Health, Social Security and Housing Scrutiny Panel

MONDAY, 14th APRIL 2014

Panel:

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

Deputy J.G. Reed of St. Ouen

Senator S.C. Ferguson

Witnesses:

Chair, Clinical Directors Group

Clinical Lead, Future Hospital Project

[12:00]

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

Good morning, and welcome to the Health, Social Security and Housing Panel. This is a public meeting being held with Dr. Martyn Siodlak, Chair of the Clinical Directors Group. We will start by introducing ourselves. I am Deputy Jackie 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 sadly unwell at the present time. Thank you for coming this morning. You are Chair of the Clinical Directors Group. Can you just clarify who the Clinical Directors Group is - the membership of that group - for us?

Chair, Clinical Directors Group:

There are 8 clinical directors that work with us, so they are Richard Downes, Clinical Director of Surgery; Mike Richardson, Clinical Director of Medicine; Chris Hare, Clinical Director of Radiology; David Lawrenson, Clinical Director of Paediatrics; Akin Famoriyo, Clinical Director for Women, Obs and Gynae; Simon Chapman, Clinical Director of Accident and Emergency. What have we got? Pete Southall, Clinical Director of Pathology Services. I have got one more, do I not? Who have I forgotten?

Clinical Lead, Future Hospital Project:

Akin Famoriyo.

Chair, Clinical Directors Group:

I have got Akin, I have got him. Mike Richardson. Who is the other one?

Deputy J.A. Hilton:

Okay, that is lovely.

Chair, Clinical Directors Group:

There is another one.

The Deputy of St. Ouen:

Who is it?

Senator S.C. Ferguson:

It is old age.

Chair, Clinical Directors Group:

Carolyn Coverley.

Clinical Lead, Future Hospital Project:

There you go.

Deputy J.A. Hilton:

Carolyn Coverley is ...

Chair, Clinical Directors Group:

Yes, she is psychiatric.

Deputy J.A. Hilton:

Oh right, okay. Thank you very much indeed for that. Could you please ... sorry.

The Deputy of St. Ouen:

Are all those individuals consultants?

Chair, Clinical Directors Group:

Yes, they are. Yes. There are now ... I do not suppose there is any reason why we could not have a middle grade as a clinical director, but they are all consultants, yes.

Senator S.C. Ferguson:

Senior consultants?

Chair, Clinical Directors Group:

Not necessarily senior consultants. They are appropriate consultants.

Senator S.C. Ferguson:

I do not know, but ...

Chair, Clinical Directors Group:

I do not know, you mean senior, someone that has been there years and years and years or somebody ...

Senator S.C. Ferguson:

You do not talk about housemen any more and things like that.

Chair, Clinical Directors Group:

Oh no, we do have housemen, but they are called F1 and F2s.

Senator S.C. Ferguson:

I know, absolutely. Totally confusing.

Chair, Clinical Directors Group:

Yes, that is not our fault. It is to us as well. It is like schools.

Senator S.C. Ferguson:

It is like ...

Chair, Clinical Directors Group:

My daughter is in year God knows what, 4.

Senator S.C. Ferguson:

... doctors and surgeons are all doctors now.

Chair, Clinical Directors Group:

No, they are not. I am Mr.

Senator S.C. Ferguson:

Oh, somebody told me that it was the E.U. (European Union) was trying to get everybody ...

Chair, Clinical Directors Group:

Oh, I am sure they are, but they have not done it yet. They have not done it yet. We are still basically ...

Deputy J.A. Hilton:

So your correct title is Mr. Martyn Siodlak?

Chair, Clinical Directors Group:

Yes, and we are still basically surgeons, yes.

Deputy J.A. Hilton:

Okay. All right, thank you. The first question I would like to ask you is could you briefly outline your personal involvement in the Future Hospital Programme, that is the Health White Paper, and the new hospital? We will start with the Health White Paper.

Chair, Clinical Directors Group:

The White Paper was ... that is a long while ago now, is it not? The project began with KPMG, what was it, 4 or 5 years ago. It was quite a long time ago.

Deputy J.A. Hilton:

Yes.

Chair, Clinical Directors Group:

So I had loads of interviews with the KPMG team personally. They had a massive conference at the place in Trinity; what is it called?

Deputy J.A. Hilton:

R.J.A. & H.S. (Royal Jersey Agricultural & Horticultural Society).

Chair, Clinical Directors Group:

Yes, where the big hall is, there was a big conference there. After they distilled all the data, they came out with 3 options, of which only one was viable, because if you say to people: "You can carry on doing what we are doing and the Island will be broke very quickly, or we can cap the spend and everyone is going to be dying on the streets or we change things and everyone will be fit and well and healthy" everyone is going to vote for number 3, are they not? If you put it like that, you know the answer you are going to get before we start.

The Deputy of St. Ouen:

Then more recently ...?

Chair, Clinical Directors Group:

The Future Hospital ... that came after the White Paper, so it was recognised that the hospital was getting a bit old and we were having problems with stuff breaking down, the sewerage does not work great, the drains do not work great and stuff, the adjacencies are not right within the hospital; we have been higgledy-piggledy for years. There was a bid to build a new hospital on perhaps a new site or refurbish the single site, the present site, at Gloucester Road, but when there was not enough money to do that, we had a long discussion about probably 2 years, or last year, I cannot remember ... in the town hall there was a big discussion with lots of clinicians, including middle grades, consultants and the third sector, lots of different people. It was postulated that within the money envelope that had been voted by the States that the best option was to develop a dual site.

Deputy J.A. Hilton:

You were party to these discussions at the town hall when it happened?

Chair, Clinical Directors Group:

Yes, there was loads of doctors there, I cannot remember how many, but 30 maybe.

Deputy J.A. Hilton:

What is the general view of the Clinical Directors Group to having a hospital based on 2 sites?

Chair, Clinical Directors Group:

If that is what we have to do, that is what we have to do. Obviously a single-site hospital is always going to be better, but if there is not enough money to have a single-site hospital and there is only enough money for a dual site, we just have to get on and do it as best we can.

The Deputy of St. Ouen:

It has been suggested or stated to us that a sort of prioritisation process was undertaken on the decision to limit the amount of money available to provide for a new hospital. Were the Clinical Directors Group involved in those discussions?

Chair, Clinical Directors Group:

Sorry, can you explain that? I still do not understand. I am being a bit stupid.

The Deputy of St. Ouen:

We were told that following the decisions around having this hospital on 2 sites and limiting the money available, the funding, that a prioritisation process took place to look at what could be provided and funded within the £300 million envelope. My question is were the Clinical Directors Group involved in any of those discussions?

Chair, Clinical Directors Group:

What, you mean about whether it would be possible to build a hospital for £300 million on a single site or ...

The Deputy of St. Ouen:

I believe it extended further than that, to what services would be provided, because KPMG obviously did the work, as you rightly said, and identified a cost of £450 million, and subsequently a political decision was taken that £300 million was the funding available.

Chair, Clinical Directors Group:

£297 million, I think, or whatever.

The Deputy of St. Ouen:

So we were told that all of the provision that was provided for are services provided for within the KPMG report were reviewed, but you were not obviously ...

Chair, Clinical Directors Group:
I was not aware of that.

The Deputy of St. Ouen:
No, okay.

Senator S.C. Ferguson:
I was going to ask virtually the same thing, although I was coming to it from another direction. I was going to say what services are we not going to have at the updated hospital compared to the services we might have with a very new hospital?

Chair, Clinical Directors Group:
I think it should be exactly the same. It is just how you get around the system to provide it, so some of the ongoing costs of splitting the site are going to be higher than if you had a single site. There would need to be duplication of equipment, duplication of staff in some cases as well. We would probably need to change the whole way we run the acute medical take and probably surgical take as well, so there will be challenges in trying to do it on a dual site that you do not have with a single site.

Senator S.C. Ferguson:
So the revenue costs are going to be higher?

Chair, Clinical Directors Group:
Higher?

Senator S.C. Ferguson:
Yes.

Chair, Clinical Directors Group:
Without any doubt. I have been told that somebody has calculated - and I do not know how - that that is about £2 million a year excess. I do not know if that includes the capital costs of refurbishing the 2 sites instead of one. If it was £2 million a year, that gives us about 50 years, 70 years or something, does it not, before we equalise the 2 costs, in which case we would need another hospital by then anyway in 70 years' time.

Deputy J.A. Hilton:
Can you tell us what your view is on having the hospital split into 2 sites with regard to your role as Consultant for E.N.T.?

Chair, Clinical Directors Group:

E.N.T.? Yes, I think it is some specialties would be able to make it work easier than others. We only have 4 doctors in E.N.T., so it will be challenging to work out how we are going to put that system in place. It is doable. It will be challenging.

Deputy J.A. Hilton:

Because of the split between the 2 and holding outpatients up there and ...

Chair, Clinical Directors Group:

Yes. E.N.T. need a lot of equipment, okay, and how we run our on-call is that whoever is in clinic is on-call during the day and then we are on-call from 5.00 p.m. at night until 9.00 a.m. in the morning and we see patients that come from A. and E. (Accident and Emergency) in the clinic. We see patients that are on the ward in the clinic as well, because quite a lot of the stuff needs either a microscope or a flexible laryngoscope, it is equipment-dependent, and you cannot cart that equipment around the ward very easily, so there will be some logistic problems about where you see inpatients. What that probably is going to take - we have not discussed this in-depth - is a room somewhere that is equipped with the full kit that we have in outpatients to be able to see the inpatients on the inpatient site, otherwise we are going to rolling patients up the hill. But they are the things that we are working on at the moment to work out how we are going to be able to do that stuff.

Senator S.C. Ferguson:

So there is a hidden cost, because none of the equipment would be cheap.

Chair, Clinical Directors Group:

No, but I am told that all that duplicate equipment is in the £297 million.

The Deputy of St. Ouen:

Who has told you that?

Chair, Clinical Directors Group:

All our meetings, Julie, Helen.

Senator S.C. Ferguson:

Bernard?

Chair, Clinical Directors Group:

Bernard, yes. Everyone, yes.

The Deputy of St. Ouen:

All right. So that has been confirmed, not only to yourself, but to the Clinical Directors Group, has it?

Chair, Clinical Directors Group:

Yes, pretty much we have been told that that is how much it is going to cost to get the 2 sites working. It is obviously £2 million, but that extra £2 million a year I do not think can cover all that equipment cost.

Senator S.C. Ferguson:

No, I would not have thought so.

Chair, Clinical Directors Group:

It would just cover ongoing cost of salaries, I think.

Deputy J.A. Hilton:

So is your speciality, would you say, the one that is worst affected by the difficulty with equipment?

Chair, Clinical Directors Group:

It is difficult, really. If you talk to all the clinical directors, they will say they are the worst; each one will say they are the worst affected, I am pretty sure. Some lend themselves much more easily to it and there are already some specialities that work on 2 sites already. I think Dr. Gibson works on 2; Andrew Mitchell is really looking forward to having 2 sites; Mike Richardson already works on 2; urology work on 2, so there is quite a lot of specialties that already work on 2.

Deputy J.A. Hilton:

We have had Dr. Gibson here last week talking to us and he explained quite clearly that he is well-used to working on 2 sites. It does not really hold any difficulty for him.

Chair, Clinical Directors Group:

Yes, lots of people work on 2 sites in the U.K. (United Kingdom). Before I came to Jersey, I worked on 2 sites, 3 sites.

Deputy J.A. Hilton:

What, for your outpatients and your inpatients? Is it split in the same way?

Chair, Clinical Directors Group:

Yes, I worked in Ormskirk Hospital and I worked at Walton Hospital in Liverpool, so we did big surgery at Walton and all our emergency stuff was admitted to Walton. It is slightly different from here, because it was 20 miles up the road, it was quite a long way, but we worked it like that so people did not have to travel so far for much more minor surgery and for outpatients. So 90 per cent of my outpatient clinics took place in Ormskirk, so people did not have to travel into Liverpool. Head and neck cancer clinics took place in Liverpool; all the major surgery took place in Liverpool, but day-case surgery was in Ormskirk. But if something went wrong - touch wood, it does not often go wrong - if there was a complication during surgery that the patient needed to be admitted, we then had to move the patient to Liverpool. So it is done, it is not an exceptional thing to have 2 sites. Probably a bit unusual for such a small Island.

The Deputy of St. Ouen:

What do you think are the most significant challenges facing those delivering the health services with regard to the redesign of the Health and Social Services?

Chair, Clinical Directors Group:

The whole of the redesign of Health and Social Services or the hospital?

The Deputy of St. Ouen:

We can start with the hospital.

Chair, Clinical Directors Group:

The hospital, Bernard, the project lead, is consulting and he is talking to lots of people all the time about how we plan the sites, so the right things are in the right place, that is the first thing. The second thing is going to be we are going to need more staff, because you are going to need more staff on a dual site than you have on a single site.

[12:15]

As I have alluded to, we are going to need to change the way we run some of the acute care, but we probably should be changing that anyway.

The Deputy of St. Ouen:

Much play has been made of linking the improvements to community services with reduced demand on the hospital.

Chair, Clinical Directors Group:

Yes.

The Deputy of St. Ouen:

What challenges do you think face ...

Chair, Clinical Directors Group:

Workforce.

The Deputy of St. Ouen:

Workforce? Within the community?

Chair, Clinical Directors Group:

Yes. I think we are where we are. I think it is more labour-intensive to have people in the community, being looked after in the community, rather than on big wards - not necessarily big wards, it could be single rooms on big wards, but in a single unit - but we are where we are and if you were given a blank sheet of paper with no medical services at all on an island this size, what you would do is find the middle of the Island, pick a site, put a massive diagnostics care service in the middle of it, surround it with acute care beds and surround that with intermediate stay beds and long-term care beds and run the whole shop from one place. But we cannot do that because we are not living in isolation and there is all the politics of 100 G.P.s (general practitioners) out there looking after patients, there is the fact that lots of people will want to be looked after in their own homes. I was at one of the meetings 3 or 4 years ago at the town hall when they were discussing the White Paper and somebody got up and said: "It is all very well and good saying everyone wants to be looked after in their own home, but my mum - when her husband, my dad, died - was stuck indoors in her own home, miserable, really just basically was waiting to die. Broke her leg, got taken into hospital, got moved out of the hospital into a nursing home and loved it, because she had much more social interaction when she got to the nursing home than she had living in her own home." So people need to be given the choice, but sometimes they do not know the choice, because she just thought she wanted to stay in her own home, but did not realise that in fact it would be much better if she was in a bigger community. It is difficult to know how you plan that. My mum lives in Essex and she just wants to be in her own home, but she does not have anything to compare it with.

Deputy J.A. Hilton:

No, that is right.

The Deputy of St. Ouen:

So what differences will the proposed changes make to the role of the medical staff in the hospital apart from the obvious ones about working from 2 sites and so on?

Chair, Clinical Directors Group:

You mean the White Paper thing?

The Deputy of St. Ouen:

Yes.

Chair, Clinical Directors Group:

Hopefully, with the Intermediate Care Project, there will be more consultant-led stuff that takes place outside the hospital, so the interface between the community and the hospital will become more blurred. In fact, Mike Masding, the Foundation Dean from Wessex, already thinks that our hospital is one of the most community-orientated and integrated hospitals he has ever been to mainly because it is in the middle of town, you can walk in and out, and it is not stuck on a greenfield site 20 miles from town where you have to pay a fortune to park your car, so I think we are already partly there. He says that we can, for our junior doctors, say: "Well, you guys are practically doing primary care anyway, because patients use the hospital almost as their first stop." So I think we are partly there already.

The Deputy of St. Ouen:

Do you see the consultants being more actively involved in community-type services?

Chair, Clinical Directors Group:

No. I think they are actively involved, but I do not see ... Andrew Luksza was the first. It was supposed to be C.O.P.D. (chronic obstructive pulmonary disease) that was the first thing run through - what is it called - intermediate care and somebody was talking the other day and saying he was going to be going out and doing this, that and the other. I said: "You may have thought he was going to do that. I am sure Andrew did not think he was going to do that. What he thought he was going to do was train some nurses to go out to help the G.P.s run the clinics." I do not think he foresaw him being out in the clinic. It is the same for England, they have things called G.P.w.S.I.s (G.P.s with a Special Interest). They tried them in E.N.T. and they are just a really inefficient way of using E.N.T. services, because each surgery needs to have a shedload of equipment, the consultants then need to spend one day a week with their G.P. making sure that they are doing everything right and teaching them and it is a really inefficient way of running many services, and especially ... how big are we, 9 by 5? Why do you need to have outreach clinics all over an Island that is 9 by 5?

The Deputy of St. Ouen:

Have you been involved in the development of these new improved services in the first phase of the White Paper at all?

Chair, Clinical Directors Group:

Me? No. We were involved in discussions about setting it up, but I have not been involved in the delivery of that stuff. I am a pretty much dyed-in-wool acute care surgical consultant.

Senator S.C. Ferguson:

Do you not think though that perhaps it would be better if the clinical side took a greater interest in it, because otherwise, with great respect to Bernard, you are going to end up with something that is organised by the admin people?

Chair, Clinical Directors Group:

The hospital I think everyone is massively involved in, because they see that is going to affect their everyday life all the time. The community care bit I do not think people are that - what is the word - motivated to get involved in all that stuff.

Senator S.C. Ferguson:

Yes, but do you not feel that that perhaps is, with respect, a little short-sighted?

Chair, Clinical Directors Group:

Yes, it may be a little short-sighted, but the provision of primary care, which is what we are talking about, should be run by primary care physicians.

Senator S.C. Ferguson:

Yes, but there should be communication, surely.

Chair, Clinical Directors Group:

There is communication, because we talk to each other every day.

Senator S.C. Ferguson:

Yes, but there should be good communication between consultants, and G.P.s are effectively sort of almost the advocate for the patient or the co-ordinator for the patient, but they are co-ordinating with the consultant and that is surely where the main ...

Chair, Clinical Directors Group:

But that already happens. I talk to G.P.s every day about their patients and I am sure most of our clinicians do. I mean, we are a small place. Not only do we talk to G.P.s every day, they are our friends. We socialise with them and go on holiday with them.

Senator S.C. Ferguson:

You must hear the grumbles from them ...

Chair, Clinical Directors Group:

Yes.

Senator S.C. Ferguson:

... which would be very useful if fed back into the system.

Chair, Clinical Directors Group:

Yes, we do hear the grumbles, but what are they grumbling about?

Senator S.C. Ferguson:

What are they grumbling about?

Chair, Clinical Directors Group:

What they are grumbling about is that the White Paper said initially: "We are going to get all this money and we are going to put it into primary care so that more care will take place in primary care" and the G.P.s, quite rightly, had thought: "Great, there is loads more money coming our way" but when it came to the nitty-gritty of it, it did not get to go to the G.P.s, it went to ancillary care workers of one sort or another, i.e. how many new psychologists did they put in, 17?

Deputy J.A. Hilton:

Talking Therapies is about 8, I think.

Chair, Clinical Directors Group:

Talking Therapies, midwives out in the community, loads of things that ...

Deputy J.A. Hilton:

That do not involve the G.P.s.

Chair, Clinical Directors Group:

Yes, so they are upset because the dollars they thought were coming their way did not come their way.

Deputy J.A. Hilton:

Yes, I understand that, because when we first discussed the White Paper, I thought that Talking Therapies, they might be based in G.P. surgeries - but I do not think that is going to happen - and somehow the G.P.s would be involved in that, which I thought would be a really good thing, but I do not think it is going to pan out like that.

Chair, Clinical Directors Group:

But that is one of the big problems, 17 new Talking Therapist people, where do they all come from? That is why I said about workforce, if we keep saying that this stuff has to be delivered in the community, you need far more people to deliver it in the community than you do within an institution.

Senator S.C. Ferguson:

This is where I would have thought you needed the communication with the G.P.s. Instead of the Health Department and the hospital trying to keep control of all this at the centre, they should be pushing it out to the G.P.s.

Chair, Clinical Directors Group:

That is what they are trying to do. The G.P.s do come to ... well, that is the problem. If you say the G.P.s, it is Philippa Venn and ... just Philippa now. It was Bryony. Nigel has started to come now, but it is difficult to say that they are the G.P.s because there are 100 or so of them, are there not, but there are only 2 or 3 you go and see at the meetings.

Deputy J.A. Hilton:

What, the meetings when you were discussing the White Paper?

Chair, Clinical Directors Group:

Yes.

The Deputy of St. Ouen:

In regards to your colleagues and those that support them within the hospital, do you get a sense that people are generally happy with the proposed changes and the move to the dual site?

Chair, Clinical Directors Group:

Not everyone is happy. Some people are quite happy, because that is how they are used to working and know how it works. Others are very worried about how their service will work on the dual site and others are worried about the ongoing costs are going to be more expensive.

The Deputy of St. Ouen:

Do they believe that they are being listened to?

Chair, Clinical Directors Group:

Some do, some do not. Everyone is different. Certainly I had somebody really moaning at me the other day about it, and I said: "Well, what can I do? At the end of the day, there is not enough money in the envelope to run a single site." However you think that this Island runs and every democratic system in the world runs, it is the politicians that run it, and they run it on behalf of the people and they decide what they are going to spend their money on. At the end of the day, health, in any Western world system, could spend all the G.D.P. (Gross Domestic Product) of any country in the world easily, so we have to decide priorities and how much are we going to spend on health, and that is a political decision that has to be made by the people.

The Deputy of St. Ouen:

But that will have an impact on the services they provide, will it not?

Chair, Clinical Directors Group:

Of course it will, of course it will, because how much is it, in the United States, 90 per cent of a person's life-long health care is spent in the last year of their life.

The Deputy of St. Ouen:

I come back to you with the same question that I asked previously, what input have you had in considering what variations and changes to the service will ...

Chair, Clinical Directors Group:

That is something that is ongoing at the moment. That is all we are discussing, and Bernard has been round to see us twice. He has seen all the E.N.T. surgeons. He is going to come around and see us again - I think it is in the diary the week after next - to try to get more down to the nitty-gritty about what exactly is going to be where and how we are going to run it, and Bernard is doing that with every single consultant in the hospital so that we can hopefully have a system that will work. The most important thing is splitting the 2 sites makes it just as safe as it would be one site, which is just the most important thing. Okay, it is going to cost a bit more to do it on 2 sites than it

would on one, but from what I have been told, it is going to take 50 to 70 years for those costs to equalise.

Deputy J.A. Hilton:
How often does the Clinical Directors Group meet with ...

Chair, Clinical Directors Group:
Fortnightly.

Deputy J.A. Hilton:
... the Chief Executive Officer or the Hospital Director? Do you have weekly meetings to discuss ...

Chair, Clinical Directors Group:
Fortnightly with the ... what is Helen called?

Deputy J.A. Hilton:
Hospital Director.

Chair, Clinical Directors Group:
Hospital Director. Fortnightly with her and monthly with Julie.

Deputy J.A. Hilton:
Do you have ...

Chair, Clinical Directors Group:
It is Friday morning for Helen and Wednesday evening for Julie.

Deputy J.A. Hilton:
But the White Paper and the new hospital, is that always an agenda item?

Chair, Clinical Directors Group:
Not always. Quite often, but not always, and I think as time goes on at the moment, it has been more and more often an agenda item. Not so much the White Paper, it is the future hospital that is the main agenda item because, as I say, people are much more interested in how their everyday lives are going to work.

Senator S.C. Ferguson:

In the middle of all this, Lean is sort of trundling gently through the hospital, your colleagues on the Clinical Directors Group, have they taken to it, have they applied it and so forth?

Chair, Clinical Directors Group:

It has been around for a long while, but it is still in its early days really in implementation. The Lean principle is fantastic. I cannot remember the first time I heard it, 10, 12 years ago.

Senator S.C. Ferguson:

I have been very keen on getting John Seddon in.

Chair, Clinical Directors Group:

Who?

Senator S.C. Ferguson:

John Seddon, Vanguard.

Chair, Clinical Directors Group:

Yes. What it is called, Six Sigma, that was all part of the Lean programme.

Senator S.C. Ferguson:

No, it should not have a name. They have given it a name so you can tick the boxes.

Chair, Clinical Directors Group:

Yes.

Senator S.C. Ferguson:

Most of it is common sense.

Chair, Clinical Directors Group:

Most of it is just common sense.

Senator S.C. Ferguson:

But how have your fellow clinical directors been applying it?

Chair, Clinical Directors Group:

Hopefully, by common sense, every day of their lives in their working practices.

The Deputy of St. Ouen:

What consultation has taken place regarding our proposal to provide 100 per cent single-bedded rooms in the hospital?

Chair, Clinical Directors Group:

There was a lot of consultation about that, and that divides opinion massively, I have got to say. I was really against it, mainly because of personal experience from my mum - we will talk about my mum again - when she was in the Marsden, she loved being in a 4-bedder, she just loved it, nose in everyone's business, listening to what was going on here, there and everywhere, because we are from Essex and Marsden is in the middle of Chelsea, so it was like really lovely posh people in the bed next to her and she was like: "God, this place has got such and such, it is fantastic." She loved it. But having read Bernard's paper recently about how you can run single-bed wards, I would probably change my opinion.

[12:30]

I think that there is a lot to be said for single beds. It is really important how you organise them. I think that - you must have read it - pretty much you have to have interleafed bathrooms so that it can work properly, in a way. It may be a generational thing: the question is whether it is really a generational thing, that people have become more private and want more of their own space and that that is going to happen throughout the rest of their lives or whether it is just that when you are younger you are like that, and when you are older, you want more community.

Deputy J.A. Hilton:

It may be an age thing.

Chair, Clinical Directors Group:

You are younger than me, but I can remember going on holidays to Butlins. There was a little chalet and you all trooped off to the washroom to have your bath and your shower and stuff with a bunch of sinks. That does not happen anymore, does it?

Deputy J.A. Hilton:

No.

Senator S.C. Ferguson:

After Harold Wilson brought in currency controls and everybody found they could go to Spain for £25 and they had an ensuite bathroom, then nobody wanted to go down to the washroom.

Chair, Clinical Directors Group:

So it could have changed for good and it may not be that the generation that is now used to going to Spain and having ensuite bathrooms gets to be older that they will still want to have that and will not want to go back to big rooms.

Senator S.C. Ferguson:

It is the one thing I hated about being in the hospital, the shared facilities. Awful.

Chair, Clinical Directors Group:

Yes, so I think that, as I said, from personal experience I thought that single rooms were a bad thing, but having read Bernard's paper, I think it was probably the right way to go.

The Deputy of St. Ouen:

You say generally it is still a contentious subject?

Chair, Clinical Directors Group:

Yes, I think a lot of people have not read this paper and once that has been circulated a bit more, I think that people's minds will be changed.

The Deputy of St. Ouen:

Is that the role of the Clinical Directors Group to circulate it to their membership?

Chair, Clinical Directors Group:

Yes, it will be, but Bernard may need to finish writing the paper.

Clinical Lead, Future Hospital Project:

Well, 2 papers. I did a summary of the issues, where the evidence would be and the huge amounts of the evidence so that people might access those, but I also listened very carefully to when people were saying about the risks of social isolation and then try to think about it, because I am agnostic about all of this. My job as the Project Manager is to make the best of the project brief as set up, and so I have done a more detailed piece of work: "Let us look at the issue of risk of social isolation" so there are 2 papers, which again you are very welcome to read.

Senator S.C. Ferguson:

Because you are going to have to be terribly careful with oldies coming in that they do not get institutionalised.

Clinical Lead, Future Hospital Project:
We absolutely are.

Senator S.C. Ferguson:
That is the crucial thing.

Clinical Lead, Future Hospital Project:
The length of stay for patients in the future is going to be significantly less than length of stay now. Even now, we have made inroads into that, so that whole institutionalisation is something we will have to address in a very different way, because the institutionalisation may be along the pathway. It may not be the hospital, it may be something that is when people are going into settings which are institutionalised outside of the hospital.

Senator S.C. Ferguson:
So is this something ...

Chair, Clinical Directors Group:
People say that it is worse going into a single room for oldies, as you call them, but I think that just taking them out of their normal environment and plonking them down anywhere else, whether it is a 6-bed or a 4-bed or a single room, it is equally disorientating for them. That is my experience.

Senator S.C. Ferguson:
Yes, although if they are in a 6 or a 4, they can at least keep their brain going by getting so furious about the old lady in the bed next door.

Chair, Clinical Directors Group:
That is true.

Senator S.C. Ferguson:
You have seen it with your mother, I have seen it with mine.

Chair, Clinical Directors Group:
Yes, they do, they love that, but the world is changing. T.V. (television), Skype, if all that stuff, all the I.T. (information technology) can be put into single rooms, they are going to be much less socially isolated than they are at the moment. If they are in a single-bedder, they will be able to talk to their grandchildren and Skype and continue to talk to their grandchildren on Skype like they are doing at the moment, because that is just the way stuff is happening.

The Deputy of St. Ouen:

But just to confirm that in your opinion, no firm decision has been made the provision of single-bedded rooms ...

Chair, Clinical Directors Group:

Absolutely.

The Deputy of St. Ouen:

... and a consultation is taking place?

Chair, Clinical Directors Group:

It is still taking place, yes, and so there will be single rooms, there is no doubt about it, the question is will it be all, will it be 70 per cent, will it be 80 per cent? We do not know yet. That consultation is ongoing.

Deputy J.A. Hilton:

Do you think in an ideal world it would be a good idea to have both so that patients had a choice?

Chair, Clinical Directors Group:

It sounds great, but it could cause a few rows, could it not? Everyone might want a single room: "Why do I not get a single room? It is not fair." So I think that ...

Deputy J.A. Hilton:

So you think it has got to be all or nothing?

Chair, Clinical Directors Group:

No, I do not think it has to be all or nothing. I think that you could have criteria about who goes into a 6-bedder, for example, you might want to put some high dependency units in a 4-bedder or something for immediate post big surgery or something like that, so it is something we have to think very carefully about and that discussion is ongoing.

Deputy J.A. Hilton:

Yes, okay. Thank you. I just wanted to ask you whether you think there are any greater risks to patient safety operating from 2 sites.

Chair, Clinical Directors Group:

There cannot be.

Deputy J.A. Hilton:

No.

Chair, Clinical Directors Group:

We cannot allow that to happen, and we have talked about inconvenience and all that sort of stuff, but it just cannot happen, we cannot adopt a system that has a reduction in patient safety.

The Deputy of St. Ouen:

You say they cannot, but has anyone identified potential risk?

Chair, Clinical Directors Group:

There are potential risks, for example, E.N.T. surgeries, okay, if somebody has a really bad nosebleed in an inpatient bed when the guys are up the road at the clinic, and the others, maybe somebody is off and somebody is in the operating theatre, that could be a potential risk. That sort of exists now at weekends, no one is there, there are not any E.N.T. surgeons that live in the hospital, and we have to rely on the fact that that is almost first-aid medicine and any doctor trained in acute care should be able to put a pack in a nose. But that is no greater risk really on a 2-site than on a one site, but it is going to be a bit less convenient for the patient, but it should not be any greater risk.

Deputy J.A. Hilton:

Certainly you have mentioned that ...

Chair, Clinical Directors Group:

But we will need to change the way that acute medicine works.

Deputy J.A. Hilton:

Yes. Consultants do not generally work on the weekend and ...

Chair, Clinical Directors Group:

They do work. They may not ...

Deputy J.A. Hilton:

Well, they are not in the hospital ...

Chair, Clinical Directors Group:

Yes.

Deputy J.A. Hilton:

... so they might be on call, so there is a distance involved, but there is quite a big difference between being somewhere within the parameters of the General Hospital when something happens and being up at Overdale. That is quite a big difference in distance.

Chair, Clinical Directors Group:

Yes. That is why we have to be very certain and we will have to change the way acute medicine works and acute surgery works and make sure that those things are provided on the site and there is going to have to be changes into how ... especially the acute medicine rota, because what are we talking about here, we are talking about heart attacks, strokes and stuff like that.

The Deputy of St. Ouen:

So what involvement has the Clinical Directors Group had ...

Chair, Clinical Directors Group:

That discussion is still ...

The Deputy of St. Ouen:

... independently or separately looking at potential risks and how to manage those?

Chair, Clinical Directors Group:

That is happening all the time. That is the process that is ongoing at the moment, working out what we put where, how we run the rotas, how we change how medicine works, how surgery works so that the appropriate clinicians are in the right place 24/7.

Senator S.C. Ferguson:

How far down your chain of command does that go? Are you pulling in your sisters and frontline nursing staff on that?

Chair, Clinical Directors Group:

Yes.

The Deputy of St. Ouen:

When is that work completed then?

Chair, Clinical Directors Group:

Probably 2 years, I do not know. How long is it going to take? At least another year.

The Deputy of St. Ouen:

I mean, are you confident that all of the potential risks are able to be managed to enable a 2-site hospital to work or do you believe ...

Chair, Clinical Directors Group:

Yes, because I have worked in 2 sites and it can work. The difficulty is identifying all the risks before it starts, because however well you try and do it, we don't have 20/20 foresight, we are not going to be able to plan out every single thing that can possibly go wrong. We are going to try to do that, but stuff will still go wrong like it still goes wrong on a single-site hospital and we have to learn from those. Whenever there is an incident, if there is a SUI or a complaint, we have to learn from those things. It is an evolving thing. It evolves all the time.

Deputy J.A. Hilton:

Have you had any feedback from your current patients, staff on the proposal of the 2-site option, you know, what is the general ... anybody commented to you on it with any views?

Chair, Clinical Directors Group:

I have not had any feedback from patients. I do not think this is going to affect patients very much; it might be a bit better for patients. I think the General is not an easy place to come to as an outpatient and I think if all outpatients are in a new hospital at the Overdale site, it might be a much easier place for them to get around, be seen, get to and from. I think most patients either tend to be inpatients or outpatients.

Deputy J.A. Hilton:

Or outpatients, yes.

Chair, Clinical Directors Group:

So there is some logic to dividing up the 2 sites like that. They are very rarely inpatients and outpatients simultaneously, so I think that for patients, it is not going to be that big a problem. I think the biggest problem is going to be for clinicians, and especially clinicians in small specialities, like E.N.T., urology, eyes. I think we have to have lots of very serious discussions with Bernard about how we set this up, and I think we are definitely going to need dual equipment.

Deputy J.A. Hilton:

Yes, and your nursing staff, have they expressed any opinions to you about the dual site option?

Chair, Clinical Directors Group:

Yes, the same worries that I had about if there is a patient on a ward that we need to get down, how is that going to happen, how are we going to be able to manage that? How we did it in Liverpool was ... well, it is different, it is much bigger, a massive E.N.T. ward, but the E.N.T. ward had a kitted-out E.N.T. outpatient room on the end of it, but we had 30 E.N.T. beds. That is not going to happen here. We were looking after 1 million people, so it is different.

Deputy J.A. Hilton:

Okay, thank you.

The Deputy of St. Ouen:

What importance do you place on the development and delivery of an electronic patient record system in order to help minimise some of the risks involved in running a dual site?

Chair, Clinical Directors Group:

I think it is very important, but I am not very technologically whiz--kid. In fact, I am a bit of a Luddite, but I have got to say that since the E.P.R. (Electronic Patient Records) that we have got in at the moment went in ... I thought it was going to be a complete disaster, yet as you get used to it and as the problems are ironed out, it is better. I am surprised, but it is, so yes, Centricity, the x-ray system, before it came in, there was loads of articles in the B.M.J. (British Medical Journal) with all sorts of people saying: "This is going to be a disaster. It is going to be a complete nightmare. It is going to be rubbish." It is absolutely fantastic. You could not live without Centricity now and I ...

Deputy J.A. Hilton:

Can you explain that to us?

Chair, Clinical Directors Group:

It is the x-ray system, so instead of having x-rays on x-rays ...

Deputy J.A. Hilton:

It comes up on a screen?

Chair, Clinical Directors Group:

Yes, it is all digital on screens, so I can see them in my clinic, I can see them in the operating theatre, I can see them in my rooms at the Lido. You do not lose them, you do not have to carry a great big bag of stuff around, and I do not think any of the doctors could live without that now, and I think in 5 years, they will not be able to live without E.P.R., but it needs to be developed further.

The Deputy of St. Ouen:

What other I.T. type systems do you believe are essential to enable and support a 2-site hospital?

Chair, Clinical Directors Group:

Pass. You have to talk to Graham. I am just not ... I am too old. I can barely work my BlackBerry. But Graham knows all about it.

Senator S.C. Ferguson:

Like your 85 year-old patient who was given an iPad for Christmas. Have you not caught up with her yet?

Chair, Clinical Directors Group:

No, I have not yet. But my wife has got one. That is saying something.

Senator S.C. Ferguson:

Tell me, in the KPMG report, it talked about 60 per cent of the Islanders having medical insurance. Now, what is your impression of ...

Chair, Clinical Directors Group:

I think it is about 20 per cent, 25 per cent maybe. It is not 60 per cent. That is rubbish. Well, I might be wrong, but if it is 60 per cent, they are not using it. I do not know where they get the number from.

Senator S.C. Ferguson:

No, I do not either. I was just curious. We have been asking people and their opinions are not dissimilar to yours.

Chair, Clinical Directors Group:

I cannot believe it is 60 per cent, but that is not my ... the proportion of patients that get referred into private practice from public patients, it is more like 20 per cent, 25 per cent maybe.

Deputy J.A. Hilton:

Do you think there will be more or less treatment on-Island with the new proposals? Do you think it is going to stay the same?

Chair, Clinical Directors Group:

I think it is nothing to do with whether it is a dual site or a single site.

[12:45]

I think that our plan is to have more treatment on-Island, but it is serendipitous whether that happens or not. It depends who comes to the jobs.

Deputy J.A. Hilton:
Are you talking about your own speciality or other ...

Chair, Clinical Directors Group:
No, for anything, for everything. So we are going to move ... 2 new surgeons are bringing quite a lot of stuff back, simply because of their skillset, if they arrive with the skillset that is very useful, you will bring it back. When I came, I brought stuff back that was going away, but it is a bit serendipitous who you get, because you cannot ... you could write a job description and say: "This is the person we want to do this, this and this" then you have to reliably be able to attract them and you do not necessarily ... cannot necessarily attract those people. We have got a colon surgeon that does laparoscopic colon surgery, so you do it, and you have got a breast surgeon that does breast reconstruction, so we do it, and it used to go away.

Deputy J.A. Hilton:
So in the future you can see services being expanded with new staff, because I understand about half the consultants are going to be replaced, are they not, they are retiring in the next ...

Chair, Clinical Directors Group:
That is the White Paper, is it not? That is in the KPMG ...

Deputy J.A. Hilton:
I think I ... yes.

Chair, Clinical Directors Group:
Yes, they are so out of date. It has happened in like one year instead of 10 years. We have got 2 new general surgeons, a new E.N.T. surgeon, new eye surgeons, 2 new orthopaedic surgeons, 2 new urologists, so it just happened really quickly.

Deputy J.A. Hilton:
That is probably, what, the last year, 18 months?

Chair, Clinical Directors Group:

Yes, it just tumbled. I do not ... I feel sorry for our H.R. (human resources) staff. They have just been overwhelmed with the number of new staff we have appointed, and they identified that all these people should be going within the 10 years. In fact, as you say, it happened in 18 months, 2 years.

Deputy J.A. Hilton:

Yes.

Chair, Clinical Directors Group:

So the age of our staff is not that old anymore - 2 new anaesthetists - so it happened very quickly.

The Deputy of St. Ouen:

If I understood you correctly just now, you said that you believe that there will be more on-Island treatment and it would not have an impact on either a single site or a dual-site hospital. Can you just elaborate on that?

Chair, Clinical Directors Group:

Yes, it is the other way around. Whether it is a dual site or a single-site hospital will not have any impact on whether there is more or less on-Island treatment.

Deputy J.A. Hilton:

It is all to do with the skillset of the people involved?

The Deputy of St. Ouen:

Yes, size does not matter.

Chair, Clinical Directors Group:

What do you mean, size does not matter?

The Deputy of St. Ouen:

I presume if we offer a more comprehensive range of services, it is likely that you would need a larger hospital. Am I incorrect in that assumption?

Chair, Clinical Directors Group:

You need more beds, yes, or maybe not, because some people will stay in shorter, but as it is serendipitous about who we attract, okay, whether the beds are ... well, the beds are all going to be on one site. The question is ... well, they are not, because there is going to be day-case

surgery as well, but what happens is the pattern of work changes, okay, so our numbers going through the theatres have not changed very much in the last few years, but the complexity of the cases have, so instead of a breast operation taking, I do not know, an hour or so, it might take 4 hours because it is going to be reconstructed at the same time - or 6 hours - and the histology that comes out of the breast now is much more complicated than it used to be. Prostate biopsies used to be a single biopsy. Now there is up to 8 biopsies from the prostate, because they do mapping of where the tumour is. So technology makes stuff change in how we use things, but whether it is one big hospital or one big hospital split in 2 sites, I do not see how it makes a difference.

The Deputy of St. Ouen:

Well, we understood to believe by KPMG that obviously the size of the hospital is directly related to what is provided and hence the reason why the proposal to develop the community services and the need for a smaller hospital because of it. From what you are just saying is that: "Forget about all of that. We can expand the services we offer and yet nothing comes out with regard to the size of the hospital."

Chair, Clinical Directors Group:

Yes, but they will not all expand, because serendipity will means that sometimes we might get ... okay, when I go, we do not get somebody to replace my head and neck cancer, we might have to send more head and neck cancer away, so you do not know how the life will change in the future in terms of what comes to the Island and what goes away, but I do not really see whether it is a single site or a double site affects the amount of work that goes away to the U.K. or not.

The Deputy of St. Ouen:

So we do not need more theatres and we will not need other materials?

Chair, Clinical Directors Group:

Yes, but whether on one site or 2 sites, it does not matter, does it? We do need more theatres, because we just told you what is happening at the moment is theatre numbers are staying the same, but they are becoming much more complicated and operations that used to take ... take E.N.T., E.N.T. it has already happened in. When I was a boy, I used to sit in outpatients and do sinus washouts on 15 patients while my boss was next door. Lo and behold, you bring them back each week for 6 weeks until you got clear washouts, and after 2 or 3 weeks most people would stop coming back, because it is horrible, and you used to see them, they got better. Whether they got better or not or they just did not want to come because it hurt too much, you never knew. But those patients now have a C.T. (computerised tomography) scan and functional endoscopic sinus surgery, which takes between an hour and an hour and a half in surgery, so that has already happened in E.N.T., and that is happening in all specialties. There were no knee replacements

when I was a medical student. It did not exist, they did not know how to do a knee replacement. Well, they had hip replacements, but now they are both done in equal numbers, and so as the complexity of the surgery changes, the amount of theatre time that we need goes up, but in most of those cases, they can get out quicker. There was an enhanced recovery programme for colon surgery before we got the laparoscopic colon surgeon, so their stay in hospital went down from something like 10 days to 4 days, and that is going to come down even less, so the bed numbers can go down, but the amount of time in the operating theatre goes up.

The Deputy of St. Ouen:

Just to confirm, you are of the belief that within the funding or spending envelope of £300 million, regardless of where the hospital is, we will be able to look forward to being able to enjoy this, expand the services, alongside the advances in technology which may or may not put a greater burden on the consultants and the doctors that are treating the patients?

Chair, Clinical Directors Group:

I am not sure it is all going to get that in £300 million, but that is the plan, but we cannot predict far enough down the line to know.

The Deputy of St. Ouen:

But we are building a new hospital and the facilities have got to last 50 years, surely?

Chair, Clinical Directors Group:

They have got to last 50 years, but they have got to be ... it has to be built future-proof, as Julie said to one of the meetings in the town hall. We have to be able to adapt things as things change, so at the end of the day, as I said, if the money is £300 million, that is the money and that is a political decision, because we could spend - let alone just on building the hospital and providing healthcare - £1,000 million, whatever number can be spent. Look at the United States, look at England, it is completely broke with the amount of money they have spent on health care. We have to make - you, we, the Island as a whole - the political decisions about what the money is going to be spent on.

Senator S.C. Ferguson:

Have you and your colleagues ever had blue-sky discussions about changing the funding model?

Chair, Clinical Directors Group:

Yes. That took place about ... oh, a long time ago, when James Le Feuvre was in health. There was a whole ... it might have been 2 days on blue-sky thinking, about how we could do it, and hypothecated taxes perhaps, more private care, lots of blue-sky thinking, but at the end of the day,

we live in a - for good or bad - relatively low-tax society, which is good, and we have to live within our budget, which I think is also good.

The Deputy of St. Ouen:

Bearing that in mind, have any of the Clinical Directors Group been required or been involved in determining what services continue to be provided on the Island and what services will continue to be provided off-Island, in particular with regard to the value for money and the cost effectiveness of that provisioning?

Chair, Clinical Directors Group:

Value for money, cost-effective. Yes, we are involved. It has gone through one planning cycle with cardiology already. There were plans afoot to roll out to nearly all ... because we do not have strong contracts for tertiary care, there were loads of discussions about how we would continue to roll this out across all specialties to make sure that we got value for money and were not being ... what is the word? I have to be careful ... paying over the odds for our care. We are continually involved in those discussions. Jo Yelland leads on that.

Senator S.C. Ferguson:

What were the results of the cardiology review?

Chair, Clinical Directors Group:

It saved loads of money, because they had ... when the new contract was put in, they had to do ... they could not charge above tariff. If they did extra stuff or stuff went wrong on the patients, they had to pick up the bill for that instead of billing us for it and they could not do secondary referral to other doctors within their system without talking to us first, and so we got a much better handle on how the money was spent and the contract stayed with Oxford, but they were ... it was a stronger contract.

Deputy J.A. Hilton:

There has been a lot of work done on these service level agreements with hospitals in the U.K., the acute services.

Chair, Clinical Directors Group:

There was a lot of work being done. It has sort of stagnated a bit for the moment.

Deputy J.A. Hilton:

Why do you think that is?

Chair, Clinical Directors Group:

The election.

Deputy J.A. Hilton:

Election? It is nothing to do with ...

Chair, Clinical Directors Group:

The election.

Deputy J.A. Hilton:

... the person who is leading on it being asked to lead on something else?

Chair, Clinical Directors Group:

No, it is the election.

The Deputy of St. Ouen:

With the relatively small number of cases in certain specialist areas, do you believe that there is a need for certain medical support to continue to be provided off-Island?

Chair, Clinical Directors Group:

Yes. There are 2 ways we can do it. Some things will need to go off-Island for the foreseeable future. We can also bring expertise to the Island when necessary, so the answer is yes.

Senator S.C. Ferguson:

How about that wonderful system whereby the surgeon is in London and there is a computer operating on the patient?

Chair, Clinical Directors Group:

Yes, I have seen it. I am sure it will be appropriate for some surgeries. I am not sure how much it is going to cost to set it all up but I am sure it will happen in some jurisdictions, but I think it is pretty ... it is not nearly routine even in the most advanced places, but this stuff does not come cheap and it is only appropriate to certain procedures. The robot is not very good at moving around. It is pretty good at the prostate, where everything is in a little bit. If you are doing emergency surgery, I am not sure how well it copes when things start going wrong.

The Deputy of St. Ouen:

Given that we are a small Island with 100,000 people population, is there any concern about attracting appropriate consultants?

Chair, Clinical Directors Group:

Yes, there is always concern about that. We have been very lucky in that the N.H.S. (National Health Service) is in sort of meltdown, so we have been able to attract good consultants.

The Deputy of St. Ouen:

Given that there will be improvements within the U.K. in the next 4 or 5 years, let us say ...

Chair, Clinical Directors Group:

Why do you think that?

The Deputy of St. Ouen:

One would hope that in the same way that we looked to improve our health services, I am sure the U.K. must be wanting to do the same for theirs.

Chair, Clinical Directors Group:

I am sure they would, but they are lost.

Deputy J.A. Hilton:

They are given too much money.

Chair, Clinical Directors Group:

They are lost.

The Deputy of St. Ouen:

So you believe it will remain in meltdown?

Chair, Clinical Directors Group:

I think it is going to remain in meltdown for quite a long while to come yet, and that is why we have been able to attract great consultants from the U.K. recently.

The Deputy of St. Ouen:

So you do not see that situation changing?

Chair, Clinical Directors Group:

Well, it will eventually, but that might be 10 years' time, 20 years' time.

The Deputy of St. Ouen:

Right, so what consideration is being given to dealing with that particular situation if it arises?

Chair, Clinical Directors Group:

None at the moment. If we have to ... it is the marketplace, is it not, at the end of the day. We may need to increase working conditions, salaries, something like that, if we want to continue to attract, but at the moment we are lucky, because the U.K. is stony broke.

[13:00]

The Deputy of St. Ouen:

But before the meltdown we had significant difficulty attracting consultants.

Chair, Clinical Directors Group:

I think that we went through a period where it was much more difficult. We advertised for jobs where we got very few applicants, but that is not happening at the moment.

The Deputy of St. Ouen:

But that is something we need to be prepared for?

Chair, Clinical Directors Group:

Yes. The question is how long is it going to be before England turns around? I do not think it is in the near future.

Deputy J.A. Hilton:

It depends if the Labour Party gets in.

Chair, Clinical Directors Group:

What, are they going to fix it?

Deputy J.A. Hilton:

No, they like spending money.

The Deputy of St. Ouen:

Most of our consultants come from England, do they?

Chair, Clinical Directors Group:

Most of our consultants do come from England. There is no reason why we could not advertise in Australia ... well, anywhere. We could advertise anywhere we like, and in fact, the B.M.J., it goes around the world, so when the advert is in the B.M.J. it does get to everyone.

Senator S.C. Ferguson:

Especially since it is online and you could start specifying which area you want to work in.

Chair, Clinical Directors Group:

We have inquiries from all over, Canada, Australia.

Deputy J.A. Hilton:

Can I just ask you what evidence you believe is available from the Intermediate Care Pilot to demonstrate that it can replace any parts of a hospital stay and by how much?

Chair, Clinical Directors Group:

I do not know of any real hard evidence. I do not think there is any hard evidence so far. Certainly all the White Paper and steering group meetings that I go to, my main input is to say: "What are you going to put in place to measure the effect of this to make sure that the money we are spending is worthwhile?" Sometimes that is very difficult. I have been told that they think - but nobody really knows - that not this winter just gone, the winter before, when the norovirus was a big problem, that if that Intermediate Care Pathway Pilot had not been in place, we would have had more problems in the hospital. Pretty nebulous, but it is very important, and as I said, I am a pretty acute surgeon, not a community-type based physician. My main input has been to say: "Look, you have got to put stuff in place to measure the outcomes of this because you are spending a lot of money that might have been spent on something else and you have got to make sure that it is doing what it says on the tin."

Senator S.C. Ferguson:

Yes, because it is not just money outcomes, it is patient outcomes.

Chair, Clinical Directors Group:

Yes, both. Yes, we are spending a lot of money. You have got to make sure it does what it says on the tin. The money spent has got to have some effect on the patient outcomes, yes.

Senator S.C. Ferguson:

Yes.

Chair, Clinical Directors Group:

I do not mean you measure the money outcomes. The money has been spent. You have got to measure the patient outcomes to make sure it has been well-spent.

Senator S.C. Ferguson:
Whether there is a cost benefit.

Chair, Clinical Directors Group:
Yes.

Senator S.C. Ferguson:
As I say, Helen, your Managing Director, should know quite a bit about that because she was at Plymouth when they redid the Stroke Department.

Chair, Clinical Directors Group:
Yes.

Deputy J.A. Hilton:
Finally, I would just like to ask you what evidence is the Acute Services Plan providing about the scale and nature of demand for hospital services going forward?

Chair, Clinical Directors Group:
Say that again?

Deputy J.A. Hilton:
The Acute Services Plan.

Chair, Clinical Directors Group:
Yes, that is the thing that we are doing at the moment. We have to work out what we need to ...

Deputy J.A. Hilton:
Right, okay. We wanted to know what evidence is the Acute Services Plan providing about the scale and nature of demand with hospital services going forward?

Chair, Clinical Directors Group:
It is mainly about the demographics, how the demographics are changing and how we are going to get the percentage of population that is going to be older and more in need of medical care is going to go up, there is a higher percentage of the population, there is going to be less people in work paying for the care for a large number of people who hopefully are going to live a bit longer, their joints are going to break down more often, they are going to need more orthopaedic surgery, they are going to need more prostate surgery, they are going to need more urological surgery,

they are going to need more of everything because they are all going to live longer and they are not going ...

The Deputy of St. Ouen:

You are just focusing on the ageing population rather than a growing population, is that what you are saying?

Chair, Clinical Directors Group:

Yes, mainly ageing population, because the other way to approach it would be to say: "Well, our diseconomies of scale are so great that we can change the whole melting pot by saying, 'Well, can we have more than 100,000 people on this Island? Can we have 200,000 people on this Island?'" because once you get to 200,000 people, that is what things are made for in health. Most hospitals in England run for 250,000 people, so if you had 200,000 people living here, you could really seriously ... you know, a LINAC (Linear Accelerator) becomes a really viable proposition. Can 200,000 people fit on this Island? I do not know. That is a political decision, is it not?

Deputy J.A. Hilton:

Just to round off, this is a personal view, your personal view on how you feel about the health service as it currently stands and its future. Are you confident about the future?

Chair, Clinical Directors Group:

Yes, I am, I am. I think that people are working hard to try to improve the access to care to people and improved quality of care. Certainly my role within that for the last year and a bit has mainly been about revalidation and appraisal to make sure that all our doctors keep their licences. N.H.S. England came on Friday, so I had to change my date. They were here on Friday. I think they went away pretty impressed. They thought they were going to find a real backwater with us miles out of date, not running the proper systems. They looked at all our systems and they thought some of the stuff was really good. They really liked the fact that our private patients are in the same hospital as the public patients, they are not shoved away somewhere else, and they thought that was better for the public and private patients, because the people are onsite. But they thought it was good. I think we are lucky that we are trying to expand health services, rather than the U.K. is trying to cut back on what they spend.

Deputy J.A. Hilton:

All right, thank you very much indeed for coming this morning.

Chair, Clinical Directors Group:

A pleasure.

Deputy J.A. Hilton:

Thank you.

[13:06]