OFFICIAL REPORT

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SCRUTINY MANAGEMENT COMMITTEE

Committee *for* Health & Social Care
Public Hearing

HANSARD

Guernsey, Thursday, 2nd May 2024

No. 3/2024

Further information relating to the Scrutiny Management Committee can be found on the official States of Guernsey website at www.gov.gg/scrutiny

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Members Present:

Panel Chair: Deputy Yvonne Burford – President

Deputy Simon Fairclough – Vice-President
Deputy Peter Roffey – States' Member
Deputy Andrea Dudley-Owen – States' Member

Ms Suzanne Le Ray – Senior Scrutiny Officer

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EVIDENCE OF Deputy Al Brouard, President, Committee *for* Health & Social Care; Deputy Marc Leadbeater, Vice-President, Committee *for* Health & Social Care; Deputy Aidan Matthews, Member, Committee *for* Healthy & Social Care; Mr Dermot Mullin, Director of Operations; Dr Peter Rabey, Medical Director; Dr Nicola Brink, Director of Public Health; Ms Helen O'Hara, Assistant Director – Operational Support/Programme Director (Transforming Health & Social Care); Mr Darren Smith – Finance Business Partner; Ms Teena Bhogal, Chief Pharmacist; Dr Dominic Bishop, Consultant Psychiatrist/Clinical Director, Specialist Mental Health and Adult Disability; Ms Emma Le Tissier, Committee Secretary 4

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Scrutiny Management Committee

Committee *for* Health & Social Care
Public Hearing

The Committee met at 3.30 p.m.
in Castel Douzaine Room

[DEPUTY BURFORD *in the Chair*]

Procedural –
Remit of the Committee

The Chair (Deputy Burford): Good afternoon everyone and welcome to this Scrutiny Management Committee public hearing session with the Committee *for* Health & Social Care. Today we will be focusing on many of the issues contained within the Committee's mandate.

I am Deputy Yvonne Burford and with me on the Panel are Deputy Simon Fairclough, Deputy Andrew Dudley-Owen, Deputy Peter Roffey and Senior Scrutiny Officer Suzanne Le Ray.

Following this session the Scrutiny Management Committee will decide if any further review activity relating to today's hearing will be undertaken and a *Hansard* transcript of the hearing will be published on the website in due course. Please also be aware that this hearing is being livestreamed and a link to the livestream is provided on the website and on the Scrutiny Twitter feed.

We will take a short comfort break at around about 4.30. We have got a lot of ground to cover today so we would be obliged if witnesses are able to keep responses as concise as possible. So if everybody would kindly ensure their mobile phones are set to silent, I will now turn to our witnesses today. Would you please introduce yourselves, starting perhaps with Dr Rabey?

Thank you.

EVIDENCE OF

Deputy Al Brouard, President, Committee *for* Health & Social Care;
Deputy Marc Leadbeater, Vice-President, Committee *for* Health & Social Care;
Deputy Aidan Matthews, Member, Committee *for* Healthy & Social Care;
Mr Dermot Mullin, Director of Operations;
Dr Peter Rabey, Medical Director;
Dr Nicola Brink, Director of Public Health;
Ms Helen O'Hara, Assistant Director – Operational Support/Programme Director (Transforming Health & Social Care);
Mr Darren Smith – Finance Business Partner;
Ms Teena Bhogal, Chief Pharmacist;
Dr Dominic Bishop, Consultant Psychiatrist/Clinical Director, Specialist Mental Health and Adult Disability;
Ms Emma Le Tissier, Committee Secretary

Dr Rabey: Dr Peter Rabey, Medical Director for Health & Social Care.

Deputy Leadbeater: Deputy Marc Leadbeater, new Vice-President of Health & Social Care.

Deputy Brouard: Al Brouard, President of Health & Social Care.

Mr Mullin: Dermot Mullin, Director of Operations for Health & Social Care.

The Chair: Thank you very much and congratulations, Deputy Leadbeater.

Deputy Brouard: Would it be helpful just to run through everybody who we have got in the second row, who may be asked to help with some of the questions?

The Chair: I think if you wish to call on anybody perhaps you could introduce them at the time.

Deputy Brouard: Introduce them at the time, fair enough.

The Chair: Thank you.

Right, so we will go straight into questions on the Partnership of Purpose and Public Health. In 2017, there was a policy letter on the Partnership of Purpose, accepted by the States and it stated that based on extensive modelling, unless changes were made, health and care costs would outstrip the available funding within 10 years. At the last hearing with your Committee last year, we were told that it was going to take at least another 10 years from then, so that is from 2023, to implement. Does the President believe that, as a matter of urgency, work should now be accelerated on the Propositions in that policy letter?

Deputy Brouard: I think generally Partnership of Purpose is all about providing sustainable healthcare in the future. There are a couple of unpleasant truths, unfortunately. One of them is that we are going to need, and I think most of the western world is in the same position, more capacity with regard to health and social care generally because we have got the silver tsunami coming through, I am probably one of the bald-headed tsunami part, but the numbers are just increasing. No matter what else we do, the number of people that will require treatment or care is going to increase. So staying still is not going to be an option.

Treatments are improving all the time. Not only the actual procedures but new drugs are coming on stream. That will all require funding and then of course regulation and the way things are done,

of course, is a lot more complicated now than it was 20 or 30 years ago. The issue that will come is who pays.

Now, whether we do it privately and people will have to find their own funds, or whether it is a public offering like the majority that we have now, that is where the dilemmas are going to come. If we do not address both of those two issues – (1) the capacity and (2) how it is going to be paid for – we are going to have people who will be needing treatment who will not be able to be served.

All the elements of the Partnership of Purpose all feed into that. Some of the ones for capacity – things like the extension to the Hospital – are really important. A lot of the Partnership of Purpose is all about communication. Communication is key. Electronic patient records is one of those very first building blocks in that particular area, so that we can start to link different services together.

We are trialling the position in Alderney, where we have got the Alderney Care Board and we are trying to bring the Hospital, the doctors' surgery and the care home in one collegiate, working together partnership. And we have got some really good partners at the moment, both with the MSG and with doctors. I would warn anyone, if you break what we have, because we have got a very good service at the moment, although it is under pressure, make sure you have got a replacement ready to take over. Because we have seen what happens with other areas of the States where we have dismantled something, but we have not then had the wherewithal to put it together for people we are treating.

The Chair: I do not think anyone disagrees or does not understand that it is going to cost more. I think the ageing population, new treatments, increased demand, we all understand that. I suppose what I am trying to get at is what is being done to mitigate that, to do things more efficiently so that those costs are as little as they can be, even though they are going to, clearly, be there?

Deputy Brouard: You are right. But please do not hang onto that 'efficiency is going to save us'. It is not. There are things we can do to be more efficient, and I will ask Dr Brink to comment, because there are things we can do to prevent or lower the curve that we can see coming towards us. But efficiency will not cut it alone. The things that will help are things like increasing capacity, in other words the Hospital, working more collegiately, like we are trying to bring the Community Hub together, which is the new facilities that we hope to have in Longue Rue. All that is part of that journey.

But even the States, recently, were pushing back on the Hospital modernisation. We have not progressed as fast as I would have liked in the community services but they are all in our gift but we have chosen to take almost an easier route of passing it onto the next group to do. But Dr Brink you have recently given us a paper, I think you have got a presentation to States' Members about this very idea of suppressing the curve that we have got coming towards us.

Dr Brink: Exactly. We are under direction from our Committee. Deputy Brouard came to us and said he would like us to look at how prevention is modelled in the Guernsey context now, today, looking at both longer term but also what happens over the next 20 years or so. What we have done is taken a set of different chronic conditions and looked at how we can flatten that curve.

We know that from 75-plus the curve of multiple diseases goes up very significantly so what we are looking to do and what we will be presenting to Deputies on 15th May is our vision for how we would flatten that curve.

That is not to say things have sat still now. For example, the Committee has supported the implementation of diabetic health checks. That affects more than 2,000 Islanders. What that does is it detects a problem early. So if you look at diabetes and development of kidney disease, managing kidney disease early on is far cheaper than waiting until someone needs dialysis.

So you have got the very upstream preventions like looking at keeping people healthy but we must not forget the secondary and tertiary prevention, which looks at people who have a problem and how we can minimise that problem and minimise the impact on health and care services but also improve that person's quality of life.

Does that answer your question?

Deputy Brouard: Yes, thank you.

I think perhaps also, Dermot, could I bring you in on the Partnership of Purpose and what we are working towards?

Mr Mullin: Yes, so I think, as you quite rightly say, it is what measures we are taking in terms of not having expenditure at a level that it is projected to go and what steps we are taking. I think more broadly what we have done and Dr Brink does it in terms of public health alliance with Jersey counterparts but we are also working more closely with Jersey health and care system about what keeps island operating context resilience in times like pandemic but also in terms of modelling. Are there things that maybe both islands do now that we would not both do in the future? So more of a shared care model across a pan-island opportunity.

In fact we have, I think it is about 13th May, we are also linking in through the Normandy office in France, both Jersey and Guernsey, to look at what the opportunities, potentially, are to work more with our French counterparts; and the first part of that is around resilience in terms of air links for lifting and shifting medevacs from within the Island but also more broadly are there opportunities to think more strategically around partnering with both Islands but then into the French system?

So there are lots of strategic opportunities being explored. I do not think any of them will be delivered overnight, which as you quite rightly say, is why we were honest last year and said the pandemic disrupted the Partnership of Purpose from 2020 for two years so that was a lot of time lost and it is about what we can do over the next 10 years.

The Partnership of Purpose never stopped. There are lots of workstreams going on but it is against a backdrop of that bigger question of what sustainable health and social care looks like across the Bailiwick.

The Chair: Okay, thanks.

Deputy Brouard: If I could just ask the Vice-President if he wants to add to that.

Deputy Leadbeater: We have got a list of strategic areas we are working towards at the Partnership of Purpose and operational areas as well that we have got down here. Work is progressing on certain areas of the Partnership of Purpose but, as Dermot outlined, I think COVID kind of dropped a spanner in the works for a lot of the transformational pieces.

Clearly, we have got the OHM projects, the EPR projects and the Children and Families Hub because they are very key to the transformation of the services we are going to be providing. We have got the alliance with the Jersey counterparts that I think Dermot has alluded to, and clearly, we have got the Mental Health and Wellbeing Strategy Steering Group, which is going to be releasing its first annual report coming up in the next few months.

We have got the Healthier Weight technical team. So we are progressing in these sorts of areas and the Combined Substance Use Strategy also –

The Chair: Could I just ask, I do not know if you followed the hearing that we had with P&R a few weeks ago and during that hearing, on the topic of the Partnership of Purpose, including the key area of the universal offer, Deputy Soulsby said, 'We cannot let it drift any longer. We have got the model. We just need to put it in place.'

As the Committee responsible, can you advise us if you think that is a fair comment and has it been allowed to drift?

Deputy Brouard: It has not been allowed to drift and I think it is, if I may say so, probably an unfair comment. The idea of the Partnership of Purpose is exactly what we are working towards. There are a load of building blocks that you have to have in place to make it work and absolutely

we are working towards it. I think it is a very unfortunate comment and I think we can provide Scrutiny if you want, now or later, with copious amounts of evidence of things that we are doing on a daily basis towards the Partnership of Purpose.

But again, if you are doing the really big picture stuff, which may mean changing the system completely, whether you are going to go all private or whether we are going to stop employing different people, make sure you have something in place before you break what we have because we have got very good services at the moment.

At A&E you can get seen very quickly. You can be seen by a GP very quickly and we have got some very good services through the MSG. I just want to make sure we do not damage what we already have but there is a multitude of work and we could do more if we had more resources, obviously, to put towards it.

So I do not take that comment. I think it was very unfair.

The Chair: Okay. One of the components of the Partnership of Purpose is the definition of what services are delivered without charge to the public. In other words, the universal offer. What do you believe could be excluded from the current offering and should charging for certain items, which are currently free, be implemented?

Deputy Brouard: Yes.

The Chair: Would you like to give us some examples?

Deputy Brouard: Again, these are ones that have come through P&R and the initiative to ask for ideas from the public. Whether or not the public would be acceptable to it or even to politicians, but charging at A&E. A&E costs us roughly £4 million a year, we recoup back about £2 million a year. It is a private service from that point of view. We could increase the fees there.

Do we necessarily need to have free pills and potions for those over-65? That is another area where we could look to increase our income. Should we have our pills and potions at the same levels that they have in the NHS, which is probably double what we are charging? There are some very big-ticket items but we are also –

The Chair: Sorry, prescription charges, you mean?

Deputy Brouard: Prescription charges.

But there are some very big … you know, the £12 grant to doctors. Is it really providing the service that we want it to do? But changing those is quite difficult and it would need the support of the States because we know from when we tried to just move, very gently, on cancer care and A&E, what the backlash from our public was. So there are some very big ticket items. We are very happy to have those debates and put them forward.

The Chair: Are you going to be proposing any of those things this political term?

Deputy Brouard: I hope so and they are part of the, I cannot remember the exact name, but a group, *(Interjection)* Savings Subcommittee, through P&R, and that is where they are going to be coming forward and hopefully with P&R support we will be able to put them forward because that funding would be very helpful.

Deputy Leadbeater: Just to pick up on that, we are also looking at various different ways we can encourage or compel people to use their medical insurance because, at the moment, we have got a considerable amount of people, Islanders, a lot of them, certainly in the finance industry and other industries as well, will have medical insurance that comes along with their job. Many people

do not use that medical insurance. They will often get a kick back from their insurance company to not use that medical insurance.

Now if we could find a way to encourage people to not do that and use that, or even if we can compel them to in some way, that would make a considerable dent in our budget. Because it is difficult to put a finger on the number of people that we are seeing coming through our Hospital and our other services that could be paid for by their private insurance but are paid for by the States.

So that is one piece of work that we are trying to look at and we would like to bring some proposals to ... If we can get some. It is difficult because we have touched on this before and we have had advice that we cannot compel people to use their insurance. We have got conflicting advice here at the moment so we are trying to examine that as thoroughly as possible.

The Chair: I can see how that could be difficult but perhaps the kind of amount that they would get from the insurance company for not using it, would you be considering paying that instead?

Deputy Leadbeater: I think that was the suggestion that was discussed at the Committee recently.

Deputy Brouard: Yes. On Tuesday this week, one of our Members came up with an idea and it is something we are going to have a look at to see if we can –

The Chair: Okay, thank you.

Can I just come back briefly to the issue of preventative healthcare, and this picks up really on a comment that Dr Brink made at our last hearing, when you said we can always do more and I think everybody accepts that. But do you consider that you have actually allocated enough of your budget to preventative measures?

Deputy Brouard: That is a very difficult one when we are running hot already and already this year, we will struggle to meet the budget that we have. The difficulty is where do we take it away from if we want to put it into preventative facilities? This is one of the areas where we have asked our team to see if there are things we can do, and hence the presentation to States' Members shortly to see if we can release some further budget to do the preventative. Because it is really useful to do it now, but it is much easier to always deal with a problem when someone turns up at A&E or they need a long-term bed or whatever.

Dr Brink, do you have anything extra to add to that?

Dr Brink: Yes, thank you Deputy Brouard.

I think the point about preventative health and care is this is a whole Island issue. It is not just a health and care issue, and I think we need everyone to sign up and look at how we as a community can deliver that good, preventative health care. Take, for example, physical activity and the impact of access to physical activity for people's own healthcare. Access to a healthy diet.

So if you are looking at those very upstream measures, which are incredibly cost-effective, you get a good return on your investment, is we need a whole Island approach and that is one of the themes we are hoping to bring out on 15th May. It is something that we all need to sign up to and it is not simply a health and care problem. I do not know if that makes sense?

The Chair: I think that does. I think the Health Improvement Commission (HIC), if I am right, does look at a holistic approach to that. But is it the case that the Commission is purely funded from HSC's budget or are there contributions from other Committees' Budgets?

Deputy Leadbeater: I think ESC contribute towards the HIC budget as well. And E&I.

The Chair: Okay, Deputy Roffey, you are trying to get in there.

Deputy Dudley-Owen: Can I just get in on a technical issue. Because if Dr Brink is contributing, my concern is that because there is not a microphone in front of Dr Brink that the content might not be captured on *Hansard*. I was just wondering if Dr Brink was going to be a panellist that you *(Interjection)* are calling on because you cannot hear her on the microphone?

Deputy Brouard: I appreciate that. With the size of the organisation and the mandate we have, I am very likely to call on our second row, which is basically our first-class row.

Deputy Dudley-Owen: I understand that. My concern is it will not be caught on *Hansard*.

Deputy Brouard: We can make some room on the top table for people to come up –

The Chair: For people to come up alternately? Thank you.

Deputy Roffey: Thank you, Madam Chair.

I just wanted to revert back to the answer to your very first question, when Deputy Brouard you said increasing costs were unavoidable, the real question is who pays for it, whether it is the States, which means the taxpayer or whether it is the individual.

I really want to know what thought you put into that. You have clearly been very brave. You are talking about increasing accident and emergency charges, which most people find very high. You are talking about removing pensioners' access to free prescriptions and I have forgotten what the other one was but there are three that I think will make big headlines here.

But picking behind that, what is your general philosophy? Do you sit down and talk about, going forward, do we need more and more money from the taxpayer to keep the health system going or should we be moving to a more American model, if you like, or whatever model, where people are more responsible for funding their own healthcare?

Deputy Brouard: The difficulty we face is that we are having our budget curtailed, as it were, compared to the demand. The demand is almost exponential. If you just take ED, where 8%-10% for the last three years increase, that is phenomenal. And that is just the tip of the iceberg because that will then feed in later to more people needing hospital beds for even longer.

Procedures. We have done 14% more procedures between 2022 and –

Deputy Roffey: I am asking what you see as a solution going forward … are you going to charge a bit more?

Deputy Brouard: This is the dilemma we have. I would like to see Islanders treated and I would like to see it on the public offering. I think, and I voted for the GST amendment, I would like to see more funds put into health. I think that is the fairest way of doing it. I would not like to see us going to a private offering where people have to either sell their houses or have to rely on their bank balance. I would rather we provide it publicly.

The difficulty is I do not think we have got the capacity to give the funding that we are going to need, and we are seeing it today. It is not tomorrow, we are seeing that pressure now. So we have got some really awkward decisions.

I have got a waiting list, which I would like to clear by 2025 –

Deputy Roffey: We will return to that.

Deputy Brouard: Yes, but each of those comes with a price tag, where I cannot get the money to do it. I have not got capacity in the Hospital to do it. I have not got a second laminar flow theatre, which I need to get the orthopaedics through. All these things. If you push me, I will have to put up fees. I would prefer not to and I would prefer it to come from the public purse generally, from

general taxation. But if you give me the choice that you are not going to have it but I have got people suffering who need to be helped then I am afraid somebody will have to pay.

Deputy Leadbeater: We had the start of the Primary Care Review earlier on this term but that was resourced outside of our Committee and the resources had to be taken somewhere else. That was not something that we wished to stall, it was a case that the resources centrally were reallocated somewhere else. Also we have got the new model of care in Alderney. That could very well work out to be a pilot for what happens in Guernsey going forward.

There are a hell of a lot of transformational things that can take place in Health & Social Care and are going to have to take place because it is not just a case of chucking more money at it, we have to do things differently. We need the things like the OHM project to be able to allow us to realise a lot of efficiencies up at the PEH but we need to look elsewhere. We need to look at the amount of agency staff we are using in adult disability, for example, and look at the ways we can encourage people to fill those posts full time, try to encourage local people there.

I have got an idea at the moment about trying to encourage, we could say if a local person, established resident, wants to come and take on a job that is currently filled solely by agency workers, they will be first choice for key worker housings. We can try and encourage little things like that, we can encourage local people to come in and work for HSC but it is a big piece of work and it is not just done within this Committee.

The Chair: Deputy Dudley-Owen.

Deputy Dudley-Owen: Thank you.

Thinking about preventable care and pathways, the Healthier Weight Strategy seeks a reduction in obesity in preventable mortality in prevalence of Type 2 diabetes. Can the Committee report on their progress related to the key performance indicators and how this might impact on the OHM phase two and the need for the diabetes clinic on the scale planned?

Deputy Brouard: A very good question. I think I am going to turn to Dr Brink on that one. Dr Brink, would you like to come forward?

Dr Brink: Thank you for the questions.

We have just refreshed the Healthier Weight Strategy and we will be reporting on the first set of KPIs on that next year, so it should be quarter two of next year. With regard to the progress on some of the KPIs, we are in the process of establishing a tier three, tier four weight management service. As you are aware, that was a gap in our previous service provision so that is really encouraging progress.

Also, and this really has been good co-working with Education; I am not sure if you are aware of the latest round of Guernsey Child Measurement Programme measurements. We are the only place in the British Isles that is showing a stabilisation in weight in the Year 1 and Year 5s. That has really been an excellent piece of joint working. We have had good co-operation from the schools. The Health Improvement Commission has been working with the schools. Public Health has been analysing the results. It has been a joint effort between different political areas and the third sector.

I really see this as key to how we move things forward. There are other areas of the Healthy Weight Strategy, we are calling it the Healthier Weight Strategy, that we want to look at. You have mentioned Type 2 diabetes – linked to that we are measuring the health of our diabetics on the Island. Over 2,000 people.

This is absolutely key because you can then put the appropriate interventions in place, whether it is weight loss, better glycaemic control, foot care, all of that. That then takes the pressure off the Hospital. Everything that we are doing, what we are looking to do, is flatten that curve and try and cut off the pressure on the Hospital and manage more in a preventative way. Those are all key parts of the update of the strategy. In that we are looking not only at refining our data collection to

ensure that we have good local data, we are looking at the prevention, health promotion messages, but also the services. We are trying to look at the three streams together.

Deputy Dudley-Owen: But to get to the nub of that, if there is success with the key performance indicators, does that impact directly the scale of the need for the build of the diabetes area?

Dr Brink: What we would have to do, at the moment we are looking at the effective management of diabetes and we are looking at weight management. It is too soon to say whether that is going to impact on what the scale of need is going to be.

You may be aware of what is happening in the UK with diabetic case finding and really you need to go into the pre-diabetic area to actually have a look at that and look at how you can prevent diabetes actually occurring. You have got various programmes running in the UK with some success, where they look at people with marginally elevated blood glucose, etc. and look at how they can avert diabetes actually occurring.

What the measures will do is they will help with the impact on secondary care services, but we have to move even further upstream if we are going to want to stop diabetes actually occurring. I do not know if that answers your question clearly?

Deputy Brouard: Can I ask, in answer to your question, specifically about do we need to have a smaller unit in the Hospital modernisation, I think Dr Rabey is probably best placed because I think the numbers will still be high.

Dr Rabey: The Hospital Modernisation Programme went through all the modelling before we went into the design phase and we were pushed to make some very brave assumptions about prevention and about improved social support, improved community support, that sort of thing. We were not confident that those things would be done in time to affect the build so we have made some conservative assumptions about that.

So it has been considered. We have made conservative assumptions that prevention will prevent submissions, will prevent some bed days, that sort of thing. We did not dare to go for the very brave assumptions that we were being pushed to and I am very glad we did not because so far the pandemic would have stalled that work anyway.

In my view, we need a dramatic shift to a prevention agenda in Guernsey because nobody will thank us for it next year but, in 10 years' time, if we have not done it, we will be in trouble.

Deputy Dudley-Owen: That is clear. Thank you very much.

Going on to talk now more thoroughly about the Hospital Modernisation Programme, could you please talk the panel through the chronology of what the Committee and senior officers new regarding the significant increase in costs of the Hospital Modernisation Programme, from early 2023 onwards?

Deputy Brouard: Most of it has been in the public domain. The Committee was informed on 19th December 2023 and the chronology from there plays out. I sent a message to –

Deputy Dudley-Owen: I said from early 2023, the officers' knowledge going through to Committee knowledge.

Deputy Brouard: No problem. What I will do is I will ask Helen O'Hara, who was not involved in the original part but has been part of the solution in trying to see what happened, what went wrong and why. Helen, if you would like to come up here and you can perhaps talk through the chronology.

Ms O'Hara: So the key dates, there was a draft cost estimate that came into the organisation and it came in in February 2023. That was then received as a final estimate at the end of March

2023. That was then shared on 30th October. So a decision to accept the Brouard Amendment, going forward with Phase Two with the support of the Health Reserve funding, that happened on 20th October.

The report was shared then on 30th October and then we moved into a phase of evidence collation. Before then presenting it there were a number of different activities that had to happen at officer level, also reaching out to our third party who had pulled together the cost estimate, to really understand why there was such a significant difference between that cost estimate and the cost estimate that had been used as the OBC, which was what was fed into the F&IP debate.

So there was a lot of activity there trying to work out what was the differential, why, and obviously why it was only shared after that decision.

Deputy Dudley-Owen: Thank you.

How was it that the new Programme Director, who was focussed entirely on this role and was a key liaison person with senior management, independent experts and politicians, was not aware of the significant increase in costs when they took up their post last year?

Ms O'Hara: Because it was not shared with me.

Deputy Dudley-Owen: So how come it–

Ms O'Hara: It was shared with me on 30th October.

Deputy Dudley-Owen: And prior to that you had no knowledge and did not make it your business to make it your knowledge?

Ms O'Hara: I simply had no knowledge. So I did not know there was something that I needed to find out. I did not know, full stop. It was not shared.

Deputy Dudley-Owen: So at the handover between yourself and the previous postholder?

Ms O'Hara: It was not shared at that stage.

Deputy Dudley-Owen: Okay. Once other senior staff in the Department were finally aware of the potential £30 million increase in costs, how long was it before political Members were informed?

Ms O'Hara: We informed political Members on 19th December.

Deputy Dudley-Owen: Was the President informed before that date?

Ms O'Hara: I do not believe so, no. Certainly not from me. Not through a formal process at all.

Deputy Dudley-Owen: Thank you.

Deputy Roffey: Deputy Brouard, is it your policy to ask your senior officers to always make you aware of something that could be a political issue. Because most Presidents do so and say, if something could, please tell me about it.

Deputy Brouard: Without prompting Dermot, I will ask him to say what I said in October 2020.

Mr Mullin: Deputy Brouard did instruct us that there was to be no surprises. I take full responsibility for this. Because of my clinical background, we became aware of it, as Helen says, and

I asked for due diligence to understand is this really as it seems, which is why Committee became aware on 19th December.

As you know, the Head of Public Service is conducting pieces of work, looking into who knew what when and the governance structures. I have to take responsibility for that because we did not verbally make Deputy Brouard aware because we did not have all the detail. We have had a similar situation this week in relation to the Electronic Patient Record. We have verbally informed Committee, but we still do not have all the detail of the impact of that.

I did say in P&R the other day, would good governance or different governance have had a different outcome? I do not believe it would because this was about behaviours and, yes, I accept responsibility for not having verbally briefed Committee prior to 19th December.

Deputy Dudley-Owen: I have got a further question about governance, and I would suggest that governance actually encompasses behaviours and attitudes as well, rather than just process. Following the announcement of the unknown cost increase for the Hospital Modernisation Programme, what steps has the Committee taken to strengthen governance and mitigate an future risks of such failings being repeated?

Deputy Brouard: Just going back slightly, some of the officers involved were at the presentations when we were pitching to States' Members to have the Hospital modernisation included. How anyone can sit there in that room and not have realised what figure we were asking from the staff who were there also presenting.

The people concerned had ample opportunity to raise or flag any concerns about the cost then. So there was no reason for us … we had spent many months as a team, trying to put together our proposals, knowing full well we needed to go to the States, because we were not included, we were moved onto the pipeline for the next term.

Because of what we could see coming up for Health, that we needed to increase capacity in the Hospital, we put a lot of effort into making sure we could get our project into the starting blocks. So there was ample opportunity for staff to advise us whether or not the figures were right or wrong.

But going onto you second point, which was what are we doing now, I will go to Helen to explain what the review is now looking at with regard to the Programme.

Ms O'Hara: In terms of governance, so, obviously –

Deputy Brouard: I can mention governance. There has always been a tension between do we have politicians on project boards, do we have politicians on programme boards, which is the right answer? That question has now gone to the Head of Public Service and he is conducting … *[Technical interference]* I think he is hoping to publish fairly soon what the findings are from that. We are very happy to have people on the project board but, as Dermot said, in this particular case, it would not have made any difference because unfortunately that information did not come across, even at the programme board.

Deputy Dudley-Owen: So what efforts have you made to mitigate the future risk of any failings in the future? Have you changed the structure of the programme board to ensure that –?

Deputy Brouard: We have. In an interim measure, we have placed political Members on the programme boards.

Deputy Dudley-Owen: As an interim measure?

Deputy Brouard: Until we find out what the findings are from the Chief Executive's report, there is no point us doing it and saying we are definitely going to do this and he comes back and says, no, definitely not, politicians should not be on programme boards.

We pay our professionals substantial sums of money to do a job. We cannot do every single job. I have to rely, and so does our Committee, on the Civil Service to be able to come forward with their particular thing.

We have asked, again there are no surprises, that people are open and feel able to share. That is the other thing. If we make it too difficult, if people do not want to confess when something has gone wrong and something inevitably will go wrong with an organisation the size of the States of Guernsey, we want to make sure that people feel happy to whistle blow and say actually something is not quite right.

But the actual programme, now going forward, we are having a review of the pricing, we are having a review of the scope and all that is being taken care of. And we have had some seed funding from P&R to ensure that does happen.

Deputy Dudley-Owen: So just a supplementary based on what you have just said. Would it be fair to say that the view is that, despite this being a significant capital project for the Island, not just for the States of Guernsey, also using public money, taxpayer money, that the risk of that possibly going wrong, it was not deemed to be important enough for politicians to have oversight, knowledge, even granular information around the project, for a politician to be on the board right from the outset when the Committee took its seat?

Deputy Brouard: I do not take that criticism. We had the people who were on the team in the room with us. As with two States' presentations. We cannot be any more open than that. Dermot sits as SRO on the project. He was not aware of it. There was not anything else that we could have done. Someone chose not to reveal the information and it was unfortunate but of course this is a staged process going through. I think there are seven RIBA stages. This is one of them. Unfortunately, we have a fairly substantial possible increase in price.

But we have not overspent yet because we have not even put in the full business case at this stage. We are still scoping out the costs and the works. We have not involved the contractor to the full extent of actually getting a commissioning in. There are lots of steps to go on this. We may find that we are substantially … *[Technical interference]* to build it.

I think you will have the same on Education. Whether or not you can stick to the £88 million, it will be interesting to see when a contractor comes forward on those prices. We have asked for updates, and we have had updates – I think 17 of them in the last year – on the project and we were told, it is okay. It is fine. Get the £120 million and we will be okay.

The Chair: Can I ask you a quick supplementary on that? The staff who were aware during this seven-month period that the price had possibly increased by 25% or so, what was the reason for them not communicating that to either other staff or to the political board? Was it because it was not deemed to be particularly important or relevant? *(Interjection)* No. So what was the reason?

Deputy Brouard: I do not think that is … we have not been able to find the reason and I think, Helen, you have asked that question and have not been able to come to a conclusion. You have thoroughly investigated, and you still cannot come to a reason why it was held back.

The Chair: Okay.

Deputy Leadbeater: There are reviews going on at the moment, as Deputy Brouard pointed out, and there are two reviews being conducted by the Head of Public Service, one looking at the who knew, when and why, etc., within the Civil Service, so I am hoping that review will tease out the answer to your question.

The Chair: That is my next question, actually. On this particular review, the Head of the Public Service announced, and he spoke to us about that in the recent hearing with P&R, about the

governance of major capital projects, that review, we were told, was due to be completed by the end of April. Have you had sight of any draft copy of it yet?

Deputy Leadbeater: We do not think it is quite complete yet. We have had notification that it should not be too long, and it is still ongoing at this point.

The Chair: Okay, which probably means you cannot answer my supplementary to that about whether you are happy for it to be published, as you have not actually seen it.

Deputy Brouard: And it would not be our review to be published.

The Chair: But more in the point that you would not be objecting to any parts of it that P&R wanted to publish, but if you have not seen it I accept you cannot answer that question at the moment.

Deputy Fairclough.

Deputy Fairclough: Thank you.

In your March Statement to the States, you suggested that savings could be found in the next phase of the Hospital Modernisation Programme. What level of savings do you believe could be identified and, if they are available, why weren't they found before?

Deputy Brouard: As with all these things, the whole thing goes through a process. As you go through the different RIBA stages there comes a stage where you do your value engineering. There is a stage where you review. Although we were still at the early stage of RIBA 3b –

Ms O'Hara: RIBA 2 went into the OBC, RIBA 3 was the new cost estimate.

Deputy Brouard: So it is an iterative process that we were working our way through.

So all that finding whether we could do things cheaper or better, have we got the right finishes, have we got the right management, etc., that is still in that journey. Your question was specifically about –

Deputy Leadbeater: As Al says, we have gone from RIBA stage 2 to RIBA stage 3. RIBA stage 2 is very broad with just a schedule of accommodation. It does not give you any detail whatsoever. RIBA stage 3 gives you a lot more detail. That is when the cost differential was noticed but clearly was not elevated as far as the rest of the team in the Civil Service and also the Committee.

RIBA stage 3 is when you can actually start doing a value engineering exercise, because you can see all the detail and then you can make decisions. We can lose that glass screen there and we can do away with this, that and the other. We can change this finish. So it is not until it gets to RIBA stage 3, which we assumed we were at, to be honest, because we were told we were at RIBA stage 3 and we were told the costings were given as RIBA stage 3, but it was not.

Now it gets to this stage and we are not just going out and doing value engineering, we are looking at the design in totality. Because, as I think has been pointed out before, the costings that we have been given have not come from the contractor. These costings are an estimate that has come from our consultants that are estimating what the costs should be.

We have not engaged with a contractor and also, when you have got a big project like this, a very big complex project on a hospital, there are a lot of assumptions made about what the contractor needs to do to mitigate certain problems as you go on. It is not until you engage with the contractor that you are going to nail these costs right the way down.

This is the stage now where, going out back to the design team, and even further afield to maybe other design teams, because we need to make sure we get this design right. We do not want to change the scope. If we have to alter the scope, we will do, but the ultimate aim is to provide the

exact same scope within the same cost envelope. We are not going to achieve that completely through value engineering, we know that, but we may be able to achieve that through some design alterations and that is what we are looking to try and do.

Deputy Fairclough: Could you give us some examples, Deputy Leadbeater, of what those might be, just the types of things those might be?

Deputy Leadbeater: When I have examined some of the costings, unless you have got a construction background, it is difficult for me to try and explain to you. You might have the structural parts of the existing building and they have looked at ways that they are going to get around teething into those bits, so they have said you are going to need to put this stanchion here, you are going to need this element of steel. These are assumptions being made by our cost estimators. When it comes to the actual building of this, the contractors may look at it and say, 'No, we have not got to do that, we can do it this way.'

So we are still at a very early stage. We are still at OBC stage at this point. We are very hopeful that we can try and get the costs down from the estimates that we have been given. Our ultimate aim is to try and get within the original cost envelope.

The Chair: Of course, observations from contractors could push the figure both ways. They could go the other way as well.

Deputy Leadbeater: Yes, they could do. I think the cost estimates we have been given have erred on the side of caution. They have said, we will allow £5 million for that, when you might be able to get away with £2.5 million.

The Chair: Okay, can I come back to something else you said, Deputy Leadbeater, when you mentioned about the RIBA stage that you thought you were at. Am I right in thinking that the staff who did not disclose the increase in cost were also the ones who informed you about the wrong RIBA stage?

Deputy Leadbeater: Yes.

The Chair: Okay, thank you.
Deputy Dudley-Owen did you have a supplementary?

Deputy Dudley-Owen: I think so because I think exactly that point, for me, highlights the need for someone in the room, someone who is a politician, who has got ultimate responsibility and needs to be held to account for the spend of taxpayers' money that had someone been in the room to understand that detail then there could have been challenge questions asked at the time within that space. I just wanted to make that comment. It highlights the need –

Deputy Leadbeater: I do not think that any politician could have challenged. I do not think it would be right to challenge at an early stage. If you are talking about the assumptions that have been made by our cost estimators, which is what I was referring to –

Deputy Dudley-Owen: No, I was talking about the stages that you had moved through, all the RIBA stages, you would have been kept up to date with, someone who was sitting on the governance board would have been able to understand the timeline of progression and would have been able to challenge that timeline of progression.

Deputy Leadbeater: We can look back in hindsight and say that may be the case, but we have been advised by our officers who were also sat on those governance boards that that necessarily

was not the case. The costings that we were given for RIBA stage three were the costings that we shared with the public and with our colleagues in the States.

Deputy Brouard: And as I have mentioned, we were in the room, the States' Members, from our professionals, saying we need £120 million to progress this project. None of those people, who are no longer with us, stood up and said, by the way that is the wrong figure, because I have got this one. If we had needed to ask for a different figure, we would have asked for a different figure. We rely on the professionals to advise us.

As we go through RIBA stages, as Mark says, we will be doing the challenges, which is what we do. It is very unfortunate, and my apologies as well, that it has gone up by a possible £30 million.

Deputy Fairclough: One of the reasons you have given for continuing with phase two straight after phase one was to keep the contractor on site. I think we heard that at our last Scrutiny hearing with Health, to ensure continuity and also the benefits of familiarity with the site as well. Is that still the position and, if so, how will you ensure the rigour that would normally come from a competitive and open tendering process?

Deputy Brouard: This is now going to be the difficulty. The original project was meant to carry on seamlessly from phase one to phase two. The learning that the contractor, builder, was considerable, working in a live environment where we have got patients and knitting their services in with ours is quite complex.

Unfortunately, P&R did not provide us with the funding earlier to move forward. We had this stasis for a year and a half. Then it was left that we were no longer going to be a project for this term. So from that point of view, that started to widen that gap. So any advantages that we may have had then are probably now not so tangible. The difficulty will be which other contractor locally could do the job and we have seen what happens when we have had contractors from outside. I have been in politics long enough to know that that has not always gone so well either.

We are in a difficult position as a small Island of 60,000.

Deputy Fairclough: So could you just remind us, then, Deputy Brouard, of the timelines because it was intended this seamless transition from phase one into phase two; when does phase one now finish and when is the earliest you can hope that phase two might start?

Deputy Brouard: Phase one finishes, and I will be corrected, this summer, and I think fitting out by the end of October.

Ms O'Hara: By autumn, we hope to have service uses in the autumn.

Deputy Brouard: When would you think we might have a spade in the ground, assuming we would be within our cost envelope and done all the work for the next six months, which we are doing, and re-evaluating where we are?

Ms O'Hara: The original planning was always 2025 but obviously now we are going through the value engineering exercise. We have been given five-six months as a guideline of doing that work. We are going to have to see what the outcome of that is and we are going to have to bring that back. So I am not in a position to be able to state a date at this point in time.

Deputy Fairclough: When you say bring that back, will that be to the Health board or will that be to the wider States?

Ms O'Hara: All through our normal governance processes, absolutely through to the –

Deputy Brouard: It will come to the board and, as I said in the States, if it is outside of our envelope, we will need to come to the States to ask for further funding. But if we are inside the envelope then I believe that P&R will be in a position to sign us off. But of course you also have to be very careful about anything that has changed substantially because, as Marc says, it is fairly critical that we try and make sure that the main elements of our project go ahead. Because otherwise we are not going to have the capacity for our Islanders who are desperately now, I have got a waiting list of people who need to be treated and I have not got the capacity to do it.

Deputy Leadbeater: I just wanted to add to that because you talked about the wish of the Committee not to have Rihoys decamped from the site completely, and that is not the intention at all because there is advanced work ahead of phase two that will need to be completed and those will need to be completed if phase two goes ahead anyway. So there are bits of work that need to be done on the campus in between the two phases.

So the hope is that they will be a smaller team, still on site, carrying out those works while we go through the value engineering and the design review process.

The Chair: So those works would still be done even if you are then in a position where you have to come back to the Assembly and take your chances on approval of additional funding?

Deputy Leadbeater: I think some of the works would need to be completed anyway, regardless of whether phase two goes ahead.

The Chair: Right, so they are not works specifically for phase two that you are referring to.

Deputy Brouard: Things like Giffard roof I think is one. And some of the other surfaces as well that we must make sure of.

The Chair: I think that is a suitable point that we will just take a brief comfort break. If I could ask everyone to be back at 4.30 for the second part. Thank you.

The Committee adjourned at 4.25 p.m.
and resumed at 4.31 p.m.

The Chair: Deputy Roffey.

Deputy Roffey: Thank you.

I want to take you back to where we started, I guess, which is about this tidal wave of demand for the services that you provide, coming down the road. We have heard a lot about the physical response to it, the capital response to it. You want more laminar flow theatres, you want to extend the PEH, etc. But what about all the other aspects? What modelling have you done about how much demand there is going to be on various parts of your service in, say, five, 10 or 20 years?

Deputy Brouard: I think you are walking us into SLAWS, Supported Living and Ageing Well –

Deputy Roffey: I can get onto that, but it is not just about that.

Deputy Brouard: Public Health has the figures probably better than I do but the modelling is, I think, we are going to soon have double the number of over 85-year-olds. It is fantastic that people are now living to the age that they are. When I started work, it was three score years and 10 was your lot. We are now far exceeding that, but it will come with more and more comorbidities.

Deputy Roffey: I have no doubt of that. I want to know what work you have done to quantify it, what that will mean in terms of orthopaedic procedures, in terms of this, that and the other.

Deputy Roffey: That has all been done and that has been factored into the Hospital Modernisation but perhaps Dr Rabey could probably speak on that better than me.

Dr Rabey: We can produce quite detailed predictions of the demand coming down the line and that has been modelled up to 30 years forward, as part of scoping the Hospital Modernisation. So we have modelled that. We have various assumptions, as I have said earlier, about how heroic are the assumptions we want to make about prevention, about community support, about things like the SLAWS agenda and how that might impact on preventing admissions and things.

We have got various models that show if this and that and various, they all show huge increases in demand and that is what we modelled phase two on to provide the right amount of beds, outpatient capacity, theatre capacity, for the preferred, the model we accepted as the most realistic model for Guernsey. That detail is all available and it is a worrying piece of work.

Deputy Roffey: I am sure it is. Would it be a good idea to be sharing it more broadly with the States because this is going to be one of the biggest challenges the Assembly as a whole has to face over the next few years? We have looked at it through the lens of your request for a hospital modernisation but that is just the bricks and mortar part, really. It is really the whole impact on the cost of healthcare I would like to know about.

Deputy Brouard: Very much so and it is exactly why we have asked Dr Brink and Public Health to look at that issue. Dr Brink?

Dr Brink: Thank you, Deputy Roffey. I think this is a really important aspect. There are 10 chronic diseases that are likely to increase, particularly in the 75-plus population. The challenge we have is how we then cope with that demand as these conditions increase. We have used some modelling data from Jersey. So Jersey have done some quite detailed modelling on a collection of chronic conditions and their impact on bed capacity.

We have looked at that and what that means for Guernsey. If you take our population demographic now and our population demographic in 20 years' time, in 2043, at the moment 10% of our population are above 75 and it will be 17% in 20 years' time. The argument that has been put forward, if you really put prevention in, it will just increase people's longevity, and we have done quite a lot of work to show we are probably at our ceiling of longevity, age-wise. You might increase it a little bit but you are not going to significantly increase it.

So if you take those 10 chronic conditions and you have modelled those on what our increase of bed capacity will be in hospital bed days in 20 years' time, you are looking at about a 30% increase in hospital bed days. So what we can say is that the current Hospital capacity will not serve our needs and that is the biggest and strongest argument for putting prevention in and not only the very early prevention, the very upstream prevention, stopping people getting ill but with people with chronic diseases, how do we keep them healthy and how do we keep them out of hospital? And it is that flattening of the curve.

Deputy Roffey: While you are here and talking about that I am going to do a question that was going to come later but I do not want you having to jump backwards and forwards. Are you comfortable as a Committee, while Dr Brink is here, with the cost and therefore of accessibility of primary care? Because Dr Rabey keeps talking about the sooner you start treating these conditions the less costly it is, so surely you want people to access primary care in a timely way and yet we know there are people in the Island for whom that is a very expensive and challenging thing to do.

Deputy Brouard: Absolutely, and of course there was a working party that started off at this term of Government, which you actually sat on –

Deputy Roffey: I did. I am wondering when it is to start again.

Deputy Brouard: – as part of it.

First of all, we do have good doctors and we have very good access to primary care. But you are absolutely right. It is the cost. It can be preventative or prohibitive for some people.

Those who are reasonably wealthy or comfortable, like most of the people in this room here, it is not a problem. For those who are on the lowest paid percentile, again, that is not an issue because you know, in Social Security, you will cover that. It is that middle ground. We do provide a £12 grant. That could be, and one of the things we were looking at, was redistributing that to make it more accessible to those who are just above Income Support levels. That has not, because of resources, unfortunately has not really gone as far as it would like.

But if you are going to look at moving or wanting to make it a lower cost, I would imagine that the doctors will still need their sum. So therefore somebody else will have to pay. Whether that is the Government or some other scheme, there is not much in our budget, because we are already up against it, to be able to say we are going to now give a further subsidy.

Deputy Roffey: Okay. I would love to explore that further, but I do not think we have got time today.

Going back to building on Jersey's projections that they have already done, you have said that this would need this many beds, this many whatever. I hate to just come back to money, but have you done financial projections of where it comes from – the public or the taxpayer or whatever – what the increasing cost of healthcare is going to be in Guernsey in say 10 or 20 years' time? Because I worry that maybe some in the community think you are crying wolf and it would be useful to actually have that data.

Deputy Brouard: Dr Rabey, would you be able to comment on that?

Dr Rabey: I do not think I have seen figures for that extra cost, but you can work it out from the staff you need to deliver the services. So I am afraid I am trying to think which document to point you to. Can we think about that and come back because I am just not coming up with the right document.

Mr Smith: I can answer on our cost projections.

Deputy Brouard: This is Darren, who is our finance partner.

Deputy Roffey: Imagine I am President of P&R and I am asking what sort of money are we going to have to find in 10 years' time? What can you point me towards?

Mr Smith: So a number of modelling approaches have been taken, some with partners, going back to 2015, BDO, a baseline exercise basically finance-led but using all States' Committees and entities that ultimately informed where we are in terms of our full investment plan and the GWP. Year on year there is an allowance for health costs, outside of inflation, for any specific initiatives, that is equivalent to £4 million per year. So that is effective and that is part of the challenge of affordability for the States. It is built in and it is effectively recognising there is a year on year increase through demand and predominantly the demographics.

Of course**,** it does not fall evenly. We have step changes in cost, we will have particular challenges in certain years and that is what we are seeing as well. There is capacity in the Budget and in the terms of the planning and then what we are doing really is reviewing how far out to that are we and

do we need to revisit that. In terms of the sustainable healthcare modelling, looking forward, it is due a revisit, as it were, in terms of assumptions.

The next opportunity for a baseline review and estimate would have been the FBC for phase two, which would be the next natural point to do those costings but obviously that is Hospital-specific. We would then broaden that out to look at broader care, Children's Services etc., to do a holistic approach.

Deputy Roffey: Here in the community, with treatment that is required there and prescriptions, I suppose what I am trying to get at is do you believe we need to look at an entirely different way of funding our healthcare? You have mentioned incremental figures, like taking away free prescriptions from pensioners and putting up fees in A&E. But is it bigger than that? Are we really saying we need a new health tax?

It is sort of going back to the question I was asking earlier. I was asking then how we divvied it up between the public and the taxpayer, now I am asking how big is the thing that we have to divvy up, really?

Deputy Brouard: I think you are right. We would only be looking at some of these alternatives if there is nowhere else to go and we are caught between either providing a service to Islanders who have an entitlement to it and absolutely so, but I would think we need to … we cannot provide services in this century on last century's Income Tax or taxes. The services we require will need a substantial increase in charges or raising funds. Whether that is Income Tax or GST, or whatever product it is, if we want it to be provided universally, which is fine if you do not, but if you do – and I do – then someone is going to have to pay more and I think Islanders will have to move …

The Isle of Man, I will give you a classic there. They had £27 million over their budget on healthcare. Overall they were £40 million-odd short. They have moved their Income Tax by 2%. I do not think that will cut it –

Deputy Roffey: That is on top of 20% VAT there.

Deputy Brouard: We are almost, perhaps I am going to go off *piste* here a little bit –

Deputy Roffey: Please do. It is always interesting when people do that.

Deputy Brouard: Okay, I am going to be really honest. I do not think, and I am a last term politician, I am not going to be standing again, and I think I am partly to blame. I do not think we have raised enough tax. I do not think we have funded ourselves. We should be in a position now where we would have had the Harbour walls repointed and built for £13 million. We should have had the Hospital up and running. We should have had the key worker accommodation up and running. We should have had houses for our Islanders up and built. But we are behind the curve.

So from my point of view, and I am partly to blame, because we want to do popularism, we want to make sure that we have more services and lower taxes. Those economics just do not work.

Deputy Roffey: Okay. One more on this and then I think we have got to move on but you started, your first answer on this section was saying SLAWS was very important and I would like to understand better, if there is a constrained social care sector and it is not growing to meet the demand what impact is that going to have on the healthcare because they are not two totally separate entities, are they?

Deputy Brouard: It will fall to our doorstep, and it is falling to our doorstep today.

Deputy Roffey: So HSC will be supporting radical reforms to the social care funding and provision, will they?

Deputy Brouard: That is a real political question!

Deputy Roffey: This is a political process.

Deputy Brouard: From my point of view, yes. But I do not think it is going to be able to get through the States that we have at the moment, this political term. I think it is going to struggle. I think you are not going to be able to go in front of an elector and say, I want to increase your taxes or whatever it is because I want to provide care in the home for you and your relatives in older days. I think that is going to be a very hard sell.

As politicians, you stand individually, and you want to be popular. You want to be voted for. It is not like where we have got in the UK, where they have got parties and you have got one party pitched against another, you need to have a level of popularism to be voted in and I think, as we saw last term, or at the start of this term, those who said we are going to get rid of waste and lower taxes got elected in and then suddenly found themselves in a different position when they actually looked at the books.

I hear what you say. I think it is going to struggle to get through. And although it is the right thing to do, I think with the social media and the media generally, plus with an election coming up, it is going to be pushing water uphill.

Deputy Roffey: You feel Guernsey is ungovernable. We will have to stop at that –

Deputy Brouard: No, that is not what I said, Deputy Roffey, Please withdraw that.

Deputy Roffey: Okay, I withdraw that.

I would love to come back to your current waiting list if we get a chance later on but I am going to hand back to the Chair.

The Chair: I think Mr Mullin wants to add something.

Mr Mullin: From an operational perspective, Deputy Roffey, yes a whole system approach is required and I hope that is what the middle pillar of GWP will do because you cannot look at one part of the system without looking at unintended consequences across others and that is what has been learned in other parts of the world, with taking a piecemeal approach to things. As I have said in numerous presentations if we were opening a health and social care system on Monday morning it would not look like it does today.

The Chair: While the finance director is sitting up with a microphone, could I just ask you how the forecast for 2024 is looking on your budget? Do you expect to remain within budget this year?

Mr Smith: No. To summarise, 2022, we have overspent by £4 million; 2023, final figures after adjusting for the underspend on off-Island and returning funding to the Health Reserve, was £4 million and the latest forecast is just over £4 million. In each of those years we have got what I would call medium-term challenges. We do have significant vacancies that we are trying to manage and that has been resourced, significantly, within the budgeted FTE but significantly above the budgeted cost because we are covering at a premium.

Overtime and, obviously, agencies have been much discussed, and they are challenges that we are grappling with. We are looking at options and efficiencies. The next step is into potential e-rostering to improve the tools, to give some mitigation, although there are multiple trusts across the UK who operate those systems and are still overspending on agency. But it is about making small efficiencies on a monthly basis that have a material effect every year.

So that is a regular focus for the operational team through our weekly challenge process. But those challenges do not go away. We are not funded for that premium. We are trying to manage and recruit to reduce that need for that premium. We are reliant.

In conjunction with the challenges on accommodation, where effectively we need to bring those staff to the Island or where we successfully recruit, we are struggling to place those staff, they are at a premium cost as well and those two combined are effectively driving the overspend.

The Chair: Okay. So a significant part of the overspend relates to agency staff, housing costs surrounding it.

Mr Smith: Yes, in 2023, the overspend on staffing in total was £1.8 million, but for Agenda for Change, the frontline nursing, medical professionals, it was £3.4 million. So we were reliant on vacancies across the broader HSC to mitigate it but it cannot fully cover it and it is looking similar for this year. We will do what we can. We will look ahead to things like e-rostering, which is about managing ahead in real time and finding those small efficiencies, and it is small efficiencies. If you save an hour on every agency worker where we are currently employing, it is hundreds of thousands across a year.

That is kind of where we are. But those challenges will not be removed for the foreseeable future but within a few years they should be something we reduce and resolve.

The Chair: Okay, thank you.

Deputy Brouard: If I could just add on that it is the cost of agency which is pushing our budget over the envelope we have been given. I want to, if I can, use this opportunity to bust one myth. Key worker housing is not being propagated by us for agency staff. It is for permanent staff in the Island that we want the key worker housing for.

I do not know how many times I have to say it, key worker housing or housing for local people generally, is just so important to how we can run our business. I have politicians, very senior ones, who keep on about the fact that we are trying to house agency staff by building key worker accommodation. Nothing could be further from the truth.

So I hope they are listening today because I am getting extremely cross that they are not able to understand the problem that we are facing with regard to recruitment and having key worker housing is key to that.

The Chair: Okay, I think that point is made.

Does the Committee believe that the current model of providing secondary healthcare medicine largely via the MSG will continue to be sustainable beyond the life of the existing contract?

Deputy Brouard: I personally think so. We work in partnership with the MSG. I think they provide a very high standard of service. We are very fortunate. We have consultants and there are other models but I think the one we have got serves us extremely well. But I think I will probably turn to Dr Rabey because you are probably closer to that than me.

Dr Rabey: When the current MSG contract, secondary healthcare contract, was signed there was a huge amount of work done by the States to ensure that it represented value for money and those financial reviews, which now continue to ensure that continues. So we continue to believe we are getting a service for the money and if we ever decide that it would be a lot cheaper or better quality to bring it in house, that option is available to the States. It is a rolling contract with five years' notice. At the moment I would say we still believe we are getting value for money from the contract.

The Chair: Deputy Roffey, do you want to carry on at 21?

Deputy Roffey: Waiting lists? Yes.

I will be brief. I want to pick under the covers both on orthopaedics and on gastroenterology but let us deal with the latter because you have put stuff in the *Press* about it today, which was quite striking. You have had an absolutely massive increase in demand. You have done a real special initiative last year that did any number of procedures. You have increased your capacity. And yet you are saying that the waiting lists are still going up and there is nothing more that you can do about it, basically, as I read the *Press*. I may have got that wrong. Just tell us what the situation is.

Deputy Brouard: The situation is probably as you described, apart from the last sentence of yours. There are lots of things we can do about it but most of them will require resources and funding. There are things we can do as a society to improve it but whether or not we can get the funding to do them, whether that is a new surgical cube, so we can do cataract operations etc. quicker, there are lots of things we can do but they will all require funding and resources and before I get cross I will ask Dr Rabey to carry on.

Deputy Roffey: Could you just confirm that number on the waiting list? Was that correct? Did I read something like 6,000.

Dr Rabey: The number on the gastroenterology waiting list, the one I look at, was 493 last I looked. But you can add to that, you can add follow-ups and things but that is the number on the waiting list, 493 last I looked, which was about two weeks ago, because I was going on holiday.

When we came to see you last, we told you that we were doing about 110 endoscopies every two months. The reason we say two months is because the waiting time is supposed to be eight weeks. So if you have got a waiting list of 110 we would have been in budget. We are doing 250 every two months now. We have gone from 110 to 250 in that time, with local Guernsey capacity, by having the two gastroenterologists, the nurse endoscopist, working the system ever so hard and that is a fantastic success story but, in the same time, we have increased the number put onto the waiting list from 1,300 in 2022 to 1,900 to 2023. The growth is like that.

Part of that was pent up demand because GPs were holding things back because they knew there was a long waiting list. We did the waiting list initiative. GPs released some of that to us. But it is not slowing down yet, in 2024, which is worrying. So we have increased our capacity locally, hugely. We are still seeing huge increases in demand in that particular specialty.

The other specialties do not look like that. Orthopaedics, we have added exactly the same number last year as the year before to the waiting list. It is just steady state. If we could do two more operations a week in orthopaedics, we would be dealing with our demand. But it is two a week we are falling behind, and the number is growing ever so slowly in orthopaedics but it is growing. So those two specialties are very different pictures.

Deputy Roffey: I was not being the least bit critical of what you are doing in gastroenterology, I was absolutely struck by the amount you have done and that demand and waiting lists are still going up. I just really wanted to ask what is the solution?

Dr Rabey: We model that we think what we are doing now can keep us in steady state. In the Hospital modernisation we head into the new theatres with the new endoscopy suite and that will allow us much better throughput. But until then I think we just suck it and see because I think doing what we are doing, 250 cases locally every two months, ought to be about right, but if I am wrong and if the numbers adding to the list keep doing that, we will have to think again.

We cannot do much more with our current capacity. We would need more space, or we would need to do weekend lists, that sort of thing, as extraordinary measures, if I am wrong.

The Chair: It did say in the *Press* that the reason was an ageing population and higher health demands. But you are actually saying that, in this particular speciality, it is a little bit of a mystery as

to what the demand is. Clearly the ageing population is not going to make that kind of percentage difference in the space of one year.

Dr Rabey: There is a huge demand for these investigations from the 'worried well' and it is prioritising those who potentially have cancer. It is very difficult work because some of those worried well do actually have cancer or something seriously wrong with them but the amount of demand from the worried well is huge in that particular specialty, it is fair to say.

The Chair: Who is the gatekeeper for this? Is that the GPs or the specialists?

Dr Rabey: Yes. GPs refer to the gastroenterologists, the gastroenterologists have the right to turn down any referrals they consider to be inappropriate but actually test pretty carefully at the GP stage. The GPs will do a FIT test, if they suspect cancer, which is a test that says it is worth doing an endoscopy on this patient and we introduced that as part of demand management three or four years ago. So we are not putting a lot of rubbish in the waiting list, I do not think. We will work closely with the gastroenterologists and the GPs if we think there is anything else we can do.

At the moment, the gastroenterologists do not tell me they are getting a lot of bad referrals and I am still hoping that it is pent up demand from the years when there was not enough capacity.

The Chair: That is very helpful. Thank you.
Deputy Fairclough, over to you.

Deputy Fairclough: I would like to turn to the Electronic Patient Records. This has already been alluded to earlier on in the hearing. I understand that the new Electronic Patient Records system will now be further delayed until at least the end of March next year and that you are currently reviewing cost impact. When do you expect to have that information?

Deputy Brouard: We only basically have the information, to start with, with regard to the request that to mitigate risk we need to move the start date.

Mr Mullin: We expect to have more details in the next month. Teams are actively working on it. Compared to the way I handled the OHM, we have verbally told Committee on Tuesday and requested that the team working on that piece may be quicker than a month. But the key thing to remember is the previous EPR implementation did not deliver the outcomes or efficiencies that were expected so we are cognisant of the post-implementation review into that and getting this right.

This is a massive piece of work in terms of all we have talked about in terms of sustainability, what health and care looks like in the future. So we want to make sure that we do not repeat the sins of the past.

Deputy Fairclough: I understand that you want to get it right but that presumably has always been the case. I mean, only three weeks ago, States' Members were assured the project was on time and on budget, so what has changed in that time?

Deputy Brouard: I think we had … how can I say this politically correctly, the States has had a chequered past with regard to electronics and computers and even your own review, I think, which was meant to be a short, sharp review into it, was meant to be producing the report on Agilisys in December 2023; because it is so complex, you have found it difficult, so you are now producing the report in this summer, six months later.

We also have a very complex project, actually, to provide the service, and we have had a new director in place. Staffing has not always been as good as we would have liked for the last few years on this. We are very pleased we have got a new director in place and he has advised us, I believe –

if I am wrong, Dermot, please … he has advised us he needs a little more time to be absolutely certain because we cannot have patient records going wrong in the migration from one to the other. The mirroring has to be absolutely perfect. The staff have to be trained. New business practices need to be put in place to get the benefit from it. Hence, we are taking that opportunity to delay the project.

It may well be that it will not be as long. It may well be that by next March they may need some more time. But it is so important we get this right. I have been through some major projects in my banking days. Some of them have done really well and some of them were absolute catastrophes.

Deputy Fairclough: Is it fair to say you have given political ownership to this to one of your Members now, as well?

Deputy Brouard: Yes, and in fact he is here today.

Deputy Matthews: Deputy Matthews, a Member of the Committee for Health & Social Care. One of the things that we did when we looked at the Partnership of Purpose and programmes in general is we thought it would be useful to have some greater oversight, political oversight, on project boards and EPR is one of the areas that I have an interest with so I will be taking a position on the project board for the EPR programme.

Deputy Fairclough: So, are you confident, Deputy Matthews, that once operational, the new system will allow for patient access to records, as was originally envisaged?

Deputy Matthews: Yes, as confident as you can be. It has been a very well-planned project that has gone through a lot of detailed analysis in terms of its selection of the right software. The issues that we have had have not really been to do with the functionality of the software, it has been to do with things like recruitment and availability of infrastructure. I do not have a level of concern about the functionality of the software. At the moment, I do not expect that to be an issue.

Deputy Fairclough: Is there any intention to come back to the States with this, as you are with the Hospital modernisation work, or is this something you are going to manage as a Committee?

Deputy Brouard: I think we have said that we will keep States' Members advised.

If we need to come back to the States for anything we will obviously come back to the States if we need to. But if we are within our cost envelope then we are within our cost envelope. Probably in hindsight it was unfortunate the cost envelope was pared down early on from £20 million to £17.5 million but, hey ho, hindsight is a marvellous thing. This piece is one of the key jigsaws of the Partnership of Purpose. Once we have got a new management system in place and a new patient record, then we can start thinking about integrating the doctors into it. Then we can start thinking about how St John Ambulance could have that information in the ambulance that means that they can then perhaps treat patients in their own home and not have to bring them to the Hospital.

It is a massive piece, but we just have to get it right because I would shiver to think of something like this going wrong. That is why we need to be absolutely confident. Hence, I would rather take the delay and the criticism from States' Members and the public, rather than have a mistake.

Deputy Leadbeater: Also, as Dermot pointed out and as Al has mentioned, this has only been verbally raised to the Committee as recently as Tuesday, so we are not fully appraised of the full situation as yet so we cannot give you any more than we have given you at this point but we can certainly get back to you once officers have come back to us with a further paper so we can fully understand the problem.

Deputy Fairclough: Thank you.

Deputy Matthews: What we can probably say on that, we did have a previous re-plan of the live date and it is based on the idea that when you are going live with a system you need to make sure that you have full confidence you have got the training place that the implementation will go smoothly, and things will go well.

The last thing you really want to be doing is going in with a system early and not have that confidence. So we do need to make sure that we do this one right.

The Chair: Thank you.

Deputy Dudley-Owen.

Deputy Dudley-Owen: Thank you.

Can we move on to medicinal cannabis? The States' figures show that 13,200 prescriptions were issued for medicinal cannabis in 2023. Is this in line with the forecast expectations as set out in the original policy proposals in 2019 and are we following NICE guidelines?

Deputy Leadbeater: I think when it comes to the previous policy letter, that was the previous Committee, their assumptions for the amount of prescriptions, I think they drastically underestimated the amount of people that would be interested in procuring medicinal cannabis. I think that is safe to say.

You allude to 13,000 prescriptions. I think what I have found all along is people ask how many prescriptions, but they fail to ask the question how many patients. In a 12-month period you will generally get one patient having 12 prescriptions, so you can do the maths yourselves and figure out how many people. I think the last time we looked, there was about 1,550, something like that, people, patients locally, with the three local clinics that were operating. I think there are only two local clinics at the moment. And there was about 100 people still using UK clinics and importing their medications from UK pharmacies.

Deputy Dudley-Owen: Okay, thank you.

Presumably, your advisers, your expert advisers, are the same that the previous Committee had, though?

Deputy Leadbeater: I could not tell you that, I am sorry.

Deputy Dudley-Owen: So, anecdotally, there are increasing levels of diversion fraud. Have you seen a rise in psychosis or any increase in admittance to Crevichon Ward for this condition?

Deputy Leadbeater: We had a freedom of information request come to the Committee asking just that question some time ago. The problem is, as we do not routinely collect that data at the moment. What we need to do is start collecting that data going forwards. So I think if you asked us that question in a year's time then we could give you a better picture.

Deputy Dudley-Owen: Okay, thank you.

What controls have been put in place to ensure that those who may have comorbidities that may cause psychotic episodes are not prescribed medicinal cannabis?

Deputy Leadbeater: It is the consultants that prescribe the medicinal cannabis, the same as they prescribe any medication and it is not for the Committee to tell clinicians what they can and cannot prescribe, whether it be medicinal cannabis or otherwise.

But you talked before about diversion and there is anecdotal evidence to support the claims that there is a diversion of medicinal cannabis. I think what we really need to get our head around is there has been a real big problem in Guernsey with the diversion of prescription medication across the board for decades now. People are making a big deal, and rightly so, about medicinal cannabis

being potentially diverted. But we have had Fentanyl being diverted, we had opioids being diverted. They have been killing people in Guernsey for a considerable period of time and I have not had one politician come to me saying, what are you doing about this?

I think we really have a problem with diversion of prescription medication in Guernsey and it is something that we need to do something about. Law Enforcement, again, it is very difficult for them to try and police this. But it is a problem in Guernsey. It is not a new problem. It is an age-old problem and I think that we do not need to just narrow our focus into medicinal cannabis. I think we need to look a bit more broadly at the bigger diversion piece.

Deputy Dudley-Owen: I will ask a supplementary before I go to my final one but given that you have got a focus on the broader picture, have you tried to bring this to the attention of the Committee to prioritise it?

Deputy Leadbeater: What do we do? We have spoken about it. Yes, we have had conversations with the Chief Pharmacist, the previous Chief Pharmacist, with the States' Prescribing Officer, and I, myself, last term and this term, have made enquiries about what we can do about this. We have been reassured – and you can see if you look at the prescribing rates of some of the more dangerous prescription medications have gone down – if you look at the opiate replacement therapy, for example, I think when I came into HSC back in 2020 we had about 150, 160 people using opiate replacement therapy.

The problem we have with that, because we have not got people, generally, that are addicted to heroin in Guernsey, they are addicted to opiate replacement therapy, diverted opiate replacement therapy. So the more addicts we were getting we were actually creating those addicts by giving people opiate replacement therapy that were then diverting it.

In the last few years that number of the 160 has come to about 70-75 people on opiate replacement therapy. It is a really good piece of work because the initiative that was put forward was that for that sort of medication you had to get it given to you. You had to go to the pharmacy and it had to be specifically given to you.

There were issues with people trying to keep it in their mouth, blah blah, because addicts are quite resourceful in that sort of way. Certainly from that point of view we are going about it in the right way but it is a really broad piece. We need to work with primary care and Law Enforcement if we are going to make any headway whatsoever.

Deputy Brouard: Can I just ask Teena Bhogal to add something, if you would like to come forward? It is mainly just to make sure that you are baptised into this system!

Ms Bhogal: I am Teena Bhogal, I have been here for a year, I am the Chief Pharmacist. It has been raised to the Committee and me that there is an issue generally of prescription diversion within the States of Guernsey so we have been doing a lot of work to try and gather the data. It is anecdotal. For me I need that factual information so we can make informed decisions. So we are looking at that and working with Home and other areas to make sure we have got that information before we make any big policy decisions or changes. So yes, we are looking at it and hopefully we will present that.

Deputy Dudley-Owen: Teena, my last question, you may not be able to answer but I am going to put it out there for the record, at this time would you be able to say whether you have received any information from any agencies or the Children and Young People's Board that would highlight any increased use or incidence by vulnerable children in regard to cannabis?

Ms Bhogal: Yes, we have had previously anecdotal evidence raised to us, so as part of the safeguarding we have been looking at collating that information and looking at incident reports, encouraging people, staff members that deal with those children and vulnerable young people to

record those incidents so we can start looking at that information and collating it, so we know we have got an issue with young people accessing medicinal cannabis or other prescription medicines. I just want to be really clear on what that is so we are collating that data and encouraging our staff working with those young people to collate that and report it back to us and we have got a working group that will be looking at that.

Deputy Dudley-Owen: You have been very helpful.
Thank you.

Deputy Roffey: You may want to stay there, as well! I do not know whether you need to be or not but I want about to talk about the subject of NICE-TAs and obviously many of them are pharmaceuticals. They are not all pharmaceuticals. I know we have got a presentation coming up in a few weeks about it, States' Members, but now we are in a public arena. How has the introduction of the policy on NICE-TAs gone from the HSC perspective?

Deputy Brouard: I think it has gone very well. I think we have used the same company that advised us the first time in putting in solutions for Public Health.

Deputy Roffey: Not how has the review gone but what has your experience been of being able to prescribe these drugs, mainly, that you were not able to some years ago?

Deputy Brouard: The feedback, certainly we used CareWatch, who are in the room today as well, it has been very positive from patients with regard to their experience and our ability to basically move from 30 QALY up to a 40 QALY, where we are now. There are some significant challenges, which will come if we move further and even to stay the same will be significant challenges. I probably would go to Teena at this stage.

Ms Bhogal: In terms of feedback, do you mean?
I think in prescribing we have had uptake on the NICE-TAs that are appropriate, we have had obviously negative feedback from some patients that said they did not understand why they could not access the drug for their NICE-TA. So it is just making sure that we explain it well to patients and the public, understanding what drugs are available and why they cannot have it. The ones that are available, we have had really good uptake and really positive patient feedback. It is where we have had to say no unfortunately to those people who do not qualify for that drug within that TA.
Does that answer the question, or do I need to –?

Deputy Roffey: I think it does. The obvious other side of the coin is what has the cost been, what is your estimate of the annual cost of the change of policy that the States approved some years ago?

Deputy Brouard: Yes, it is approximately £5 million but some of this data if you can just sit on your hands for a couple of days.

Deputy Roffey: I can but the public will not necessarily be at the Peninsula, or are you going to make that a public presentation at that time?

Deputy Brouard: I have found that when I do things to States' Members it ends up in the media anyway, bless. I think we would like to present to the States' Members first. I am sure we will do some sort of announcement to the public, as well, afterwards.

Deputy Roffey: But I picked up it was about £5 million a year. I suppose the obvious question is you still have not gone all the way, though. Guernsey patients do not have access to the same

drugs and treatments that UK patients would because once a NICE-TA is approved there it is almost obligatory in UK health authorities. Are you comfortable with that or would you like to move to parity with the UK?

Deputy Brouard: I am going to answer that purely for myself, I would like to move personally, but I do not know what the Committee's position is, but when you get to the higher levels of costs of drugs the effectiveness of what you could use the money for, and you have been very keen about prevention, would that money have been better spent on prevention, or not? Are we best to stay at 40,000 QALY, or are we best to move to 50,000 or are we best to do all?

There are some very difficult choices. If you are giving me the money to do it all, fine. But if you are not, we have got some very difficult decisions to make. Can I just bring Dr Rabey in because we have asked you this question.

Dr Rabey: We can spend all your money and we must not. So there are going to be some hard decisions. If we want to go to the Cancer Drug Fund type funding that the UK has in place, that is a political decision, we will take the money and spend it and some patients will benefit. But, for me, the best next investment in healthcare, in health and social care in Guernsey, is to ringfence some money for prevention because we will be thanked, in 10, 20 years' time, for doing that and that is where I would put the money first. If there is money left over after we have done that, let us look at where the next best spend is. But drugs would not be my first choice.

Deputy Roffey: Okay. My last question on pharmaceuticals and probably my last one of the hearing, I notice that the Prescribing Support Unit's annual reports now several times has warned that the cost of the generic drugs that are prescribed in very large numbers have been sky rocketing, really going up in recent years. What impact is that having on your budget? Is there anything that you can do about it?

Deputy Brouard: We have benefited in the past from the move to generic drugs and I think there has been a lot of work done by Geraldine O'Riordan on that particular area, but I think I am going to turn to Teena.

Ms Bhogal: Yes, so generics are increasing but we are trying to make savings in other areas and getting the rebates for drugs at a lower price similar to the NHS. It has not had a dramatic effect on the total cost of drugs at the moment so hopefully it stays like that. But we do keep a really close eye on that. We are in the process of doing the next annual report and that will be out in three months, hopefully. So far it is looking okay.

Deputy Roffey: Thank you very much.

Deputy Dudley-Owen: Thank you.

I just wanted to touch on maternal health and ask what the current percentage rate of elective, non-medically induced C-sections is and what the costs of these C-sections is to the States?

Deputy Rabey: I cannot tell you the figure at the moment because we were told to stop counting them. We were told to stop counting them because the evidence was that Caesarean-sections were a valid choice for mothers to make, in terms of delivery, and if a mother wanted a Caesarean section for no other reason than that they wanted it they should be encouraged to make that choice. That was a decision made in response to findings in the UK.

Before that, we used to try very hard to drive Caesarean-section rates down. It was seen as good practice to drive Caesarean-section rates down to the lowest safe level, whatever that was, 20%, whatever it was. We have quite a high Caesarean-section rate here and the reasons for that include that our maternity unit is far from our operating theatre and if the obstetrician, the midwife is in

doubt about the safety of that baby when there is a transfer time that involves transferring the baby along a long corridor into a lift down and into another corridor to get them to theatre and we know that takes about eight minutes, in addition to the decision time, mustering the team time, all that stuff, we are not well placed to deliver a baby very quickly.

But you asked about elective. The fact is elective sections are becoming more popular with mothers and we do that when they ask for a section now. They get all the information to make an informed choice but having been handed the information and having made their informed choice that they would prefer a Caesarean-section, we have been told to go ahead and do that.

I think we ran about 45% total deliveries, something like that. If I am wrong, we will send you the figures. That is not for elective, that is for combined elective and whatever. I am probably miles off but we will send you the data.

Deputy Dudley-Owen: Are we running a midwife-led service or a specialist service?

Dr Rabey: You can have a midwife-led delivery in our hospital. We do not have a separate dedicated, midwifery led unit, because the numbers we deliver are tiny. We deliver about 550 babies a year, here. So we do not have a separate, midwifery led unit. But in our delivery section, a lot of deliveries are midwifery led. More deliveries that need obstetrician input are defined in the same way as the UK and those would be the same, they would get an obstetrician involved in their care.

Deputy Dudley-Owen: Is this proportionate for an Island of our size?

Dr Rabey: Yes. Women who choose to have midwifery led delivery and with no complications that makes that a safe option for them have that choice and take it.

Deputy Dudley-Owen: But women do not have an option of a home birth?

Dr Rabey: We will try to facilitate a home birth. We cannot guarantee to do that because we do not have enough midwives to guarantee the safe route in the hospital. We have tried very hard to say 'where we can we will' but the fact is we cannot offer that service.

The Chair: I think that sounds like a new policy announcement that Deputy Brouard is rather concerned about!

Dr Rabey: I may have misrepresented –

Deputy Brouard: We do not offer a home birth service. That stopped last year.

The Chair: I think it was before that, but yes.

Deputy Brouard: There are many reasons why, including staffing and safety, etc. You can have your birth at home but it will be at your own risk and not ours. We recommend that pregnant mothers come to the Hospital, where we have got the best care that we can possibly give them on the Island.

The Chair: Can I come back to something you said in answer to one of those questions, Dr Rabey, which was about it takes eight minutes once a decision is made to transfer a woman to the operating theatre, and then you also said you have to muster the team but surely mustering the team and pushing the trolley along the corridors and in the lift are things that happen concurrently?

Dr Rabey: We do all of that, but the fact is if I can make a decision to get this baby out now and push them through those double doors into that operating theatre next door, the baby will come out quicker than if I have to do all of that –

The Chair: I accept that but when we have got the new Hospital, if we go ahead with that, presumably that anomaly will have been resolved (***Dr Rabey:*** Yes.) so at that point it is still not going to make any difference to the elective rate, is it?

Dr Rabey: To the emergency rate. So if I think this baby is in trouble and I have only got to go there, I am more inclined to watch the CTG for a bit longer and see if it settles down, rather than make the decision to call a section now.

The Chair: I understand.

Dr Rabey: That is where it will help us but you are right, women who want an elective section or need an elective section for various reasons, *placenta previa,* many previous sections, that sort of thing, they will still need to have an election section.

The Chair: Okay, thank you.

Deputy Dudley-Owen: I have got one more question to ask and I am going onto another area that has been in the news recently about gender identity.

HSC stated last year that a clinical level it endorses the spirit of WPATH. WPATH stands for World Professional Association of Transgender Health and on the basis of a recent and significant leak of internal files is an organisation which … *[Technical interference]* science, proceeding with treatment without informed consent and which has led to medical malpractice on children and vulnerable young adults. Further, Dr Hilary Cass, in her recently published review stated that WPATH guidelines were found by the University of York appraisal process to 'lack developmental rigour'.

Does the Committee feel confident that it can continue to endorse the spirt of such an organisation and to contract with private clinics who state that they operate in accordance with WPATH standards of care?

Deputy Brouard: Thank you.

I will take that one to start with. I believe we are working to the WPATH guidelines ,seventh, I do not think we have accepted the next level. I am going to very quickly – hopefully he is still behind me and he has not left. Oh, he is at the end! Even better! – invite Dr Dominic Bishop, who can probably advise us far better than I can.

Dr Bishop: So the WPATH guidelines from version seven, written in 2012, were fairly uncontroversial and they speak a lot about respect and dignity and equal access to healthcare, non-discrimination. WPATH version eight changed quite significantly. They introduced new concepts and they also removed age barriers for certain treatments and the documents you are talking about are almost a Wikileaks leak of professionals who had concerns about the eighth version, which has not been widely accepted.

The difficulty, in all honesty, is this is a very evocative issue. It is a very difficult situation and people are very reticent to produce guidelines. It is the only thing that I have ever seen that does not have any NICE guidelines and I think people have been too worried to produce them. There are some NHS recommendations, but Hilary Cass is the first person to have actually taken on the topic more broadly.

You also need to know that over the last 15 years, there has been a massive evolution in this cohort and the demographics of the people therein. In 2009, for example, there were fewer than 50

children and young people referred to gender identity services. Last year, there were 2,500, and they have completely changed in their demographic.

Is there a surprise that things are out of date? No there is not because things have moved along so much. There is no one who is an expert in Guernsey, but we have never done anything in and outside of what the NHS recommends. We based our policy and our procedures on the NHS recommendations, as were. The fact that we contracted a private clinic did not mean that we have changed those. We just prevented our community from having to wait five years before accessing that care. We did not commission anything outside of the guidelines the NHS do on a daily basis.

The Chair: You can get round to asking your questions on primary care, I think.

Deputy Roffey: I can ask the one on primary care, we have sped up somewhat.

The Chair: Three minutes left.

Deputy Roffey: Deputy Brouard, you mentioned earlier that we started this term with a working party looking at accessibility to primary care and the cost of primary care. I understood it was suspended because of the need to focus on Alderney. When is the work going to start again?

Deputy Brouard: I think we have got a paper coming shortly on that particular topic. I do not have a date as to when it is starting again. We do have, unfortunately, not a very large Civil Service, in the Island generally, and on this particular case we were relying on central services, which were then moved elsewhere for other things, which were much more pressing at the time. I will just check with the Committee secretary if there is a date for a primary care update.

Ms Le Tissier: The joint Committees, Policy & Resources and HSC, met about a month ago, early in April and were looking again at the scope of how much resources need to be allocated to each of those workstreams. There are some smaller projects in there, potentially some quicker wins, that might enable some change, but it is to be scoped because the resources were not available to take it forward. I think it will get picked up after the strategic portfolio, the work on the sustainability of health and care. It is absolutely fundamental to that piece.

Deputy Roffey: You mentioned earlier about the £12 grants. What is the HSC position on this? It was 50% of the cost of going to a GP when it was introduced, now it is about a sixth. It seems pointless to let it slowly wither on the vine. Is that policy, to let it wither on the vine? Would you like to increase it a lot, to help accessibility or would you want to scrap it, which I think you hinted you might do, earlier?

Deputy Brouard: To be fair, it was ESS who let it wither on the vine.

Deputy Roffey: I know, my predecessors did that!

Deputy Brouard: Thank you!

It is a conundrum. If you want to increase it, that money will have to come from somewhere or something else does not happen. That is going to be the dilemma, and I think from the work that you and I did on it, we discovered that the only thing we could do is move the deckchairs around, so it was making the grant move perhaps to somewhere where it did more good but somebody will be upset because they will not have that grant any more and that is going to be the difficulty going forward.

Deputy Roffey: Because we have got one minute left, I would like to ask what questions should we have asked that would have been revelatory in your response? What is happening at HSC that

you think the Island would be interested in knowing about? Or is nothing else happening beyond what we have asked you about today?

Deputy Brouard: Dr Rabey.

Dr Rabey: We have saved the Island £750,000 a year by reviewing the oxygen service and nobody knows.

Deputy Roffey: Sorry?

Dr Rabey: The respiratory team have looked at the oxygen contracts over the last couple of years and they have put in savings of £750,000 a year and nobody notices because when we do really efficient things it just goes unsaid. So I am really proud of that.

The Chair: I am glad Deputy Roffey has managed to afford you the platform to make that announcement. I think that brings us nicely to half-past five and the close, so thank you to all of the witnesses in both rows here, for attending and increasing the public awareness of what HSC does. We undertake regular hearings, as you know, and we are in the process of scheduling the next one.
Deputy Brouard.

Deputy Brouard: Again, can I say thank you Chair for the questions and the manner in which they were asked, and can I also just thank my top table team and my other top table team behind us, whether they were used or not, so thank you very much.

The Chair: Okay, well thank you everybody and the hearing is now closed.

The Committee adjourned at 5.30 p.m.