STATES OF JERSEY

Public Accounts Committee
Emerging Issues - States Spending Review
Review of the Report of Comptroller and Auditor General

FRIDAY, 15th JANUARY 2010

Panel:
Senator B.E. Shenton (Chairman)
Connétable J.M. Refault of St. Peter (Vice Chairman)
Senator A. Breckon
Senator J.L. Perchard
Mr. A. Fearn
Mr. K. Keen
Mr. M.P. Magee

Witnesses:
(Director of Finance and Information for Health and Social Services): **(DFI)**
(Acting Chief Executive Officer for Health and Social Services) **(ACE)**

In attendance:
Ms. M. Pardoe (Scrutiny Officer)
Mr. C. Swinson (Comptroller and Auditor General)

[14:08]

Senator B.E. Shenton (Chairman):
A couple of things before we start. The proceedings of the panel are covered by parliamentary privilege under Article 34 of the States of Jersey Law 2005 and the States of Jersey Regulations 2006. Witnesses are protected from being sued or prosecuted for anything said during the hearing unless they say something they know to be untrue. This protection is given to witnesses to ensure that they can speak freely and openly to the panel when giving evidence without fear of legal action although the immunity should obviously not be abused by making unsubstantiated statements about third parties who have no right of reply. The panel would like you to bear this in mind when answering questions. For the benefit of the tape I am going to ask you ... we will go round the table and if you could just introduce yourself so that we can pick up who is speaking.

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

Mr. C. Swinson (Comptroller and Auditor General):
Chris Swinson, Auditor General.

Mr. M.P. Magee (Independent member):
Martin Magee, independent member.

Mr. K. Keen (Independent member):
Kevin Keen, independent member.

Connétable J. Refault of St. Peter:
Constable John Refault, P.A.C. (Public Accounts Committee) member.

Senator B.E. Shenton:
Senator Ben Shenton.

Senator A. Breckon:
Senator Alan Breckon.

Senator J.L. Perchard:
Senator Jim Perchard.

Mr. A. Fearn (Independent member)
Alex Fearn, independent member.

Ms. M. Pardoe (Scrutiny Officer):
Mel Pardoe, Scrutiny Officer.

Acting Chief Executive Officer for Health and Social Services:
Acting Chief Executive Officer for Health and Social Services

Senator B.E. Shenton:
The first question to Russell is are you satisfied with the progress of the department in implementing the proposals canvassed in the C.M.B. (Corporate Management Board) and *Emerging Issues* reports?

DFI:
I think that is obviously quite a complicated and long question to answer. I think there are various components of the report that are progressing and it is unique to each of the proposals that were included in the report, so I am not quite sure whether it is worth us getting into the details of the individuals schemes and what that progress looks like for H.S.S. (Health and Social Services) or whether it something else we could summarise up for you.

Senator B.E. Shenton:
I mean just an overall sort of macro view, are you satisfied that progress has been made or has changes at Health or upheavals at Health hindered you in any way?

DFI:

I would suggest that if we are talking about hard cash and tangible benefits then progress is not to the degree that the report would like to have achieved in H.S.S. and the various reasons of justifications for schemes as to why that is the case.

Senator B.E. Shenton:
How high up the in-tray would a report like this be when you are sort of looking to what you can achieve at Health?

DFI:
For me personally, in my role, it is extremely high up the in-tray because obviously achieving value for money and working through the cash limits and maximum services for the resources we have is fundamental to my role in H.S.S. There are a variety of managers in H.S.S. who have to enact those changes that effectively result in the changes in spending in H.S.S. So from my perspective it is extremely high on the agenda because it is a significant finance issue which demonstrates opportunities in H.S.S. to either create savings or to invest in other services.

Senator B.E. Shenton:
If we just start with procurement then, what steps have been taken to improve procurement since the report came out?

DFI:
Taking the management procurement, I believe firmly in the opportunities that are available from an effective procurement process in H.S.S. and possibly across the States of Jersey overall, so we have engaged with Caroline Hastings as head of States Procurement. She is working with us to develop a best practice system which ideally will be presented for all States departments, with H.S.S. being the pilot of that. Our view is if you can make it work in H.S.S. you are removing bits of it for other departments rather than having to add bits in that no one thought of if you do a pilot in a different department. So that work is being planned and prepared, initial presentation has been given to the H.S.S. S.M.T. (senior management team) who have fully supported the concept of that. Another presentation is coming on the detail of what that means in 2 to 3 weeks' time for final S.M.T. approval because there is resource needed to fund the consultants that Caroline Hastings will employ to undertake some of this work, and obviously the benefits accruing from that we are expecting to be in the region of £800,000-plus.

Senator B.E. Shenton:
Within these plans that you present forward, do they have fixed timeframes and who is ultimately responsible for hitting those timeframes?

DFI:
That is right, the project plan will be undertaken as per States of Jersey procurement office staff so there are clear cut-offs and review at certain stages on it to ensure it is still going to deliver what is expected and to make sure that it goes according to track. That is what is due to be presented to the Health S.M.T. in 2 to 3 weeks' time which will then hopefully endorse that approach and that will then be effectively a project that is in train.

Senator B.E. Shenton:

Who is responsible?

DFI:
I am taking the S.M.T. lead on working ... from an H.S.S. perspective I am working with Caroline Hastings to deliver that project.

Senator B.E. Shenton:
You are taking the lead, does that mean you are responsible?

DFI:
I suppose the accounting officer always retains responsibility but while we did not directly discuss it I assume that it is a delegated function to me, to deliver on behalf of the accounting officer.

Senator B.E. Shenton:
There were a lot of purchasing cards within Health which sort of implies that purchases were being made on a piecemeal basis, have you done anything about reducing the number of purchasing cards and what have you done?

DFI:
Yes, we have undertaken a comprehensive review of all the purchase cards that are out there in H.S.S. The first job was to cull those quite spectacularly depending on what rationale the individual had for holding them, so for example all of the S.M.T. team said basically they held these cards purely when they are over in the U.K. (United Kingdom) to pay for incidental expenses. Well, to be quite frank, the risk of having all of those cards out there compared to the use they got and also the fact that we can reclaim our travel expenses via a different route, all of those cards have been pulled in. So I no longer have one, Richard no longer has one, et cetera. So various pieces of work are in train to ensure that only those who need to have a purchase card because of the essential nature of what they do, or the fact that there is not another system in place to enable them to make up the types of purchase they need to at this stage, only those people have retained their cards.

[14:15]

The Connétable of St. Peter:
Can you give us an example of who that might be?

DFI:
An example is the senior nurses. The senior nurses in the acute unit, you tend to think: "Well, they should not need a purchase card because if there were incidental expenses they could reclaim them" but there is a unique situation that when patients effectively have an emergency transfer, out of hours of the H.S.S. travel office, and if their relatives need to go with them then obviously there needs to be a process of booking their flights for them. Because this all happens out of hours and the fact that an emergency transfer from the jet service has taken that patient off to, say, St. George's for example, the senior nurses have to get on the internet and book basically flights and pay for them. In no other circumstances should they need a purchase card and ideally we would come to a solution over time which says that there will be a different way of managing that particular problem so they do not need a purchase card

or there is only one purchase card available to the on-call sister, et cetera, to deliver that rather than having one each. There are options around that but at the moment I cannot see an instant way of removing those purchase cards only for that purpose, to retain a sensible system, I suppose, of looking after emergency transfers. Importantly, on that though, we will be restricting their category expenditure, so instead of having an open card that can purchase stationery as well as all other sorts of items, that will be restricted purely to the categories of travel. There is an example of a piece of work where those individuals have been reviewed and hopefully we have got ourselves to a place where only those who for essential urgent reasons in the absence of any other systems will hold a purchase card.

The Connétable of St. Peter:
You have just concerned me slightly, in your answer you use future tense rather than past tense. "They will be", "They shall be" rather than "They have been."

DFI:
Sorry?

The Connétable of St. Peter:
Talking about restrictions in uses will be put in place.

DFI:
That is right.

The Connétable of St. Peter:
So you are talking about future, so this is all future work that perhaps could be on the hoof comments now rather than things that are in train.

DFI:
They are in train at the moment. I am currently pulling together all of the individuals who require either a purchase card or have a different limit to the financial direction set so that I can understand what all those are. Once I have established what those are Richard and myself will sign those off to say that in the meantime this is the only operational way of delivering that service. We have a view obviously to remove that over time. Some people have been culled already, hence the past tense, and some of that is work in progress at the moment, hence the present tense.

The Connétable of St. Peter:
What is your timeframe to complete that piece of work?

DFI:
Two to 3 months maximum.

Senator B.E. Shenton:
On the procurement side it would seem logical that there would be advantages in perhaps working with Guernsey Hospital in certain areas. Is this something that you have explored or done any work on?

DFI:

I think we are always open to that expression and I ... sort of coming in from the U.K., one of the first things I did not fully appreciate around the uniqueness of the Island was that there was not more working together due to the relative size of it. Maybe I could hand over to Richard to explain more about some of the things that we have undertaken in that area.

ACE:
We have worked in the last couple of years trying to work with Guernsey in developing joint services and my own particular interest was around the air ambulance service. It seems an obvious thing to do to achieve the economies of scale. Actually the prize there in terms of ... the prize there from my perspective is around patient safety and effective and efficient services but there is a bigger financial prize, which is actually around the more routine movement of outpatients, which is significant numbers of patients moving from both hospitals to the south coast, so we are going across to meet the new chief officer in Guernsey, on about 7th February I think it is, with our ministerial team to meet the Ministers in Guernsey and the opposite numbers to try and work some of that through and see where we can develop this further. It is not through lack of want or trying, I can say on our behalf. There are obviously different ways in which the health system in Guernsey and Jersey work which sometimes make it difficult to bolt these things together but we will continue to endeavour because it must be the right thing to do.

Senator B.E. Shenton:
You have not really looked at procurement work in Guernsey yet? Apart from air ambulance?

DFI:
If you are talking about procurement of effectively hospital type supplies, we have undertaken a considerable development there working more on the U.K. side, so instead of lumping in with Guernsey, in effect, we took the approach in this - and has also been in agreement with Caroline Hastings - as saying that if we access an N.H.S. (National Health Service) contract that has been tendered with the purchasing power of the N.H.S. then that is considered adequate for States of Jersey financial directions and demonstrating value for money that we are piggy backing on the back of such a large purchasing power that by definition there is an assumption and expectation that that will be generating the best possible price and value for money.

Senator B.E. Shenton:
I am well aware of the N.I.C.E. (National Institute for Health and Clinical Excellence) guidelines and so on and so forth, and use an N.H.S. consortia for gross(?) purchases.

DFI:
Indeed that is right and we are currently for other consumables, such as syringes, et cetera, instead of working with Guernsey on that we are accessing with N.H.S. logistics to take advantage of the prices that they can secure. The other key thing about going to that more single supplier is they batch up our orders effectively into one container and it comes over so we reduce our carriage costs as well rather than piecemeal ... single orders with single carriage costs being applied.

Senator B.E. Shenton:

That leaves the question of whether proper prescribing controls are in place. Do you follow N.I.C.E. guidelines in this respect?

DFI:
Generally the decision that has been made is to follow N.I.C.E. guidelines in instances where it makes sense and clinically appropriate. I will hand over to Richard who can give us some more detail.

Senator B.E. Shenton:
Do you follow N.I.C.E. guidelines in prescribing?

ACE:
As far as our organisation is concerned the consultants will prescribe according to N.I.C.E. guidelines and if they are going to deviate from that, they will take that to the Drugs and Therapeutic Committee or there may be circumstances whereby we may wish to not do that but those decisions will not be taken lightly or individually. That will be a considered decision. In terms of getting into the clinical detail we will probably need to bring some clinical expertise with us to talk about the ... there may be circumstances whereby the position taken by N.I.C.E. we may argue against it. That is something that we would listen to.

Senator B.E. Shenton:
Just as an aside; the financial impact of introducing free prescriptions to the department was a loss of revenue of what?

DFI:
£100,000.

Senator B.E. Shenton:
Are you concerned about the fact that since prescriptions were made free the general level of prescriptions has gone up? I know this is not an area that you are funding but obviously it did have an implication on your department when it came in.

DFI:
To answer that question comprehensively we have recently approved a post in the pharmacy to review ... their prime role is to review drug prescribing by clinicians to ensure that it is appropriate, cost effective and, from a planning point of view, this post is about delivering estimates and plans as to what is happening with drug dispensary in our organisation. Obviously the outputs of those types of reports should be options for the senior management team to consider around where certain clinicians are operating in certain ways that may be, for example, outside N.I.C.E. guidance and what the options would be on those. By having this pharmacy post dedicated to that role it means that another clinician effectively is in a position of expertise to challenge other senior clinicians about what they are doing.

Senator B.E. Shenton:
For the benefit of the other members around the table, I was Health Minister at the time prescription charges were abolished and not only did we not agree to the abolition but we also asked for it to be delayed while we could do a piece of work on the financial implications. But unfortunately the political decision was to abolish

charges without that piece of work being in place. One of the things that did cause a little bit of sleepless nights was, of course, the massive investment into the new I.T. (information technology) software. Can you give us an update on how that is going and the process of that because it is obviously significant.

ACE:
I think from my perspective, I have obviously taken over as chair of the board more recently with respect to the I.C.R. (integrated care record) project, and having not been involved with it prior to October last year that did give me a degree of nervousness because it is a huge and complex process and I am aware of the NPfIT program in the U.K. spiralling massively out of control in terms of its cost control. So that is certainly something that has been on my radar to be concerned about. I am pleased to say that I think the project has been very well managed and it is about to deliver its first key deliverable, which is the RIS/PACS system on 2nd February, on time and on budget. I cannot really ask for more than that from an I.C.T. (information communications technology) project. That is the system whereby we introduce electronic digital imagery across the organisation. The real win here is if we can not just introduce the I.C.T. effectively and safely into the organisation, the key is that we can change the business processes around it and become more efficient and that is the trick. So that is what we have really got to watch, is that not just the successful implementation of the I.C.R. project but we see a change in how business operates so the people do not just do the same old thing using new kit, that they actually change the way in which they do their processes.

Senator B.E. Shenton:
You have got quite a big job ahead of you managing the behavioural change required for people to use that. Have you got structures in place to manage that? Do you know what the cost of that part of the project will be?

ACE:
What we are putting in at the moment is really the background infrastructure to the organisation so it can reap all the benefits in terms of order comms, which is the second phase of the programme which is not at this point in time funded. The future is that you put the consumer much more in control of the service so if you want to reduce non attendance at clinics then do not send them an automatic appointment which is when they are taking their kids to school, give them a choice to choose and book. The point is that choose and book in the U.K. is not working properly yet. There are lots of things that we need to do. It is very much ... I can book online for a variety of different services, airlines and such like, so we should be able to bring that technology. It is not new technology, it is not cutting edge. We should be able to bring that into the public sector. It does require a change of behaviour and a significant amount of investment over the next 5 years.

Senator B.E. Shenton:
Are we talking about appointments? One of the problems in the past - and it was not put in the review so I am drifting a little bit - was patients simply not turning up for appointments which is a cost to the department because you have staff lying idle because the person did not turn up. Then you have to re-book the appointment. They do not even have the courtesy of phoning up to say they are not turning up, they just do not turn up. It is quite significant. We did look, or it has been looked at in the

past, of bringing in a charge for this. Is that something that you ... a charge for people that fail to notify and do not turn up to appointments?

ACE:
That is not the right solution to the problem. The right solution is to reduce the waste first of all. The waste is those wasted appointments. You may have heard in the press the other week, we introduced a system of text messaging for colposcopy. If that works, and I have no reason to believe it will not, then we will be rolling that out across other services. But D.N.A. (did not attend) rates across different services are different. It is quite high in paediatric clinics, it is quite low in others. It depends on a variety ... It is not one size fits all. There are a variety of solutions but a punitive approach to failure to attend, I am not quite sure that is what we want to be doing. During the snow I looked at our D.N.A. rates across the board and people did really well, most people were ringing in and a lot of people did make it into their appointments, and our staff never lie either.

Mr. M.P. Magee:
Can I just ask the question of scale because I have no idea how big this project you mentioned is on time and on budget. What are we talking about money-wise?

DFI:
The I.C.R. programme as it stands at the moment?

Mr. M.P. Magee:
And the follow on, just out of interest.

DFI:
The current resources allocated to the delivery is the States approved £12 million and the next stage of that is being worked up for the States capital programme but it is circa £6-8 million.

Mr. M.P. Magee:
So it is £12 million that has been spent already?

DFI:
No, it is planned to be spent really. It is approved so it is being spent currently.

Mr. K. Keen:
If you only got the £12 million then that would be okay, it would not mean that the whole project was, to an extent, a failure because you could not get the balance?

ACE:
You would not realise the absolute benefits of it all.

Mr. K. Keen:
That is quite important, is it not, that you have got an £18 million project or £20 million project but you have only got £12 million towards it, when there is a structural deficit and everything else around.

DFI:

If I can help maybe. Part of the extensive work that went into planning that project before it was started was to answer that question exactly. To make sure that we only did things that we could afford but also that we did not find ourselves in a place where we had made commitments that were in excess of funding so that the project would fail for lack of funding, because it was a £15 million project that had been started when there was only £12 million. That was a lot of the comprehensive work that went into making sure that we knew what we were going to do, what we were going to get for our £12 million and it made sense to draw the line at that point in the project. A lot of work went in over a number of months in planning that project to deliver that objective.

[14:30]

Mr. M.P. Magee:
Again just out of interest, was it a formal business plan to justify that project in terms of what financial or non-financial outputs would come out of that?

DFI:
There is a very comprehensive document. There are many lever arch files full of the main business case plus all the annexes.

Mr. M.P. Magee:
Would you intend doing some form of appraisal after the event to see whether that has been delivered?

DFI:
Most definitely. That is why we can say the RIS/PACS element of the project is planned to be on budget because we know exactly what we planned to spend on that project and we know what we have spent to date on it.

Mr. K. Keen:
I thought Richard had said you would not get all the benefits if you only went to £12 million; just to understand what you would sacrifice.

ACE:
There are some key deliverables at the beginning of this project. The risk pacts, which is electronic imagery, there is a patient administration system, things absolutely key, critical, central aspects of delivery of business across the board. But the bells and whistles, the things which really make it fly ... like I say order comms which is an opportunity to interact with the patient, that is not there at all in terms of the phase one. So, the ability for the business to run is in phase one, critically. Without a patient administration system you do not have a hospital.

Mr. K. Keen:
You will be better than you are now with your £12 million?

ACE:
Absolutely.

Mr. K. Keen:

You have got value for money for the taxpayer even if it stops at £12 million?

ACE:
Yes. Or I would be very disappointed because we would be a long way behind what we would expect, first world medicine to be doing anywhere else, if we do stop.

The Connétable of St. Peter:
Can you quantify in cash terms those efficiencies?

DFI:
The complication of it is, is the first stage generates an investment because efficiencies come from the second stage, which is not funded and therefore is not going to be delivered, so it is at that point, as part of that business case, that we will work out the detail of what those ... for example, order comms working in that way with other clinicians will generate in savings.

The Connétable of St. Peter:
Just to get my mind clear on this one; you are saying the £12 million investment is not, itself, going to bring forward any efficiencies which can be quantified in cost saving?

DFI:
The signed off business case demonstrates a £12 million capital cost and a £1.2 million investment recurrent infrastructure costs, maintenance of systems, et cetera.

The Connétable of St. Peter:
But you need to spend another £8 million to develop some real efficiency cost savings?

DFI:
That is where the next stage of the business case would be and that is estimated currently at £6-8 million, correct.

Mr. K. Keen:
Is that a capital rationing thing that it has ended up like that, that instead of saying: "Well, the real project is a £20 million project, we want £20 million" you were rationed, in effect, and had to split it in the way that you have done. Is that why it has ... it is not a risk thing, is that why it has happened that it has split.

DFI:
It is not wrong to say that the project vision delivers a whole suite of items of which some of these are many of the benefits that we talked about. When that was costed up in detail that was far in excess of the £12 million that was assigned to the project by the States of Jersey. I personally worked very hard to make sure the project was reworked to deliver the priority items that were essential for the infrastructure and the platform but only up to the level of £12 million which would then create a cut-off so that then there is ... because there is a further approval process to go through to obtain those extra resources and the business decision to make.

The Connétable of St. Peter:

Just moving on then with cost efficiencies, looking at locum services and human resource management, what sort of initiatives are you being interfaced to bring forward some cost efficiencies in those areas, bearing in mind we have got a structural deficit looming in the next 2 to 3 years' time, we all need to be working towards improving efficiencies and cutting costs?

ACE:
Across the board, again, I will put squarely my focus of interest is on patient safety and effectiveness of service and I obviously have, as accounting officer, to have an eye to efficiency and value for money but my prime objective is patient safety. In fact I would wish to address issues of locums and agency nurses, those areas, on those grounds alone even if there was not value for money issues because bringing in people who are not used to the environment in which they work, the agency nurses or locums, adds risk to an environment so even if it was cost neutral I would want to address locum and agency cost. I just want to raise that. The reason I am saying that is it is not as if we are not trying to do this. It is a fundamental part of the business to want to ... while we are always recognising we will have to rely to some degree on locum services and agency staff because of the nature of the 365 day a year business, we want to drive that down as far as we can from a risk perspective. Having said that, the budgets that sit to fund locum staff and agency are ... those are not fully funded, are they? While we can drive down the usage, and we could demonstrate particular areas where we have done that, that does not mean it is cash releasing. It means that you are not overspending in an area where you did not have a budget.

DFI:
The department does not have recurrent budgets set to the level of locum expenditure as being incurred, so the effect of that means that other things are stopped, usually temporarily, permanently where I can, but in nearly all instances they are temporarily, to ensure that the department can live within its cash limit, so we will slow down on a less priority or lower important service to release the money to pay for the excess locum costs generated possibly by a long term sickness of a middle grade doctor who therefore we are obviously paying their salary but we are also then paying for someone to come in and cover their job. So the reality of the budgeting currently is that there is not sufficient recurrent budgets to cover the level of locum expenditure that is being incurred.

The Connétable of St. Peter:
How important do you see the importance of human resource management in driving your expectation or your wish for safety reasons to produce the requirement on locum and agency nurses and provide, at the end of the day, cost benefits back to the taxpayer?

ACE:
We have significant issues with recruiting nurses to Jersey. It is a worldwide problem but I would suggest our problems are more acute than elsewhere. We have got a 6.4 per cent vacancy rate for nurses. You have got 5 per cent in inner London, 2 per cent in Guernsey, we are ... this is one leader board that we do not want to be top of and we have got significant issues there. It is not a simple issue.

The Connétable of St. Peter:

Can I come to that one afterwards? There is room to explore that. But if we can just stay with the overarching human resource management issue, that is what I would really like you to answer first.

ACE:
What I was trying to get to there is if you have got a significant vacancy rate then you are going to use a lot of agency and bank nurses. That was my point.

The Connétable of St. Peter:
That is only part of it. What about your management of your staff you have already got in absences and sickness absences, controlling leave, making sure all those other aspects about management of staff.

ACE:
Do you want to stay with the nurses or do you want to move on? Because if you look at nurses they are an interesting area to look at because you have the recruitment and retention issues. You have got the issues of a very busy workforce with very high levels of demand for the existing beds, so very high bed occupancy and insufficient ratio of staff to beds, so all these issues interrelate. What you have got is the existing staff on a ward working very, very hard with not enough colleagues around them with vacancies around them, which, guess what, makes them get ill and sick. So it is a very circular problem that has to be broken into somewhere, so really what we are doing this year, that is why there has been the States ... we are very grateful to the States to approve investment in nursing for 2010, is we are looking to increase the number of nurses on the ward per bed, so increasing the skill-mix ratio, we are looking to increase the capacity of the hospital which should reduce down the bed occupancy ratio of the hospital from 100 per cent down to hopefully something around 85 per cent, which is safer and more optimal for a hospital to work, which means you do not cancel elective surgery, which means you do not waste time getting people all prepped up for something then telling them there is no bed for them to go into. An efficient business is not one that is running at 100 per cent capacity. An efficient business is running at an optimal capacity and that is what we are trying to do. I am afraid I did not answer your question, sorry, what was it?

The Connétable of St. Peter:
I am still really waiting to hear, you are saying about your human resource management.

DFI:
I think the other thing too, I think H.S.S. fully respects and appreciates the important role that an efficient and effective H.R. (human resources) team brings to its staff management.

ACE:
I am not sure that answers his question either. **[Laughter]**

The Connétable of St. Peter:
You are telling me what I would tell you, is that why you are doing that?

DFI:

So is the question whether that is happening?

The Connétable of St. Peter:
Yes, and how you are doing that?

DFI:
I suppose the key thing is obviously the H.R. team are part of the Chief Minister's Department rather than H.S.S. and I think there is multiple issues involved in effective staff management of which some of them are very clearly the responsibility of the H.R. team, and other aspects are market practice on recruitment, et cetera, which cause the various operational problems that we have got.

Senator B.E. Shenton:
The centralisation of H.R. with the Chief Minister, is that working from your point of view?

ACE:
I would like to answer your question but I am not quite sure what you are getting at here with this line of questioning.

Senator B.E. Shenton:
Let me just give you a little bit of background. It is fairly well recorded that within the hospital type service across both Jersey and United Kingdom there is a higher level of sickness absence. That can easily be put down to not necessarily the fact there is a shortage of staff when people are sick. But quite clearly you would not want people with a cold coming into work on wards so therefore ... that probably gives you higher sort of numbers than anyone else would expect. But underlying all that, are you managing the absence rates of particular people. Are you monitoring people who are perhaps more sick than others and how are you doing that, and what measures you are bringing to make sure you are not wasting staff by not managing their attendance more closely and using sickness as an excuse not to come to work. Is that happening within the hospital or are you just accepting the fact that because you have less staff, people are going to be sick therefore you have got a higher sick grades. Are you defeating yourself before you start by using that type of analogy?

ACE:
Not wishing to contradict you, but I believe, and correct me if I am wrong, but our sickness and absence in Health and Social Services as a whole is rather good and it compares favourably both with the private sector and ...

Senator B.E. Shenton:
That was not the information I got from H.R. several weeks ago.

ACE:
Okay, that is the information that I am aware of.

DFI:
I think one of the important things is the H.R.I.S. (human resources information system) system is designed to ... it is planned to give managers the level of

information that can assist them in exactly making sure that those factors are dealt with.

Mr. C. Swinson:
Can I just ask a question: we listened to the Deputy Chief Executive earlier saying that unless the people who work in the organisation, any organisation, have effective resource management, their ability to change the organisation and make developments will be constrained. I think Constable Refault's questions were directed partly at the specific absence as an indication of whether your staff are happy, but also the general question about whether your human resource management practices are such as to ensure that you have a team working in Health who are going to be well attuned to the changes you are going to make, for example, to use the investment in information services which you are making. I do not think Constable Refault would have heard in your answers yet any indication that you understand the relationship between the effective resource management and the ability to achieve the outcomes in the organisation you want. That is without making sure your people are happy to work towards the corporate objectives of the Health Department you are going to be stuffed. That is probably the technical language. I think that is what the questions are getting at.

ACE:
We are a business where about 75 to 80 per cent of our expenditure is on people. So to ignore how those people are behaving would be foolish, we can recognise that. To ignore how they are feeling in the workplace and whether they are being used effectively would be foolish. I would suggest that a significant amount of our staff were experiencing quite high levels of dissatisfaction and low morale last year. If you went on to a ward as I would do and say: "What can I do to improve your lot?" they will say: "Give us more staff." It was not give us more money, it was give us more colleagues to work alongside us so we can do our job properly.

The Connétable of St. Peter:
That has been said in the House by your Minister actually.

ACE:
Good. Good, consistency, fantastic.

The Connétable of St. Peter:
Yes, she supports your view.

[14:45]

Mr. C. Swinson:
Would you also give that answer if you went into the Social Security Department which is also part of your ...

ACE:
Social Services, do you mean?

Mr. C. Swinson:
Social Services.

ACE:
I think we would have different reasons for dissatisfaction in there.

Mr. C. Swinson:
I just made a point because it is quite important to remember this is not just a question of hospitals.

ACE:
Absolutely. I mean Health and Social Services are a hugely diverse portfolio. It is 2,500 employees. But, as I say, the point is 80 per cent of the business cost is on people so you have got to get that bit right. Morale is not great, the business is running very hot, people need to ... and human resource practices are fundamentally important. We have got to get both ends of it right, though. You have got to get the bit about reducing the average sickness from 7.5 days to 6.5 days, is just as important in cost terms and in business terms as also sorting out the one or 2 outliers who are off sick for 2 years. You have got to do both of those things. Are there practices in train to deliver both of those? No. I do not think so. They are not within my power to control those, they exist as central States policies but I think they need to be addressed.

Senator B.E. Shenton:
This is part of the problem because going back a couple of years to the H.R. function being centralised, it was not working as well as it should have done. It certainly was not when I was Health Minister. Going back to a previous hearing where Russell appeared at, he said: "That when people come to me with and are over budget, they tell me they are over budget, and they believe that they have passed the problem on to me." Now I got the impression within Health and Social Services that if there is a H.R. problem they would pass it on to the Chief Minister's Department, the H.R. Department, and then they would pass the problem on. There was not a lot of people within H.S.S. actually taking ownership of H.R. resources because they were not responsible for it.

ACE:
I agree up until the last line. There was not a lot of people in H.S.S. taking responsibility for H.R. issues because there is not a lot of people in H.S.S. in H.R. roles.

Senator B.E. Shenton:
But if you are a manager you are in an H.R. role.

ACE:
Yes, in terms of H.R. ...

Senator B.E. Shenton:
That is where, I think, if you are a manager of a department or supervisor you are in an H.R. role? You do not need to have the initial ...

ACE:

No, you are a manager of people but in terms of getting specific H.R. advice who would always look to the centre in terms of making sure that our decision making around suspension or whatever, or disciplinary process, is consistent across the board. That is what we would be looking to the centre for. But believe you me if we put somebody on long term sick or long term suspension it is something that we are absolutely wishing to address on a day by day basis because it is causing us pain.

Senator B.E. Shenton:
Can you put your hand on your heart and say that the centralisation of H.R. in the States is generally to be working well?

ACE:
I believe the centralisation and the devolution of H.R. on a 5-year rotation, it appears everywhere in the world, is a complete waste of time. I believe that we would work more effectively if we had a departmental H.R. Department which understood our business of recruiting.

Senator B.E. Shenton:
Understood the business.

ACE:
Absolutely. But is it not a fact that this is what happens to H.R. and other corporate functions is they centralise and they devolve and they centralise and they devolve?

Mr. C. Swinson:
So you would make exactly the same point about information services?

ACE:
I am just trying to think which bit of centralisation works well.

Mr. C. Swinson:
I asked you whether you would make exactly the same point about information services because logically the same point applies elsewhere.

ACE:
It might do.

Mr. C. Swinson:
If your point is you go through cycles, it would apply to I.S. (information services) as it does to H.R. So you must have implied that.

ACE:
The reason I did not answer immediately is because I think if you look at things like property, if you look at H.R ...

Mr. C. Swinson:
I asked you specifically about I.S.

ACE:

I think about I.S. it would depend on whether ... I am not sure I agree with you. I am not sure there is the ...

Mr. C. Swinson:
I was asking what you meant.

ACE:
I think there may be grounds for the centralisation of information services where there may be benefits. I do not pretend to be an expert in that area but I think there were such significant differences in systems that existed beforehand that the centralisation of I.S. could be a valuable thing to do. I am not so sure that is the same rationale I would use for H.R.

Mr. M.P. Magee:
Can I just go back to what you said about H.R. because to me I think whether it is centralised or decentralised is irrelevant, it is back to the manager or the supervisors, or the people who are there to control sickness absence, to keep staff happy or unhappy or whatever. I do not really see the relevance.

ACE:
If you are talking about line management of people, I agree with you entirely. I mean the relationship ... that is right, but in terms of recruitment, the broader H.R. issues, then you do need to have an H.R. function. You have got 2,500 employees with a significant amount of rotation, you need to have an H.R. function that understands the business.

Mr. K. Keen:
The reason it has devolved is, I would probably agree with Richard, you would agree with centralising it. It is not ...

DFI:
Possibly that is your 2 levels though.

Mr. M.P. Magee:
I think it is recruitment versus the management of sickness and absence.

Senator B.E. Shenton:
I think it is the perception whether you have given up that role whereas in fact you are still retaining part of it.

The Connétable of St. Peter:
Excuse me, Mr. Chairman, I think our time is running short.

Senator B.E. Shenton:
On primary care, moving to a different issue, Jersey has a large number of doctors and G.P.s (general practitioners), and the doctors charge, but there is a doctors' surgery that does not charge, which is called the A.&E. (Accident and Emergency) Department, what actions are you looking to rid the Island of this anomaly?

ACE:

The ministerial position on this is that seeking further user pays in A.&E. is supported but it would require public consultation before it occurs, significant public consultation, because the first child who dies of meningitis because a mother decides not to take that child to A.&E. because they thought they should go to the G.P. and they did not have money to spend on it, will cause us a significant problem. In other words, there are people currently who are accessing A.&E. because they are saying they cannot afford to go to their G.P.

Senator B.E. Shenton:
Yet those people would be on income support of which a component is for G.P. care.

ACE:
As long as people are using the argument that there is a barrier to entry to G.P.s we have to sort out that anomaly. Okay, what I am saying is should we be introducing user pays into A.&E., I think acceptance of that would be a good idea but should it be a charge across the board or should it be a charge for inappropriate use, in other words using it as a primary care provider. That needs to be discussed, there needs to be a public consultation. From our perspective, I hold my hands up, the reason we are not doing that public consultation right now is because we have got a lot on. What we are doing in 2010 is around user pays. The user pays issue we are dealing with at the moment is around sorting out the path charges, the States approved that at the end of the last year, we are making sure that system works efficiently, working with the G.P.s about developing those links.

Senator J.L. Perchard:
Richard, if you do accept the principle that user pays at Accident and Emergency you are effectively starting the biggest G.P. practice in the Island because people will use it and they will think it is legitimate to use because they are paying for it. It needs very, very careful thought before you do.

ACE:
Absolutely.

Senator B.E. Shenton:
The ambulance ... in Guernsey you pay £150 for an ambulance.

ACE:
Absolutely.

Senator B.E. Shenton:
Is that on your radar to look at, at all?

ACE:
Personally, no. The reason that occurs in Guernsey is because Guernsey's ambulance is a charitable organisation. That is why it happens, it is not a user pay, it is a charitable organisation. That is why we have fees for Family Nursing and Home Care, not because community care should be user pays. It is because F.N.H.C. (Family Nursing and Home Care) is a charity.

Senator B.E. Shenton:

How much would Jersey save if the Jersey Ambulance Service became a charitable organisation?

ACE:
Are you asking what the cost of the ambulance service is? To summarise that question, user pays in A.&E., yes it is on the agenda, the Minister has asked that there is a significant public consultation before she takes any of those issues into the States. That is absolutely right and proper because we have already heard now, 3 possible ways in which you could make that work.

Senator B.E. Shenton:
Health tourism is another issue that has been floating round for years and numerous people have mentioned about sorting it out. I think I even saw a paper about 3 or 4 years ago where it was down as a quick win. It is not very quick. What is happening with health tourism? It seems to me that nothing is happening in health tourism.

ACE:
There is a draft policy, I have forgotten its title.

DFI:
The provision of healthcare to overseas and foreign nationals.

ACE:
Or the health tourism policy, for short. That policy is currently with the Scrutiny Panel for consideration. We are waiting for it to come back from Scrutiny so that they can add their comments to it. We will take it from there to the Medical Staff Committee and then seek to introduce it. The only caveat on that is that we are looking at the ... the Minister has indicated that she would like to begin dialogue again with the U.K. with respect to a reciprocal health agreement and in doing so that may have implications about what would sit within this policy. I am not making any promises about policy will be on the desk in 3 months.

Senator B.E. Shenton:
You mentioned about charging for A.&E. and the first person who dies from meningitis because you refused treatment, do you not have a similar problem with health tourism?

ACE:
To correct the first thing, it is not about refusing treatment, it is about people being reluctant to attend because of the ... we would never refuse treatment. We treat first and look for the credit card afterwards. That is how it works. With respect to health tourism, what we are looking at there is people who are deliberately - that is the key - deliberately entering a system to access healthcare. So, if you create a system that does not enable them to do that then the situation does not occur. We are talking about emergencies.

Senator B.E. Shenton:
At the moment you ask people when they come in for their address locally. Now, they will just give you the address of a friend or this, that and the other. You do not

ask them for their social security number or anything like that, which would pin them down to being whether they are Jersey residents.

ACE:
Or would it?

The Connétable of St. Peter:
They can get a card tomorrow.

Senator B.E. Shenton:
It would make it slightly more difficult.

ACE:
It does not actually.

DFI:
If I maybe explain what we do at the moment to deal with the U.K. visitors, in effect, because ... what the policy is about is removing the big obvious loopholes that are high cost. We recognise that there will always, at this stage anyway, there will always be a level of hospital activity, outpatient appointment that sneaks through, through the route that they have got relatives on the Island, they give that address. If it is a relatively low cost procedure ... we need to concentrate our resources on removing the big abusers and those first of all. So this policy is designed to try and tackle that issue, to get on to those, and the whole policy principle really is about saying it is for the individual to demonstrate to the satisfaction of those on the ground who are accessing their status, that they are genuinely entitled to free treatment. So, where someone is essentially picked up as a risk, then the onus is pushed on to them to state that they would have to demonstrate that they are entitled to free treatment, rather than us trying to disprove that they are entitled to free treatment, which has been essentially the problem in the past. Because of the lack of information we are unable with the resources at H.S.S. to investigate all of these factors; we have been unable to disprove people's information. So it is about turning it around and saying ... We have done the same with the travel entitlement as well. We have said: "If someone wants to effect the benefit of supported travel it is for them to prove they are entitled to it, rather than for ..."

Senator J.L. Perchard:
It is easier for us to listen to ...

DFI:
It is easier.

Senator J.L. Perchard:
It is easier to do.

The Connétable of St. Peter:
Can I give you a hypothetical example? How would you deal, for example, with either a (j) cat or a foreign national coming to live and work in Jersey who then imports their elderly relative who needs ongoing intensive care and ultimately some sort of residential care as well? Somebody turning up, an elderly person turning up,

who is living now with a son or daughter in Jersey, never contributed a penny piece towards the Jersey economy, how would you deal with that one?

DFI:
Effectively you are right. Currently, the indication is if that person had been here for longer than 3 months they are therefore a Jersey resident and therefore they are entitled to the whole access to every treatment. That is the current situation. The policy that we are proposing has effectively set times, and we are looking at the same indication as the social security and income support benefit. So someone would have to have been here for 5 years before they could start to access care. That is the way of trying to remove the obvious abusers who have deliberately brought someone over with the express purpose of knowing that they are going into care soon and they want them to be there.

[15:00]

Senator J.L. Perchard:
So you would have different qualifying periods for different ailments. One 5 years for residential or specialist nursing care. Is that what you are saying? Perhaps 3 months for something else? Perhaps a week for A.&E.?

DFI:
I think they key thing is if someone is here for legitimate reasons associated with a partner, for example, who is working on the Island, we would not necessarily want to restrict their health care, even if it is genuinely high cost, because if the individual is here for legitimate reasons, then as a health service we are taking a stance at the moment that says they should be able to access free care. The ones we are looking to cut out of this policy are the ones who deliberately undertake actions to access high cost treatment because maybe they are unavailable in their own country, or, for example, it is an ability to access into the U.K. referral via a Jersey referral at the expense of the Jersey taxpayer. So, in order to clarify, the current draft at the moment talks about a 5-year residency period, in effect, before someone would be able to receive free long-term medical care.

Senator J.L. Perchard:
Even if the reciprocal health agreement was reinstated with the U.K., we still have a problem with health tourist, with or without that reinstatement.

DFI:
The important thing is the reciprocal health agreement is about emergency and urgent treatments, not about elective care or long-term planned care, for example with a nursing care issues. So that is what we do.

ACE:
Can I just pick up on that? Senator Perchard and Senator Shenton will recall perhaps this very live issue for us of individuals being brought over. So you have a (j) cat put up by a bank for example, and a partner may have, as you may recall, a condition which suddenly put him another £80,000 on our bottom line in terms of expenditure. So, that can just happen with no control over that. That is the reality of dealing with the unexpected costs of health.

Senator J.L. Perchard:
That really is my last question there from me this afternoon. Have you any idea what sort of expenditure you are paying out on an annual basis, of account you are looking at, potential health tourism? What the current cost to the Island is?

DFI:
We have not quantified that up in any detail, but let us say a reasonable sum has been discussed, I believe, as part of this policy when it is ready to go. So, I cannot give you those exact ... or they have not been calculated to an exact degree.

The Connétable of St. Peter:
Ballpark.

DFI:
I would say in excess of £500,000.

Senator J.L. Perchard:
Okay. Thank you, Russell.

Senator B.E. Shenton:
Departments are undertaking this Comprehensive Spending Review. When you were last here you admitted that you did not know the cost of a hospital bed, because you had some people who were in the hospital that should have been in nursing homes or residential homes, and that was seen as a saving because you were not paying a third party provider. But you did not know the cost of keeping them in the hospital.

DFI:
If I can just clarify what exactly that is about. What it is about saying is that traditionally Jersey Health and Social Services has not undertaken the same rigorous costing exercises that I have come from in the N.H.S. So, for example, the reference cost process, while has flaws in it in the N.H.S., is a comprehensive N.H.S.-wide process of costing hospital activity. There is not the resources in the finance team in H.S.S and has not been seen as a high enough priority piece of work to undertake to ensure that we regularly and routinely cost and understand all of our activities in a systematic way. If someone wanted to know a specific cost of a certain hospital bed or a certain activity, we would undertake a costing exercise as a specific one-off to deliver that. So, I think the important thing is saying we can identify what the costs are in response to questions, but we do not routinely cost up all of the hospital activity in the same way as with the N.H.S.

Senator B.E. Shenton:
As part of the comprehensive spending review, you will be looking at all the activities of Health and Social Services.

ACE:
Another issue is the I.C.R., of course. There is not the metrics to provide that kind of information. That is one where you bring in the lifetime bed management.

Senator B.E. Shenton:

You will not know what those services are costing, you see. You will not know whether you are getting value for money, or whether they would be better off out-sourced and funded.

DFI:
I think there are ways to focus our efforts into areas where we feel that there are opportunities and then the resources diverted to undertake the financial work.

Senator B.E. Shenton:
I am trying to get my head round how you can do a Comprehensive Spending Review if you do not know the cost.

ACE:
It is not just a press of a button, is it? That is the point. We know what our average length of stay is; we know what our delayed discharges are. But I am sure we could calculate for you an average bed cost, but it is like saying how much does a car cost. An intensive care bed is entirely different from a bed on an acute ward.

Senator B.E. Shenton:
But the implication is that this whole Comprehensive Spending Review system is a mirage, because you are just going to go through and look at all the costs and carry on spending the budget exactly as you were spending it before.

ACE:
Well, I hope not, and I hope things like the A.&E. Department user-pays will be issues that we put into Comprehensive Spending Review looking at where costs were incurred and where we can make savings. So I hope that is not the case. We wish to fully participate in the Comprehensive Spending Review, absolutely.

Senator B.E. Shenton:
In New Directions, I think; I hate to say it, obviously there are responsibilities for primary care and their are responsibilities at H.S.S. Will you be looking at going back to your core services within and the provisional of core services?

ACE:
I think that is a really good question, particularly with respect to saving money across the health economy. The real trick is in all the transition points between primary, secondary and tertiary care, and if it is co-ordinate ... I mean, you have got to look within the box to find savings and efficiencies; I do not doubt that. But it is the interface between primary and secondary care, and secondary care and tertiary care that are big savings to be made. We are now moving in a positive direction with primary care, as of last night.

Senator B.E. Shenton:
Which says that you were not moving in a positive direction before last night.

ACE:
I am not sure we were moving.

Senator B.E. Shenton:

You were not moving at all. **[Laughter]**

ACE:
The primary care body is making very positive noises about working with us in the future.

Senator B.E. Shenton:
Okay; because the State does do an awful lot that perhaps we should not be doing.

ACE:
I just think they could be more effective. There could be more effective interface between primary care and secondary care.

Senator B.E. Shenton:
Does anyone have any more?

Mr. K. Keen:
Can I just ask: just thinking about this £50 million structural deficit. If that was being sliced up in a business and somebody said: "What shall we put you down for?" sort of thing, can you see now how you could save £10 million, £15 million, being one of the biggest projects, without ... because you run the thing and nobody will probably know it better than you already. I am not sure that these reviews are going to produce a lot that is not known now.

ACE:
We can cut services. We can find efficiencies. A business that is a £160 million business, if we were to sit here and tell you that there are no efficiencies to be made we would be fools. Of course there are efficiencies to be made, ongoing efficiencies in such a large business. £10 million, that is service cuts, and there are different ways you can do that. You just look at some of the high cost areas in long-term care. That is why we have a Green Paper today about how you fund long-term care going into the future. These areas have certainly got to be addressed. You are talking about £50 million deficit. The evidence will say that health expenditure is going to rise significantly into the next 10, 20 years, so we have to do a comprehensive spending review just to ... even if we want to stand still. Many of the issues that are in this report are exactly that. Finding efficiencies in drug expenditure are important, not to cash release but because the expenditure on drugs is going to rise exponentially over the next 10, 20 years. So we have to be absolutely right about what we are spending our money on, just to stand still, in terms of cost containment.

Mr. A. Fearn:
To me, I think there is a difficulty. It just sounds like all we can do is constrain the growth of your spend, not cut it by 10, 15 per cent, which is ...

ACE:
Well, we can, but you have to cut services.

DFI:
Then it may be that is part of the business planning process. We do undertake pieces of work to identify what is the clinical perspective as seen as priority services, and

those are health put together, the options that the H.S.S. may have. Obviously it is very important that those are robustly thought through. They are not seen as shroud waving or all those kind of negative words that are used in light of service priority work. But it is possible to do it, it is just highly emotive.

Senator J.L. Perchard:
Yes. The Grand Vaux Youth and Community Centre was a wonderful example. It is not directly affecting the health and welfare of patients, so it is a candidate, if you like, for a cut. But look at the emotion that that stirred up when it was suggested, albeit maybe a little tongue in cheek by the department, but it certainly got a lot of response, did it not?

ACE:
Well, the cuts which were put up by the department for the Minister to approve were purely based on risk. That was the only criteria about risk to the service. Absolutely. That was all there was. So, the areas which presented the lowest risk were the areas put up for cuts.

Senator B.E. Shenton:
You have got some staff within your department, or within H.SS, that are perhaps, I think it is fair to say, grossly overpaid through evolution where their terms and conditions have got way out of sync with what they are doing. H.R. now comes under the Chief Minister's Department. Who looks at the remuneration of individuals within H.S.S. to see whether you are getting value for money from each role?

ACE:
I think, broadly speaking, in terms of the terms and conditions that that is something for the States Employment Board to consider. When we come down to the role of an individual, we were discussing this only the other day about protected pay and how those issues are worked through with respect to issues in N.H.S. and how that works in Jersey. In the U.K. you would be ... after 5 years there would be no further protected pay, but I believe in the States, it is for life. Now, that is a problem, because as an individual if you are going to protect my pay for 5 years and then no longer protect it, then I am looking pretty hard to find a suitable role for me to be in to ensure that I remain at my salary. But if you are going to put me in a position whereby I am going to be on that protected pay for life, and there is no incentive for me as an individual to move, then it is very difficult for the organisation to move that individual unless they are incompetent in that role. Now, do not forget, they are unlikely to be incompetent in that role because they have come from another role.

Senator B.E. Shenton:
But Russell, as finance director, was working for a big entity, he may well turn round and say: "Well, Freddy in accounts is paid far too much, we are going to have to lose him" or something like that. I think that you do not look at salaries in any way, shape or form as you would in the private sector, because it is all just central and that is the States payment.

DFI:
I suppose, when I started in H.S.S. the first thing I asked for was effectively a list of all of the senior individuals, because I assumed those would be the ones I would be

working closely with to deliver the various objectives of H.S.S. So we are aware of those and the line managers of those individuals will be aware of what they are paid. I would say it is the responsibility of the line managers, that is part of ... because we have touched on H.R. management already, to review the functions that that individual is carrying out to ensure that they are comfortable that they are competent et cetera to do the job. If the States of Jersey terms and conditions dictate how that individual is remunerated for that, then I think that is more an issue for the H.R. team to take forward in regards to policy, rather than the manager in reviewing whether that person is adequate.

Senator B.E. Shenton:
But as finance director you would never ask a line manager or a manager, how can you justify paying him that much for doing that?

DFI:
I can do that, and I have done it with various individuals. But the reality is as long as the manager of that area can justify the individual, the post they are in and the costs that they are incurring, then depending on obviously how grossly out of line it is, then I would rely on that manager to make sure that they are achieving their objectives in value for money for the States of Jersey in employing that individual.

Senator B.E. Shenton:
The public sector is certainly a very different world to the private sector, is it not?

Mr. K. Keen:
Chairman, does protected pay mean frozen pay, or does ...?

DFI:
No. Protected is the grade they are at.

Mr. K. Keen:
So as the value of the grade goes up, then that goes up.

Male Speaker:
Goes up, and they would still get an annual rise each year ...

Mr. K. Keen:
So you still get a rise each year. Your pay is not frozen for life; your grade is protected.

The Connétable of St. Peter:
Yes. It is not protected pay; it is protected grade in terms of ...

Senator B.E. Shenton:
Can you be downgraded?

The Connétable of St. Peter:
Never heard of it.

Senator B.E. Shenton:

You have never heard of anyone ever being downgraded?

The Connétable of St. Peter:
It does not mean to say they have not.

DFI:
That is the fact, I am sorry, that in the N.H.S. it would automatically happen after 5 years that a person goes to be remunerated, to the level of the grade that they are now working at, rather than that they may have been in the past.

Senator B.E. Shenton
We are all sitting here thinking we are in the wrong job. Thank you very much.

[15:14]