Health, Social Security and Housing Scrutiny Panel Full Business Cases Review

FRIDAY, 22nd FEBRUARY 2013

Panel:
Deputy K.L. Moore of St. Peter (Chairman)
Deputy J.A. Hilton of St. Helier
Deputy J.G. Reed of St. Ouen

Witnesses:
Ms. H. O'Shea (Managing Director, Hospital)
Mr. M. Siodlak (Medical Director)
Dr. N. Minihane (Chairman, Primary Care Body)

[10:30]

Deputy K.L. Moore of St. Peter (Chairman):

Good. Well, everybody seems settled so we will get started. You have in front of you a notice reminding you about the privilege under which we operate. If you want to take a few moments to acquaint yourselves with that it is probably a good idea. To our member of the public, welcome. We have a code of behaviour which is helpfully over here and not so easy to read, but it basically just asks everybody to turn their mobile phones off and to leave the room at the end of the meeting without any discussion, and that is really it. So we will start by introducing ourselves. I am Deputy Kristina Moore, Chairman of the Health, Social Security and Housing Scrutiny Panel.

The Deputy of St. Peter:

So, Dr. Minihane, if we could start with you, back in the beginning of January we saw a draft letter from yourselves, the Primary Care Body, and the Medical Directors. We saw a draft letter. Was that draft sent and was it sent in the form that we would have seen it?

Chairman, Primary Care Body:

That draft was sent and unchanged, yes.

The Deputy of St. Peter:

What has happened since that time?

Chairman, Primary Care Body:

We have had a formal response and the formal response I did not bring with me today as it was not on the list of things to do, but I can provide that at any point. It just answers all the areas, but it talks really about future developments and what we want to do. That was really an introductory letter, so what we want to do is to use that as a way to move things forward. We have followed up with another letter which looks at some of the overarching principles that we want to look at and ways in which we would like - which I can go into more detail if necessary - the White Paper proposal so far to be reassessed from a more clinical perspective. That is really the direction we are taking it. We would like to look at it, to be as constructive as possible, from a traffic light perspective. That is the way we have explained it to Health and they accept that as a very reasonable way. So with a green light everything is fine. The way we have phrased it in here ... A green light, good evidence base, cost effective and appropriate for the local setting/economy with the review of outcomes agreed. Amber, appropriate priority but more work required in any or all of the above areas or a wider context to be considered. Then red, poor evidence base, nice to have but inappropriate in the current economic climate or risk of fragmentation of services or other work to be prioritised.

The Deputy of St. Peter:

How many of the proposals at the moment do you see as red as the primary ...?

Chairman, Primary Care Body:

We have not established it. I think it would be fair to say we are in early discussion around that and at the moment the vast majority are probably amber. There are not too many green and there are not too many red.

The Deputy of St. Peter:

Right.

The Deputy of St. Ouen:

Could I ask the Joint Medical Director to confirm whether some of the views or all the views, concerns shall I say, that have been raised by the G.P.s (general practitioners) are reflected within the hospital staff?

Medical Director:

As with any group, there is a massive difference of opinion. There are some consultants that would agree with a lot of the sentiments of the G.P.s and some that do not agree. That draft letter was not signed both Medical Directors as far as I am aware.

Chairman, Primary Care Body:

We were asked to keep the Medical Directors separate because they were looking at this from a different direction. So it was the medical staffing committee and the G.P.s.

Medical Director:

That was the second letter, not the draft letter.

Chairman, Primary Care Body:

The draft letter ...

Medical Director:

The one that was leaked was not signed by anyone.

Chairman, Primary Care Body:

Well, the leaked letter was, yes, sent before it should have been, obviously.

The Deputy of St. Peter:

You have subsequently met as a joint group, though, have you not?

Medical Director:

I have not been in any of those meetings, they were while I was away, but some of the consultants have been to those meetings, but not everyone by any means.

The Deputy of St. Ouen:

Do you support that particular approach, that the medical staff, the consultants, should work more closely with the G.P.s?

Medical Director:

Oh, yes, without any doubt that is what we need to do. There needs to be greater integration between the hospital and the community in the provision of healthcare. I think we need to start from the base of a strong, safe, sustainable hospital. We are a small Island. We do not really need those bits spread all over the Island. We are not Yorkshire or Norfolk. It is 9 by 5. We do not need an outreach E.N.T. clinic in St. Brelade and St. Martin. Most people can get to St. Helier pretty easily. I am an E.N.T. surgeon. They have tried things called G.P.w.S.I.s. Have you heard of G.P.w.S.I.s, G.P.s with special interests? They have tried that in the U.K. (United Kingdom) a lot and in E.N.T. particularly it has been completely refuted because it just does not work. The amount of kit that we need is very, very expensive. The amount of time that is spent with consultants overseeing the G.P.s in those situations is so great it is very inefficient and does not work. So there are some things where we could and probably should try to move stuff from the hospital into the community because it will take some of the pressure off the hospital, but there are other things where economies of scale make it better to stay within the hospital. But it needs dialogue between the G.P.s and the doctors in the hospital.

The Deputy of St. Ouen:

What point are you at regarding that dialogue? Has the dialogue just started or is it still to be?

Medical Director:

Do you mean with regard to the White Paper or in real life?

The Deputy of St. Ouen:

Well, with regard to the development and redesign of services.

Medical Director:

Well, in real life it goes on all the time because all the time Nigel or other G.P.s ring me up about patients and I say: "Try this, try that." I think we have a pretty good relationship for the most part between consultants and G.P.s, probably better than most hospitals in the U.K. because it is a very small place and one of the strengths of the Island is that everyone knows everybody else, so that helps. Formal dialogue I think is some way behind that. There have been G.P.s on the White Paper steering group, Philippa and Bryony come, and there are some discussions, but it is probably early days.

The Deputy of St. Peter:

Would you as the Hospital Director agree with those statements made about going back to discussing what should be moved out to the community and concentrating on making your hospital a safe, centralised health centre?

Managing Director, Hospital:

Absolutely. You cannot separate the hospital from what goes on in the community because the hospital is part of a process and we have to agree with clinicians what is appropriate to happen in what setting. The hospital needs to be acute. It has high volume, it has high tech, it has high expertise. We need to use it appropriately. So the conversation has to go on long-term conditions, for example, are patients living in the community with chronic conditions? We can improve on that. We can keep them healthier and safer outside hospital. That should be done. As Martyn just said, if you have specialist clinics like E.N.T. that does not make sense to be putting them all around the Island. So it is a sensible conversation between clinicians that needs to take place.

Deputy J.A. Hilton:

Are you all in agreement? You mentioned just earlier, Martyn, that some stuff could be moved out of the hospital. Are the 3 of you ...

Medical Director:

That was maybe some poor wording on my part. Some stuff, if cared for better in the community, might not come to the hospital and some patients might be able to be moved out quicker were there appropriate places to put them so they did not ... it sounds terrible calling patients “stuff”, does it not? Some patients could be moved out from the acute beds that are very expensive to run into beds that were not so expensive to run managed by intermediate care.

The Deputy of St. Peter:

The interim care facilities, yes.

Medical Director:

Which is stuff that is working well.

Deputy J.A. Hilton:

What I wanted to know, were all 3 of you basically in agreement with the business cases that are currently being worked on? Are you all in agreement that those types of things, that you all agree with that and that you can provide a good service in the community rather than the hospital?

Managing Director, Hospital:

From my point of view, there might be 2 different questions there. The 7 headings, the work streams, I think everybody agrees are the right sort of things to be looking at.

Deputy J.A. Hilton:

Okay, so you are all in agreement?

Medical Director:

Yes, the work streams are good.

Managing Director, Hospital:

Yes. How you then start to get the detail underneath them I think is the work that needs to be finally agreed so that we are doing the right things in the right order to deliver those work streams. Because they are all the right work streams and there is lots of models out there, there is lots of experience. It does not surprise me that a project of this size there is this sort of dialogue going on. It is an enormous project.

The Deputy of St. Peter:

Until recently there has been a lot of emphasis on timing and having to move forward and start achieving goals as quickly as possible, but are you now as a department happy to take a step back and have that dialogue?

Managing Director, Hospital:

I think without doubt the dialogue is going to happen. I think everybody has understood from the conversations that have been going on that we need to. Engagement has been happening but if people are not feeling fully engaged then we have to address it and that is not an issue and that will be done. The timing issue, there is a timing issue. The hospital will run out of some of its capacity if we do not start to work on some of these issues and agree how we are going to take things forward. So we cannot delay for too long.

The Deputy of St. Ouen:

I suppose that is a point that the Joint Medical Director made earlier that it is a little bit chicken and egg. You have to think about what the hospital is going to provide and how it is going to provide it, and then you look at what can be delivered within the community. As an outsider looking in at the moment, we saw in P.82, if you like, a number of outline business cases which included acute services. Suddenly, all the focus is on 4 business cases, children's, alcohol, I.A.P.S.(?), and adults and older adults. There is no mention of acute services and we wondered if you are saying that to have a sustainable hospital you need to decide what you can do and how you are going to do it first before you extend all these other services out into the community, how does it fit with what seems to be being proposed, which is we will work out what is going to be provided in the community and then we will just pick up the slack from the hospital.

Medical Director:

Are you asking me?

The Deputy of St. Ouen:

Yes, any of you.

Medical Director:

It is what you said. It is which is chicken, which is egg. We were asked late last year to come up with strategic plans of where we think each of our departments would be able to be going in the next 10 to 15 years. For E.N.T. our plan totally predicates what happens in the White Paper. We are driven by referrals. E.N.T. is just driven by G.P. referrals, nothing else. If it were to happen that some of those referrals could be managed by the G.P.s in the community rather than being referred into the hospital, we could probably go to having 3 consultants running the team within the next foreseeable future rather than 4 members of staff running the team. If that does not happen, we will need more staff. So which is the chicken and which is the egg? It is very difficult to say. So if we build a hospital that says that loads and loads of stuff is going to get done in the community and it does not work, the hospital is going to be seriously undersized. If we build a hospital that says nothing is going to get done in the community and, in fact, it does get done, it is going to be severely oversized. So there needs to be a constant dialogue and I do not think that we can make a plan that says: "This is what we are going to be doing in 30 years' time." I started E.N.T. 30 years ago and at that time there was no such thing as a flexible nasal endoscope. No one even foresaw it. We used to do operating lists that were just dozens and dozens ... well, dozens, not dozens and dozens, but dozens of things called direct laryngoscopies to look at people's larynxes when they were hoarse in case they had laryngeal cancer. Now we can see all those things in outpatients. We can see everyone now in outpatients, so we only have to take people to theatre who have something wrong and need a biopsy. You could not have predicted that. Likewise, the sinus surgery, as a junior registrar I used to sit in the room next to my boss washing people's sinuses out under local anaesthetic. I do not think any of you are old enough to have had it done. It was pretty traumatic and patients, if they did not come back again, you assumed it was because they were better. In fact, it was because it was agony. Nowadays we never do that, but instead we do sinus operations because we have C.T. (computed tomography) scans that can take an hour and a half or 2 hours instead of a washout that took 10 minutes. So it is pretty impossible to predict where medical technology is going to take us in 30 years.

[10:45]

Medicine and everything that is complex does not evolve by making a plan and sticking rigidly to it. What happens is that it emerges from what is going on in the complex situations.

The Deputy of St. Peter:

That is a big and an interesting point but I would be interested to hear what your G.P. colleagues feel about ...

Chairman, Primary Care Body:

At the risk that Martyn has put you all off your lunch **[laughter]** I would go back to a more strategic level and really to take his point about earlier on with the G.P.w.S.I.s and that not working. G.P.s are generalists and that is one of the things that we have to remember. That is one of the good things. One of the risks of this is the gatekeeper role that we feel may be threatened and which actually does help to reduce the hospital burden. As I was saying about the G.P.w.S.I. role, often all the G.P. will need is guidance, whether that is telephone guidance or whether it is more formal guidance, but I think we have a pretty educated population in Jersey. They will not want to see somebody who is "second class", who is a G.P.w.S.I. or something. My preference would be if I was a patient to go to the top of the tree: "Right, what do I need to do? What investigations do I need that may be sophisticated ones within the hospital setting? Now what is my priority? What should happen after that?" This is not about a vested interest about whether it should be in the community or whether it should be in hospital. It is what is best for the patient. I think the important thing that we have lost as well in this issue is where the funding should be. G.P. funding has to be looked at because at the moment I think there is a risk in what has been put forward that G.P.s are being bypassed because it seems expensive, either expensive to patient or expensive in general. There is no evidence to suggest that from other jurisdictions, in fact, if the gatekeeper role is persisted with then actually it does help to save money in the longer term. But if the funding follows the patient, then I think that would be the way, the model, that would allow the clinical decisions to be made. Again, following on from Martyn, I think we have lost some of the clinical involvement in all of this and that is really what our contention is with the hospital at the moment. We are saying what we put forward in the O.B.C.s (outline business cases) was very much watered down because we were only one or 2 clinicians among a large number of people and then when the final business cases came around, they said: "Well, actually, no, there will be lots of detail that you will be able to sort out" having not had an opportunity to contribute in any meaningful fashion by having editorial rights in the O.B.C.s. Then the next thing that came along was: "Well, no, this is what the States Members have voted for so really we cannot change it very much." We said: "Hang on, that is not quite what you said at the beginning." So really, we have now got to the point where we are saying there are priorities that need to be looked at. There is funding. We have some concerns around the commissioning process as well as clinicians. Commissioning may be necessary, but in a small jurisdiction such as Jersey is it absolutely necessary; for example, where there is only one provider? It is money that is not going to the patient. So you have a commissioning board. You then have an overarching commissioning board, which the hospital have suggested we set up. My concern about that is that is yet more

money and it gives Health more power than it really ought to have. Scrutiny is already in place to overlook and see whether the money is being spent appropriately and you are all answerable to the electorate. If there is a separate board set up by Health, they will not be answerable to the electorate and that, in my mind and in the minds of most of my clinician colleagues, gives Health too much power and should not be persisted with. So I think there are some overarching things. The other overarching thing, if we are going to stay strategic for a minute, is the I.T. (information technology) strategy. I think one of the things we are trying to push more from the general practice side of things, although again we have to work very closely to make things as integrated as possible, is how things will be integrated. At the moment, general practice and primary care are light years ahead, 20 years ahead in terms of computerisation compared with the hospital. If you follow the data flow, most data flow is to general practice. So whether you go to see a nurse, a private consultant, the hospital, all the letters, all the information, goes back to general practice. So we feel strongly that that is where the centre of this should be, not through the hospital, although again we have to work very closely. But that means that we have more data about the patients so we can provide a better service. So when it comes to the funding flow, to the process of clinical care where, as I was saying, you might have a consultant indicating this is the direction of travel, but now back out of general practice but the funding then follows the patient so the patient is not disincentivised to go to general practice. We then have a much better system with the I.T. and the data following them so that everyone who is involved with that person's care knows what is going on, which is a much better system than we have at the moment.

The Deputy of St. Peter:

But how possible is that because there is no allocation at the moment in the budget, as far as I remember, for enhanced I.T. services, is there?

Managing Director, Hospital:

It is in the plan. It is one of the enabling factors and there is an I.T. strategy being drawn up. I absolutely support that. I think the one thing that would really improve some of the care is to get good communication and it ought to be electronic these days. We all ought to be sharing patient records and information far more freely, and that is part of the White Paper. It is expensive and it will take time, but it is absolutely one of the things that we should be ... and we will jointly support that.

The Deputy of St. Ouen:

I wonder if I could pursue that because some would argue actually that should be a given now. On a small Island such as ours, why is ...

Medical Director:

Our I.T. lead has come up with a number, it is just high.

Managing Director, Hospital:

There are people working on it now and we are already making some progress. The G.P.s already have some quite sophisticated systems set up. We have a new system in the hospital that I think went in about a year ago, a bit over a year ago. They are going to be able to start to talk hopefully quite soon. We are looking at electronic ordering of tests and giving of results and that should be extended to the G.P.s., so all of those things. There are small projects going on as we speak.

The Deputy of St. Ouen:

Sorry, just to follow up on this, what priority is being placed on making sure that we have proper information that can be relied upon and shared, whether it is between G.P. or Medical Director or consultant or, indeed, practice nurses or whoever else you want to include, family nursing, along the way?

Medical Director:

How close are we?

The Deputy of St. Ouen:

How close are we?

Managing Director, Hospital:

I think it was in the next 3-year phase if I remember correctly.

The Deputy of St. Ouen:

The next 3-year phase?

Managing Director, Hospital:

Because this is in 3-year phases. I think the plans are being worked up now ready for the next phase.

The Deputy of St. Ouen:

So you are suggesting that we are building the foundations of a new redesigned service based on sand because we do not have one of the main building blocks necessary to support that flow of information that is essential if you are going to have this overall wraparound care that we as the States have committed to seeing delivered?

Medical Director:

No, you can build some of the wraparound care without having the electronics to go with it. We have functioned for the last 2,000 years without all that electronic stuff. It used to work 30 years ago without electronic stuff, slowly.

Chairman, Primary Care Body:

We are talking about efficiencies in care, though.

Medical Director:

Yes, I know but you can put some of this stuff in place before all the electronic stuff is in place. It is very expensive and it is very, very complicated. I do not think it is as easy as Nigel is saying.

Chairman, Primary Care Body:

Well, we can tell you in terms of funding. I think to date in the hospital, perhaps I am being a bit too cynical but I think it is a half implementation of a fair product from what I get from what has gone on, and that has cost £17 million to date.

The Deputy of St. Peter:

That is the I.T.?

Chairman, Primary Care Body:

That is the I.T. We hope to do the same thing for general practice for under a million or around a million, and that product, as I said, already links or has the potential to link the community so the important thing really, as I said, is actually looking at how the process works. At the moment, I think we also fit in with the general States approach, so we are trying to fit in with the population index, et cetera, as much as possible, so we spent our time working not just with Health but also with Social Security and with the I.S. (Information Services) Department to make sure that everything will work in the future, so even linking in towards the citizen's portal, et cetera, which I think is very important.

The Deputy of St. Peter:

Thank you. I would like to just go back and address the issue of the boards. You professed some concern about this. However, I was aware that one of the concerns from the medical profession was a lack of outcomes, measuring outcomes, and clinical governance as well. Would that not be a function of the boards also?

Chairman, Primary Care Body:

I think the board, as I understand it, is to look at the commissioning process. At the moment, the outcomes, I do not think it has been established who will be looking at the outcomes, to my knowledge, but certainly the outcomes of what we are putting in place, firstly that we need to have a prediction of what the expected outcomes are, what evidence is there that this has worked in other jurisdictions, and then how we monitor that, which goes back to the I.T. to some degree as well, but equally I think if we are looking for value for money, which of course that is your remit, then I think we will need a process in place. There are models elsewhere and it is a matter of looking at the models that will work for Jersey.

The Deputy of St. Peter:

Going back to business as usual, there is great concern at the moment about the waiting list situation, which obviously has a big impact on this piece of work and is leading some people to ask the question can we manage business as usual as well as reforming our health service. We were quite concerned to hear the Minister say there was not, perhaps, the theatre space to take on another consultant in trauma and orthopaedic where one of the biggest waiting lists lies. What do you think of that conundrum?

Managing Director, Hospital:

I think we are running 2 parallel processes. You have business as usual, which absolutely has to carry on, and that will not mean that we stop investing or we stop making changes just to deliver business as usual; and then you have the change programme running in parallel. Martyn has already made reference to it. If we are able to look at the demand coming into the hospital - so, for example, through referrals - then that affects how long the waiting lists are. It affects how many people need to go on for surgery. They blur, these lines blur, so if we start to look with the G.P.s at how we look at referrals and what criteria we might use and what advice might be given rather than face to face, whatever the appropriate method is, that will impact on our demand so that affects the business as usual. The theatres are getting very full. This is why the whole business case is there saying we need some more facilities for a new hospital. There are ways of looking at that. We are moving things out of theatres where it is appropriate into procedure rooms or into outpatients where technologies have changed. We are looking at extending the day. We are looking at how we can get better use out of the theatres. We are also just about to start a new project looking at the fifth theatre, which is a combined maternity theatre with the rest of the theatre stock, and that work starts later this year. So we are doing business as usual as well, but unless we look at who is using the hospital and is that appropriate, which is the White Paper work, they have to come together. One helps the other.

Deputy J.A. Hilton:

I think it would probably be fair to say that those people currently on the waiting list are there for a very, very good reason and I am not sure exactly how you think that by looking at the people being referred by the doctors as though the doctors are referring people who do not actually need to be referred ... I do not quite understand that. Really, what I wanted to ask you, Martyn ...

Medical Director:

It depends whether you are talking about waiting lists for inpatient treatment or waiting lists for outpatient treatment.

Deputy J.A. Hilton:

People being referred from G.P.s to see a medical specialist who are waiting maybe 6 or 7 months to actually see somebody, which is in my view unacceptable and I think to most people is totally unacceptable. So the question I wanted to ask you, Martyn, as Joint Medical Director, with your colleagues do you feel that enough resources are actually being put into the specialities that have particularly long waiting lists? Do you think it is acceptable that somebody has to ...

Medical Director:

No, there are some waiting lists that are not acceptable, they are too long.

Deputy J.A. Hilton:

Which waiting lists would you say are unacceptable at the present time?

Medical Director:

Urology, cardiology, dermatology, general medicine.

Deputy J.A. Hilton:

Quite a few waiting lists, in effect.

Medical Director:

Medical type ones mainly, and those things do need some more resource and they do perhaps need some more serious thinking about how we attract staff. In medicine at the moment we have staffing of 8 middle-grade doctors, 4 of whom have left in the last month or so, so we are down to 4. You then have to employ locums to cover those. That impacts on the amount of work that those people can get through. We have a plan, we have resource to increase that complement to 10 middle grades plus 3 ... we are calling them FY3s but clinical fellows might be a better use of the name, to take some of the pressure off those middle grades for their ward work and acute take days so that they can actually spend more time in the clinic. So there are plans to try to address

these things, but it does take a very long time and, as I said before, these are complex situations. No one could foresee that 4 middle grades were going to walk out in one month.

Deputy J.A. Hilton:

Can I ask you why when a consultant, Dr. Leska(?), gave 6 months' notice of his departure, as far as we are aware has not actually been replaced yet? I do not quite understand. You are saying these things take time. You were actually given 6 months' notice and so that ...

Medical Director:

I am not talking about Leska. There are problems with our ...

Deputy J.A. Hilton:

What do you mean you are not talking about ...?

Medical Director:

I was talking about the middle-grade doctors.

Deputy J.A. Hilton:

Oh, okay. No, I just threw that in.

Medical Director:

Four left in one month.

Deputy J.A. Hilton:

I just mentioned that because we are aware that he did give that length of notice and he has not been replaced. Why has he not been replaced?

Medical Director:

Because of complications, I would say, in the recruitment process. We seem to be ... for one, H.R. (human resources) are seriously understaffed. Andrew write a job description which some people did not think was very good and it got rewritten. It then got sent to the college.

[11:00]

The college did not like it. It gets sent back. Nothing seems to be able to happen in parallel, it all has to be one thing at a time. It has to go to S.E.B. (States Employment Board) that have to approve his replacement, and everything just ... one thing delays another. I think that is what we have seen has happened in this case.

Deputy J.A. Hilton:

So how do you intend to address that failure in the future?

Managing Director, Hospital:

We had that conversation this morning. We have some new medical staffing H.R. people just arrived and we have agreed just this morning that we are going to run things in parallel. So if jobs have to go through S.E.B. - and only some do - then we will have the job descriptions being drawn up at the same time and the advert being drawn up at the same time and the college approval going on at the same time so that we get the advert out a lot faster.

Deputy J.A. Hilton:

It seems very basic and I am just really surprised that that has not happened previously.

Managing Director, Hospital:

Yes. It is not unusual. Getting a consultant appointed is usually a 6-month process from beginning to end in anywhere I have worked. What we are saying here is we need to shorten that as much as we possibly can.

Deputy J.A. Hilton:

So are you saying now that the mistakes that have happened around trying to get Dr. Leska replaced will not happen in the future?

Medical Director:

We cannot say it is never going to happen in the future. We have a plan in place ...

Managing Director, Hospital:

We will try hard for it to be shortened.

Medical Director:

We have a plan in place to make it shorter.

Deputy J.A. Hilton:

Okay, thank you.

The Deputy of St. Ouen:

With regard to these middle-grade doctors, just help us. You are looking at the redesign of acute services and how health services are provided on the Island. I suppose I come to Nigel first. Is

there a role that G.P.s can play in adding value or supporting the work that is being undertaken in the hospital to give a greater continuity and help perhaps in part reduce some of the waiting times?

Chairman, Primary Care Body:

I am glad you asked me that. I was going to try and comment on that if I could. One of the things that we were talking about was the funding flow and the disincentives for patients. Now, whether that is the main reason, but we do see that patients stay within the hospital system for a good deal longer than is sometimes necessary. So if we take neurology, which was the first on Martyn's list, if people are being looked at every year: "Have you had a fit?" "No." "Thank you for coming back", why are they going back to the clinic? If we have a protocol, a way of caring for patients whereby if a certain criterion is hit they should be referred back, there is no reason why those people should not be seen in general practice from the clinical perspective at least. However, as I said, if there is a funding problem that is possibly their choice to, therefore, be followed up at the hospital, but that is not good in terms of the overall efficiency of the system, which is after all what we are looking at and why we are here today.

Medical Director:

It depends on specialities. E.N.T. have sent out protocols to you time and time again without any doubt and we still get loads and loads of referrals, most of them, I must say, appropriate. The efficiencies depend on what you are providing. Nigel is right. There is no point in bringing people back all the time to see them. Sometimes, if you are having to provide ... and I think this might be one of the reasons that the surgical specialities are not under such apparent strain. The surgical specialities have to be on call much ... it is more onerous, more often. They have lots of people on their rotas. For general surgery there are 4. We have 4 on the E.N.T. rota. Now, those 4 people have to do that if they are on call because you cannot make people be on call one in 2 anymore because the law has changed a few years ago. So those people are going to be employed anyway. A lot of their time they are on call, but some of the time if they are not on call they will be sitting twiddling their thumbs because we cannot all get into the ... although we are all fighting to get into the operating theatres, there are not enough operating theatres to get us all in there at times. So those people would either be sitting there twiddling their thumbs or seeing outpatients. So for E.N.T. we do not have a big waiting list because we have 4 people that are seeing those patients anyway. It is cheaper for the Island to pay us to see them than for the Island as a whole to pay the G.P.s to see them on a cost per case basis, but that will vary depending on specialities.

The Deputy of St. Ouen:

So are those discussions taking place now with regard to the redesign and what primary care should look like and how it could best support acute services?

Chairman, Primary Care Body:

Well, we feel that the cart has rather gone before the horse. If the funding issue, which I think scrutiny has already identified in previous reports, is sorted then those disincentives do not exist so we can concentrate more on the clinical process and, as Martyn and I are agreed, on what is best for the patient, whether that is in a hospital setting or in a community setting.

The Deputy of St. Peter:

The funding will not be agreed until September 2014. Is that a problem?

Chairman, Primary Care Body:

I think perhaps account has not been taken of that sufficiently in what has been produced so far because there are elements which are part of the amber that we are looking at in the traffic light scheme whereby the G.P.s to some extent are being bypassed in favour of other models, which do not have the evidence base in terms of how cost effective they are or clinically effective they are.

The Deputy of St. Peter:

Some stock has been placed in the answer to your point there, though, that there is a concern about charging and the differentials. I have the answer to the written question from Deputy Higgins of 11th December about the referral rates and the cost of a visit from a G.P. There is a great difference in each G.P.'s charging. It is difficult for the public, I imagine, to understand and I believe for other medical bodies as well.

Chairman, Primary Care Body:

One of the reasons for that is, in fact, the competition authority. We tried to standardise charging and with great effort we managed to do it for out of hours, but it took a long time because we were recognised apparently as a cartel rather than something that was actually providing a service for the Island. The same, therefore, now applies to our charges. So there is a band of charging and it is within a reasonable scope, but unfortunately at the moment the incentive is not for us to standardise our charges. I do not think there would be a great problem if we did so.

The Deputy of St. Peter:

That is interesting. Would that help, perhaps?

Medical Director:

Well, there cannot be many jurisdictions in the world where it is cheaper for the patient per se to go and see a general practitioner than it is for them to go and see the consultant specialist. That is a bizarre situation to be in.

The Deputy of St. Ouen:

First of all to Nigel and then, Martyn, would you answer the same question after? With regards to the proposed redesign of the health service and the work that is going on, are there any particular overarching concerns that you have in relation to the process?

Chairman, Primary Care Body:

Well, I think the 3 that I mentioned earlier, so the commissioning process, is it appropriate for Jersey within the Jersey context; the integrated I.T.; and the funding for G.P.s, so funding following the patients so they are looked after in the appropriate setting.

The Deputy of St. Ouen:

All right. Martyn, from your side of the table, as it were, are there any particular overarching concerns that you have with the way things are currently moving?

Medical Director:

I think the basic principles are motherhood and apple pie. They are pretty much what was talked about in *New Directions* in 2007. It has not changed that much. I think that if we do continue on the present rate, the way things are going the hospital will be overwhelmed. We do need to think of different ways of working. I do have concerns about the I.T. It will be very expensive to put it into place. But as Hospital Medical Director, my overarching concern and priority has to be that the hospital remains a safe and sustainable place, so I still feel although we want the hospital plus community-based medicine and health service that it stands really on a safe and sustainable hospital.

The Deputy of St. Ouen:

Has any work been undertaken as yet to determine the sorts of services which would be provided on Island and what should be provided off Island?

Medical Director:

Yes, that goes on all the time, actually. It is constant and it constantly changes. A lot of what happens here and what goes away depends on serendipity. Before I came here a lot of head and neck cancer surgery went away. I do a lot of head and neck cancer surgery so it stays here. Before Gerard Williams came a lot of vascular stuff went away. We are now in the process of bringing the vascular stuff back here. So some of it is sort of serendipitous about who you get in post to do certain jobs. But there are certain things that we are never ... and I hate to say never because you can never predict, but a linear accelerator is unlikely to arrive on this Island any time soon, so we do need to be sure that we have good things in place for radiotherapy and cancer patients to go to the U.K.

The Deputy of St. Ouen:

I hear exactly what you are saying and I can understand the reasons for providing services on the Island, but you have highlighted a number of things. First of all, you have flagged up the fact that we are only 100,000 roughly population. Secondly, problems with staff, whether it is recruiting the right consultants, middle doctors, and, in fact, we know that further down even to the extent of nursing recruitment, too.

Medical Director:

Yes, exactly. You are going to have a demonstration tomorrow.

The Deputy of St. Ouen:

I suppose as much as I can understand that you want that and one would wish that sort of flexibility within a new hospital, which we are hopefully heading towards in whatever shape or form, I am just trying to understand what thinking is going on behind the scenes regarding how we deal with some of these key matters and whether that will ultimately determine that we actually say we cannot provide these services on the Island.

Managing Director, Hospital:

If you want to attract a good workforce here, a sustainable workforce to manage the emergency care, the more we can do on Island the better. It has to be safe and we have to have the skills to do it, but if you want an A. and E. (accident and emergency) department and a maternity department, you are going to need an intensive care department, you are going to need acute surgery, you are going to need acute orthopaedics. There is a knock-on effect. It is like a set of dominoes and the more we can concentrate here the better the skilled staff we will attract, the more nurses we will attract and the better sustainable hospital we will have. There are some things that only happen so infrequently that it would not be sensible to do on Island and you would send those to specialist centres. But most of the normal emergency care and routine elective work we ought to be doing here for the sustainable hospital.

The Deputy of St. Ouen:

I suppose my simple question, and it should have been more simple perhaps, is will access to the right staff be a limiting factor moving forward and have implications to the redesign of the health services on the Island?

Medical Director:

You cannot predict very long in the future. We are actually very lucky at the moment because of the chaos in the N.H.S. (National Health Service). We are actually able to attract high quality candidates to practically every post we advertise, but how long the U.K. remains in absolute chaos

is anyone's guess. Because we did go through a period ... I have been here 17 years. We went through a period when there had been loads and loads of investment in health in the U.K., when Tony Blair and Gordon Brown were throwing money around like they were printing it in the back room, like they were, that meant that we did have some difficulty attracting staff. Now they have decided that they can no longer print toy money anymore, we are attracting high quality candidates for every consultant post that we advertise.

The Deputy of St. Peter:

You do not see that changing at the moment, that trend?

Medical Director:

When is austerity going to finish?

Chairman, Primary Care Body:

We are very lucky to have the high quality consultant colleagues that we do, actually, and I think from a wider economic perspective, as I am sure you are aware with the finance industry here, the patients that we see in general practice are expecting to have that sort of facility available to them. Again, if you are looking at maintaining that, then I think the hospital - and the safe, sustainable hospital that has been talked about - again is crucial. I think from the point of view of where people are cared for again, though, so going back to that, there are aspects that we still need to look at as well. So there may be Jersey-specific reasons for people staying in hospital or community care rather than being at home. We have, if I am correct in my figures, something like 50 per cent of our workforce are female, which is one of the highest in western Europe. So, therefore, the traditional carers are not necessarily there for the more elderly people, move off Island because they cannot find jobs here or they have better career prospects in the U.K. So I think we may have special circumstances that bear looking at in yet more detail.

The Deputy of St. Peter:

If we could stick with the recruitment and retention point, it is important to talk about the nurses and that issue because we have received some letters suggesting that it will be impossible to undertake the recruitment that is necessary to put this plan into place with nurses and the current situation.

Managing Director, Hospital:

It is difficult to say. We still recruit nurses. We put adverts out; we still get applicants. I think living on Jersey is different to living in the U.K. They need to understand that. They need to understand that it is a higher cost of living. However, salaries are enhanced and there is a better tax system. We have to make the place attractive. We have to make sure that the jobs they are coming to are

attractive, that they have training opportunities, they have development opportunities and it is an attractive place to work because of some of the things with the White Paper and the fact we have an integrated Health and Social Services Department.

[11:15]

That is something that actually attracts U.K. staff to the Island. We do have to recognise what the nurses are saying and all the other staff groups in terms of terms and conditions and how we can help to make these jobs attractive, but we are still able to recruit. We are still getting applicants.

Deputy J.A. Hilton:
I think about a year ago the recruitment levels were causing a bit of concern, the vacancy level. Has that changed now? Are you up to maximum recruitment?

Managing Director, Hospital:
We are not up to maximum. I have never worked anywhere that is. There is always a natural turnover. We look at the vacancy figures on a weekly basis and we have a lot of people that are just in the process of ... they have been offered a job and are waiting to come. So we do have a vacancy factor but it is very low.

Deputy J.A. Hilton:
It is low, so it would be fair to say that at the moment, at this moment in time, you are satisfied with the way things are panning out on the recruitment front?

Managing Director, Hospital:
I have development plans for more nurses. I would like to see some specialist nurses. I would like to see some enhanced roles being introduced. So I would never say that I think we have got there. That is the business as usual part where I think we still need to remember we need to invest in services over the next few years.

Medical Director:
I am not sure your question was aimed at high tech nurses within the hospital or are you talking about the more basic care, home care type of person?

The Deputy of St. Peter:
Well, the White Paper calls for both, does it not, really? I was just going to direct a question towards the G.P.s actually to find out what their views were about having more nurses on board

within their practices as well. But if you had a particular view with regard to one aspect or another, I would be interested to hear it.

Medical Director:

No, I was going to support your question that I do personally have some worries about whether we are going to be able to attract enough carers to look after the vast number of elderly people who, as Nigel says, do not have natural carers because those people have to work. Now, I do not know where we are going to be able to attract those people from. I do not know where they are going to live if they come here. I do not know where their kids are going to go to school if they come here. So I do think that there are some problems that need to be addressed.

Chairman, Primary Care Body:

I think that will be compounded by the large number of nurses and, indeed, doctors who are approaching ... a cohort, in fact, are approaching retirement age, so there is going to be quite a challenge in the next decade probably to recruit simply because of the age that people are at at the moment.

The Deputy of St. Ouen:

That leads me quite nicely on to ask both the Joint Medical Director and Dr. Minihane your views and the benefits or otherwise of step-up and step-down services and facilities. How do you see those fitting with any improved service that we are planning to offer?

Medical Director:

I think that is the number one best thing in the White Paper.

The Deputy of St. Ouen:

That is because ...?

Medical Director:

Because it works. We do have difficulty getting patients out of their acute phase of treatment back to home and they just need some step-down/step-up facility. Where you put them is another matter. Where those places are located is difficult because there is restricted area within the hospital. Ideally, they would be near to diagnostic services, and if you were starting from a blank piece of paper without anything else going on in the Island you would build a big hospital with diagnostic services around the edge of it and step-up and step-down care services around the edge of that so that the patients in the step-up would have pretty quick access to the acute care if they need it, acute instant access to their diagnostics, and perhaps those patients in the step-up/step-down services would be looked after by G.P.s and nurses that are not high tech nurses. If

they needed some investigations they could be done very quickly and then they could make the decision about whether they needed to go into the acute expensive bed or stay in their cheaper step-up/step-down bed. But we do not have that. We have to ...

Deputy J.A. Hilton:

Do you think that could actually be achieved on the present site?

Medical Director:

We would need to have an unpopulated Island to start with to have that.

Managing Director, Hospital:

On the current site?

Deputy J.A. Hilton:

Yes, with the purchase of any available sites surrounding it?

Managing Director, Hospital:

I do not think anybody has tried to design that particular model at the moment.

Deputy J.A. Hilton:

Oh, so that is not ...?

Chairman, Primary Care Body:

I share that imaginative view, actually, and I think this is where I was talking about clinical leadership coming back in. One of the things that we have seen is the intermediate care facility being put in place with a collaborative approach, not a commissioning approach, and it worked very, very well. There is some maybe extra work to be done on how cost effective that was because the emphasis was on keeping people out of hospital, not necessarily because it is cost effective. Let me give you a very simple example. If you have 4 people at home with gammy legs, it makes perfect sense to have somebody go and do their shopping to keep them at home because it is so expensive to put them in any kind of long-term care facility. Leaving aside human rights issues, if you have 4 quadriplegics you need 4 full-time nurses to look after them at home. Somewhere between those 2 extremes there is a tipping point where it is more sensible to keep people in an institution than it is to keep them at home; hence the no vested interests. Now, at the moment we have hospital, which is obviously acute, diagnostic, et cetera, and then we have home and there is nothing in between. One of the things that I agree totally with Martyn, and this is where the G.P.s could be used very effectively, we are presently part of out of hours, although that is being questioned, but at the moment G.P.s are quite prepared - which our G.P. colleagues in

the U.K. have given up, you will remember - to work out of hours. Now, if they are already in a base working their out of hours, that could be part of an out of hours service which is provided in-house, if you like - the lower tech but not enough to keep people home - that would work closely with the district nurses. That could be part of it as well, and the therapists could go between the 2. So we have that step down. Because we know what people have in their home situation because we know them, we know when it is sensible to get them out. That can be protocol driven, but we can work across the community. Those are the sorts of schemes that clinicians are very, very interested in and that is the sort of negotiation that we hope is going to take place soon.

The Deputy of St. Ouen:

Could I ask again both Nigel and Martyn just briefly to tell me in your view what discussions, what progress is being made with regards to consideration and development and provision of step-up/step-down facilities as part of the general redesign. Maybe Nigel first.

Chairman, Primary Care Body:

Well, at the moment this was a project that was put in place quite suddenly, you will remember. I think the money was identified by Senator Ozouf and then suddenly we had to put everything together. I may need to be corrected because I am not part of the hospital itself, but I understand the money initially was not recurring - whether it has been made recurring or not I do not know - and, therefore, it has been a problem in terms of keeping staff on. I think staff have had to take on additional duties rather than being recruited specifically to that post. So I think it is in a state of flux it is probably fair to say at the moment, but if we can look at this imaginative way in which we could deal with things in the future and work towards that model, and certainly the clinicians are keen and the managers we can get on board, I think it is worthwhile pursuing negotiations.

Medical Director:

I think Nigel is right. Suddenly somebody said: “You have to spend this money quickly. What are you going to spend it on?” You asked what our thoughts were on step-up/step-down. For me, without doubt that is the single most important quick thing that we could do to make things better and that is what we did.

Managing Director, Hospital:

It currently sits within community services and the funding has been extended for the rest of this year because the early pilot has shown some really good results.

The Deputy of St. Ouen:

Just for my own benefit, Overdale, what would you class that facility as? Is it a step-up/step-down facility?

Managing Director, Hospital:
It is a rehabilitation facility.

Medical Director:
It is rehab. It is very nice. Have you been there? It has loads of room. No, it is a rehab.

Chairman, Primary Care Body:
It is more specialist.

Medical Director:
For neuro rehab, basically.

Chairman, Primary Care Body:
So people who have had strokes, et cetera. It is designed with particular emphasis on that.

Medical Director:
But, yes, in the past it has been used as a step-up/step-down facility.

Chairman, Primary Care Body:
It is the old cottage hospital, really, that used to be in place many years ago, and it is just not in fashion at the moment.

The Deputy of St. Peter:
This I think has been a very positive and constructive conversation. I am interested now to hear where each of you think we should go next. What is the next step in the eyes of the clinical directors?

Medical Director:
We are having a meeting on Wednesday night with all the clinical directors plus all the senior nurses to talk about red, green and amber and decide which of the greens we like and which of the ambers we like and which are the ones we do not like. That is where we are going next.

The Deputy of St. Peter:
Good. For you?

Managing Director, Hospital:
Well, obviously we are having that meeting. My view is that if people have felt that they have not been fully engaged then we need to rectify that and make sure that people are engaged. I see this

as making sure that we are putting the patient first and designing processes around patients and we are delivering what is right for the patient. I accept all the I.T. issues and the funding issues, but we need to get the pathways right for patients first of all and fit everything to that. I think that is in process.

Chairman, Primary Care Body:

We echo that as well. We have invited the chief of primary care redesign or healthcare design, Rachel Williams, to a meeting on Tuesday organised by the Primary Care Body and the Jersey Medical Society, and again we want to look at the red and amber and green and look at how we can progress things from a more clinical perspective highlighting all the issues or many of the issues that we have discussed this morning.

The Deputy of St. Ouen:

One area that we have not touched on yet, just again briefly I would like your views, is how do you see the voluntary and community sector playing a part in supporting the work that you both undertake? So, Martyn?

Medical Director:

I knew you were going to ask me that. The only ones that I really have any interaction with as an E.N.T. surgeon and Medical Director has been hospice, which I think do a fantastic job. As part of the end of life stream we need to be engaged with them fully because they do do a fantastic job. I think that their remit in some ways needs to be expanded because at the moment they just do cancer and motor neurone disease, but people die of lots of other things rather than just those 2 things. Family nursing and home care, I think they do a good job and that probably needs to be expanded in some way or another as well. I do not have very much interaction with diabetes.

The Deputy of St. Ouen:

Thank you. Nigel?

Chairman, Primary Care Body:

I echo those thoughts. It is about working together and one of the nice things about Jersey is the collaborative working. I will take you back to commissioning. I think many of them feel threatened by this commissioning process. They do not really understand it and again it is the resources that we quite possibly do not have or cannot supply for this. I think the big worry for them, which is shared by the G.P.s, is false economies and fragmentation of care. When you are used to working with certain providers, as we did with the step-up/step-down care, when we met together we were able to sit down as a group of clinicians, doctors, nurses, therapists, and we put up something very quickly which has worked very, very well. We did not need the commissioning process, et cetera,

that went around that. So I think that is their concern. I have heard - I will not use names, obviously - that one particular charity were told by one of the commissioners here that they would have to tender. The particular person running that charity said: "Well, I will not." They said: "Well, we will outsource it outside of the Island." He said: "Well, that may be the case but ..." Hearing that kind of threat is very, very concerning for us in general practice with people that we work with.

Deputy J.A. Hilton:

Who made the decision about the commissioners, employing 4 directors of commissioning?

Managing Director, Hospital:

It was before I arrived, I am afraid, so I cannot answer.

Chairman, Primary Care Body:

I think it was KPMG directed and basically KPMG took the King's Fund direct and it was almost transplanted to Jersey. There was some work specific to Jersey but a lot of it was basically what was going on in the U.K.

Deputy J.A. Hilton:

I get the impression that you feel that we do not need to be bringing some of these things into Jersey because we are such a small jurisdiction and that money could be much better spent on care and patients rather than what is actually happening at the moment.

Chairman, Primary Care Body:

That would be my question.

Medical Director:

That was my absolute belief until yesterday and I realised I do not actually understand what is meant by commissioning. **[Laughter]**

The Deputy of St. Peter:

What made you change your mind?

Medical Director:

Meeting one of our commissioners.

Deputy J.A. Hilton:

Maybe we should meet the commissioners.

Medical Director:

I think you might need to because I was always under the impression that commissioning meant that instead of giving all the money to Health and Social Services to run their services, you gave it to a bunch of faceless commissioners who decided on behalf of the patients where they would spend that money. That is what worries me a little bit about money following patients because you need to employ shed loads of accountants to follow up where the money is going. When I worked in Boston Children's Hospital, the E.N.T. department used to go round seeing all their referrals with little chits saying: "You owe us $1,000, you owe us $1,000" within the same hospital within which they worked. So every department had to have their own accountant. There are loads of inefficiencies in that sort of thing. That was how I understood commissioning would work. The commissioner would wave a stick, like Nigel said, and say: "If you will not do it for this amount of money, we will send it all to Southampton" or we will send it all to wherever you want to send it to. Having met one of the commissioners yesterday, I am glad to say that my impression was wrong and it is really about planning and coordinating care. So perhaps you should meet them.

The Deputy of St. Peter:

Were you heartened by their clinical knowledge, background, expertise?

Medical Director:

I was by her knowledge, yes. She understood stuff.

The Deputy of St. Peter:

Because they are not essentially clinicians, are they?

[11:30]

Medical Director:

They sometimes come from nursing backgrounds and things like that, but they are not essentially clinicians. I met one and it changed my opinion about commissioning yesterday, and I was absolutely in Nigel's camp until yesterday morning.

The Deputy of St. Ouen:

This commissioner was responsible for acute services or focusing on acute services?

Medical Director:

Yes, the acute services commissioning.

Managing Director, Hospital:

Commissioning is perhaps the emotive word here, but there are necessities as far as making sure we have service level agreements with people that are providing care for our patients and our population. What do we get for that? What standards should we expect? What term is it over? A lot of that is not in place, and so I think some of this is about just good housekeeping, of how we are spending our money and what we are getting for it. I can understand how some people are feeling the word "commissioning" is difficult and I think ...

Medical Director:

We need a different word on the Island. It is not a good term for Jersey because it has such a bad name because of the U.K.

The Deputy of St. Peter:

Okay. We have one final burning question if you do not mind us running a little bit over time.

Deputy J.A. Hilton:

We have heard from you today that there is a difficulty around theatre time, available theatre time, and we have talked about the safe and sustainable hospital, so I have 2 questions, really. Firstly, when you have theatres running at maximum capacity do you think the safety of patients is being compromised at all because of the risk of infection, and because they are operating at maximum capacity the deep cleaning that needs to take place maybe does not happen when it should?

Managing Director, Hospital:

Deep cleaning does happen when it should. We have an annualised programme. We usually do it in the summer holidays when things are quieter, but every theatre gets its annual maintenance programme. Some of our theatres are now quite old and we are having to replace the handling units within them, and that is planned in as part of the work.

Deputy J.A. Hilton:

So it is not an issue then as far as that goes?

Medical Director:

I do not think that is an issue.

Deputy J.A. Hilton:

Okay. The second question I had, I want to try and understand who makes the decision regarding the use of theatre time with public patient versus private patient. How do you decide what percentage of time each of those 2 groups of patients access theatre time?

Medical Director:

Yes, there is an agreement that it should be up to 30 per cent private patients and 70 per cent public patient time.

Deputy J.A. Hilton:

That is normally abided by?

Medical Director:

It is normally abided by and I would suggest that, in fact, it probably comes out at less than 30 per cent. The problem with theatre time is the time. If you give surgeons 24 hours a day in theatre, they will go and use it if you can put nurses in there to operate for them. We fight over Saturday mornings. We fight over every spare list that becomes available. We have extra lists that when people are away they go up for grabs and most of those lists get filled with public patients. The reason that we do that ... well, there are lots of reasons to do that 30/70 per cent mix. Jersey is a bit schizophrenic about the relationship between public and private services. If you are Minister for Education, Sport and Culture you know all the rows that have gone on at J.C.G. (Jersey College for Girls). J.C.G. parents think they are subsidising the public purse by spending money to have their children educated. All the parents of kids at Les Quennevais and Grainville think that they are subsidising the kids at J.C.G. and Vic, and it is exactly the same in healthcare. We need to have that income in our hospital to make that hospital run properly and we are in danger if we try to restrict the number of private patients because it is the only place that people can provide private surgical services in this Island. If we try to restrict that, we will have danger in recruiting surgeons. So it is a really delicate balancing act. The waiting list problem is to do mainly with resource. It is the number of operating theatres, but also the number of nurses that you need to run those operating theatres and how much you are going to pay them, and also the number of beds that you have in the hospital. Because you mentioned dangers of cross infection with running operating theatres at full time, but the danger is not in the operating theatre. It is to do with the occupancy in the hospital. We know that if you get above 85 per cent occupancy you start running into dangers with cross infection. We run above 85 per cent occupancy, and I wrote to one of the Ministers for Health 5 years ago, no, maybe 6 or 7 years ago, when they shut one of our wards saying: “We will run into infection problems with this if you shut this ward and we will run into cancellation of patients” and both those things came to happen.

The Deputy of St. Peter:

Going back to this public/private dynamic, it is quite interesting because actually there is quite a high percentage of people here in the Island who have private health insurance, but do you perhaps find that they do not use it all of the time?

Medical Director:

Yes.

The Deputy of St. Peter:

So we need to encourage people to actually use the insurance that they are paying for?

Managing Director, Hospital:

Yes, some people choose not to use it and sometimes the insurance companies incentivise them not to use it, but yes, the more we can get people to use their insurance then the less burden on the States.

Chairman, Primary Care Body:

There is a private waiting list now for some procedures and that is actually disincentivising people to use the service, so they are asking to be sent off Island.

Medical Director:

There are big dangers in the way it runs.

The Deputy of St. Peter:

Well, it has been very interesting. We have run a bit over time, for which I apologise, but thank you all very much for attending today and for your time. It is much appreciated and we look forward to seeing you again. I will close the meeting.

[11:36]