STATES OF JERSEY

Public Accounts Committee

MONDAY, 20th JULY 2009

Panel:
Senator B.E. Shenton (Chairman)
Senator A. Breckon
Connétable J.M. Refault of St. Peter
Deputy T.A. Vallois of St. Saviour
Mr. A. Fearn
Mr. M.P. Magee
Mr. P.J.D. Ryan

Witnesses:
Mr. M. Pollard (Chief Officer for Health)
Mr. R. Pearson (Director of Finance and Information)

In attendance:
Ms. A. Heuston (Committee Clerk)

Senator B.E. Shenton (Chairman):
… in front of you. I will not read it out. You have both been to quite a few Scrutiny hearings before so you know that you are covered by privilege and whatever you say and so on and so forth. We cannot sue you unless it is something that you know to be totally untrue, so there you go. Thanks for coming along. We are going to let you do most of the talking today. We are going to butt in now and again with the odd questions, but let us start off with asking Russell … I have got to introduce everyone, that is probably the start. We have got Alexander Fearn, Martin Magee, Deputy Vallois, Constable Refault, Senator Breckon, Anna and Rebecca, Mike Pollard and Russell Pearson.

Mr. M. Pollard (Chief Officer for Health):

Chief Officer for Health.

Senator B.E. Shenton:

Russell is the Finance Director. I will start by just asking Russell where do you see the main problems last year in respect of managing the department ... or so far this year, let us talk about this year. Where are your main problems so far this year?

Mr. R. Pearson (Director of Finance and Information):

I am sorry, just to clarify the question, are we talking about the sort of financial pressures that the department is facing?

Senator B.E. Shenton:

That is right, yes, in keeping to budgets and allocations for funds and looking at the accounts where you had the pressures last year as well.

Mr. R. Pearson:

Okay. I think to try and overview how the department needs to be managed and my view on making it all work and hang together is that one always needs to have a level of flexibility around it, to be able to respond to pressures and priorities that inevitably change throughout the year. So we manage the department with that always in mind. As I say, we have experienced considerable pressures last year and into the year we are in at the moment around … especially last year was very much around non-pay expenditure, drugs, consumables, increased patient activities that is generating more renal activity, those kinds of clinical areas that while a level of planning can be undertaken, inevitably things do not always turn out the way that we would expect and obviously the more time and effort we put into planning, the better obviously our predictions can be but even then it still requires a level of flexibility between the 2. So it is a kind of overview, I suppose, of where the numbers are, effectively. The planned development and things that we were intending to do in the year that we are talking about were very much restricted out to effectively pay for the non-pay pressures that the department was experiencing. So as a kind of an overview of the numbers, you can hopefully instantly see around the change in the year between the actuals and the comparison to the Business Plan figures, it is very around ... in comparison to the budget figures, it was very much around underspending or not achieving that plan in pay or in staff costs and that is very much around how we restrict the developments or vacancies, difficulties with recruitment, all those kinds of factors add up into there. The main thrust is that obviously that money was utilised to cover the non-pay pressures of additional drugs and supplies and consumables. I do not know if there is anything in particular …

Mr. M. Pollard:

One of the additional problems is really obviously the placement. I know that the Senators and Deputies here present will understand family X. Sadly, there is not just one family X and we have maybe 20 to 30 patients who we call our £1 million patients who, over a 5-year period, can cost us that kind of money. Family X most certainly will. In a small Island, we have the volatility of having to manage the fact that ... let me just speak figuratively. If I have 2 cases like that, then I can manage it. If circumstances present me with 10, we have got a very, very serious in-year financial problem. So we are always managing that volatility which, as Russell has described, is really quite important to us. We have found it very difficult always to reconcile the 2 things. Firstly, there is the volatility of our business and, secondly, the need for very clear time lines and procedures by which the business planning and the budget-setting takes place. They are actually inherently in conflict and that makes us probably as uncomfortable as your good self, Chairman. A good example of the volatility this year is that you will find absolutely nothing in the 2009 Business Plan to deal with swine flu. You will find quite a bit to do with H5N1, of course - that was avian flu - but as we know swine flu presented itself to the world in April this year. If I was slavishly following the Business Plan, we would not be doing anything in that particular area which would be clearly not the signal that we are receiving from the Government, your good selves.

Connétable J.M. Refault of St. Peter:

Just coming back, Russell, if I could just ask you, you spoke about delaying planned developments and pay lines. Can you just clarify that for me?

Mr. R. Pearson:

Well, yes, obviously, a part of the business planning process is we make a view of where the additional resources that have been voted to health would go to and obviously by restricting … I suppose our view is basically if we do not do what we do today safely, then we should not be adding to it with a new scheme, in effect. So the way that the management or the flexibility is built into the system is to have those plans but to delay those or cease them altogether if ultimately the resource is needed for another

higher priority that materialises in-year which is, as Mike says, around the difficulty between the Business Plan timetable and then us finding out between effectively now and maybe January of the following year that actually there is a new priority or a new pressure that has materialised. You know, often a nice pronouncement around a certain type of drug can cost £200,000 or £300,000 at the stroke of a pen, so these kinds of sums are quite large for our department.

The Connétable of St. Peter:

Just again for clarity, in pay lines, are you talking about procurement or are you talking about staff costs there?

Mr. R. Pearson:

Sorry, staff costs I meant.

The Connétable of St. Peter:

So are you saying you are deferring some staff costs?

Mr. R. Pearson:

Deferring, I suppose it is about delaying the development of a scheme ...

Mr. M. Pollard:

Which tends to be staff-related.

Mr. R. Pearson:

So for a new development in service, maybe around additional establishments for a new development in a service, effectively the way management have worked in that year is we have slowed that down to a degree to release that money in the year and, therefore, that gives the flexibility to be able to cover the excess costs on the non staff.

Senator B.E. Shenton:

So, for example, like manpower expenditure £108 million actual against a final bill budget of £117 million?

Mr. R. Pearson:

That is right.

Senator B.E. Shenton:

Obviously, some of that money was diverted to supplies and services?

Mr. M. Pollard:

Correct.

Mr. R. Pearson:

That is right.

Senator B.E. Shenton:

Now, you obviously had a problem with the cost of drugs because you highlighted it in the actual report. Moving forward, what are you doing to alleviate that problem going forward?

Mr. R. Pearson:

Well, we have got a lot more intensive work now with the pharmacy department to actually undertake a more robust planning process, which has been in place for the financial year that we have now entered. So the resources that have been allocated to H. and S.S. (Health and Social Services) for 2009, a significant portion of what is optimistically termed "growth" is put against dealing with those pressures in a more planned way, whereas in that particular year the rigour of work had not been undertaken, which has been a lesson we have obviously taken on board in our planning processes.

Mr. M. Pollard:

We benchmark our consultant spend on drugs with consultant spend in the U.K. (United Kingdom) and Jersey is under and is well performing in comparison.

Senator B.E. Shenton:

So what was the main reason for the pressures on that side of the costs that sort of ran away last year?

Mr. R. Pearson:

Well, I think very much around oncology/haematology drugs and anti-fungals, et cetera. As I said, we had a few unique cases that really did boost costs up and while it is very hard to call ... you know, there are 2 ways of looking at them as unique. You can either say they are unique and, therefore, they were inevitable or ... sorry, you had to plan flexibility for them, or you build in a level of planning for them. The difficulty I have got, if I keep building in every risk, what I end up is I end up with attempting to set a budget that is so high and, therefore, outside of the resource limit for an event that may not happen within the year. So it is about making sure that that flexibility is retained basically by the senior management team and managed by myself and the Finance Department to be able to divert those resources into the right area.

Senator B.E. Shenton:

So how do you manage it? For example, if you have a number of people presenting themselves with very high cost treatment, how do you, as Finance Director, manage that?

Mr. R. Pearson:

Okay. Obviously, the first thing I would do is I would assess that with the Directorate where those costs were going to hit the service, where those costs were actually going to hit. I would assess whether they were capable of absorbing those costs themselves, whether through relatively minor actions whether they could reduce their expenditure on part of their set budget to manage that. That would be my first view on it. Obviously, then, the second thing I would look to do in my role is I would attempt to

manage that from ... providing it was a valid expenditure category that was outside of the manager's control, in effect, or outside their influence, I would then look to try and balance off a development that they were planning to do and explain to them obviously that they are unable to start that development because, effectively, they have got a real cost pressure that is hitting them right then, which is, as I said, around not building new services where there is already a potential for overspend. Finally, if that is not the case and there is not the resource available for that, then it would go forward to S.M.T. as part of our discussion and a management decision at P.S.M.T. level on reprioritisation of resources.

Mr. M. Pollard:

Overlaying all that is the body that I chair called the High Cost Drugs Committee, which looks at all of the very, very expensive drugs. We are talking here about £80,000 or £90,000 per patient. This committee comprises of doctors, Finance Director, nurses, Medical Officer for Health. We sit down and we try and determine how best we can manage that cost. It does involve us turning drugs down. We have turned down lifesaving drugs. A percentage, Chair ... the last case I dealt with, which I think you were Minister at the time, Chairman, was that there is a 35 per cent chance of an Islander living an extra 6 months if we actually use a particular drug that costs £80,000. Those kinds of judgments and decisions are made and they are very difficult ones to make. But they are actually made and some drugs are turned down. I would not like the committee to think we simply sign off absolutely everything that is suggested by way of medical practice.

Senator B.E. Shenton:

Just going back, what you are saying is if an area does have problems on the funding side, you may well take the money from ... relocate it from elsewhere within that area where a new initiative or something was being planned and hold back on that initiative?

Mr. R. Pearson:

Yes.

Senator B.E. Shenton:

Another area within the hospital where there are no funding problems, that new initiative may well go ahead as normal. Is that right?

Mr. R. Pearson:

No, unlikely. I would say the first process would be to turn around to say: "Is the area that is managing that cost, is there effectively a development associated solely with them?" and that would be the first. I am sort of creating a sort of a ranking almost of how we would work through ensuring that resource was available to deal with that unavoidable …

Senator B.E. Shenton:

But what happens if a development in the area under pressure is on a macro view much more important than a development in another area which, under your system, would go ahead, ahead of a very important development, but just because of by pure bad luck it is in an area that there is a spending pressure?

Mr. R. Pearson:

It is not quite as rigid as that. It might indicate …

Senator B.E. Shenton:

As you just explained it to me?

Mr. R. Pearson:

Well, that is my start point of my approach, but you are right. If there was a fundamental development that was assigned to that area that we knew from our senior management perspective that had to go ahead or was of a higher priority than, say, something that may have been occurring in another service area, then we would manage that flexibility.

Senator B.E. Shenton:

How do you do the basis of priority? How do you prioritise what is and what is not important?

Mr. R. Pearson:

For a significant and large decision that would have that kind of risk and impact, that would be part of the discussion at S.M.T. and obviously Mike, as Chief Executive, would be the lead in ensuring that we came to the right decision. Obviously, depending on the size of it, then it would go to the Minister for consideration as well.

Senator B.E. Shenton:

Your background, Russell, is N.H.S. (National Health Service) background, is it not?

Mr. R. Pearson:

That is right.

Senator B.E. Shenton:

Is this very similar to the way that in the U.K. the N.H.S. would manage their budget?

Mr. R. Pearson:

It is. I have come from N.H.S. Foundation Trust, which is at the forefront of U.K. public sector accounting, and that is the way that we would manage a health organisation.

Senator B.E. Shenton:

So it would tend to have a fixed budget. It would not have a sort of budget that is more little ebbs and flows with regard to illnesses and so on and so forth?

Mr. R. Pearson:

No, it becomes very fixed for the organisation that you are in and you have to prioritise and manage

within the resources that you have got.

Senator B.E. Shenton:

You are managing within the resources that you have. Everyone will argue that they never have enough money in just about any area of life.

Mr. R. Pearson:

Yes.

Senator B.E. Shenton:

Is the amount of money that you have within Health adequate to do the …?

Mr. R. Pearson:

That is a very difficult question, is it not, because everything is associated with the level of service that you are going to provide. So if you were to ask the clinical viewpoint of probably any clinician exactly what you just asked there, it would say that there is not enough money and there are always more things they can do and there are always treatments that could be provided which, on the margins, you would say would change someone's life but you might be, for example, changing one in 1,000 and you have to prioritise your resources into your major benefits and, obviously, depending on how much resource is available to you, it depends on how much of that difficult prioritisation you have to take. So I think it is a very difficult question because the only way you can answer it, I believe, is if you define exactly what service you are going to deliver and if you define it in that detail and you constantly define it every year in that detail, which would be a huge piece of work because of the sheer size and breadth of the Health and Social Services Department, then I believe I could answer that question conclusively with a: "Yes, there is enough money to deliver this service" or: "No, there is not." I believe at the moment we work on a basis that says we have got a level of service that we do deliver. I see my role as often about making sure that it does not creep upwards rather than take large incremental steps because creeping upwards is the worst thing to manage because that is where you discover in 5 years' time that there are

problems everywhere, whereas if you can manage the enhancements to services very tightly then you can always keep your service in line with the resources available.

Senator B.E. Shenton:

In the past, you have ... you are Health and Social Services, and in the past you have taken money from the Social Services side to cover shortfalls on the Health side. Have you ever considered ring-fencing the Social Services side so that it can never be accused of being neglected or being used to the detriment of Health?

Mr. M. Pollard:

The curious thing in 2010 is that the poor relation in the Health and Social Services Department will be Health.

Senator B.E. Shenton:

But that is quite a rarity and, certainly looking back, that has not been the case, has it?

Mr. R. Pearson:

I think my personal view on this and how I would advise managing an organisation such as Health and Social Services or the Department of Health and Social Services is to retain the flexibility because, to be quite frank, I always feel that I need the flexibility to be able to respond to the pressing issue rather than to be constrained by saying, effectively, that is a Social Services component and, therefore, that will take priority, in effect, over something that would be pressing maybe in acute services.

Senator B.E. Shenton:

Okay. Alex, do you …?

Mr. A. Fearn:

Yes. You obviously mentioned the continual battle between prioritisation and I know there have been

some challenging developments over the year. You mentioned Children's Services, for example. What areas have you had to prioritise over 2008 just as a …?

Mr. R. Pearson:

One small example is prison health care. There has been a programme to develop health care in the prisons, a very worthy, recognisable development that I would not argue is not something that we need to do, but as a pure example of that, the overspending on oncology drugs, for example, on people's direct access to those cancer … and, as we know, speed is of the essence in cancer. That is an example where effectively prison health care services have not been developed in the way that our previous Business Plans would have suggested we would have done that because we have prioritised in exactly the way I have described.

The Connétable of St. Peter:

Yes, there is just one thing I would like to deal with, going back to when we were just talking about given unplanned illness events such as H1N1 and the cost involved. How does that affect you with your procurement strategies?

Mr. R. Pearson:

Well, with procurement strategies I suppose there is no … depending on how quickly the emergency arises depends on whether you have to waive your procurement practices to get the job done. In Health and Social Services, basically we have a waiver process, so the only person who can waive financial directions - and the current financial direction 5.7 on procurement defines how we should do things - only Michael or myself can actually authorise a manager to not follow those procurement processes. So obviously on the assessment, if it is considered to be of such a high risk and such an urgent and necessary spend of which we would alter our procurement processes, then that is something we are aware of and would sign off and take responsibility for.

The Connétable of St. Peter:

What would cause you to trigger a change? Let us take H1N1 as an example. Has that triggered any changes in your procurement so far?

Mr. R. Pearson:

Yes, it has, actually. The main issue, I would say, or one of the key ones, is around a drug called Relenza of which we were contemplating building into our plan, going through an appropriate procurement process to secure the supplies, of which we are then informed that because of the worldwide rush on Relenza, it is suddenly of high priority to purchase rapidly, and that would be an example of where we would make an informed decision to go against our ... or basically to waive the procurement processes and to get a purchase in quickly without maybe testing as much as we would have on different prices and different suppliers, et cetera.

The Connétable of St. Peter:

I think the Medical Officer for Health said that that order has already been placed, has it not?

Mr. R. Pearson:

It has, yes.

The Connétable of St. Peter:

How have you worked your pre-funding of that? Where have you drawn … what have you had to sacrifice to bring that funding in place?

Mr. R. Pearson:

Well, that is right. We have made a decision at ministerial level that that would be prioritised over and above the other elements of Health and Social Services expenditure so, as I say, at the moment we are going through a very detailed service priority piece of work around for the 2010 Business Plan and obviously elements of that that can be brought forward into the year that we are in would contribute to those such decisions.

The Connétable of St. Peter:

So you have had to cut back in other areas to fund that, then?

Mr. R. Pearson:

Well, I think inevitably at the moment we have no choice as there have not been any additional funds voted to us for the swine flu potential pandemic. So, as I say, Health and Social Services has no choice at the moment apart from to reprioritise its expenditure to deliver that.

The Connétable of St. Peter:

Let us just hope the birds do not fly overhead with the H5N1 then.

Mr. R. Pearson:

It is a bit of a worry, yes. **[Laughter]**

Deputy T.A. Vallois of St. Saviour:

With regard to the reallocation of the funding, how is that managed in the case of when you go on to the next year with regard to the Business Plan you would have had key objectives of what you were going to achieve. Now, obviously, having to reallocate funds, how do you keep an audit of that going forward to the next year to say: "Well, we never achieved this and we have got no money and we are not going to be able to get money for that next year"? So how is that kept in tally for …?

Mr. R. Pearson:

Okay, I suppose there are 2 sides of it. It is whether it is a temporary reduction, so effectively we miss our Business Plan target for that year but the recurrent funds still exist because basically we use them in-year to deal with a one-off, or it is whether there is a permanent effective change that says we are no longer going to be doing that and we have to reappraise what our Business Plan says we are going … or what we said we are going to do and we are very clear that we have not done it and we are very clear

that we are not going to do it as well, and that … I suppose the audit trail is effectively kept on the finance system because as budgets are moved, either non-recurrently or recurrently, there is a trail of that on the J.D. Edwards system which is obviously maintained by Treasury and my team as an audit trail of the clear decisions that demonstrate, for example, that prison health care money is now no longer available for that scheme because it has had to be utilised for our deficit position in 2009. So that would be where the main audit trail was. Anything very specific then obviously it should be highlighted up into our Business Plan to say that that is no longer a priority of the department in light of the other priorities we have.

Mr. M. Pollard:

I think there is something missing, though, from the accounting processes in the States. If you go back to this issue about volatility, which we have to deal with on an in-year basis, and the need for some clarity around the timetabling of the Business Plan, there is an audit trail and we can demonstrate that and I do not lose any sleep over that, but what I think there is is there is a lack of post-hoc rationalisation. In other words, we know what we have done, the Minister knows what we have been doing or, indeed, not done, but I do not think the States more generally does and I think there is something lacking there. It might well be that what we have to do as we look forward to a Business Plan is to come up with a post-op rationalisation that tells in a transparent way the States why we have not done something. Because, of course, if you tell us to do something, the Committee, and we do not do it, you should want to know about that and that is something I think is that is actually missing and it will allow that reconciliation between in-year pressure and plan.

Senator B.E. Shenton:

I was curious. In the accounts, you wrote: "To compensate for overspends, vacancies were held open in administrative posts." Now, obviously, the obvious question there is were those administrative posts vital, then? If you can hold vacancies open in administrative posts indefinitely, you have got to question whether those administrative posts are necessary. The other part was: "And savings were achieved within services for older people by reducing the usage of nursing and residential beds in the private

sector" which implies that by using private sector beds you are significantly increasing costs, or have I misread it?

Mr. M. Pollard:

It means keeping such clients that require institutional care in hospital so they would still be residing in the general hospital rather than having their episode of active treatment being completed and then moved immediately to an institution, a nursing home, be it private or be it public.

Senator B.E. Shenton:

So it is cheaper to keep someone in hospital than it is to keep … it does not make sense, does it?

Mr. R. Pearson:

No. The situation there is the bit that is missing in that discussion is the bit that says the nurses in the hospital are already budgeted and paid for and there is a saving opportunity of not putting someone out, to be quite frank, an appropriate care setting. We are talking about prioritisation that is creating a less enhanced level of care. So what you may turn around and say then is: "Well, actually that obviously means there are too many beds in the acute hospital and, therefore, you do not need so many" but what is being dealt with there is the flexibility of demand because there is … obviously to be able to manage the acute unit, you need to have a cushion of empty beds to be able to deal with the emergency activity that spikes up every now and then.

Senator B.E. Shenton:

So what you are saying is these are only savings in terms of the appalling way the States does their accounts and, in reality, they are not savings at all?

Mr. M. Pollard:

It is a break because if we get to … I think we have probably got about 12 patients requiring institutional care at the moment. If that got to 13 or 14, however reluctant it is but if we are under pressure, then that

would be fine. If it gets to 20, 30, 50, that is not a sustainable position because we are eating so far into the bed stock that it is making the ability for the hospital to serve the Island ... but it is restricting the capacity we have. So it is an opportunistic thing. It is used as a break rather than as a full stop. Perhaps until the next year when you can try and reset some of that.

Senator B.E. Shenton:

Sorry, Martin?

Mr. M.P. Magee:

I have got a few questions. One is linked to the last couple in terms of ability to deliver objectives. I think it is quite a difficult one. Is there any incentive whatsoever for ... once you put your budget in place for you to deliver below budget or will you just find another home for a chunk of money to pay for another initiative that you have parked from another time?

Mr. R. Pearson:

Yes, that is very difficult to answer, is it not, because that ... or difficult to ... because until you can ... if you list up all of the examples and all of the individual services, then they all seem very valid and very positive and all the things that … the reason why they are on the table in the first place is because they will assist in patient care. To be completely frank, you are right, there is very little incentive for a department such as H. and S.S. to under-spend because when ... as the Chairman indicated, there is always a constant demand on the resources, always more, and, as I say, my job I see as very much about keeping the lid on it and making sure that the growth goes in the appropriate steps rather than as a kind of a free for all spill-out. So, you are right, there is virtually ... if someone says to me: "What incentive would there be for Health and Social Services to underspend?" there is very little, but I feel it is part of my role of stewardship to ensure that we do not inappropriately provide services just because we happen to have the money and it is a very ... across an organisation, a department as big as Health and Social Services, it is quite difficult to make sure that discipline is instilled in everybody who is involved in a purchasing decision.

Mr. M.P. Magee:

As a follow-on to that, we had a discussion recently with our colleagues from Guernsey and what came into the conversation was would there be any merits in the departments working closer together, for example Health in both Islands? My only worry, I guess, in what you just said to me is, fine, you could work together and potentially there would be savings, but you would just spend it on something else.

Mr. R. Pearson:

I think the way to manage that is very much having the upfront plan that explains what in the instance of, say, working together is. For example, I with my counterparts in Guernsey have started consolidating up what we do with U.K. specialist treatments, so patients who go over to the U.K., instead of a sort of a bit of a free for all that means they can be sent virtually anywhere, which might be very good clinical care but ends up with a whole raft of problems around transport links and appropriate accommodation and the other elements of the patient journey and care that will not be so positive, is I work very closely with them on that. If we say: "What incentive is there then for the savings to be … what happens to any savings, I suppose, generated out of that?" and I just say: "Well, we have a variety of programmes that are put forward by the States, both in last year's Business Plan and in this year's, very much so" which I think if we are upfront and straight about what we are doing, then obviously I can build that incentive in right at the start to say: "This money is not available to be reinvested in other services or pressures but it is there to deliver this objective", which may be to return money effectively to the spending power of the States such as the efficiency savings that have been put together or, alternatively, to have a very targeted plan internally that says we are reducing costs in that area but we are going to deal with the pressures in renal, for example, rather than bringing forward yet another case forward to the States and saying we need £400,000 for investing in the growth of renal services on the Island. So many of that could be done or is done internally but I see it as my role of trying to make sure that that plan is done upfront rather than during or after which is where the risk you are talking about exactly comes in because then I will lose control of it if it is not upfront about what we are doing.

Mr. M.P. Magee:

Our colleagues in Guernsey Health and Social Services Department confided in us about their financial difficulties next year, and I think it is that more than an exhortation of joint collaboration that is going to bring both parties together to try and incentivise it. They have had it not exactly easy - no one has it easy in health - but that is what has changed, I think, over the last 2 or 3 years. People are looking at that now with some increased level of urgency. We are looking very much to … we have a thing called J.E.T.S., which is Jersey Emergency Transport Service, which is the flights that we have for the public/private partnership to get emergency treatments in the U.K. for brain injury and various other things, and we are working with Guernsey at the moment to see if they will share the overheads with us and make it a Channel Islands rather than a Jersey. We will have to have a new acronym, then, but that is really an easy win if we can pull that one off.

Senator B.E. Shenton:

It does have a much more user pays mentality, though, does it not? I think you would pay for A. and E. (Accident and Emergency) and you pay ...

Mr. M.P. Magee:

Pay for A. and E. and ambulance.

Senator B.E. Shenton:

You pay £150 if you call an ambulance, do you not?

Mr. M.P. Magee:

Yes.

Senator B.E. Shenton:

Alan, do you …?

Senator A. Breckon:

Could you give us some idea of any opportunities there might be for increasing income from 2008 in 2009?

Mr. R. Pearson:

Yes, most certainly. We have touched on A. and E. there which is actually in the 2010 Business Plan. We are working a lot on costing and pricing of our private patient activity to ensure that not just we are obviously covering our costs on it but making an appropriate level of return, which as an aside is interesting. As we are not a trading committee, I believe the financial direction says that I have to deliver my services at cost, whereas I am probably breaking financial directions on that basis because I believe it is obviously not very sensible if we are having a private patient unit but being forced to run it at cost because the whole point of it is to generate additional revenue to create other services and investments in H. and S.S. So we are also exploring around pathology and some of the tests that are undertaken in primary care there as well. So there are a lot of opportunities for increasing charges if the will and desire is there.

Mr. M. Pollard:

One of the things you have to be careful of, though, is the dictum in the States that we cannot unfairly exploit our infrastructure to get a marketing edge. We are a private company. That is what has prevented us being able to market our laundry because our laundry we could … I was going to say "clean up" but I do not think I should term it that. We could make a considerable amount of money but then we would be an unlevel playing field with many other private sectors, so it is a very difficult area. It has been fully explored.

Senator B.E. Shenton:

Although within catering, I think you are expanding the catering side, are you not, within the private sector to a degree?

Mr. M. Pollard:

Yes, we do that, yes. It is a difficult market so it ebbs and flows quite a bit.

Senator B.E. Shenton:

Have you thought about top-up fees? Big argument in the United Kingdom at the moment, is it not?

Mr. R. Pearson:

Sorry, top-up fees?

Senator B.E. Shenton:

Top-up fees, yes.

Mr. R. Pearson:

Yes, there is definitely something to be explored in the long run about … like I say, obviously people's desire to have a level of health care and then ... sorry, residential care, nurse care, and then the ability to be able to pay more themselves depending on how they choose, I suppose, to utilise their funds. I think there is a complex debate to be had around that, is there not, about the kind of ethical nature of someone who is in effectively a public service but then can have an enhanced service because they can afford to pay for it. I think that is all going to be part of our longer term discussions around that.

Senator B.E. Shenton:

Well, that has been a moral maze about the ability to pay for certain drugs that you cannot get.

The Connétable of St. Peter:

In airlines I would call it economy plus rather than club class, but certainly it is a debate ... is it not a debate that is actually, in this current climate, not better brought forward sooner rather than later to when it has to be had, you know, just to get the funding stream?

Mr. R. Pearson:

I think it is a vital component to the future discussion on funding of long-term care on the Island, definitely.

The Connétable of St. Peter:

Do you see that as a role of your department to bring that forward?

Mr. M. Pollard:

Yes.

Senator B.E. Shenton:

Tracey, did you have a …?

Deputy T.A. Vallois:

Yes, with regard to a written question to the Minister on 30th July that I asked with regard to reduction in full-time equivalent employees, it was 42.57 F.T.E.s (full-time equivalent) were reduced between 2007 and 2008 and I was advised that the decrease in this was associated with a restriction of recruitment in the attempt to contain costs within the approved 2008 H. and S.S. cash limits. Then it goes on to say that with regard to the increase in funds of £11.4 million between those 2 years, that the above manpower increases account for £5.4 million, so how is that being addressed? I am assuming this "above manpower increases" is overtime or increased workload or contracting or …

Mr. R. Pearson:

Sorry, when you say "above manpower" are we talking about the …?

Deputy T.A. Vallois:

It says: "above manpower increases."

Mr. R. Pearson:

If I could just view that ... Sorry, I believe it is saying that the extra costs are associated with the non-pay, so supplies, consumables, drugs, et cetera, rather than the manpower. I think what we said is there is £11.4 million difference between the total costs in H. and S.S. between the 2 years of which £5.4 million is manpower and the balance is supplies, consumables, drugs, et cetera.

Deputy T.A. Vallois:

All right, okay, because it just said it was "above manpower" so I did not know whether that was with regard to …

Mr. M. Pollard:

I think it means "the above manpower" as opposed to "above manpower".

Deputy T.A. Vallois:

All right, okay.

Mr. R. Pearson:

Yes.

Mr. M. Pollard:

It is just poor phrasing. It means the above, it means above that.

Mr. R. Pearson:

It does, I wrote it, yes. **[Laughter]**

Deputy T.A. Vallois:

With regard to the actual F.T.E.s in Health and Social Services, by reading the statement that was made on that written question, is more recruitment required and, if so, why are you decreasing F.T.E.s?

Mr. R. Pearson:

All right, I think what we have got is we have got a very high level of vacancies across Health and Social Services both in the financial year that we are talking about for the accounts as well as currently. So I know from personal experience my finance team has had … I think we have been running at almost 20 per cent vacancies for the whole 2 years I have been here. So you can appreciate any team that is trying to deliver the same plus actually the enhancements of financial management that the States and Treasury are expecting of us is actually putting that team under a lot of pressure. Exactly the same exists obviously in all aspects of … the ward establishments(?) in Social Services and teams are struggling to deliver what they need to deliver purely because they are finding it very difficult to recruit suitably qualified and appropriate staff.

The Connétable of St. Peter:

Given that you are breaking relatively even on your costs, if you had that staff you would not be able to contain it within your budget, would you?

Mr. R. Pearson:

That is right.

The Connétable of St. Peter:

Moving on, then, I notice on your report it says: "At yearend Health and Social Services had 4 capital projects showing total overspend of £262,000. The department is currently in discussion with Property Holdings." Is this a case of selling off the family jewels to make the budget work?

Mr. R. Pearson:

That particular bit is not, no, that was around feasibility studies where money was supposed to be flowing … or I believe the Property Holdings Department had made a commitment to pay for the studies, in effect, and then decided at some point that they were not.

Mr. M. Pollard:

They gave us a bill back.

Mr. R. Pearson:

So, effectively, then, suddenly we have got costs that are hitting our lines that we thought we were going to either receive reimbursement for or were going to be part of Jersey Property Holdings' costs of which they then left with us, which obviously creates a problem now for me on my capital programme because I either need to keep arguing with them or I have to reduce a different capital programme to pay for it.

The Connétable of St. Peter:

Just coming out of that from a slightly different angle now, does that, in fact, reflect the fact that there was not a proper robust sort of plan put in place when that study was put in place about who was going to fund it and whether the funding was going to fall?

Mr. M. Pollard:

It was really around the transition of what Jersey Property Holdings was to become. As we know, it started, I think, in 2007, and it had not sorted out its internal trading arrangements with departments, so we got caught out on this one. It will not happen again, I can assure you.

Senator B.E. Shenton:

Is that a case that there is 2 departments … we have come across this in other areas where 2 departments working together, because it is 2 internal they do not put the same robust terms of reference in place when something is happening as they would if they were dealing with an outside organisation?

Mr. R. Pearson:

I do not think that is the case in this one. I think that obviously an informal conversation has occurred which indicated everything was going to work between the 2 departments in the spirit of 2 departments

of the same organisation working together and, ultimately, maybe other priorities took place in Jersey Property Holdings and it did not materialise in the way that those who had those conversations expected. So, as I say, I am very clear about formal plans and notifications to ensure that before the funds start getting spent then everybody is clear about who is picking up the bill.

Senator B.E. Shenton:

Well, I will just put you on notice. One of the things we have picked up from the Energy from Waste Review was that when departments do work together, the robustness of the actual setting out exactly who is doing what is not always there through familiarity so ... sorry, Alan, you were …

Senator A. Breckon:

Can I just come back to the manpower, the Business Plan and the approved budget. Manpower was about £117,000 million and the actual was about £109,000 million in 2008 as recorded in the accounts, which is an increase of about £6 million on 2007. There is a significant difference there and some of that money is about £6 million gone to supply and services and £2 million to premises and maintenance generally. What would happen, then, if you worked to a full staff complement?

Mr. R. Pearson:

You are right. One of the big risks, I suppose, is we would lose a big proportion of the flexibility that we had in that particular year to manage the non-pay expenditures and obviously the senior management team would have to … or I suppose I would be advising the senior management team that the options that maybe were available in this particular year are no longer available because obviously the posts have been recruited to, if that were to be the case, and obviously then we would have a more difficult management task in ensuring that we lived within our cash limit.

Mr. M. Pollard:

Which would involve cutting services.

Senator A. Breckon:

Is it true to say, then, that actual vacancies or failure to recruit gives you the flexibility to run the service?

Mr. M. Pollard:

To some extent it does, but we have to mitigate … you have to understand that we have to pay lots of overtime out to some staff. I mean, the vacancy factor in nursing and midwifery at the minute is about 5 per cent, but it does give us some flexibility in areas where we do not have to automatically cover the posts in the way I have just described. Departments like ours do have a level of turnover so, although I would love to envisage it, I can never conceive of a time in reality when I would have no vacancies.

Mr. M.P. Magee:

Can I ask a follow-on question, Russell? I assume that you are doing forecasts for through to the end of 2009. Is it the same picture again?

Mr. R. Pearson:

Very similar, very similar, albeit many of those vacancies are in different places but it is a similar situation, yes.

Mr. M.P. Magee:

So it could be a challenge for your direction(?) that you have got to an extent an element of contingency always in your manpower number because you are never going to fill the vacancies?

Mr. R. Pearson:

I think that could be the case. The difficulty is obviously at that point then you are making a conscious decision to redefine the service that you are going to provide because it is no longer a temporary inability to provide some of the elements of the service. It becomes permanent if you view it as a contingency of which must not be recruited to.

Senator B.E. Shenton:

I suppose, looking at it another way, if you are running to the maximum in every single sort of business area, let us talk about suspensions. If you have got senior staff suspended, a lengthy suspension could force you to cut services to the public.

Mr. R. Pearson:

Yes, that is right.

Senator B.E. Shenton:

On suspensions, it is well known that you do have some suspensions, and one in particular is a very high cost, in excess of £1 million. How are you budgeting for that going forward or …?

Mr. R. Pearson:

Effectively, that for me is planned. I have planned that into the plan for this year or ... obviously it is more than actually I think we expected it to be in 2009 as well, and I will be assessing where it is when I prepare the full detailed 2010 plan for Health and Social Services.

Senator B.E. Shenton:

So in the 2009 plan, had you budgeted for that suspension to be for the whole of 2009?

Mr. R. Pearson:

I had done for an element of the cost, about 6 months' worth.

Mr. M. Pollard:

Chairman, it would be prudent for us not to budget for that but that does not mean in any way we are anticipating that an individual would be suspended for that length of time, because obviously what we are required to do by the States is to minimise the period in which all members of staff subject to

suspension are given that status. We must reduce that time on every occasion. So there is nothing in our financial planning that suggests that this individual or any other individuals will be suspended for that length of time, is the point I am trying to make.

The Connétable of St. Peter:

Just moving on to another subject, just noting in your income and expenditure in the Annual Report, you get an income, or you have done shown in here, of 2007-2008 of a grant from Drug Trafficking and Confiscation Fund. Is that something you budget to in expectation of or was that a windfall?

Mr. R. Pearson:

Basically they are set programmes that are accelerated or slowed down depending on the availability of those funds, so I view that very much as the money is there to be spent on the scheme that it has been provided for but that is not part of … if the funds were no longer available, then we would be ceasing those services that are currently being provided on the back of that money.

Mr. M. Pollard:

This fund is used for pump priming schemes so if it has got a recurring revenue impact beyond 2 to 3 years, then that falls outside the rules and one cannot make a bid against the fund for that purpose, to guard against what you described, Constable, as having a permanent service with a kind of problematic source of funding.

The Connétable of St. Peter:

So this is not an automatic grant? You have to bid for it?

Mr. M. Pollard:

You have to bid for it and specify the time period for which you are seeking funding. The idea is that normally … if it was a desirous scheme - because, of course, we would not put it into anything that was not desirous and relevant - then we would pick it up from the general funds later in a specified year.

The Connétable of St. Peter:

Is there a temptation that something that you should be developing, a new policy or procedure, would go forward as a grant under this fund?

Mr. M. Pollard:

There is always that temptation. I will admit that.

The Connétable of St. Peter:

Okay, thank you.

Senator B.E. Shenton:

Can you benchmark your costs? Take oncology. Can you say: "Well, the costs of oncology should be X if we use somewhere in the U.K. as a benchmark. It costs Y in Jersey"? Is that something you can do and is that something that you do do?

Mr. R. Pearson:

I think the answer to that is anything is possible. We can always undertake those pieces of work. It does depend on the level of detail versus the variance in the accuracy and how important the variance of the accuracy would be. So the answer is we can undertake any of those pieces of work if it is of the right strategic importance for us to use our resource effectively in the management and finance team to undertake that piece of work. My plan is to very much - this is obviously depending on resources available in the Finance Department - create a lot more of a regular kind of an annual process of ensuring that our kind of cost base … or I suppose I see it as a way of managing our cost base is to know where I am in light of other services. So, for example, if I wanted to seriously consider oncology in that level of detail, I would undertake the appropriate level of costing work to determine the costs of oncology services in Jersey. I could then compare, with the right activity stats, into an appropriate service in the U.K. or I could, for example, go to … I could tender to a U.K. service if we decided, as a

management team, that would be a desirable way to go forward. So the answer is, yes, we can do it. The difficulty at the moment is I do not have the resource in the finance team to routinely do that, but I am actually trying to reconfigure my team to try and reduce some other tasks that they are undertaking to get a lot more of that kind of information routinely available to the management of Health and Social Services.

Senator B.E. Shenton:

So do you know how much it costs for a bed in the Rainer ward or a bed in the Samarès ward and different costs of a bed in different parts of the hospital?

Mr. R. Pearson:

Yes, effectively we do. We have it done fairly blanketly across the whole of H. and S.S. actually rather than detailed by ward at the moment, but if I wanted to get stuck into a particular area, then I would undertake a piece of work that would do that.

Senator B.E. Shenton:

You would assume that the cost of a bed in one ward would be higher than another if it is in a ward where the nursing staff have to have higher skills, but you say you do not actually know the cost?

Mr. R. Pearson:

I think the answer is we do not routinely keep on top of every change that occurs to make sure that we are always on top of costs, because what I could propose to do and what my plan is, is to start to undertake an exercise every year that utilises obviously the activity information that we have for that financial year and the costs for that financial year to then put the 2 together to create exactly that piece of work so that I would build up my costs by paediatric services, by ward area. At the moment, that is not routinely done.

Senator B.E. Shenton:

I come back to this in the accounts where you are saving money by keeping people in hospital beds rather than putting them out into the private sector, but you do not know how much those hospital beds are costing you but you do know you are saving money so …

Mr. R. Pearson:

Yes, I think the slightly complicated answer to that is the purchase of a bed for an elderly person out of the acute unit is very clear what that is because obviously you get an invoice and a charge for it. Now, I think we would say it is more effective health care and it is more effective in every aspect to have that patient out into that bed in that case. The issue comes around saying there is effectively a level of spare capacity in a hospital bed because, by definition, the emergency admissions that an acute unit receives fluctuate daily, so it can be trended fairly consistently over an average but on a daily basis it is very variable. So the thing is you have to staff your ward for your expected and sometimes it will be less and sometimes it will be more. So the example of saying about the … it is not really about the cost difference between the ward and the care home. It is about saying the staff who are providing the care are budgeted and there in place and if I put that person out, those staff are still going to be there in place and being paid for but I am also going to get an invoice from a care home for a bed day. So it is about saying in cost terms it is probably … it is cheaper ... well, it is more effective, that is for sure, to have the person in the right care setting, but the fact that the staff and all the rest of it is already in place on the day that that person stays an extra day in the acute unit rather than going out to a care bed means that, by definition, I save the charge from the care bed and it is a cost that I was always going to bear anyway.

Senator B.E. Shenton:

That reminds me I had a conversation with the former Minister for Education who had an office at the time(?), and he said the office did not cost the taxpayer anything because it was already there. Alex, sorry.

Mr. A. Fearn:

Just to follow up on that, there are obviously overtime costs involved in providing services so there is

obviously a tipping point where you have got a core team required to meet your expected service. You are saying that you can leverage that core team to provide beds that would be otherwise provided from the private sector but you have also got overtime, so there has obviously been some use of overtime to maybe fund those people that would have normally been in the private sector, for example.

Mr. R. Pearson:

Depending on the exact circumstance but basically the shift pattern is in place on a permanent regular basis, so having an empty bed on a ward does not mean … because of the sheer numbers, one empty bed does not mean that you drop a member of staff because you need maybe 6 to 8 empty beds before you would drop a member of staff. Having an extra patient in that bed does not necessarily generate overtime, although it could be that case. I think it is a tool of flexibility which we have to employ along with the level of vacancies we have, the types of developments we have got going on, as well as, in this case, the capacity of the acute unit at any point in time that is organised to run at that capacity and depending on the fluctuations in that.

Mr. M. Pollard:

It is probably about 11 to 14 institutional care patients requiring placement in nursing or residential homes and there will always be people there because, of course, they have to remain there. Once the decision has been made that their active treatment cannot be progressed, then there is the process of consulting with them and their family to try and get them in the right place. So there will always be a number and there is a big danger, I think, that we actually exaggerate the size of this.

Senator B.E. Shenton:

Yes, sorry, Tracey.

Deputy T.A. Vallois:

Russell, you mentioned your background in N.H.S. but also that the financial structure and the management in the N.H.S. is similar to here, you said?

Mr. R. Pearson:

The process, yes.

Deputy T.A. Vallois:

So with regard to that, is the N.H.S. not separate to Social Services and, in that case, would not separate in the areas, because you did mention the flexibility volatility within the area and having to transfer monies, reallocations. So with regard to the actual structure and the management or the process, even, within N.H.S., how does it compare?

Mr. M. Pollard:

What we do - because I am from the N.H.S. as well, actually - is that you seek to develop flexibility over your entire organisation, but the organisation of the National Health Service is most certainly different from the Health and Social Services Department here. If we were in the United Kingdom, there would be a trust that would be purely focussing on general hospitals. That is my background; I have worked in general hospitals for 27 years. So it would be an enormous hospital but that is the only business it would do. I could also then work for another organisation called an ambulance trust. This would typically be 5 counties. The only thing it would do is ambulance. Its entire infrastructure, its entire management, its process, an executive board would be entirely focused on that. If I was in Social Services, I would be working for a local authority. The only thing this body would do is social services. The level of literacy of the management would be very, very high in that specific class. The same for mental health. Here, the problem that we that have is that we have to run a highly complex organisation, albeit the numbers are smaller. The dynamics, the variables, and the unintended consequences are all the same. It is simply the order of magnitude.

Deputy T.A. Vallois:

Do you believe there is a problem there?

Mr. M. Pollard:

A problem where?

Deputy T.A. Vallois:

You just mentioned that the problem is that …

Mr. M. Pollard:

Well, I think the problem is the size of our brains to be able to comprehend the level of complexity that we have to have here in Jersey, which is not something that one knows when one comes. I think the problem ... or it is the opportunity because if it was in a general hospital, if we had a problem in, say, medicine, we would be looking across our entire organisation to use these devices. Here we can look over basically a very large, complex department … a rather complex department with many sub departments, and we do the same kind of techniques, vacancy factors, using breaks where possible, buying ourselves time until we can establish the funding on a more sustainable basis in the subsequent year. So we are always playing that kind of … I use the word "game" but I mean it is too serious to call it a game.

Deputy T.A. Vallois:

Can complexities not cause budgetary problems, though? More complexities within an area can cause more budgetary problems?

Mr. M. Pollard:

In one sense they do simply because we have to be generalist, given the complexity of the organisation, and we obviously do not … we cannot in one sense trade with the shire county down the road in terms of solving problems, so we do have the problems of trying to work within an Island, you know, it is a fixed base(?). We have to consume our own smoke. We cannot, as I say, go down the road and seek help as we … there is a duty of partnership in the National Health Service where all organisations in extremis have to help each other. We have to recognise that we very much have to sort this ourselves.

So it is a matter of complexity and matters of size of the problems that we often have in management.

Deputy T.A. Vallois:

So more emphasis on co-operation with the other Islands as well?

Mr. M. Pollard:

Yes, that is something that we are actively pursuing.

Mr. M.P. Magee:

Could I ask a linked question to that? What is the relationship for Russell with Treasury? You know, just in terms of Treasury Department and how that links with departments. Some of it is how much … who has got the, I guess, not so much power, that is the wrong word, but how does that relationship work? How much influence does, say, Ian Black have over you? Is that linked to an F.D. (Finance Director) in an archetype organisation?

Mr. R. Pearson:

Yes, it is exactly that. Ian Black is my professional head. Obviously, from a management perspective I report into Mike as the Chief Executive and Accounting Officer of Health and Social Services. So while it is constantly up for debate, the structure that we have at the moment is very much that Mike, as Accounting Officer, is responsible for the financing, et cetera, of the Health and Social Services Department and the Treasury ... as I say, see that relationship. So while they are keen to discuss with us the various issues that we may be facing, the bottom line is there is generally an expectation that most things will be sorted out at a departmental level and only things of great significance or Island-wide, et cetera, would start to generate a level of Treasury involvement. So I am fairly comfortable working in that arrangement. I could work … I do not see any reason why it would not work the other way around either, you know, with Treasury having far more involvement if they so wish, but I think the difficulty for that, then, is the concept of accounting officer then is slightly undermined as it becomes unclear about who is taking real responsibility. I can give an example. Some of my colleagues in Health and

Social Services believe that if they tell me it is a problem and it has got a financial sum attached to it, somehow or other it becomes my problem, and it does not change the fact that actually they are still potentially … the plan that they might be undertaking is going to incur resources they do not have. I do not think it is positive to create a similar confusion between the department and Treasury but I do think there is a lot more work than can be done at, I would say, a policy type guidance type level across the States overall from Treasury that would assist the smoother running of the department overall.

Mr. A. Fearn:

That does not exist at the moment?

Mr. R. Pearson:

It does exist but I think it is slightly uncertain as to …

Deputy T.A. Vallois:

It is not consistent.

Mr. R. Pearson:

That is probably the right way of saying it. There is an element of inconsistency. We have the F.A.B. group, the Finance Adviser Board, which is the pulling together of the Finance Directors, but I think there is a mixture of some things that need a lot more clear steer and maybe a bit more dictat about: "This is how it will be done" rather than an option that then never happens, and I think that is something I think that we, in our role as Finance Directors, in our relationship with Ian Black and the Treasury, we will constantly be defining as we go.

Mr. M.P. Magee:

Is Ian chair of that committee?

Mr. R. Pearson:

He is.

Deputy T.A. Vallois:

How often do you have meetings at the moment with Treasury, on an average scale, say, 2008?

Mr. R. Pearson:

I am probably involved 2 to 3 times a month, so I have various formal sessions with the F.A.B. Board, which is once a month, and we have a monthly session about our particular finance position in H. and S.S. with Treasury which we discuss on a monthly basis regarding our forecast and where we are and what is happening, as well as a variety of informal meetings that I have with other Treasury officers, especially around reports and propositions, et cetera, that may be going to the States. So probably 2 to 3, maybe 4 meetings on average a month.

Senator B.E. Shenton:

Does anyone have any very short questions they want to ask?

Mr. A. Fearn:

Just quickly on the I.T. (Information Technology) system which is obviously mentioned in the report and accounts. Sorry, just quickly, how do you see that transforming or the benefits of that system to running the Health and Social Services Department?

Mr. R. Pearson:

Maybe if I maybe major on the finance side and then maybe Mike will pick up on the sort of whole clinical side of it. For me personally this is a kind of a massive, necessary development purely ... as I say, ignoring all of the clinical benefits for a moment, but as I was discussing around costing of our services, the way the information is managed at the moment is not particularly conducive to pulling together the right type of information for me to undertake the type of costing work that we were discussing, and obviously part of my drive behind this project is very much about getting a routineness

of kind of activity type information out which then makes it a lot easier for me to start hanging the costs on each month to understand actually what is really going on in our activities. Because obviously at the moment I have got very much a sort of a pound basis of what is going on. Only, as we all know, when we mix that up with the volumes do we really get good at management information. And I think if Mike talks about the clinical benefits.

Mr. M. Pollard:

Okay, the I.C.T. (Information and Communication Technologies) programme is basically 2 phases. The first phase is fully funded by the States of Jersey and the second phase is yet to be considered in any formal sense. The trigger for the investment was the fact that the company that maintains the current systems, called E.D.S. (Electronic Data System), was to withdraw from the market because they had been squeezed out of the I.C.T. health market in the U.K. That creates a lot of problems for us, as we described it kind of aeroplanes falling out of the sky kind of crisis, because, of course, they maintain their own equipment. You cannot get other people to maintain it. You can all fill in the dots on that. So that was the trigger. The state of our I.C.T. systems are fairly parlous, as Russell has made clear. The first phase looks at 2 basic projects. Firstly is a thing called P.A.C.S., which is Patients Archiving Communication System, which is digitised X-rays which I am sure you are familiar with. Everybody who comes to Jersey from the radiological role looks curiously at having these old things you see on the soaps where, of course, these days it is all digitised, available at speed, so that people can retrieve them instantaneously and that could save quite a lot of money in storage and films and things like that. That is the first part of the first phase. The second part of the first phase is to replace this what I call the E.D.S. with a passing database, and those who are familiar with this, it is a bit like I am trivialising it to call it like a hotel rent-a-base where you know who your guests are but it is only a system like that. One has to have that kind of basic system when you are dealing with 100,000 outpatients, 50,000 inpatients, 30,000 A. and E. attendances. There is only one way of managing it in the modern world and not making mistakes but at least minimising those mistakes. That is what the project is about and it started on the procurement deal on the £12 million project 2 weeks ago.

Senator B.E. Shenton:

We have overrun a little bit, but thank you very much for coming in, thank you.