OFFICIAL REPORT

OF THE

STATES OF GUERNSEY

SCRUTINY MANAGEMENT COMMITTEE

Committee *for* Health & Social Care
Public Hearing

HANSARD

Guernsey, Wednesday, 1st March 2023

No. 1/2023

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Members Present:

Panel Chair: Deputy Yvonne Burford – President

Deputy Simon Fairclough – Vice-President

Ms Michelle Le Clerc – Non-States' Member

Mr Mark Huntington – Principal Scrutiny Officer

Business transacted

Scrutiny Management Committee

Committee *for* Health & Social Care
Public Hearing

The Committee met at 10 a.m.
in Castel Douzaine Room

[DEPUTY BURFORD *in the Chair*]

Procedural –
Remit of the Committee

The Chair (Deputy Burford):. Good morning everybody and welcome to this Scrutiny Management Committee public hearing with the Committee *for* Health and Social Care. I am Deputy Yvonne Burford and with me on the panel today are Deputy Simon Fairclough, who is the Vice-President of Scrutiny, and Michelle Le Clerc, who was a former Deputy and President of Employment & Social Security and previously a Member of the forerunner to Health & Social Care. We also have the Principal Officer of the Scrutiny Management Committee, which is Mr Mark Huntington.

It will not be possible to cover everything in the very wide mandate that HSC has but we have, in preparing the questions, tried to be as wide-ranging as possible, focusing particularly on areas where significant sums of money are involved or matters of significant public interest. Nevertheless we have got quite a lot to get through so if I could try and encourage the witnesses to be concise in your answers, it would be greatly appreciated, thank you.

Following this session, the Scrutiny Management Committee will decide if any further review activity is needed and a *Hansard* transcript will be available in due course, in addition to the live stream, which will be on the Scrutiny website.

We will take a short break at 11 o'clock, half-way through. But if I can just ask everyone to ensure your mobile phones are switched off, please? I will turn to our witnesses now and ask you to introduce yourselves and perhaps we can start at this end with Dr Brink.

EVIDENCE OF
Deputy Al Brouard, President, Committee *for* Health & Social Care;
Deputy Tina Bury, Vice-President, Committee *for* Health & Social Care;
Dermot Mullin, Director of Operations;
Dr Peter Rabey, Medical Director;
Dr Nicola Brink, Director of Public Health;
Lynne Duckworth, HR Business Partner;
Lucy Cook, Assistant Director for Children & Family Community Services;
Matt Jones, Senior Responsible Officer – Our Hospital Modernisation Programme;

Deputy Brouard: If I may, Chair, can I just say a few words of introduction, thanking you for your welcome?

The Chair: If you would like to keep it brief, please go ahead.

Deputy Brouard: I will do. Thank you very much.

On behalf of the Committee *for* Health & Social Care, Deputy Bury and I would like to thank you for inviting us to this Scrutiny Management Committee hearing today. The Committee has asked Dermot Mullin, our Director of Operations; Dr Peter Rabey, Medical Director; and Dr Nicola Brink, Director of Public Health, to be on our first line and we also have a number of staff on our second row who are very happy to answer any questions you have.

I think we are being filmed today so please, colleagues, if any of the team go off-*piste* or misremember one of the thousands and thousands of pieces of data we get every single day that crosses our desk, please do pick us up. Since we last sat before you, in October 2021, Health & Social Care has continued to work in unprecedented and challenging times across its wide mandate, which, as you have mentioned, Chair, actually covers over 110 different service areas, all of which we know are important to the community.

I just was reflecting last night how much has to come together for one simple, single operation in one of our theatres. This is just a fraction. From the GP visit, going to the MSG, the appointment, the pathology, the theatre, the oxygen, making sure all utensils are clean, the pills, the right surgeon at the right time and the right gases, the car park, the catering, all the way through to the physio to the return home to domiciliary care. Every single point critical, every single point under scrutiny and every single point part of the team. It is an amazing operation that we do and at the start of this hearing I would just like to say, in case I do not get any other chances, to just thank publicly our staff for all the efforts that they do.

I have no doubt in the time available it will be challenging to do justice to the valuable work that goes on every day and the sheer dedication of our staff. As I said before, we have nearly over 2,000 employees and a budget of £212 million. We need support and expertise from those at the top of their game and we literally operate 24 hours a day, seven days a week; not without consequences in a highly complex and integrated system to provide Islanders with health care as best as we can and we do not have that luxury to stop every now and then and have a pause and review. We have to carry on every single day.

Thank you, Chair.

The Chair: Thank you and I think you have, in that case, introduced everybody in your speech there, so thank you for that.

I would like to start off with waiting lists, which currently stand around about 2,500. That is clearly something of great concern, obviously, to many Islanders at present. We know that the endoscopy procedures had to be paused during the pandemic for reasons that were explained. However, it was reported in the *Press* last Friday that you believe you can have the endoscopy waiting list under control within two to four months. How confident are you that that will be the case and what constitutes 'under control'?

Deputy Brouard: Thank you. You have reflected the position very well.

We have gone out to tender to see if we can get some firms from the UK to come over and provide services. I think we had seven firms that tendered and we are just in the final recruitment processes, through Procurement, to dot the i's and cross the t's. But it is hopeful that a team will come over. They will work, we have arranged theatre space, or space, on the Thursdays, Fridays, Saturdays and Sundays and they will do a blitz over probably eight or so weekends and they should be able to see quite a substantial number of our patients.

Once that backlog starts to eke down we can then start back the FIT screening scheme as well. I think Dr Rabey is probably better placed than me to give the details on that.

Dr Rabey: The waiting list for gastroenterology just before COVID struck was about 130 patients. Within a year it had gone up to 450 and it has stayed about 450 ever since. Now, that is for patients waiting for a first endoscopy. There is another group of patients waiting for follow-up endoscopies, which brings the total number waiting to be done on the Island to about 1,000. The plan is to get that back down to the sort of figure we had before COVID and keep it within the eight-week waiting period.

The Chair: So, 100-odd cases is what you would consider. (***Dr Rabey:*** Yes.) So, in four months' time, by June, we can hope we are back to that point?

Dr Rabey: That is the plan.

The Chair: Okay, thank you.

You have been given an extra £7.8 million for a four-year programme to deal with all surgical waiting lists. Do you also think that these resources will reduce the backlog and what is the timescale on that for those other elements?

Deputy Brouard: One of the other elements is, of course, hips, knees and those sorts of replacement joints. We have opened up the De Havilland Ward a few months ago, using some of the money, as you have mentioned, that has been earmarked. Again, I think probably Dr Rabey will probably be able to give you more details as to how that is actually progressing. We have seen the numbers hold. I think they are just starting to show a dip.

Dr Rabey: They are. The De Havilland Ward is a dedicated ward for planned orthopaedic surgery, so it is separate from the trauma surgery, where people break their hips and need that sort of operation. It is absolutely key to us because, when you are prioritising patients and you are short of beds, for example, you have to prioritise the urgent and that usually means patients with cancer, patients who have got a life-threatening condition – the ones who end up being cancelled are the poor people who have waited with their hip and knee operations.

We were cancelling a lot of patients during the COVID period, during periods when staffing was affected or bed numbers were full because of other patients. We have had a lot of patients in who could have been elsewhere.

So for those two reasons the orthopaedic list always seemed to be the one that got hit and the De Havilland unit means that because we do not admit emergencies there that we are not cancelling patients for their planned operations because of lack of beds, since October.

Since October we have started to see the orthopaedic waiting list come down. That has been a significant investment. De Havilland needs its own staff. It needed some estates works to make it suitable so that has been a significant investment. But we believe it is the right thing to do for the waiting list.

The Chair: Michelle, did you want to come in?

Ms Le Clerc: Just picking up on the response to the first question, have there been any delays in the FIT tests being sent out, as a result of the backlogs, and if you are putting in, which is fantastic to hear, the team coming over from the UK, surely that will result in some of those people actually requiring some form of treatment? How confident are you that with the current waiting lists you will be able to then slot in those people requiring treatment because there will be some expectation from them that action will be taken?

Deputy Brouard: Thank you for that question.

Part of the second half we were actually only discussing yesterday at the Committee meeting, exactly that. And we have had assurances that we will be able to get the urgent patients who need any follow-up treatment through fairly quickly, but I think Dr Brink is probably best placed to say why you do not do a FIT test when you cannot do the follow-up testing, as it were.

Dr Brink: So the Bowel Cancer Screening Programme was paused because of the problem of getting people in for colonoscopies. You cannot do a FIT test, get a positive FIT test and then not be able to do the whole screening pathway. So the plan is to first of all deal with the symptomatics but then to move on, restart the Bowel Cancer Screening Programme and move on and do that after the symptomatics or the majority of the symptomatics have been cleared. That means that the entire bowel cancer screening pathway will be operational again and that will include the treatment, if required, for people in whom pathology is found.

Ms Le Clerc: And when do you think that the bowel screening will start to recommence? What is the anticipated timeframe on that?

Dr Brink: We are hoping in the second quarter of this year. That is what we are planning and hoping for.

The Chair: So everything is hinging around June from the sound of it, from that. It is encouraging to hear that this progress is hopefully going to be made and I am sure people who are understandably worried about their health will be pleased to hear it. However, Dr Rabey, at the last hearing we had with you, which was about 15 months ago, you said, and I will just quote you here:

> The answer for getting waiting lists down lies in our own hands. If we can get those operating theatres working flat out then this will come down and we have done it before.

But since then, of course, waiting lists have gone up by 40%. So, given that, how confident can those people who are on those waiting lists be that this really is going to get moving now?

Dr Rabey: Well the gastroenterology list will come down because we are paying people to come over and do those cases that we cannot get done and the fact is we have not had a clear run at the other problem because we did not have the beds. When I spoke to you 15 months ago we then moved into a period, since then we have had the Omicron wave of COVID, which knocked our staffing back and must not be forgotten. It also significantly filled our Hospital. And secondly we have been working the whole of last year with approximately 20 patients who should not be in Hospital and the response to that has been to open the De Havilland unit to protect our planned orthopaedics.

Unfortunately, we were not given a clear run at it. We have done the best things to correct that.

The Chair: Can I just clarify for people listening, when you say you have not got the beds, is that more accurately described as you have not got the staff for the people who would be in the beds?

Dr Rabey: There are two separate reasons. During the Omicron wave of COVID, we had large numbers of staff off with COVID, just like every other business in Guernsey was affected with staff being off with COVID, and we also had the Hospital full of people with respiratory symptoms. So there was that period during the spring of last year, which a lot of people have forgotten, but it did massively set back our planned surgery and planned procedures in the PEH during that time.

But on top of that, a point that is important is that the whole of last year, we had a large number of patients in the Hospital who should not have been in hospital. They were waiting for packages of care in the community or for a care home or nursing home bed and we have had to cancel a lot of operations simply because we did not have the –

The Chair: Yes, I think that is a point that we will come onto later in the hearing, thank you. Understandably, I am sure you are expecting that.

The focus has been largely on surgical waiting lists. Can you advise of which other areas within Health & Social Care are experiencing serious pressures and backlogs outside of the surgical issues? Are there any?

Deputy Brouard: Well the gastroenterology and the orthopaedics stand out as the largest ones but there are other areas where there are issues. On some of the dermatology, I think is one which we discussed yesterday and, again, I will probably let the clinicians talk better than I can on it.

Dr Rabey: Yes, dermatology is skin conditions and we prioritise obviously the urgents, the teams are very good at prioritising the urgent cases. But there has been a growth in the number of patients being referred and being seen by the dermatology team, who are flat out and so I think that needs flagging. Then there are other areas of health and social care that are not surgical that you may want to be asking about them.

The Chair: I think I was thinking more about under the Social Care side of your mandate. Is there anything?

Mr Mullin: In terms of autism diagnostic pathways, there are a number of people waiting there and one of the complications is because of multi-disciplinary assessment, it is very prolonged, very detailed. It is not turn up for an appointment and be diagnosed on the spot. There are a lot of assessments going, which involve clinical psychologists, paediatricians, other specialists, speech language therapists, occupational therapists, etc. It is a multi-disciplinary team so there is a challenge in terms of meeting the demand in that side of the service.

The Children and Adult Mental Health Service did have a problem post-COVID and that was really just a backlog because of the various lockdowns and people not being able to access services in the normal way. We have started to get back on top of that but of course there will be bumps in the road and, as Deputy Brouard pointed out, that is a 24/7 365-day-a-year service and demand for service will peak and trough in those areas. But autism is probably the one that is of most interest.

The Chair: Yes, and do you have a strategy for getting back on top of that?

Mr Mullin: Yes we have agreed recently as a management team to commit to the psychology services. We have seconded someone over from Adult Mental Health Services to support that team and then we are looking more broadly about at what point in the future do we get back to, like gastroenterology, back to a steady state and what that team needs to look like.

The Chair: And do you have a timescale on that?

Mr Mullin: Probably 18 months, two years.

The Chair: Okay, thank you.

Deputy Bury: Could I just add something in about data that we share as well?

The Chair: Please do.

Deputy Bury: Recently we have been discussing how we look at the data and I think it is really important for the public to see the fluidity of it. If we just share a number, it could almost look like we are not doing anything but obviously there are people coming off the list and people joining at the other end. So we have committed to starting to bring that in so that the public can actually see that movement coming through as well.

The Chair: Okay, that is helpful, thank you.

I think on this section, the only other comment I have on waiting lists for question is the number of days patients stay in hospital unnecessarily. You have issued some figures recently: 629 patient days per month against a target of 100. So what is the plan to address that?

Deputy Brouard: It gets complicated.

This almost goes back to what we were saying earlier about people who are delayed, discharges from Hospital. That can be for many reasons. Part of it would be our own fault because we will have difficulty in arranging a community package for somebody to go back to their own home because we are struggling to get staff to fill those roles. That used to be one that we would be able to fill locally but that labour market has literally dried up, and we have got people who are getting to the age where that is not the work they want to do any more. So that is a challenge there.

We have also had a difficulty with some to find beds in care homes for people who needed either nursing or residential provision and that has been difficult to find at times. Although we assist, it is for the family to decide and the family may decide that is not the care home they want or they do not want their loved one to share a room or they do not want it to be in Torteval. All those sorts of issues come into play. So those are some of the issues.

Luckily, at the moment, we are down to 10. We have got six, I think, who are waiting for assistance in their home, I think, and the other one was looking for sheltered housing and I think three or four for residential home care. So the numbers have come down well but to keep it in that position is going to be a challenge.

The Chair: I do not want to get onto anything which might go anywhere near individual cases here, obviously, but somebody could continue to occupy a bed in the Hospital because their family want a care home in a different part of the Island.

Deputy Brouard: That can be how it works out but I will go to one of our people. Dermot, do you think you could pick that up?

Mr Mullin: As Deputy Brouard says, we are in the fortunate position at the minute that there are 10 individuals waiting mainly for packages of care. In community, probably about 35,000 contacts per month from the services across the Health & Social Care spectrum and community services. Last year, when we announced the reduction, to be more safe and effective in the delivery, we were short about, I have got in front of me here, 240 hours because of the staffing issue. That has reduced to, yesterday, about 127 hours that we are short in terms of being able to safely provide those services.

The good news is we have seven new recruits who are in pre-employment checks. But again that will get us back to I think a state of even keel and then the demand probably, on average per year, increases by 100. That can be people who are already in receipt of a domiciliary care package, whose needs change in the intervening period and that is just reflective of the ageing demographic. We are living longer and the longer we live, we probably have up to five long-term conditions.

It is the complexity in the system and how that is managed but care homes are phoned every Wednesday. There is a check-in with them. I know there has been some reference that that does not happen. It does. I think that is reflected in the fact that the numbers waiting for a nursing residential bed this week, there are not any. It is two for extra care and there is one for residential but the rest are mainly packages of care, which is a challenge for HSC resources in terms of the senior carers.

Deputy Brouard: I think also that is one of the issues that the States has yet to resolve, the SLAWS issues, the Supported Living and Ageing Well Strategy. That very much comes into play and is one of the reasons why we, as the holder of last resort, assisted with the taking over of St John's residential because we could not afford to lose that number of beds in our system.

Deputy Fairclough: I would just like to come in with a supplementary, Mr Mullin, if you do not mind. You mentioned the fact that the 240 hours, which you were short of, which meant the withdrawal of some care in the community, that has been reduced down to 127, you said. As a result of that, is care now being re-provided to some of those individuals from whom it was removed?

Mr Mullin: No. As part of a dynamic assessment, the care packages were reviewed. Some people were in receipt of private care packages so we – in conversation with, in consultation with them – withdrew from those services. Everybody else was risk assessed and anybody who had high levels of complexity, high levels of need, we continued to provide those services. There was a very small number of people affected.

Deputy Fairclough: What sort of numbers are we talking about?

Mr Mullin: I honestly could not sit here and tell you. Ah, I can sit here! In practice there was about 25% of service users affected.

Deputy Fairclough: I am sorry, how many people does that equate to?

Mr Mullin: Forty-seven people.

Deputy Fairclough: Okay. So what you are saying is after some of that care had to be withdrawn there was a reappraisal of who needed the care most?

Mr Mullin: Yes. That is continual assessment and evaluation of care packages. Some people's care packages will increase over time. Others may reduce as they gain levels of independence or maybe move to more suitable accommodation.

Deputy Bury: I think the language is really important as well. The higher proportion was a reduction, not a removal but a readjustment rather than an outright cancellation.

Deputy Fairclough: Okay, thank you.

Ms Le Clerc: Just to follow up on some of those in this specific area, I understand that the Needs Assessment Panel – this panel is the panel that gives out the care certificates for people needing the care and going into care homes – and I understand that they are falling behind on those assessments at the moment, although that is slightly different for probably three people and one of the people I spoke to at the weekend was actually an owner of a care home, saying that they know that there were people waiting for the Needs Assessment Panel and also, as well as private care homes, for Nouvelle Maritaine and Grand Courtil as well, are we behind on those assessments?

Mr Mullin: No. So the Needs Assessment Panel meets weekly and there has been this narrative for quite a while that it is a delay because of the needs assessment process. People will not be presented to the Needs Assessment Panel until everything, in terms of their assessment, is completed because it is – as you know, part of the 2001 legislation in respect of long-term care benefit – HSC has to make sure that those assessments are robust, they are complete, before they make a determination on whether someone will be in receipt of residential or nursing care.

So they meet weekly and they have never had to call extraordinary meetings because of the demand that is coming through. Again, there will be peaks and troughs. There will be Thursdays when they meet that are busier than others. The nursing homes are contacted every Wednesday and there seems to be a narrative that goes on that all roads lead back to the Needs Assessment Panel but that is not our experience.

Ms Le Clerc: But have you got staff to be gathering the information to put forward the request to the Needs Assessment Panel?

Mr Mullin: By and large, yes, but again, where we have vacancies, for example social workers, social work is a real challenge, both in Adult Services and Children's Services. We deal with agency social workers at the minute. We have two social workers that we dedicate … although they are community based, sit within Acute Services, so in the Hospital, and work closely with the discharge team up there to carry out these assessments. Nurses also carry out the assessments so it is quite a multi-disciplinary approach. GPs will have input. Geriatricians will have input and various occupational therapists, physiotherapists.

Deputy Brouard: Some evidence that it is working is that the numbers we had, we were nearly touching 30 delayed discharges from the Hospital middle of last year and we are now down to 10 and we keep a close, active eye on it. So the system is working from the point of view of moving people through.

Ms Le Clerc: Just picking up, Dermot, you responded saying that you are recruiting another seven staff. We hear a lot about medical nurses being required. What additional staff, what recruitment have you got in place for domiciliary? And we talked about, in the Key Worker Requête, about growing our own, so where are we on growing our own and relying less and less on agency staff?

Mr Mullin: So those seven that are in pre-employment checks at the minute are domiciliary care workers, so unregistered work staff in the sense that they are not with one of the major registering bodies in the UK. In terms of grown your own, so we have several initiatives across psychology, we have a long-standing nurse programme, we have linked with Robert Gordon University in terms of social work training. Unfortunately, the last time, although we got interest, there was no one who actually finally went through and undertook that course. We have nurses training in adult learning disability and, I am trying to think through this, we have the Associate Nurse Programme.

So there are various grow your own initiatives as part of moving forward, and again I think there has been some reference that it is almost a strategy of ours just to rely on agency staff. That is so far from the truth, as Deputy Brouard said, we are in unprecedented times post-pandemic and, globally, health and social care providers are struggling to get staff.

We certainly felt the impact of COVID as well. So as part of a longer-term workforce strategy we are looking at what are the different career pathways that individuals can either take locally or be sponsored to go off-Island to universities and then come back and work as part of the Health & Social Care family.

Ms Le Clerc: We have got lots of questions that we are going to follow up on agency costs. We have got some concerns following on from the Rule 14 questions that Deputy St Pier asked. But just

to ask, coming back to Deputy Brouard, you picked up on the long-term care and SLAWS and I am just interested to know your views on where we are with the funding of long-term care now because I know that when the policy paper came in August 2020 you were opposing the proposals that came forward in that paper for the funding of long-term care through people having to partially pay for their care and if they had insufficient funds there would have been an equity release programme in place for them to be able to have the money from that way.

Now you have been two years as President of Health & Social Care, what are your views now on the funding on long-term care and where are we with the work on SLAWS' joint partnership with ESS?

Deputy Brouard: Right.

My position is probably softening, a bit like it has with GST, because I have realised the amount of funding that we are going to need or our community demands of us on a daily basis. So I am probably more amenable to looking at some of the more awkward areas of getting the funding. Where it is, the whole of SLAWS is still unfunded. It was not even part of the tax debate we have just had. It has still not been quantified. We are in discussions with P&R, who basically hold the mandate for it – although the two Committees, as you rightly say, ESS and HSC fall under it – and discussions are under way as to how we take that forward. But funding will be a critical part of that. Of course, that is against the backdrop of people saying we want to have smaller Government and lower taxes.

Ms Le Clerc: I think in that policy paper it was approximately £25 million additional was required and part of that funding would have provided the additional funding for care in the home, as well as because, at the present time, the long-term care only covers care in care homes.

Deputy Brouard: But of course, having the funding to provide the care is one part of it. The other part of it is to provide the people to actually provide the care and then of course we come onto the key worker accommodation and recruitment generally for those particular workers.

Ms Le Clerc: But part of the proposal was that people would be able to purchase their own package so they would be less reliant on Health & Social Care packages and it would have included that people would have been able to purchase packages from the private sector. So, actually the delays that we have had are causing Health & Social Care, probably, additional problems because, at the present time, everybody is reliant on the Health & Social Care packages.

Deputy Brouard: But the same sort of people that would be providing private care are also the same sort of people that would be providing public care through ourselves and just as we have seen with Brexit and the way some of the tourist industry areas are staffed now, it is a completely different position, two years after COVID, than it was before. The whole marketplace has changed.

So although we may well be providing funding for people to go privately, they still need to have somebody actually physically there. Where that person is going to come from is going to be a challenge.

Ms Le Clerc: But you are still progressing the work on SLAWS with Employment & Social Security?

Deputy Brouard: Yes. I think we had a meeting within the last month.

Ms Le Clerc: And when will we expect a policy paper coming back to the States of Guernsey on that?

Deputy Brouard: I have not got that information in front of me, so I do not know.

Mr Mullin: Can I come in there?

Deputy Brouard: Please do.

Mr Mullin: I was part of a programme board yesterday in respect of SLAWs, looking at what the Resolutions were the last time and what are the next steps because, as Deputy Brouard says, this is key to the long-term provision of continuing care, whether it be in someone's own home or with other providers.

At present, the plan is that there will be a policy letter in 2024 that will be put before the States in April of that year and that is what is being mapped out at the minute. That might be subject to change, depending on how much work is required.

Ms Le Clerc: I think the President wants to come in.

The Chair: Could I just come in on that last point that you made, Deputy Brouard, about it is essentially the tension between the publicly provided and the private sector provided care, that it is the same resource at the end of the day. Of course there is a difference between what is provided by the state and what is provided by the private sector because you have the profit motive in the private sector, so someone is not going to run a care home unless they can run it economically. Obviously, we have had the St John's issue recently.

You have just taken charge of St John's Residential Home. Do you think the States should be stepping up, providing more care homes, rather than waiting for conditions to be right in the private sector because we hear that the reason that the private sector is reluctant, in some cases, is due to the difficulties that we are well aware of in finding staff at the right price and finding accommodation for those staff? Is the States going to have a bigger role in this sector?

Deputy Brouard: Difficult question!

The States deliberately over the years has moved away from having its own care homes and we have changed them all to sheltered housing and supported living. I think the position, as far as I can tell at the moment, is that we very much would encourage more care homes to set up or to increase their facilities on the back of perhaps revisiting what we pay by way of co-payment from the Government towards them, rather than us taking on, expanding our portfolio. But a very interesting question.

The Chair: Okay, thank you.

Ms Le Clerc: Can I just pick up on that? I think from my time when I was ESS President and we were talking to the care homes ahead of the policy paper, back in 2020, part of the reason why they have been reluctant to invest any further in the care home sector has been the cost of funding and the uncertainty of the Long-term Care Fund and the sustainability of the Long-term Care Fund.

So wouldn't you agree that finding a solution sooner rather than later, particularly with the ageing demographic – and I think 2040 is probably our peak time on that ageing demographic – and the fact that, probably, we would need to purpose-build some of those facilities, really using old hotels and guest houses is not fit for purpose in this day and age, so we need to do something sooner rather than later in providing that financial stability to the Long-term Care Fund so that we can get the investment into that care home sector and again in the private sector for home care packages?

Deputy Brouard: I think you are absolutely right and I think Deputy Roffey, and I think Tina, might have some words because she sits on ESS now.

Deputy Bury: Obviously, we have been doing our best at ESS recently. There has been the increase to try and bring the co-payments onto more of an even keel or where they would prefer to be. But when you look at the overall issue, private or public, the issues remain the same. If we had the money to build something, fantastic, but we have still all got to find the people to do the work.

You do start to feel like you are in a bit of a rat maze, that we do not want to be poaching from one place to the other because it is really the very same pool of small staff that you have to do the work. But that dovetails nicely into some of the agency –

The Chair: I will hand over to Deputy Fairclough in a moment but just on that point, certainly, anecdotally or historically, it has been said that staff in the care sector are relatively lowly paid. Does that not have to be addressed for this to move forward? Because we come back and as you have said, these rat runs and everything, we come back every time to the fact that there are not enough care staff and we also know that they do not get paid very highly, which obviously is even more crucial in an expensive place like Guernsey. How is that addressed?

Deputy Bury: Just anecdotally, there are sometimes other tweaks that can be looked at and recently I have had a few contacts from care workers who perhaps, because of Population Management or licensing, have not been able to access States' housing. So looking at other routes, if they cannot access States' housing they cannot stay here and they cannot be a care worker. So can we look at a tweak in that policy that allows that person to remain here on the salary that perhaps is the baseline for that job and still be able to fulfil the role?

So I think it is one of those things that Deputy de Sausmarez often looks at things from a different angle. I am not saying that pay shouldn't be increased. We are in a cost of living crisis and inflation, etc. But sometimes, if the money is not there, are there other ways we can look at facilitating those people to be able to stay here?

The Chair: When you say States' housing, do you mean social housing?

Deputy Bury: Yes.

The Chair: Which already has significant waiting lists.

Deputy Bury: Exactly. We are in the rat-run again.

Deputy Brouard: And that is one of the reasons why, when we took over St John's, we also took over their residential building to house their staff because that was key to us being able to retain the staff and also give the continuity to the residents there.

The Chair: Okay, I will hand over to Deputy Fairclough. I think we are going to go onto agency costs.

Deputy Fairclough: Notwithstanding the earlier comment from Mr Mullin about agency costs, in your Committee's recent response to Deputy St Pier's written questions, you state that agency costs in 2022, for the year to November, were more than double than for the whole of the previous year. Do these figures include housing costs?

Deputy Brouard: That is a question. Just bear with me for a moment. We think it was just pay.

Deputy Fairclough: Okay. It was just pay. So have you any idea how much the housing costs are in addition to the pay?

Deputy Brouard: Not off the top of my head. I will just look to my colleagues behind me, if there is anything that they would like to add. It will be off the cuff rather than researched. Can I just ask Lynne to answer on that one for me.

Ms Duckworth: I have not got the figure but we did have to take on additional accommodation to house additional agency staff.

The Chair: Is that something that you can provide us with subsequently, in that case?

Deputy Brouard: Yes, of course.

The Chair: Thank you.

Deputy Brouard: I think what you are referring to are things like Blue Horizon and some of the other hotels that we have had to use to provide the accommodation for the staff.

Deputy Fairclough: As you can probably imagine, we are just trying to get an understanding of the total cost here for agency staff. So what initiatives have been put in place by your Committee, Deputy Brouard, to reduce agency costs?

Deputy Brouard: Right, okay.

I am going to go back a little bit to first principles. One of the key issues we had when we took over in 2020 after the election, as health team, was staffing. Staffing was one of our major issues and the major answer we had from the professionals was that we needed to provide more key worker accommodation. That was absolutely key and I sit here, another two and a half years later and I have not even got a spade in the ground.

So, from that particular point, we need to provide accommodation for the key workers. If we can recruit permanent staff, although they may well be living in John Henry Court, or John Henry Court 2, as we would like to have, they are still permanent staff, some of them will leave after a few years, some of them will stay a long time, some of them will marry and stay locally forever. But we need to make sure, if we want to tackle this issue, we need to provide accommodation for our permanent staff.

We have always used agency but it is because we cannot find other staff. We do not grow enough of our own, even with the 14, I think, staff who go through the Institute each year, I think a third of the nursing staff of the Hospital have all been through the Institute; it is still not enough for the demands that we have.

We have increased our hospital beds from 116 to 134. That needs more staff. When we have brought the other theatre on, that needs more staff. Our staff have increased by, I think, 44, over the last five years, I think is the figure I have had. So when we increased the number of hours that

we work radiology, when we opened the De Havilland Ward, when we managed COVID, that all brings about an increased demand for staff and if we cannot get that staff locally, we have to use agency staff. Otherwise we do not have a service. So we are really grateful to the agency staff.

But agency staff rates have rocketed as well because we are all fishing in the same pond. Us, the NHS trusts, we are all in that same position. So if you want to unlock this particular locked door or this Gordian Knot, give us staff accommodation, certainly for some of our staff, as near as or on the PEH campus, and I need it yesterday.

We inherited a position that we did not have a John Henry Court 2 in build. The previous ESS team did not leave us with a building ready to go. We are having to fight with one hand tied behind our back and now two-and-a-half years I still do not have that nursing and healthcare professional accommodation.

And we need it to be quality. We have got people staying in hotels. That is not right. Are they going to want to stay here forever when they are sharing facilities? That just does not cut it this day. And we are in competition with the rest of the world for these staff and we want to have the highest quality and the best quality care, and yet we are left fighting with one hand tied behind our back.

So that gives you some of the background.

Deputy Fairclough: Thank you for all of that. So, accommodation. What other initiatives have been put in place by HSC to reduce agency costs?

Deputy Brouard: To reduce agency –

Deputy Fairclough: You are saying it is solely accommodation?

Deputy Brouard: I think accommodation will be one of the major factors. Another major factor will be pay and of course we have had the pay rises the staff have had for the last four years. The last one now, which then goes for last year I think, the next two years going forward, is just about to be announced. I think you will have to look at the websites for the nursing unions as to where they are. Again that will be a tremendous boost for us because we can then now publish the new figures for what our pay is here, which will certainly help.

And you want to make the job an attractive place to work and I have got Jan Coleman behind me here who has been on the Hospital Modernisation programme. If we have a nice hospital that is professional, that is clean and modern, we have got more chance of either retaining staff or attracting new staff. So all these other factors come into play but the main one is staff accommodation and I would think probably pay second. But I will go to my professionals who can advise me whether I am right or wrong.

Ms Duckworth: In terms of accommodation it is two aspects, one is the staff accommodation that we do need more of but the other is also the availability and the cost of accommodation in the private sector because a number of staff will choose or will not be eligible for staff accommodation so we need to rent privately and we know that rents have increased and we know that for a number of properties there are lots of people going for the same property. So it is a mix of both of those.

Deputy Brouard: If I can just add as well, I mean one thing we have done is we have increased, from two years to four years, the rent allowance to retain staff.

The Chair: Don't you think, this is again another thing where things are perhaps pushing against each other, but the very act of providing a rent allowance, and I am not suggesting you should not do it, is inflationary in the private rental market? So it is almost acting against itself.

The question I was just actually going to interject and ask is, in terms of agency staff generally, do you have a figure that actually says, and I know it will vary with every different sort of band and

all the rest of it, but do you have a figure that gives you an idea of how much more, in percentage terms, an agency staff member costs the States, compared to if you had a permanent employee?

Deputy Brouard: Yes.

The Chair: And what is that kind of uplift?

Deputy Brouard: I think it would be probably about two to three times.

The Chair: Between two and three times what we are currently paying? Right.

Deputy Brouard: Yes, but they are absolutely essential for those operations that are happening today.

The Chair: Yes, and I completely accept that but, as everybody knows, it is something that you need to move away from as quickly as you can.

Deputy Brouard: Absolutely and if I could provide the accommodation I have got a fighting chance of doing so.

The Chair: Mr Mullin.

Mr Mullin: Just in terms of assurance we do have a weekly challenge process so any posts that the teams are looking to recruit to, we review. Where there are agency requests we also scrutinise to make sure and ask questions around if there is a different way of doing this. The challenge we have with the agency, as you know the UK had what they call a glass ceiling in terms of price point that they were willing to go to.

That has been lifted because they are in the same situation that we are, in terms of service continuity. So, as Deputy Brouard says, the lived reality at the minute is that we are paying two or three times more than we would have pre-pandemic, for agency staff, and that is true of whether you are in Jersey, here or in the UK. It is just the way things have gone post-pandemic.

We would hope to have settled down at some point but when that is we do not know and I think, as Deputy Brouard says, it is not just one factor, it is the accommodation, it is the cost of living, it is the cost of travel on and off the Island. Island life is not for everyone but everything we can do to make it as attractive as possible we are doing.

The Chair: Could I bring it back to pay now because that is one of the areas that Deputy Brouard mentioned? I am sure that has relevance because everyone is interested in how much they get paid. Have you done any analysis on the cost benefits of increasing pay to hopefully attract more workers who could perhaps then more easily afford the private rental sector, so increasing pay for these staff in the hope of reducing the significant premiums that you are having to pay by using so many agency workers?

Deputy Brouard: If I could interject on that, that is almost counter to the other argument you just had a moment ago. But pay, although it is extremely important to us, it is not within our mandate as such.

The Chair: No, you would have to make representations to Policy & Resources.

Deputy Brouard: Absolutely.

The Chair: Have you done that?

Deputy Brouard: We talked to Policy & Resources and in fact we had a meeting Monday, talking to Deputy Mahoney just about these very issues and they are very much aware of them. But of course you have a situation where, if you just increase pay, without some of the other factors coming into play, you do not necessarily solve the problem.

The Chair: Exactly, and it would need a detailed analysis to see whether it was beneficial. But is that work underway?

Deputy Brouard: Definitely, Deputy Mahoney is very much aware of it and is fully cognisant of the position that we are in with regard to the –

The Chair: Yes, but I do not think that is getting to what I am saying, which is if there is going to be a positive trade-off between pay and levels of agency workers, is that something that you have analysed as a proposal and decided whether it is worth doing and if it was, put a proposal to P&R requesting that?

Deputy Brouard: We have not done that analysis. That, I think, falls more into the P&R mandate rather than ours.

Ms Le Clerc: Could I please pick up on that? I think just picking up on Deputy Burford's point, if you have increased the rent allowance from two years to four years, in effect you are giving those agencies an uplift in pay. Are more local staff going to be disgruntled because they are not getting that uplift in the rent allowance because they will not get the rent allowance as a local paid member of staff? But would you, increasing the pay, retain those staff? So you are just paying out more and more on agency with extra rent allowance but actually would some of that remuneration be better going to locally paid staff to keep and retain those staff and attract new, permanent staff?

Deputy Brouard: Agency staff would not get –

The Chair: I do not think you meant agency. I understand the point that Michelle is making here but I think it is more a case on staff who have been brought to the Island with an accommodation package, compared to the staff who are local or staff who do not get the accommodation package.

Ms Le Clerc: Sorry, that is my mistake.

The Chair: I think the question is comparing those two.

Deputy Brouard: I think the main issue is accommodation cost. Again, when we have staff that have been on the rent allowance and then that falls away, they suddenly lose a really big chunk of their income and that is when they have to move. If we had more accommodation that we would control the price on then we have got more chance of retaining those staff long term.

The Chair: Yes but I think you are going to have to accept that a proportion of staff are going to have to live in the private sector and you are not going to ever provide accommodation for everybody?

Deputy Brouard: Of course and we would very much prefer that people did.

The Chair: And if people are paid more, then they are in a better position to likely afford to live in the private sector. That has to go without saying.

Deputy Brouard: Of course and that would chase out somebody else who is living there now who then will not be able to afford it.

The Chair: Okay, we have probably gone as far as we can on that one. I think it is back to Deputy Fairclough

Deputy Fairclough: Just one final question, if I could, Deputy Burford.

We have referred in passing to growing our own, for want of a better expression but of course people have got to want to pursue a profession within healthcare. Do you consider, as a Committee, the amount of money being spent on training healthcare workers at the Guernsey Institute represents value for money, or could those funds, do you think, be more effectively spent on recruiting ready trained staff? What is your view on that?

Deputy Brouard: My personal view, and I will go to the panel, is that if we have somebody who is born and bred in Guernsey who then goes to the Institute, there is every likelihood that at some point in their career they will be back in Guernsey working and that would be far better for me. So the more staff we can get through the local Institute, absolutely, would be my first port of call. But there is a finite number of people in the community of any given year who wish to go into that particular role. But I have no problem with Education, Sport & Culture doing that funding.

Deputy Fairclough: And what are the numbers, incidentally, going through the Institute at the moment? Do we have those to hand?

Deputy Bury: About 70, I think, going through the Institute.

Deputy Brouard: About 12 or 13 a year, I think.

Deputy Bury: Taking in each year.

Deputy Brouard: Yes, the cumulative is 70, about 12 or 14 every year that go through as a cohort.

The Chair: I think this is a good point to take a break, so if we could just reconvene around about 11 o'clock.

Thank you.

The Committee adjourned at 10.55 a.m.
and resumed at 11.02 a.m.

The Chair: Okay, welcome back. Thank you.

I would like to follow on just one more little point briefly on this housing rental allowance for staff coming to the Island, which you say you have doubled from two years to four years.

Deputy Brouard: We have not. Just to be fair, this is a States of Guernsey, States-wide policy. We are receivers of it. It comes from the centre.

The Chair: Okay, but in relation to Health & Social Care, could you tell me how much extra those extra two years are budgeted for? Do you have a figure for that?

Ms Duckworth: I have not got the figure but what we do know is that the costs have gone down because we have not got as many staff. So, whilst the rent allowance has increased in terms of over the last few years, the costs have gone down.

The Chair: Because there are fewer staff in that sector?

Ms Duckworth: If you have somebody on rent allowance for two years and then they leave and you recruit somebody else, you are paying them rent allowance for two years. So by paying over the four years the intention is that hopefully you stabilise the staffing.

The Chair: Okay, that is understood. That is helpful, thank you.

Michelle.

Ms Le Clerc: Just going back to the Rule 14 questions from Deputy St Pier and just finishing off on the agency, the 11 months for, I think it was to 2022, it was approximately, £11.8 million total agency costs. Of that, the Adult Disability Services was a staggering £4 million and that has risen from £0.5 million in 2018 to £4 million. So that is five years, eight-fold increase. Can the President explain why there has been such a significant increase in that specific area of agency costs? So that is Adult Disability Services.

Deputy Brouard: Yes, I think, and again please colleagues jump on me if I get this wrong, this is mainly about the Autism Hub and I think it is basically with regard to where we brought Islanders back to the Island who were being treated in the UK, which was an expensive treatment for them in the UK but it was the right thing to do if we could bring them back to the Island safely and provide the care that they need.

I think from the original business plan, that we would be able to recruit locally when this happened. This was going back many years, before our tenure, but unfortunately that has not happened and in fact we rely very much on agency staff in that particular niche market, but I will go to Dermot, perhaps.

Mr Mullin: Historically, any of the unregistered roles predominantly we would have recruited locally into those roles, so support worker roles across Adult Disability, Children and Family Services, Residential Services, etc. Post-pandemic that has changed and people have opted that it is not an area they want to work in. So we have seen a steady increase in the need to bring in agency support workers than we ordinarily would have in the past, over the last number of years.

As we said, hopefully we will start to see that cycle turn again and we will be able to attract more local people into those sorts of roles but I do not think there is a quick win for it but certainly we would prefer if it was a local, permanent workforce rather than an agency.

Ms Le Clerc: So is it now actually costing more to have brought people back on-Island than it was originally when they were off-Island? I am not saying that bringing them back was not the right

thing to do because again I think people want to be here and they want to be with their family, etc. but it seems to me that through these agencies it is costing substantially more than was anticipated.

Deputy Brouard: The figures go back to, the figures I have got here from 2019, when we had 33 staff and now we are up to about 42 agency staff in that particular area. You pose a very good question. That is an assessment we continuously have to make but we would very much like to be able to recruit locally or have permanent staff, rather than using agency staff and keep the staff on-Island. It goes back, I am like a broken record, it goes back to the accommodation. If I can provide accommodation I have got a fighting chance and my team have of then getting permanent staff to work in those particular areas.

We do have Islanders off-Island. I think we have had three in the first two months of this year, which are going to be costing us north of half a million, for the three, at least, for this year alone, because they need specialist care in the UK, which we just cannot provide.

Mr Mullin: If I could come in. To answer your question, off-Island complex care, the price point for that has rocketed as well. What the UK providers have experienced is the fallout of Brexit, where support workers or staff that they would have engaged in those environments are harder to recruit, therefore providers have moved out of the market, which means now there are two or three, maybe four key players. Post-pandemic, we have just seen the price point for that, especially around high levels of complexity that we would never have been able to sustain a service for here, has rocketed.

It is a difficult balance to say accurately whether it would be cheaper to have people off-Island. My personal thought is it would not be and, as you say, you lose that whole social side where this is their home, this is where their family are and we can deliver better outcomes where they have been brought up.

Ms Le Clerc: Within the Island, yes.

Just one, really, last question on agency and that is Children's Services, because I understand at the moment there are teams that come in from the UK, called the Innovate teams, and they are providing, I think, social workers for young people needing social care. I believe that the staff change every six months with the Innovate team, so there is a lot of churn. I just wondered, because the agency costs, again, in the Rule 14 questions, for Children's Services, was fairly low, so do the agency costs, the almost £12 million, include the cost for the Innovate agency teams; and if they do not, approximately how much are they costing?

And I think back to my time when I was fostering and actually in those days there was still churn but it was usually every three years on the social workers. That is not necessarily the best for young people when they have got constant changes in their social workers and social care providers. So do we think that that is the right approach and what are we doing to try and get some more permanency into that Children's Services team?

Deputy Brouard: You are absolutely right and if we could have recruited permanent local staff to that area, we would have done. In fact, we had seven, I think, staff, or possible people who would join that area and we were going to support them through their training and in the end, out of the seven, none actually went forward; (*Interjection*) it was four, was it, and none in the end went through to the final to actually take it up. So we are trying in that area. Lucy can you help us with that?

Ms Cook: Yes. I mean we have had significant retention problems and recruitment issues in social care over the last two years, particularly, and we made the decision to bring the Innovate team over last summer and they will be with us for a year. What that has enabled us to do, because part of the work with them as well as bringing a managed service over, is they are helping us to recruit permanent staff, so it has given us some time to restructure and rebuild our own service.

So our vacancy numbers in our social work teams have now more than halved and so we are recruiting permanent staff, which is really encouraging. It is slow and steady recruitment. We are

not out of the woods yet, but it is better than it has been in the last couple of years and so we are hopeful that by the time Innovate leave us in June that we will be in a much better position with staff teams in our frontline social care.

I take your point, Michelle, about the turnover. The Innovate staff have stayed for six months and then we did have a change. But that is no different to any other agency staff; quite often they will come and go after three months. The maximum they will stay is six because of the double tax issue that they face here.

Ms Le Clerc: And what are the costs? Can someone come back to us with them, the costs on that, please?

Deputy Brouard: No problem at all.

Thank you.

The Chair: I think cost is the next area we want to explore and I am sure it is something that is at the forefront of your mind all the time, your Committee is responsible for pretty much half of the States' Budget. The budget for Health & Social Care, excluding COVID, increased by 11% in the last political term, so over that four and a bit years. It has already increased by 18% in the first half of this political term and that is before inflation is starting to ramp up. It is just not sustainable to go along on that basis, is it?

Deputy Brouard: You know, there are certain costs that we cannot say 'no' when someone turns up to ED or needs an operation. That is the difficulty that we face. And some of the areas where we would like to – you picked up, very rightly, the extra costs we are having to pay for agency, again – if we could recruit permanent members of staff then that agency cost, which is substantial, there is £5 million alone from what it used to be almost to what it is now, if we could recruit permanent staff to those positions – again, it goes back to the accommodation – we have got a fighting chance of doing that.

But we are facing a continuous increase in demand. We have got the backlog to deal with, which we have never had before. We never recruited enough staff to cover a backlog, hence the issue that we have got a backlog of operations. Then we have got the added problem of the demographics, which are just working against us. There is no denying that.

Who would be best to pick up from here?

The Chair: I think we are going to follow up on some of those aspects shortly, so we will probably come to that. Just as sort of a supplementary there, as you know, Policy & Resources have written to all Principal Committees asking them which parts of their areas and work and projects could be de-prioritised under the refresh of the Government Work Plan; what have you told them?

Deputy Brouard: Again, it is in the public domain in the Billet, I think one of the main areas –

The Chair: I think it is more recently than that, though, that they have written to you.

Deputy Bury: They did ask all Principal Committees, didn't they, to examine the GWP priorities –

Deputy Brouard: Oh, from that point of view.

The Chair: Thank you.

Deputy Bury: Policy and legislation areas and our spending on capital and things like that.

The Chair: So what have you identified that you can de-prioritise?

Deputy Brouard: Not very much , to be honest, because with 110 service areas, we could take one or two out from each one but there are some things that are already in train, which we are nearly finished, which would just be barking to stop and not carry on. The Children's Law needs to progress. There is a whole load of other pieces that we have already got in train, need to progress. To be honest, there is not very much that we could say actually we are just not going to do that.

We could stop on NICE drugs. That could be one. It is nice and simple and easy. But the uproar would be horrendous. I am not prepared to take that at the moment.

The Chair: Okay. I think that leads us quite nicely actually to the Health Transformation, because the increase in costs is looking pretty unsustainable for the Island and your Committee is always going to be in the forefront of this, as being the largest spending Committee. There was a report by KPMG on Transforming Healthcare, which identified four areas for development, which was out of hospital reform; finance and accountability reform; organisation and governance reform and technology reform.

The States agreed that that would be achieved through a collaborative approach under what was called the Partnership of Purpose in the last Assembly. That was a 10-year transformation programme. It is at the halfway stage and work began in the previous term, with the Health Improvement Commission, Hospital Modernisation and Electronic Patients' Records. Can you advise what work has been instigated this term to move to the more sustainable model of care envisaged in that policy letter?

Deputy Brouard: I am not really understanding the question, sorry. What are we doing now towards the Partnership of Purpose, do you mean?

The Chair: Yes, towards what was agreed by the States in the previous term, as a way of transforming our health services in Guernsey, in the Bailiwick.

Deputy Brouard: Well, one of them is obviously the Hospital Modernisation Programme, which the first phase is now –

The Chair: Yes, but that was started in the last term. I am just wondering if there are any new initiatives that this Committee has brought forward.

Deputy Brouard: No, I think most of the initiatives that we have got, we decided very early on in our term that we would not go back and revisit what the previous Committees have done because that takes two years of time. We have accepted what was already in train and are putting it into practice. The difficulty we have had is of course COVID came for the second time and bit us again.

But we have not changed that particular goal of trying to be more integrated, trying to work closer with the GPs to get the MSG more on a … literally they are our partners as we have progressed forward.

Ms Le Clerc: I think, Dermot, it would be useful if you came in.

Mr Mullin: I think it is important to understand the Partnership of Purpose is a journey. It is not something that is going to be delivered overnight. As Deputy Brouard says, the new Committee signed up and said, 'We are not going to seek to change direction.' Community transformation is

under way. Now there have been some delays in terms of prioritisation of that in respect of the Government Work Plan.

For example, one of the aspirations is a principal community hub. That will not be revisited until the next Government. However, there are pieces of our programmes and projects of work going on around in specialist housing for adults with complex needs, either mental health or adult disability. There is also an aspiration, which has been progressed, around potential for a children and family hub, which is being progressed. Hospital modernisation, as has been pointed out, and the EPR.

There are lots of things going on and we will continue to drive in terms of transformation of services, which all are underpinned or the Partnership of Purpose is the overarching umbrella. Work goes on with primary care, as Deputy Brouard said, Medical Specialist Group, St John Ambulance and Rescue, looking at ways we can transform. A good example from St John Ambulance is we have got a seconded paramedic who specifically focuses on frailty and those that fall, in the community working with us.

The Chair: So, more joined up working?

Mr Mullin: Much more integrated and the principle has been applied to transformation of health and care in Alderney as well.

The Chair: It is strange. Alderney was what I was going to pick up on next and we do understand that work is to integrate the health and care provision is underway in Alderney. Does the Committee consider that work could be used as a trial for the roll out of the joined up model or carers out in the Partnership of Purpose?

Deputy Brouard: We were only discussing, again, that yesterday at the Committee meeting. Some of the aspirations from the Alderney Care Board and how we look after Alderney; Alderney is in a unique position, they are probably 20 years ahead of us in terms of their demographics and needs and we can use some of the learnings we have as we integrate there, to ourselves, to use as a bit of a model, as we have brought in there. We have had to support their GP practice, how they work with the Memorial Hospital and all the other aspects, the pharmacy and everything else, which all become critical on a very small Island.

Dr Brink wanted to come in a little bit on the last question as well.

Dr Brink: So, just to give you specific examples, which I think is what you are seeking, the Committee approved the Combined Substance Use Strategy. So that was a refreshed strategy and, if you look at the alignment, then, to the Partnership of Purpose, you have got your arms of prevention/early intervention; you have got your harm reduction and promoting recovery rehabilitation; and the third arm is your policies and treaties.

So it really aligns very squarely with those principles of the Partnership of Purpose of creating an environment for health, moving up stream and going to prevention/early intervention, but also focusing on the provision of those joined up services. So examples are working across the *piste* substance use support services in the Prison, just as an example.

That is one example. The other is the advances in women's health, public health, which have been strongly promoted. They started with Deputy Soulsby and Deputy Le Clerc with the teenage pregnancy, under-21 contraception, but have moved onto free cervical screening, the expansion of the HPV immunisation programme, making it really possible for us to eliminate cervical cancer as a public health problem in the Bailiwick. So again aligning not only to the treatment of disease, so to speak, but moving the argument upstream and looking at the very strong prevention/early intervention.

The Chair: I think that is the point I was probably driving at because there does appear to be an unsustainability in the budget of Health & Social Care at the moment and one way to deal with that

has to be reducing the demand through preventative programmes. But it is not going to pay back for some time. But this is the work that is undergoing and you have given those examples.

Dr Brink: And it is that strong partnership working, as well, that Public Health works really closely with the Health Improvement Commission and we work hand in hand on these interventions. Often, we will look at a task and we will say, 'Who is best to deliver it?' So it is true partnership working and I think that is really important.

So if you think of the smoking cessation, the QALY's associated with smoking cessation are extremely cost-effective. So instead of treating the lung cancer, or treating the chronic lung disease, you are moving the argument upstream. We are really passionate about doing that and we have had strong support from our Committee for that.

The Chair: Excellent. You mentioned the Health Improvement Commission, in the hearing that we had, 15 months ago, it was discussed about SLAs for the third sector, generally, and how having a longer SLA for any third sector partner organisation is beneficial because it enables them to plan and recruit much more effectively. You said at the time that was something you agreed with. I believe they may still be on a one-year SLA, is there anything changing, where the Health Improvement Commission is concerned, into extending that into possibly a three-year SLA?

Dr Brink: I think that is certainly underway and I will speak maybe with Dermot and our finance section but the idea is to have longer SLAs because you have got to have a sustainable model.

The Chair: Okay, that is fantastic. Thank you very much.

Coming back to the previous topic, however, you signed a joint letter, together with the Presidents of, I think it was, Home Affairs and Education, in the lead up to the tax debate and there was a lot in that letter about the demand for health services in the community and the fact that, obviously, they need funding. I am just on the same Partnership of Purpose thread here but I think that was recognised previously in the Partnership of Purpose, when covering the concept of a universal offer and there was an agreement, I think, in that to publish indicative costs for common procedures, so that the public were aware of what these things cost. Is that work being done because I do not think we have seen any of it?

Deputy Brouard: I have certainly quoted in some of my updates to the States, the cost of a knee operation and those sorts of –

The Chair: Yes, but I mean on sort of a published thing that people could be aware of what these things cost?

Deputy Brouard: I certainly have no difficulty in doing that. I have mentioned several times what they are and I think Deputy Trott, as well, in the States does other issues of the cost of different parts that we provide as a Government. But I certainly have no difficulty in us publishing, for a standard knee operation or for a standard cancer treatment or whatever because, unfortunately, everyone will be slightly different but just to give some idea of what a triple bypass will cost at a London hospital.

The Chair: Again, continuing on the unsustainability versus sustainability thread, we are getting to a point, aren't we, where we have really got to differentiate between needs and wants when it comes to healthcare?

Deputy Brouard: We try and do that. Well, we do that on a daily basis now, really, the system that we have in place. It should, when you go to your GP, they should be able to decide at that point

whether you need to go to the MSG or whether you just need some physio. Those sorts of issues, that sort of triaging, is already happening.

I would probably look at Dr Brink or Dr Rabey to help me on this question.

Dr Brink: I think again, it is trying to put in that prevention/early intervention because that is going to be much more cost effective and if we can move that argument upstream. Yes, of course you have got to look at the efficacy and the cost efficacy of interventions and we do that all the time when we recommend them.

There are several examples. We look, for example, at the efficacy and cost efficacy of the flu vaccination programme. It would be nice to give everyone everything but actually when we are looking at a specific intervention, with regard for example to vaccination, we will look at the efficacy and cost efficacy of that particular intervention.

So I think you are right. I think we do have to scrutinise what we do and we do have to look carefully at what we do and we have to spend that money as wisely as we can because it belongs to the people of Guernsey.

The Chair: In terms of the prevention strategies, I know that you do other prevention other than the stuff that is parcelled out to the Health Improvement Commission. I understand they receive about £1 million a year, which is half a per cent of your budget. Is enough actually being diverted into prevention, do you think, out of the budget, in the hope of having future savings coming home?

Dr Brink: We can always do more. There is no doubt about it.

The Chair: I meant from a rate of return point of view.

Dr Brink: I think it is a difficult question to answer. What we can say from Public Health, we have been really supported in our initiatives and we are trying to progress these initiatives as fast as we can with our current staff profile that we have.

Now, we could always expand the staff and do more. However, what we really want to focus on is doing what we do well and moving that forward. So an example is the free under-21 contraception, the smoking cessation service, looking exactly at what we do, creating that environment for health.

But I think Public Health is going to be so much more. There is not only the health improvement messages but actually looking at that environment for health, so when we look at things like climate change and pollution and so on, that is going to be bad for people's health as well. I think one of our values is not only saying what Public Health or the Health Improvement Commission can do, but their joined up working; and I think that is something we did really well in the pandemic, as a community, where it was all of our problem.

If you look, for example, at building a healthy house, we can recommend what we think a healthy house looks like. However, when you look across the *piste* it is working with Planning, it is working with Environment & Infrastructure. It is joined up working. I think that is where our value will come from. So it is a bit of a round about way of answering the question.

The Chair: I think just to sum up on this section, I suppose the nub of the question that I want to get back to is, Deputy Brouard, do you consider that healthcare and health and social care is going to be affordable for the Island – I do not mean for individuals but for the Island – going into the future, given the rate at which costs are accelerating?

Deputy Brouard: I think it has to be and it will be. We will tailor our cloth as best as we can.

The Chair: So that may be we may need to withdraw some of the less crucial services?

Deputy Brouard: You will have a really difficult job taking away, we have had a few challenges in the short time that we have been here, even with domiciliary care. it is not easy to reduce the service down and it is not something that the staff want to do, it is not something that we want to do, but we have to do it for necessity to make sure that the service was still of quality.

You are going to have that dilemma when they come with the next set of NICE drugs. Do we expand? Do we use the money elsewhere or do you spend it somewhere else in Government or do we not take the taxes in the first place. Those issues will come to the table but they are extremely difficult.

As a collective, joint Island, we might say we do not want to spend any more on health, until it is your aunty or until it is your mother and then you do and that is the difficulty because we are picked off individually for specific care and specific things. Any tiny part of our infrastructure from the GPs through to the operation that goes wrong, someone will jump extremely quickly and extremely fast. Rightly so.

The Chair: Yes, but that is the nature of being in a community and it is very understandable, as you say, when something affects you personally or a relative of yours. But at the end of the day it is the responsibility, isn't it, of Health & Social Care to take an overall strategic approach?

Deputy Brouard: And we do and we think that we are managing what we have as best as we can for the amount of money. Every time we put more money in one area, the money has to come from somewhere else or it does not go into that area.

Ms Le Clerc: That is surely where the Partnership of Purpose is so important, because it was not relying everything on Health & Social Care; that was working with partners in the community such as the Health Improvement Commission, such as Headway, such as Health Connections, such as MIND and it seems to me that we are almost at a standstill and we have got some very good partnerships but surely we should be looking at expanding some of those partnerships so that the Budget that you have got is spent in the best way possible?

Some of those partners can actually raise funds from elsewhere, through the Social Investment Fund. Health Connections, for example, Bella is doing a fantastic job with the charity shops in Town, so the money need not come of all of that Health & Social Care budget, if you can work those partnerships with other organisations.

Deputy Bury: I think we need to be really careful not to play into the narrative that the Partnership of Purpose has stopped in any way, shape or form.

Ms Le Clerc: Well, I think Deputy Brouard was sort of saying that was –

Deputy Bury: All of the people that you just mentioned, HSC still work with and continue to work with, so I just think it would be quite scary to the community if that was what was taken away from today because it is not the case. While we might not have been able to progress some of the workstreams as quickly as possible, because of external factors, the recruitment issues, etc. that we are also dealing with, all of those partnerships continue and continue to be looked at of how we can do things better in that way.

Deputy Brouard: If I can just come back. I do not know where you have got that impression that I am not keen on the Partnership of Purpose; we absolutely took it on on day one and we are very happy to continue to progress it.

Ms Le Clerc: I think the words were that it has slowed down.

Deputy Brouard: Well, some bits have slowed down, inevitably.

Mr Mullin: I think, as I said earlier, the Partnership of Purpose is a journey. It is not something that is going to be delivered overnight. I think we need to remember that service delivery was disrupted significantly because of the pandemic. So, yes, there are reasons why things have slowed down but in terms of all those key partners we are still working with them.

The other challenge with a lot of the strategies or initiatives, we do them as they are evidence-informed and evidence-based but what you tend to find, certainly in some of the longer term things, is social care, you do not see your return on investment for about 20 years, and that is where successive governments in the UK have failed because they are very quick to change direction of travel every time there is a new government.

As Deputy Brouard says and Deputy Bury has said, we are still signed up to the principles of the Partnership of Purpose but it is not all going to be delivered in this term. You are probably looking at another 10-plus years, before all the parts of it fall into place.

Deputy Bury: And to go back to the Government Work Plan, a lot of the workstreams of the Partnership of Purpose had to be timetabled, scheduled, as part of the Government Work Plan. We cannot do it all at once.

Deputy Brouard: And some of it is not necessarily cheaper.

The Chair: I would like to move on at this stage to questions on Hospital Modernisation, which Deputy Fairclough will be asking.

Deputy Fairclough: Yes, phase one of the PEH modernisation has a price tag of £44.3 million, I understand, in its completion. Is the project currently on target to be completed on time and within budget?

Deputy Brouard: The latest information I have is, yes, it may well be a week or two behind schedule but nothing more than that.

Deputy Fairclough: So when is that, Deputy Brouard? My understanding is March/April 2024, is that right?

Mr Jones: So it is a two-year programme, which commenced in March 2022, so we are expecting March 2024 to receive phase one. Just to talk about the cost, though, I do not recognise that figure, that cost. We can provide the cost after the meeting but it is significantly lower than that for phase one, its price.

Deputy Fairclough: Okay, do you happen to know what that cost is for phase one?

Mr Jones: I do have the figure. It is *circa* £34 million for phase one. Now just to be very clear, that is not what our construction partner will receive. There are lots of costs that we have to have over and above the construction: the commissioning, the equipment that goes in, the training for transition of the staff, the team that looks after this and all those ancillary costs. But it is *circa* £34 million but what we agreed was a fixed price with our construction partner and, as Deputy Brouard says, we expect that to be within that allocated funding, Deputy Fairclough.

Deputy Fairclough: And presumably this facility will require additional staff when it is fully operational? If so, how do you intend to staff it, given the current problems with staffing?

Mr Jones: It is a really interesting phenomena at the moment. We are building a new ICU unit that is absolutely critical. It was a bit of a bottleneck for us historically and it is going to be a fantastic facility. Our manager there, John Eaton, is currently out to market to recruit, and I think he wants to bring in 14 colleagues there. We have already filled 10 of those. So when we were talking earlier about the value of excellent facilities and how attractive they are for staff, we have got real evidence of that in respect of the ICU unit that will be put in place there.

So that is our experience at the present time. However, as we move to phase two, as I am sure we will talk about in a moment, staffing really is a concern for us. To attract and retain the best is really the cornerstone of how HSC can deliver that continuity and quality for our service users.

Deputy Fairclough: Thank you for that.

You mentioned phase two and in the 2019 policy letter, it was estimated, and I hope these figures are right, that phase would need between £27.6 million to £36 million, from the Capital Reserve, to enable its delivery. Please stop me if that is wrong!

Deputy Brouard: Stop. I do not think that is the right –

Deputy Bury: That was when we were going to have three phases of development, wasn't it?

Mr Jones: That is quite a historical figure.

Deputy Brouard: Yes, I think phases two and three have been combined.

Mr Jones: What I think would really help, if the Chair is agreeable, I have got a kind of ready reckoner there, would you like me to just hand that out?

The Chair: No, I think we will –

Mr Jones: Okay, we will do that afterwards.

Deputy Fairclough: And, subsequent to this hearing, we can obviously write to you and get confirmation in writing. Recently it has been reported that, due to the impact of pressures such as inflation, that second phase could be higher than the original estimate.

Mr Jones: Would you like me to talk to that?

Deputy Fairclough: Please.

Mr Jones: So, phase one is progressing as we would expect but phase two completes the programme and, historically, we have talked about phases one, two and three. Just to be really clear, phase one is what you see on the ground now. If you go up to the PEH location, it is really coming to life, it is really exciting, what we are seeing there. Phases two and three were combined together because that is the best way the market can respond to that challenge of delivering that quite significant programme.

Obviously, we can talk you through the individual components but it is much bigger than phase one in terms of its scale of magnitude and contribution to what we are trying to achieve in the future.

We have done a very detailed outline business case and that is the product of many months of work that we presented to the HSC Committee in December of last year and we made the case therefore of what we think is the final design, the right design, to cope with everything that we know is coming down the line there. The demographics, the desire to provide as much as we can on-Island, the innovation that we want to bring in there.

What we also did, at outline business case stage, was take the very latest figures that are published from the market and we plugged that into our design. So, in November/December 2022, very recently, we uplifted our figures, which at that point were probably 12-13 months old, and that is where that figure, I think Deputy Ferbrache said in the recent tax debate, we may need to make the case for £13 million to £15 million more.

Now a good chunk of that is what you have seen in the market. It is a very difficult time to get things done at the right price. Inflation is a big factor there. But we went onto the Policy & Resources Committee, after HSC, to give us their full support. Deputy Brouard and I made the case, explained our outline business case and really broke down what that plan and why the £13 million to £15 million, we felt, was necessary, unavoidable, but a good investment over what will be a 50-year investment in the PEH facility for our community.

Deputy Fairclough: My understanding is it was always intended that phase two would continue immediately after phase one was finished. Is that still the case?

Mr Jones: Ideally. My team would dearly like to close phase one and then move straight into phase two. I think J. W. Rihoy, if they are our partner for stage two, would appreciate that as well. There are certain costs to get your presence on site, which obviously if we stepped down and there was discontinuity there, we could lose there.

But also more practical things such as our partner, and I think John and I view J. W. Rihoy as a real partner, working excellently with us, we are co-located, they have got to learn HSC and the PEH site quite intimately in the last year and all of that knowledge, with all of those staff that we work with day to day, that is why we would want the practical ability to continue if at all possible. But coming to some of the previous discussion we have had in the Scrutiny hearing, it is a big decision and it is an even bigger decision because of that impact of uplifting those prices for that final design.

Deputy Fairclough: We also understand that there is a narrative now, particular post-Tax Review, about revisiting the Capital Programme and we were told, I think, over the last couple of months, that progressing phase two was potentially on hold until after the tax debate. So sitting here today, what is happening with that? What are your discussions with P&R?

Mr Jones: So Deputy Brouard will, I am sure, complete the political picture, but when we presented in December, Deputy Brouard and I, we had 50 minutes of discussion and debate about the outline business case, some excellent questions, and we went through all the detail there.

We were then politely asked to step out and then, after the meeting, colleagues in P&R, said: 'Look we would need the result of the Tax Review –' which at that time, of course, was February and then we wait for the second part of the Tax Review.

So as an officer, we are ready to go in terms of taking that outline business case to a full business case but we are not going to push that button until of course we have got the political clearances to do so. Now the very latest political dialogue, obviously, I cannot comment on that. Deputy Brouard?

Deputy Brouard: Yes.

Deputy Fairclough: So, given the change in delegated authority, we know that that has changed, although it does not necessarily affect projects that have started, is this something that is going to come back to the States, Deputy Brouard, or not?

Deputy Brouard: I do not know whether it will not. I would have suspected not but I may be wrong because it is part of a phased approach. Of course, from our point of view, we have spent a considerable amount of time in doing this. It aligns well with the Partnership of Purpose. This is the

modernisation of the Hospital, this will make things more efficient. It will not make things, necessarily, cheaper. But it is going to make things much better.

It will also take away one of our major risks in maternity because it will bring the theatres and maternity to a level that they can go straight across. We run multi-million pound risks every day. So this is a critical area for us to go. We have got planning permission. We are ready to go. It becomes a political matter, whether or not our colleagues in P&R will support it or eventually whether the States will.

But I think we would be foolish, with the demographics we face, and the challenges we have ahead of us, not to take this opportunity to increase the size of our Hospital. Just on the figures, we are talking, this phase two will be well over £100 million. We are not talking £20 million or £30 million. It is a substantial piece of building. It will not futureproof our Hospital because no one will ever be able to do that, but it will give us a substantial increase in our ability to service the needs of our population.

Deputy Fairclough: Thank you for that.

I do not have any further questions on that area.

Ms Le Clerc: I think we will move on to some questions regarding the MSG. If the MSG underperforms or fails to meet its contractual targets, what levers does the States have, as a commissioner, to obtain improvements in performance? Despite the size and value of the contract to MSG, isn't the reality that the States in fact desperately needs the MSG to deliver secondary healthcare to the community and there are no effective levers? Do we think that actually the MSG are delivering good value for the Guernsey taxpayer at the present time?

Deputy Brouard: I do not know which one to pick up first.

I think you have to remember, we are in partnership with the MSG. it is like a marriage. I am sure we have good days and we have bad days. They are extremely good at what they do. We are very grateful for what they do. I believe we hold them to account and we work together to resolve problems. Sometimes they will go over the top to help us, sometimes we will go over the top to help them, but I think Dr Rabey is probably better placed to answer than me.

Dr Rabey: Yes, the contract, as you know, was put in place five years ago, and it has performed through that time, I would say, fairly well. I would say we saw the partnership at its very best during COVID, when our partners in MSG did not sit on any clause in the contract to reduce their input. They were right on the front line and rolling their sleeves up and going into the dangerous areas and we worked ever so well with them then.

If we have a problem and, for example, there are problems that come up, waiting lists for gastroenterology for example, there is a mechanism in the contract – as Deputy Brouard said, it is a partnership – to jointly agree a remedial action plan, and we do that. We have, due to problems in recruiting gastroenterologists who also wanted to do general medicine, which was a model five years ago, we have put in place a remedial action plan to have a gastroenterologist with no commitment to the general medicine rota, so they will not be doing the nights on call. That gives us a fighting chance of recruiting because the world has changed around us.

So that remedial action plan mechanism is used regularly and it works. Beyond that there are other sanctions that can be done. We can go to mediation if we fall out and, of course, there are fee reviews and there are built in reviews of the contract itself. So I believe it has worked well for the States of Guernsey. It has shown flexibility over the five years it has been in place and, yes, I believe it has been a good contract.

Ms Le Clerc: And it is on a five-year rolling contract, is it? When is it next due for renewal?

Dr Rabey: There is a fee review taking place at the moment and, yes, the contract is such that if the States of Guernsey gives notice on it, it would give five years of notice, which it could do at any time.

Ms Le Clerc: And so you think it is still delivering the right secondary care for Guernsey or should we be looking at alternatives?

Deputy Brouard: As a non-clinician, I think it is serving its purpose.

Dr Rabey: The States has outsourced risk in recruiting medical specialists and that is basically what the contract does and so when it comes to the cost of a very expensive locum, those costs fall to the Medical Specialist Group, rather than directly to the States of Guernsey, and there have been significant costs in locum fees, for example in gastroenterology, where they have had to have very highly expensive agency locums during a period where they have been unable to recruit.

They have been successful in recruiting almost across the board. Gastroenterology, I think, stands out because it is an exception. Neurology was another one where it was difficult to recruit a neurologist, another shortage specialty, but they have successfully recruited there. So, in that sense, they provide the services they are contracted to provide, they recruit the specialists to do that, we get high quality doctors in MSG and that has worked according to plan. The politics of whether that is the way Guernsey always wants to be are strictly political.

The Chair: Okay, primary care. Are you happy with the way primary care operates the model in Guernsey or do you think that benefits could be had from some form of reform?

Deputy Brouard: I think when you look around at other places as to what they have, we are obviously English speaking and we look mainly to the UK, you can literally see your GP within hours, virtually. You may not have the exact one that you want but you can certainly get to the practice and see someone very quickly.

It is a very high quality service, as shown from Dr Rabey's reports when he reports on the doctors' practices, so we have got a very high quality, a very good accessibility. Funding becomes an interesting issue. For those who struggle financially, they have full support through the ESS and of course there is an ongoing review, with regard to whether or not we need to look at the co-payments that we make with regard to the £12, I think, for the doctors and £6 for the nurse and whether or not we should introduce more money and pay for more people to be able to access the doctor.

From the survey that was done through Carewatch with our support, it was interesting in the findings and this is some of the work that is ongoing at the moment. But from the point of view of the quality and the accessibility and from the point of view of being able to see a doctor it is really good. There are some issues. We need to make sure that everybody who needs to see a doctor, can do so not for fear of finance.

The Chair: I think that is understood insofar as there are people in the middle who fall through the cracks, they are not helped by ESS and they cannot afford £60 or whatever to go to see the GP. Clearly, the accessibility to get to see the GP must be to an extent driven by the fact that it costs so much to go whereas in the UK are not comparing apples with apples because obviously people do not have to pay to go, so one would assume the demand would be higher.

You mentioned the point of the £12 subsidy and that is something I wanted to ask you about and I think it has been a point of discussion for some considerable time. The question is could the money be spent better? How much does that £12 cost? What is the aggregate cost that HSC pays for that? Are you actually going to come up with some proposals on that or is it still just an ongoing debate?

Deputy Brouard: There are some proposals. I do not know when they will come to the States but there are some proposals. We have been working very closely with ESS on this as to whether or not … politically I do not think there is going to be a demand or an ability to have extra funding. So in other words, I do not think new money would come in but I think maybe there is some appetite to look at a redistribution of those funds so those people that do not need the £12 grant, could that money be better spent for those who are just above the threshold for ESS.

The Chair: What is the aggregate figure? What do all those £12s add up to?

Deputy Brouard: I think it is about £4 million, from the top of my head.

Deputy Bury: I think it is about £4 million but once you do a few other things with it, it actually reduces quite a lot. So I think, as part of the primary care review, that has been the conversation and is ongoing but unfortunately the resource there has to be deployed to other urgent matters, so it has slowed a little, is in redistributing that money where is the best value you can get from it?

So the question you have asked is, is that work ongoing and it is. As ever, it has stumbled a little but it is certainly the intention to bring that to some sort of conclusion and proposals. They might not be as ground-breaking as possibly they could have been but that is the work that is happening.

The Chair: Thank you.

Ms Le Clerc: And what has the feedback been on the, I think it is, reallocation of part of Family Allowance, to reduce the cost of doctor visits for children to £25? Has that been successful?

Deputy Bury: Successful in what way?

Ms Le Clerc: As in making it easier for parents to take their children to the doctor. There were cases where people were saying, 'I cannot afford to take my children to the doctor.' Has that eased the problem? Have we got more people now being prepared to take their children to the doctor with the £25?

Deputy Bury: That is a good question. I am not sure if a review stage of that work has been done yet.

Ms Le Clerc: Okay, that may be worth following up, I think.

The Chair: Do you want to carry on with the cannabis ones?

Ms Le Clerc: Yes, I would just like to follow up from the last Scrutiny hearing and it was a question, I think, that Deputy Dyke asked at that time and at that time there were over 3,000 licences that had been issued for medicinal cannabis. I just wanted to know exactly where we were and I think there were three staff handling those licences and I think you were either putting a cost of £25 on or thinking of putting a cost for that.

So how many licences have we currently got issued at the present time and how many staff have we got handling those licences. Then I have got a couple of supplementary questions.

Deputy Brouard: I am probably not as close as I should be on that one, to be fair. The issue changed dramatically when the local market was able to sustain issuing licences themselves, or prescriptions. In the early days you would have to go to the UK, you would need a licence from us to be able to import your cannabis for your particular condition. When local prescribing came into play and our fee for providing licences also came into play, the dynamics changed completely.

So our licences that we were issuing have dropped considerably and locally now there are doctors who are prescribing cannabis and it is just business as usual. So I do not know –

Ms Le Clerc: Okay, so do we know how many prescriptions are being issued? So how many licences are being issued and now how many prescriptions are being issued locally for cannabis?

Deputy Brouard: Yes –

Emma Le Tissier: I do not think we have all of the information for the on-Island clinics but we know that our numbers (***Deputy Brouard:*** Our numbers are …) are reducing down. (***Deputy Brouard:*** Yes.) They are about a third, I think, of what they were.

Deputy Brouard: Because some people would wish to stay with the clinic that they were in, where they had already made a relationship in the UK.

Deputy Bury: We might not have all the figures that you are asking for, Michelle, right now, but obviously we can provide them. The context has changed and certainly, just as an indication, there were quite a lot of complaints at the time about how long licences were taking and people worrying. That has reduced dramatically because of the change –

Ms Le Clerc: And if the doctor is prescribing locally for the medicinal cannabis, the purchase of that medicinal cannabis locally, is that at the cost of just a normal prescription, £4 whatever, or is it a private prescription?

Deputy Brouard: Private prescription.

Ms Le Clerc: How much does it cost to fulfil that private prescription for a month? How much would the medicinal cannabis be costing a person when they have got either a licence or a prescription?

Deputy Bury: I think there is quite a broad range, isn't there? It is depending …

Deputy Brouard: Yes, I think Dr Brink will be able to answer.

Dr Brink: Just to answer the first of your questions, which was how many licences (**Ms Le Clerc:** Yes.) are being administered a month, it is just over 100. It obviously bounces up and down slightly. It was a lot more before we had on-Island availability, so that is –

Ms Le Clerc: It was 3,000 in October 2021.

Dr Brink: Yes. So it is just over 100 a month.

Emma Le Tissier: It is a cumulative figure. Sorry, excuse me –

Dr Brink: Yes, there was a cumulative figure.

Emma Le Tissier: That is the running total for the year so it is not at any one time. Some of those will relate to the same individual who would have had multiple prescriptions.

Dr Brink: For example, in September 2021, (**Ms Le Clerc:** Yes.) we issued just over 500 licences and if we look at February 2023 to date, we have just over 100 licences. So that gives you some sort of idea of the figures.

Ms Le Clerc: But what we do not know is how many prescriptions, locally now, are being issued by GPs, presumably?

Deputy Brouard: Now we did ask –

Dr Rabey: Excuse me, they are nearly all issued by specialist cannabis clinics working in Guernsey and not by GPs.

The Chair: I think perhaps the question which might clarify it all, is do you know how many individuals in Guernsey are using medicinal cannabis?

Dr Rabey: No, but we can ask the Chief Pharmacist or their team to provide that figure.

The Chair: Because I think that is probably what we are trying to get to at the end of the day.

Dr Rabey: You also asked about the administrative costs: the costs of the administration of the licences is no longer borne by the taxpayer. There is a charge for the licences and so they pay for their own administration costs. I think there are three people in the office and they may not all be full time. The licences are dealt with very quickly and promptly and at no cost to the taxpayer now.

Ms Le Clerc: So they are not issued through the GP, they are issued through different …? So what tie up is there between the GP and a person that is receiving medicinal cannabis through a prescription? So for example what other medication … so is the GP aware of a person taking medicinal cannabis and then perhaps other medication might be taken for pain relief, such as fentanyl or tramadol or gabapentin, etc., those sorts of drugs?

Dr Rabey: Every patient that goes to the cannabis clinics is encouraged to have information sharing with their GP.

Ms Le Clerc: But only encouraged, it is not –

Dr Rabey: Exactly. The patient might refuse to share information with their GP. They have that right under the Data Protection Laws but in fact there is a very high uptake of sharing information with GPs and the patients. The GPs do see that information.

The Chair: That is fine.

We have got to 12 o'clock, so I think we will wrap it up now. Thank you very much to everyone who has attended and this has been very beneficial to explain the workings of Health & Social Care to the community. Thank you to the members of the media, I think we have one or two today, and obviously to everyone who has tuned in on the livestream.

We undertake regular hearings with all Principal Committees and I have got two dates if anyone wants to make a note of them: Policy & Resources on the afternoon of 21st March and Education, Sport & Culture on the morning of 5th April. Once again, thank you to everybody and the hearing is now closed.

Deputy Brouard: Thank you, Chair. Thank you very much.

The Committee adjourned at 12 p.m.