Health, Social Security and Housing Scrutiny Panel

Full Business Case - Hospital Review

FRIDAY, 11TH APRIL 2014

Panel:

Deputy J.A Hilton of St. Helier (Vice-Chairman)

Deputy J.G. Reed of St. Ouen

Senator S.C. Ferguson

Witnesses:

Chief Nurse

Clinical Director, Future Hospital Projects

[10:33]

Deputy J.A. Hilton of St. Helier (Vice Chairman):

Good morning, and welcome to the Health, Social Security and Housing Panel. It is a public hearing with the Chief Nurse of the General Hospital. We will start by introducing ourselves. I am Deputy Jacqui Hilton, Vice-Chair of the panel.

Deputy J.A. Hilton:

Thank you, and welcome. I would like to start by drawing the public's attention to the code of behaviour, which is outlined on the wall and also to offer the apologies of our Chair, the Deputy of St. Peter, who is unwell at this present time. We would like to start by asking you what you think are the most significant challenges facing the Health White Paper reform.

Chief Nurse:

Gosh, a nice opening question.

Deputy J.A. Hilton:

You can take your time.

Chief Nurse:

I will take my time. I think from a chief nurse perspective I think certainly one of the challenges is a workforce-related one and that relates not only to the workforce that we currently have in Jersey and our need to build the skills of the workforce that we have in Jersey, which we have already been doing for a considerable time, but also the increasing demographic among our nursing workforce particularly, along with other professional groups - I know particularly in terms of medical staff - at a time when the demographic changes and ageing workforce is also affecting other jurisdictions. So we are in a competing market in relation to recruitment and attracting the staff. The other aspect is to make sure that our staff that we currently have and the staff that we attract are able to respond to the new ways of working, which will be required as part of some of the changes that we will putting into place. So the workforce challenge is one challenge. Other challenges do relate to not just the fact that we will be remodernising the hospital and proposing to introduce a dual-site service, but also in relation to how patients manage those services. So it is not just a case of a new hospital, if is a case of thinking about how patients flow through the system, how practitioners are best placed to support those patients and where they will be based in terms of work. Also our ability across community services to respond to the increased need to support people more at home and through the primary care model. So they are the main challenges that I have in my mind.

Deputy J.A. Hilton:

With regard to the workforce challenges, and you have spoken about an ageing demographic of existing staff which is replicated in the U.K. (United Kingdom) as well, what measures do you believe that we should be taking that we are not currently taking to overcome some of the difficulties of possibly moving from the U.K. to come and work in Jersey?

Chief Nurse:

In terms of measures that we are not currently taking, there is nothing that comes to mind at the moment. We have got a whole range of measures in place which include the changes that we have made to our on-Island pre-nurse training. So again, that is the work we have done with Education, Sport and Culture in relation to increasing the number of places that we have year on year for local Islanders, which fits with the Island strategy as well. At the moment ... we started our first cohort last September with 15 but we can trade that up and down. There is a critical mass issue in terms of the volume that you can train at any one time, because obviously you have to have an appropriate ratio of registered nurses to students. In addition to that we are increasing the amount of time that we are able to take students in, so previously it was anything between 2 and 3 years. We are now taking them on an annual basis and we have just recently announced that we will also be training ... offering local Islanders the opportunity to train as midwives, mental health nurses and paediatric nurses. That is with a model that we have developed with the University of Chester, through our links there. We are also able to offer a whole range of opportunities for nurses already registered in Jersey to retain them on the Island so that they get the opportunity that their colleagues may get elsewhere. That is a whole range of qualifications up to Masters level provision, which again is in line with academic access that nurses have elsewhere. We have also been working with Highlands in terms of the work that they do around the BTech (Bachelor of Technology). We have a very good profile at the careers fairs, and my team were out yesterday, and also attracting people to come into care as a profession in the first place. In addition to that, the work we have done around advancing practice for nurses, so again this is about the nurses that we currently have in Jersey and the nurses that we want to attract in Jersey in relation to the work we have done around non-medical prescribing. So we have our first cohort of nurse prescribers working across the Island now. They qualified last year. We have a cohort at the moment that is also ... in their training at the moment, but the changes to the legislation meant that any nurse that has the prescribing qualification and works elsewhere will no longer be put off working in Jersey because they could not use those skills that they already have. The work that we did last year, particularly with our first cohort, who I have to say were chosen for a whole range of reasons, we were very careful in our selection, not just in terms of the area of service that they work and the demand required, but also they were chosen for the very sort of people skills that they have as well as their academic ability, to make sure that our first nurse prescribers had the right interpersonal skills and could really promote this as good practice across the Island. So there are a whole range of measures that we have in place at the moment. Then the other side, as you mentioned, attracting nurses to Jersey and cost of living and everything else. We are hopeful that the work through the workforce modernisation project and the reform of the way our nurses' job descriptions are developed, the way that nurses are expected to work in Jersey is matched to their salary and that is commensurate with the work that we have been doing in relation to equal jobs of equal pay over the last 12 months.

The Deputy of St. Ouen:

When is that particular piece of work likely to be completed?

Chief Nurse:

At the moment we are doing our work with the ... it is not being run through the workforce modernisation team, so it is not directly being run by our department but all of our staff are working really on their job information templates. So when they did the initial piece of work my understanding was there was some concern that the nursing job descriptions that we had needed to be updated in order for them to do the job matching properly. So all the nursing staff have been working with the unions, managers and everybody to profile their jobs, and that work is ongoing at the moment. There is a whole heap of work that is being sent over to the workforce modernisation team. They have job-matching panels who meet. So it will not be nurses looking at nurses' jobs. It will be trained job evaluators who come from different areas of service, looking at jobs and potentially matching them. I understand they are aiming to complete that part of the exercise in the next couple of months. There is a lot of pressure on us to get that work completed, but it is important we do it properly.

Senator S.C. Ferguson:

But inbetween all this are you managing to apply a sort of Lean process?

Chief Nurse:

In relation to which aspect, Senator Ferguson? In relation to the job description process or in relation to the way people work?

Senator S.C. Ferguson:

In relation to working practices.

Chief Nurse:

There is a range of Lean projects in place across the organisation, across different areas at the moment so, yes, there is a lot of work at the same going on across our services. It is a lot of work, and then there is the work around the changes to the way people work in relation to the community services, the White Paper, the single-point referral. So you are right, there is a lot, but Lean principles should be underpinning everything that we do anyway. We are building the workforce in terms of the capability around Lean and we have got some good early projects that we have created. One that I was personally responsible for was the review of nursing and appraisal documentation which was cumbersome, lots of paperwork and really did not hit the point. We did that piece of work last year. I think you saw it. So that is just one project but there is a whole

range where they are looking at phlebotomy services, pharmacy, different aspects of the way we do things.

The Deputy of St. Ouen:

Rose, you spoke about a number of initiatives to be undertaken on the Island to provide the necessary skills for people to enter the nursing profession at different levels. Is there any specific Advance to Work programme currently being run to help people become carers and the like?

Chief Nurse:

You will have to forgive me, because I do not know what is badged under what particular programme, because there are a lot of different ways in which people get into our services ... into a career in our services, I should say. So I know there is a range of flows of people coming in, whether it is through people identified as having been unemployed for a period of time, and we have just been working ... well, I have recently met with a lady from H.R. (Human Resources) who is leading on that with a view that we present opportunities for people who are currently employed to do meaningful work for a period of time. That may not be appropriate that they work in nursing, but it could be that they do something office-based. There are opportunities again that we have taken people through Advance to Work schemes on to our nurse bank as healthcare assistants. What we are very mindful of is whoever wants to enter the caring profession has to have the right skills and attributes and that is very important that we do not let that side of our recruitment slip in any way because of pressure to obviously find local work for local people. But it has to be right for you and it has got to be right for everybody else.

The Deputy of St. Ouen:

Right, thank you. The only other question I have at the moment is around the current level of vacancies.

Chief Nurse:

It has been fairly static for quite a number of years now. Probably at any one time we have up to 50 registered nurse posts unfilled, which is a mixture of posts that we are currently out to recruit and a mixture of posts that we have already recruited to and waiting for individuals to come into post. Now, that is across all Health and Social Services nursing posts, it is not just the General Hospital, but the other thing to factor into that that keeps it fairly static is we have had some real positive investment in frontline posts as well, so the figure tends to start topped up because we are ... as we are filling posts, we are bringing new ones online as well.

[10:45]

So, for example, at the moment we are just recruiting into 8 posts for critical care nurses. So those posts were not available to recruit to until the funding became available this January. Those 8 automatically go on to our vacancy factor which tops it up again, if you know what I mean. So while it looks as if we have a fairly consistent level, because I recall we have had this conversation previously at one of our previous scrutiny hearings, it is a positive message because it is part of increasing our frontline staffing levels as well.

The Deputy of St. Ouen:

So currently we are able to recruit the various different nurses with the skills that are required?

Chief Nurse:

I would say it varies. I would say I recently was involved in the recruitment of a specialist nurse post and we found a very good candidate who took quite a lot of time to consider and unfortunately withdrew. That was on the basis of what that candidate considered a significant step to moving to the Island. It goes back to the same issue around housing. The cost of housing is quite startling for people.

Deputy J.A. Hilton:

So with regard to that, because housing has always been a big issue, in your opinion do you feel that the States of Jersey are not doing enough to address that issue? We are going to be relying more and more on people coming from the U.K. to fill these posts and especially as we are switching from hospital-based services to services in the community, we are going to need those additional staff to carry out those services in the community. How much does that concern you that you will be faced with that issue again in the future, about housing?

Chief Nurse:

Yes, we have been doing some work with Andrew Green's department and with colleagues in Jersey Property Holdings, looking at the whole issue around accommodation stock, the housing policies within Jersey as well, with a view to developing the essential workforce gateway. That work is progressing slowly but it is progressing. I would not say we are in a position at this moment in time where I could say, hand on heart, we are there yet. But it is a very encouraging positive conversation.

Deputy J.A. Hilton:

In your discussions with the Housing Department ... you know, we have moved on from the days where nurses lived in a nursing home in a single room. We have moved on from that, so in your discussions with the Housing Department, is this to open up all types of accommodation available to incoming staff? Does it involve that?

Chief Nurse:

I think in terms of the conversations we have had so far, it is about registered nurses working for Health and Social Services with an opportunity that, by the time they come to Jersey in the future, they will have a choice of how they would choose to live on the Island. The choice would be they could potentially rent, they could potentially buy or they could potentially move into one of the gateway schemes or social housing schemes.

Deputy J.A. Hilton:

So when we are talking about the housing needs of staff we are talking about qualified staff coming in, not people coming in to fill other maybe more basic roles at the hospital?

Chief Nurse:

Yes, generally we would recruit people in non-registered posts locally so people who worked as healthcare assistants or support workers would generally be pulled from the local community. That said, obviously we are very keen to develop local students and give them the opportunity to develop as nurses as well.

Deputy J.A. Hilton:

Would it be fair to say from our conversation this morning that it seems to me that you are confident that we will be able to fill the need for those specialised nursing posts to deliver the Health White Paper in the community?

Chief Nurse:

I would never like to say I am 100 per cent confident, but what I would say is that the feedback we have had from nurses who have applied recently for the post, certainly since the work has really begun in earnest around the White Paper and the plans around the future hospital, people see what is happening in Jersey as a really exciting opportunity and see this is an attractive place to come to work. That has come through not just from candidates but it comes through our links with U.K. universities and our regulator as well. So I think the real positive message is about what is happening in Jersey getting out there and people like the idea of living in the community they are going to be caring for.

Deputy J.A. Hilton:

We will just move on to the subject of the new hospital. We are interested to know what your direct or personal involvement in the new hospital plans has been and also how the nursing staff in the hospital have embraced the idea of, say, for instance, a 2-site location with your hospital services. So if you could just talk to us about that, that would be good.

Chief Nurse:

Okay. In terms of my involvement, I have been involved from the point of view of I have attended and supported events that were held at the town hall with a range of different professionals last year, going back to the very early stages in terms of the work with KPMG on the technical paper and the collaborative event. I was one of the people who co-ordinated one of the groups up there. I am a member of the transition steering group, so again, in terms of the oversight on the White Paper, I have a key role on that. In terms of my sort of involvement in the work around the future hospital, Bernard I employed as a senior nurse initially before he got moved into this role. So I see Bernard as a professional link on a very regular basis and we are able to touch base on things. I also have very regular access to the senior nurses, so these are the nurses who are responsible for running the divisions and I see them on a fortnightly basis as a group and we are able to discuss future issues affecting all aspects, workforce issues as well as future plans for the hospital. I attend a meeting with the Clinical Director, so this is the medical staff. Helen O'Shea chairs that meeting and that is once a month on a Wednesday evening. Again, the future hospital, the dual-site plans and pathways are things that regularly feature in our discussions around that, along with the issue around single rooms. In terms of your question about how nurses are feeling, I hear things through a variety of different means, so the sisters meet together on a fortnightly basis in the hospital; I have an open invitation to those meetings. I do not get to them very often just because of my diary, but I do get all the minutes of those meetings and if there is anything anybody has to raise as a concern I do have an open door policy, even though they cannot always get to me straight away, and I meet with our nursing union reps on a very regular basis. I do know that the nursing staff feel very strongly about the physical environment in which patients are cared for at the moment. That is to say that they are ... what was I going to say then? Yes, so they feel very challenged and concerned about the physical environment. In terms of proposals about the environment moving forward, I think those discussions in terms of viewpoints, what the ward should like, I think they are still at the stage where they have got more questions than they have come to a consensus thinking. So it is really at the moment around the thrashing out of ideas. I know Bernard met with a group of the sisters fairly recently and I have had feedback from that meeting as well in terms of where their thought processes are and I think it is fairly typical - I can say as a nurse myself - of how people think, in that when you are presented with an opportunity to think quite creatively at a time when you are used to dealing with business as usual, it is sometimes quite hard to visualise what will be in the future and think backwards from that. So while everybody knows that this is not a done deal in terms of the design of the new build or anything, to be asked their views and opinion, I think they are still formalising those and their thinking around that, so: "What will it mean for me? What will the ward look like?" I think they are coming to a point where they will have quite a clear idea but I think there is going to be some site visits as well to different types of hospitals in the U.K.

Deputy J.A. Hilton:

You mentioned that nursing staff had raised concerns about the nursing environment. Could you tell us what some of those concerns are?

Chief Nurse:

Some of it relates to the fact that the bays are particularly cramped. I mean, I saw this for myself when I visited somebody in the hospital recently who said the care was fantastic but when you visit you really are mindful that everybody can hear everything that is said. So people do very well within that quite cramped environment. There is an issue around lack of storage, there is an issue around lack of space basically, so private rooms to take patients and visitors to have a confidential discussion is limited. Use of day rooms that always used to be available in the past have gradually become eroded just because of the pressure of space. So it is mainly around those issues and when we do recruit nurses from the U.K. or other areas the model of care that we provide in Jersey is very welcomed and very liked by nurses but the environment is usually quite a shock because they come from quite different environments.

Deputy J.A. Hilton:

You also mentioned that nursing staff had concerns around what is being proposed. So what are you directly doing to address those concerns with nurses? You said yourself that sometimes you found it difficult to get to the sisters' meetings and other meetings but what about the level below the sisters, how are those concerns being addressed?

Chief Nurse:

I know all of the sisters have regular meetings with their staff and their teams and these will be issues that they will be discussing with their teams. I think in terms of ... if you take the single rooms as a particular issue of discussion, we are doing some work around feedback from patients particularly at the moment to see what patients think, because it is easy for us to say: "As nurses, we think this." It is best to ask those who have experienced it what their opinions are. But I understand that the discussions around the wider nursing team will be taking place within those ward areas and those ward teams, so I would expect the sister on the surgical ward to be keeping her staff briefed and involved in a discussion and a debate, and Bernard is a very accessible person as well, so any information, whether we want information out or we want to share thoughts and feelings, would go back into Bernard through that process.

The Deputy of St. Ouen:

Following the decision made by the ministerial oversight group that a fully zoned new hospital costing £430 million was unaffordable and a decision that the new hospital should be provided within the £300 million envelope, what involvement have you had in the prioritisation process that

has been looking at what services should be provided and how the new hospital could fit within that new funding envelope?

Chief Nurse:

My main involvement was the meeting that we had at the town hall. So they presented the proposals for what was affordable within the costs envelope that had been set for it. It was at that meeting that we discussed in groups as clinicians if the model was to be a dual-site model what services would be on one site and what services would be available on the other. So that was my main involvement in that part of the process specifically.

The Deputy of St. Ouen:

You do not believe that any ... that the services that we currently provide would be limited or reduced by the decision to provide a hospital at a lesser sum?

Chief Nurse:

I think that the ... I think in terms of where we are at now, I think the opportunity that we have got as practitioners to the building as a building, how do we decide what happens in that building is a real opportunity. I think that the way services are configured, we have a real opportunity to get it right for people here so that they are not down at the hospital, over at Overdale, down from Overdale, back at the hospital. We have what we have and I think now we are all in the process of talking about how patients will come into the system, flow through the system, what care will be provided at the Overdale site and what care will be provided at the acute hospital site. That is where the real piece of work is going on at the moment.

The Deputy of St. Ouen:

When will that work be complete?

Chief Nurse:

It is part of the acute strategy which I am not personally leading on, Helen O'Shea is. Bernard might have an idea of when it is going to be completed.

Clinical Director, Future Hospital Projects:

We are in the process now of developing what is called service plans, so E.N.T. (Ear, Nose and Throat), Neurology, but that process will be finished by June as a first draft. We will be ... at that point we will have the technical advisers recruited on to the process and they will take those plans and begin to test our thinking. We are down to a shortlist of 5 as the moment, they will have built many hospitals before and they will be able to say: "This is your thinking now. Are you aware of this or that?" So that will be June, that process, in a first draft.

[11:00]

The Deputy of St. Ouen:
All right, and when is the target provision date?

Clinical Director, Future Hospital Projects:
We have to have all this done for an outline business case to be ready in January 2015, and in autumn 2015 the full business case, so that tells you what ... we have a ... we shared with M.O.G. (Ministerial Oversight Group) this week detailed deliverables at each stage through that process until the F.B.C. (Full Business Case).

Senator S.C. Ferguson:
Yes, but in the middle of all this you are looking at patient flow with Lean, so the odds are that when you have analysed what the patient flow is like, then whatever it is that you started out with is probably going to be quite different.

Clinical Director, Future Hospital Projects:
Would you like me to respond to that?

Chief Nurse:
It some cases it may be, but in some cases the work we are doing on patient flow will inform the way it will work in the future.

Senator S.C. Ferguson:
Yes, but if you are not going to have the work done before ... you are doing everything in parallel, that is fine, but you do need to get a lead surely with the patient flow approach in order to make the rest of it work together.

Chief Nurse:
Yes.

Clinical Director, Future Hospital Projects:
We are doing that, so the process of service planning is currently identifying the key pathways within those specialities ...

Senator S.C. Ferguson:

Yes, but ... I am sorry, but if you will excuse me, you are trying to make the flow ... improve the flow, which is the essential part of Lean. Really we are talking about ridges, are we not, through a factory?

Chief Nurse:

No, we are talking about people. I cannot imagine it ...

Senator S.C. Ferguson:

But the concept of a flow ...

Chief Nurse:

Yes, yes, through a system.

Senator S.C. Ferguson:

... and the outcomes. If you are trying to redesign the organisation at the same time as you are charting the flow, are you not going to get yourself all tied up?

Clinical Director, Future Hospital Projects:

No, what I mean is obviously more complex than what I am going to say here ...

Senator S.C. Ferguson:

Yes, I know, it should not ...

Clinical Director, Future Hospital Projects:

The Lean is essentially taking out steps that do not add value. We currently, in our flows, for a range of services, have steps that do not add clinical value for the patient. I think in previous sessions I have talked about, for example, if you have heart disease and diabetes, which is a common combination, you will go currently for your cardiac appointment at the General Hospital and your diabetes appointment at Overdale. Those are unnecessary duplicating steps. What we could do, and should do, is have those services collocated in an ambulatory care centre, which is part of the dual-site model so that you can go and have your diabetes appointment on the same morning as you have your cardiac appointment. So in a sense, whether we call that lean or not, that will take out an unnecessary transport step, an unnecessary morning of work and an unnecessary carer appointment. So you are absolutely right, there are lots of ways to do this but absolutely we can do both in parallel by engaging the clinicians in this process. The stage we are at at the moment is identifying the key pathways at service level that we can then look at and understand how they fit together.

Senator S.C. Ferguson:

I believe that the important thing is to get the senior consultants to understand what is going on and to buy into it. How are you doing?

Chief Nurse:

As I say, we have done that through a range of meetings and through the clinical leadership route as well within the organisation, so through the clinical director route as well. But also as Bernard is talking about these pathways, these are for the frontline clinical teams with the individuals. Rather than individuals saying: "You cannot do that" we need them to be on board and engaged and part of ... vis-à-vis they understand these services better than any manager does. They know their patients as well and they know the Jersey context, so it is about engagement with them. There are also plans to introduce almost a clinical champion role so a senior consultant within the organisation who will be another lead to support Bernard in the development of services and their colleagues as well. So again, modernising services, looking at patient flows. As I said, around nurses, when they are dealing with business as usual it is a bit of a challenge for individuals and getting people to think about things differently and question things differently is quite new to some people and it is an evolving process. Some people are there already, some people have been developed and some people have still got a bit of a way to go.

Senator S.C. Ferguson:

Yes, and you still have the suggestions box?

Chief Nurse:

A staff suggestion box? We did have ... well, we have got some on the intranet now rather than a box. In terms of feedback to Bernard, people can feed back to Bernard in terms of any of the future hospital stuff either directly through email ...

Clinical Director, Future Hospital Projects:

They are doing so.

Senator S.C. Ferguson:

That is good, because in my experience they usually work best if there is some sort of a Marks and Spencer voucher or something for the best idea of the month.

Chief Nurse:

Yes. Yes. We can consider that.

Deputy J.A. Hilton:

Before we move on to the subject of single beds, I just wanted to ask you as Chief Nurse and also with your ear to the ground in the hospital, listening to what is being said, is there any service which we are currently not providing that you are hearing that maybe we should be considering that we should provide on-Island?

Chief Nurse:

Only in so much as what I know, the proposals that I have already seen, so that they are considering the radiotherapy services potentially. In terms of my ear to the ground and is there anything else, not particularly.

Deputy J.A. Hilton:

I asked that question because obviously you guys are the professionals, you are there in the hospital and so you are privy to the conversations that are circulating within the medical staff. You mentioned radiotherapy as a possibility. Has there been any advancement on that, or is that in the very early stages at the moment?

Chief Nurse:

I think that is quite early stages. Bernard could give you a more accurate update.

Clinical Director, Future Hospital Projects:

We are just writing a specification now to go out to an ... this is specialist work that is done by specialist providers, either obtained through what is called a national radiological advisory group, which is a national body, or through the Royal College of Radiologists, or indeed through a range of commercial providers. We have our data, we have our population, we have our epidemiology, we have our mock into the future and an organisation would then put that together and say: “Does it meet certain standards?” and there are certain standards to be able to provide what is called a linear accelerator on the Island. We need to meet those standards. So that work will be tendered out. Interestingly, I was doing the specification with Jo Yelland, who you may have met in other settings, because she is experienced in that kind of work, working again at engaging the clinicians in that. Chris Hare in terms of radiology, Amanda Jones, who is one of the consultants, an oncology consultant, and that piece of work will be done for this period in terms of the June deadline. We need an idea about that, about whether that is feasible, safe, sustainable, affordable, things we apply to all the work we do. So, yes, we will look at some feasibility on that.

Deputy J.A. Hilton:

A decision would be made around that before presumably the full business case in January 2015?

Clinical Director, Future Hospital Projects:

Absolutely. We need that because you need to build a bunker, so it is a big concrete ... it is not just buying a machine, you need to put that into your planning, your outline planning application, into the design, it goes in the basement, generally speaking, so yes, that would need to be done and the decisions made about whether that is something we want to proceed with by autumn really in terms of getting that ready for the outline business case. For the Island, it is a very complex decision because we believe, for example - or in fact, we know - that there is a potential unmet need on the Island that we might want for palliative care and others. So it is quite a complex discussion. It is a strategic decision for an Island this size to invest in that.

Senator S.C. Ferguson:

Have we done the cost benefit?

Clinical Director, Future Hospital Projects:

We have not yet. That is what this work would do, because they are expensive. Once you build the bunker and buy one, then you cannot turn it off again in 5, 10 years' time. So it is really quite a complex decision. The Island's population is only 100,000. The recommendation is that you would need 5.5 per million population. However, there are health communities on the mainland with populations smaller than we have here who are safely running it. It will be a ...

Senator S.C. Ferguson:

It is not a question of safety, it is whether the cost ... if you compare it with the cost of people going to Southampton and other places onshore, whether it justifies the expenditure of £14 million.

Clinical Director, Future Hospital Projects:

That is right. We currently have money going off-Island that we could repatriate but there are some things that we would not be able to bring back. So that is the work we would do to look at how much we are paying Southampton at the moment, could that fund services on the Island? But there is a safety threshold, because even if it made sense financially, if we could not work with a partner, for example ... we work with a partner, cancer centre, they would have their governance arrangements. If we did not meet that safety threshold then we would obviously have a conversation and it would not ... that is why we are contracting with a specialist organisation to do this work for us.

Deputy J.A. Hilton:

But we also have to bear in mind both the cost of providing a service, the human cost, to being away from family and friends at a very, very difficult time in a person's life when they are undergoing treatment.

Clinical Director, Future Hospital Projects:
Yes.

Deputy J.A. Hilton:
Okay, thank you. Right, we would like to ask you some questions around the question of single beds and single-bedded rooms and we would like to hear your view on that. What you think the advantages and disadvantages are?

Chief Nurse:
I have a personal view. My personal view is based on my family's experience of being in hospitals - not in Jersey, I have to add - and my own personal experience of working in other organisations. I think single rooms are entirely appropriate. From the point of view of your ability to comfortably nurse somebody in a private environment where you can have very difficult conversations with individuals, where you have got space, where you can manage any potential infection control risks, I think single rooms are entirely appropriate. Personally I know what I would prefer and what I would prefer for my family as well. My daughter has been in a hospital in the U.K. which was all single rooms and my daughter has also been in a hospital where it was an old-fashioned Nightingale ward. There was no difference in terms of contact with nursing staff when she was in the single room and she had the opportunity to go out, walk out, do what she needed to do. So that is my personal view. From an organisational point of view, I understand in terms of the evidence base around single rooms, I know that with the exception of England new hospital builds in Northern Ireland, Scotland and Wales are all to be built to 100 per cent single room occupancy. I think England is still sitting at around 50 per cent at the moment, with some hospitals going for 100 per cent. I know one of the hospitals I worked in, Liverpool Royal, is going for 100 per cent single room. I think there is great benefit from a patient point of view, not just for the reasons I have already specified, but also in terms of managing your total bed base, which from an Island's perspective gives greater credence to full single rooms, or as many as we can have because basically when you have a bay and you have mixed bays, you could have a male bay and a female bay next door to it, if you have suddenly an influx of men coming through the organisation as patients, you then have to start moving beds around, moving patients around. If you have got patients already in single rooms that does not become an issue then. You can manage the beds that you have much better. Every time you move a patient from one bed to another you introduce an element of loss of information, loss of communication in between the transfer of patients to another bed or to another team or another ward. So from a patient's point of view, I think it would be much better. They come into hospital ... unless there was a clinical need that meant that they had to move beds. So, for example, they deteriorated and needed to go to critical care, that room would be the room for the duration of their stay in hospital. Again, this goes back to what I have heard from patients who have been nursed in bays who get very anxious when they see other

patients opposite them who look like they are in a little bit of difficulty or have some challenges throughout the night which makes quite a lot of noise, people find that quite difficult to sleep and it does not really help their recovery. Sometimes people are quite keen to be discharged from hospital because they found it quite disruptive being in a bay with other people.

[11:15]

So I think provided the design is appropriate and right and that there is space for people to meet together, there are areas for nurses to come together and work and private spaces that they could talk to relatives, I think it is the design that is important.

The Deputy of St. Ouen:
You have said that there is no difference in contact between people in a ward and in a single room. Can you just explain what you mean by that?

Chief Nurse:
In relation to ... partly it would be in relation to your staffing levels, so again you would need to make sure in the same way you have appropriate staffing levels for patients in bays that you would have appropriate staffing levels if patients were all in single rooms. Again, depending on how those rooms were configured and what sort of line of sight there was for nurses to those patients in those single rooms would determine your staffing needs. In terms of contact with other patients or other people on the ward, I think you give people a choice, as we have on the rehabilitation centre up at Samares Ward, which is all single rooms. There is a choice, they have quite a lot of choice in terms of where they want to go. They can go and eat in a communal area for lunch, they can sit in a communal lounge or they can go to one of the quieter lounges if they want to, or stay in their room. So I do not think if there is a concern around it, any potential social isolation, that that would necessarily be borne out, provided the design was appropriate. But it is important the design is right.

The Deputy of St. Ouen:
We have heard of an occasion from a certain individual that once you are occupying a single room it is out of sight, out of mind, and there is a greater risk that the needs of that individual could be not ignored but not noticed.

Chief Nurse:
I understand, yes.

The Deputy of St. Ouen:

Basically from what you are saying the way you deal with that is increase the number of staff to ensure that you have got sufficient provision?

Chief Nurse:

I think there are 2 issues there. One is that I obviously do not know which hospitals these individuals who have fed back to you were nursed in, but say if they were nursed in our hospital, at the moment the design of the wards does not lend itself particularly well so those single rooms are not designed in the best way that they could be. So the patients do not have a lot of access to see what is going on outside the room, so they cannot necessarily see people walking past, they are quite closed off, they are tucked away. Again, because we have such a limited number of rooms available at the moment it generally means that they are used by people who potentially have an infection. So again that limits the amount of contact with somebody coming in and out of the room, because you have to manage an increased infection risk. I do think it is very much incumbent on the design of a single room and the design of the ward, which would then determine your staffing levels. If you designed a ward area potentially where all of your single rooms were almost like hotel rooms, in that they were so private that staff could not see and the people inside the rooms could not see, then I could understand that. If the single rooms were designed in such a way that there was clear visibility, particularly for patients who wanted it or needed more visibility, that they were designed so that there was a choice in terms of line of sight into those rooms and potentially the patients. But we have to build a model that creates that fair line of sight and that opportunity, but bearing in mind in the future model the majority of the people who will be in hospital will be acutely unwell so we need to make sure the wards are configured and designed in a way that we can safely manage that. So people's experience today will be different tomorrow in the new model.

The Deputy of St. Ouen:

From what you said there are a lot of advantages but you have not necessarily mentioned any disadvantages. Are there any?

Chief Nurse:

To single rooms? I do not know that I have necessarily thought in that way. I cannot think of any particularly. From a nursing point of view, how you organise and deliver your care is important when you are working in single-room facilities so that you do not stockpile stuff in people's rooms. You only have enough for that day, and you can manage your workload provided it is organised in an appropriate way. It lends itself very well because you have more space available to you in that room than you ever have in the bays. I cannot particularly think of anything obvious. Sorry.

The Deputy of St. Ouen:

That is fine.

Chief Nurse:

I am trying to.

Deputy J.A. Hilton:

Are ensuite bathrooms an integral part of the single room concept?

Chief Nurse:

I think, again, from a personal point of view ensuite bathrooms would be great. I think from a patient perspective they would be absolutely desirable because, again, this goes back to privacy, dignity and how you care for patients in an appropriate environment. So if you were very unwell, to have the privacy of your own bathroom is a massive plus.

The Deputy of St. Ouen:

Obviously, as you quite rightly point out, the focus is going greater on the medically unwell who may struggle to access on their own ensuite facilities. I suppose that is where the question arises: how appropriate is it to have large sums of money being spent on these extra facilities when individuals are more likely to need help?

Chief Nurse:

Yes, that does not take away from the fact that they will still receive help and they will get the care that they need. You said that they may not be able to use the bathroom facilities but they would have the privacy to use other methods, a commode, a bedpan, in the privacy of a room which is also soundproof.

The Deputy of St. Ouen:

I was just specifically focused on the ensuite facilities in each room.

Senator S.C. Ferguson:

You still have a bell.

Chief Nurse:

Yes. You still have staff, you are still cared for. **[Laughter]**

Deputy J.A. Hilton:

With regard to the issue of single rooms in the dual site, what sort of feedback have you had from staff?

Chief Nurse:

About the dual site?

Deputy J.A. Hilton:

Well, say about single rooms firstly, what sort of feedback have you had from medical staff?

Chief Nurse:

Particularly from nursing staff I think around single rooms we have had the discussion around infection control practice, which having single rooms alone is not enough to improve ... infection control is all about behaviour and equipment and appropriate means of cleaning. It definitely improves the situation because you reduce the movement of patients because you can use your bed base. We have also had conversations around things like patients who are at risk of falls. There are lots of things available on today's market to help manage patients who are at risk of falls. So along with tools like risk assessments there are high/low beds, which we already use, so if somebody is particularly at risk of falling we can nurse them on the bed that goes very low, close to the ground. This also monitors so that you know if somebody started to move to get out of the bed. So there is a whole range of things that we can use that would help and support patients and staff, and those are the sorts of things that we have had conversations about, as well as what will it look like, where will the nurses' station be, what will our staffing levels be like, what will our skill mix be like or what will registered nurses be doing in the future? So again it is about getting people to think differently, not just about the physical environment, but about the way they work within that environment and the skills they need within their team to respond to the needs of the patients in the future. So upskilling our non-registered workforce to take on additional roles, upskilling some of our registered nursing workforce and making sure that their most senior doctors are available to deal with the most sick patients, so making sure that the skills are stratified appropriate to the patient's needs.

Deputy J.A. Hilton:

Yes, okay.

The Deputy of St. Ouen:

Would you agree that more nurses will need to be recruited when you consider the potential combination of single-bedded rooms and dual site?

Chief Nurse:

I cannot answer that question without knowing what the model looks like. So without knowing what the wards will look like in terms of how they are configured and how the rooms sit, and whether they sit around a central hub or ... it is impossible for me to say whether we would need more staff. I certainly think that we have got work we can do now to get us in the best position and this is about the skills escalation of the current staff we have got.

The Deputy of St. Ouen:

Okay, just for my benefit, obviously decisions have taken place around moving from a single-site option to a dual-site option. Are you saying that no real discussion has taken place around the additional resources that the dual site would require ...

Chief Nurse:

Sorry, I was obsessing with single rooms. I think in relation to the dual site, certainly there were conversations I have been involved in and I have observed, for want of a better phrase, have related to, again, how people work, so whether or not ... in terms of the way things currently work where you will have some people in an outpatient clinic who potentially could be called into a ward to see a patient halfway through their clinic. This is about getting people to think about how they currently do their rotas now, so look at why are they on call when they are doing an outpatient clinic, and when we change the way we deliver services through redesigning the rotas and the way people work, you can work around that. There will be potentially some additional resource required because if you are delivering laboratory services on 2 sites, if you are delivering pharmacy services potentially on 2 sites, there may be some cost implications there specifically from a nursing point of view. I do not know yet until I see the design of the wards.

Clinical Director, Future Hospital Projects:

The M.T.F.P (Medium Term Financial Plan) 2016-2019, which is currently lodged with Ministers, has in there prioritisation of dual-site working and the I.C.T. (Information, Communication and Technology) that goes with that. In terms of the costings of that, the detail cannot be done yet because we have not, at this stage, agreed the disposition of services between Gloucester Street and Overdale. We have modelled that already as a proposition but clearly that is a conversation with a range of ... that has come from conversations with clinicians that need to be fed back to clinicians. Until we have a settled distribution of services, we will not be able to do the full costing of that. In terms of the cost of single rooms, that requires a ... until we have a ward template so, for example, at the moment one of the inefficiencies in cost is we have ward sizes that go from 16 to 28. If we were to standardise ward sizes, say at 24 - we have not made this decision yet - then you could make the nursing staff more efficient in a standardised ward template. We do not have a ward template yet and we are not able to do that work, so it is correct to say that we are aware of

the types of areas that would drive costs. For the M.T.F.P., because we have put the bid in already, we have had to estimate what those might be at this stage but in terms of a final document that says: “Here are the costs” we are not at that stage yet.

The Deputy of St. Ouen:

Once that work has been carried out, if it identified that there was a significant additional cost that would be required due to the decision to have a split site, do you believe it might influence and encourage a review of whether a single site was the preferred option?

Clinical Director, Future Hospital Projects:

No. No. Categorically no. If it is a single site, on the work we have done, costings come out between £450 million and £500 million, and you have all the documents that indicate ...

Senator S.C. Ferguson:

Yes, but, excuse me, that is the single site on a new site, on a greenfield site. Now, if we are talking single site down on Gloucester Street including the 2 bits of hotels that are possibly available, then that is a different scenario, surely?

Clinical Director, Future Hospital Projects:

The scenario we have looked at, so that has been worked through, says if you do that ... you have the document, I understand, for that. You do not achieve the outcomes that you wanted for the money you have, so you do not end up with single ensuite rooms. You have a hospital template which changes the whole axis of the hospital, you have a phasing challenge that will lead to significant disruption for many years more, you have a question that says - this is not my decision, so forgive me - if it costs £450 million and we have already been told ...

Senator S.C. Ferguson:

Yes, but the £450 million ... I am sorry, excuse me, £450 million was for a greenfield site, and that has been ruled out. Forget that, we are talking about a single site either in Gloucester Street or the 2 sites, Gloucester Street and Overdale.

[11:30]

Clinical Director, Future Hospital Projects:

The costings were done and looked at the 3 options, the shortlisted options, on the Gloucester Street site, greenfield site and the Esplanade. They came out broadly in the same price range, each with benefits and disbenefits and broadly they were all not feasible in the way that has been described. So we looked at different models again. The model that has come from ... for the 297,

I think that is the amount, of running an ambulatory care and diagnostic centre, is a perfectly tried and tested model which has a lot of clinical benefits. If you said to most people would they prefer a single site, I think most people would say yes. But that is not what we have been asked to do. I think that is the dilemma. If you asked me would I prefer a single site, I would say yes, but the project brief is not that and so what we are not doing is delaying the work on the project brief as set out because we run out of time to do that. So the pros and cons ... you are absolutely right, who am I to say ... but the work you have got shows those 3 options and the costings for them, but in terms of the detailed costing, until we have a settled scheme with an agreed distribution of services, with a ward template, with a design, we will not be able to do that detail of costing, which will be available for the outline business case clearly because we need that to then go forward to the next stage.

Deputy J.A. Hilton:

We are going to wrap the meeting up here, but we have enjoyed it so much we are going to ask you come back again ...

Chief Nurse:

That is very kind of you all.

Deputy J.A. Hilton:

... because we have lots of other questions that we would like to ask you.

Chief Nurse:

You mean I talk too much?

Deputy J.A. Hilton:

Or maybe we talk too much. So thank you very much, it has been very interesting and very helpful.

Chief Nurse:

Thank you. Thank you for your time.

Deputy J.A. Hilton:

I will close the meeting.

The Deputy of St. Ouen:

Thank you.

[11:32]