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Health and Social Security Panel

Proposed Budget 2026-2029

Witness: The Minister for Health and Social Services

Wednesday, 15th October 2025

Panel:

Depuy L.M.C. Doublet of St. Saviour (Chair)

Deputy J. Renouf of St. Brelade (Vice-Chair)

Deputy P.M. Bailhache of St. Clement

Deputy L.K.F. Stephenson of St. Mary, St. Ouen and St. Peter

Connétable K. Shenton-Stone of St. Martin

Deputy C.D. Curtis of St. Helier Central (Vice-Chair, Assisted Dying Panel)

Witnesses:

Deputy T. Binet of St. Saviour, The Minister for Health and Social Services

Ms. H. Cunningham, Director of Finance

Mr. M. Carpenter, Health Chief Information Officer

Mr. P. Bradley, Director of Public Health/Medical Officer of Health

Ms. R. Johnson, Director of Health Policy

Ms. J. Hardwick, Director of New Hospital Facilities Programme

Ms. D. Raffio, Deputy Director, Public Health Transformation and Commissioning

[11:55]

Deputy L.M.C. Doublet of St. Saviour (Chair):

Good morning, everybody. We are the Health and Social Security Scrutiny Panel, and this is a public hearing with the Minister for Health and Social Services on the proposed Budget 2026-2029. I am Deputy Louise Doublet, I am the chair of the panel. I will let my panel introduce themselves.

Deputy J. Renouf of St. Brelade (Vice-Chair):
Deputy Jonathan Renouf, vice-chair of the panel.

Connétable K. Shenton-Stone of St. Martin:
I am Karen Shenton-Stone, Constable of St. Martin, a member of the panel.

Deputy P.M. Bailhache of St. Clement:
Deputy Philip Bailhache, a member of the panel.

Deputy L.K.F. Stephenson of St. Mary, St. Ouen and St. Peter:
Deputy Lucy Stephenson, a member of the panel.

Deputy L.M.C. Doublet:
We also have an additional member today.

Deputy C.D. Curtis of St. Helier Central:
I am Deputy Catherine Curtis. I am the vice-chair of the Assisted Dying Panel.

Deputy L.M.C. Doublet:
Deputy Curtis is joining us for some questions on assisted dying at the beginning of the hearing and then she will be leaving after those questions. Minister, welcome to the hearing. Could you introduce yourself and your officers, please?

The Minister for Health and Social Services:
Deputy Tom Binet, Minister for Health and Social Services.

Health Chief Information Officer:
Martin Carpenter, Health Chief Information Officer.

Director of Health Policy:
Ruth Johnson, Director of Health Policy.

Director of Finance:
Hazel Cunningham, Director of Finance for H.C.J. (Health and Care Jersey)

Director of Public Health/Medical Officer of Health:
Peter Bradley, Director of Public Health/Medical Officer of Health

Deputy L.M.C. Doublet:

I know that you have some additional officers so, as and when those additional officers come to the table, please ensure they introduce themselves before they answer any questions. Thank you for making time to come to the hearing today, everybody. We have until 1.40 today and, as always, lots of questions to get through so we will try to keep it at pace. Minister, your proposed budget is the highest ever set for your department at £381 million. Do you feel confident, if that amount is approved, that that would be adequate to ensure that Health Services can run smoothly, resolve issues around waiting times and provide the care that Islanders need?

The Minister for Health and Social Services:

Am I entirely comfortable with it? No, I have to be honest I am not, but I am very grateful for the fact that we are going forward into the Budget debate with the numbers that we have got in place. I do think, and I do not mind saying, it is the bare minimum. To the extent to which you can actually reduce all the waiting lists I am uncertain, and I am grateful that you are asking these questions at the beginning to set the context. Because I think it is important that you know and that the public know that some of the headlines that have suggested that we are getting an extra £60 million simply are not correct. Hazel will go into some of the detail but, in principle, I think members of the panel will know that for a number of years the budget that we have started with is not the budget we have finished with, and the Assembly has voted to put money through to bring that deficit up. I have referred to that all the way along. It is not an overspend but an underfund. Now, as I think has been accepted, our deficit this year is lower than last year and lower than the year before. It is coming in at around a projected £12 million but it has been accepted that we cannot keep running that deficit just to provide the core funding that is not dealing with the waiting list. So I am very grateful that that now has been accepted into core funding. That is going to be made good, and the plan is that that extra £12 million will be there next year. What I had referred to all the way through in the Assembly meetings as a baseline funding will roughly represent something that gives us an odds-on chance of finishing the year just about breaking even so we do not have this constant talk about overspend. But if you take that assumption, add in the fact that this year we are going to get a funding formula that is not 2 per cent above inflation but 3 per cent, that will give us an extra £3.6 million. We are looking for an extra £12 million; £4 million for preventative health and £8 million for digital. That ongoing number relies on £9 million worth of savings. If we achieve those savings, we come out with an extra £15 million. But, as I say, that relies on saving £9 million. So in terms of real additional money, we are not talking of a great deal. The effect of long-term care, I think, is going to take away over half a million pounds net of that additional money, and to come in within the £12 million deficit we are probably going to have to push about £1 million worth of spending into next year.

[12:00]

If we wanted to absorb that and finish the year without pushing £1 million in the year after, that is £2 million next year that will be taken up with that additional money. So if we are going to look after digital and preventative work and spend that money where it needs to be spent, and I can guarantee that will be ring-fenced for that, we start the year not far off just having the money we need to come in with our deficit. Far from these figures of £60 million that have been claimed, it really is not that figure. There is a key issue as well that gave rise to that, is we transferred ambulance and some other services in, which transfers £22 million. It has the appearance of being a much bigger number, but it includes an awful lot of different things that are not explained in the press. If the press are listening, I am very happy to brief them separately so that the public have got a very clear view of what we have got and what the expectations are for us going forward against that sum. You asked the question: how confident am I? We have not just won a huge international lottery that is going to put everything straight. We will be in a much better position than we are now, but we will still be very tight. I hope that provides a picture. I do not know if, Hazel, you wanted to add anything to that.

Deputy L.M.C. Doublet:
I will just follow up, and I might come back to you in a minute. Thank you for that detailed answer.

The Minister for Health and Social Services:
Sorry. I am grateful for you giving me the opportunity to explain that.

Deputy L.M.C. Doublet:
Thank you, Minister. Will the standard of care overall be maintained or increased or decreased?

The Minister for Health and Social Services:
I am hoping, because I think we have got a good team together and a very clear vision, that things will continue to improve. I think that can be achieved, to be fair.

Deputy L.M.C. Doublet:
Okay, thank you. In terms of the underfunding, as you have described it - and you have mentioned several different figures - the additional money that you are asking for to address this, is that money just going to plug the gaps, as it were, or have you done a piece of work to understand at a base level what each service needs within your department?

The Minister for Health and Social Services:

No, what I have tried to explain ... as I say, it is difficult to get your head around those numbers. It is all very well for me explaining them, but we spent some time going through to make sure we are sure of them. That is why I am happy to do a separate briefing if you wanted to go through it at a later stage. But really, all we have got for standard funding is the money we need to deliver what we have been delivering next year without running a deficit. That is about where we are.

Deputy L.M.C. Doublet:

So it is plugging a current gap?

The Minister for Health and Social Services:

Well, it is basically accepting the additional £12 million that we are getting is accepting that we cannot keep starting the year without enough money and then filling the gap. What we are saying is accept that as baseline funding and then we will work very hard to try and finish the year without a deficit. Now we will be getting the £4 million and the £8 million, and that money over a 4 to 5-year period will prove progressively more useful to Health and improving matters over the course of time. We are going to cover digital, and I am not going to steal everybody else's knowledge, they know much more about this than I do, but where we are from a digital point of view, we start from a very low base. So over the 5 years our objective is to have a first-class health service to move into a first-class hospital, when the hospital opens. So we have got that period of time, we have got the money that we need to build up the digital provision to, I think, a really decent level, and the progressive application of £4 million per year for health prevention, it will be sort of an exponential gain as you go forward. When you put that money in at the start, it is not going to make a huge difference in year one, but by year 4, year 5, you will really start to see benefits from both of those investments. So I hope that makes sense in terms of setting the context.

Deputy L.M.C. Doublet:

It does, thank you.

Deputy J. Renouf:

Just to pick up on your point about whether it is an overspend or an underfund, would you say that you will be able to stop referring to the Health Service as being underfunded as a result of this budget?

The Minister for Health and Social Services:

Yes, I am hoping that we are going to change the narrative and that with some real effort we can come in with a balanced budget. But, as I say, there are lots of other things going under the surface. There are quite long waiting lists in certain areas and that this sort of money does not allow us to

savage those things and really bring them down. We can bring them down over the course of time, gently as we go.

Deputy J. Renouf:

Is the Health Service going to still be underfunded after this Budget?

The Minister for Health and Social Services:

Unless we had a massive windfall you could argue that every health service around the world is always going to be slightly underfunded. It is a case of what can we tolerate as a society, what can we tolerate as an Assembly, what is appropriate, bearing in mind that you cannot give everybody everything they want all the time. Those are very delicate balances to strike, but that is the job that we have got. I think, to be fair, if we can get this through we will be making some real progress.

Deputy J. Renouf:

The chair has pointed out and got from you the information that this is plugging a gap rather than a rebasing of Health spending. What is the long-term plan for financing Health?

The Minister for Health and Social Services:

This is more than plugging a gap. We live in a real world. We are already going some to be asking for the money that we are getting. We are very grateful for getting it. I think this is a rebalancing, but it does not take us to ... it is not a delivery to health paradise, if you like. It puts us in a good strong position to make real progress. In the real world, I think that is probably as much as we can ask for at this point in time.

Deputy J. Renouf:

The Budget makes reference to this funding being pending or being before work on sustainable health funding, so what is the long-term plan?

The Minister for Health and Social Services:

There has been much talk of this. I think there was an item from a clinician in the paper. Sir Philip made some comments recently at a party meeting, and all quite correct that we need to be looking at where money is coming from. Our view is that that work has to take place starting next year, but what the Health Service cannot do is wait for that work to be done to introduce charges in 2027 or another tax, whatever it might happen to be, and I am not pre-empting anything. What we need to get the job done is some money ... we need to put our hands on some money now. That is why we are putting our hands in the till and saying let us get on and get the job right. I think it is difficult to say to people you want more money to fund their health service if there is no clear plan to put it straight, and you are not starting to show signs of delivering a slightly better service. I think we have

got to have people's confidence that we are going in the right direction before we start looking anywhere from the public for extra money. I do not know if you would agree, I just think that is a sensible course of action.

Deputy J. Renouf:

I think what I am just trying to ascertain is, is there definitely going to be a piece of work done next year that will look at sustainable health funding, in other words a long-term basis for funding healthcare?

The Minister for Health and Social Services:

Some of that has already started, yes, and as we go forward that is going to be a major focus. It has to be.

Deputy J. Renouf:

Any idea of how long you would expect that to take?

The Minister for Health and Social Services:

Ruth, I am not sure, I do not know if we have got a set timetable even, have we?

Director of Health Policy:

So we have started some work, we are working with our Treasury colleagues on modelling what we think our healthcare costs will be in future, taking account of the general cost of health inflation, so increased costs of drugs and treatments but also the ageing population. But in addition to the ageing population, changes in disease prevalence, because even people of middle age and young people, more of them are living with more disease.

Deputy L.M.C. Doublet:

What are the timescales on that work?

Director of Health Policy:

We are actively doing the modelling work at the moment. We are hoping that within the first few months of next year, that modelling work will enable us to understand what the future costs of health and care will be as a percentage increase on current budgets. Once we have got that figure, we will then need to start exploring what the options are for plugging the size of that gap.

Deputy L.M.C. Doublet:

Will that be ready then for whoever the next Minister for Health and Social Services is for the next Budget?

Director of Health Policy:

That is absolutely the plan, that we understand the scale and the size of the problem before the elections, in order that the incoming Council of Ministers have got 4 years to address the issue of how we fund our health system moving forward. We do not know what that solution is going to be at the moment, and one of the reasons we do not know what that solution is going to be is that we do not have a forecast for future expenditure that everyone is confident with at this point in time.

Deputy J. Renouf:

So the Health budget since 2022 has gone up £150 million, £149 million, some of which I granted is moving in ambulance services, and inflation accounts for some of that, but not by any means all of it. You are confident with this £15.6 million extra a year that you can put a cap on that and we will now just see inflation plus 3 per cent going forward?

The Minister for Health and Social Services:

We are looking at that 3 per cent formula to decide whether that 3 per cent formula is appropriate, and probably best that Hazel gives a bit more information.

Director of Finance:

Thank you. Following on from what Ruth has said, that is the work that the working group are looking at, at the moment, in terms of modelling, so what is appropriate. Some initial work, indicative work, was done that indicates that that figure should be higher but it needs fully testing, and that is the work that both Health colleagues and Treasury colleagues are doing together so that we can make sure that we are kicking the tyres and everybody is really confident about how we have built that model. That the factors that have been included are relevant and that we have got the data sitting behind it. That is what we will bring forward, as Ruth has mentioned, to the new Council of Ministers next year.

Deputy L.M.C. Doublet:

When does that work start?

Director of Finance:

It is really weeks. What we have been doing is continuing the work that was started as part of this Budget proposal preparation. Going back to your other question, we have got data sitting behind the £12 million deficit that we are forecasting at the moment, and that is supporting the additional investment that was within the proposal. We have got broad areas identified within there, which are creating those pressures, where it is difficult to control expenditure, as you have probably heard and read in other reports that we have done. For example, tertiary care, referrals over to the U.K. (United

Kingdom) is a significant pressure. Those packages of care are quite often hard to predict, and we are subject to inflation increases within N.H.S. (National Health Service) trusts, mental health packages, just single packages can be very expensive, complex care. There are those areas that are difficult for us to predict and manage, as well as other pieces of work that we have been doing. There are a number of key areas. The Minister mentioned also the implications of long-term care benefit increases, which impact on the Health budget, where we top up packages of care. There have been significant costs there. There are a range, and that will feed into the ongoing work that we will bring forward next year.

Deputy J. Renouf:

This is being done alongside a health strategy, because obviously some of the things you could do, you might go and put more care in the community, which might reduce costs. How does this interact with a strategy for how we are going to treat people into the future?

The Minister for Health and Social Services:

I am always interested when people refer to "strategy". I think we have got a strategy on the move at the moment, implementation of a partnership board which is going to give us the means by which an operational strategy can be developed, sorting out the core funding. They are looking for additional funding to get digital underway and to get health prevention underway. Unless you have got these cornerstones and foundations down in your health service ... you said: "Why do we not have a strategy?" Well, what would we base a strategy on? If nothing is digitally connected, you are not doing any health prevention work, you have not got the right funding and you have not got the means to actually do anything. It is like saying you are going to go on a journey in a car and you are planning the journey and booking the hotels, you have not got a car. What we are trying to do is ... our strategy at the moment is to get the ship in shape, as it were, so that we can actually then say, right, where do we want to fine-tune the delivery of this. I think the Partnership Board is going to be quite fundamental in terms of not just the board itself but the subgroups that we are going to develop for each speciality that bring people into the room from the whole of the health journey for each section to actually define that. That is work to come but, as I say, let us get the foundations down before we do that.

Deputy L.M.C. Doublet:

Thank you, Minister. A general question which has arisen this week after some reporting on safe working hours, and in the context of the Budget, could you give us some detail as to whether there have been any changes made to how your department employs staff as a result of attempting to make savings. For example, a decrease in bank staff, was that an attempt to make savings?

The Minister for Health and Social Services:

No, we are trying to get more permanent employees in place because they are cheaper, the whole system is more reliable. That is a different exercise. I am just looking around and wondering why we have not brought Stephen James, our H.R. (human resources) director with me because he has been doing the work on this and, to be honest with you, the amount of other stuff that has been going on ... I know that has been in the news, and I have to say that I have not been able to put any particular focus on that just through simple lack of time. But I know that in Stephen we have got a very reliable H.R. boss, and I think he is doing a good job. I am comfortable that whatever problems have arisen he will get to grips with them.

Deputy L.M.C. Doublet:
Okay. Is that something that you could look into and get back to us, given the importance ...

The Minister for Health and Social Services:
It is on my agenda. I am hoping to have that discussion with him tomorrow. We do meet on a Thursday afternoon. It is on the agenda.

Director of Finance:
You will be aware we have a financial recovery plan, which has numerous streams of work. There are a number of streams that look at our pay-related costs and how we make best use of our resources. As the Minister has said, there has been a really big push on permanent recruitment, moving away from the use of agency and using bank where it is appropriate and over time. We have made really good progress actually. In terms of the current forecast and our use of substantive staff over time and agency, we have made really good progress in balancing that budget, using that mix of substantive and temporary staff where we need to. Particularly in nurse recruitment, we have made great strides forward in nursing recruitment. We have still got a pipeline of new appointees coming through until the end of the year, so we would expect vacancies to be falling further in nursing.

[12:15]

There is still some more work to do around use of locum doctors, and that is part of the work that we have been doing as well in terms of how can we effectively use, whether it is locums, whether it is bank, how can we do that in the most cost-effective way? There has been a significant focus this year across the department in those areas.

Deputy L.M.C. Doublet:
Is the well-being and the safety of the staff and the patients as important in the decision-making as the saving money?

The Minister for Health and Social Services:
More.

Director of Finance:
Yes, any consideration around savings, there would be a quality impact assessment that would be conducted as part of that. If it was affecting staffing, there are ratios of staff to patients, for example, that are obviously followed.

Deputy L.M.C. Doublet:
Thank you. Minister, I think you said that it is more important, which is good to hear, so will you be taking on board those recommendations from the safe working hours guardian?

The Minister for Health and Social Services:
Indeed. As I say, it is up for discussion tomorrow afternoon and we will be going through that very thoroughly.

Deputy L.M.C. Doublet:
Okay, thank you. We may come back to some of these areas as we touch on the different sections of the Budget but I would like to go to Deputy Curtis, who is my vice-chair, on the Assisted Dying Panel, and she has some questions around assisted dying.

Deputy C.D. Curtis:
Thank you. Minister, within the growth allocations table it shows that the estimated funds for assisted dying go from £525,000 in 2026, £727,000 in 2027, £688,000 in 2028, and £718,000 in 2029. Could you please outline how these funds were forecast and the reason they go up and down over the span of the budget.

The Minister for Health and Social Services:
I am going to hand straight over to Ruth, who has got the answer to all of that.

Director of Health Policy:
Yes. As we have been very clear about the assisted dying budget, so the budget that is in the Government Budget is exactly the same as the budget that is set out in the report and proposition for assisted dying. We are very clear that at this point in time it can only ever be an indicative budget based on best possible predictions that we have been able to make. Because we quite simply do not know the numbers of people who will request an assisted death, the numbers of people who have an assisted death. We also do not know about the complexity of those cases and therefore

the numbers of hours staff each case will take. We have done some projections around that. But the way that the Budget works is, as you know, we are assuming that the States Assembly agree the law in January next year. We are anticipating an 18-month implementation phase. So the budget for the 18-month implementation phase is the 2026 and half of the 2027 figures. That is the money that is required to do things like bring in a project manager to support us to stand up what is a novel service. It is to do things like develop the training package that we need, so we will have to develop a bespoke training package for assisted dying, the cost associated with that,. It is the costs associated with training the staff, it is an allowance for recruiting staff, for the development of all the guidance. In the 2026 and half of 2027 budget what you have got is you have the costs associated with standing up the service, and then in the 2027 budget we are working on the assumption and prediction that people will start to request assisted deaths partway through 2027. So in 2027 you have still got some implementation costs but you are starting to see, coming through the costs, the staffing costs associated with people making requests and people having assessments and people accessing counselling support for assisted dying. We then move on to 2028 and 2029 in the budget, and the costs in 2028 and 2029 are almost all related to the provision of the service. There is a core amount of costs that is related to audit, oversight and governance of the service.

Deputy L.M.C. Doublet:

What is that figure for the core costs?

Director of Health Policy:

Sorry, I cannot ... it is a complicated budget, I would have to send that to you separately. Then you have got people coming through for those assessments. What we are anticipating will happen, because this is what has happened to assisted dying services in other jurisdictions, is that the numbers of people requesting an assisted dying in the first 12 months is relatively small, but over a period of time the numbers of people requesting assisted deaths increases as more people become aware of the availability of an assisted dying service. The reason why you see that increase from 2028 to 2029 is we are working on the principle that we will have more people requesting assisted deaths and therefore more staffing costs.

Deputy C.D. Curtis:

My next question was going to be asking you about the costs in 2026, but you have mentioned about training, bringing in a project manager, and so on. You are saying that 2026 and 2027 includes a lot of setting up costs?

Director of Health Policy:

Yes, it does.

Deputy C.D. Curtis:

Could I just ask, when you mention about training, has there been much research done on how much training will be available in the Island? Here or will people have to be sent away for training?

Director of Health Policy:

The way that we are envisaging that the training will be done is that we will develop a training package, a bespoke training package, that is delivered on-Island for assisted dying practitioners. You may recall that in order to be an assisted dying practitioner, to be registered as one, you have to go through mandatory training. What we are talking about is the mandatory training package for the Jersey assisted dying service, which will be different to any assisted dying training delivered in other jurisdictions because it will need to reflect the law and the requirements of the law. So it will be on-Island training and we will very shortly, within about the next 2 weeks, be lodging an addendum to the assisted dying report and proposition, which provides a lot more background about how the training will work. It will be a mixture of online modules but also face-to-face training, including scenario training, et cetera.

Deputy P.M. Bailhache:

One can understand that with a new service it is very difficult to understand what funding is going to be required. But some funding has been allocated, I understand, or the panel understands, from the Central Reserve. I wondered if you might tell the panel how much funding assisted dying has been allocated from the Central Reserve Fund?

Director of Health Policy:

I am afraid that is a ... I can talk to you about the assisted dying budget, but I do not know the detail of how the Treasury have made decisions about the allocation through from different parts of government money.

Deputy L.M.C. Doublet:

Perhaps the Minister could answer.

The Minister for Health and Social Services:

To be honest I cannot cast any light; that would be a question for the Minister for Treasury and Resources, I am afraid.

Director of Finance:

It is not allocated to us yet.

Deputy L.M.C. Doublet:

Would you like to answer?

Director of Finance:
In the Budget proposal it states that the assisted dying money is being held centrally. So at the moment it is not sitting in the Health allocation. Once it is agreed and once the work continues then we would draw that down from the Central Reserves. So it is being held centrally by Treasury at the moment.

Deputy L.M.C. Doublet:
Just one small follow-up question related to something that you said about the training. We noticed in the legislation, and when we have been scrutinising it, that the training ... I think it was in the appendix to the report, the training would be renewed every 3 years.

Director of Health Policy:
Yes.

Deputy L.M.C. Doublet:
How does that compare to other jurisdictions? Is that shorter or longer or standard?

Director of Health Policy:
So lots of other jurisdictions that provide for assisted dying do not have any requirements relating to their training established within their legislation, so our law is different on that extent. In terms of the renewal of training, we have looked at what they do in some of the Australian states, where they often have mandatory training, but it is not necessarily enshrined in law. The periods of renewal tend to be between about 3 and 5 years, and we have gone for the shorter timeframe.

Deputy L.M.C. Doublet:
Thank you, that is helpful. Any more questions on assisted dying? Thank you so much for joining us, Deputy Curtis. We are going to move on to ...

Deputy J. Renouf:
Did you not want digital dealt with?

The Minister for Health and Social Services:
No, it was the health deficit. The funding, we wanted to provide the context.

Deputy L.M.C. Doublet:
Are you happy to go to ...?

Deputy J. Renouf:
The new hospital?

Deputy L.M.C. Doublet:
Yes. So we have some questions ... thank you for your answers.

Deputy J. Renouf:
Actually Jess is not here so we might as well wait.

The Minister for Health and Social Services:'
She said she was coming as soon as she could.

Deputy L.M.C. Doublet:
Deputy Stephenson, are you happy to begin your section on the health system digital foundation.

Deputy L.K.F. Stephenson:
Minister, you have already touched on it and said that the cost of Digital Health stated in the Budget is £8 million year on year. Is this figure adequate and how certain are you that the plan can be delivered within this funding allocation?

The Minister for Health and Social Services:
A number of things that are reasonable obviously; it is a lot more than we have got at the moment. I have to be honest, in an ideal world I think we could have done with a little bit more but in terms of what can and cannot be delivered it is much easier if I hand straight over to Martin who has got a very comprehensive view of that.

Health Chief Information Officer:
The Minister asked us to develop a plan that would enable better delivery of healthcare through the introduction of digital technology, so that is both the technology and more integrated data. We produced a plan that we then circulated and went with to Treasury colleagues, which was just over £70 million over 5 years, and it consisted of 5 elements within that plan. There is an element that is to do with implementing something called e-referrals, which allows the electronic transmission of patient data, referral information from G.P. (general practitioner) practices to acute practices and off-Island as well, and for that information to come back as discharge information so there is a really good flow of information around the system. Currently that happens in a very ad hoc and sporadic manner. It also allows us to put in place e-prescribing that gives better patient choice in terms of how medication is supplied across the Island. The second element is to create a single patient

record based upon technologies that are used in very well developed digital economies such as Estonia, Slovakia, technologies also used extensively in the U.K. in London. The third element was to create a digital storage for documents. Jess will tell you that in the new hospital facilities programme there is no room for any analogue documents, so the old folders that contain patient notes, so we are going to have to digitise that. The fourth element was what we call Get Smart, where we are able to take information from various remote monitoring devices. That allows us to develop virtual wards and remote monitoring, so allows us to do more in-community care and provide preventative services in terms of if we can see that someone is becoming unwell have treatment in the community rather than allowing people to become more unwell and then take them into hospital. The fifth element was for an advanced analytics platform. What we have done is we have said we can afford to deliver the first 2 elements of that plan, and because our colleagues in Digital Jersey have done an award to Family Nursing there is an element within step 4, which is the Get Smart platform, that we are also able to make progress on. The remaining budget of £30 million-odd would pay for those other elements that we were unable to deliver as part of the initial programme, but I am confident that within that we are able to deliver our commitments.

Deputy L.K.F. Stephenson:
So although the first 2 are only covered in that £8 million a year you are saying that other areas are going to cover the other 3?

Health Chief Information Officer:
No. Digital Jersey have made an award that allows us to get on with the Get Smart platform but the document management system and the advanced analytics platform are currently excluded from our plans.

Deputy L.M.C. Doublet:
Can I just ask for clarification? Can you just give us the heads of each of those sections? So e-referrals was the first one.

Health Chief Information Officer:
So e-referrals and e-prescribing and we also need to get hold of N.H.S. numbers.

Deputy L.M.C. Doublet:
So is that the third thing?

[12:30]

Health Chief Information Officer:

So that is as part of step one. The second one is a single patient record.

Deputy L.M.C. Doublet:

So e-referrals and e-prescribing with N.H.S. numbers is your first thing?

Health Chief Information Officer:

Yes. Number 2, single patient record, number 3 is the document management system. Number 4 is the Get Smart platform and then number 5 is the advanced analytics platform.

Deputy P.M. Bailhache:

Does this embrace primary care as well?

Health Chief Information Officer:

It does. We are taking a whole system approach, so very much how as a system are we going to work and improve flow. What I recognise is we are a small community and what we cannot afford to do is have multiple platforms doing the same thing. Irrespective of whether they exist in private provision of healthcare or public provision of healthcare we need to make or figure out commercial arrangements where we can have single platforms that are for use across the community to make things really effective.

The Minister for Health and Social Services:

Just as we were saying from a political point of view, Martin's remit is very clearly not just to deal with H.C.J. but to be part of the overarching department of the board and link up every element of healthcare.

Deputy L.M.C. Doublet:

So would that include health visitors, for example?

The Minister for Health and Social Services:

Whichever. Tertiary care connections to charitable provision, the job is to link up the whole. That is part of the beauty of having an overarching department for the board that deals with Health as a complete provision rather than this sectionalised approach that we have had to date. The other thing - I hope you do not mind me barging in and making another political statement - to be honest in year one it would be difficult to have spent more than £8 million; I think that is probably safe to say. We are comfortable we can spend that £8 million. We probably could not have spent much more because we hit the ground running in January but I do not know what is going to happen from a Ministerial point of view when we come to the next Assembly, but whoever sits there I would urge them strongly to perhaps look at trying to build up the funds for digital because I think proper digital

connectivity and having all the bells and whistles and introducing A.I. (artificial intelligence) and all the rest of it is going to be what is fundamental to make us more efficient. I think there will be an argument for increasing that £8 million by a few more million over the course of time because it is only through being efficient that we can bring our costs down.

Deputy L.K.F. Stephenson:

I am going to come back to that point in one minute and ask for a follow up on that, if that is okay, but just before we move away from it, the Get Smart programme with Family Nursing and Home Care that they are now, will you still be linking with them to ensure that it is all working together?

Health Chief Information Officer:

Absolutely. I am working very closely with F.N.H.C. (Family Nursing and Home Care) and also Digital Jersey in terms of making sure that this is an integrated Island approach. In fact when the technology was chosen, Digital Jersey asked me to scan through and make sure that I was satisfied that the appropriate technology was chosen. I want to add that this is not only about efficiency; this is about patient safety. In the hospital we record an average of about 80 patient safety incidents a month as a result of fragmented data, and when I have talked to colleagues in primary care they say: "Yes, but you are not recording any incidents in primary care as a result of that fragmented data, nor are you when you are talking about domiciliary care and secondary care provision" and having that integrated view of Islanders' health is going to be instrumental in reducing those numbers of incidents.

Deputy L.K.F. Stephenson:

When you say it is 80 incidents, can you give us an example of what an incident is?

Health Chief Information Officer:

We have had incidents whereby we have had "do not resuscitate" on a patient record but because people are not aware of the patient record people have been resuscitated. That is an extreme example. We have had other examples where referrals have come in and people have not known exactly about the medical history, issues to do with allergies and reactions to drugs and medication are not being flowed through the system, so they all create issues in terms of safety. In terms of efficiency, what I have been told by some of the big consultancies is we can expect to see a 15 per cent to 20 per cent improvement in the efficiency of people who work at a cross-system level in the provision of health and care. That is definitely not saying we can reduce our workforce by 15 per cent to 20 per cent but we can certainly improve the quality of care that we are giving to Islanders.

Deputy L.K.F. Stephenson:

Thank you, which brings me nicely back to the follow-up question I was going to ask you, Minister, about the projected cash releasing benefits of this type of investment. You have talked about a 15 per cent efficiency saving. Have you done that work?

The Minister for Health and Social Services:

I do not think we can look at this from a cash-releasing benefit point of view. I made the mistake of not mentioning patient care being central to every single thing we do. When I talk about efficiency it is efficiency that is going to mean that the care we give people is more joined up and that when people enter the health service they move more quickly through the system and they do not fall through. A number of issues that I see, a number of complaints that end up in my inbox, and myself and the Assistant Ministers have an inbox full of people complaining about things and very often rightfully so, quite often, in fact more often than I care to think about. It is because people have fallen through the system between the various departments or drifted on to a too difficult list and we have not got the systems to pick these up and keep people's health journey flowing sequentially through the system. What we are trying to do is to shorten that journey to make sure people get in, get properly seen, and that everything that happens to them gets carried through to the next stage. When I talk about efficiency everything that we are doing in all this stuff is centred around patient care, and you make a good point, Martin.

Health Chief Information Officer:

So just to follow up, within our business plan, which is quite a lengthy document, we do have listed quite a lot of benefits that we expect to accrue from implementing the digital plan, both in terms of efficiency and in terms of patient safety. In my mind, digital is an answer to part of the issue that we face and we were talking about earlier, in that gap between demand for health services and the amount of activity that is going to happen as the population gets older, there is more comorbidity, there is more activity, and the ability to service that effectively. It is about bridging that gap as opposed to delivering core, cashable savings.

The Minister for Health and Social Services:

Another thing to point out is that it does link in with health prevention and you can gather data about the effects of what we are doing, the effects of the investment and see that coming through. Everything is interwoven.

Deputy J. Renouf:

The single patient record, we have been working on an electronic patient record system since 2020. There is a C. and A.G. (Comptroller and Auditor General) report on that. Are those 2 things the same?

Health Chief Information Officer:

They are different.

Deputy J. Renouf:

So how are we going to make sure that the single patient record does not fall into the same category?

Health Chief Information Officer:

The electronic patient record that I think you are referring to is the one that went into the hospital to replace TrakCare, which was seen as a risk. That system is designed for use in a hospital rather than as a whole system approach.

Deputy J. Renouf:

Has it been thrown out?

Health Chief Information Officer:

No. It is augmented, so what we are doing is we are taking all of the core systems, so we have the hospital system, we have the community-based systems, which is around E.M.I.S. (Egton Medical Information Systems) so the system that is used by G.P.s, Family Nursing and the Prison Service, and also the system that we are putting in for adult social care and mental health, and all of that information flows into a central repository so that we get a complete 360-degree view of what is happening to those individuals. There is a lot of work that is happening in the background about data sharing and data controllership. As you can imagine, people having access to that data and appropriate and secure access to that data needs to be really well controlled, but that is the architecture. As we accredit new providers of data we will be able to bring data into that process as well, so whether it is from optometry, dentists, hospice, so a much wider variety of data than exists just within Government.

Deputy P.M. Bailhache:

Is this all health service-centric in the sense that it is designed to help medical professionals access information more easily across the board or is it also concerned with the patient? Can I look at my phone and see whether my blood test results are there?

Health Chief Information Officer:

That is a really good point and, yes, the intention is to allow that and, in fact, we are quite a way down the track at the moment in the hospital by implementing a system that will allow people initially to have a look at blood tests, and then over a period of time - and when I say over a period of time, less than a year - we will be able to offer online appointments for people into hospital by using their mobile devices. We do have a little bit of a way to go in terms of working with colleagues in primary

care to allow people to access records and I believe that some practices already do it but the intention is to allow people to access their own medical records because I think that is another important step in people owning their own health as opposed to it being the doctor's problem and understanding what is going on with yourself and owning your own health outcomes. I think it is also going to lend itself to improved and healthy Islanders.

Deputy L.M.C. Doublet:

That is a good question. I wanted to follow up on that in terms of the data sharing. If a patient does not want their data, for example, from a hospital specialist to be shared with a health visitor or a G.P. would it be customisable in terms of permissions?

Health Chief Information Officer:

Up to a certain point. I think it is important to understand that as a health and care professional to give the best possible intervention you need as much information as possible, so certainly within those organisations that are in receipt of public money we would expect by default that health information is shared. For those organisations that Islanders are contracting with on a private basis, then I can completely understand if they would prefer not to have their information shared; and that is custom and practice. If you look across the water in England, Scotland and Wales, that happens by default that health information is shared among providers.

Deputy L.M.C. Doublet:

Could consideration of that be built into this work because certainly from the casework that I have with parishioners, it is something that comes up quite a lot? Given the small nature of our Island there is a hesitancy around people having such … I mean, medical data is the most personal so if that could be baked into this project and that understanding of the Jersey context I think that would be …

The Minister for Health and Social Services:

It has occupied quite a lot of our discussion and we are trying to find the best way to make sure that people get the best care, and some of that is just about information to them because if somebody decides they are going to stop at various points it is likely to compromise the care that they receive.

Deputy J. Renouf:

Will the information be sold at all?

Health Chief Information Officer:

No.

Deputy L.M.C. Doublet:
Even anonymised?

Health Chief Information Officer:
The technology that we are implementing would allow that if it was a decision by the States Assembly to allow that to happen, but I have got no plan at all to sell that data.

Deputy L.M.C. Doublet:
Will it be available to other departments and to Statistics Jersey, so will Public Health be able to analyse the data from that?

Health Chief Information Officer:
Absolutely, and I have been working very closely with Public Health colleagues to make sure that the digital health plan meets Public Health needs as I believe - we both believe - that it is absolutely crucial that we have better and more consistent and reliable data to drive the public health agenda.

Deputy L.K.F. Stephenson:
Just to wrap up on this section, then, if we talk about the standards of systems or whatever, what is the gold standard of digital health and how close or far away will Jersey be in achieving this? Then just as a follow up to that, what is the future plan for the 2 out of the 5 that were missing?

[12:45]

Health Chief Information Officer:
So when I set off on this journey earlier this year I asked an organisation called H.I.M.S.S. (Healthcare Information and Management Systems Society) to come in and do a maturity assessment on how digitally mature Jersey is as a system and they measure between 0 and 7. So the hospital, because of the investment that we have done in the electronic patient record, is currently sitting at 3 and a bit and we are hoping to get that to about 5 over the course of the next 6 months. As a system we are at level 0 and, out of the 26 jurisdictions where they have made that assessment, we are number 26. My ambition is for us to move rapidly up that chain. I do not believe that us hitting level 7 is necessarily something that we should absolutely aim for. I think, though, that aiming for the high levels, the high 5s, 6 level, is probably where we need to be. Just to give you an indication, Middle East countries, which have got lots of money that they are throwing at digital health, are achieving level 7 but they operate in a different world. The second part of your question, what are we doing about the remaining elements; I have been working with Treasury colleagues and they have said that we should resubmit in 2026 for additional funding to fund those elements that we have not been able to get over the line in 2025.

Deputy L.K.F. Stephenson:
If that were to happen and funding was in place for them and those 5 elements happen, would you be confident that you would achieve the ambition of 5 to 6?

Health Chief Information Officer:
I think we would very confidently be hitting level 6.

Deputy P.M. Bailhache:
Which are the jurisdictions in 1, 2 and 3?

Health Chief Information Officer:
Interestingly my ex-colleague at Hampshire and Isle of Wight N.H.S. Integrated Care Board are currently at level 2.5 and that was back in 2023 I think, so they have made improvements since then.

The Minister for Health and Social Services:
Just to say that our current position, I think you would agree, is pretty sobering and that the ambition is for the opening of the new hospital to be as near as we can to level 6. It will require a little bit of money but I hope if people watch the progress of this that they will see that it is well-justified.

Deputy L.M.C. Doublet:
I would like to have some further breakdown on that £8 million but probably not in this hearing. I think we will ask for that in writing as a follow up.

Deputy L.K.F. Stephenson:
Sorry, Minister, just to pick up. So that bit of extra money, if I did my maths right when I think you said … sorry, I do not want to get my maths wrong. You tell me.

Health Chief Information Officer:
£70 million is what we asked for over 5 years and we have got £40 million, if you extrapolate this.

Deputy L.M.C. Doublet:
So it is £30 million?

Health Chief Information Officer:
Yes.

Deputy L.M.C. Doublet:

Thank you. Okay. I think we have finished on the digital health. Thank you for the answers. We will soon come to the questions on the new hospital facilities but we will go first to the Prevention First programme and we will go back to those questions on the hospital. I will give you a chance to get settled. There is £4 million per year in the draft Budget set aside for preventative health year on year. Could you briefly describe how you reached that figure of £4 million and is it considered adequate for everything that you want to achieve?

The Minister for Health and Social Services:

We started from a different place. As you probably know the background to this, we started with a higher number and, as with all politics, you start with what you want and you end up with what you can get, and over the course of the summer and various negotiations we came to a figure of £4 million. I will just state while I can, I am grateful to other Ministers for sitting on the sidelines and watching Health move along with some fairly big increases while they have been restricted. So I am very grateful for that, and I think after explaining everything through I think people sort of understood. But it has been a bit of a difficult journey. What we have got is we have got in the Budget, and I know it has not passed yet, £4 million there now. We had a very ambitious target but …

Deputy L.M.C. Doublet:

Can you just detail how much was the original bid for, for this?

The Minister for Health and Social Services:

This all started a long way back with Project Breakwater and it has gone in different directions, and it was £12 million we were looking for. We are looking at £4 million. The truth is, as with digital, we would have had trouble in year one to spend that sum of money. Once again with the £4 million, we know we can spend it and I think there is an argument for trying to up that sum of money as we go forward but, as I say, these are early days. We had various sessions where we evaluated what we thought if the sums were going to reduce we had a priority list, and what we have ended up here with, with the £4 million we have got, is what we collectively thought was the best way to use that money to prioritise. It has been a process and that is where we have ended up.

Deputy L.M.C. Doublet:

Sure, so the bid was for £12 million and £4 million is what you are asking for in the Budget. Could you or colleagues outline briefly what kind of interventions will be covered under that £4 million, if it is approved?

Director of Public Health/Medical Officer of Health:

I can start. Just the ambition here was particularly underlined by the modelling that we did a bit earlier when the Director of Public Health report showed that people on average have about 20 years of ill health and that would require, in time, in the next couple of decades an increase in our bed days in hospital by about 30 per cent. That is the situation that we were trying to address as well as giving individuals better health. There are 3 main themes to our proposal. One is about identifying those people at highest risk of developing those chronic conditions, and we can do that in a number of ways. We can offer a health check or, if people have consented, we can, working with the Health Chief Information Officer, Martin Carpenter, look at people's data. So if they are seen to have raised blood pressure or raised cholesterol or other factors we are able to offer them timely advice and support. The second theme is about using evidence-based programmes that are specific to either preventing or helping people manage a condition at a very early stage. An example of that would be diabetes prevention. We know that diabetes can be prevented 80 per cent of the time if people are given the right support. That would be potentially a mixture of medical advice, medicines but also lifestyle advice. The other element is about earlier diagnosis. Typically this would be around areas such as cancer screening. We know that there are a number of cancer screening programmes that have either recently been introduced in the U.K. or are coming onstream, so things like lung cancer screening, extending the bowel cancer screening, that is where the bulk of our money would go. In fact there are about 10 or 12 elements that would be a long list to give you at the moment but we can certainly provide that after the meeting.

Deputy L.M.C. Doublet:
Thank you. I have just realised we do need to introduce a colleague.

Deputy Director, Public Health Transformation and Commissioning:
I am Daniela Raffio. I am the Deputy Director for Public Health Commissioning.

Deputy L.M.C. Doublet:
Thanks very much for joining us at the table, and my follow up to that would be with the £4 million and those programmes that you have outlined, does that fall mostly under primary, tertiary or secondary prevention?

Director of Public Health/Medical Officer of Health:
It is primary and secondary.

Deputy L.M.C. Doublet:
So there is some primary prevention in there?

Director of Public Health/Medical Officer of Health:

There is some primary prevention in there in particularly, I think, some of the lifestyle interventions. Possibly in your question is how much we would relate this to other government activity. We know some of the drivers for poorer health are related to factors outside of health; service provision certainly, so housing, income, those sorts of issues. I think we would have a long-term ambition to look right across government to see if we could develop services that were really focused on an individual because it may be that at any one point of time an individual has a particular concern, for example, about their housing, and we should in time be able to provide that advice and then move on to the health issues later. That would certainly be a personal ambition that we could do that.

Deputy L.M.C. Doublet:

In terms of public health and health prevention in other jurisdictions, how does Jersey compare and will this additional money bring us closer to what might be the ideal standard?

Director of Public Health/Medical Officer of Health:

I think it is slightly similar to the picture described for digital health. I think we are coming from a fairly low base. Although at times gold standard prevention is offered to individuals, I think our prevention offer currently is very fragmented. This is our opportunity to bring us much closer to other comparable jurisdictions. I think the thing that would make this a smarter way to work is certainly the joint working that we will be doing around digital health. If we were able to identify those people most in need, that is going to take us much closer to what we might wish to see. So it feels like a very positive trajectory but I fully acknowledge we have quite a way to go.

Deputy L.M.C. Doublet:

Sure, and this joint working, if your digital project proceeds as you wish, Minister, which year would the data from this digital project, if it is fully realised, be able to be utilised for health prevention?

Health Chief Information Officer:

Our ambition is that we get level one in place by the end of 2026, which is the N.H.S. numbers, e-referrals with electronic prescribing to come in 2027, and during 2027 we will implement the single patient record. We are going to be working on these things in parallel. It is more complicated in terms of the single patient record and initially that will consist of information coming out of the hospital and information coming out of G.P. practices and information coming out of our adult and social care practice, so that is going to be the core information set that we can then share.

Deputy L.M.C. Doublet:

But when could that be usefully …

Health Chief Information Officer:

Then that can be used by Public Health colleagues at that point.

Deputy L.M.C. Doublet:
At which point, sorry?

Health Chief Information Officer:
In 2027.

The Minister for Health and Social Services:
Is it not safe to say though, Martin, that it gets progressively better and more constructive as you go through? Rather than having a single point at which it will become useful I think it just becomes more and more useful. The more developed that both sides become the more integrated it will become.

Deputy Director, Public Health Transformation and Commissioning:
I just wanted to answer in respect of your previous question about spend on preventative healthcare in Jersey compared to other places. Within the main business case it outlines what we spend compared to other places, and it is currently 2 per cent of our C.H.E. (Combined Health Expenditure) as a total. The U.K. spends 4 per cent and Canada spends almost 6 per cent, so it just gives us an idea of where we are pitched.

Deputy L.M.C. Doublet:
So 4 per cent in the U.K. and Canada 6 per cent?

Deputy Director, Public Health Transformation and Commissioning:
Almost 6 per cent, yes.

Deputy L.M.C. Doublet:
That is interesting. So, Canada, for example, is that the gold standard in terms of health prevention, public health, or is there another jurisdiction that we should be aiming for?

Director of Public Health/Medical Officer of Health:
I think we need to look at best practice across the world. Canada would definitely be good. Some of the other English-speaking countries have very good records with prevention. I think we need to develop our own model for Jersey partly because of the nature of our communities and partly because we do have this opportunity working very closely with digital, and I think we will look across internationally at best practice and we will do that on a case-by-case basis.

The Connétable of St. Martin:

Just leading on from that, this is quite a Constable sort of question, but have you liaised or spoken with the Parishes about a preventative health strategy? We deliver a huge amount in the Parishes from babies, baby yoga right up until 90-plus classes, for sitting Pilates or whatever it is, and I just think because Parish Halls are easily accessible, we have parking, it is right at the heart of the community, and in St. Martin as well we have health and nutrition classes and all sorts of things like that.

[13:00]

The Minister for Health and Social Services:

That is a very good point and you can rest assured in the next week somebody is going to be in touch with you to meet your committee, Connétable, and see what we can do to understand that. It is a very good point indeed.

The Connétable of St. Martin:

I just think we could deliver a huge amount in the community. Thank you.

Deputy L.M.C. Doublet:

Great. Thank you for the question. I am just looking at my questions because some of them have been answered. In terms of primary prevention, what might it look like to an average person if this £4 million is granted? Can you give some examples in primary prevention what that might look or feel like to an average Jersey person?

Director of Public Health/Medical Officer of Health:

I am slightly repeating myself, so excuse me, but certainly we would see people invited to cancer screening at the appropriate times. That offer would expand. Sometimes that would be an expansion of the age group that is offered or sometimes a new programme. We are planning on having a health check at around the age of 40 because we think that is the age where people begin to think about their long-term health. Should anybody find that they have a number of risk factors, such as raised blood pressure or raised cholesterol, they then would be offered more support. That would be comprehensive support so people would get their advice as a package, so it may be that they are offered some medication but it may be that they are offered some lifestyle advice at the same time. That is the sort of thing that we would expect and I would hope that that will change the culture. So increasingly in healthcare, when people are visiting for a medical reason, they would also be offered these prevention measures and we would be able to make sure that anybody at risk was offered the support that they needed to keep themselves well.

Deputy L.M.C. Doublet:

Okay, so screening and health checks, so more of those, and I may be wrong here, but that feels more like secondary prevention from the definition I am looking at. What I want to understand is in terms of primary prevention stopping things from occurring at all, possibly interventions that target children and education, is there anything covered in this £4 million that would address that at that level?

Deputy Director, Public Health Transformation and Commissioning:

So we had all of that in the original £12 million business case.

Deputy L.M.C. Doublet:

Could you give some detail on some of the things, Minister, that you would have liked to have had the funding for?

The Minister for Health and Social Services:

I believe that was all presented to you yesterday by Daniela. Really that was more about lifestyle interventions at an early stage, tapping children when they are young, getting people to lead a slightly different, healthier lifestyle. It all ties in with a number of other things, some of which I hope come back on to the agenda, such as increasing investment in sports facilities. I just think that at the moment these things are causing children an awful lot of problems. What I am hoping is that the link-up between preventative work and digital when everybody starts to have their health records on their phone and kids can have apps on their phone that register what they are doing from a physical point of view, that they use these damn things to encourage kids to look at their health from a very early stage and encourage their parents to do the same thing. As I said, there is initial stuff that we can do. Like I say, I think we can make a bigger case as we go forward for spending more money on health. If you get in on the ground floor with kids you can bring down a lot of those costs all the way through the system. Already what we are doing here I think is quite bold, but I think we have got to be more bold as time goes on to try to get to grips with something that if we do not tackle it now is going to consume us at the end of the day, because medical science does not stop inventing things that keep us alive for longer, tackling more and more problems, more and more expensive drugs. Everybody wants them. You can rest assured my inbox is full of people saying: “I want this, I want that” which is fine, but people have to start taking ownership from an early stage and we need to set the agenda for them and help them through that journey. This is, if you like, step one in trying to get everybody thinking along those same lines.

Deputy L.M.C. Doublet:

Are your colleagues able to give us any examples of specific programmes?

Director of Public Health/Medical Officer of Health:

We could have supported work in schools as a healthy environment, for example, and that might mean that the schools set their own priorities for how they would like to establish themselves as a healthier environment. Positive activities for teenagers would be another example. That could cover a range of things. Then the whole issue about vulnerability in communities and individuals and ensuring that we are very comprehensive in offering the support. Those would inevitably include some of the issues we mentioned earlier where we are looking at people's housing and other factors that may influence their health.

Deputy Director, Public Health Transformation and Commissioning:

We are quite lucky in Jersey that we do have some rich data, so we do run the Children and Young People's Survey every 2 years and we can see what the groups of vulnerable families are right down at a school and community level. So for quite a small investment we could be looking at how to target that understanding a bit better about our more vulnerable groups. To your point also, Connétable, using the Parishes and the local communities to step up with what is needed in that community, which might look quite different in St. Ouen from St. Helier, for example.

Deputy L.K.F. Stephenson:

To return to your point about the screening - investment in screening - is Jersey currently meeting current guidance and good practice on screening for cancer specifically, and if not would this investment mean that we would be?

Director of Public Health/Medical Officer of Health:

I think we do have some challenges with our screening programmes that we need to address and this funding would allow us to do that. Partly this is about the introduction of new screening programmes, so although it is not prescribed what any jurisdiction needs to offer there are certain examples where we do not offer the screening programme to the full age range that might be offered, for example, in England. That said, there are variations between Wales, Scotland, England and Northern Ireland. Everybody varies it a little bit but I think now is the time for us to invest and to ensure that we get our screening programmes up to the best level that they can be.

Deputy L.K.F. Stephenson:

Are there any specific examples that are included in the plans for the £4 million that are screening for what types of cancer?

Director of Public Health/Medical Officer of Health:

Yes, it is certainly extending the age range for the bowel cancer screening programme. At the moment it is offered to those who are most at risk but we would like to extend that out a little bit

more. Lung cancer screening we are fairly certain is going to be offered, certainly in England, so that would be another example. There are constant recommendations made about screening programmes so we would anticipate more things will come in time.

Deputy L.M.C. Doublet:
What data-driven methods are being used to identify areas of the population that need specific types of help? I think you mentioned the Children and Young People's Survey, so perhaps you could start by telling us what have you noticed in terms of concerns around health?

Deputy Director, Public Health Transformation and Commissioning:
We completed a women's health J.S.N.A. (Joint Strategic Needs Assessment) which covered all ages, which showed some of the big challenges we have got for half of our population, particularly around children being able to exercise and girls having enough exercise. We also know that there are some challenges with women living longer but in poorer health. We have other datasets. Public Health have a number of health profiles that go across different populations that we can use. We have G.P. records that we can access at an anonymised level to show disease prevalence and we can drill down to understand a bit more about that. We do have some quite good data to be able to undertake needs assessment and plan services better and make sure that they are targeted more effectively at those more vulnerable populations, and also make sure they are more culturally sensitive.

Deputy L.M.C. Doublet:
Thank you. Some of those reports we have read with interest and we noticed that there are health inequities across the Island and that perhaps the needs of certain types of people in the population are just not being met. Would those needs be fully met with this £12 million or would we need to invest even more to fully address health inequity in the Island?

The Minister for Health and Social Services:
This is good stuff.

Director of Public Health/Medical Officer of Health:
The £4 million is a start and I think we need to begin to think about how we are going to meet those inequalities. We will gain more knowledge as these programmes begin to be implemented because we will see who is coming and who is not. The other point that has been raised today that is relevant is about the other assets that are on the Island, whether they are run through Parishes or in other places, because we need to begin to co-ordinate those so that we have a community outreach and part of that is about identifying people in the community who are influential. I think we have some

more work to do there to meet people where they are. That is going to be part of the future work, I think.

Deputy L.M.C. Doublet:

Minister, could you reflect for us on what you have learned from these various reports that point out inequities around gender, income level, disability, age? How have you reflected on that and is it informing your work at a political level?

The Minister for Health and Social Services:

Among other things, yes, of course it is. It is an important part of what is happening but I tried to make the point that the more joined up we are the more we can look at these things in a meaningful way and bring about the change that is required right across the piece. Hopefully you can see that everything is starting to be much more joined up and then it is much easier to take that data and do something with it, otherwise you can look at it, you can see there is a problem, but you do not have the mechanism to make the changes all the way through the system if it is fragmented. That is one of the reflections, I would say.

Deputy L.M.C. Doublet:

So addressing those health inequities is something that is important to you?

The Minister for Health and Social Services:

Yes, and I would make another point while we are on prevention. It is worth mentioning that although we have not had our first meeting yet the Determinants of Good Health Ministerial Group, which is going to bring together health, ourselves, Social Security, Housing and the Minister for Children and Families I think will be a very good forum once this is underway and we are running to look at those things in the round from the top down position.

Deputy L.M.C. Doublet:

You have pre-empted my next question. I was just going to ask you about in terms of wider society, and again this is very much at the political level, if we are talking about housing and we see lots of units being built that are one bedroom or 2 bedroom, and I know that Andium are thinking about this because I have had some conversations with them, with this Determinants of Good Health Group could you raise the issue of housing? How can we build housing that helps with health prevention and allows people to live more communally and care for each other?

The Minister for Health and Social Services:

All the things we are trying to address and this particular group is very much in its initial stages. We are just drafting it up to try to get terms of reference and make sure it is properly formulated. As I

say, it is very early days but I look at that going forward as being quite a key body of people looking at stuff to bring all the threads together, and that is where data capture and good data analysis is going to be quite crucial. You can bring all the threads together from all those different departments, marry them up and see where you need to be. It is a big piece of work and it is going to take a while but you have got to start somewhere, and we are starting.

Deputy L.M.C. Doublet:
We would love to hear some more information about what is on the first agenda of that group and to view any minutes.

The Minister for Health and Social Services:
Yes. I am looking forward to that.

Deputy L.M.C. Doublet:
Thank you. I think we will quite naturally go on to the questions to A. and E. (Accident and Emergency) now and then we will come back to the hospital questions.

The Connétable of St. Martin:
We will move on to promoting the appropriate use of the Emergency Department. Bearing this in mind ,will the system be managed within the current resources?

The Minister for Health and Social Services:
I think they have to be.

The Connétable of St. Martin:
As that is the case, what analysis, if any, has taken place to ensure the current resources required for management of this system is adequate?

The Minister for Health and Social Services:
I do not know that we have done any analysis to that effect. What we are trying to do is we have got to look across the piece at the things that we think might be useful to drive good behaviour. I will make a more political comment about the 2 things. We have got do not attend fees and A. and E. charges. The do not attend fees I do not really struggle with at all. I think that is fairly straightforward. The A. and E. charges I know is a difficult one, and I know we are going to have to be very careful with it. What we are looking for is permission to introduce them if required, but it is not a done deal that that particular charge will be introduced. I think we have got to go through that in more detail or carefully. What we do not want to do is introduce something that ends in an illness or a fatality because somebody has been put off going to hospital. By the same token, we want to

drive good behaviour, we want to make the A. and E. Department more efficient, so if somebody is sitting there that is going to go down with a sepsis or something they are not kept waiting for 4 hours because somebody has gone in with a graze that they should have taken to the doctor. It is a very delicate balance, and I just want to assure you and the public who are listening in that before that one goes anywhere we are going to do quite a lot more work to make sure that we sort the wheat from the chaff, so that you get the right outcome without putting anybody at risk.

[13:15]

I think it is important that everybody knows that. We have committed at an early stage that when we were looking at things we would go public straight away so that people cannot say: "Why are you hiding everything?" So we wear our heart on our sleeve a little bit in that we go public and say: "We are looking at this and looking at that." I just hope people see that as being a positive way of keeping people informed, but there are certain areas where we need to provide people with reassurances and that is one area where people can rest assured that we are not going to put anybody at risk, if that makes sense.

The Connétable of St. Martin:
That is good to hear.

The Minister for Health and Social Services:
It is work in progress and if something happens it will happen at the right time, having given the things you thought …

The Connétable of St. Martin:
Yes. We appreciate it is a difficult step to take but one that is probably quite necessary. You have probably already answered this, but I was going to ask you how you would determine what an emergency is, because that is what is on everyone's mind.

The Minister for Health and Social Services:
That is what we have got triage doctors for, but you might have to get to a point where they need particular training. As I say, it is work in progress and I do not want to determine how we do that. But I just want to let everybody know that it is work that is going on.

The Connétable of St. Martin:
So you do not have a date in mind for when the public will be asked to pay a charge.

The Minister for Health and Social Services:

Nothing has been determined. If that comes about it will be ready when it is ready. We are not working to a fixed date.

Deputy L.M.C. Doublet:

Can I just jump in and follow up your question about who will determine what is an emergency? Minister, you said triage doctors. Will there be published criteria that states what is or is not an emergency, so people will know?

The Minister for Health and Social Services:

Rather than me committing to anything, that sort of thing might well be where we end up going. As I say, I would rather we did the work and then came and discussed it rather than me saying: "We are going to do this or do that." I just want to give you an assurance that it is work that will be done. We will be very open and transparent about what we do, how we do it and when we do it.

The Connétable of St. Martin:

I appreciate it is a long game but maybe I should ask this so that it can be put within your workstream. What measures are going to be put in place to safeguard the person, and I assume the triage nurse who will be assessing and communicating the need to proceed with charging members of the public? We realise that is front line and is very difficult.

The Minister for Health and Social Services:

I will just take a note of your question and go away and look at that. If you have got any reservations the more you have got the better, put them on the table, because it helps us.

The Connétable of St. Martin:

I am friends with an emergency nurse and I think it is quite difficult for them, if they are saying that they have to turn away.

The Minister for Health and Social Services:

They are effectively playing God, yes.

The Connétable of St. Martin:

Have you considered having extra security to be added and, if so, where would the funding for that be considered?

The Minister for Health and Social Services:

When you talk about extra security …

The Connétable of St. Martin:

I know that quite often security is called into the Emergency Department.

The Minister for Health and Social Services:

That is a slightly separate question. It is about how we manage A. and E.

The Connétable of St. Martin:

I think it follows on because if a nurse or triage or the doctor is saying to somebody: "You need to pay. You are not an emergency" somebody might get quite …

The Minister for Health and Social Services:

That is a good point. If the charges outweigh what it would cost to have a security guard we might think twice about it. That is a point well made.

Deputy P.M. Bailhache:

You are going to introduce a new policy of charging people who do not attend for appointments. Would you like to say a few words about that?

The Minister for Health and Social Services:

Yes. The statistics that have been made available to me suggest that one in 10 appointments are not kept. Most of those nobody gets alerted to the fact. That causes delay and at the end of the day instead of getting through X …

Deputy P.M. Bailhache:

One in 10, did you say?

The Minister for Health and Social Services:

Yes, I think I am correct in saying that, one in 10 appointments people do not bother to turn up and most often they do not bother to let anybody know, which is disruptive. I think it is discourteous and I think what we would like to do is try to make people … this is the thing when everything is free, people do not tend to quite value it as much as they should. I think if people knew and, as I say, when your appointments can be done on the phone, I accept that at the moment we have got a system where the appointments are not quite as reliable as they might be. I have heard instances where somebody gets an appointment letter in the post that refers to an appointment time that was 2 weeks before the appointment was received. That system is not where it needs to be. This gentleman here is going to be looking at that but once we have got a failsafe system in place and people will get reminders on their phone and so on, we can be assured that they are not being messed about. Once we have got our house in order then I think it is everybody's duty to get their

house in order. At the moment we are only looking at applying a charge to the second time it happens in any given year, which I think is generous, and that might have to be reviewed. It is on the second occasion that it happens and that charge will only be absolutely payable if they come in for treatment on the third occasion. They will be billed and if they do not pay on the third time they come in we will say: "You will have to pay your charge before you get the treatment." I think it is trying to get people to have some degree of ownership of the system and encouraging people to feel that Government have a responsibility to deliver a good health service but they have got a responsibility to help them to do that.

Deputy P.M. Bailhache:

There is going to be some process presumably for allowing people to express an excuse for not attending?

The Minister for Health and Social Services:

Absolutely. There will be criteria, they will be given a certain period of time in which they can do it and if there are exceptional … I mean, a number of people have written to me and said: "Well, if I am in this position or that position why should I be charged?" and I have said: "Well, if you have got an exceptional circumstance you will not be." If there is some sort of family mishap that happens and people can explain that, that is something, somebody who has hearing difficulties, perhaps. There will be exceptions and we have to work on those to make sure that we have got the proper criteria and we are being fair and reasonable. I do not personally think that it is wrong to encourage people to help to make the system more efficient. If you could reduce 10 per cent of non-attendances to 2 per cent you are going to get that much more through your system, your waiting lists are going to fall and you are going to save some money. We need to be doing that. I think it is just about trying to introduce some gentle discipline.

Deputy P.M. Bailhache:

When is this going to come in?

The Minister for Health and Social Services:

When it is ready. As I say, there is work going on. The first thing is we have got to get our house in order in terms of appointments. We have got to make sure that when people get their appointments they are 99 per cent reliable and we are not messing up. You cannot have somebody being sent a fine when they have had a …

Deputy P.M. Bailhache:

So is it fair to say that you are trying to drive a culture change, rather than bringing it in for financial reasons?

The Minister for Health and Social Services:

This is not financially driven. It is behavioural change and culture change, as you say, trying to engage with people more and make them a little bit more responsible and feel more a part of the process themselves.

Director of Health Policy:

Just picking up on that point, that is the reason why in the Government Budget there are no income targets for these 2 fees because we are not doing it to raise income. We are doing it to change behaviour.

Deputy J. Renouf:

Can you make a commitment that you will not introduce any charges until the systems are robust enough to support them? Certainly I know from experience that those appointment systems do not work well. It is not easy to let the department know sometimes that you cannot make an appointment and the rescheduling also is sometimes problematic. Can you make that commitment?

The Minister for Health and Social Services:

Yes. To be fair, I think when we issued that statement in the first instance we did have a line that said that we would not be introducing that until everybody has got their house in order. Before we start putting in charges we need to make sure that our house is in order first. That is a plain statement and I am happy with that.

Deputy L.M.C. Doublet:

Thank you. Could you also reassure Islanders who may have disabilities, that would impact their ability to access or use these systems that those people will not be charged?

The Minister for Health and Social Services:

Anywhere where there is a credible exception is fine.

Deputy L.M.C. Doublet:

Are there any accommodations, for example, assistance in accessing those systems? Is that something that you are considering as well?

The Minister for Health and Social Services:

Those are the fine-tuning areas that we will be needing to look at. Sometimes I do not know if we release too much information too quickly, because perhaps we invite controversy, but at least people know the direction of travel and they have got time to settle into that mode of thinking, so we are not

descending on people and saying: “We are making this change tomorrow.” So people know what is coming through and it gives a chance for things to be discussed in the public domain, which is helpful.

Deputy L.M.C. Doublet:
That is why we do these hearings.

The Minister for Health and Social Services:
It is useful. I do not know if it gets headlines but some of the stuff hopefully will translate and people will get some clarity on it.

Deputy L.K.F. Stephenson:
So the Budget states that both fees will be introduced during 2026 after a period of advanced public communications. Is it just communication or is there going to be consultation as well? Are you talking to the likes of unions about the impact on staff who may be administering the charges? Are you going to go out to public consultation? What is the plan?

Deputy L.M.C. Doublet:
Can I answer that? So as well as unions …

The Minister for Health and Social Services:
You can answer all the questions. I would be much obliged.

Deputy L.M.C. Doublet:
I will add to it. Will you consult with charities, for example, that represent Islanders with disabilities so you know what kind of accommodations might be needed?

The Minister for Health and Social Services:
I think what we will need to do is assess it and we will consult as we see appropriate. I do not want to spend money on a wholesale consultation process where it is unnecessary. I think what we need to …

Deputy L.M.C. Doublet:
Conversations, then.

The Minister for Health and Social Services:
Leave our team to look at it and ask what we sensibly need to do and what we do not need to do so we can keep our costs down and make sure we consult if and when appropriate.

Deputy L.K.F. Stephenson:

So you will tell people then what is happening? It will be a process of deciding and then communicating?

Deputy J. Renouf:

There is a conflict there, as Deputy Stephenson says. It says in the Budget they will be introduced next year. You are now saying, I think, not necessarily.

The Minister for Health and Social Services:

I would say that there is a likelihood that it will be 2026. As I say, there is a slight difference between the 2. The A. and E. charges we will need to be certain that we can do safely. If it had to be abandoned it will be abandoned. I do not really want it to be because I think there is some good work that could be done, but of the 2 there is one that I think is wholly justifiable and can be done more simply and there is one that is more contentious and has more risk associated with it and we will take a slightly different approach to that.

Deputy L.M.C. Doublet:

Okay, so to summarise, these charges are not being introduced 1st January 2026?

The Minister for Health and Social Services:

No, that has never been the intention.

Deputy L.M.C. Doublet:

But you are considering it, having conversations with relevant people and you will be giving information as you go.

The Minister for Health and Social Services:

We will do our homework.

Deputy L.K.F. Stephenson:

Do you need the permission of the Assembly via the Budget to do it or is it something that could still be done by the Minister?

Director of Health Policy:

The Minister needs the Assembly's permission to do it. He does not necessarily need the Assembly's permission via the Budget but he does need the Assembly's permission to do it, as a

result of an old proposition, I think, back from 2010 when any new fee or charge needed Assembly permission to introduce.

Deputy L.K.F. Stephenson:
That is permission to do the work or permission to just introduce it?

Director of Health Policy:
Permission to introduce.

Deputy L.K.F. Stephenson:
Okay, thank you.

Deputy L.M.C. Doublet:
Will you need to come back to the Assembly again after the Budget?

The Minister for Health and Social Services:
If it goes through with the Budget it does give us permission to do that. But you have had the assurances that you need and they have been very publicly made. I do not think there is any difficult there.

Deputy L.K.F. Stephenson:
But that is asking States Members to approve it without knowing any of the detail of it, whereas a future proposition would require more detail.

The Minister for Health and Social Services:
Effectively, but I think we work on the basis there has to be a degree of trust in allowing people to get on and do the job, particularly if they are being open and transparent in making public commitments. It is really about the convenience of knowing that if we are going to put the resource into doing the work we have got the backing to know that we are doing it; we are not wasting our time, if that makes sense. Because I think every penny we spend on doing any preparatory work, we are going to make sure that if we are doing preparatory work it is going to prove useful.

Deputy L.K.F. Stephenson:
Thank you.

Deputy L.M.C. Doublet:
Okay. I think we will move on to this section now, Deputy Stephenson.

Deputy L.K.F. Stephenson:

Okay, yes. On to men's health. What funding in the budget is allocated to men's health?

The Minister for Health and Social Services:

I have got to put my hands up here and say quite openly I have not made anywhere near as much progress on the men's health situation as I would have liked. Is there any money put aside specifically for men's health?

Director of Public Health/Medical Officer of Health:

No, not specifically. There are a number of initiatives which would be beneficial to men particularly. The work that we have done on suicide prevention, things of that nature, but we have not got a specific earmarked fund for men's health. It is interesting as we go through the prevention proposals as well because you know that men have a lower life expectancy than women. There are quite a number of areas around prevention, which, again, should benefit men. Heart disease particularly would be an area. But that is where we are at the moment.

Deputy L.M.C. Doublet:

In terms of the screening programmes, are there improvements to the prostate cancer screening programme?

Director of Public Health/Medical Officer of Health:

We are still waiting to see the best way to deliver that prostate cancer screening programme. I think it is one of the things that is likely to be recommended at some stage. There is quite a lot of health debate about how you best run that. The current proposals would mean a lot of men got false/positive results, which may lead to more harm. But I think there are various ways to target that programme. The lung cancer screening programme will also benefit men particularly because of the legacy issues, the smoking. But, as I say, we do not have a dedicated fund.

The Minister for Health and Social Services:

I think it is fair to say - and I understand what you are saying - with the money that we have got, hopefully, that we will get from the £4 million and that will give us some money to start with. We can try and use our existing resources to get through year one. While we are on record - I am making a number of commitments today - I will make a commitment that before we have our Budget meeting we will have our first men's health meeting. That pins me down to making sure that that gets underway because I would like it to be functioning before we get into 2026. I will make that commitment that we get our first meeting together.

Deputy L.M.C. Doublet:

That is great news, thank you.

Deputy L.K.F. Stephenson:
Is there a men's health strategy in place currently?

The Minister for Health and Social Services:
No, not to my knowledge.

Director of Public Health/Medical Officer of Health:
No. Work has been done in the past, there is an older strategy which is now out of date.

[13:30]

But a lot of the issues are known to us, partly through the public health profiles and the work that was done previously. I do not think we will find many surprises in there. The way that programmes are delivered is an issue, more than identifying the particular health areas of concern.

Deputy L.K.F. Stephenson:
Okay, thank you. Do you know how long ago that or is that something you could come back to us with?

Director of Public Health/Medical Officer of Health:
From memory, I think it was around 2012; something around that. I might be incorrect about that date but it was around that time.

Deputy L.K.F. Stephenson:
Thank you.

Deputy L.M.C. Doublet:
That is achievable within your current budget, a men's health strategy.

The Minister for Health and Social Services:
We used to have this issue about strategy. We can identify what needs to be done and we can get on and do some stuff in the next 12 months. Put it more basically, have a formal strategy.

Deputy L.M.C. Doublet:
Okay, thank you.

Deputy J. Renouf:

Moving to women's health, is there a figure for how much is being spent on women's health in the Budget?

The Minister for Health and Social Services:

Is that something that Hazel might be able to identify that?

Director of Finance:

We do not particularly categorise in that way from a budgetary perspective. As other colleagues have described, there will be interventions and care packages which will be addressing women's health issues. I do not know whether that is from policy …

The Minister for Health and Social Services:

It is covered within various existing budgets, yes.

Director of Finance:

Yes, across a number of different areas that we have. But certainly from a monetary perspective we do not tag it in that way.

The Minister for Health and Social Services:

It would be difficult to extract it from all of the figures and work out what is specifically for women's health because there is overlap, is there not? Yes.

Deputy J. Renouf:

Yes, we are running out of time. I think the women's health strategy has been talked about for quite a while. Is there a women's health strategy underway?

Director of Health Policy:

No, there is not a women's health strategy underway. The previous Minister made a commitment to produce a women's health strategy. A decision was then made by the previous Minister not to progress with the development of a women's health strategy. But that was not communicated before the changeover, before the changes to Government. There is a Women's Health Political Advisory Group. There is an intention that the Women's Health Political Advisory Group will publish what is called a statement of intent setting out what they think some of the key changes to women's health need to be and some of the key interventions. At the last meeting of the Women's Health Political Advisory Group, we spoke to them about 5 key areas of work that we thought should be progressed. Some of it was work that was already under consideration. Some of it was findings that came through from the strategic needs analysis we did on women's health. The delivery of some of those

5 activities hinged on additional new monies through the prevention work, but in the cut from the £12 million to the £4 million have not made it through.

Deputy L.M.C. Doublet:

Thank you. Just on the women's health strategy, Minister, I understand that something will be published, a statement of intent. I just wanted to compare this area of health to one of the other areas where you seem to have a really comprehensive strategy in place with Digital Health and that has spanned several years. That means that the next Minister or next Government will be able to follow that roadmap and make comprehensive services along that roadmap. Would you consider doing something similar for women's health so that that could be part of your legacy?

The Minister for Health and Social Services:

I am thinking we have just got a job to do. But it is a bit more complicated than that. I think when you break it down, if you compartmentalise everything you end up with everybody being looked at specifically. If we look at women's health and men's health and both of those subgroups work out what the priorities are, what needs to be done? You then feed that into the existing work that you are doing and you look at where your preventative funds break down to help that particular category or that particular category, how your digital breaks down. If you like, you have got the strands of funding across the piece and what you are really doing is looking at those subgroups to feed in what needs to be done. You could call it a strategy, if you like. You can call it a job list. We can get tied up in the semantics of it. But really it is about identifying what needs to be done, looking at the resources we have got, and feeding that into the system to make sure that the work gets done.

Deputy L.M.C. Doublet:

It sounds like most of it is there but I think what the public wants to see is something published so that they can …

The Minister for Health and Social Services:

The trouble is when you put …

Deputy L.M.C. Doublet:

Sorry, Minister, I will just finish. I think what the public would really like to see is something published with intent from you that will show where the direction of travel is, something really clear. Is that something you could consider doing?

The Minister for Health and Social Services:

Yes, I had hoped we have been fairly open about it. If you want it slightly more formalised I think we can do that on both the men's health and women's health front. As I say, if you want to put a

label on it and call it a strategy, I think we are working to a strategy across the whole health piece. But we do not call it a strategy, it has become our business as usual. But I understand you want some clarity about what is intended for women's health and you want some clarity about what is happening for men's health. We will try and formalise that process so that it fits in with the framework of what we are trying to do. Very happy to do that; it makes perfect sense.

Deputy L.M.C. Doublet:

Thank you. We only have 5 minutes left and we have still got 2 sections. Let us try and get some questions in on the health insurance things.

Deputy P.M. Bailhache:

Minister, we have touched on this, I think, really at the beginning already. But the Budget states at page 88 that: "The Minister is continuing to review the Island's health and care costs, with options for the future funding of our whole health and care system being developed in discussion with the Council of Ministers" and so on. Is it fair to say that the efforts of you and your department have really been directed towards ascertaining what is the real cost of the health system and what we need to operate a proper health system in Jersey, rather than where the money is going to come from at the moment?

The Minister for Health and Social Services:

You are probably right about the priorities because I made the point where we have got under the heading deficit is timing, okay. At the moment if we start to work out what we need and where the money is going to come from we could lose 12 to 18 months. I think that we are in - do not like to use the word - crisis but we are not where we need to be. We are not as organised as we should be. If you want things to start changing for the better you need some money now. That is why I am trying to get some money in to start work on 1st January, and everybody here is geared up to start that work on 1st January. I have made it plain that we need to be starting to look at where money is going to come from in the future, how much we are going to need and where it is going to come from. It is a longer piece of work; that has to be the secondary piece for me. Let us put it, if we have got some money sitting there at the moment that is being invested by someone else, we need to invest that in us. Let us get the work underway and let us worry about how we start to fund that as we go forward.

Deputy P.M. Bailhache:

It is not something which perhaps concerns you but the …

The Minister for Health and Social Services:

It does.

Deputy P.M. Bailhache:

No, but the panel has been concerned for some time about the gradual diminution of the Health Insurance Fund running down to very low levels. I must say that I was under the impression that work was being done 2 years ago at least on this particular topic but that seems to have ground to a halt.

The Minister for Health and Social Services:

In the first instance, for those listening, the Health Insurance Fund sits with the Social Security Department and not with us and that makes it a bit difficult. I do not know if you can elaborate a little bit more, Ruth, but it is not within our remit.

Deputy L.M.C. Doublet:

Very briefly, if you can.

Director of Health Policy:

Yes. We did start some work with the previous Council of Ministers; that work did not progress. What we have done is we have picked up the work. We are working with our Treasury colleagues. We are working with our Social Security colleagues. As you rightly say, at this point in time the first task is to get a sense of the quantum of the size of money we need across the whole of the system, which we are working on. Alongside that we have started work into …

Deputy P.M. Bailhache:

No options developed yet.

Director of Health Policy:

No, no options developed yet. We started some of the preliminary research work and we will bring forward options.

The Minister for Health and Social Services:

It is accepted that it is running out and that needs to be addressed, and I think long-term care probably can be looking at as well. There are an awful lot of things about health funding right across the piece that needs to be addressed. I know you have raised these issues, you are quite right and they will be addressed. As I say, unfortunately so many hours in a day, you can only work on so much at any given point. Our focus has been on trying to get operationally more functional. But you make a good point.

Deputy L.M.C. Doublet:

Thank you, Minister.

Deputy J. Renouf:

Very briefly on the hospital, the budget continues, essentially, with the programme that was established last year. Can you just outline the reprofiling that has gone on to slightly change those figures?

Director of New Hospital Facilities Programme:

Are you happy for me to …

The Minister for Health and Social Services:

No, of course. Yes.

Director of New Hospital Facilities Programme:

At the moment we have a plan to build a hospital, do we not? The days are going on and that plan is becoming more and more certain. Obviously one of the key things that we need to do in order to build a hospital, an acute hospital at Overdale, is to have a main works delivery partner. I think what we have always said in the programme is that we do have a programme of how it could be delivered, which is really important for financial modelling in order to come up with the forecasts that are in the Government Plan. However, it will very much be a function of the contractor who eventually will build the hospital because they will have a methodology for building it. I can say that the forecasting that is in there at the moment is on the basis of the modelling that we have done, obviously with experience of construction professionals to say how we might go about building a new hospital. Once our invitation to tender process is complete and we have a main works delivery partner, they will have a programme and associated with that programme will be a cash flow, and then that would replace what was ever in the Government Plan. The forecast at the moment is based on our modelling.

Deputy J. Renouf:

In terms of what you can say publicly at the moment, where are you with that process?

Director of New Hospital Facilities Programme:

I am really happy to say that we have received our invitation to tender stage 2A proposals for main works delivery partners. We have proposals from people very capable of building an acute hospital at Overdale. We are in the process of considering those and also launching the next stage of our tender process, which will be the invitation to tender stage 2B. That is in order to converge on the main works contract that will deliver best value for Islanders in terms of the new facility. We are right

at the point between those 2 points in that competitive process at the moment. Hopefully, we will have news in the coming weeks of the combination of that process.

Deputy J. Renouf:
Okay, coming weeks.

Director of New Hospital Facilities Programme:
Coming weeks.

Deputy J. Renouf:
Then there is just something we wanted to clear up in the Budget, there is an allocation in 2029 of £10.5 million from the Central Reserve; what is that to do with?

Director of New Hospital Facilities Programme:
I am afraid I am the person who spends the money. I am not the person who puts together the funding proposal and I rely on my colleagues in Treasury to do that.

Deputy J. Renouf:
Okay, all right. We can follow that up with …

Director of New Hospital Facilities Programme:
I can certainly clarify that or Hazel indeed, of course.

Director of Finance:
I can. In a similar way to the assisted dying, the money in this Budget proposal in 2029 is held centrally. It has not been allocated to Health Department yet. It is being held by Treasury centrally and the detail is based on the outline business case that was put together for this project. As Jessica was indicating, this is a future estimate around revenue costs that will be incurred once the hospital is built.

Deputy J. Renouf:
Are you confident that you are still within the £710 million envelope for the facilities?

Director of New Hospital Facilities Programme:
Yes, for the whole of the phase one of the new healthcare facilities programme we are still within.

Deputy J. Renouf:
Okay. I can keep going but we are out of time.

Deputy L.M.C. Doublet:

We are over time, so we may have to follow up in writing. Thank you for everybody's answers. Minister, just finally to close the hearing, could you just briefly summarise what this Budget, if it is approved, would mean for the average Islander?

The Minister for Health and Social Services:

I think the average Islander would be able to know that their health service, that some of the misconceptions in the past have been recognised and that now there is a very serious approach to getting health right on the Island. These set the foundations for that process to begin. As I say, I will repeat the ambition is to have a first-class health service ready to move into a first-class hospital. I have said all along do not go and spend £600,000 or £700,000 building a hospital if you are going to move your third-rate or second-rate health system into it. I will also say I think there is a very good team come together and I am looking forward to the next 6 months, because that is all I have got left. But anyway, thank you.

Deputy L.M.C. Doublet:

Thank you very much for your answers today and all of your officers that have joined us, and thank you, panel. I will close the hearing.

[13:44]