Health, Social Security and Housing Scrutiny Panel

THURSDAY, 8th MAY 2014

Panel:

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

Deputy J.G. Reed of St. Ouen

Senator S.C. Ferguson

Witnesses:

Director Assisting Redesign and Delivery

Chief Executive Officer

Hospital Managing Director

Director of Finance and Information

[11:58]

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

Good morning and welcome to the Health, Social Security and Housing Panel. We will start by introducing ourselves. I am Deputy Jacqui Hilton, vice chair of the panel.

Deputy J.A. Hilton:

Thank you very much indeed. I would like to start by offering the apologies of our chair, the Deputy of St. Peter, who is currently unwell. Thank you for coming this morning. I would like to start by asking you if you could explain the decisions which led to the 2-site option being the preferred one.

Chief Executive Officer:

Thank you, Chairman. I am trying to think where to start with this one. As I think you are well aware, there has been quite a long programme of discussion and planning looking at the future hospital.

[12:00]

Initially, that piece of work was looking for a number of options, looking at a greenfield site, a brownfield site, and perhaps staying on our current site in Gloucester Street. A good deal of work was done being supported by WS Atkins, who I think you are familiar with the role they have played, looking at the various options. A great deal of time was spent looking for sites, working with the Planning and Environment Department. Initially, we came down to 3 sites. At that stage we were looking at a complete new build. I think it is probably fair to say that in an ideal world you would look for a new build on a new site because it is the way to do it the quickest, the best value for money, but you can get the absolute best adjacencies and can just build the most cost-effective, cost-efficient and patient-orientated hospital.

Deputy J.A. Hilton:

Can I just ask you had you been given a funding envelope at that point?

Chief Executive Officer:

No, the initial work was done on the basis of design what is needed, set out the specification, and Atkins were working with us on that, but also looking at how that quantified from cost terms at a very high level using building notes and guidance and advice largely from the U.K. (United Kingdom). So we reached a point where we had identified a number of potential sites and we had a range of costings, most of which were in the region of £400 million to £450 million. It was at that time really that 2 things were starting to happen. One, it was becoming incredibly difficult to find a completely new site; and secondly, the cost at £450 million was starting to feel really quite challenging in terms of amassing that amount of money to build that type of facility. So there were 2 aspects to it, both the difficulty of the site and also the cost of it.

Deputy J.A. Hilton:

Who raised concerns about the costs that were coming out at that point?

Chief Executive Officer:

I think everybody had some concerns because it was such a large number, and obviously while it would be fair to say that a figure had been included in the Green Paper/White Paper consultation documents we did, that was very much pretty much a finger in the wind estimate by KPMG at the time. Obviously, this was the piece of work that was firming that up, but that was quite a big change going from £300 million, which was their guesstimate, to £450 million. Some of that was to do with the cost of building buildings in the Island and some of it was to do with the way things are specified in the health building notes that build very, very large spaces. But there was a general view, both a political view and I think an officer view, that this was starting to look incredibly expensive and it was proving difficult to find the site. We got to a point where we were thinking it would probably have to be on the current site, which in itself concerned a lot of us because it would be a very large building on that site in order to get anywhere near the sort of relevant and appropriate building spaces. It is quite a land-bound site. Although we could look at acquiring additional pieces of the site, it was going to be a challenge, particularly from the point of view of maintaining and running a hospital for patients and the length of time it would take. It would have had to have been a very, very detailed set of phases to go right the way round the hospital knocking down, rebuilding and providing services at the same time. Certainly, I had concerns about that, which is one of the reasons why if it is at all possible it is better to build somewhere else and you can carry on your business as usual, ready to move into the new facility. So after a lot of debating we were looking very hard at can we bring those costs down, and there is no doubt that £450 million was a high-level cost and it would have reduced. How much I cannot say by but we would have value engineered in the feasibility phase, but it would still have been an awful lot of money. In order to help us move that debate forward, we then set ourselves the challenge: if it was this sort of sum, £250 million, could we get anywhere near the sort of service requirements that we had set out that we needed. We initially gave that challenge back to WS Atkins as well to say: “If this was the sum of money, what would we be able to develop on the current site?”

Deputy J.A. Hilton:

How did you agree the sum of money at that point?

Chief Executive Officer:

I think it was really just a sort of this feels like a reasonable amount - it is still an awful lot of money - and I suspect it was close to where the KPMG figure had been set. It sort of felt in the realms of the possible in terms of perhaps making an argument to politicians at some stage to say: “Could we have this amount of money?” It was to test, really, to say: “What can you get?”

Senator S.C. Ferguson:

I am sorry, in the beginning you said: "We were looking around about £300 million" and then Atkins came in with £400 million to £450 million on the various sites, and now we are back to £250 million. Where did the figures come from?

Chief Executive Officer:

I think, as I explained at the beginning when I answered your question, Chairman ...

Senator S.C. Ferguson:

Were you dreaming them up, Jason?

Chief Executive Officer:

I think what I said was there was no figure in mind when the piece of work was commissioned from Atkins. It was let us build the best hospital and cost it. It was as it was being costed that the £450 million was the figure that was starting to emerge. The reference I made to the £300 million was that was the sort of finger in the wind figure that KPMG had put in as part of their work some 2 and a half years earlier. But there never was a £300 million budget at the beginning of this process. There was no sum in mind. There was: "Let us see what it would cost." It was as it was coming out of that very large cost it seemed sensible and prudent to look at something which was a more manageable figure.

Deputy J.A. Hilton:

All right. I know that you looked at Cramlington Hospital, which is up north, and they delivered an acute hospital with services elsewhere. I think you used that as some sort of benchmarking. So was that driving you at that point? Was that the point where you started to think maybe we should deliver in 2 sites rather than one?

Chief Executive Officer:

No, at that point what we were looking at is there had been quite a shutdown of new building in the U.K. because of the recession but there were some examples and Cramlington was one. The Cramlington model was very interesting because it was not a traditional full-scope district general hospital. So we went to have a look at it because it seemed like they were doing a remarkable amount of new build for quite a remarkably low amount of money. When we dug into it, it is not a district general hospital. It is what is known as an emergency hospital and then they take their patients out very, very quickly back to local hospitals right around the region. So it is quite a dispersed model. It was clear that they were not abiding fully by the health building regulations in terms of sizing.

Deputy J.A. Hilton:

I just wanted to ask you that because I know that the rooms, the space is smaller. That obviously must be allowed in the U.K. that there is some reduction in size for them to build something new that they recognise is smaller than the guidelines stipulate?

Chief Executive Officer:

The health building notes are guidelines and they are good practice. What I think we found interesting is we were looking at European hospitals and North American hospitals as well. It became quite clear that the room sizes that the U.K. health building notes used were at the high end. They were very, very big and most other places were at a lower level, although there was a range, which is why we felt reasonably comfortable in trying to trim costs that we could look with our clinicians at various areas and say: "That really needs to be the full size but that we can probably trim back."

Deputy J.A. Hilton:

So presumably when Atkins did their initial piece of work on the 3 preferred sites, they were working on health guidelines ...

Chief Executive Officer:

In full, yes.

Deputy J.A. Hilton:

In full.

The Deputy of St. Ouen:

You have just mentioned that one of the trade-offs, if you like, in delivering a hospital at £300 million rather than £400 million or £450 million is that we end up with smaller rooms. What other trade-offs have there been?

Chief Executive Officer:

The trade-offs between what we originally planned and what we are planning at the moment is largely that we do not get complete new build. Obviously, there are some buildings that we will be refurbishing and they will be fit for purpose but their lifespan will not be the same as the new build buildings will be. So there is a trade-off in terms of the whole new build gives you everything brand new and they all have the same longevity going forward. With any refurbishment of current buildings there are always some compromises that have to be made just to make them useable and fit for purpose.

The Deputy of St. Ouen:

When you talk about refurbishing the building are we primarily talking about the current hospital site?

Chief Executive Officer:

Yes.

The Deputy of St. Ouen:

Will there be any other refurbishment happening elsewhere?

Chief Executive Officer:

No, the plan for the buildings that would be on the Overdale site will be that will be new build, other than obviously the buildings that are retained, such as the rehabilitation unit, Samarès ward and the Poplars and Willows, which are fairly new buildings still with much lifespan within them and which are used largely by community and social services rather than hospital services. Everything else up there will be removed and it will be new build. On the hospital site it is a mix of some new build and some refurbishment.

The Deputy of St. Ouen:

So what percentage of the current hospital site will be new build?

Chief Executive Officer:

I do not have that figure off the top of my head. Do you?

Hospital Managing Director:

I do not know about percentages, but the granite building and the 1980s building are the 2 that are getting major refurbishment. The 1960s building is not in the plan and the rest would be new.

The Deputy of St. Ouen:

Explain the 1960s building not in the plan?

Hospital Managing Director:

At the moment, in the concept design that we are working with at the moment, it would probably be clerical space. It will not be clinical space. So the 1960s building is not getting refurbished.

Deputy J.A. Hilton:

Just to clarify, that is the building which makes the corner of the Parade and Gloucester Street?

Hospital Managing Director:
Yes.

Chief Executive Officer:
Yes.

The Deputy of St. Ouen:
When you talk about clerical space, is that not the use put for Peter Crill House at the moment?

Hospital Managing Director:
Peter Crill House has some clerical space in it. It also has some accommodation. It has the education centre, so it has other things in it. What we are saying is the 1960s building is not really, going forwards, fit for purpose for clinical use because of its sizing, so we have excluded it from the planning.

The Deputy of St. Ouen:
Right, so although on the one hand we end up with improvements in the facilities, we do not end up with a new hospital and we have ongoing costs because we are choosing to refurbish some of the buildings rather than build from new?

Chief Executive Officer:
To build new, yes.

The Deputy of St. Ouen:
Regarding services, how have those been affected?

Chief Executive Officer:
By the concept of the dual site?

The Deputy of St. Ouen:
Yes, by the changes from the Atkins proposals, which you obviously helped develop, and the ones that are currently being discussed.

Chief Executive Officer:
It certainly makes a difference to the models of the way the services are delivered because obviously we will be looking at distributing the services that are currently largely on one site between the 2. But some services do cluster well together and make good sense to be together. For example, we refer to the Overdale development as an ambulatory care centre because the

plan is there are no beds, there is no inpatient stay, it is all what can be done on an outpatient or a day visit basis. Do you want to add to that, Helen?

Hospital Managing Director:

Yes. There is very little difference. The number of beds are the same. The number of services are the same. The difference is just where they are delivered from. So we have not had to say we are not going to deliver something just because of the change in concept. What we have added in is our view to take a look at the feasibility of radiotherapy, so that is in addition to.

The Deputy of St. Ouen:

I am still struggling. Certainly, we are talking of something being two-thirds the cost of what was originally identified and it is a £100 million to £150 million difference, a significant amount of money. I am just struggling to understand that by shrinking the size of a few rooms and doing a bit of refurbishment - because some would argue that refurbishing buildings can be as expensive as building new - we can "save" all of this money without having any impact on all of the things that you put forward that you believed as a department were essential in the future around a hospital. We have heard about prioritising services and yet you are saying now, no, the services are not going to be affected. Can you help me understand why it can be the case and yet reduce the cost by such a large amount?

Chief Executive Officer:

Well, perhaps, Jason, you could help us with that because a significant chunk of the £450 million was other things that were not specifically related to the design of the building as such.

Director of Finance and Information:

Without the detailed analysis in front of me, it is quite difficult to go through it line by line. There is a composition of the £400 million to £450 million and a composition of the £300 million. What might be most helpful is to break down where the key differences are.

The Deputy of St. Ouen:

Great. Well, maybe as we are meeting you next week ...

Director of Finance and Information:

I am not sure I will have that ready for you on Monday. We are seeing you at 12.00 on Monday ...

The Deputy of St. Ouen:

Okay.

Senator S.C. Ferguson:

What are you doing tomorrow? **[Laughter]**

Director of Finance and Information:

It is Liberation Day tomorrow, Senator.

Senator S.C. Ferguson:

Can we just go back a moment? I am a little in the dark. When did we have the eureka moment? When did we decide we were going to have a 2-site hospital?

Chief Executive Officer:

I think the eureka moment - and I think it is quite a good expression for it as well - came when we initially asked Atkins to tell us what they thought we could do with the £250 million to £300 million and we were quite disappointed with the lack of creativity with what came back. In essence, we were getting very little for the £250 million. While we would be getting things like new laboratories and new theatres, which we do desperately need, much of the investment was going into areas that were not patient facing, because obviously the patients are asleep hopefully when they are in theatre and they do not go into the laboratory areas. The ward areas, which desperately do need investment, would not have been touched in that plan and we thought this is ridiculous. This cannot be good value for the £250 million. It was at that point that I think it was the Treasury made a suggestion of bringing in a fresh pair of eyes who we refer to and I know that Laura refers to as the design champion. This chap came in who has a vast amount of experience of designing and working on new builds and particularly hospital builds. Because he could come in with a fresh pair of eyes, we said: "We have a figure in mind of this and we need to have a new hospital. This is what Atkins has done. Will you have a look at it?" I think in doing the trip around saying: "Show me the sites, show me what you have, show me what the issues are" he was also shown Overdale. He looked at what could be done with that money staying on our site and he looked at what could be done using the 2 sites that we have that we deliver acute services from. It was him who more or less said: "If you design it this way and have a split which is not elective and emergency, which is quite a traditional split side, but go for the more creative, forward-thinking ambulatory centre and then inpatient centre, you can get an awful lot of the things you set out at the beginning that you said you wanted within this envelope of money." There is a compromise because you cannot do a complete new build on both sites, but other than that ... and obviously there are issues you have to work through in terms of by having 2 sites.

[12:15]

You do not want staff and patients constantly rushing up and down to Overdale so how do you then make that model work? That was the eureka moment when he almost reminded us: "You do have another site called Overdale, which is not that far away, where you do provide some services from. If you bring that into the mix and look at it differently, perhaps you can get a bigger bang for the buck." So that was the eureka moment if you want to call it that.

Deputy J.A. Hilton:
Could you just tell us who and when that decision or the recommendation was relayed to the Ministers involved?

Chief Executive Officer:
We were having ongoing conversations with the ministerial group all the way through this process, but I suppose it was probably the early part of the summer of last year when we were getting to the point of saying: "This does not feel viable at that level of funding." We had a good long look at where Atkins had got us to with this idea of having a reduced budget, and so it was over the summer of last year, June, July, August time, that Graeme Underwood, who is the design champion, the architect, worked with the team at the hospital and the team in the Treasury and came up with the concept that we then shared with clinicians. I think it was probably August or September time ...

Hospital Managing Director:
It was August.

Chief Executive Officer:
... August time, and that gave us the ability to go into the budgeting process with the proposal that we look at the dual-site option with that sum of money and where there are lots of benefits that we could accrue from that.

Deputy J.A. Hilton:
I believe a meeting took place with the officers and the Council of Ministers where an envelope of money was discussed. We are just trying to understand how that decision was reached, the sum of money.

Chief Executive Officer:
I think the sum of money as a target budget was identified as part of a seminar that we held for the Ministerial Oversight Group. It was then tested with the Council of Ministers in the various meetings that were held in the run-up to agreeing the budget proposals.

Deputy J.A. Hilton:

Okay. So who, as far as you were aware, was responsible for the decision around the £250 million? Well, it is actually £297 million.

Chief Executive Officer:

Ultimately, I would say the Council of Ministers endorsed it. Subsequently, it was then endorsed as a figure within the budget proposals signed off by the States Assembly. So the trajectory was Ministerial Oversight Group put it forward to Council of Ministers put it forward to States Assembly.

Deputy J.A. Hilton:

You do not personally have any idea how that sum of money was reached, how that figure was reached?

Chief Executive Officer:

I do not think ... well, I do not know, but I do not think anybody ever sat down and did a special sum with a formula behind it to say: "We think the sum is this." I think it was more a case of saying: "This feels like a more reasonable amount to seek support from the States Assembly for" and it was as fluid as that.

The Deputy of St. Ouen:

You spoke earlier about KPMG originally sticking their finger in the air and saying: "We think a new hospital can be delivered for around about £300 million." It certainly sounds from what we have heard today that somebody somewhere went back after having the experts look at what is required and what is provided and what is the necessary funding for a new hospital that someone turned up, put a finger in the air and said: "Well, no, forget about what the experts say, it is going to be £300 million. Now we are going to try and make it all work." Is that a fair summary?

Chief Executive Officer:

I think I would interpret it slightly differently, which would be to say there was a view that it was looking too expensive to be viable. What felt like a more realistic sum, let us see what we can do with that. I would like to believe if having worked with the design champion we had come back and said: "There is not a viable hospital here," then there would have been a further iteration and we would have had to have had a different type of conversation about the funding.

The Deputy of St. Ouen:

So where is the future-proofing in the current proposals bearing in mind that you have shrunk the size of the space and so on and so forth?

Chief Executive Officer:

Well, I would look to colleagues who know far more about running and operating hospitals than I do to answer that. Future-proofing is an important part of this because what we do not want to do is undersize the hospital, nor do we want to oversize it and have inefficiencies in cost terms.

Hospital Managing Director:

I think some of the future-proofing comes in what might come over the horizon. We know we have the demographic challenges and the ageing population but we also know there are technological advances and there are different ways of treating people going forwards. I do not think we are oversizing this hospital at all. I think we are being quite conservative. We are adding an extra 50 beds, which will help support the ageing population and the increasing population. We are not building in spare wards so there is nothing in there that is oversized. We are working with the current team looking at the modelling again. We keep going round separate iterations of this and we have the technical advisers coming on board very soon. They will again look at all of our modelling and our assumptions and they will again assure us or reassure us that we are sizing this correctly. So future-proofing will come from where there is still some site. If we wanted to invest in the future, there is the potential of the 1960s build and we still have some site space. There is still space at Overdale and there are different ways of delivering care that we expect to change over time, but it is not an oversized hospital.

The Deputy of St. Ouen:

What bothers me is that all of that work and consideration and assumptions were made around the development and the agreement of P.82, a new way forward for health services. Obviously, delivering services in the community, we have reduced the burden of cost and the hospital pressures and so on and so forth. Right, Atkins knew that. You knew that when that work was undertaken and the report was written, conclusions reached around about the £400 million to £450 million. You cannot double count it, surely, and say: "Oh, well, forget about what we have already believed to be necessary to keep our costs down and limit the demand space of the hospital because we can do more in the future," can you?

Hospital Managing Director:

That has not changed. The work that Atkins did that modelled the activity and modelled bed numbers is the same. We have used that for both models. So the bit you are talking about size wise is the difference between a U.K. guidance building note and what we are now suggesting which is about 10 per cent to 15 per cent less that we are looking at. But the number of beds, the number of clinics, the number of spaces needed for maternity, the size of the A. and E. (accident and emergency) Department, all of those sorts of things are the same in both models.

The Deputy of St. Ouen:

Right, okay. This is where it would be extremely useful to have the before and after picture.

Director of Finance and Information:

I have that noted.

The Deputy of St. Ouen:

Thank you.

Deputy J.A. Hilton:

Can we ask you what the main concerns are operating from the 2 sites that have been raised by your staff?

Hospital Managing Director:

It is obviously different for Jersey. There are some people that are working here that have worked on dual sites before but not by any means everybody. The main concerns are given their current working practice they are worried about how they, if you like, can be in 2 places at once. The obvious answer to that is that we change the way we work. Nobody is expected to be in 2 places at once. The teams will do their clinics on the Overdale site and they will do their theatre and their inpatient work on the Gloucester Street site. They have teams. They will have registrars and they will have junior housemen working on the different sites, so both sites will be covered. It is just about how they work differently. But that is new to them so they are sitting with each of their specialties and saying: "What would this look like for us?" Some services do not alter. A. and E., for example, it does not make any difference to them. They just need to look at what they need in the new spec for them. Some services are already doing it. If you look at neurology and most medical specialties they have inpatients at Gloucester Street and they do all their outpatients at Overdale already. So we are only expanding Overdale, it is not a completely new concept. That is the major concern. Those that are currently not working on both sites are thinking how will it work for their specialty.

Deputy J.A. Hilton:

This has obviously come about through consultation with the medical directors. Are there any other issues? Because I believe there is duplication of services with some. Have any opinions been expressed on the duplication of services and how that is going to be managed?

Hospital Managing Director:

There are a few services that we are still working through. This is not a given footprint yet in the sense that we are going through the whole of the working out of the clinical services what should

be where. But, for example, pharmacy, we are suggesting that the major new build, the storage, the aseptic technique rooms, would all be at the Overdale site. The pharmacy team are saying: "Fine, as long as we have a dispensary down on the Gloucester Street site that will work for us." So they are quite comfortable with that. The laboratories, on the other hand, it does not matter where you put the laboratories, you will have tests coming from both sites. You have a large footfall of patients going to the Overdale site that will need blood tests and you will have the inpatients needing blood tests. So you either duplicate services so you have something on both sites or you make a decision it goes on one site and you have to have a very good logistics plan for moving tests around. So they are still working that through. We have agreed that we will have a look at it, a thorough review of pathology, to see what is the best result for them because some of their tests are urgent, some of them are not. About 50 per cent come from G.P.s (general practitioners), not the hospital, so we have to factor all of those issues in, what technology can do, because most of these things go through analysers now.

Deputy J.A. Hilton:

I suppose as a layperson I do not profess to have any medical knowledge but it would seem to me that a laboratory, a path lab, should be where the acute services are being provided, not where outpatient care is being provided.

Hospital Managing Director:

You have to have a service where the acute patients are because you need the rapid turnaround of the test, so logic tells you you want something that can give you that rapid turnaround. In the U.K. they have had something called the Carter report, which looks at laboratories across the U.K., and the main thrust of the Carter report was the hub and spoke model, which some places have managed and others have not. But they were suggesting you have a big central hub, possibly that serves counties, not just small areas but whole counties, and then you have smaller hot labs in your acute hospitals. Like I say, that has been taken up by some areas and not others. But for Jersey, we need to work out what is right for us and that has not been decided yet. They have raised concerns. We are looking at it with them. We are planning to do a full review with them.

Deputy J.A. Hilton:

So is the review going to be taking place shortly?

Hospital Managing Director:

Yes.

The Deputy of St. Ouen:

Could you give us an indication of when a firm decision will be made on the dual-site proposal?

Hospital Managing Director:

Well, the plans are being worked up at the moment on the dual-site concept because ...

Deputy J.A. Hilton:

Are we in the outline business case stage now?

Hospital Managing Director:

We are in feasibility and when we get the technical advisers in the outline business case will be about January time.

Deputy J.A. Hilton:

That is January 2015?

Hospital Managing Director:

Yes.

Deputy J.A. Hilton:

So no decisions are going to be made prior to January 2015?

Hospital Managing Director:

Yes. So that is the timescale.

The Deputy of St. Ouen:

So a single site option has not yet been dismissed?

Chief Executive Officer:

Yes, it has.

Hospital Managing Director:

Yes, it has.

Chief Executive Officer:

We do not have a single site option and we are not working up a single site option because a single site option (a) we do not have a site other than the current site with all of its challenges and problems; and (b) we do not have a budget sufficient to develop something that is single site.

The Deputy of St. Ouen:

Right. I hear what you are saying, but you have a budget; not you personally. There is a budget of £300 million, you say, or £297 million, whatever. There is still an option to spend £300 million on the current site or £300 million on 2 sites, is there not?

Chief Executive Officer:

Well, I think the proposals we put forward as part of seeking support for the £297 million in the budget process last year very clearly indicated that was for a 2-site option. We have not been able to find, either from the design champion or Atkins themselves, a viable spend for £300 million that gives us anything that we as the health team would be confident in bringing to the States Assembly to say: "This is a fit for the future hospital development for Jersey."

The Deputy of St. Ouen:

Right, so you are saying that the design champion, together with yourselves, looked at the £300 million being used to redevelop and provide the services on the existing site alongside looking at the dual-site option?

Chief Executive Officer:

That was the initial question to Graeme was to say: "This is what we are thinking the budget may well look like. What can be done?"

The Deputy of St. Ouen:

So there is information and reports or evidence to show that you have considered both the single site option and the double site option within the same financial funding envelope which has been now determined to be £297 million?

Chief Executive Officer:

My understanding is that was part of the brief that was given to Graeme. I would not go so far as to say he produced documents that set out his thinking and the pros and cons because I think he quite quickly came to realise there was not a viable option that gave us anywhere near the benefits we were looking for from a delivery of service point of view, trying to spend £300 million on the one site. So I think he moved quite quickly to if you use both the sites at your disposal you will get a much better value for money outcome.

The Deputy of St. Ouen:

Right, but he equally did not consider the other uses of the Overdale site that had been identified prior to that for relocation of mental health services rather than ...

Chief Executive Officer:

No, that was not part of his brief.

The Deputy of St. Ouen:

Which is a bit odd because suddenly there is still an issue which we have known about and decisions have been made about to relocate mental health services and now suddenly that is left to one side as we are going to use the full site now for the hospital redevelopment.

Chief Executive Officer:

I think, to be fair, and I would need to check this because this predates me taking up my post in the Island, while there has been a long-held view in the department that mental health services need to move and that Overdale would be a good site for them, I am not aware that any specific decision had ever been taken either within the department or certainly at a political level in the States that that is where the future lay for mental health services. There needs to be a full feasibility study on the future of mental health services.

[12:30]

Because that will take some time and obviously the planning of whatever capital is required for that needs to be built into the long-term capital plan as well, there has recently been quite a significant refurbishment of the Clinique Pernel facilities which will give us at least another 5 to 10 years' worth of decent accommodation while we work that through and look for a future solution. What is more pressing is to find a solution for the Orchard House facility, which is on the other side of the road, which is not really the facility ... that certainly cannot last for another 5 to 10 years. We need to find another solution for that more quickly.

Deputy J.A. Hilton:

I just wanted to ask you whether you feel that there are any greater risks to patient safety operating from 2 sites rather than one.

Hospital Managing Director:

From the patient experience, they will be coming into Gloucester Street site for inpatient care or emergency care through the A. and E. Department or maternity care, so that is no different and is the same. They will only be going to Overdale if it is an outpatient appointment or a diagnostic test of some sort. So we are not expecting them to move between sites on any one visit so there is no risk in that sense to patients either getting lost or getting lost between people.

Deputy J.A. Hilton:

I think specifically I was thinking about a situation where you have a consultant at Overdale doing his clinics, that suddenly somebody in the General Hospital relapses. How is that going to ... the time lapse from getting from Overdale down to the General Hospital to deal with an acutely ill patient?

Hospital Managing Director:

That is about how we do that now. How do we manage an acutely ill patient now? We have other doctors always around, so we have the juniors, we have the middle grades, we obviously have the nursing staff, we have a resuscitation team. All of our physicians do all their clinics up at Overdale now. So if one of their patients relapses that is exactly what they do. The middle grades sort out the patient and they come down. It is very close. I think we forget how close it is. In the U.K. people work on split sites all the time.

Deputy J.A. Hilton:

But then I would say minutes count when somebody is ...

Hospital Managing Director:

If there was no doctor or no provision and no team, yes, of course but, of course, you have a fully trained group of staff looking after patients all the time, day and night. Consultants are not available on site all night. We have a safe service at night. It is just recognising that our model will work if you have the right people on the ground at the right time.

Deputy J.A. Hilton:

You do not believe there are any risks associated with pathology labs being moved and not being where acute services are being delivered?

Hospital Managing Director:

No, because whatever model we come up with for pathology, the acute services will have a facility to get quick-turnaround tests. That has to be a given. So even if the big lab is up at Overdale, you would have a hot lab down at the Gloucester Street site doing the fast-turnaround tests. So that has to be a given.

The Deputy of St. Ouen:

Could you confirm that it is generally accepted that operating a hospital on 2 sites has a greater risk to patients than operating a hospital on one site?

Hospital Managing Director:

I think it has more challenges for operationally working it, but I do not think it has any greater risk to patients. I think the staff will find it more difficult because they are having to work between 2 sites but for patient safety it is not an issue.

The Deputy of St. Ouen:

So why is that a dual-site option is not the norm in the U.K. and elsewhere if, as you are saying, it has lesser risk and it is cheaper to build?

Hospital Managing Director:

Well, it depends where you are starting from. We have always said our preference would have been a single site new build, but given how much we have to spend and given what value we can get out of doing this particular model, it is worth us working on changing our models of care to have a better facility for our patients. There is no increased risk to patients. This is about how we operationally run a hospital system and the challenges.

The Deputy of St. Ouen:

It is far more challenging to operate a hospital on 2 sites than it is to operate a hospital on one site, and by its very reckoning the risks increase because you are then relying on human nature and individuals that are expected to be at certain places at certain times and cover for people. We have already known ... past experience, relatively recent experience, has shown where things can go wrong around a patient because a particular doctor, consultant or whatever was not necessarily available at the time.

Hospital Managing Director:

It is about rostering staff appropriately, so if you have a clinic running, as we have now ... our clinics are obviously in the hospital but they are not on the wards and they are not in the A. and E. Department, they are in a separate section of the hospital. If you have rostered somebody into the clinic, you also have a team running the ward, you also have a team running the theatres and a team running the A. and E. Department. If that doctor is needed from that clinic, then they are called and they will go, but there is always a time delay to that. Our service does not run on the fact that only a single doctor can ever provide an emergency service. Bear in mind all of our consultants take study leave and annual leave and we cover it perfectly safely now. It is just about rostering staff appropriately so that they are in the right place and do not have another responsibility at the same time. So you would not have somebody up at Overdale who is also covering the A. and E. Department, but that is normal practice. That is what all hospitals do.

The Deputy of St. Ouen:

One last question. How would you plan on monitoring ...

Senator S.C. Ferguson:

But you do have some middle grades. Sorry, you do have some middle grades who are on call at the same time as they are working the wards or doing clinics up at Overdale. So how are you going to cope with that?

Hospital Managing Director:

This is about the change in models of care. Most of our on-call staff are either in the emergency assessment unit or in the A. and E. Department or working on the wards. That is where they would be based. If we have separate clinics and if that is the only on-call doctor, they will not be in clinic as well as being on-call in the new model. So you just change their rostering and the way that you work the teams. The smaller the team the harder that is and that is why we are still working it through with each specialty as to which one should be where. It is not going to be a one solution fits every specialty. So that is the part of the work we are doing now.

Senator S.C. Ferguson:

Does that mean we are going to have to get extra staff in as well?

Hospital Managing Director:

To do what, to increase the teams?

Senator S.C. Ferguson:

Well, to make sure you can cover?

Hospital Managing Director:

There will be some extra staff in terms of some duplication because we are going to have imaging on both sites, but that is highly appropriate because you need inpatient imaging and lots of outpatient imaging. So there will be some duplication of staff around imaging. Most of the teams, our outpatient clinic staff are dedicated outpatient clinic staff now, they just change location. So most of that will not alter.

Senator S.C. Ferguson:

No, I was thinking about extra consultants and doctors.

Hospital Managing Director:

For consultants we would only increase if the patient numbers were increasing. We do think that will be the case in some specialties so we will be looking to grow our medical teams as patient demand increases. Just because we have split sites you should not be needing to increase the teams dramatically at all.

Deputy J.A. Hilton:

Thank you. We would like to move on now. Has the intermediate care scheme provided value for money and how would you make that assessment?

Chief Executive Officer:

Well, as the person who has commissioned this from its pilot stage through, Rachel, do you want to take that one?

Director of System Redesign and Delivery:

Yes. So the strategic driver for intermediate care or, as we now call it, an out of hospital model, was exactly that, was to help to keep people out of hospital so that when we do redesign, rebuild, refurbish the new hospital we do not need as many beds as we would have done if those services were not in place, which is the conversation that we were just having about seeing this in the round. So it was really important to make sure that we have built up those services in the community so that we can care for people in community settings rather than them being in hospital beds. From a future-looking value for money perspective it means we need to build less expensive hospital beds and staff less expensive hospital beds than we would do if we did not have intermediate care, so that is looking far forward into the future. What we have been doing for the last year or so is piloting intermediate care and the reason we are doing that is to make sure that we have the model right for Jersey. We have said all along we do not want to pick up a model from the U.K. or from Australia or from another country and plop it on to Jersey because it might not work and it might not be right. So we have used pilot money to test out parts of the system for intermediate care to test out the model, to make sure that it is right, and to make sure that we are getting the best value from that as we go through. That is the purpose of the model.

Deputy J.A. Hilton:

Was the pilot £1.4 million?

Director Assisting Redesign and Delivery:

Jason probably has the exact numbers but it was in that region.

Deputy J.A. Hilton:

The 2013 funding, because you started the intermediate care programme last year as a pilot.

Director Assisting Redesign and Delivery:

Late in 2012, yes.

Director of Finance and Information:

On intermediate care of one sort or another we spent £1.4 million last year.

Director System Redesign and Delivery:

Yes. You have seen the initial reports that have come out from intermediate care and it is important to remember that it is not just about the money. It is about the patient experience, the care experience, the care provider's experience. We are gathering the information and the data as we go and you will be aware that we have had some challenges around some of the metrics that have not quite been available. But we do have some good metrics coming through as well as some great patient stories. For example, some of the figures that are starting to come through now as the first quarter of 2013, for those patients that were deemed as delayed discharges in the hospital, their average day of delay was about 6 days. Same quarter of this year, with intermediate care in place and a discharge co-ordinator in place, instead of 6 days average it is now 3 days average. That is reducing the delays.

Deputy J.A. Hilton:

Can I just ask you a question about that?

The Deputy of St. Ouen:

So waiting times have reduced correspondingly because now the beds are available in the hospital, is that what you are telling us?

Hospital Managing Director:

Well, we are saying that it is freeing up the beds. Obviously, wards are different wards. These patients are mostly on our medical wards and obviously the waiting list usually refers to surgical patients. But it is releasing the beds. This time last year I know I was only just arriving but we were struggling every day to have enough beds to admit patients into. The winter just gone was an awful lot easier. I know we did not have norovirus in the same way so there are other factors.

The Deputy of St. Ouen:

If we look at the medical waiting lists, we should see ... because obviously what we are looking to do is to help you demonstrate to the public that what you are doing and what the extra funds are

providing for not only does what it says on the tin but will deliver the savings necessary so that we can have a smaller hospital. So am I right in saying that if we look at the medical waiting lists during the corresponding time that Rachel has just spoken about we will see a reduction?

Hospital Managing Director:
I do not know what you mean by medical waiting lists because there is not one. You do not wait for anything inpatient wise medically, only surgically.

Chief Executive Officer:
Because they are usually emergencies.

Hospital Managing Director:
The only difference it makes for a medical patient is if you come through A. and E. or you get referred by your G.P. you get into your bed more rapidly because there is a bed for you. So these are freeing up those sorts of beds. The waiting list to be seen in clinic by a physician, so a medical waiting list, is not impacted by the beds. That is a clinic issue.

Deputy J.A. Hilton:
Just taking you back, it was a 6-day delay in the first quarter of last year and you said it is now a comparative period of 3 days?

Director of System Redesign and Delivery:
Yes, the indicative data that is coming out is now 3 days for the same period.

Deputy J.A. Hilton:
How much did this report have a bearing on that, this report that was done into inappropriate bed usage because of the delays? They talk about quite high percentages, really. I think this report was carried out last year. How much of that was a driver to reducing bed stay and how much of an impact has that had?

Hospital Managing Director:
The difficulty we are going to get into now is the more changes we make it is saying which ones have the impact.

Deputy J.A. Hilton:
All right.

Hospital Managing Director:

The M.C.A.P. (medical care appropriateness protocol) work has been 2 snapshot audits that have identified and confirmed that we have a number of patients that should not be in an acute hospital, they should be somewhere else. The work that we need to do to maximise the impact of that audit is still in the very early stages. The intermediate care was in place over winter. I saw less patients coming to A. and E. last winter and we admitted less into medicine. That could well be attributable to the intermediate care work.

Deputy J.A. Hilton:

Going back to the delays, you said a delay of 3 days now. Is that a delay of 3 days of being diverted to another place of care? Is that what you are saying?

Director Assisting Redesign and Delivery:

There are a whole set of reasons why there may be a delay. It may be because of ...

Deputy J.A. Hilton:

Is that why there is a delay of 3 days now?

Director of System Redesign and Delivery:

Well, I can get you the exact detail that breaks down what the delays are and why the delays have occurred. Some of it, as the Managing Director said, is in the M.C.A.P. report in terms of some of the processes and the systems of the patient flow between different parts of the system, which is work that is being done now to free up that. Some of it is about availability and capacity in community settings.

Deputy J.A. Hilton:

Do you have data available which will tell us how many bed days have been saved through intermediate care or maybe that you could provide after this meeting?

Director of System Redesign and Delivery:

I think as the Hospital Managing Director was just explaining, it is very difficult to say this directly led to that because there are a number of changes that all together are leading to the ability to manage within the capacity that we have.

[12:45]

We know, for example, last year we lost 60 beds at one point through norovirus but we coped and we coped during the winter because we have more services in community settings. So there was an alternative for patients rather than just the hospital.

The Deputy of St. Ouen:

What forms of analysis/option appraisal have been undertaken of the role of off-Island services in the development of the hospital plans?

Director of System Redesign and Delivery:

So, again, looking at on-Island and off-Island services from a strategic perspective, our aim is always to provide as many services on-Island wherever we possibly can. The reasons for that are because it is better value for us. It helps us with the clinical viability because we need a certain volume in order to stay clinically viable and, importantly, because in the main Islanders tell us that that is what they want. People want to be cared for and treated on-Island surrounded by their families where they can get back home very easily. There will always be a need for some services to be provided off-Island, particularly those very specialist services that we just do not have the volumes on-Island to be able to support them safely and to the right level. We are looking at each of the services within the hospital as part of the acute services work that we have just been talking about as we develop the models of care for the future hospital, but we are also identifying certain services where we believe that we could get better value and better treatment, better care, better pathways for patients. For example, last year we tendered out the cardiology services and we got a much better deal and we also got a better deal in terms of the patient experience and the flow from here back to the U.K. and then back again. In terms of options appraisal, to answer your question specifically, we are looking service by service as we are doing the acute services strategy and then the plans on the care models to look at what the demand is, so what volumes do we have now and what will we have in the future; what the clinical viability is, the safe level of services that we need to maintain on the Island; and, therefore, what services will have to be provided by a non-Jersey provider. Then we need to look at is that our patients going off-Island to be cared for or is it a strategic partnership using some of the new technologies that were talked about earlier on where some patients could be cared for, particularly as outpatients, here in Jersey with a video link to the U.K. or with a visiting consultant coming over to Jersey and using our facilities. But the strategic aim is to keep Islanders in Jersey and care for people in Jersey wherever we possibly can.

Deputy J.A. Hilton:

Has that been factored into the ... I think you just said that you are currently doing the acute services strategy. Has that changed? It is a change because I think we used to send a lot of

patients off-Island for treatment. So has that change been factored into the facilities that will be required in the new hospital because we are still in the process of making that decision?

Hospital Managing Director:

It is going to be a shifting ... it will shift constantly over the years because it will depend on technologies and whether things change and whether things become affordable and you can do them here. It will change with the skills of the personnel. We saw a lot of new consultants come on to the Island last year and they brought with them a whole new set of skills, so we have been able to keep different patients on the Island. Usually in terms of facilities they just need more theatre time and they need more beds, so we know that that is part of the modelling. If you need expensive equipment then it quite often is not viable for us to provide that on-Island and you send those people back to the U.K. It does boil down to what is a core hospital and if we want a hospital on this Island that is going to keep people safe in the case of emergencies, you have to have quite a large hospital because you have to have theatres, A. and E. pathology, imaging, pharmacy, rehab, maternity. You have to have all those things regardless of what goes off the Island. Then you look at other services like dermatology and ophthalmology, high-volume cases, quite easy in terms of removal of moles and relatively simple surgery but thousands of patients. You are talking about 20,000 patients between those 2 specialties. You would not want to be sending 20,000 people across to the U.K. for simple treatments at a high cost.

The Deputy of St. Ouen:

Has a detailed analysis of these been undertaken?

Hospital Managing Director:

We know the volumes by specialties. We know all of that, yes, volumes by specialties.

The Deputy of St. Ouen:

A cost analysis to ensure the best value? Because obviously one of the things, again, we were informed about early on is that I acknowledge that obviously a hospital has to be a certain size but, equally, the more services you provide on-Island the likelihood is that the larger the hospital and the more facilities that you need to provide on-Island. There is also an issue which we have not spoken about and we do not need to touch today. It is around we only have a population of 100,000 people. The U.K. model and models elsewhere are all drawn and seek to provide specialist services at a dedicated hospital with dedicated top-rate staff, consultants, medical experts, et cetera, who are best placed to provide the services. We have not seen the proliferation of a whole lot of general hospitals across the U.K. and elsewhere to provide those sorts of facilities.

Hospital Managing Director:

Nor would we.

Chief Executive Officer:

No. I think the issue here is that in the U.K., as in many other European countries or other parts of the world, health systems interlink. So groups of hospitals can take views about: "We will do this but we will send everything for that over to you" and that is how you can get your concentrations and your specialisms. That is just not so easy for us because we are an Island system at the end of the day and I know that you appreciate that. The reason I was smiling is because it is quite interesting how these things come round in cycles. A lot of the latest policy thinking that is coming from the U.K. at the moment is starting to be quite worried about the demise of district general hospitals because lots of local areas with populations between about 150,000 to 300,000 are seeing their hospitals become unviable because too much work is being centralised in big specialist hospitals 50, 60, 70 miles away. We are starting to see now people producing reports, the Kings Fund, the Nuffield Trust, all of these august bodies saying we may have gone too far here, we do need to have sustainable local hospitals as well. They might need to change the way they operate. They might all be part of a large-scale federation of hospitals to make them viable, but you cannot remove them from their local area and they have to have a broad range of services.

Deputy J.A. Hilton:

Can you tell us whether you believe you will achieve a new model of primary care by September 2014?

Chief Executive Officer:

No. No, I think you are aware that we had some difficulties last year in terms of getting that piece of work up and running as quickly as we would have liked. It was important that we fully engaged and had on board primary care practitioners. We were not able to do that successfully with our first attempt in terms of securing off-Island partners to work with us so we have remodelled the way that we approach that piece of work and it has now started with an on-Island partnership between the department, the Social Security Department and primary care practitioners. So no, we will not be able to complete the work by September but we do believe by September we will have the broad outline of what a future strategy and model might look like.

Deputy J.A. Hilton:

When would you say that the piece of work would be complete and presented to the States?

Chief Executive Officer:

I would envisage and hope, providing that we can move forward with stakeholders ... because clearly if we cannot take them forward we have to just iterate until we do, but if we can create the model that everybody is comfortable with I would expect and hope that we will be consulting with the population in the early part of next year on that and that we would then be firming up what that would mean in terms of how primary care would be delivered and how money might flow around the system during next year.

Deputy J.A. Hilton:

Okay, thank you for that.

The Deputy of St. Ouen:

Can I just ask what evidence do you have of the value for money being obtained from the sums expended to implement the White Paper to date?

Director of System Redesign and Delivery:

A number of services have already commenced and are well in train with the White Paper, in addition to those pilot projects that I talked about earlier on. We are continuing to collect evidence, metrics, patient stories, to demonstrate exactly what we are doing with the money and the impact that it is having on people in terms of their lives as well as in terms of the value for money. I will just give you a few examples. The Jersey online directory, in the 5 months that that has been up and running it has had 7,000 page views.

The Deputy of St. Ouen:

Sorry, I want to stop you there. I am specifically asking about value for money because there were specific commitments given by the Treasury Department that they would closely monitor the additional sums that were being allocated to deliver the White Paper initiatives. I want to know how you have been able to demonstrate that to Treasury, simply on the financials, please.

Director of System Redesign and Delivery:

Okay. On that example that I was just giving you, 7,000 clicks, that is 7,000 pieces of information that people have found for themselves from an online directory rather than going to speak to somebody and using that staff resource and then that staff having to look in lots of different places for the information rather than an individual going and getting information within 3 clicks. That is better value for money because it is using staff resources better and it is much better for the patient as well on the same issue.

The Deputy of St. Ouen:

So you are seeing a reduction in staff costs?

Director of System Redesign and Delivery:

Most of the areas of the White Paper are not about reducing cost, they are about using resources better. Because we know that we have increasing demands, increasing expectations, we are not cutting staff and cutting costs. We are using those resources better to cope better with the ever-increasing demands that we are finding.

Senator S.C. Ferguson:

But if you are using Lean, which you are still developing, I assume ...

Director of System Redesign and Delivery:

Mm hmm.

Senator S.C. Ferguson:

... then you should be seeing a reduction in costs. John Seddon sat across the table from us and said: "You do proper systems work, you can cut your costs by 20 per cent to 30 per cent."

Director of System Redesign and Delivery:

Within Lean there are a number of different ways that you can get the benefits. Most of them are around avoiding costs.

Senator S.C. Ferguson:

Yes, but do you have the evidence ... yes, you can get rid of the ...

Director of System Redesign and Delivery:

Not reducing costs, though, but avoiding costs that should not be expended.

Chief Executive Officer:

If demand was not increasing, if everything was static and we could reduce something, we would make a saving, I absolutely agree. What we are seeing is increasing demand so what we are doing is containing costs to then treat more people for the same levels of resourcing.

The Deputy of St. Ouen:

Right, so you would see it in treatment numbers. So are you saying that is one of the evidences that you would use for value for money?

Chief Executive Officer:

Yes.

The Deputy of St. Ouen:

Because you say we were treating this amount of people with this amount of staff; we are now treating X plus?

Chief Executive Officer:

Yes. There are some areas where you can show an absolute saving; for example, the work that I know you are aware of, Senator Ferguson, in relation to the canteen at the hospital where Lean has been used and it has driven savings and it is very clear, and there will be other areas where we can demonstrate that. But generally speaking, where we are making savings we are either reinvesting them to deal with demand or, in fact, we are picking up other pressures. Pension changes in the system have given us a significant pressure on our budget, which we have not had an additional allocation for. Like all States Departments, we have been told to just deal with it. Well, for us, that puts another million on the bill, which we have to meet internally.

Director of Finance and Information:

Could I perhaps also add there it is important to understand, I think, that in all the changes that we make we are seeking a range of benefits. Sometimes they are hard savings, cash coming out of the system to be reinvested elsewhere or to meet savings targets that we have been set. Sometimes they are avoiding a cost that would otherwise hit us. Sometimes they are about creating capacity, so that could be capacity for some extra outpatient appointments in the clinic. It could be capacity in the theatre to do more operations. It could be capacity in terms of bed days, so the intermediate care that we have been talking about. It could be capacity in terms of saving a small amount of time for an individual or group of individuals, so a group of nurses. They can then reinvest that time away from perhaps an admin role into direct patient care. So there is a whole range of benefits that we are targeting and trying to capture. Some give us pound notes in our pocket, some stop us spending pound notes in the future, some avoid us having a bigger hospital than we might otherwise have to do, and some enable clinicians to see more patients than they might otherwise.

Senator S.C. Ferguson:

So that your unit cost drops, in fact, as an incidental of seeing people more efficiently.

Director of Finance and Information:

In some circumstances it would do, yes.

Senator S.C. Ferguson:

So where are the reports on that and where is it factored into your hospital calculations?

Director of Finance and Information:

We are at the very early stages of implementing a lot of these new services that will have those impacts. We will capture before and after but we do not have the after at the moment because they need some time to bed in and operate. They are absolutely factored into the plans because if you go right back to the Green Paper and the White Paper and what underpinned that, it was the investment in these services such as intermediate care. It is the effective operation of those services that enables the hospital to be sized at 300 beds and not 400 beds. If those services are not there and do not work, then you need a bigger hospital. That gets reflected in the cost as well.

Deputy J.A. Hilton:

Can I just go back to the Health White Paper money?

Senator S.C. Ferguson:

Sorry.

[13:00]

Deputy J.A. Hilton:

On the Talking Therapies in particular, I note that £500,000 was spent in 2013 and I also have a figure here of total spend January 2013 to date of just under £6 million. Is that correct?

Director Assisting Redesign and Delivery:

I think it is £500, not £500,000.

Deputy J.A. Hilton:

It is £500, is it?

Director of Finance and Information:

It is £500, yes.

Deputy J.A. Hilton:

Oh, right, because I was going to say I know Talking Therapies has not been implemented yet. Right, okay, that is fine, so that is £500 and ... so it is just under £6,000 to date. Okay, that is fine. I was just a little bit alarmed when I saw that because I knew it had not been implemented yet.

The Deputy of St. Ouen:

Can I just ask one question just around that? You mentioned obviously a number of benefits and different sorts of benefits that can derive from improving practices and so on and so forth and the requirement to demonstrate value for money and the way that you are utilising money to ... apart from the public for the Treasury Department. Do you plan to publish information to demonstrate and identify those benefits?

Director of Finance and Information:

Yes. At the moment, one of the things that we are required to do is to report to the Treasury on a quarterly basis on all the money that we spend and particularly the money given to us under the White Paper heading. So we report that in terms of the progress of the various schemes and how much has been spent on them. So the information that we have provided to the panel through the Treasury last week I think it must have been, we report that to the Treasury on a regular basis, a quarterly report.

The Deputy of St. Ouen:

I was thinking more of the outcomes. You are saying that the patients and other people will see improved outcomes. Are you planning to provide and capture evidence that will demonstrate those positive outcomes?

Director of Finance and Information:

When the States accounts are published this year you will see in there for the first time some initial indicators of what has been achieved, and it is not specifically related just to these new initiatives but in terms of the Health Department and other States Departments there are the beginnings of certain measures in there which we will obviously be looking to develop.

The Deputy of St. Ouen:

But separately the department is not planning on publishing the good things that are happening and the good outcomes that you will be achieving through the investment that is happening in the community services?

Director of Finance and Information:

Yes.

Chief Executive Officer:

We do, as you know, publish press releases to flag up that new services are starting. We will be probably producing in the next few weeks a very high-level newsletter for the public setting out many of the things that have happened over the last year. As more of these services bed in and

more evidence becomes available, we will be publishing more information both to the public, because at the end of the day it is the taxpayer who is funding all of this, and to States Members so that you can see what you are getting for the investments that are being put in.

The Deputy of St. Ouen:
Great, thank you.

Deputy J.A. Hilton:
That is really important. I was talking to somebody the other day who has received services through the C.O.P.D. (chronic obstructive pulmonary disease) White Paper money and was speaking very glowingly of the staff that she had encountered and everything else, so I just wanted to pass that on to you. She certainly felt that the staff that were working with C.O.P.D. patients in the exercise referral programmes were doing an absolutely fantastic job. So, we will end the meeting on that note.

Chief Executive Officer:
Thank you.

Deputy J.A. Hilton:
Thank you very much indeed.

[13:03]