OFFICIAL REPORT

OF THE

STATES OF GUERNSEY

SCRUTINY MANAGEMENT COMMITTEE

The Committee *for* Health & Social Care

HANSARD

Guernsey, Thursday, 24th May 2018

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Members Present:

Panel Chair: Deputy Chris Green – President
Deputy Jennifer Merrett – Member
Advocate Peter Harwood – Non-States' Member
Mrs Gill Morris – Non-States' Member
Mr Mark Huntington – Principal Scrutiny Officer
Mr Alistair Doherty - Advisor

Business transacted

Scrutiny Management Committee

The Committee *for* Health & Social Care

The Committee met at 10:00 a.m.
in Moulin Huet and Petit Port Rooms at St Martin's Community Centre.

[DEPUTY GREEN *in the Chair*]

Procedural –
Remit of the Committee

The Chairman (Deputy Green):

I would like to welcome everybody here today, elected representatives, our witnesses, senior public servants and members of the public.

Our session today is one of our public hearings looking at major issues of public and political concern and our focus today will be on the implementation of the HSC transformation process. This is the first in a series of SMC public hearings focussing on public sector transformation.

Our panel today comprises myself, Deputy Chris Green, President of the Scrutiny Management Committee, SMC Members Deputy Jennifer Merrett, Mrs Gill Morris and Advocate Peter Harwood.

Following this event the Committee will decide whether any further review activity will be commissioned on this area.

Turning to the arrangements for today, I can confirm that a *Hansard* transcript from this proceeding will be published in due course. If we can start please by saying if anybody has any mobile phone devices please put them on silent as it is essential for us to be able to hear the evidence from our witnesses without interruption from the Public Gallery.

EVIDENCE OF
Deputy Heidi Soulsby, President, Committee *for* Health & Social Care;
Mr Mark de Garis, Chief Secretary; Dr Peter Rabey, Medical Director;
Dr Nicola Brink, Director of Public Health and Mr Keith Davies, finance business partner,
States of Guernsey

The Chairman: If I could now turn to our witnesses. Could you introduce yourself please?

Dr Rabey: Yes, Dr Rabey. I am the Medical Director at HSC.

The Chairman: Thank you very much.

The President (Deputy Soulsby): Deputy Soulsby, President of the Committee.

The Chairman: Thank you.

Mr de Garis: Mark de Garis, Chief Secretary to the Committee.

The Chairman: Thank you.

Dr Brink: Dr Nicola Brink, Director of Public Health.

The Chairman: Welcome.

Mr Davies: Keith Davies, finance business partner for HSC.

The Chairman: Thank you very much. Welcome.

Okay. Without any further ado, if I could start with Deputy Soulsby. Your Partnership of Purpose policy letter was recently endorsed by the States and that sets a fairly clear direction of travel in terms of overarching strategy.

I think it is quite important in politics sometimes, before we start delving into what the potential solutions might be, to talk about the scale of the actual problem we are talking about. Deputy Soulsby, could we start with a sense of the scale of the problems that you believe your Committee is grappling with? In other words, what are you trying to solve with the transformation process in Health and Social Care?

The President: I suppose in a nutshell, the problem we are trying to solve is we have got a system that has evolved over many years, reflecting demands, requests, wants, who shouts loudest, and it has evolved over a long period of time. That has been fine when we have had loads of money and we can throw it at things; when people demand this and they demand that we could give it to them. We are not in that case. We have not been for the last 10 years, since we have had Zero-10, FTP and now the Medium Term Financial Plan – we might want to park that and talk about that later.

Resources are very tight in a system that is not necessarily efficient and effective, where we could do more to make it so; but structurally based around demand rather than need. That is exacerbated by an ageing population. I quoted last week, we expect about 2,200 people over 85 by 2038. We expect to see over 130% increase in the over-85s in that 20-year period. We have got medical inflation; we have got those innovations coming through, new drugs constantly being developed; and having to meet those demands and people's expectations. The expectations, quite rightly, are very high in the Bailiwick. I think one of the things KPMG found when they were doing the review was just how high those expectations are.

So we are not in the place of the NHS at the moment, but that is because of good management over the last couple of years; but we are meeting those same problems that the NHS have got. You will have seen the King's Fund has put out a report this morning (**The Chairman:** Yes.) with the Institute for Fiscal Studies basically saying more money needs to be poured in – and that is just the NHS. We are Care as well; we have got to cover both of those things. So that is really the scale of what we are dealing with at the moment.

The Chairman: Okay, thank you.

Can we talk about the Partnership of Purpose document on transformation? It is undoubtedly a very ambitious document. Would you accept the view, though, that at this stage the wording of that policy letter in many ways is rather vague on detail and short on specifics?

The President: I think it is because it is such a vast area of work. Just prepping for today, talking about transformation of what is an incredibly complex organisation … It is its own organisation – £190 million we spend every year on health and social care – and that is just us; that does not include what people put in personally, and insurance and what have you. It is an incredibly complex area. Quite rightly, we had to look at a high level. But this is about giving that direction and it is not as if it is something that is on paper. This is becoming really real and as

much as we talk about, in here, 'We will do this and we will do that and that will restructure this and that will restructure that,' at the end of the day this is all about culture and changing the culture of an organisation. When you can change a culture and get people to understand what is possible that is when change happens. It is not just one proposition after another proposition, saying, 'We will build this. We will move that. We will put money into this.' It is all about getting the whole organisation, the people in the Bailiwick really behind it. That is really what it is about.

The Chairman: I suppose the overarching question I would like to explore is at this stage, because we can only really talk about 'at this stage', does Health & Social Care actually know what you intend to do in order to progress the Partnership of Purpose at this stage?

The President: Absolutely. It started before this document actually and we had these conversations with KPMG when we were putting together the policy letter, and they were saying, 'You could do this and you could do that,' and I said, 'We are already doing it actually.' They were saying, 'Well, you could make these things,' 'Well, we are actually doing it.' I think Keith over there will nod his head quite vigorously on that front, having had those conversations.

So the whole cost service improvement element has been developing, we have been making changes; clinical pathways led by Peter and his team, the Clinical Reference Group, changing things from here. It is not FTP, about transformation from above; this is very much within the organisation, the Clinical Reference Group changing pathways, making things more efficient. The whole structural stuff we have already started. We set out what our 2018 priorities were in the document and we have started on them. I can go through those now if you would like.

The Chairman: Just to come back to the question in terms of the policy letter, it is obviously quite rich on buzz words, if I can put it like that, but in terms of actual specifics and actual detail it was relatively limited in terms of specifics and relatively limited on detail. Would you accept that?

The President: Mark? Is that okay?

Mr de Garis: A lot of what the Committee was seeking to do is to seek the endorsement and approval of the Assembly to move forward to the next steps, but what had been happening behind that was engaging with the key stakeholders and getting them ready for change but agreeing on the general direction. So a huge amount of effort was made last year with all of the various key groups. So actually they can all own a bit of that change in the future that we need to move to.

The Chairman: Okay.

The President: That is why when we publish this you were not hearing in the media, 'Well, we do not know about that. I do not know what this or that because we had been talking to people and this, the policy letter, is not HSC's policy letter,' yes, it is, in terms of ownership and we own those Propositions, but it is all those people that have been involved in that. We did proper engagement. It was not about ticking boxes to say we had done a consultation. A huge amount of effort in putting together the policy letter was that engagement. A lot of the groundwork is making sure that you have got people behind you before you put these things together.

The Chairman: Okay, can we ask about the universal offer? You have the policy letter in front of you? If I take you to paragraph 4.26. Page 9, paragraph 4.26.

It is the final sentence of paragraph 4.26:

> The Committee is of the opinion that some services which are currently charged for may need to become free-of-charge (or charges set at a lower price at least in certain circumstances) but this may have to be balanced by introducing charges elsewhere in the system.

Are you in a position today to give us some examples of services that might become chargeable in the new system under the universal offer?

The President: No, because that will be a matter of negotiation between us, ESS and P&R. Clearly, we know where we stand and we could ask for the earth. We would not like to have to balance charges elsewhere in the system, but that would be a negotiation we would have to have primarily probably with P&R, but it might well be with ESS, depending where it comes from.

But what we are trying to do with the universal offer is very much focus on that prevention and early intervention. So if this is leading to where you might think in terms of primary care, there are concerns, as you know, in your in-work poverty review and, as we have expressed, issues about certain people not being able to access primary care. (**The Chairman:** Yes.) How anecdotal that is, that is another point and that is something Nicky will be able to address.

The Chairman: We will have some questions on that in due course.

The President: Yes, so primary care might be an area where we specifically want to put more subsidy in, and as a Committee we have agreed that is what we want to do. We have had negotiations with ESS who provide that subsidy for primary care about what we do. So that might be some area that we can adopt but if you want to talk about primary care later on I will leave what I want to say on that. But really our focus in terms of subsidy has been making sure we are putting our money to where there is the greatest need.

The Chairman: On the universal offer are you saying you are not in a position today to say what services may become chargeable in the future? Is that because you do not know?

The President: I am not saying they might be chargeable. That is just a 'may', it is not a 'will'.

The Chairman: Right. So is it –?

The President: It is a cautionary point which I think if we had not put it in it would have been unfair to Deputies to say, 'Well, yes, okay, if we give that free we might have to put money in there.' We know that costs are going up in Health full stop, even before we think about whether we provide more services free, but then at the end of the day that is a decision for the States of Assembly as a whole – what our budget should be – and ultimately the electorate.

The Chairman: Can I ask the question the other way around in terms of what services might become free services that you presently have to pay for?

The President: I think, as I say, our focus has to be more in terms of prevention and early intervention. It might be areas in terms of screening because we are conscious in some areas people have to pay to be screened, possible vaccination programmes or other elements of access to primary care services. It does not mean more GPs but more access into enabling people to be able to be seen earlier. But these might be new services that are free. We should not be just looking at the services we have got now. So they might be new services, they might be free, but that is addressing the gaps that we have got currently.

The Chairman: Okay. Again, in the policy letter, paragraph 4.31, which is page 29 into 30. Paragraph 4.31 included this statement:

> The States should seek to identify alternative mechanisms to support Islanders who may struggle to fund private health care insurance.

Does HSC have any idea of how you might be able to help those with existing conditions or the elderly who are currently, in effect, excluded from private health insurance cover?

The President: We have had these negotiations all the time about what we … We have had discussions with ESS about how we could expand that particular area. There are two aspects to this. There is one thing where we could do a quick fix and certainly in primary care we could work with ESS to provide a solution in the short term, but these things are not going to be straightforward. It is an incredibly complex area. We are going to have to model out where that demand is and a lot of people will say, 'I can't go. I have put off going to primary care.' We have some evidence of people who use the services in a different way to try to circumvent primary care, but then people do not like paying for things anyway so you have got to balance that as well.

It is about understanding where the need is and as much as people would like us to fund this, that and the other, we have to be focused on where we have put limited resources.

The Chairman: Advocate Harwood.

Advocate Harwood: Can I just ask, as part of your Partnership for Purpose, to what extent have you had discussions with the private health insurers? Are they going to be part of your partnership going forward?

The President: They might well be. We have not directly as part of what we put together in this policy letter, but there might be an element of using private insurance. The German model is one option for primary care, but there are others as well. What we need to do is look at the need, and that is what … I know I keep on going back to it and I might sound like a broken record but that has not been addressed in the past.

It is all about people saying, 'We want this,' but we need to look at it in terms of the community as a whole and the result of what we have had is that community services have been under invested for years and years, because it is less … people find it hard to address those issues which are hidden, compared with what is the latest drug that will cure this, that and the other.

The Chairman: Mrs Morris.

Mrs Morris: On the same lines, in the KPMG paper the first stage of the plan really revolved around data collection and analysis and you mentioned in that last piece about finding the need and getting the data. (***The President:*** Yes.) So the policy paper talks about the health intelligence unit. Has that been set up? If it has not, when will it be and how much is it going to cost? Is the collection of the data being done first or concurrently with your other work streams? Are we putting the cart before the horse?

The President: No, concurrently, and I think this is probably where Dr Brink might be best placed to speak.

The Chairman: Dr Brink.

Dr Brink: Thank you.

To answer the first question of our data collection, the first Joint Strategic Needs Assessment (JSNA) we are doing is on older people and we selected that particularly in light of our ageing demographic. We are going to use two methodologies to collect data. The first is a quantitative analysis and we are going to use a combination of surveys that we already do. For example, we are due to do the healthy lifestyle survey again this year together with other bits of data that we collect, either our prevalence data, our screening data, for example, our diabetic prevalence and we will have a disease prevalence.

So we will use our quantitative data, but we are also very keen to use qualitative data as well. As part of the JSNA we have already started this and we are literally using hundreds of hours of stakeholder engagement with a huge variety of providers – primary care, secondary care, social care, community sector, voluntary sector, specific consultation with Alderney and the Ambulance Service. So really across the spectrum and we want to use that quantitative and qualitative data and then further enhance that by looking at the stories of various older people. We will put that together and look at what services we have, what services our population are telling us we need and then map what our unmet need is.

That is the first part of the question. The second part of the question was the Health Intelligence Unit and the costing of that is in the Partnership of Purpose, which I think is £170,000. With regard to that, we have already written the job descriptions for three at the enhanced Health Intelligence Unit. We are focussing it across the *piste* of public health, so to look at health improvement, which is your tobacco control, obesity; your health protection, which is your immunisations and screening; and your health care public health, which are all your health care pathways. So those job descriptions are written and will be going out to advert shortly with regard to those.

The President: I should add that that money was obtained through ... We did a transformation and transition fund bid to Policy & Resources about a month ago now and that was a bid for £1.9 million. We were asking for £500,000 at the first tranche and that included the £170,000 for the Health Intelligence Unit.

The Chairman: Okay. Can I come to the Partnership of Purpose policy letter? Paragraph 4.26, page 29. In there it says, and I quote:

> The Committee believes there needs to be a greater distinction between the services that are available free or at a fixed price to those met through private payments.

I suppose the question there is where is the current confusion in terms of free or fixed price versus private payments? What has led to that?

The President: There is confusion across the board and I think people tend to think … for medical … 'What do I get free? What can't I?' But this is around community services. 'What can I access? What can't I access?' I think within community care particularly it is very difficult for people to ascertain what they need. Where do they go to understand what services are available?

That is one clear area which we need to address. If you have got this condition you will be entitled to these services; and that links to our care and support framework we have developed, so people know, 'Well, if I have this condition this is what I can expect to get,' through the services which we have been implementing.

The Chairman: In your response to some of the first questions, you were talking about the whole purpose of the policy letter and the process before that was trying to get the people behind what you are trying to do. I suppose one of the nub-of-the-matter questions is what exactly is going to be the headline difference for people in the community – Mr and Mrs Le Page of the Castel? What exactly is this going to mean in practical terms? I think that is probably what we are trying to get you to discuss.

The President: I think the policy letter is quite clear on that. What it is about is joined up care, providers coming together providing joined up care to people which is patient-centred, not around people's conditions but around them, making every contact count so people know if they go to one provider it will tell them … they will make sure that they do not have to go and access someone else. If they see someone and think, 'Right, they have got that condition but they have also got that,' and they are putting them in the right place. But also that clarity; people know what

they can get. At the moment it is a minefield when it comes to health and social care. So it is about being people-centred, not professional-centred.

The Chairman: Just so we are absolutely clear, you have given some clear answers on what the universal offer is and I think what you are saying is you have not had the opportunity to fully develop what would be within that universal offer.

The President: No, it was not within our 2018 priorities. It is a start. We will be starting that and that universal offer will develop over time. We cannot, as you say … Nicky has just said, she talked about the older people's needs assessment, but this will be something that will have to evolve so we might start with the universal offer which looks quite similar to what we have got now, but that will evolve over time.

The Chairman: When exactly could we expect more meat on the bone? I know it is a long-term project but when will it emerge?

The President: It is and it is not going to be this year because we have set our priorities, but we will be starting that from 2019 through to 2020. We need to because we want to evolve that offer alongside everything else we are doing. That is how it will evolve.

The Chairman: Can we expect another policy letter in the States of Deliberation before June 2020, for example, in this political term?

The President: I suspect you will. Given the discussions we had last week, part of that is around what that universal offer will be. What entitlement do you have to this sort of pain relief? What entitlement do you have to this sort of care? Those will be the difficult decisions because there will be various options and it will be for people to decide in the Assembly, 'Right, this is the finite pot of money we have got. Is this right or should we be raising more taxes to pay for more?

The Chairman: Deputy Merrett.

Deputy Merrett: Thank you.

Parts of the policy paper allude to the universal offer, universal care, potentially regardless of need. So for example, on page 42 it states the GP subsidy is provided to all Islanders, whereas a more focused application may go further in addressing concerns in respect of equality of access.

Do you agree that alludes potentially to this universal offer being more related to the needs of the patient or the ability to pay of the patient to get that equity?

The President: I am not quite sure I understand the question. The point of the universal offer is so people know that there is a set entitlement and that will be linked either to, it might be the ability to pay, but it is more a link to making sure people get the care and support early on, that prevention and early intervention, before things get worse. That is the core to sustainability. If we leave all of our funding, which a lot of it is at the moment, into secondary care then that is where we are not getting best value for money.

So yes, there might be an element of universal in terms of everybody gets it regardless of need, but it might be because that is where that makes most sense in terms of the Island and the whole need and population need as a whole.

The Chairman: You talked about some of the drivers for this problem – the high expectations, the medical inflation, very tight resources – I think those were three of the ones I noted – but I remember a former Deputy and Deputy Chief Minister, Allister Langlois, when I used to sit on

Social Security, always used to have quite a healthy dose of scepticism about medical inflation. Do you share that view?

The President: No, I totally disagree. I do not recall that former Deputy Langlois ever sat on Health & Social Care, (**The Chairman:** No, he didn't.) but clearly medical inflation is real; whether it is as high as some people like to point out … but it certainly is in terms of drugs at the moment, and it might even get more so as we get into precision medicine and those really targeted drugs which just affect a small number of people but will have great impact. I think that is an area we have really got to be wary of and think about how we manage it, because that is going to be a whole change in medical practice.

The Chairman: Dr Rabey, do you have a view on medical inflation?

Dr Rabey: Yes, I think the trouble is we can always do more and so with the same population we can do so much more for them because new services are developed all the time. People do not like to look at their UK counterparts choose a service that we do not offer at the moment – a sleep apnoea service for people who have risky health impact of sleeping badly. We just do not offer it. We could offer it; it would be a cost to the taxpayer. We can try and do it in existing resources by reducing spend somewhere else. There are examples right across the board of that sort of thing. There are drugs that we do not offer in Guernsey that you might get if you were in the UK. I know there are postcode lotteries in the UK as well. I do not want to sound negative but we could spend all your money on health care, couldn't we? (**The Chairman:** Yes.) So you tell us how much money we want to spend on health care and we will do our best to spend it equitably, fairly, prioritised properly and get the best outcomes for that. That is the discussion that I see us taking part in.

The Chairman: Mrs Morris.

Mrs Morris: Do you see that medical inflation being balanced by technological advances in tele-medicine and tele-care?

Dr Rabey: We do realise some savings from that, but the net impact is upwards, isn't it? I am afraid the NHS sees that and developing economies see that, so we have to be as efficient and effective as we can. We have to embrace new technologies where they save us money. Remember new technologies cost money as well, but we have to be as lean and efficient as we possibly can be. There is lots to go at here still.

The President: Looking at the finance industry and technology, 'We can do this. We will be able to process all this information really quickly without people.' I was looking at the *Guernsey Press* of 50 years ago because I am … that was when they brought in their computer in Income Tax. So they said this means that we will not need more staff and they only needed half the use of that computer and they wanted to outsource the use to other people, which was interesting. But they were saying, 'Oh yeah, this technology will change everything. We will not need people. We will just have robots. But you need people to look after the robots. You need the people behind that to know what the robot is actually doing and programming it in. It is going to make things more expensive but it might provide better service'. But the cost is inexorable.

I was speaking to our secondary healthcare colleagues. I think at the moment they have got some scepticism over the use of robotics … i.e. getting rid of them in the theatre. You might say, 'Well, they might say that, mightn't they!' At the moment it is not there, but it might be in the future. So we have got to think about it so in our re-profiling we are thinking should we take account of the fact there will be artificial intelligence robots within the Hospital? Do we need to take that into account? We do, looking at new aspects for re-profiling. We cannot ignore it.

The Chairman: Advocate Harwood.

Advocate Harwood: Dr Rabey, you clearly identified the issue about managing expectations and, President, I think you also commented on that. Is the mechanism under your programme for managing that expectation … actually the level of universal offer, is that really what will fix the expectation of the public?

Dr Rabey: Yes, I believe it will give us a very clear baseline that everybody in Guernsey will know what they are entitled to, what to expect and how to access that. So absolutely yes, I think the universal offer is key to that, but it will need a discussion with the people of Guernsey as to where they give and take to reach something that we are content with.

Advocate Harwood: How often do you envisage that universal offer being readdressed?

Dr Rabey: I would suggest annually. In the sense of we do commissioning intentions annually as part of the new contract and things do change that frequently. So next year, for example, we need to look at genetic pathways. It may be that something falls out of that that we need to look at the universal offer and say: do the people of Guernsey have access to genetic counselling for certain conditions? So I think we need to keep it under constant review and I suggest we do that through commissioning intentions.

The President: Yes, we will constantly review our service. In some areas they will need reviewing more frequently than others. In terms of drugs, every month you will see in the Billet there will be a new drug that is added to the health benefits and any treatments. So that is ongoing all the time. Some areas of community care, if we have got the right model, will not need to change for a few years. But the whole point of this is it cannot be set in aspic because it has got to change with the change in the population.

The Chairman: Dr Brink, do you have anything to add on medical inflation and on public expectations about what level of health and social care they should expect in Guernsey?

Dr Brink: I think one of the things that we are looking forward to is, with our strategic needs assessment we will actually be able to determine the need and determine the barriers to health care as part of the needs assessment. So I think that is going to be important, but I think with regard to medical inflation, unfortunately as technology advances … In my clinical role I treat hepatitis. Three years ago I probably had a 30%-40% cure rate; with new drugs it is a 95% cure rate with eight weeks of treatment rather than a year's treatment. But those drugs are expensive.

All of those expectations, inflation, new technologies, they are going to increase, but so will our health outcomes, they will improve. I think it is balancing both of those.

The Chairman: Deputy Soulsby, do you think there needs to be more of a public discussion about expectations? We are an offshore Island, we are a small community, in many ways we are a prosperous community, but there will always be a limit to what your Committee can provide in terms of services. Do we need to have more of a public discussion about this, a debate?

The President: Absolutely. This is why I welcome the scrutiny hearing, to be able to get that message out. That is why I write articles in *The Guernsey Press* and I go on the radio to try and let people understand what we are trying to do, what the issues are, and that not everybody is part of the problem, but everybody has got a part to play in how we develop it.

Certainly we have got it within our plans for developing Partnership of Purpose communication, ideas, what we are going to be doing, both internally and externally; because it is

not just about the general public here, it is about making sure both our staff and our partners to understand where we are going here. We did a lot early on bringing our people and partners together and we did do work with the general public on this but I think we are better placed internally, but that understanding about what is coming up to hit us in the next 20 years is not well understood, which is a part of the reason why I went off and did the speech that I did last week.

The Chairman: Do you think the public has too high expectations of what can or will be provided by Health & Social Care?

The President: High expectations are great. I have got no problem with people having high expectations because then that puts us on our toes, it makes us do the best that we can. I think the question we need to ask is: that is what you want; that is how much it is going to cost; are you prepared to pay for it?

That is the question because we would love to be able to meet everybody's expectations. I do not think we can ever meet everybody's expectations but if people want more it will come at such and such a cost. People want the whole of primary care free at the point of delivery; that will be an eight-figure sum. People want all the drugs that you can get, not necessarily all over the UK, but in the UK; that is going to be another £4 million-odd. It is stacking up so you can be doubling … another 50% of what we currently get in Health & Care. That is what people, I think, struggle to understand. Of course people see now; they have got the internet; you see what happens in the UK. Some new drug comes on the market and everybody says, 'Why can't we have that one here?' But it is all more complicated than that anyway. Not everybody gets it because not every local authority or any NHS trust can afford it. Life is just a bit more complicated than just what might be given and provided in the media.

The Chairman: Any other questions on transformation?
Mrs Morris.

Mrs Morris: Thank you.

I have some questions on the financial transformation, of which there has already been quite a bit. This is more about getting the successes out in public and looking at some of the challenges and opportunities too.

Unlike its predecessors, this HSC has managed to stay under budget in 2017 by quite a significant amount. Can you briefly explain how this has been achieved and whether it is truly sustainable?

Mr Davies: It is sustainable, but there are obviously challenges. There are a number of things that have contributed to it. Reduction in agency spend is a significant one. Agency spend in the 12 months mid-2015 to mid-2016 was about £7.7 million and since then agency spend has been about half that – about £3.6 million to £3.7 million. So that is quite significant.

At the same time one of the drivers for that is increased recruitment of substantive staff, so obviously you save some on the agency but you do have some going up on substantive staff. That is obviously better, promotes continuity of care and deliverance and so on. So that had a huge impact and yes I think that is sustainable as we go forward, obviously with better staffing and more staffing.

We brought the ED service in-house; it was previously outsourced. That model is still a net cost to the States of Guernsey but it is significantly cheaper than it was previously.

There has been a significant reduction in expenditure on complex placements for people off-Island year by year over the last few years. Again, a lot of that is driven by recruitment here and development of services here, which means that conditions for which service users previously would have to have been cared for in the UK, we can provide that for them here. From a non-

financial perspective, I obviously support that. I think that is better in terms of patient outcomes and so on if people are back at their home with their families. But it has also reduced our costs quite significantly, balanced a bit by some investment in recruitment here. So there is a whole range of things. Those are the bits and pieces. We changed the way catering was provided to Extra Care and that has produced a saving as well, and so on. So there is a range of things there and many of those, yes, are sustainable, though obviously as we have alluded to, there are significant challenges going forward.

Mrs Morris: Has there been any impact on patients as a result of the savings.

Mr Davies: I do not believe a negative impact; I think it has been a hugely positive impact. I think Peter can speak more to this. I think the impact of having ED in-house has been beneficial, there is better continuity of care and so on – but again, this is more Peter's area – and I think that the repatriation of service users from the UK back to their home in Guernsey has to be beneficial as well. But I am sure Peter can explain more.

The Chairman: Dr Rabey.

Dr Rabey: Well Keith is right … bringing extensive cases back on-Island can (a) save you money, but (b) it is better for the person involved and the family involved. So these are gains. Having proper substantive staff in post who care about the service and feel part of it and are here for the long-haul provide a much better service than a locum or an agency, a person who is just dropping in and does not have the commitment to the service; and that is no objection to those in an agency but they know they are here for a short period.

We have been able to significantly invest in certain areas knowing that we would save the money further down and also there has been, with the appointment of Mark De Garis and Matt Jones, laser focus on any waste. Nobody benefits from waste so just reducing waste in the service has been really helpful. So I would say overall service quality has improved in the last few years.

The President: On top of that, a lot of change has happened that has not necessarily resulted in savings but has meant that we have avoided costs, so future proofing the service in terms of changing the pathways. I was talking about Peter dealing with the Clinical Reference Group, looking at the pathways and seeing how we can bring people through more effectively, trying to prevent people going directly to secondary care when they do not need to – in all manner of different areas.

And that is becoming embedded now, so that is where I was talking at the start about cultural change. It is saying how can we do things differently? I know we get told off about buzz words and buzz words in our policy letter, but it is really important for people to latch on to what we are trying to do. One phrase that we used early on was, 'Thinking differently, working differently,' and that has become very much part of the organisation. I am not saying it is everywhere, not everybody will adopt it, but we are getting to that critical mass where I believe people are really behind it.

I think Children's Services in particular, I heard the other week that they did a presentation, I think it was a seminar, either a morning or afternoon, going through all the things that they were doing to update people in the community, partners, third sector, people in other parts of the States. It was headed up, 'This is what Heidi Soulsby says, "Thinking differently, working differently".' They were showing all the things they had done and I thought, wow, that has come such a long way in the three-odd years that I have been stuck in Health and Social Care anyway.

Mrs Morris: Thank you.

So the modelling that KPMG and BDO did said that, 'This transformation would result in savings of at least £8 million per annum'. We had quite a long discussion about this yesterday and

what we were trying to understand is: is that a further reduction or is that just a slow-down of the inflation?

The President: No, BDO and KPMG say – and BDO said it but it was not in their document as much, it was implicit though, and KPMG definitely said – 'There is no way costs are going to go down.' Demand is rising beyond any capability of making costs go down. We have brought things down because there was waste. We have done a heck of a lot, but that demand is putting huge pressures on. We have seen that over the last winter or into March period, but it is not going to be a reduction, it never was, so when BDO were showing their figures this was based on what we have got, what demand was at this particular moment in time. No analysis was done of future demand.

So they said we could make £5.2 million recurring savings. That was net so it was £7.4 million, I think, with £2.2 million additional investment in there so we would make £5.2 million recurring savings. KPMG are saying, 'Yes, we could do similar,' but as they show in their report what we are doing instead of an exponential growth is flattening that demand curve. So that goes back to all the changing pathways; how can we make sure people are getting the right access – the right people are getting the right access to care. So that is where the whole transformation bit comes in. It is flattening that curve, not making it go like that, which is what our current model will create because it is all demand-led.

The Chairman: Advocate Harwood.

Advocate Harwood: Can I just follow up on that? Apologies to Gill. (**Mrs Morris:** That is okay.)

In terms of managing expectations I think your predecessors got it totally wrong because when the BDO report came out I think the view was that suddenly we could save £8 million against your current budget. In terms of managing expectations and getting the message across, I think it is absolutely right.

KPMG are more honest in saying, 'Well, we can mitigate against the future incremental cost increase but we cannot reduce your initial budget level.' I think that is an important message for you to get across because the public, I think, are assuming that suddenly we can wipe £8 million off.

The President: I totally agree, but then we commissioned KPMG and T&R at the time commissioned BDO. It was a different report for a different time and that was clearly about how inefficient, or otherwise, we were.

Looking at BDO now, I think that part of that report should be discredited because they were saying that we could make savings based on what they were doing in the UK at the time, which was around care in the community, pressuring it down, making it cheaper with the cheapest staff, and now that is all unwinding in the UK. You have got care homes saying, 'Oh, we cannot afford this. Here you are, local authority, you look after it now. People go on about the NHS but social care in the UK is going to hit a real storm. It literally is. We are not like that and KPMG said we are in that real important moment in time where we have got that ability to make that change now, which is why I am really committed to driving it, which is why again last week I said this is a commitment. This is why I took the office that I did – to drive it through.

Mrs Morris: Do you think you have captured all the low hanging fruit in terms of cost savings already, or is there more to come?

Mr de Garis: There is more to come, definitely. I mean a really good example that others on this table are able to speak to as well is primary care are thinking differently and they are very engaged in changing the demand-led model which is a high-cost model. So a recent example that actually we are going to fund, hopefully with ESS's support, is in a new physio service, looking at

musculoskeletal (MSK) conditions. This will be where traditionally you have to access your GP who then refers you to secondary care, who then refers you to imaging, then back to secondary care.

This would be where you could then see an advanced practitioner in the GP practice that would be free of charge, which actually with a pilot that has been done with the support of secondary care, all run through Peter's Clinical Reference Group, and we have got all the clinicians in agreement, including primary care, it is estimated that we can reduce referrals by 40% to secondary care, but also the people that are suffering from those conditions can be actually treated much quicker, can go back to work and not endure unnecessary lengthy waiting times and things like that.

So there are lots of opportunities where we can continuously review the pathways, the way that the system works, to bring about efficiencies, avoiding costs but improving the quality of the experience and service for the individuals.

The President: But can I also add, yes, we can do all those things and make things more efficient, but one area that we do need to look at – and I am glad we have got a Chair for the review – is the pay and conditions of nurses and staff. I mean that is going to be crucial. This is something our Committee have been calling on since the moment we took office, just looking at the figures, comparing with elsewhere. That review has been long overdue and I am really pleased that we have got it in place and we have got it within the policy letter. That took some time, it took some getting in the policy letter, but I am glad we did and I am looking forward … I think there will be more on that tomorrow. But that review is about to start and we will be reporting by the end of the year. So that is something which will inevitably, I would suggest, increase costs, but I think that will help for the future.

Mrs Morris: You mentioned earlier that you had already been to P&R for, I think it was, £3.5 million from the Transformation Fund; are you –?

The President: No, we have for £1.5 million.

Mrs Morris: Was it £1.5 million? Sorry.

Mr de Garis: One point nine.

The President: One point nine this time, yes.

Mrs Morris: Okay. You said 'this time', so when do you expect to go back and how much do you expect to ask for next time?

The President: No, £1.9 million is what we have bid for a whole range of things. We have just asked for £500,000 now. So that is all we have actually asked for this time round, a bit of the £1.9 million.

Mrs Morris: That £1.9 million, over what period?

The President: That will be over this term.

Mr de Garis: Yes, but I would expect us to be going back next year as well to develop other elements of the Partnership of Purpose. It is a five to 10 year plan, but what this does –

Mrs Morris: Yes.

The President: But it does not mean we will be asking for that. We will be spending £1.9 million this year and then saying we need another £1 million. It is about planning for the future, it is not as if we are spending it all now and then we are going to use it next year.

Mrs Morris: Yes, I am just conscious that there are other Committees where they say one figure and by the time we got to the end of the programme it had actually cost several multiples of the original figure.

The President: No. Actually when it comes to the whole transformation piece, under BDO we are expected to have £3.3 million as one-off costs to help us with the transformation. We have not delved into any of that and we have been reinvesting savings to do what we needed to do. So we are in a much better place from that point of view, yes.

The Chairman: That £1.9 million being requested, what specifically is that to be used for?

The President: That partly was the Health Intelligence Unit. First of all, it is for the core transformation team leading the whole process. That is about £800,000, £835,000, but that will not all be spent at once; that is over, I think, the next year, but it will not be this calendar year, it will be over 12 months.

Work on TRAK, which is a whole change management process. Yes, it is bringing in a new upgrade of the IT system, but we do not want to replicate all the problems of the EHSCR –

The Chairman: We have a question on that. *(Laughter)*

The President: I can give you an answer on that.

Mrs Morris: Go on then.

The President: From a TRAK point of view, that for me is a massive change management programme but gives us huge potential so it needs to be managed properly as a proper change management system, not an IT system. It needs engagement with clinical professionals, people throughout the organisation. So that is £400,000. We talked about the Health Intelligence Unit. We have got expenditure in terms of any *ad hoc* external resource we want to bring in.

What we want to do is develop our own team. It is all about doing this internally and building up that expertise. We did that with the first, as we built up the policy letter, and we have a core team which we only had funding for up to that policy letter, which is hence this bid. So it is building that team. Then we have got that resource of people who can make the change happen, not buying in consultants who tell us what happens in the UK and then we say, 'Thank you very much and goodbye.' *(Interjection and laughter)*

Then a regulation specialist, talking about the whole care, the care regulator we want to appoint. We are putting a policy letter to the States by the end of this year in terms of the new proportionate regulation system, so we need specialists on that front to make sure that we are doing that appropriately.

Mrs Morris: Should I move on to technology?

The President: Yes.

Mrs Morris: Given the somewhat chequered history of IT implementation in HSC, or HSSD, how confident are you that TRAK and the other technological changes that you will need to implement are going to go to plan? By which I mean to time, to budget and actually delivering what you thought you wanted in the first place?

The President: Well personally in my history I delivered IT systems on budget, on time and they delivered. I am not in charge necessarily of running all these IT projects, but I will be certainly having my eye well and truly over them. Of course HSC is not responsible for IT now. That is the responsibility of P&R and its central IT resource, so we are very much needing to work in partnership with IT. I do not know what they call themselves but IT – (**Mr Davies:** ISS) - ISS in the centre to make sure that this is done.

I think the States has learnt lessons from all these previous projects. EHSCR, yes we know it did not cover the States in glory. I think the post-implementation review on that has just been agreed, signed off. The Committee saw it yesterday.

The Chairman: Are you willing to share that with us?

The President: Yes. I think you will get it at any moment.

Mrs Morris: Because we just love a PIR!

The President: We want to share it. As you know in my previous life with my previous hat on, I want to be able to share it with other Committees so that they can also learn those lessons, because it is not us who have got that issue. What is probably even far more complex is the P&R and ESS transfer, change of IT. That is going to be huge. I think it would be very useful for them to see that report.

The Chairman: Do we know how much the EHSCR has actually cost the States?

The President: That is the one thing which I was surprised … We did commission PIR but PIR did not cover the cost element of that. I thought it was somewhere around £12 million. I might be wrong. But clearly I do not think the issue was whether it was above or below budget, it was that it did not deliver the services it was meant to deliver. I think it clearly lost focus when GPs were not included and then other things, like prescribing, fell by the wayside. But what we did when we went in … it was the last term, myself and the Director of Information, Colin Vaudin, said no, it needs to stop. It was just dragging on and on, and we stopped it. It was absolutely the right thing to do at that point in time.

No, I think it is a good report which sets out key learning points such that it should have been stopped earlier and other aspects like that. But that should really be used for these projects because we have got TRAK and we have got LAN which is coming in now and they both need to be –

The Chairman: Yes, we are not starting from a blank page, are we? There is that history of learning –

Sorry, Mrs Morris.

Mrs Morris: That is okay.

I think this one is a question for Dr Brink. You were talking about the – I keep forgetting what it is called – the new data unit (***Dr Brink:*** Health Intelligence Unit.) That is the one.

Guernsey is predicted to have one of the highest dependency ratios globally. Have we tested that prediction and in particular do we have any data on the net migration of different age groups and the impact that would have on our dependency ratio?

Dr Brink: We are going to try and look at this in our needs assessment and look at what our needs are now and what we think they will be in five years' time and 10 years' time. So we are going to try and do some modelling as part of the needs assessment.

We do not have good data on this currently, but we know that we have an ageing demographic and we know that we are going to have to look at our health care needs for our ageing demographics. So we are hoping to model some of this with the process we are doing now, and really having an enhanced Health Intelligence Unit that can help us model some of this data is key to planning what we need to have in the future.

The President: We can only plan on the basis of what is current policy, what are we allowing, what the economy is like. We could plan and say, 'Okay if we have this many more young people this is what we will need,' but really how much the ageing demographic is going to change is the key, because that is where the costs are.

Mrs Morris: That is why I have asked the question, because I was just wondering when people reach pension age, is this the point that they migrate off the Island, for instance? So they go to live in Spain or they go back to the UK. Equally, do we have older people who still have families on-Island coming back; and what is that figure? Are we mapping in to say population management and the tax office to actually map those people, because dependency ratio seems quite high level? We all accept we have an ageing demographic, but so does everybody; and how many of those are permanent residents who are never going to move away and how many of them are migrating?

The President: I think there is very little migration off the Island.

Mrs Morris: Do you *know* though? That is the point.

The President: I think you can work out probably from ESS. ESS will hold that data. But we are taking the figures – and we had a presentation last week from the statistics … I do not know what they are called these days, these people, but certainly showing us what the impact was likely to be with different curves of, 'If it was not this and if it was that'. (**Mrs Morris:** Okay.)

But we are finding that – and this might be something more for ESS, to talk to ESS about, but – people are bringing their elderly relatives on-Island. So they might not qualify immediately for care but then within a few months they do. That is an issue. We do not know how big an issue it is. Again, from Alderney, people can retire there and there are no residential qualifications. We have seen that there is a growing elderly population, but it is not huge so we do not know how much that will impact. But all these little things do add up.

Mrs Morris: I am glad to see that there are some numbers involved somewhere, not just assumptions.

The Chairman: We will take a break now for five minutes and reconvene in five minutes' time. Thank you very much.

The Committee adjourned at 11:00
and resumed at 11:10

The Chairman: I think you have finished your questions now, Mrs Morris? (**Mrs Morris:** Yes.) Deputy Merrett.

Deputy Merrett: Thank you.

I would like to discuss access to drugs and treatments, please. This question is to the President of the Committee. The Bailiwick does have quite a detailed policy on the use of NICE drugs and medicines. We are dealing with a lot of acronyms today so I will spell out what that acronym is. I believe it is National Institute for Health Care Excellence. (***The President:*** Health and Care.) Do I get an excellent star for that? Okay.

The drugs that are detailed in G1033, do you consider, Deputy Soulsby, that putting a top price on lifesaving drugs is correct; and can you confirm what that top price is?

The President: G1033 is designed and developed over the last 10 years as resources have got tighter to ensure fair access to drugs treatments and care across the health and care spectrum, and it reflects the difficulties that we have. Would I like to be able to provide more drugs and treatments to people? Of course I would. Do I feel comfortable that we cannot? No. That is one of the hard things about being in this job: I cannot give everything that everybody wants.

The policy is being reviewed, as you know. We have confirmed that within the amendment that we laid yesterday against the P&R Plan. Again, it is all about how much is the States willing to pay? We can give more money for those drugs – I think the estimate is that it will cost us about an extra £4 million and that is a rough estimate; we would have to do more work to identify that – but then it is for the States' Assembly to decide, 'Right, well, that is fine. Put it all into there and cut community care, cut mental health, cut support to people who need physiotherapy,' or we say, 'Right, we want this so we are going to give another £4 million to Health and Care.'

That is something that the States' Assembly has to decide. We can say, 'This is what the facts are,' and we will do, but we need to be cognisant of what the Health and Social Care budget is, what we currently provide and what other services we need to provide as the States of Guernsey. These are the difficult decisions we have to make.

The Chairman: I think the question my colleague was trying to get at was do you personally believe it is right to have a top price on life-saving drugs? Do you think that's correct?

The President: I do not think you can say whether it is right or wrong. It is what it is. If we have to make a decision on how we spread our resources as equitably as we can, that is what we have to do.

We can say the same in community care. Is it right that we do not provide one-to-one 24/7 to everybody who needs care at home? I would say we should be providing far more care in the community. I would love to be able to provide lots more. We are looking at re-ablement and that is going to be a huge change and support to us, but we also do not want people to get ill in the first place. But if we put it all in the drugs at the end of that process then we have not got the money to put it into prevention and intervention. These are the debates we have had within Health & Social Care since before – certainly before my time and since the whole big pharma-drug industries have really come on board and after the days of just aspirins. These things are really expensive. A lot of research is going into it and we have got that challenge all the time. It is easy to say, yes, put money into drugs, but we have got to think about how do we stop people needing those drugs in the first place.

Deputy Merrett: Thank you.

I refer to the fact that you said you have had this debate in your Committee on numerous occasions, but I would be really pleased if this would come to the Assembly for debate so that all States' Members could be involved in that decision making.

However, the second part of my question is can you confirm what is the top price? In G1033 – and I quote, it says:

> 6.2.1 Treatments whose cost-effectiveness is estimated to be above £30,000 per annum per quality-adjusted life years will not be funded, unless exceptional circumstances apply.

So my question to you, Deputy Soulsby, is please could you explain what is meant by 'quality-adjusted life' and can you give examples of when exceptional circumstances have or might apply?

The President: Quality adjusted life - One is when somebody has perfect health for a year; whereas 0 is dead; 0.4, I think is if somebody is possibly blind. I am not quite sure. I am not a technical expert in this. QUALYS – now, that is a good question. Should we be using QUALYS? That is what NICE use and more or less we follow NICE. Although there has been this big debate about whether we should be following NICE drugs, most of the time for most of the drugs we provide we follow NICE. It is where we have got these end-of-life period drugs and specific cancer drugs where it is different. That is where we are saying can we afford those extra high premiums?

Linking back to QUALYS, there is a question of whether QUALYS are what we should be using. It is great from a purist point of view because then it sets criteria that says whatever it is it is going to be just up to £30,000, but then we need to think, 'Well, is that fair?' These are the debates we are having. Should somebody who has got … let's say a young mother with children and wants that drug and it is £30,000, it does not match it, she would not get it but that is fair because Joe Bloggs, a single bloke living by himself, will not get it either. Are we saying perhaps should we be thinking that young mother with children … do you give a premium for that? At the moment we do not. That is what the QUALY system is like; that is basically what NICE follow.

That is why we are reviewing it because we are conscious, we are humans as well – the whole Committee – and we want to make sure that what we are doing is fair. I think Peter might be able to provide you –

The Chairman: Yes, Dr Rabey.

Dr Rabey: I see absolutely no easy answers in this. I really applaud this Committee for getting that prioritisation policy in place because it is a result of really hard-thinking, it is a transparent policy and people are welcome to scrutinise it. But it sets out an attempt to be fair.

These decisions have always been made perhaps behind closed doors and perhaps not in the public domain, but we have never been able to offer everybody all the healthcare that they could benefit from. So I think that policy is an important part of providing a fair approach to these things.

I am a doctor; if you give me more money I will spend it. If you gave us £4 million more for health services would we choose to put it all with a big pharma and buy some more drugs? I would suggest there are other things we could spend the next £4 million on that might include some drugs and some other things that we would probably benefit better. I think naming a 'qualy' price is at least fair and it is transparent. So £30,000, you could argue it could be higher or lower, but I think it is a fair approach, it is transparent, it is something that I think politicians have been very brave to take in the way they have and I applaud it actually.

Deputy Merrett: Thank you and I appreciate you saying it is fair and transparent but I must state that I found it quite difficult to find. But now I have found it. It is announced in the public domain.

The President: But that is not our fault. We are not responsible for the website.

We did have everything on there actually and then things were transferred. Now you have raised that, Deputy Merrett, I would love a website which is far more user-friendly and interactive, and not the kind of stale, very corporate website which is great in terms of services here, services there, and this is what we do and this is what we do not, but something from a Health & Social Care point of view is more meaningful to the people that want to use those services.

Deputy Merrett: Absolutely, and it makes it much clearer if people understand what the expectations are. (***The President:*** Yes.)

I am very appreciative of the amendment that was lodged, I think, in the last 48 hours. It does say that you are going to review the process used to consider whether new drugs or medicines should be funded by the end of the political term.

However, it does not give much comfort for some of the members of our community who may need drugs or medicines which are not currently on our white list. So what are the interim timescales that the patient would expect from the request from the medical practitioner, if it is actually approved, to actually getting it into the patient's hands? What is the sort of timescale that patient or the medical practitioner from point of request, the point of a decision and getting that drug? Or in reality, the patient knowing they are not going to get that drug? What sort of timescales are we talking?

The President: I think it varies but it is about six months, isn't it?

Dr Rabey: Our clinicians work within this. So, for example, if you go to see one of our oncologists on the States' contract they will know which drugs you have access to on the States' contract. So the decisions are made in real time and our oncologists would love to be able to provide very extensive drugs that exist, but they know they cannot.

So in real time, patients are having these decisions made about them all the time and that is just the way the Health Service is working. Patients can appeal and they can write a case that says they need a particular drug, and we will hear that.

I am really sorry, I do not know the timescale for that but we would have a meeting probably within two or three weeks of an appeal being received in that way.

The President: It depends on what it is you are talking about, because we have also got the Individual Funding Request Panel which can deal with drugs that are not necessarily something that is going to go on the white list but because that person has a particular condition and under particular circumstances, that drug can be made available to them.

If we say we will make it available to them but it will also include other people, that would be a service development and then we will go through G1033. But individual funding requests are slightly different and that would be – *(**Dr Brink:*** It is monthly) - monthly. It will depend on the condition and the treatment required for that person; because they might be in a critical condition and a decision needs to be made quickly or other things need to be assessed more in the round.

Dr Rabey: If I may add, it can be done as an emergency. So if it is an emergency treatment we would have had a trauma meeting straightaway.

Deputy Merrett: That is really good news. Thank you very much for clearing that up.

I am led to believe that in the Isle of Man they just adopt all NICE recommendations, drugs and medicines, and that Jersey are more in line than we are. Does the Bailiwick want the reputation of being the stingiest member *per se* of the Crown Dependencies when it comes to funding drugs for people with life threatening conditions?

The President: I think it depends on what we want to think of ourselves, full stop. Do we want to think of ourselves as a low tax jurisdiction? Do we want to think of ourselves as somewhere that does not have VAT where other places do? You cannot just isolate that: what do we want to be seen as? Last week we were being quoted as being seen as 'a death haven'! These are not the things that we will be known as. I think what we need to think of is we see what the NHS is supposedly spending money on, but not necessarily the case everywhere.

Just last week I think there were issues over one of the cancer drugs that the NHS is trying to avoid prescribing because not all the trusts have got the money to provide it. So they are saying,

'Well, I know NICE have said that this drug is okay but they are saying it only needs to be in these situations.' So the NHS is really struggling with this drugs bill and it is being skewed by the fact it has to follow NICE guidelines on drugs, whereas I believe in terms of other treatments and stuff they are more advisory.

So it is skewing the expenditure of the NHS which means issues like, are they resourcing A&E, are they doing other things, are being put in the shade. It is that balance. That is what G1033 was designed to do. It means that we cannot make everybody happy. This is a clear example of demonstration that although as a politician I want to keep everybody happy, this is the reality: that we cannot. It is up to the States' to decide whether we are being too stringent or not.

Deputy Merrett: Again, I will just repeat my comment that I am really pleased it is coming to the States for that debate, whereas previously this has been given affirmation from the HSC Committee, I believe.

The President: I would not say that, Deputy Merrett. There are a lot of these things that will have to come to the States and certainly we are very cognisant of where issues are politically sensitive. Clearly, around the Universal Offer – that certainly will be one and what that is and this will fit into that whole concept of the universal offer.

The Chairman: Advocate Harwood.

Advocate Harwood: I am trying to put together the pieces of the jigsaw that are within your strategy. We talk about the universal offer. The partnership approach interests me, not least as a lawyer, because in your statement you say:

> Participants in the Partnership will each have shared leadership and have shared ownership and responsibility.

Do you mean that in a legal sense? Are you contemplating actually that somehow you are creating limited partnerships within that leadership –?

The President: Not limited partnerships, no. This is the Partnership of Purpose, so certainly to start with and of course this can be evolutionary. We are looking at bringing people together to work together so through service level agreements is what we are starting on; we are working on that structure now – how we bring people together from that point of view.

Ultimately it might become a coherent organisation, but for us actually you are making me think, when we were developing the policy letter a lot of what KPMG were doing … they were saying, 'We will have this organisation and it will be this, that and the other,' and we were saying it is not about organisations, this is about people and outcomes. We were going, 'What is it? What is it?' and then we realised it is not the 'it', it is not a legal entity that is important here, it is the purpose, it is what outcomes are we trying to get out?

So it is not about partnerships, as in setting up a limited partnership, or at least not setting one up now.

Advocate Harwood: So in that context, in this slightly amorphous partnership concept, how actually will you achieve the leadership role which you refer to in paragraph 5.5 and 5.4 where you talk about shared leadership? Who actually is going to be leading the Partnership?

The President: I think I will pass this to my Chief Secretary who had quite a big role in this.

The Chairman: Mr de Garis.

Mr de Garis: In the first instance I will be chairing it at the start. One of the difficulties is we have got so many different elements that comprise the system, which Deputy Soulsby explained

earlier that have evolved over time – some are private businesses, some are Government services, some are third sector. But they all have their own business plans, they all have their own internal aims and objectives that often are not actually aligned.

So it is not a legal entity. The idea is we want to ensure that there is a common purpose and a common focus, and that puts the service user or patient right at the centre. So decisions are made around what is in the best interests of the service user, not what is in the best interests of business A, Government department B or through sector charity C. That is effectively one of the driving principles we want to establish – putting the people of the Bailiwick first.

Advocate Harwood: So do you envisage that you will have the primary health care providers included in this Partnership of Purpose? That they will sign up to this?

Mr de Garis: We would very much like them to be –

Advocate Harwood: But do you know for a fact that they are likely to sign up?

Mr de Garis: I believe they will, yes.

The President: We have regular conversations and the Chief Secretary meets them monthly altogether.

Mr de Garis: Dr Rabey and myself meet with them every month and we are actually talking about the elements that we will bring together to form this collective partnership, and some of the difficulties. One of the immediate difficulties that springs out is the sharing of data, getting the information that we need from private businesses so that Dr Brink's team can actually look at it in an anonymised way but to bring those evidence-based forecasts and decisions forwards –

Advocate Harwood: What leverage have you got over the primary healthcare providers that can actually bring them in, or how can you incentivise them to actually participate and to be involved in this partnership?

The President: To start with we have got the subsidies that we currently provide to primary care. The free access to radiology and pathology. We can also incentivise in terms of saying, 'Right, we want to be able to ensure that those people with diabetes are dealt with in this way, we can improve those outcomes and we can actually fund to incentivise.

We are talking about the musculoskeletal (MSK) pathway, about how that will help working with the primary practices, pushing people through using a musculoskeletal pathway extended scope practitioner – is that right? (**Advocate Harwood:** Right, yes.) That role will mean that we can divert people through primary care instead of having to go to secondary care and help with waiting lists there.

This is about working together, and what was good about the policy letter was it was about very much working together as a partnership trying to develop … it is so easy to have a go against, 'Oh that is primary care, primary care are charging this. Oh it is expensive going to the doctor and why are they charging this and that?' But they are running their own business, they are doing what they want to do. But they also have the same desire for the population as a whole to be healthier.

Advocate Harwood: Okay. Can I just find out how that relates then to your universal offer because which comes first? Do you determine your universal offer, then you go into your participants in the partnership and say, 'This is what we want to offer. Can we work towards that?'

In your priorities for the next couple of years you have focused on the partnership, bringing that together but before necessarily you evolved your Universal Offer. I just question whether that is logical.

The President: I think because the Universal Offer will not start as being … we are not going to go from a-z immediately, the –

Advocate Harwood: So you assume the *status quo* for the moment as you populate the Universal Offer?

The President: Yes, that will clearly have to evolve through all the reasons we have already talked about. So, yes, the first stage for what we are trying to do is get that high-level structure sorted out with the partners and how we work that out. But there is that running where we are looking at aspects of the universal offer we can change now. We are looking at the whole primary care aspects of this. But primary care is not all of it, it is part of it.

Advocate Harwood: Can I then understand the commissioning intentions … because I think you said in the document somewhere that there will be an annual report and that will be done by the Committee rather than by the partnership or anything else; that is the responsibility of the Committee?

How detailed are the commissioning intentions going to be? Are you going to be saying, 'Next year we will cut down the number of hip replacements to 10 or 20 and we will only give them to people below a certain age'? I mean how detailed do you think those commissioning intentions will be and how public will those be?

The President: We have already got commissioning intentions in place that we have put in as part of the secondary healthcare contract. So we have got the first year's in place, this year. Peter, are you happy to talk about what –?

Advocate Harwood: But how much flexibility do you have in that contract with the Medical Specialist Group to be able to adjust on an annual basis?

The President: It is inherent in the contract.

Advocate Harwood: Okay.

Dr Rabey: We cannot do anything in that contract that would destabilise the entire partnership, but if we want to bring a service in-house and we have the capacity to do that, if we decide that through commissioning intention we want to stop a service that would impact on their number of surgeons in a specialty we can do that. So it is all in the contract to allow us to do that, but we cannot destabilise the entire partnership with one big hit...

Advocate Harwood: So again this will be an annual review. I mean you will be looking at this every year (***Dr Rabey:*** Yes.) at the same time you review your universal offer?

Dr Rabey: Yes.

The President: I can say what we have got for this year with secondary health care. Review and redesign the services and care pathway for pain management; that is something we have got as one of the areas we set aside for investment this year, which has been under pressure because of all our winter pressures – but that is another issue.

Changing the prime method of offering bowel cancer screening, that was from the current hit. Review and redesign care pathways for cardiovascular disease; and operational planning workshop for specific investments are being considered for 2018. So that is an example of that level.

Advocate Harwood: Again, as part of your commissioning intentions, will that include – going back to the previous questions – the policy for drugs? I mean is that part of your universal offer?

The President: It is now. What we have got on our white list is a universal offer, which is actually –

Advocate Harwood: Okay, so the white list –?

The President: Yes, that is something we will have to talk with ESS about because they are the ones that hold the actual – (**Advocate Harwood:** Purse strings.) purse strings. No, they have got legal responsibility for it in terms of drugs in the community. So when you see stuff go through to the States, the health benefit, that is all the responsibility of ESS, rather than us. So we have got a very small proportion of the drug work, to be honest; it is all with ESS.

The Chairman: Mrs Morris, were you trying to get in?

Mrs Morris: Just because we are discussing the MSG at the moment.

Obviously the contract has been operational now for almost five months. Can you update us on the implementation and monitoring of the KPIs that were inherent in the contract, please?

The Chairman: Who wants to answer that one? *(Laughter)*

The President: I can but, Peter, you are the one involved day to day.

The Chairman: Dr Rabey.

Dr Rabey: Yes, nearly all the KPIs are being reported live. There are a few that we are still shadowing, but –

Mrs Morris: What does 'shadowing' mean?

Dr Rabey: We do not have hard data in some of the areas in the way that you would hope from the electronic record. So we have to, for example, find out whether … I will give you an example; it is easier. Has every patient on the ward been assessed for their risk of blood clots and are they getting the right treatment for that?

You would hope you could just interrogate the electronic record and do the audit, but no, we have to commission several audits to go around the ward and count patients and things. So rather than doing every patient in the Hospital we are doing a blitz on the ward and move it at the end. So it is still in shadow form, but when we get the new IT and the new TRAK system that will be a self-filling thing. (**Mrs Morris:** Oh, okay.) So some of them are not being recorded in real time in that way.

But they are proving incredibly useful actually. The early meetings, the operational meeting and the contractors' meetings, have been better informed, quite challenging. We have had hard discussions about waiting times in some specialties. Yes, it is a start.

The President: Can I just say also, when we had the last scrutiny hearing there was a sense of - would we have the resources to be able to monitor it?

Mrs Morris: Yes.

The Chairman: Yes, I was just thinking that.

The President: I did say at the time that I said I would only sign the contract if I got the assurance that we would be able to get resources for it, and we have. (**The Chairman:** Good.) I think two have joined already and we have got the head of that service, and we are just about to recruit two more to reach the complement that we need. We have had other staff helping in the meantime to ensure that we get this working. So it is real, it is really important because that client monitoring team will then be responsible for ensuring that the commissioning intentions that we set out every year are followed across the Partnership of Purpose. So that will evolve.

Mrs Morris: Will that be published? Is there any way you can publish the kind of KPIs you are using and whether the MSG is using them?

The President: Yes, I have absolutely got the intention to publish KPIs. I think it will not be this year because we have not got anything to compare to anyway, because this is the first year, but as –

Mr de Garis: We will publish at the end of the year.

The President: Yes, exactly. We will publish it *at* the end of the year.

The Chairman: Okay.

Mrs Morris: Good.

Advocate Harwood: Could I just go back to commissioning intentions? I think, as I understand it, you said there are already commissioning intentions or commissioning bodies. Are those available to the public? Are they in a public form? (***Dr Rabey:*** Yes.) So they can be accessed by the public?

Dr Rabey: They are published in September every year on their website.

The Chairman: Are you done, Advocate Harwood?

Advocate Harwood: Just one other point.

When you are establishing your universal offer is there any intention there should be a sort of rebalancing of the amount of expenditure that goes between Health and Social Care? I mean will that be part of the consideration of your universal offer going forward?

The President: Absolutely. To the extent that we have to use funds that we have already got – or we need additional funds … is another matter though, and that again links to that huge demand that is coming our way and the pressures on us. We have got a 1% cut expected under the Medium Term Financial Plan next year. That is going to put huge pressure … We have done so much in terms of managing our budget over the last two years, we do not believe that 1% is going to be achievable without having to make really difficult choices.

Advocate Harwood: Final question from me.

In terms of actually identifying the real needs and the cost of the health and social care, would you favour having some sort of link-in with fiscal rule in the sense that there is the expectation that *x*% of GDP would be applied to health and social care?

The President: Yes, that is something that is doing the rounds. I have heard that talked about in the UK and certainly within Europe – whether there needs to be that link to GDP.

What I do like about that is it gives it that transparency – whether it is the right figure or not, because nobody knows what the right figure is. At least people understand. We have set that percentage of the money that we are generating to health and care. I think it makes sense because otherwise you are still going to get that, 'Well, I need this and I need that.' We can say, 'Well, look, we have got this budget. It is what is agreed and understood.' I think it is far easier to understand that than –

Advocate Harwood: It also means you can compare yourself with other jurisdictions.

The President: Yes, absolutely. Sorry, Keith, did you want to add something?

Mr Davies: Just that you can compare yourself with other jurisdictions, but it is important to know that the Isle of Man was mentioned earlier … we often talk about Jersey – neither of those really compare with us for the lack of economies of scale that we have here.

In the UK, for example, you would not have an A&E unit or other facilities that we have at PEH for less than a population of about a quarter of a million. Those are essential. I do not think anybody, realistically, is going to talk about us not having those facilities, but if you were to start trying to apportion GDP here to the same as you might have in a far larger jurisdiction then you just would not be able to afford some of those things which are absolutely essential.

The President: The percentage could not be the same, (**Advocate Harwood:** No.) but the concept of the percentage, (**Advocate Harwood:** The concept.) I like it in terms of that transparency. There will always be debate on what that percentage will be and then you get debate from other Committees saying, 'Well, steady on, if you are going to do that, what are we going to do …? That will impact us, quite likely.'

Advocate Harwood: It will be easier for the States' Assembly perhaps to agree and approve that sort of percentage.

The President: Yes and that is the big debate.

Advocate Harwood: That is the nub of the whole debate, isn't it: how much is the community prepared to spend on health and social care?

The President: Absolutely, and we have shown that we have made efficiency savings without cutting services by having to cut our budget even further. It is just under increasing demand, what we have experienced at the beginning of this year. We have got pay review – other issues coming down the line. I am really worried what impact that will have and I think, probably speaking for my Committee, we will be challenging that expectation quite hard.

The Chairman: Can we turn to a different subject, which we touched upon in the first hour, which is the issue of fair access?

Obviously one of your stated key ends is to enable fair access to care and help to ensure that those on low incomes have access to health and care services. First of all, what exactly do you mean by 'fair', because fair can mean equal, it can mean in accordance with a set of rules, it can mean not arbitrary? Deputy Soulsby, what is your take on what fair access means?

The President: 'Fair' does not mean equal. Fair means if you need something that you get that and there are not barriers to you getting that treatment; but it is fair in terms of the population as a whole, so somebody individually could say, 'It is not fair, I am not getting this,' but then you say, well, in terms of the population as a whole, we have got to think from a population level not an individual level and that is where we are coming from.

The Chairman: That is tricky though, isn't it?

The President: It is, absolutely, and it is all open to interpretation.

The Chairman: Are you in a position today to tell us if you have any concrete proposals or ideas for achieving the fair access that you talk about in the policy letter?

The President: The whole concept of this is about moving to greater prevention and intervention, giving people the opportunities to not become ill in the first place. Of course fair access is being fair, it is not just the responsibility of Health & Social Care; as we have said in our policy letter, it is about health in all things. Every Committee, the whole States, has got a responsibility to ensure that there is greater fairness so people do not get ill in the first place.

The Chairman: Yes, your policy letter talked about health inequalities resulting from social inequalities, (***The President:*** Absolutely.) which I understand the logic of but I did wonder whether that was to some extent perhaps passing the buck. Would you accept that?

The President: Absolutely not! Absolutely not, because we are the ones that in many cases are picking up the pieces. We need to have a Government that does understand the importance of the social elements of health. The poorer you are the more likely you are to have poor health. The poorer your education the more likely you are to have bad health.

Sir Michael Marmot's report into the social elements of health show a clear line of linkage there and we will see that in terms of the people that we have to look after. So it is not just for Health & Social Care to make everybody better; if we can improve people's social positions and their living and their circumstances the easier it is for us.

The Chairman: So I think this was certainly a topic that was picked up in one of the previous Medical Officer of Health reports; about if the States actually did more to perhaps address some aspects of policy, policy on poverty, relative poverty, housing, social security and education, then actually, directly or indirectly, that would improve health outcomes.

The President: Absolutely. What we have done and one thing we have been really pleased with – and I know Dr Brink will be itching to tell us all about it – is the free under-21 contraceptive policy. That has already proven to have made a difference. Long overdue – a few people tutted about that – but an absolutely fantastic thing that has come in and we are really pleased with it.

The Chairman: Dr Brink.

Dr Brink: It goes back to what is fair access and we know that teenage mothers are more likely to have mental health problems when they are 30, not to be in regular employment, not to be in a stable relationship; and if you look at providing contraception to under-21s often it is dependent not only possibly on the person to pay but also on the parents to pay for contraception.

From our point of view we did not feel that was fair access, so the under-21 contraception, we started that on 16th December last year and today we have seen 465 under-21s which we have provided contraceptive provision to. That is 22% of our target population already within the first quarter.

What we want to see is a reduction in our under-18 conceptions which sit at 16.9 per thousand at the moment. We really do feel that this is an example of how we can use a policy of provision of contraception to not only look at immediately what happens to that individual, but also look forward into where they are going to be at 25, where they are going to be at 30. We feel that this is a good example of a social policy that addresses the concept of fairness.

The Chairman: I think it is very useful.

Deputy Soulsby, I think what you were saying was that you are not in a position to say you have got any concrete proposals at the moment.

The President: No, that was one.

The Chairman: Apart from that one, yes?

The President: That is just one of the things we do. It is very easy just to say, 'Oh, look, what have you got here and there?' There are sheets and sheets of transformation programmes, projects ongoing. We have got a transformation team working through them, but it is something that is part of the culture, the organisation now, and I think that is what I am trying to get … It does not need to be top down. We have to set the policy here. We have said the policy … 'What are you doing about fair access to care?' We had that with Children's Services. A lot of things have improved on that in terms of access to the Croft, making sure that people who need that access are the people that got it and not people who are using it particularly. It is getting that need and understanding. That is how we will help people – by focusing on the need and not who shouts loudest.

The Chairman: Okay.

I think in the policy letter you certainly acknowledged that the cost of primary care consultations should not be a barrier for those on lower incomes, but does your Committee accept now that the current charges do exactly that – they are acting as a barrier?

The President: Anecdotally, we hear that people are putting off going to the doctor because of the cost or they are going late. There are indications that with lung cancer people might be going too late to the doctor and that is why lung cancer, the incidences of that might be higher and diagnosis at a later stage. So, yes, we have that.

At the same time we hear from primary care who say, 'We will at no point turn anybody away,' but we do know we do not want that barrier anyway. But it is how do we deal with that? And that is something that we are discussing at the moment.

The Chairman: Can I try to get some sense of what the evidence is? Perhaps Dr Rabey or Dr Brink …

The President: I think Dr Brink because she can talk about how she is going to try to do that.

The Chairman: Yes. I mean is the evidence base purely anecdotal or is there – not to discount anecdotal evidence because clearly it is relevant and valid, but is there – any sense that there is a greater evidence base than that?

Dr Brink: To my knowledge, the evidence base is largely anecdotal. We agree that we need firm data in this area and we are going to try to get this data through two mechanisms: one is our Healthy Lifestyle Survey, which is a population-based survey which is due to go out in August/September this year and that basically goes across the ages; we are also trying to gather

additional evidence through our joint strategic needs assessment, when we interview stakeholders, we will speak to stakeholders, we will also speak to individuals.

The Healthy Lifestyle Survey is also going to have an older people's boost on it, so we are going to get some further information from care homes, from older people across the ages. So both of those mechanisms should provide us with … when I say proper evidence, but an evidence base for whether the cost of primary care represents a barrier for people accessing care. So we are hoping to have complete information on that certainly by January next year. We always publish the Healthy Lifestyle Survey, so those results will be published and we will be publishing the results of the joint strategic needs assessment as well.

The Chairman: Is there any evidence from the anecdotal evidence that it is particularly an issue or particularly a problem for children – the cost barrier of primary care?

Dr Brink: Again, we hear anecdotal stories, but looking at the evidence-base now the Healthy Lifestyle Survey only goes from a particular age, so we usually only do it from 16 and above. But we should be able to get some information from parents of children because we ask if access to health care represents a barrier through cost.

The Chairman: Whilst we are on it, my colleague quite rightly reminds me of A&E, the Emergency Department. Obviously, relatively recently there has been a rather more granular approach to the charges applicable there. Dr Brink, is there any evidence that that is a barrier to the fairness of access to health care?

Dr Brink: The charging of –?

The Chairman: At the Emergency Department.

Dr Brink: Again, we hear anecdotal stories about people concerned, but I do not have any population-based data on this representing a barrier across the population.

The Chairman: Deputy Soulsby.

The President: Can I talk from an ED point of view, because we are a bit concerned about some of the comments made in your draft or your interim in-work poverty review which accused us of having introduced exorbitant charges since we were asked to take over, I should point out?

That is not the case. In terms of attendance charges, they are very little changed. There is an increase but that was more from an inflationary point of view compared with PCCL. What we did do is create a four-stage charging structure, so PCCL had a minor and an intermediate charge, but then not a major and critical. We have got an excellent ED Department now, with fully trained consultants which were not there. We took on board the Royal College of Emergency Medicine recommendations after several years of that not being implemented. So we have got consultants there that can really do their thing. So we have got higher rates for major and critical care in ED, but that is the only place where it has had significant increase.

If you ask me whether I like the fact that we have to be charging, personally I do not. It sits uncomfortably with me that people, if they are in distress and they are thinking, 'Oh, gosh, I cannot afford it.' We can assure people that they will never be turned away if they need care. It should not impact anybody. That is a message I think it is important to get out – that we do not want that.

But I do not want people to even have to think about it. This is something we have inherited because primary care everywhere has always been private. But clearly it does not sit well and comfortably with what our Partnership of Purpose is about.

The Chairman: Yes, I think that is the point we were trying to get at.

The President: Our issue is that it gives us £2 million!

The Chairman: Yes.

Mr de Garis: It costs us £3.6 million.

The President: Yes, and it costs us £3.6 million because we have got all the consultants. It is where economies of scale do not work, because we have to have these people now to follow guidelines, follow what is required, but we do not have all the demands of an A&E in the UK where you are waiting four hours stuck on a trolley.

So we have got a brilliant service, but you have to pay for it. So we are investigating where we can look at a short-term measure to address this in the short term, but then have that longer view because this is all wrapped up in primary care. We could say tomorrow, 'Right, it is free. We will take the £2 million hit.' Everybody would come to A&E and they would not go to their GP. (**The Chairman:** Why?) We want to make sure that people go to A&E when they need to go to A&E and go to the doctor when they need to go to the doctor.

The Chairman: Yes. Is there a sense that the A&E Department in Guernsey is an under-utilised resource?

The President: I think we have got a skilled resource that we know we can possibly use and that is one of the ideas that we have got: it is possibly linked to the walk-in clinic we have got there, yes.

The Chairman: Could a better use of it be made, do you think? Is it as efficient as it could be?

The President: It is efficient in terms of how they operate. They are an excellent service. Whether we can do more with it is certainly something we are considering: a walk-in clinic, other services that we can run off what we call a PEH campus that might provide stuff that is connected but different. So, yes, that is something that we have considered.

The Chairman: Have you got figures for what the average number of patients seen per hour is for the Emergency Department?

The President: How many?

Dr Rabey: Fifty a day. It is about two an hour.

The Chairman: Fifty per day, two an hour.

Advocate Harwood: So it is quite an expensive service per –?

The President: Absolutely expensive and it kind of epitomizes the issues we have. We are expected to have that care. If somebody is in an emergency you expect them to have the care that they are expected to have!

The Chairman: Oh, you do, yes!

The President: But it totally and utterly does epitomise our problems when it comes to economies of scale and it is not something where we can say, 'Oh, Jersey, how would you like to do ED with us?' We cannot.

The Chairman: No, that is appreciated.

The President: We can in other areas, but not that.

The Chairman: I suppose the question is – and I know the colleagues on the panel looking at in-work poverty have been considering this, so I might as well float it at this stage – I know they have been looking at the possibility of trying to have a better use of it, a better use of what could be seen as an underutilised resource, potentially opening it up for free primary care for children to be serviced by the Emergency Department.

If that were to be a recommendation of a panel in the future what would your view be on that?

The President: We are actually looking at that now. I know you have got a common member of your in-work poverty review and my Committee, so it is probably not a surprise. I do not know. But certainly that is one area we are actually, actively floating at the moment and talking to ESS about what we could do from the children's point of view.

Whether it would be absolutely free I think is something to consider, because I know Jersey and particular private operators did something similar and everybody went to the doctor saying that they had –

The Chairman: Perhaps some sort of co-payment…

The President: Yes, they will go along to the doctor and say, 'Little Johnny is not very well. Look after him. He's got this. Oh and by the way I have got a bad knee.' *(Laughter)* So we have got to be aware of that, but ultimately we need to look at a bigger picture. I should just point out that the ED are not all GPs. They have got their training up to a certain level, so they will not be able to take over that full primary care function.

But ultimately, we do need to move to a position where people are not thinking, when they have got something, 'Oh, God, have I got the money to pay for it?' How do we do that? We set some of the ideas out in our policy letter. One of those I personally think of being something around the German model with compulsory insurance … might be an aspect, but this is something we need to model and we have got to be really careful because if we get this wrong it could really cause a lot of problems everywhere.

We have also got to remember that for most people it really works well in terms of the care they get, they go and see, but we should not be just thinking of it in terms of the model we have got at the moment: we have got primary care, you go to the GP and they will put you on to another service. We have got to look at what is primary care there for – everybody going to the GP for everything? So we do not want to create a whole model here when actually we are looking at designing something far more linked to the terms of the policy letter, because we have got a demand-based system: go to the GP and he will put you through to somewhere else and you want something because you paid some money, so we will give you a blood test. It has got to be around what is the need.

The Chairman: Okay, can I just turn to another matter that was flagged in the policy letter about increased investment in health promotion and the case for that which was flagged up in the policy letter?

It could be said that the argument for increased investment in health promotion is slightly complicated by the time-lag for benefits. (***The President:*** Yes.) In other words, you potentially have to fund it more in the short term for a benefit in the longer term; it may be 10 years before

you get the full benefits realised of anti-tobacco or anti-obesity promotion. (***The President:*** Absolutely.)

How do you reconcile that when you may need more money now to front-load it to save in the meantime? Does that mean more money for health promotion but less for other health and social care services?

The President: No, this is the one area that I – Politicians do not generally like to put loads of money in areas of prevention because they do not see the benefits and they cannot show their electorate what they have done – *(Interjection)*

The Chairman: I am afraid so, yes.

The President: But it is the right thing to do. Because we have not done that in the past we have the health issues in a population which we probably do not need to have and we can do so much better.

In terms of investment, yes, we have already set aside, as part of the savings that we have made over the last two years, money to go into the Health Improvement Commission. We are putting the budget from drug and alcohol that we are putting in now and the Healthy Weight Strategy into the Health Improvement Commission and we have got P&R to give matched funding to the Health Improvement Commission, which is due to come on stream in a shadow form next month. So it is actually happening. We have got an interim CEO, the people are actually sat in the same offices where your offices are in Raymond Falla House now as well.

The Chairman: Can we just be clear regarding what would be the focus of that promotion? We are talking about anti-obesity, tobacco and alcohol – that kind of thing, are we?

Dr Brink: I think I will talk to this, because it is a –

The Chairman: Dr Brink, perhaps, yes.

Dr Brink: The Health Improvement Commission in the first instance is going to take responsibility for the Drug and Alcohol Strategy and the Healthy Weight Strategy. So we have particularly done this in a phased approach rather than putting all the health improvement strategies there in the first instance.

So health improvement is drug and alcohol, it is tobacco control, it is healthy weight, mental health and wellbeing. So it is that whole group of services. So the healthy weight and drug and alcohol are going to go in in the first instance. We are looking forward to trying to decide whether we just need a single substance misuse strategy so that we can have an overarching strategy with different operational arms.

I think the advantage of the Health Improvement Commission is the very close partnership working with Public Health and the Committee for Health and Social Care. For example, the strategic aims of the various strategies are going to remain with Health & Social Care, but we will work in partnership to implement these areas through the Health Improvement Commission.

A Government message of 'lose some weight, stop smoking, drink less,' often does not come across well and actually working in partnership with a community organisation we feel would be really powerful, and I think our advantage is that we have already developed really close and good relationships between the Health Improvement Commission, some of which are seconded Public Health staff anyway and from Health & Social Care. So I think that is going to be really a very innovative way of trying to deliver our services. But you are right; we will measure our results in decades.

The President: It is really exciting what we have achieved here because I think it is different, but we have got people really behind it and it has to be … all I want to do is to get it separated out from Government. We have health messages that come out every month and it is not then good for politicians to go out there … as I know to my cost, telling people that exercise will do them good. So it is about pushing it to the people who can then tailor those messages and the support.

The Chairman: We should be wrapping up in a minute. We are going over time. I suppose I will perhaps make this the last question.

In terms of comparison of the amount of investment you are talking about putting into promotion at this end and the potential estimate of the size of the benefits 10 years hence, we presumably know what it is going to cost you now, but what kind of benefits are we talking about potentially if it goes to plan?

The President: We can measure that and it will be something that the Health Intelligence Unit, as it is beefed up, will be able to do, because then you can link that to say, 'Well, now we know the cost of smoking is £15 million a year, whereas we can tailor it far more and actually say, 'Well, this is the amount of people who are smoking, the amount who are drinking,' and link that back to what the cost to our services are.

So, yes, absolutely.

The Chairman: Dr Brink.

Dr Brink: We can measure, for example, the impact on our Guernsey Child Measurement Programme. We measure all our children in Year 1 and Year 5. So we can look at what the impacts of our interventions are on children being overweight and obese. So we will have some very tangible ways of measuring efficacy. We can measure our smoking rates. So we can look at all of those and those will extrapolate into the long-term health benefits.

Mr Davies: It is also worth noting that all of that work is essential, but it will mitigate increases in costs in the future, it will not reduce how much healthcare is going to cost in the Bailiwick because of the issues we talked earlier on about demographic change in an ageing population.

The Chairman: Yes, the KPMG report, which seemed to suggest, I think, that even if everything goes to plan with the transformation and Partnership of Purpose and promotion and all the rest of it, we are still talking about, is it, 8% of the overall budgets that would need to be reallocated from across the States into health care, (***The President:*** Yes.) rather than 12%?

The President: Yes, what we are doing here is mitigating the increase in costs. It is about instead of an exponential rise we are flattening that curve. There is still going to be a gap and that goes back to Peter talking about do we look at percentages of GDP? But that is a conversation we need to have in public now, because this is not well understood at all.

The Chairman: Okay. Any other questions?

Advocate Harwood.

Advocate Harwood: The timing of your new regulatory commission – I think you said it will be established as a commission, so you are establishing lots of commissions under your strategy – the intention is you will set it up and it will work in a shadow form; but does that mean it actually would have powers to impose regulation or not? You said in 2019 it would be established in shadow form, but how long do you reckon it will be before they actually have powers within the care sector?

The President: That will be something that we will put together for our policy letter. We have not got to it, the policy letter comes in at the end of this year. We have not discussed how quickly it will be able to do that. What we are doing is looking at how we can work with Jersey on that in terms of regulation –

Advocate Harwood: In terms of legislation, this will require legislative input; have you been in any communication to establish this as a priority with the Law Officers?

The President: I thought that it had been already established as a priority. (**Advocate Harwood:** Okay.) But we might need to –

Mr de Garis: It will follow the policy letter submission and the priorities.

Advocate Harwood: So you do not yet know the priorities, so you cannot really predict when the legislation will be up and running.

The President: No, all I would say from a care regulation point of view is it is a priority and it is in our P&R plan, but then it is another battle about how we prioritise that in the whole process.

Advocate Harwood: So it is a question of who prioritises the priorities!

The President: Well, legislation is an issue we do need to discuss, but that is not for us, that is for P&R.

Advocate Harwood: Thank you.

The Chairman: Yes, alright. Thank you very much. We would like to formally express our thanks to the witnesses for attending our hearing today and increasing the public awareness of this area of work. The Committee intends that these hearings will improve the level of public understanding of key areas of Government policy and there will be a *Hansard* transcript of today's hearing.

So thank you very much. Much obliged.

The hearing adjourned at 12:08 p.m.