STATES OF JERSEY

Corporate Services Scrutiny Panel Comprehensive Spending Review: 2012-2013 and Delivery

WEDNESDAY, 11th MAY 2011

Panel:
Senator S.C Ferguson (Chairman)
Senator J.L. Perchard
Deputy J.A.N. Le Fondré of St. Lawrence
Deputy D.J. De Sousa of St. Helier
Mr. N. McLocklin (Panel Adviser)

Witness:
Deputy A.E. Pryke of Trinity (The Minister for Health and Social Services)
Deputy E.J. Noel of St. Lawrence (The Assistant Minister for Health and Social Services)
Managing Director of the Hospital
Chief Officer
Deputy Chief Officer
Director of Finance and Information

Also Present:
Ms. K. Boydens (Scrutiny Officer)

[11:36]

Deputy E.J. Noel of St. Lawrence (Assistant Minister for Health and Social Services):
The Minister will be here. She is at a private appointment that she has to attend, but she hopes to be here by quarter to-ish. It just depends how long her appointment lasts.

Senator S.C. Ferguson (Chairman):
Good morning, ladies and gentlemen, welcome to this hearing of the Corporate Services Scrutiny Panel regarding the next stages of the Comprehensive Spending Review. For anyone who may not have been here, we do have a health warning, if you would read it and inwardly digest. In the meantime, if you could say your name and position for the benefit of the ladies who will be doing the transcribing. Can I suggest we all move our microphones so we can talk into them?

The Assistant Minister for Health and Social Services:
Deputy Eddie Noel, Assistant Minister for Health and Social Services.

Chief Officer, Health and Social Services:
Chief Officer for Health and Social Services.

Managing Director of the Hospital:
Managing Director of the Hospital.

Director of Finance and Information, Health and Social Services:
Director of Finance and Information for Health and Social Services.

Deputy Chief Officer, Health and Social Services:
Deputy Chief Officer, Health and Social Services:

Senator S.C. Ferguson:
The panel?

Deputy D.J. De Sousa of St. Helier:
Deputy Debbie De Sousa, part of the Corporate Services Panel.

Senator J.L. Perchard:
Senator Jimmy Perchard.

Deputy J.A.N. Le Fondré of St. Lawrence:
Deputy John Le Fondré.

Senator S.C. Ferguson:
Senator Sarah Ferguson.

Ms. K. Boydens (Scrutiny Officer):
Kellie Boydens, Scrutiny Officer.

Mr. N. McLocklin (Panel Adviser):
Neil McLocklin, Panel Adviser.

Senator S.C. Ferguson:
I am sorry, I should have introduced Neil to you. I apologise.

Deputy A.E. Pryke of Trinity (Minister for Health and Social Services):
Apologies.

Senator S.C. Ferguson:
Welcome, Minister. If you would just like to say who you are for the benefit of the transcription ladies?

The Minister for Health and Social Services:
I am the Minister for Health and Social Services, Deputy Anne Pryke.

Senator S.C. Ferguson:
We will give you half a minute to catch your breath. What do you understand is the purpose of the C.S.R. (Comprehensive Spending Review)?

The Assistant Minister for Health and Social Services:
Just to give the Minister a chance to catch her breath, in my mind, and in the Minister's point of view, is that it is to endeavour to ensure that every pound of taxpayers' money is ultimately utilised and not wasted, basically.

Senator S.C. Ferguson:
Right, so how are you going to ensure that your department is going to make genuine savings as per the Auditor General's 2008 report?

The Assistant Minister for Health and Social Services:
Okay, well that particular report covered 9 areas where savings could be made. Plans have either been implemented or are in various stages of development to generate those savings throughout those, with one exception and that is nursing costs.

Senator S.C. Ferguson:
I am sorry, no, the Auditor General was fairly clear that there was only £5.98 million worth of genuine savings in that report.

The Assistant Minister for Health and Social Services:
Over 9 different areas of our business. It was based on procurement, locum services, nursing costs, U.K. (United Kingdom) treatment costs, charging in A. and E. (Accident and Emergency), health tourism, H.R. (human resources) management, drug expenditure, and working more closely Guernsey. So out of those 9 areas we have either addressed or are addressing 8 of those, one of those areas - nursing costs - we have not done.

Senator S.C. Ferguson:
But how are you going to ensure that you are going to make the genuine savings?

The Assistant Minister for Health and Social Services:
Through the outcomes of the C.S.R. and through work with the management team.

The Minister for Health and Social Services:
I think also - I have got my breath back now - it is important to say that we are signed up to the fact that we have to make savings and we had a ... when the States and the Council of Ministers were charged with saving £65 million, our C.S.R., if it was 10 per cent, would have been £18.7 million, which is something that we ... which was an awful lot of money. I think at that time we had an independent review panel, as you know, chaired by John Mills and Paul Marriott(?) who looked into these savings and into the efficiencies. So that is where we realised across the board that that was not achievable because it would, at that time, have effect across main services and in 2011 we were charged with saving £3.7 million.

Senator S.C. Ferguson:
So your total £18 million is not £18 million any more, is it?

The Minister for Health and Social Services:
No.

Senator S.C. Ferguson:
So what is the figure now?

The Assistant Minister for Health and Social Services:
The total is £3.7 million, that is the 2 per cent for 2011, and it is a further £1.5 million in 2012, and a further £1.5 million in 2013.

Senator S.C. Ferguson:
So you are talking in terms of something in the order of £6-7 million in total?

Senator J.L. Perchard:
£6.9 million.

Senator S.C. Ferguson:
You are also talking in terms of invest to save, if I remember rightly, of something like £2.5 million. What is the invest to save for the 3 years?

Director of Finance and Information, Health and Social Services:
A key component of the invest to save monies are around the V.R. (voluntary redundancy) programme that has been put in place by the States, and our other component is around the P2P procurement projects, of which Health and Social Services is leading on behalf of the corporate and strategic procurement need to pilot those projects and to set up appropriate procurement processes to realise savings. H.S.S. (Health and Social Services) is the leader in that programme.

Senator S.C. Ferguson:
So how much is the invest to save total for the 3 years?

Director of Finance and Information, Health and Social Services:
For the whole 3 years I believe it is around about ... it £1.9 for ... it is the main components of the 2011 programme and I believe we put in some additional bids, as we develop our schemes in 2012 and 2013, to obviously request further funds to support those programmes.

Senator S.C. Ferguson:
So how much more have you put in for?

Director of Finance and Information, Health and Social Services:
We have only put in a bid at the moment for additional resources for the project management and the programme of the scheme, but for the 2012 and 2013 projects we have still yet to work out the fine detail of what those mean and therefore what the invest to save sums would be.

Senator S.C. Ferguson:
So you have put in a bid for 2011?

Director of Finance and Information, Health and Social Services:
We have.

Senator S.C. Ferguson:
Of how much?

Director of Finance and Information, Health and Social Services:
Well, we received £365,000 of P2P work in 2011, another £1.5 million for the B.I. (business improvement) programmes in 2011 and there are some others, about a couple of hundred thousand pound just for some other minor stuff, such as some I.T. (information technology) enablement projects.

Senator S.C. Ferguson:
Have you not also had some growth allocated?

Director of Finance and Information, Health and Social Services:
When you say "growth allocated" ...

Senator S.C. Ferguson:
According to the original documents, it was something in the order of £6.5 million in growth.

Director of Finance and Information, Health and Social Services:
Okay, so the growth sums are around the 2 per cent growth that is normally planned in for Health and Social Services on an annual basis as part of the business planning process. We also requested and received another £1 million to work on the middle grade doctors' terms and conditions reviews, a further £600,000 for senior medical staff and their retirement, and the sub-specialisation as our senior medical staff retire away. That basically makes up the growth figures that we requested for 2011.

Senator S.C. Ferguson:
So you are looking again for 2 per cent in 2012 and 2013, are you?

[11:45]

Director of Finance and Information, Health and Social Services:
As part of the routine States Business Plan processes, yes, we are requesting the additional healthcare inflation growth that we normally would assume through the normal process of having healthcare inflation running in excess of normal States inflation as well as maintaining the services and delivering the increases in activity that we can manage on a small scale. Obviously we put in larger bids for very specialist components of extra service that is required.

Senator S.C. Ferguson:
Right, I do not know whether you have got a numbered list of ... yes, thank you for that. Before we go any further, what methodology have you adopted to identify the savings? Have you identified your core services?

The Assistant Minister for Health and Social Services:
No single methodology has been used. We have a broad spectrum and Andrew maybe could come in on this point.

Managing Director of the Hospital:
The primary area we have looked at is things that have been successful elsewhere in terms of acute services most specifically. So we have tried to learn from others and there is broad experience that we have been able to pull on both from people that work in the hospital and who have worked in other places around the U.K. but also from some of the advisers we have had recently who offered very good opportunities for savings.

Senator S.C. Ferguson:
What about the frontline staff?

Managing Director of the Hospital:
Frontline staff, we have had a consultation with frontline staff, we have got a suggestion scheme where members of staff put forward suggestions into the process where they believe that we are currently potentially wasting resource or could do things more effectively, and we are taking those forward, and there has been feed back to the staff who have put suggestions forward.

Senator S.C. Ferguson:
Have you managed to get the managers to go down effectively to the shop floor and work with the staff?

Managing Director of the Hospital:
Sorry, which managers would that be ...

Senator S.C. Ferguson:
As I suppose you obviously know, there is command and control and there is bottom up management, and unfortunately with a lot of our States it is command and control. Have you had proper consultation, you know, detailed consultation with the frontline staff? Have the managers gone down and gone through what is the work with them? Has the manager of, for instance, cleaning gone around and worked with the staff? That sort of methodology.

Managing Director of the Hospital:
Right, I understand, Senator. My experience of lean schemes is that there are 3 main phases as you are implementing those saving schemes. The first one is you have to create the right climate. You have to ensure that staff are ready for that challenge, they understand that they are going to be leading it, because it has to be a bottom up process, and that process is very much around establishing who your change champions are going to be but within a clearly defined structure where there is clinical leadership at all levels. So if the staff do not feel that they are leading the services and that they are accountable for the services and the spending then they do not engage with the process of making those services more efficient. So we had to start at the ground level effectively by ensuring that we had an appropriate leadership structure in place with the right people in leadership roles. We then needed to

create the culture, and this is an ongoing process, whereby people felt that they were able to engage with managers, clinical leaders, change champions, whoever it might be, and have their voice heard. There was a significant degree of scepticism and cynicism in parts of the organisation about what C.S.R. was all about and we have been trying to build confidence that this is about doing the right thing in terms of using public funds as effectively as possible to ensure the best patient care results. So I think we are well on the pathway there. We are now in the process of establishing who our change champions are going to be. We have had a number of volunteers from different staff members, and we are looking at how we will be skilling them to ensure that they can lead that change process from the ground level. So I do not think it is appropriate for any senior manager to go and tell people how to make their services more efficient, it is a process of engagement and getting the staff themselves that are delivering the services to tell the management how those services can be delivered in the most effective and efficient way. That is the way the change embeds in the organisation and the savings are sustained going forward.

Mr. N. McLocklin:
Is it possible to give us an example of anything that has come up from the bottom up process or a suggestion that has come through that process of engagement?

Managing Director of the Hospital:
The obvious one would be the design of the day surgery unit where there was a significant amount of engagement with staff at all levels in the design and the building of that unit and the moving of surgical procedures that had previously been conducted as in patient procedures, where the patient was admitted to a bed, usually on the day of surgery but sometimes a day before surgery, and then would have their procedure and would remain in a bed for a number of days before they would go home and we had moved a number of those procedures, a significant number, particularly in orthopaedics, into the day surgery unit where the patient arrives on the day of surgery, is prepared, having had a pre-admission clinic appointment, on the morning, goes in, has the surgery and walks home at the end of the day. So that is a much more efficient process. It is better for the patients. It reduces the risk of infection, it is cheaper for the States, in that it is very expensive to have somebody in a nursed bed for any period of time. So if you can avoid that, that makes it more efficient and that process change was only possible because of the engagement of the staff and the suggestions from the staff as to which process, which procedures, could be treated as day surgical procedures.

Deputy D.J. De Sousa:
One of the first questions was what is the purpose of the C.S.R and what do you understand it as being and Deputy Noel said optimising the spending. I wonder if one of you could tell us, has there at any time ever been a complete cost analysis on provision of services, cost of patient care, cost of equipment, across the board, have you done a complete analysis of what it costs for health today?

The Minister for Health and Social Services:
It is part of KPMG so ...

Chief Officer, Health and Social Services:
I think the KPMG work has taken us quite a way in terms of understanding what we utilise our resources for currently, in terms of what range and kind of services we offer, and whether we offer them in the best way compared to best practice internationally and how we might start to change those services to get better value for money and provide a more appropriate offering to the people of the Island. But I think your question is quite specific around a detailed cost analysis of the resource and what it is spent on, and levels of detail. Obviously we have done quite a lot of work over the last year, being mindful that this question has come up before at Scrutiny, in terms of putting in place a very detailed scheme of delegation with budgets allocated to appropriate levels of staffing right through the organisation to the front line. That allows us to start the next stage of work which is to do the very detailed costing that you are suggesting. But perhaps if I could hand over to Russell and you could just expand on that.

Director of Finance and Information, Health and Social Services:
Yes, definitely. Obviously the cost of Health and Social Services activities are and have been for many years identified in an annex to the business plan and are detailed by certain service areas. The development we are undertaking now is to align those service areas more to the activities so that we can undertake more of a unit based and activity type costing so that when we align our budgets better to those services we can understand the cost per unit rather than the cost of, say, medical wards or doctors in H.S.S. or nurses in H.S.S., which is how things have traditionally been costed in the business planning annex. So I think it is a slightly difficult question to answer because we do have a lot of information on cost, how useable it is depends on what the business needs to use it for and what the States would like to use it for at any one time. Obviously in those circumstances we would undertake any kind of costing work that was necessary to make sure that we could support the managers in managing their services.

Deputy D.J. De Sousa:
My point is, surely to make any real savings you need to know the full cost of everything. So without that cost analysis you cannot make true savings.

Director of Finance and Information, Health and Social Services:
That is true but, for example, under the previous structure of the department we would know the costs of the medical wards. Maybe if you could give me some more examples about what you think is missing, that might be helpful for me to be able to answer the question to the panel.

Deputy D.J. De Sousa:
I do not know what is missing that is what I am asking you. Have you done a complete and full analysis of every service, every procurement, staffing, the estate that you occupy and rent out, because you rent out nursing

accommodation and things like that? Have you had a complete analysis of everything that the department controls?

Director of Finance and Information, Health and Social Services:
I would say all of those costs are known and understood, how we use them is maybe what the analysis is about. In the examples of C.S.R. we have used the information we have got to develop schemes and proposals and to make sure that the savings should be achieved. So all of the costs exist. It is how they are presented that possibly is part of the question maybe, respectfully, you are asking and I think we will adapt that presentation to the purpose of what the information is needed for. So at all times the costs of the activities of Health and Social Services are known in their entirety, because they are presented through the business planning process. How we as a finance team support the senior managers - and all managers - and frontline services in identifying the specifics of the costs that they need to know in the format that they need to know them is a permanent job of the Finance Department, and an ongoing development that we are putting in place through the scheme and delegation work and realigning our budgets to the new service areas that have been put in place.

Senator S.C. Ferguson:
Which leads very nicely on to the question, have you sat down and identified your core services?

Chief Officer, Health and Social Services:
Could you elaborate more ...

Senator S.C. Ferguson:
What are your core services?

Chief Officer, Health and Social Services:
Well, I consider that the services that we offer are core. They are a basic range of hospital based services, community based services, mental health services and social care services. As part of this process we have set up a whole range of projects linking to the areas that were identified earlier in the Comptroller and Auditor General's report but also a whole raft of other service areas, and part of the work that you are describing of detailed cost analysis is based in each of these projects. Each project has a project initiation document, it has a timeline developed, it has a project manager and an executive lead sponsor. The work that we are doing and engaging the same for that area, what are we spending our resources on, what type of service are we providing, is that the right type of service, can we look elsewhere and see people do it differently - and that is where some of the lean methodologies can come in - working with our frontline staff, because they will generate that change for us. They are the best people to go and ask where there might be efficiencies and improvements that we can find, and that project is built up that way. So on an individual project level, we can drill into the costs of what we are spending in those areas and look to see if we can take savings. If we cannot take savings, having done that analysis, then obviously we need to find new schemes, and that is a constant process that we are engaged in.

But I think what I would add to what Russell has said is that is fine but it is project based, so it does not give you the totality of the costing, and we would all like to work in a department, I think, where we understood the totality of what the money is being spent on to a very detailed level so that we can make sure that our frontline staff who are our managers - because we do not have other layers of management - are able to know what they are spending when they are delivering their services, because that empowers them. When they know what it costs for them to do things in a certain way they also think: "Well, if I did that differently then I would be able to redeploy that money in a different way, I would give a better service to my patients and I would be being more efficient." We need to get the processes in place, and there are ways of doing that, and I am not a financial expert so forgive me if I am a bit loose on this - and Russell might add more - but there are techniques used in the U.K., for example, such as service line reporting and P.L.I.C.S. (Patient Level Information and Costing System) which I can never remember the definition of, which is patient specific costing where you understand the cost of delivery a service to an individual patient. The U.K. have driven into that way of working and it has taken some resourcing in terms of financial staff to do it because they have had a purchaser/provider relationship where money changes hands under contracts, and therefore in order to get the right price for your contract you have to understand very specifically what it costs to treat each patient for each type of service they receive. What we are looking at doing is bringing at least service line reporting into our services and we will need to roll that out and train staff up so that they understand how to use that methodology but also, presumably, in time we would look towards the patient level information as well. It is getting the balance between putting money into more financial people to do that with the view to ensuring that our clinicians, our nurses and doctors, really understand the cost of what they are doing and therefore have the power to change that.

Senator S.C. Ferguson:
But what I was saying was have you identified your core services? For example, accommodation for nurses, is that really a core service? Is that not something that might well be outsourced or transferred elsewhere?

[12:00]

Chief Officer, Health and Social Services:
I think that is a good example and the answer would be yes. What we have not done in a comprehensive way is look right across the wide span of services that we provide and say: "That is core, that is not" but as each of these projects is developed we look within that project and say: "Within this area are we doing everything we should, are we doing more than we should or are there some choices that we can offer to say: 'Let us stop doing that but do a bit more of this or let us stop doing that and make a saving'?" That is the process we are going through but across the whole range of services, no, not yet.

Deputy J.A.N. Le Fondré:

That helps because it has halved my question, I think. If I pick up where I was going to pick up on Debbie's point, you said we are doing it and it sounds like what you are doing is what we hope you should be doing but what is the time scale to complete it across the entire department, bearing in mind the size of the department?

Chief Officer, Health and Social Services:
I am almost inclined to say it is an iterative process, I am not sure you get to the end of it because we offer such a wide range of services across all of those areas, and I suspect there is probably bits of the service we offer that until we have had a look at it we did not even know was there, or certainly we were not giving close attention ...

The Assistant Minister for Health and Social Services:
To be fair, the rate of change in technology in health and social care means that ... it is a bit like completing the fourth bridge, by the time you have got to the end of it things are done differently anyway so you have to keep ...

Deputy J.A.N. Le Fondré:
Yes, but in terms of going back to identifying core services, you as medical ... well, yes, okay, one assumes that as medical technology changes you can provide more things and there is a political decision, or medical decision, to be made. But presumably in the wider context, yes, okay, staff know about nurses accommodation but there will be areas where you can say: "Actually, that is core, that is non-core." In the wider context that is unlikely to change, I would have thought. So what I am trying to say is at the detail level there will be additional stuff you can always do but surely as a principle across the department you must be able to identify the wider core areas.

The Minister for Health and Social Services:
I think you have also got to put in context, I think that work needs to be done ... and you picked up about hospital nurses accommodation. That is a classic, and we are addressing that issue, but these things just do not happen overnight. They need to be worked up and it does not just affect our department with the hospital accommodation, it affects other departments too, and to make sure that if we offload it - for the want of a better word - that we make sure that the nurses still will have first ...

Deputy J.A.N. Le Fondré:
You want the service, okay.

Senator S.C. Ferguson:
But is that not a bit sort of backwards way on? Surely you identify what your core services are and then you start looking at C.S.R.? Was that not something that really should have been preceded C.S.R.?

The Minister for Health and Social Services:
But I think Health and Social Services ...

Senator S.C. Ferguson:

You identify your statutory requirements, your core services ...

The Minister for Health and Social Services:
I think a lot of things that we do with Health and Social Services ... we are so diverse and as I have said before many times, I thought I knew health and social care, I can tell you I did not because it goes down to the fact of special needs services, elderly special needs, because we are an Island base we have to provide those services and that is important. If you were in the U.K. it might be another country providing that service.

Senator S.C. Ferguson:
We are not criticising the breadth of the services you provide, we are asking if you have done an analysis of core services, and you have told us that you started it and its ongoing and I merely raised the question that is it not something that you do at the beginning.

The Assistant Minister for Health and Social Services:
That is exactly when it was done. If you look at the results of the Comprehensive Spending Review you will see that very little has been done to social services. That is because they are already doing just the core services, just statutorily what they need to do.

Senator S.C. Ferguson:
Well, you did not say this before. Anyway, okay, so you have done some of it but not all of it before you started looking at savings.

Chief Officer, Health and Social Services:
Sorry, could I just comment on that, Senator Ferguson. I think at the beginning of the C.S.R. process, which slightly pre-dated my arrival on the Island, we had to find savings for the first year of C.S.R., which is 2011, very, very quickly. I think like most departments you go and look for the easy things and they tend to be things where you just salami slice a little bit off the budgets and look to just tighten your belt a bit. Most of our 2011 C.S.R. savings are very much those sorts of projects. With a little bit more lead in time for 2012 and 2013 you can start to look at service redesign, which allows you to start asking those questions about is it core and is it non-core. As the Minister has said, what would be defined as core on this Island will be much broader than what you would define as core in the U.K. because you have got less opportunities go elsewhere for your services.

Senator S.C. Ferguson:
So have you done this - forget me for interrupting but, you know, time rushes on - for 2012 and 2013?

Chief Officer, Health and Social Services:
The 2012 and 2013 schemes are service redesign schemes, which as the Managing Director for the Hospital explained we looked to other jurisdictions to see the sorts of things they had already done, because again time is still of the essence. 2012 and 2013 are not that far away and if you are redesigning services and creating something very different for patients that takes some

time. Again, you have to go to your frontline staff and work that through with them in order to put something in place which is safe and secure and good value for money. What we have done as part of the KPMG work, though, across all of our areas, the hospital, social services, mental health, is have those conversations about what do you have to do on this Island. You have to have an emergency service on this Island. You have to have a maternity service on this Island. So we have built up building blocks as part of the KPMG work to say that these are things are things which really we would suggest, and we will suggest as part of consultation, must be on this Island. We have also identified areas where you could have a conversation with the public to say: "Should we carry on providing some of these services?" They are nice to have but they are not absolutely essential to have. They are very valued by people but if we are wanting to tighten our belt and restrain the amount of growth we have to put into Health and Social Services, there are some choices. But to be perfectly frank, those choices are at the margin because the bulk of services do need to be provided on the Island. So we have done some of that work.

Deputy Chief Officer, Health and Social Services:
The other issue, just to add to that, is that in Jersey there is not a lot of statutory obligation to provide health care so while we might be obliged to register ice cream vans, we would not be statutorily obliged to provide on Island maternity services. So while in other departments you might look at the statutory obligations first of all, I do not think that is particularly useful within health and social care. There is better statutory obligations within the social services as the Assistant Minister pointed out. Less so across health care.

Senator S.C. Ferguson:
So we are going to take the second tranche of questions first, starting at number 12. I presume you are using the same numbering as we are.

The Assistant Minister for Health and Social Services:
We will find out. **[Laughter]**

Senator S.C. Ferguson:
So what is the relationship between the departmental plans and the business improvement programme/C.S.R. programme?

Deputy Chief Officer, Health and Social Services:
What question do you make that?

Chief Officer, Health and Social Services:
It is question 12.

Deputy Chief Officer, Health and Social Services:
Well, the requirement to achieve the targets of C.S.R. savings appears as a business plan objective for the 2011 Business Plan and is monitored quarterly, as is the organisation improvement plan, and they are also featured in the 2012, 2013 Business Plan as well.

Mr. N. McLocklin:
I am interested in the day-to-day working relationship between the central programme and the departmental programme in terms of are they supporting you, are they helping you, are they a hindrance ...

Deputy Chief Officer, Health and Social Services:
Sorry, who is the "they"?

Mr. N. McLocklin:
The C.S.R. programme as an entity and the programme ...

Deputy Chief Officer, Health and Social Services:
I see, at the centre, you mean?

Mr. N. McLocklin:
Yes, and the relationships between other programmes within the C.S.R., overall programmes. I am just trying to work out how that happens on a day-to-day basis. Is there a challenge from other areas, are there ... is there cross-learning, all that type of stuff, really. It is for our benefit to understand how it is working for you because it is a programme that has benefit to you as well, obviously. You know, it is a bit of a carrot as well as a stick, I guess.

Deputy Chief Officer, Health and Social Services:
Picking up on the Managing Director of the Hospital's point, there are project leads on an initiative on the ground, you know, often somebody has come up with an idea or will be leading on an initiative. Leading that there will be an executive lead and those schemes will be monitored by the project management office which sits within my team, and we report on a weekly basis to the corporate directors and to the ministerial team. There is a very regular - I would not necessarily say daily but almost daily - interface between the project management office within my team and the central C.S.R. team. A lot of the schemes also are running across the States, for example, as the Finance Director said in terms of procurement, as are other initiatives running across the States. So there is that cross-fertilisation of ideas so that if something works in Education, Sport and Culture then we get to hear about it very quickly and we are not opposed to stealing good ideas.

Mr. N. McLocklin:
If there was one aspect you would improve, what would that be?

Deputy Chief Officer, Health and Social Services:
There are potential opportunities to bring forward schemes and make savings now but really we just have not got the capacity to carry out all the feasibility studies that we are required to do. Sometimes it would also be nice to bring forward capital, monies, to carry out something which might be in a capital plan for 2013 and we know that initiative will save money if we started it today. So it is about trying to drag that money forward. But, of course, everybody is competing for scarce resources.

The Minister for Health and Social Services:

But I think also, as Richard has pointed out, within the team and the government's accountability, and the update comes to the ministerial team fairly regularly as well, if not weekly then it is fortnightly so we are kept up to date on where the department with their savings.

Chief Officer, Health and Social Services:
We have a detailed reporting mechanism that goes through all of the managers as well to my corporate management team, so we know if something is going off track very quickly and we are able to therefore look at whether it can be rescued or whether we need to say: "This sounded like a good idea, we have investigated it, it is not going to deliver what we thought so we will find a replacement scheme for it." That is an iterative process and it is happening on a daily basis.

Senator S.C. Ferguson:
So what is the current position with the lean approach to patient pathways? How are the staff responding to this, how is it being rolled out and when will the first results be available?

Managing Director of the Hospital:
I will speak to that, Senator. I think of it really in 3 phases. The first phase is about engagement, education and establishing the readiness for change. I think we are towards the end of that phase now. So we are entering the phase where we will be putting together the phase 2 comprehensive plan which will have all the various projects identified with clear project leadership for the 2012 and 2013 schemes. That is the transition point we are at. We have a number of staff who have come forward and expressed a desire to be trained up in the new methodologies and to lead those change processes through, so that is very encouraging. That is where we are, that is what staff engagement is. I have forgotten the third part of the question.

Senator S.C. Ferguson:
When will the first results be available?

Managing Director of the Hospital:
The first results are available now in that some of the schemes that were identified as part of the early scoping exercise for 2012 and 2013 it has been realised could be delivered now. So you might have seen the announcement last week around the introduction of a charge that will be made on insurers for anybody involved in a road traffic accident. While that was a future scheme it was quite clear that there was no obstacle to that being introduced now and work has been taken forward and we begin those charges from 1st June.

Senator S.C. Ferguson:
What other sort of projects are coming up with that then?

Managing Director of the Hospital:
The quick projects or the medium term projects?

Senator S.C. Ferguson:

We have had a quick project, what is a medium term project.

Managing Director of the Hospital:
A medium term project is how can we improve our discharge process so that once a patient is no longer assessed as being acutely ill we can move them as rapidly as possible out of the acute setting and into a more appropriate setting for their care. At the moment there are potentially patients who are considered medically safe for discharge and they might spend a day or 2 or 3, or even more days, in the hospital before the various processes are in place for them to move on to the next stage of their treatment. Clearly it is best for us all, and particularly for efficient use of resources, if we can reduce that waiting phase for the next stage of care to the minimum possible. A paper has already been put forward on how we might move to that improved process. We considered it yesterday.

Deputy D.J. De Sousa:
Do you have any long term processes you are looking at?

Managing Director of the Hospital:
The long term process, probably I am the wrong person to speak to this, is very much wrapped up with the Green Paper and the consultation exercise will be conducted in the later part of this year, because we need to understand what Jersey wants from its Health and Social Services Department, particularly with the challenges that we know are coming in the next few years in terms of the increasing proportion of the population who will fall into the categories that are the highest users of Health and Social Services, i.e. the very young and the very old. That is something we are hoping to get the maximum possible engagement with so that we can provide the right services, services that people want.

Deputy D.J. De Sousa:
When are you looking to produce that Green Paper?

The Minister for Health and Social Services:
At the end of this month.

Deputy J.A.N. Le Fondré:
Just a detail point ...

Senator J.L. Perchard:
That is based on the KPMG initial recommendations or is that parallel to?

[12:15]

Chief Officer, Health and Social Services:
No, that is based on the work that we have been advised on by KPMG.

The Minister for Health and Social Services:
There is 5 key areas coming out which for States Members who were at the presentation I think that was quite clear.

Senator J.L. Perchard:
While I have the floor, Chairman, the Minister said at the outset, quite categorically, 10 per cent C.S.R. request for savings was not achievable, the effect on frontline services would be too dramatic and it would represent £18.7 million. That has been taken by the panel here as not being disputed but I would like to just challenge you on that really. I understand, having had some experience in health, the consequences of an £18.7 million hit under the current environment that the Health Department is operating in, but has the Council of Ministers or the Minister for Treasury and Resources in particular put you under some pressure to achieve these savings? How have you managed to persuade him that they are unachievable?

The Minister for Health and Social Services:
I think going back to the process which is about a year, 18 months ago, when we all knew that we had to find £65 million savings and we had to have a start point somewhere, and the start point was each department had to come up with 10 per cent. That is where our independent review panel did their work of looking at what it meant if we did have the cut of £18.7 million, which was totally unrealistic. We had to start from somewhere and that is what the review panel did, and at the end of the day it was the recommendations of the review panel that worked out that we could find the £3.1 million and the £1.5 million in 2012 and 2013. The review panel, as well as this team, put the argument forward to say that even though we were asked to look at 10 per cent we could not achieve it without doing serious cuts on frontline services.

Senator J.L. Perchard:
I can understand that but it looks to me that is just a salami slicing exercise we are doing in health and that really we are not challenging the norm, we are not - I hate the words “thinking out of the box” - challenging the system, we are mirroring the N.H.S. (National Health Service) system, we are not looking at health insurers, we are not looking at perhaps procuring services from France, we are not really challenging, which would probably take longer. Do you think that is a fair criticism?

The Minister for Health and Social Services:
I think you have to put this in perspective, and I think one of the recommendations from that review panel is that with the pressures ahead of us, that we had to look seriously on what type of health and social services that we want in the future. It briefly mentioned on the 5, the ageing population, our workforce, our estates, including the hospitals as well as the other homes, and - there is 2 more - the cost of drugs and the cost of treatments. People physically are living longer and ...

Senator J.L. Perchard:
Yes, we know all that.

The Minister for Health and Social Services:
Yes, but also the costs ...

Senator J.L. Perchard:
Are you challenging ... this problem is not going to go away. Are you looking to procure services from the private sector? Are you involving the private sector in the provision of services? How are we going to ever catch up if we want to offer a top rate health service.

Chief Officer, Health and Social Services:
That was the whole point of doing the piece of work with KPMG. Yes, everything was on the table and from the start of that process we have asked questions exactly like you have, should we be looking to France, should we looking to outsource services, should we send more work to the U.K. or to some other part of the world, should we be doing services very, very differently. What that finds is a number of things, and I know you had the benefit of one of the presentations from KPMG. The reason that we ended up not finding the full 10 per cent was because after a very rigorous process of challenge - and there was a very challenging process by the Council of Ministers - because it was not good news to be told that Health could not find its share of the 10 per cent clearly and there was a very rigorous challenge but the 2 messages were very clear. When they looked at what we were trying to do and they looked at the rate of investment in other countries, not just the U.K., and they looked at the rate of investment here, and we have invested over the years in Jersey but not at the level that other systems, we are starting to find some really big challenges. So challenges coming over the horizon potentially have a big price tag on them and there was a desire to take £18 million out of the current base, and what the independent panel said was: "It seems rather unwise to be trying to do that which will inevitability impact on your frontline services before you have looked at how can you do it differently and how can you tackle the challenges that are coming. That is the piece of work we have done with KPMG, they have come up with ideas within their technical document and that has informed the Green Paper which we will be publishing. Yes, we do have to be radical but we also have to remember that this is an Island and therefore there is an expectation that a wide range of services will continue to be provided on the Island. One of the things I hope we will test in consultation with the public is where is the balance between wanting all of these services located on the Island against wanting to pay for them. You are quite right, there is a price tag to all of this. There are options and we explore an option in the Green Paper that says: "What happens if you peg the money?" What happens if you just say: "What we spend now is what we are always going to spend, what can you have for that?" I may well be that the view that everybody comes to - and I am a taxpayer too on this Island - is: "Well, we do not want to spend more money so we will have the service that we can afford." It will be a very different service to the service we have got now. But we have been very challenging and we have been challenged by KPMG and we have challenged KPMG to be as radical as possible to say: "What are the options for doing this?" Every jurisdiction in the world is having the same conversations.

Senator J.L. Perchard:
Are you working to the fundamental principle that healthcare will be provided free at the point of ...

Chief Officer, Health and Social Services:
No, absolutely not. No.

Senator J.L. Perchard:
That is good news to me.

Chief Officer, Health and Social Services:
We have worked on the principle that there are a range of services that we believe should continue to be provided but there are options about how they are paid for. That is the debate that you as politicians and the public need to have.

Senator J.L. Perchard:
It is a debate that will take time and there are no quick 10 per cent options here, it is going to take years to develop a ...

The Minister for Health and Social Services:
That is the real debate that we will need to have in the next few months when the consultation paper comes out, because the problem is not going to go away.

Senator S.C. Ferguson:
In actual fact, has anyone challenged the assumptions underlying the various dire warnings on the demographic front, because the New Zealanders have just done a 40 year strategic forecast and they have said that they are very surprised but the care of the elderly is not rising anything like as rapidly as the general consensus seems to think it will.

Chief Officer, Health and Social Services:
Well, in terms of the numbers, in terms of what we can expect from older people in retirement ...

Senator S.C. Ferguson:
This is the expenditure on them.

Chief Officer, Health and Social Services:
The expenditure on them ... well, KPMG are a global consultancy and they work in places like New Zealand as well so they will have taken all of that information into account, but as far as I am aware that has not been proven across a whole range of jurisdictions. It is interesting to look at and as we move forward with whatever the preferred solution is that comes out of this consultation we will be looking to test that, because certainly we do not want to spend money we do not need to spend. But at the moment what most people would say and what the evidence would suggest ... and I came from Norfolk where we have a very high elderly population and it was one of the most rapidly increasing ones in the country, and we were feeling the pressures of demand constantly. It is interesting to note with the change of government and the change of their capitation formulas, Norfolk received the highest weighted capitation formula this year in order to deal with its older

population. So I think the New Zealand work is very interesting, I will certainly look at that, but I think we also have to look at evidence from elsewhere.

Senator S.C. Ferguson:
I will send you a copy.

Chief Officer, Health and Social Services:
Thank you.

Deputy D.J. De Sousa:
Can I just pick up from where Senator Perchard was going with this £65 million in savings that we need to make and the fact that Health cannot make their quota of 10 per cent, we are going to achieve around a third of what was asked, because originally it was £18.7 million and we are going to find £6 million. That is going to mean there is going to be an impact on other ministerial departments to find their savings that Health cannot make.

The Assistant Minister for Health and Social Services:
That is completely true. Other departments are stepping up to the mark. For example, Planning and Environment are making a 13 per cent saving, Education a 6 per cent saving, so it varies across the board but overall £65 million be saved.

Senator J.L. Perchard:
But the fact is Planning and Environment have opted for a different route to that of the Health Department. Planning and Environment are in fact increasing their revenues by putting up charges to the public for their services, unlike your department.

The Assistant Minister for Health and Social Services:
I cannot comment in detail but my understanding is that they are also stripping out a significant proportion of costs as well.

Senator S.C. Ferguson:
I wonder if we can move on.

The Assistant Minister for Health and Social Services:
But that is for a different ...

Senator S.C. Ferguson:
Yes, sorry, because we do not have a lot of time.

Deputy D.J. De Sousa:
Can I just quickly touch on one other thing, Sarah, that has been missed?

Senator S.C. Ferguson:
Yes, if it is very quick.

Deputy D.J. De Sousa:

It is. I am always to the point. Some time ago procurement was mentioned and we do know that there was a case before where purchase cards were used and many people had them. In the C.S.R. are you looking at amending that process, and can you say in what way?

Director of Finance and Information, Health and Social Services:
I think purchase cards throughout the whole States have been obviously a subject of debate and audit, and pre C.S.R. ... and even if C.S.R. was not happening all sorts of controls would be put in place to tighten up on the use of purchase cards in Health and Social Services. So obviously first of all a clearer alignment with the people who need them, so a reduction in the numbers and then tighter controls on the expenditure that people can undertake on them and also the authorisation routes to make sure that the team leaders, managers, et cetera, are approving the transactions they undertake. So there is a whole separate raft of work that internal audit will be reviewing again later this year to ensure that what we have said we were doing to tighten up on purchase cards will happen.

Deputy D.J. De Sousa:
Do you have the data on the number that were issued and the number that are now issued?

Director of Finance and Information, Health and Social Services:
Unfortunately I do not have that off the top of my head but I can provide that quite easily.

Deputy D.J. De Sousa:
Thank you.

Senator S.C. Ferguson:
There were 600. **[Laughter]** Anyway, how is the department addressing the prevention agenda?

The Minister for Health and Social Services:
I see prevention as very important, because preventing it is better than cure and we need to get those ... and this is where public health departments have got their part to play to making sure that the information that will get out about looking after yourself and how you can look after yourself is very important and there has been quite a few initiatives. Like we have had a new tobacco strategy, so even if we can reduce people from smoking, that is important because research has shown that there is problems further on with one's health. There is a number of health improvement programmes that continue, especially like the Healthy Schools Programme. So it is not only within the public health, it is working across other departments as well, especially Education, Sport and Culture.

Senator S.C. Ferguson:
What are you going to do with Family Nursing?

The Minister for Health and Social Services:

In what way do you mean?

Senator S.C. Ferguson:
Well, that is part of the primary surely?

The Minister for Health and Social Services:
Yes, it is part of our primary care, yes.

Senator S.C. Ferguson:
I would imagine that their method of operation has not changed for the last 30 years.

The Assistant Minister for Health and Social Services:
They volunteered to be part of the C.S.R. process and, as far as I am aware, have been going through a C.S.R. process of their own. They are first third sector organisation to come forward and ask to be part of it.

Senator S.C. Ferguson:
Yes, well part of the C.S.R. is not the same as part of improving the primary healthcare, is it?

Chief Officer, Health and Social Services:
No, they have been a key part of the KPMG work. They participated heavily. They are well aware that this sort of system we are suggesting we need going forward will require them to work very differently and to be part of different ways of providing services. As to have our primary care practitioners, our G.P.s (general practitioners) have also heavily involved in designing the suggestions that we are making in the Green Paper. One of the areas that perhaps we could offer as an example around the prevention agenda, we did have a very fragmented approach to vaccination and immunisation of children until quite recently. We have worked with G.P.s, we have now put in place a single method of delivering vaccination and immunisation through general practice, and from very poor rates of coverage we now have better rates of coverage than the U.K. The U.K. coverage is quite high. So that is a good example, I think, of where, working with primary care practitioners and looking at providing services differently, we have had an improvement and we have seen a better outcome for children.

Senator S.C. Ferguson:
What about electronic monitoring of chronic conditions?

Chief Officer, Health and Social Services:
Absolutely, it is a key feature of the proposals that we would want to put in place on the back of the KPMG work. If we want to help people to maintain their independence and health in the community, the fact that they have a chronic condition should not affect that, but they will need support through tele-medicine and tele-health.

[12:30]

Senator S.C. Ferguson:
Yes, but there was a pilot project suggested 2 years ago which was held up by Health.

Chief Officer, Health and Social Services:
Held up? You mean delayed or was being put forward as a ...

Senator S.C. Ferguson:
It just was not implemented by them. They were dragging their feet.

Chief Officer, Health and Social Services:
I am not aware of what that project would be. We are actively working with a number of the parishes at the moment. St. Clement would be the best example, where we are looking at working with them to support older people in their own homes in different ways. That is part of a project called P.O.P.P.S. (Partnerships for Older People Projects), which has been very successful elsewhere, which is about offering what might seem like fairly low level types of service and support but by doing that, by offering contact, groups of people to go out on day trips to help with perhaps getting shopping in, somebody just to pop in and check that somebody has got milk in, those sorts of very low level services and support can help older people to stay well and healthy in their own homes for a very long time. That is the sort of initiative that we are working on.

Senator S.C. Ferguson:
I was talking about a genuinely electronic monitoring programme.

Chief Officer, Health and Social Services:
I am not aware of that project, Senator Ferguson, that predates my time here, but it is exactly the sort of thing we would be looking to do.

Senator S.C. Ferguson:
I will send you the details later because ...

Chief Officer, Health and Social Services:
I would be interested to know about that.

Senator S.C. Ferguson:
... the money was obtained.

Chief Officer, Health and Social Services:
Well, if money was obtained I shall look into where it has gone.

Senator S.C. Ferguson:
No, it is nothing to do ... it was a cross-departmental project which appears just to have disappeared.

The Minister for Health and Social Services:
Part of the KPMG work is that we have been working very closely with our charitable organisations and with the third sector. So they have been very

much a part of the framework, including the G.P.s, because primary care is going to become more important.

Senator S.C. Ferguson:
I know, and the G.P.s got their patient records programme going before yours.

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

Director of Finance and Information, Health and Social Services:
I think if there was investment available for tele-medicine, we would be very keen to hear about it because if we could deploy that early that would be ...

Senator S.C. Ferguson:
It was discussed with your department. I will send the Chief Officer the details. I think we have probably covered 15. Is there more potential for specialist services being provided across the Islands?

Managing Director of the Hospital:
I will start off, if I may, Senator. I think the answer to that is yes. I am having conversations on an almost weekly basis with my opposite number in Guernsey to see where we have staff shortages, how we can co-ordinate our recruitment so that we are able to create posts for specialities where there is less demand that can be shared across the 2 Islands. Sometimes this is where we have an existing service and the growth has not reached the point where we could justify another consultant but we might be able to justify a part of a consultant and sharing that, co-ordinating that with Guernsey helps. Certainly on the environmental health side we already share some support with Guernsey and I believe there is other work going on in the public health, but that is not my specialist area. So I can assure you that we are looking for opportunities to share specialist services across the Islands wherever we can.

Senator S.C. Ferguson:
Do you share information about demand for a particular service? For instance, I gather that if you are a surgeon you need to be doing about 400 operations a year at least in a particular specialty for it to be worthwhile doing it, if you see what I mean?

Managing Director of the Hospital:
Right, okay. It very much depends on what the specialty is and what the procedure is. So the guidelines were mainly started through the improving outcomes guidance that came in for cancer surgery in the U.K. which led to the centralisation of a number of cancer surgical services. There are guidelines that are being developed around other surgical services and particular surgical procedures within those services. The 400 number I am not familiar with but certainly there are numbers of procedures that would be expected to be performed at a service level. It is important that we take account of that in our strategic work because in some instances the population base we have in Jersey will not support certain services and even the population base we have by combining Guernsey and Jersey will not

support them. So there is a difficult balance there between having the safety, which has to be a given, and the expertise but also the population and the demand to support that service being provided locally and it is very expensive to provide a service from a consultant who flies out to Guernsey or Jersey to deliver a service because you then need to duplicate all of the surgical provision and the diagnostic provision on the Island that may be available in a specialist centre. There is a balance to be struck there that we are looking at very closely on a specialty by specialty basis.

Senator S.C. Ferguson:
Obviously demand figures come into it?

Managing Director of the Hospital:
Absolutely.

Deputy J.A.N. Le Fondré:
We have touched on the Island's reciprocals(?). We also touched on France as well as the U.K. France gets raised from time to time. Is there any opportunity there or is that just a pipe dream?

Managing Director of the Hospital:
We have looked at it in the last year since I have been here. We do sometimes share services from France back into to Jersey and sometimes vice versa but it is relatively rare. While there is higher degree of fluency in French in Jersey than you would expect in another part of the U.K. there is a resistance to a service being linked to a country where English is not spoken in their acute care setting and therefore anybody being referred into that service has to either be fluent in French or have support from somebody fluent in French or we have to provide translation services, and that can prove rather difficult when the referral is based on the expertise rather than on their particular fluency in a language.

Chief Officer, Health and Social Services:
We have looked into this in the past, Richard. Do you want to ...?

Deputy Chief Officer, Health and Social Services:
Yes, it comes around every so often; people look into different areas. I think Andrew picks up exactly the right points. Communication is such a fundamental part of safety in health care that if there is any opportunity for communication to go awry in the patient pathway then that is a significant cause of worry. At the moment our focus of attention, picking up on the earlier point about working with Guernsey, is with all off-Island care and all sharing of care, we need to consider how we move our patients from one place to the other. The key piece of work we are doing at the moment with Guernsey is looking at their air ambulance service. We have a single provider. They do not have a single provider; they have multiple providers. So we are working with Guernsey at the moment to do a single specification to produce a single air-ambulance provider to transfer patients off Island. Once we have a single provider, then you have the opportunity of moving patients and staff around much more easily between Jersey, Guernsey and

wherever that tertiary care may be. With that larger number of patients we have better leverage to buy better tertiary care, whether that be in the U.K. or whether it be in France. France, as we all know, has excellent health care but it is also very expensive.

Mr. N. McLocklin:
Just as more of an observation but coming into this afresh, there has been a lot of comment about the uniqueness of the Island and the diseconomies of scale because of size but also I guess there is an opportunity because you do have far more controls of all the levers around this table than perhaps in the mainland. Is that not an opportunity almost to create the new model?

Chief Officer, Health and Social Services:
Absolutely, yes. One of the most interesting things about this Island is that you have everything on the Island. This department does cover ambulance services, social services, mental health services. The opportunity to provide services for patients which are totally bespoke to them and which are wrapped around them is much greater on this Island than anywhere else I have ever been. That is a really exciting prospect. If Stuart Brook, who is the equivalent of Andrew for Community and Social Services, was here, he is really passionate about the way that we could start to create a new way of working that is community based; that is primary care based; that does empower people with both keeping themselves healthy and well but also giving them the tools they need to support themselves in the community. There is so much more we can do and we do not have the boundaries between different types of provider that you would have in other jurisdictions. So there are immense opportunities as well as challenges. Absolutely.

The Minister for Health and Social Services:
It could be a very exciting time because we have got all the bricks in the right place and Health and Social Services is one department rather than split and you start with that. But the diseconomies do prove that it is going to cost us more if we want to provide those services here. That is why the Green Paper coming out at the end of the month is going to be important. We hope that the Islanders will get engaged with it because it is their health service.

Deputy D.J. De Sousa:
We are aware that time is running away with us and we have another Minister due in soon, have we not? No? All right.

The Minister for Health and Social Services:
I am told that your lunch is here. **[Laughter]**

Deputy D.J. De Sousa:
I wonder if you could enlighten us as to how much of the departmental underspend that we have been told about is from the Health Department?

The Minister for Health and Social Services:
Do you mean Health and Social Services?

Senator J.L. Perchard:
There was a press release on Friday that I think Debbie was referring to; £21 million but it was not broken down. Did Health contribute towards that £21 million?

Deputy D.J. De Sousa:
If so, by how much?

Director of Finance and Information, Health and Social Services:
We did and it is £3.2 million.

Senator J.L. Perchard:
Are you being able to reinvest that in 2011? It is not being taken away?

The Minister for Health and Social Services:
No, I can say that it is not taken away. We did confirm that we wanted our underspend and that we would be finding our cuts so we do have that. It is very important for us to keep that money.

Deputy D.J. De Sousa:
The Minister for Treasury has said that he is going to be very harsh, if achievements are not made within the C.S.R., in not letting departments have that back.

The Assistant Minister for Health and Social Services:
Correct.

Chief Officer, Health and Social Services:
We have given an undertaking that we will deliver our C.S.R. targets and we will deliver, one way or another.

Senator S.C. Ferguson:
Where does the 3.7 underspend come from then?

Director of Finance and Information, Health and Social Services:
Yes. There is a whole raft of things. Primarily it is around things that due to timing difficulties were not spent in 2010. For example, all around the legal fees associated with the historic child abuse inquiry; obviously the timing of getting those cases through, et cetera, and the legal fees settlement has been delayed and hence there is £600,000 of the underspend related to that. We have also have around £400,000 that we are requesting to carry forward around medical equipment. We are trying to set up a medical equipment library; the buildings and the space have been difficult to indentify due to the pressures on clinical space to find an appropriate area to set up such a library. Obviously we would not want to waste the money in year by purchasing a load of equipment that then lies around gathering dust and running out of warranty. So obviously we delayed the purchase and we would ask that the money is returned to us in 2011 to complete that scheme when the space is identified. So those are the kinds of components that are all

wrapped up in that underspend which has been recognised and will hopefully come back to us to be spent in the new year.

Deputy J.A.N. Le Fondré:
It is really a timing difference against budget more than a saving.

Director of Finance and Information, Health and Social Services:
It is underspending, not a saving.

Senator J.L. Perchard:
It represents just over 1 per cent, does it not, in your budget?

Chief Officer, Health and Social Services:
Yes.

Senator S.C. Ferguson:
Does the department then have the right balance between the 2011, 2012 and 2013 targets?

Chief Officer, Health and Social Services:
I think the short answer to that would be yes in as much as the bulk of the saving is required this year and it is against schemes which are within the gift of the department to deliver, providing we have good programme management in place. In 2012 and 2013, the levels of saving required are lower but it is more difficult to achieve because we are then looking at redesigning services. What I would put on the table, because I think it is important that we do recognise it, is even as we are making savings and delivering on these targets, there is pressure for growth. One of the areas that we are working on at the moment because it is a cause of concern for us and we have touched on it already ... the consultant model that we use as I know members of the panel are aware is a very generalist model. Those generalist consultants are starting to retire in significant numbers and we very rarely can appoint on a like-for-like basis. That is creating a pressure for more money. Likewise we have an ongoing problem of recruitment and retention of nursing staff at the moment. Again we are looking at whether we need to put in place specific recruitment and retention initiatives to enable us to fill those vacancies some of which we have had for over a year. Levels of vacancies in some areas of the hospital in particular, but also parts of mental health, are at 10 per cent. Now clearly we do not want that to persist into the future. So we have on the one hand the savings targets which we are driving hard to get; on the other hand we have these challenges and the need for growth to cope with these areas of pressure which have been driven by things like retirement age, by different models of the way you deliver doctors' services and nursing services which to an extent are going to happen to us come what may.

[12:45]

Senator J.L. Perchard:
How are you going to deal with the specialism of consultants and the fact that we are just an island?

Chief Officer, Health and Social Services:
There is a variety of ways of doing that, and Andrew may want to add, but obviously in some cases we can justify and make a case for the fact that we do need to replace one with 2 and that becomes a bid for growth monies and it is debated by yourselves in the States as part of the business plan processes going forward. At other times we may look and say: "You cannot justify a whole extra surgeon because there is not enough work for them" but we might have one surgeon and build a team around them. The problem with that is that one surgeon on their own is a bit vulnerable. How do they get cover? How can they take leave? What are the locum arrangements around that? Alternatively you can say this is now a service we need to buy in from elsewhere. Then you would have a debate about whether we get the patients to travel to the service. What are the benefit and disbenefits of that? Or can we get the consultant to fly in and work on the Island and what are the benefits and disbenefits of that? So there are options. It depends on the type of service and what the demand is doing and what is safe to do will inform how we deal with that.

The Assistant Minister for Health and Social Services:
Each specialty will be different.

Chief Officer, Health and Social Services:
Yes.

Senator J.L. Perchard:
I will go back to the involvement of the private sector here and the consultant having a position in a private capacity where he would import patients but be available to you as the public sector. I do feel that what we must not have as a result of financial pressure is a second-rate health service. The best way to have the best-rated health service is properly funded professionals but in an island environment where there is a limited number of patients, if we are not going to ship our patients out, we have to ship the professionals in and perhaps specialisms and even patients in a private capacity.

The Assistant Minister for Health and Social Services:
It is a different type of health service.

Senator J.L. Perchard:
It is a very different type of health service and it is probably following some of the best health service models in the world; the American model for example.

Chief Officer, Health and Social Services:
One could argue about the cost of the American model, of course. Philosophically we would not rule anything out. It is about can we offer good quality and can we do it with good value for money. As long those 2 parameters are satisfied, I do not think any of us would rule anything in or out.

The Minister for Health and Social Services:
At the end of the day making sure that the service is safe and stable.

Deputy D.J. De Sousa:
You have touched on recruitment of nursing staff. Have you within the C.S.R. incorporated follow-on nursing training to keep skills up and to advance skills?

Chief Officer, Health and Social Services:
Yes.

Deputy D.J. De Sousa:
It does seem to be an issue within mental health along these lines.

Chief Officer, Health and Social Services:
I think there is a strong tradition in the department of training, growing our own, developing our own staff, but at the moment there are blockages in terms of staff at certain levels not seeing an advantage to moving higher up because either the money does not work or there is just not enough reward for the additional responsibility. There are special areas where we need to look at whether we can train and develop differently and whether different types of staff might help us with some of the recruitment issues.

Senator S.C. Ferguson:
And also improve the accommodation. Are there any stretched targets being put in place or contingencies created? How are you going to budget round foreseen targets?

The Assistant Minister for Health and Social Services:
The department itself does not really have any contingencies built into its cash limits but with the implementation of 3-year programmes there will be centrally held contingencies that departments will be able to make a case for.

Senator S.C. Ferguson:
But you are going to be expected to have your own departmental contingency, are you not?

The Assistant Minister for Health and Social Services:
They are not there ...

Senator S.C. Ferguson:
There is no contingencies at the moment?

The Assistant Minister for Health and Social Services:
No contingencies at the moment, no.

Mr N. McLocklin:
Particularly given the fact that we have quite a lot of red RAG- (Red-Amber-Green) rated programmes at the moment, what we are trying to see is the total slightly greater than the target.

The Assistant Minister for Health and Social Services:

There are contingencies in terms of schemes, but there is not contingency in terms of pound notes?

Director of Finance and Information, Health and Social Services:
Yes.

Deputy Chief Officer, Health and Social Services:
We are continuously looking at contingency schemes to replace schemes that look like they might not provide the full realisation of the cash that we expected them to. hat is separate from saying we have a contingency pot of money somewhere else.

Chief Officer, Health and Social Services:
What we do try to do within the 2 per cent uplift that we get each year is create a very small element of that which we would not allocate at the beginning of the year. What we do know is that it is the nature of the beast that things will happen in year that will need to be tackled and we cannot constantly keep coming back and saying: "Oh, something has happened. Can we have some more money?" A good example of that so far this year is that we need to replace our breast-screening system because it is not working as efficiently as we would like. That is going to cost somewhere in the region of about £100,000. We had not put that in our business plan because we did not know there was a problem until quite recently but we are absorbing it by a little bit of flexibility sitting at the tail end of that 2 per cent. There is not a lot there but it allows to deal with things like that that come along. Eventually you get to the point where there is no contingency; there is no slack. Then you have to make some tough decisions about whether you pull back on something else in order to fund a problem that has emerged that needs to be tackled.

Deputy Chief Officer, Health and Social Services:
We do also expect some of our schemes to over-realise in terms of their target but we also expect some other schemes to do the opposite. At the moment the targets are set.

Senator S.C. Ferguson:
If all these Reds really are red, how are you going to finance it?

Deputy Chief Officer, Health and Social Services:
I need to point out what that red really means. It is not that we do not think that money is realisable; it means at this point in time there are issues that we have not yet addressed. So if you take for example the energy savings which is quite significant there along that line, it is not that we do not think we can make energy savings, it is just that there are things that still need to be done in that process mean that there are some ... until those things are done, if the feasibility studies of 32 different social services sites are carried out, until discussions are carried out with the energy providers, until we have some confidence that the behaviour changes that we expect are going to take place, that stays red. The ones which are green, if they are 2011 schemes, are realising the money. So the money is coming out and we can see the money

coming out. That is how we are working with it. It is not so much that we do not think they are going to realise. It is at this point in time there are still things to do.

Senator S.C. Ferguson:
What do you think is the biggest risk of not achieving your targets?

The Minister for Health and Social Services:
I think the biggest risk is cost containment. It is really critical to making sure that we achieve it. Also making sure that everyone is alongside with us with achieving it. We have given the commitment that we will achieve it and we are going to stick by that.

Senator S.C. Ferguson:
John, you have a couple of questions.

Deputy J.A.N. Le Fondré:
I have a couple of detailed ones, initially for Russell.

Senator J.L. Perchard:
I have a supplementary to the question you have just asked before we move off that rather than changing tack.

Senator S.C. Ferguson:
John has not actually said much.

Deputy J.A.N. Le Fondré:
Very quickly. They should be quick and dirty so keep the supplementary in mind.
Of the £3.7 million underspend, that is over and above the £2.8 that you were allocated for 2011?

The Assistant Minister for Health and Social Services:
£3.2 million.

Deputy J.A.N. Le Fondré:
£3.7 according to the figure you have there.

Chief Officer, Health and Social Services:
The underspend or ...?

Senator S.C. Ferguson:
That was on 28th March.

Deputy J.A.N. Le Fondré:
Sorry. All right. Of the underspend, the number you are quoting, whether it is £3.2 million or £3.7 million, is over and above the efficiency savings from the C.S.R., is it not?

Deputy Chief Officer, Health and Social Services:

Yes. They are not connected to the C.S.R.

Deputy J.A.N. Le Fondré:
That is fine. So the £2.8 in the C.S.R. is not part of the underspend. Good. I was assuming that but I just wanted to make sure. Second one: R.T.A.s (road traffic accidents) and red bits as it were. Andrew, I think you made the comment that you saving on the R.T.A. charges was around £100,000-odd or something. Was that right?

Managing Director of the Hospital:
We anticipate the part-year effect this year will be around £100,000; £200,000 full-year effect. That is at the current rate of charging which is significantly behind the U.K.'s rate of charging.

Deputy J.A.N. Le Fondré:
Again, it is purely a detail. Going back to Richard, I think, on your red zone, amber stuff ... sorry red zone, is the R.T.A. charges the area that you originally identified at £31,000 in 2012 and 2013?

Managing Director of the Hospital:
Is there an H.S.S. I.D. (identification) number on that?

Deputy J.A.N. Le Fondré:
The 49. Or is that something completely different? If it is something completely different, do not worry. If it is not, it is really a tick for saying it is wrong.

Director of Finance and Information, Health and Social Services:
Road traffic is a 2012-2013 scheme being brought forward.

The Minister for Health and Social Services:
Medical wards. It is a Green.

Deputy J.A.N. Le Fondré:
Ours is in red.

Chief Officer, Health and Social Services:
It has moved to green.

Deputy J.A.N. Le Fondré:
That was part of the question. It is really just to give an idea as to what the category of them being in red which is what you touched on previously.

Senator S.C. Ferguson:
I wonder if we could ask for an up-to-date ...

Chief Officer, Health and Social Services:
This one is 20th April.

Deputy J.A.N. Le Fondré:

A final question then on procurement. On this, on the one we have, the biggest sum at the very top, this is H.S.S. 25 Procurement P2P project, the £1.25 million is in red. What are the general issues? Do you want to give a 30-second expansion on what it involves and what are the issues?

The Assistant Minister for Health and Social Services:
There is a range of projects that sit under this one title of P2P and there are quite a lot of projects within that. The recurrent saving £1.25 million is deliverable within the 3-year time frame. The non-recurrent savings of this year ... and non-recurrent savings are difficult to find at this moment, so not all the non-recurrent ones have been worked up again and alternative schemes found for them but there is confidence around the recurrent saving of £1.25 million over the 3 years.

Deputy J.A.N. Le Fondré:
Thank you. Over to Jim. I can do quick.

Senator J.L. Perchard:
Minister, you have described public expectation, advancement in medical practices and the ageing population as the main reasons why achieving C.S.R. requests of 10 per cent is not on. Could you or one or your executives briefly outlined what sort of external financial pressures you are up against, over which you have no control, that also make the C.S.R. savings difficult to achieve?

Deputy Chief Officer, Health and Social Services:
Can I give you an example that we were just discussing this morning, the energy one. The energy target for example is a 13 per cent saving on our energy usage. So that is net of energy prices and we are all aware of what energy prices doing. So as the Minister said, one the real threats to C.S.R. was cost containment. So if energy prices suddenly triple over 3 years, our chance of saving 13 per cent net start to diminish and we are not in control of those energy prices. We are only in control of our usage.

Senator S.C. Ferguson:
Gas prices are falling at the moment.

Deputy Chief Officer, Health and Social Services:
They only account for £0.5 million of our energy budget. We use £1 million of electricity a year.

Senator J.L. Perchard:
But what are the threats? Energy prices and ...

Managing Director of the Hospital:
The most obvious one from my perspective is drug costs. In the U.K. we would assume drug inflation of somewhere between 6 and 12 per cent per annum. The growth here of 2 per cent can often be significantly absorbed just in drugs-cost inflation alone and we have no control over that. We try and

adopt the most efficient procurement processes to get the best prices on the drugs we use but it is something that is totally beyond our control.

Senator S.C. Ferguson:
It is something you can work on with Guernsey.

Deputy Chief Officer, Health and Social Services:
Yes, and something we are working on within this department. We are developing our pharmacy service to work with consultants to look at all their drug usage for when things fall off patent and we have made significant savings this year around drug usage against a backdrop of drug inflation. So we are working on it.

Director of Finance and Information, Health and Social Services:
Maybe I could add another one there. Just this morning I was discussing with the catering manager around 15 to 20 per cent increases in food prices; provisions, dry goods supplies, et cetera. All those various things impact on our 2 per cent growth over and above the inflation sums that the States allocate to the department, and there are not many other departments that have £1 million-plus of provisions purchases a year.

Senator J.L. Perchard:
Your main expenditure of course will be staff. Do you see cost of staff as being something that you will be unable to control if you want to compete in the international markets?

Managing Director of the Hospital:
I am currently carrying somewhere between 40 and 50 vacant posts for nurses across the hospital. It is not for want of trying to recruit them. We have tried repeatedly. We have been targeting the areas where we know nurses have been made redundant in the U.K. We have been going and doing specific recruitment exercises. We get significant interest at the time. That might convert into 30 applications. That might convert into 6 attending for interview. That might result a job offer being made. I am just thinking of one particular recruitment exercise we did very recently. That person took up the post and within 4 months of starting had to resign because they could not afford to live in Jersey on the salary they were being paid. So we have lost that person. That was in a specialist area that is very hard to recruit to. We are competing against an international market for some of these skill sets. These people can go and work in Australia, South Africa. They can work pretty much anywhere in the world. It is difficult for us to know exactly what the issue is that needs fixing; whether it is the accommodation; whether it is the basic rate of pay; whether it is the childcare issues or just the fact that the hospital is not at the level of infrastructure that they are used to finding in other places because there has not been the same investment in the hospital infrastructure in Jersey that certainly the N.H.S. has seen in the last 10 years. So it can come as quite a surprise when they come and see the conditions that we work in. We are struggling to recruit nurses.

[13:00]

Senator S.C. Ferguson:
It is a marketing thing, is it not?

Managing Director of the Hospital:
It is. We are trying to emphasise ...

The Minister for Health and Social Services:
Partially. It is more than that. It is a combination.

Senator S.C. Ferguson:
It is, I know, but in marketing you look at what the customer wants and in this case the customer is a nurse. You have to look at it from their point of view. I think that is a story for another day.

The Minister for Health and Social Services:
They are working very hard to try and recruit the nurses in Ireland and Scotland and whatever. You hear in the U.K. that nurses now are being made redundant. In fact it is not physical nurses that are being made redundant; it is just that they are not recruiting to the posts, to the vacancies that are there. That is slightly different but there is not just one issue. The staff are working very hard and continue to work hard to try and recruit the nurses.

Senator S.C. Ferguson:
I am not denying that. I am just saying it is a marketing exercise. Debbie, I am sorry. Did you have another point?

Deputy D.J. De Sousa:
Yes, if I can just quickly take you back to cost recovery on R.T.A.s. It is all green now. We have had the press release. You are going ahead with it. What liaison have you done with the insurance companies to ensure that they are not going to hike up premiums because you can bet your bottom dollar they are not only going to have to pay for an R.T.A. when they are taken by ambulance but they are going to have to pay higher car insurance as well.

Managing Director of the Hospital:
We carried out significant consultation particularly with the insurance industry regulator before we took this step. Interestingly they made it quite clear that it did not come as a surprise to them. They had been expecting it for some time. In fact, they could not understand why we had not implemented it earlier. There are a number of issues that are impacting on premiums for motor insurance this year, not the least of which is the recent ruling on discrimination which will lead, I am sure, to premiums changing. The view we have had from the insurance industry, and this was backed up on the day we made the announcement, was that this change should not alter premiums in Jersey for motor insurance. Whether or not all the companies decide that is how they are going to approach it, I cannot say, but there is not a reason I can see why this should alter the premiums. It is a relatively small amount. It has been there. I would consider it part of my fiduciary duties if I were running an insurance business to ensure that something that could be legally charged

was allowed for in the premiums. So it would be interesting to find out from the insurance industry whether that is the case. My suspicion is that it should not have a major impact.

Deputy D.J. De Sousa:
The other one is the achievement of savings. Stage 1 of the proposals that have been put forward: how many of them were implemented and you are making savings on now? There was one in particular that was put forward. There was something in the States about that one, saying it should not be done and there was a backtrack. It was not done; the hydrotherapy pool. So where do you expect the savings to come from?

Senator S.C. Ferguson:
I am sorry. We have run over slightly. I trust you are late for your next appointment.

Deputy Chief Officer, Health and Social Services:
The C.S.R. process has really been going on for years. I am sure Senator Perchard will recall going through these machinations on a yearly basis as we attempt to find savings. Many things come round again and sometimes they have more traction one year than another. Some things seem like a good idea but do not have the right conditions for to work and they may work next year. So there are schemes that we continuously look at and there is a variety of reasons why they may or may not come about but they are fruitful areas for reconsideration. We looked at the whole issue of the provision of physiotherapy services. Again coming to Senator Ferguson's point is about working with the people on the ground about how best to optimise the delivery of that service and at the same time release the cash. The physiotherapy service came up with a way of doing it which kept that pool open for the time being. Sweating the asset - excuse the pun - using the pool most appropriately until the end of its life and then considering it at that point but still delivering the same.

Senator S.C. Ferguson:
Thank you very much indeed everyone. Have you anything else, Neil?

Mr. N. McLocklin:
No. That is fine, thank you.

Senator J.L. Perchard:
Just one question, it requires a yes or no.

Senator S.C. Ferguson:
I am sorry, but no. You will ask it afterwards. It is after 1.00 p.m., unless you can keep it down to 5 seconds.

Senator J.L. Perchard:
It requires a yes or no answer. Are they any reoccurring costs involved with the reinstatement of the Reciprocal Health Agreement?

The Minister for Health and Social Services:
It is the £400,000. Yes, there is. Yes.

Chief Officer, Health and Social Services:
Yes.

Senator J.L. Perchard:
So it is not a knock-for-knock?

The Minister for Health and Social Services:
It is a knock-for-knock. Russell?

Director of Finance and Information, Health and Social Services:
We used to receive £3.9 million from the U.K. to allow for the carriage of fees. With the demise of the agreement it was considered that we would be able to gain £400,000-worth of income by charging U.K. patients. Obviously, and rightly so, the U.K. would be billing Jersey patients and their insurance companies for those in the U.K. So obviously the amount we received through the business plan was reduced by £400,000 to £3.5 million. Now the agreement is back we are unable to bill the U.K. visitors for that £400,000 and in the same way, the U.K. is not able to bill the Jersey visitors for whatever sums they were receiving in the U.K. So it is a knock-for-knock arrangement because the agreement is the same. Where the difficulty comes in, when the funding was received by the department through the business planning process for the demise of the agreement, it was reduced by the amount that we would be able to charge U.K. visitors. Now with the agreement being reinstated, we will no longer be charging those visitors and hence we cannot receive that £400,000.

Deputy Chief Officer, Health and Social Services:
So we have a hole.

The Minister for Health and Social Services:
So there is a gap.

Director of Finance and Information, Health and Social Services:
But there is no money changing hands.

Senator S.C. Ferguson:
Thank you very much indeed.

[13:07]