we will go for the sugar tax first of all. It is a little sweetener right now.

Deputy G.P. Southern:

Sugar tax, alcohol planning strategy, what is the evidence on both of those?

The Minister for Health and Social Security:

Okay, I will make a general comment and then let the Medical Officer of Health talk specifically. With the sugar tax, as a principle, I am in favour, okay, but it needs to be simple. You cannot start taxing sugar … I will give you a really good example, you have 2 tins of baked beans, this one has got a lot of sugar in, this one has not. How on earth can you work out a fair, simple taxation system for that? You cannot and taxation here is about 2 things for me, changing behaviour and providing some funding perhaps to deal with obesity and perhaps even access for children to dental care. That is as much as I am going to say, it needs to be simple. Probably carbonated drinks is the route to go down and leave it at that for the time being. I am not sure if the Minister for Treasury and Resources shares my view. I will hand you over to the Medical Officer of Health who, I know, more than shares my views and in fact been talking to me about it quite extensively.

Medical Officer of Health:

Okay. Just to set the scene a little bit, the levels of obesity that are observed in the western world, notably in the United States but increasingly the United Kingdom, and Jersey's pattern is very similar to the U.K., are a phenomenon of the second half of the 20th century, which has been rising exponentially but in tandem with the rising consumption of sugar-sweetened drinks particularly and certainly it is a problem with our own statistics. We know that around half of men are in the obese and overweight category and it has been rising. We know from our school surveys that children in reception class, about a quarter of boys are obese to start with and then it is a third by the time they come to the end of reception class, so all these children on a rising curve of obesity. Obesity in itself is a problem in itself but in terms of mobility, in terms of self-esteem, it is a problem to be massively obese. In terms of healthcare costs there is an issue about access to bariatric surgery to try to cure it, that is one thing. That is not the main thing about obesity, obesity is the main driver of much of the non-communicable chronic disease that is causing the increasing health burden in the older population and the increase in healthcare costs. It is the main cause of type 2 diabetes and all the problems that go with that, whether it is heart disease, kidney disease, eye disease. It is also a main cause in itself of heart disease, apart from type 2 diabetes, and it is a particular risk factor in a wide range of cancers: breast cancer, uterus cancer in women, everywhere from the oesophagus to the stomach to the bowel in everybody. It is a risk factor for kidney cancer. Obesity is a big problem and it is worth preventing. At the moment, without effective preventive measures, it is on the way up. If you look at the actual level of focus on sugary sweetened drinks, which is probably the only effective place to try to go to put taxation on and it has been done in other jurisdictions. It has been done in Finland, France, Hungary, Ireland and 38 states in America. They have much more public support for putting a tax when it is used to fund health and wellbeing programmes to prevent rising obesity in children, rather than just going into the general taxation …

Deputy G.P. Southern:

Is there any evidence to say that it is actually effective in bringing down obesity rates?

Medical Officer of Health:

Yes. Certainly there is evidence from other places that where you place the tax around 20 per cent, it delivers around a 15 per cent reduction in consumption. The other thing just to say as well is the consumption of sugar-sweetened drinks is higher in boys than girls, which is probably a factor in more obese boys than girls.

[11:30]

It is also more of a proportion of children's diets than adults' diets. Just to put it in the context, in a standard serving of a carbonated drink like a can of Coke there is 9 to 10 teaspoons of sugar. If you supersize that and come with these sort of larger huge cups that you get, not just the cinema but also fast-food outlets like McDonalds and Burger King, you can double that. If that is a part of daily consumption, it is part of what is causing the problems in front of us now and the rising pressure on healthcare services. It is worth doing. In terms of identifying sugar-sweetened drinks, it is as easy to do as identify alcoholic drinks. Other countries have favoured an excise duty, rather than just a sort of additional percentage. But it is easier to do and it is less susceptible to price reductions and the manufacturers making a difference to the cost.

Deputy G.P. Southern:

Minister, will you be bringing us something?

The Minister for Health and Social Security:

I will be talking to my colleague responsible for taxation, the Minister for Treasury and Resources. I have indeed mentioned it to him. You know that he has a dilemma because he is still on the policy of no new taxes but we are working on it.

Deputy G.P. Southern:

Since when what people said on hustings mean anything?

The Minister for Health and Social Security:

That is what he said. For me, the Medical Officer of Health has made an excellent case for it. I will do my best to get it but I want to see that money ring-fenced for health, work around obesity and one of the passions for me is around dental care for children.

Deputy G.P. Southern:

If I could just push it …

The Minister for Health and Social Services:

You always push it, Chairman.

Deputy G.P. Southern:

I know, I know and on alcohol pricing.

Medical Officer of Health:

Yes.

Deputy G.P. Southern:

That is, again, the latest thing to hit the headlines. What is the evidence?

Medical Officer of Health:

Huge evidence, it is the price and accessibility and availability of alcohol that drives harmful consumption. Also, the people who have an alcohol problem, at the harmful end of drinking consumption, drink up to the amount they can afford. If it becomes less affordable the people who benefit the most, if you like, are the people who need to benefit the most by drinking less. That is why the fiscal measures about driving the price upwards on alcohol make a marginal difference to people who drink at moderate sensible levels, hardly any at all in fact, and make a much bigger difference to helping the people who need the help to drink less because they cannot afford to drink more with the £5 or £10 they have, so …

Deputy G.P. Southern:

You mentioned sugar tax ring-fenced to deliver some benefits.

Medical Officer of Health:

Yes.

Deputy G.P. Southern:

Would you say that would work with alcohol pricing?

Medical Officer of Health:

I think that would be wonderful. It is not what has happened to date, but it would be an excellent thing if the revenues both from smoking and from alcohol were used to target the problems that they cause. Obviously, there are wider problems that alcohol causes, as well as the health

problems, in terms of the criminal and justice issues and so on. I think any public health doctor that you asked in the whole world that question, would that be a good thing, would say the more that is invested upstream in prevention measures is the right thing to do? If that is the way of getting more funding into it that would be a good thing because what we get, without investing as much as we possibly can, is the impact on the rising and potentially unsustainable pressure on health services provision in the future. We are already grappling with that now. Obviously, you do not get any quick wins, if you like. We cannot sort of put the prevention measures in this week and get the benefits next month but, in my view, it is entirely the right thing to do.

Deputy G.P. Southern:

I am sure your Minister is listening again. Finally, for us, when will the department publish its 2016 Business Plan?

The Minister for Health and Social Security:

As soon as I have signed it off. I know you probably do not think we have one. I have a copy here. I am not prepared to release it just yet but it is very nearly there. I have been meeting with the Chief Executive and the team just to … Essentially, it is something we have worked up. It is ready to go. We are working to it. As soon as I have signed it off, which will be in a few days, you will have a copy, Chairman.

Deputy G.P. Southern:

Jolly good, I will enjoy reading it. Thank you very much.

[11:34]