OFFICIAL REPORT

OF THE

STATES OF GUERNSEY

SCRUTINY MANAGEMENT COMMITTEE

The Committee *for* Health & Social Care
Public Hearing

HANSARD

Guernsey, Wednesday, 20th October 2021

No. 3/2021

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

Published by The Scrutiny Management Committee,
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Members Present:

Panel Chair: Deputy Yvonne Burford – President
Deputy Simon Fairclough – Vice-President
Deputy John Dyke – Member

Dr Sue Fleming, MBE

Mr Mark Huntington – Principal Scrutiny Officer

Business transacted

Scrutiny Management Committee

Government Work Plan
Public Hearing

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

[DEPUTY BURFORD *in the Chair*]

Procedural –
Remit of the Committee

The Chair (Deputy Burford): Good morning, everyone, and welcome to this Scrutiny Management Committee public hearing session with the Committee *for* Health & Social Care. This morning we will be focusing principally on the matters relevant to the Committee's mandate that are in the Government Work Plan.

I am Deputy Yvonne Burford, and with me on the Panel today are Deputy Simon Fairclough and Deputy John Dyke. We are also joined by Dr Sue Fleming, who was formerly a chief nurse and is the Matron of St John's Residential Home; and Mark Huntingdon, who is the Principal Officer for Scrutiny.

Following this session, the Scrutiny Management Committee will decide if there are any matters for further review we want to undertake from the outcome of today's session, and a *Hansard* transcript of the entire session will be published in due course. This is an official parliamentary session, and therefore questions or interruptions from the Public Gallery are not permitted. If everybody could now just check that their mobile phones are turned to silent, please.

EVIDENCE OF
Deputy Al Brouard, President, Committee for Health & Social Care;
Deputy Tina Bury, Vice-President, Committee for Health & Social Care;
Dr Peter Rabey, Medical Director;
Dr Nicola Brink, Director of Public Health;
Dermot Mullin, Director of Operations;
Emma Le Tissier, Acting Committee Secretary;
Matt Jones, Programme Director;
Nicky Gallienne, Associate Director – Children and Family Community Services;
Darren Smith, Finance Business Partner;
Stephanie Barnes, Head of Client;
Lynne Duckworth, Human Resources Business Partner

The Chair: I will turn now to our witnesses today and ask you to introduce yourselves, please, starting with Dr Rabey.

Deputy Brouard: Would it be possible if I could just do a first introduction, Chair?

The Chair: If you would like to do it that way, Al, yes, no problem at all.

Deputy Brouard: Thank you very much.

Thank you for inviting HSC to the scrutiny hearing. In preparation for this meeting, I just realised how big an organisation we have and what a responsibility both politically we carry and also those who are with us today and those who of us who are back at the Hospital in our care situations providing services.

We do have a team ethos to manage health and that goes from the board right down to the laundry assistant. We have been in post for a year and I am exceedingly proud and pleased with our political board. We have Tina Bury on the table with me and able Deputies Marc Leadbeater, Aidan Matthews, Alderney Representative Alex Snowdon and non-States' Members Emily Litten and George Oswald, none of whom I would wish to change and so from a very strange birth we had, the gods have been kind to us and we have a sound political team. What is often not said is we have an excellent team of staff here today and obviously they will introduce themselves further but Dr Brink, Dermot Mullin and Dr Rabey on the table with me. Also, ready to help answer your questions we have Darren Smith, Stephanie Barnes, Emma Le Tissier, Nicky Gallienne and Matt Jones, on the second row but first class and any one of them could be on the table with me.

With 2,500 employees and a £200 million budget, we need support and expertise from those at the top of their game and we do operate literally 24/7 and not without consequences in a highly complex and integrated system to provide Islanders with health care as best as we can. The risks and challenges are real and we deal with them on a daily basis, so I am very proud of our team here.

Thank you.

The Chair: Thank you, Deputy Brouard. Dr Rabey.

***Dr Rabey*:** Dr Peter Rabey, I am Medical Director for HSC.

***Dr Brink*:** I am Dr Nicola Brink, I am Director of Public Health and Medical Officer of Health.

***Deputy Bury*:** Deputy Tina Bury, Vice-President of Health & Social Care.

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

The Chair: Thank you, and can everybody hear okay? Thank you very much.

Right, so to kick right off then with the first question, Deputy Brouard, on the GWP and specifically the critical recovery actions. In the 10 critical recovery actions for the first six months in the GWP, bearing in mind of course that we are halfway through that six-month period, HSC have two actions. The first is supporting vulnerable children through revision to the Children Law and the second is supporting the physical and mental recovery of Islanders through a new pilot Wellbeing Centre. Could you tell me why HSC chose those two areas as their main priorities for immediate action?

***Deputy Brouard*:** Well both of them have been ongoing actions for many years, in particular the Children Law has been in revision before my time or the time of the present board, so it is very important that that work is continued.

We have a very strong responsibility as Government to look after children, not only those in our own care but also those across the Island. I will let some of my colleagues speak further on that. The second action is we all remember, especially those politically and I think, Simon, you mentioned

it as well in one of your notes to us, was the issue of mental health on-Island and we need to understand exactly what the position is. We have got a mental health provision that is provided by many people. We have got primary care at the front end. We have got a very good secondary mental health care at the other end. There are some difficulties in that middle ground and we want to understand that better so we want to progress with a pilot to have, basically, a mental health crisis centre set up. That will not only be useful in its own right, but it will also inform us as to how we then go forward with mental health provision. From the Election last term, it was a concern of Islanders certainly in our inboxes with regard to mental health, we have had many questions in the States about mental health, so we are trying to get under the bonnet to actually understand exactly what the situation is and how we can make it better.

The Chair: And do you think that pilot will be up and running by the end of the six-month period, so we are talking January?

***Deputy Brouard*:** We very much hope so.

We are in discussions with a third-party provider to bring that forward. We have premises that we have been in contact with which we hope we will put forward, and the initial groundwork has all been done so we are very hopeful to have that ready for Christmas.

Any of my colleagues have anything else they would like to add to that?

***Dr Rabey*:** I would just comment that it is a gap that we identified when Public Health did the mapping of mental health provision on the Island.

One of the gaps that was identified was this gap between primary and secondary care, and then what are commonly called 'crisis cafes' although that might not be the best name for it, but somewhere where people can drop in perhaps out of hours when they are in crisis, need some support but do not actually need to be taken to the Emergency Department or to see the on-call psychiatrist team, but somewhere where they can get support and that is a key priority.

The Chair: Okay, that is very interesting, thank you.

These two items have been singled out as your absolute top priorities, but did you consider that there were any other areas that were very closely competing with them such as waiting lists?

***Deputy Brouard*:** Our top priorities: there are probably about 10 or 20 different priorities. These are the ones that made it to the Government Work Plan. We have other priorities which are just business as usual, which are: we need to be on top of the backlog and waiting times, that is very important to us; we need to move people out of our hospital care into supported living at home or into care homes when necessary; we have got the Hospital Modernisation Programme. We have many different priorities, these are the ones that just made it into the Government Work Plan as ones that were already well in train and especially like the Children Law has been going on for many years and we have just had the report from Martin Thornton which will now help to inform us of how we work that particular item through.

The Chair: Simon, did you want to come in there?

Deputy Fairclough: Just picking up on priorities under the Government Work Plan versus business as usual thing, Deputy Brouard, I appreciate that there are some grey areas here. You have your mandate as Health & Social Care, and you need to deliver against that. But given the fact that these two areas were identified as your top priorities, are you concerned at all that some of the other things which you are saying are business as usual such as waiting times, which I think probably are in the minds of the public right up there in terms of priorities, do you think that there is a danger that those are not given the priority that they need to be?

***Deputy Brouard*:** No, I do not, but I take your point.

As soon as you make a list, you have got some at the top and some at the bottom no matter how you do a list. That is just the inevitability of it. The Children Law area is just a very small niche market, it does not involve the whole of the team. It is just one area that is quite specific and niche. Our main business as usual is really the Hospital and the waiting list. From the Government Work Plan we have got £1.9 million spread each year for the next four years to help us to deal with that particular backlog. We are very much – and I think Dr Rabey could probably speak a little bit more on it, but we are very much – focused on eating into our backlog, conscious of course that some of the usual ways of doing so are now more difficult.

One, our beds in the Hospital are tight so we cannot bring people through as easily as we would. The UK, who were one of our places that we would go to for support to do orthopaedics and things of that nature, they are exceedingly tight. Their waiting list now is now 5.7 million, which the equivalent here would be 5,500. We have got a waiting list which we are very conscious of, we know all the names on it, the 1,800 odd – we very much want to eat through that. So that is very much a priority for us, but there are some challenges with regard to staffing, the accommodation to actually get the staff in. The whole of it, it is a whole matrix of different issues that we need to solve each little piece to get the whole. I think, Dr Rabey, you might have something more on that.

***Dr Rabey*:** Yes, it would be completely wrong to feel that waiting lists have not been prioritised.

They are absolutely one of our top priorities, but we are struggling with them and that is because of the things Deputy Brouard has just said so the big hits on our waiting lists since COVID ... If we look back to March 2020, there were fewer than a thousand patients on our waiting list, it is over 1,800 now, as Deputy Brouard has said. So the waiting lists are very difficult to tackle without the number of beds we want, the heavy growth has been in orthopaedics of course because the cancer cases get prioritised, and in gastroenterology, endoscopies so procedures where you are looking down the oesophagus and into the back passage and things, those procedures are aerosol generating procedures and we have had to take special precautions during COVID so those waiting lists grew during COVID significantly.

Now the endoscopy waiting lists are coming down again because they are done as day cases and we are getting those lists back down but there has been growth. Orthopaedics – they still have not come down yet because we just have those 25 to 35 patients in the Hospital who should be in care homes and in community settings that are blocking our beds. So as soon as we can crack on with that, we will.

The Chair: Okay, thank you.

Can I just carry on a little bit more, and more broadly, with the specified actions in the GWP and perhaps you can also clarify something for me, because on page 103 it talks about an action committing HSC to developing and running an enhanced mental health service pilot and I am just interested to know the difference between that and the action we just talked about as the immediate recovery action of the pilot wellbeing centre which was for physical and mental recovery. So, is this a longer-term extension of it? Could you just tell me a little bit more?

***Deputy Brouard*:** From my point of view I think they are one and the same. (**The Chair:** Right.)

Again, there is a lot of talk about a wellbeing centre in the plans and this was from legacies from previous terms. Yes, there is talk of a wellness centre which I think is bringing together some of the children's services together in one place, in Swissville, Lukis House, that sort of things. At times, they have been conflated together with a mental health facility. It may well be that in years to come there may well be one joined up, on one site, one particular provision. But our first foray, as it were, is to get a mental health pilot up and running and that will then inform us what that looks like. If it works well and the feedback is good then we will probably incorporate that into a larger piece of work bringing more services together on one particular position.

The Chair: Okay, thank you.
Does anybody else have any questions on this particular topic?

Deputy Dyke: I have one question on the Children Law.
I also was quite surprised to see that as a priority. As a lawyer, I am somewhat sceptical of new Law. Has that been costed?

***Deputy Brouard*:** There is work ongoing on that as with regard to the costing and, would you believe it, different professionals have got different views of how it should be done. So we have got quite an interesting mix of opinions as to how it should happen, whether it should be through the Convener, whether it should be through the courts, where boundaries stop and where other boundaries start.
I think Deputy Bury could probably say a few more words. We have a working group set up that is looking at this. They have now met, I think, for the second time now. It is a priority but please do not go away from today thinking that is all that our whole team is focused on. It is just one area that was a priority, it was already progressing, and it just got into the Government Work Plan. It is as simple as that. But we have other areas which are equally just as important, and we are progressing just equally as well.

***Deputy Bury*:** Just to be clear it is not a new Law, it is an update, and it really is looking to address practicalities within the system and the whole aim really is to improve outcomes for children because at the moment one of the biggest concerns is delays in the process, confusing processes, taking part in two processes simultaneously. So it is all about looking to streamline that so that the positive outcomes are reached for the children quicker.

Deputy Dyke: Great, thank you.

The Chair: That is very helpful, thank you.
I think we will continue on the theme of spending that Deputy Dyke raised generally. Are you confident that you can contain spending on Health & Social Care to stay within your budget for 2022?

***Deputy Brouard*:** Yes, Darren has told me he can! (*Laughter*).
We may well be slightly under budget this year and it sounds a very large figure; it may well be a million pounds. But as a percentage of our budget that is half a percent and when you consider we could have two off-Island cases that could eat a million pounds without even looking sideways.
I would like to ask Darren, if you could make a few comments on the budget? We have been very much supported by P&R with the budget proposal. They have not given us everything we have asked for but we will manage with what we are given.

The Chair: Okay.

***Mr Smith*:** Yes, so 2021 has clearly been affected by the pandemic in a number of areas in terms of those volumes, so expenditure has been suppressed in certain areas. We expect that will come back, so underspends this year. There will be some budget challenges next year, but we will manage those across the piste. We have a lot of support through Treasury, P&RC, certainly for waiting lists as mentioned, NICE TAs, all of the transformational efforts including Hospital modernisation and electronic patient record.
So, we have got business as usual and transformation in a fairly strong place, but we do have clear challenges. We have got areas mainly through recruitment and retention challenges and the cost of staffing generally –

The Chair: And that is your main challenge?

***Mr Smith*:** Absolutely, that is the focus for how we manage and mitigate those challenges as demographics start to come through and they are coming through certainly in community areas as a clear focus.

So I think we are in a place where there will absolutely be challenges and difficult choices to make and that is true for the next five years at least which is why the Government Work Plan has that horizon and building in the model we have done – £3 million year-on-year demographic-driven cost pressures, and for next year we have been supported in line with that as well.

The Chair: Okay, and do you think there are any particular areas where you can actually release funds? Where savings can be made?

***Mr Smith*:** Well in terms of looking across the piece, there is a real challenge there.

Going through former challenges, the Financial Transformation Programme … heavily involved in that. So, most areas have a degree of challenge; we are absolutely conscious of and focused on the fact that there may have been some rebalancing that has happened through the pandemic, that means we could certainly look to reprioritise and rebalance some of our existing funding. That is the challenge for HSC and financial management in particular, but it is very likely that these are one- to two-year initiatives and then the cost pressures will continue to go across those areas.

The Chair: Okay, thank you very much.

Actually that leads me on quite nicely to a little area of questioning I wanted to ask you which relates essentially to the Health Improvement Commission insofar as preventative healthcare and opportunities to save through people not becoming ill in the first place which is something I am sure we would all strongly support.

It is interesting because if you look at figures from Public Health England, and I am quite sure that perhaps we have some in Guernsey as well but I located these, that the cost of obesity to the wider society in the UK is about £27 billion per year. So, if we put that into the Guernsey context that would be £27 million. I do not think there is too much evidence to think that it would be wildly different and that includes the equivalent of a £10 million direct cost to healthcare. So, I understand the Health Improvement Commission is now responsible for the Healthy Weight Strategy under its service level agreement with HSC and the total budget to the Commission is about £1 million but that also obviously includes a lot of other work streams such as drug and alcohol. And obviously a minority proportion of that fund would go on obesity issues.

So my question is, given the commitment of the Assembly in previous years and indeed the Committee to preventative healthcare, do you think we are spending enough to address the issue of obesity, given the potential savings to the Island and the potential positive health impacts on individuals?

***Deputy Brouard*:** I think the simple answer would probably be no.

We could never spend enough, that is the challenge that we have. But also, I am very cognisant as well that Islanders also want the cancer care when they want it, they want their leg fixed when they want it and although prevention, as you say, will help mitigate and make the cost lower, it does not necessarily make them go away or that they will be less in the future. The cost in the future will be greater. We will live longer; we will need more knee replacements in your 40 years between retirement and possibly moving to another world. That is not going to become cheaper as we go forward but I think Dr Brink with the Public Health hat on would probably be the best to answer further.

***Dr Brink*:** So, the Health Improvement Commission has been established and works really closely in partnership with Public Health and I really think it has been something that is proving to be a success.

What we are looking to do is focus on prevention and early intervention as much as the management of Tier 4 services for people that are obese. Focusing on prevention and early intervention, you are looking at outcomes that stretch over decades. For example, we have our Child Measurement Programme and we can map the weight of children in primary school. That is incredibly important because that is feeding into some of the interventions so, for example, the healthy meals at school, the lunchbox initiatives that they are doing. So focusing on their prevention, early intervention is of absolute paramount importance.

We are also looking at what else we can do at the other end of the scale; people, adults, who are morbidly obese, who are overweight and how we can manage that. So there have been various initiatives with the dieticians in the Hospital working with the Health Improvement Commission to look at that end of the spectrum as well.

Now to me, the strength of this initiative is that it is a true public-private partnership. For example, another strategy is the Substance Use Strategy which is drugs, alcohol and tobacco and we look at the strategy between Public Health and the Health Improvement Commission to look at who is most appropriate to deliver a certain action. Their partnership working has been absolutely key. For example, some of the Count 14 Campaign that has been so successful with alcohol is something that the Health Improvement Commission has led on. Some of the more policy aspects of the implementation of both the Healthy Weight and Substance Use Strategy will come back to Public Health. But that flexible partnership working I really believe is going to be key if we work in an imaginative way to push things forward.

It is quite interesting speaking to my colleagues in other jurisdictions, they are really interested in how we are working together in a very flexible way. I meet with the Chief Executive of the Health Improvement Commission on a regular basis and it is very much 'How is the task? How do *we* do it?'

The Chair: Yes, I have been very impressed by the work of the Health Improvement Commission and I think it is a very positive move, moving it out from Health & Social Care into this third sector partnership organisation.

I suppose my question that I am driving at here is that the budget would seem to be relatively small in the grand scheme of things. I realise the cost pressures on your budget otherwise, but given how much could be saved, admittedly not this year or next year but over the long term, and that is essentially what we are looking at when we have a debate in the States about tax; we are looking at the pressures coming down the line. So, I think it seems logical that if we could avoid some of those costs, even if it will not show benefits for three years or five years or ten years, that maybe that is something we should be doing now.

So, my question is that even if that money is not in your budget, because I realise you would have to cut something else which is unpalatable, do you think we should be investing more in prevention?

***Dr Brink*:** Absolutely. I think prevention and intervention is absolutely key, so I think it is really important. If we want a healthy, vibrant Island, I think that investment is essential. Sorry, Deputy Bury.

Deputy Bury: I just wanted to, in addition to the figures that you mentioned, obviously a commission of that nature will raise funds as well in addition to the budget that is given from HSC and then that will be matched under the P&R policy, so that –

The Chair: Yes, I saw that. I think that was £32,000 for last year, was it? So, I still think it seems relatively small. I am also mindful that if a third-sector organisation is working hard to deliver the

things under the service level agreement, how much of that time do they want to take away from that to become fundraisers? We all know how difficult fundraising is. So, I am aware of that much funding, but I think it is a limited part of the pot.

I do have –

***Deputy Brouard*:** Can I just add on that?

The Chair: Yes, please do.

Deputy Brouard: I think also, and this is where something that is just almost coming in under the Partnership of Purpose is that health is in all mandates. People become obese because of a reason. There is something that happens, a trigger point, they may have lost their job, so we need to look at Economic Development. They may have had poor housing. So, there are lots of other factors that come into play in people's general wellbeing. Their mental health issues are affected by their daily lives. Some people do not have … the cards are not dealt to them as well as they could have been, and they have challenges. But we have, with all our committees, from Education right the way through to ourselves, to ED, to Environment, all have a role to play in supporting Islanders with their health position. So, if you have got really good schooling, you are living in a really nice place, you have got a really secure job, your life is going to be better than someone whose struggling on the margins. And although we can do so much, we also need the help from all our friends and colleagues in other committees to bring that forward.

The Chair: Just one more question on that topic from me, which is that I have previous experiences as a director on a third-sector organisation with SLAs with the States and I am driving at this point where the Health Improvement Commission is concerned.

I believe their SLA possibly runs until the end of next year – I am not sure if that is right, but I certainly know that in a third sector organisation when your SLA has got an end date you start questioning whether you can embark on new projects, you start questioning whether you can recruit new staff for new projects. Do you think there would be merit in having a much more flexible arrangement with the SLAs where there was not always this end date looming on set contracts so that perhaps the organisation was a little less fettered in what it needs to do?

***Deputy Brouard*:** No, I think that is a fair point, and we have literally taken that forward with people like the MSG. It used to be a fixed-term contract to a certain date, now it is on a rolling programme. And it is the same with, I think, ESS where they are engaging with some of their people. We are now looking at it more as a rolling programme rather than a particular date that you work to. But does anyone from the team who has any more expertise want to add to that?

The Chair: Okay, well I think I have probably spoken enough for now so perhaps I can hand over to Deputy Fairclough who I am sure has got some questions he wants to ask you.

Deputy Fairclough: Yes, thank you, Deputy Burford.

Just going back and picking up on the waiting list issue then that we have introduced already, could you tell us about the system that is being implemented to address the waiting times for surgery, Dr Rabey, or indeed anyone from the Panel?

***Dr Rabey*:** I am happy to have a go.

***Deputy Brouard*:** Well have a go.

If you do not do well, we will go with the others! (*Laughter*)

Dr Rabey: We can bring the waiting lists down if we can operate normally. We showed during the release from lockdown at the end of 2020 that just working our operating theatres hard brings the waiting lists down, so we can do it on-Island using our own resources and we will when we can. That includes orthopaedics. So, the answer for getting waiting lists down – lies in our own hands – is if we can get those operating theatres working flat out, then this will come down and we have shown it and we have done it before.

The States paid for a fourth orthopaedic surgeon in recent years so the capacity for surgery in orthopaedics is there and the surgeons are chomping at the bit to do that. We would like more theatre time but with the theatres we have got we can bring the waiting lists down, providing we have all the other parts of the jigsaw and the other parts of the jigsaw are numerous. But the one that is hampering our efforts at the moment is, as I have said, the number of beds for orthopaedic patients, because at the moment our orthopaedic ward has outliers of medical patients who should not be in the Hospital at all and that is hampering our efforts there.

If I could just say in response to the COVID crisis we have got two additional medical posts to help with this. One is an additional physician and that is somebody who will free up time from the gastroenterologists and actually the cardiologists to do more of their specialist work and take some of the general medicine load off those special teams. The other is a twelfth anaesthetist post which will improve our COVID resilience but also it enables us to staff more operating lists and intensive care beds. But everything at the moment is being ruined by this shortage of beds.

***Deputy Brouard*:** If I could help there as well, just to add in to that, Simon, I think we are looking at the bed issue and we have got a plan to try and move these patients who should be back in their own home or into care homes, but it is quite a complex piece to do and I think perhaps Dermot is probably on top of that as anybody and he could perhaps give you some information of what we are doing to move that piece so that then Dr Rabey and the Hospital staff can get on with the surgery we need to do.

Deputy Fairclough: Yes, if you could explain that because obviously that is the obvious follow-on question: what exactly is being done to address those bed shortages?

***Mr Mullin*:** Thank you.

Yes, so the key issue or key challenge is downstream in terms of care home sectors. So, there is a lack of nursing and residential beds or there are nursing and residential beds closed because the care homes and the care home teams cannot staff adequately to deliver safe services. So there are conversations going on about how we can work closely with that sector in terms of supporting them with their recruitment using some of the agencies we use but also whether there is more that we could seek to talk to ESS colleagues around financial support if that is what is required. Because, as Dr Rabey said, if we did not have those who are delayed in transfers of care from the acute service, our patient flow would be much better and therefore we would have the capacity to run what is our business as usual.

We have not had this level of delayed transfer care for quite a number of years. The Committee have supported us to make significant investment and to community services, so they are actively recruiting. This morning we had seven delayed packages of care in the system. We need more domiciliary care delivery to be able to meet that demand. Committee have also supported us in respect of increasing the number of acute staff, so that is both registered and non-registered, so that we can extend the working time of the day surgery unit so that we are protecting the beds. Day surgery from November, December, once staff are in place, will remain open until 11 o'clock at night which means that more procedures can hopefully go on to theatre lists in the afternoon and then have a long recovery and be discharged home later at night rather than requiring an in-patient stay.

The other thing that we are actively recruiting to is additional staff to then increase the bed capacity with the in-patient area from 116 to 134 beds. Again, that is about trying to bring additional

staff in from the UK, but the whole context of health and care nationally is disrupted since the emergency response of the pandemic. The other contributing factor here is the lack of staff accommodation. So, we are supported through procurement colleagues and HR colleagues in trying to secure self-contained units because not everybody wants to live in nursing home accommodation which we do not have access to at the minute, and not everybody will want to live in a hotel.

So, there are numerous conversations going on, it is multi-faceted, and it is complex, but we are, as Deputy Brouard said, the scale of Health & Social Care day on day we are working on this to try and ease the pressure on the system.

Deputy Bury: Can I just come in to summarise what Dermot said there?

I think what people may be expecting or what some of us may have hoped is that there is one big solution. 'Let us do this and that is going to fix everything', but it has become very clear with a lot of the pressures that we are experiencing within the service that that just is not how it works, because if we say we are going to pump in £1.5 million and build this, how are we going to staff it when staffing is an issue across the country? If we could staff it, where are they going to live?

So instead of looking for that one big silver bullet project, we are actually having to look in all areas to just get those marginal gains in the hope that each of those will ease the pressure.

Deputy Fairclough: Yes, and I gather from all of your answers that it is a very complex situation.

What, if anything, could be done to try to speed up the process? Are you confident that you are getting the support you need from other States' departments and within the States generally?

***Deputy Brouard*:** I think so.

Some of the plans will not come out immediately but we have got plans for what we are calling colloquially 'John Henry Court 2'. So, we are looking to build some new key worker accommodation on the PEH site. Again, that will be a few years away before that accommodation is in place. We are working with the care homes to see if we can encourage them to open some of the beds that they have got, but they are struggling with staffing. We have looked at whether we buy a hotel, whether we run the Duchess of Kent all over again, whether we run King Edward VII.

But a lot of it all comes down to staffing and that is where we would rather … from the professional advice we have had, we are better off to sweat the PEH as much as we possibly can and then try to get as many staff as we can to help with the discharge of people back into their own homes. I think we have got another 10 staff we are hoping to recruit to that which will help in that area, and try and encourage and help the care homes as much as we can with taking some of our elderly Islanders who need that extra support.

I do not see it getting any easier in the short term. It is going to be a major issue as more and more people need that extra care or nursing care in their later life. We are going to need more provision and we are really trying to think of any ways we can encourage the private market because we are not in that market. That is not what we have been doing. We came out of that market about 10 years ago when we stopped having our own care homes, I think they were through housing at that time, and they were changed to supported living zones.

So if Government has to, I am sure we will end up back in that market but we really do not … we want to encourage the private sector as much as we can and we need to make sure that we have the right rates for them so that they can provide the services. We need to be happy when we have those debates in the States about SLAWS. Who is going to pay for it? Who is going to pay for dad at home to be looked after almost three or four times a day for someone to come around? That is not inexpensive, that is quite an expensive thing to do. It is almost as expensive to have someone looked after professionally in their home as it is to have them in a care home. It is us as a society, we need to make those big decisions, and they come with a big price tag.

Deputy Fairclough: I appreciate that. You have actually answered one of my next questions, but I suppose in the meantime while all of this work is getting done, and I appreciate that a lot of efforts are being made across the piece to try to address this issue, there are people who are having to wait significant amounts of time for operations. In a worst-case scenario, how long are people having to wait to have the surgery they need?

***Deputy Brouard*:** Well, anyone who needs emergency surgery gets it. Anyone who needs cancer treatment urgently, they get it. So, it is almost triaged all the time. I do have the figures in here, but it is something probably easier to send to you rather than trying to pick it out at a position like this, unless Dr Rabey or Dermot would you like to add anything?

Deputy Fairclough: Well I think it would be useful just to give us a sense of how long some people are having to wait for procedures –

***Deputy Brouard*:** It is in years rather than weeks in some cases for some orthopaedic surgery, and some people would have been offered facilities off-Island pre-COVID, did not take them because they did not want to go off-Island for them, and now are in an awkward position.

Deputy Fairclough: And I imagine that potentially has all sorts of knock-on consequences in terms of people's mental health –

***Deputy Brouard*:** Their mental health, being able to work … everything. But the people that we have who are in hospital who really need to be elsewhere, we cannot discharge them and just push them out the door. They are in a very safe place now; it is not suitable for them long-term. I mean who wants to be in hospital longer than you need to be? We would like to have them to go somewhere else, back to their own home. But unless the family can afford to have someone to come in and look after them, we do not have a large supply of people to manage people in their own homes. We have not done the second part of SLAWS – managing people in their own homes. We as a government have not done that piece of work. That is on the cards, but until that happens 10 or so of our people in hospital have not got a place to go.

With regard to care homes, I think Dr Fleming will probably be able to help us as much as anyone, having been in that marketplace and knowing how difficult it is to recruit and I know the very high standards you were running at St Johns. It is not without consequence, so for us to say, 'Actually we want another 40-bed care home', well who is going to staff it? Where is it going to be built? And as soon as you start with one spade in the ground, not here, not there ... the Government is almost being pushed to an area where we hope the private market, we can encourage them to do it.

Deputy Fairclough: Okay, I have just got one more question on this area – unless you want to come in, Dr Rabey? – and that is about the screening programmes, such as for bowel and breast cancer; are those now running normally and is there a backlog for that sort of work?

***Deputy Brouard*:** I have some information in my pack.

There is some backlog, but I would probably leave it to the professionals to talk me through it.

***Dr Rabey*:** We have recommenced the screening programmes after pausing them during the worst times of COVID, so the bowel cancer screening programme is working again, and we use FIT testing. Positive patients who come out with a positive test need an endoscopy. An endoscopy is one of our specialities hit by the COVID backlog. So, it is working again but it is not quite where we want it to be yet. So yes, we are prioritising, obviously, the known potential cancer cases and things. And in endoscopy, as Deputy Brouard said, in all our work we prioritise the urgent.

Deputy Fairclough: Thank you.

The Chair: Can I just come in on a short supplementary on that before perhaps handing over?

You will need your crystal ball for this possibly, but how long do you consider it will take to get back to pre-COVID waiting times locally?

***Deputy Brouard*:** I think that the real challenge is … our key un-locker for this is those people who are in hospital now who should not be and that is where we put in most of the board's focus and our senior team … is to look at how we can resolve that particular – once that Gordian knot is broken, then we can get on with our normal business as usual, and as Dr Rabey said, we can start eating our way through the backlogs. So that for us has been one of our key priorities. I think Dr Brink has something to add.

***Dr Brink*:** Just cervical screening, not to forget cervical screening, we did see a decline in that during COVID, particularly during the lockdown period but we have seen a pick-up of that.

So, we have met with the primary care, so that is Vital Screening Advisory, have met. We have looked at our uptake, we have seen the dip in uptake, and we have put remedial action in place and that is now picking up again. So really, as ever it is looking at what the evidence is and putting in remedial action as quickly as we can to get back to our pre-COVID levels.

Deputy Fairclough: Thank you.

The Chair: Dr Fleming, would you like to come forward with some questions I think you have?

Dr Fleming: Around the pressures within the Hospital, we are obviously very fully aware of the impacts of that, that then can impact also on nurse training, students coming through. I know students now have come under Education rather than Health as historically it did. Are you confident that you will be able to have locally trained nurses at points in the future to join the team? I know it is not an immediate solution to your current challenges.

***Deputy Brouard*:** Very much so, the more nurses we can have the better from my point of view.

Also, the more local nurses who decide to go away for a few years and get experience elsewhere and come back. So yes, you are absolutely … but there is a worldwide shortage of nurses and it is really how far do we push the chequebook? And then we have 2,500 staff, that is quite a big chequebook. So, we also have to worry about the public purse as well as the actual services we provide so it is a really difficult balance. I mean I would love to have another care home set up tomorrow and I would staff it and it will cost us £5 million and we will buy it. But that does not financially stack up and that is the difficulty that we have.

We have to live with the reality that we have, and I think most of it is going to be from our own making. We cannot rely on other places to sort us out. We need to, as you say, home grow our own staff and our own solutions.

Dermot, would you like to add to that one?

Mr Mullin: Yes, I think it is important to – and you will understand this, Sue – it is about health & social care practitioners, so we are looking at growing it across a number of disciplines.

In terms of your specific question around nursing, we do have a training programme for mental health nurses, for learning disability nurses and acute adult branch nurses. That has continued, we have continued to liaise with Middlesex University and obviously quality assure what we are doing in terms of placements. It is a challenge because of the emergency we have been in, but training continues. A new cohort started in September so, as Deputy Brouard says, we will always want to grow our own including for individuals who choose to train off-Island and then incentivise them to come back. But we are in close liaison with Middlesex because they are looking at their programmes

everywhere because every trust is suffering from or facing the challenges of the pandemic emergency response.

***Deputy Brouard*:** Would it be helpful if, Lynne, you are HR guru, is there anything you would like to add?

Lynne Duckworth: Yes, I think I will just add to what Dermot said in terms of where we are in relation to recruitment. We have realised that wherever possible we will train locally residentially qualified staff for professional roles. We are currently training staff to become Clinical Psychologists and Biomedical Scientists in addition to the student nurse programme. We are not at the maximum number of student nurses but do have a maximum number that we can take if we get sufficient suitable applicants.

Dr Fleming: And are you confident that you have enough supervisors in practice to support them when they actually are in a clinical placement?

Mr Mullin: Yes, so there is a constant mapping process when we are looking at practice education facilitators, so we map out where people are in their particular cohort, what their training needs are. So yes, that is all mapped out. It has its challenges and I cannot sit here saying it is easy but yes, we are actively working on that with the Institute all the time.

Mr Mullin: And again, just to echo really, it is very much about partnership in time to help the Hospital and the bed situation.

***Deputy Brouard*:** And we valued your workers in the care home cell with the COVID situation, so thank you.

The Chair: Can I just follow up with a supplementary on that one?

In terms of training nurses and the Institute that has obviously planned to move as part of the Guernsey Institute, do you think that is a positive move, with it moving away from the Hospital area?

Mr Mullin: Yes, I think if we are not just focusing on nurses and thinking of the wider health and care delivery and the type of roles that will be in the future because things are changing all the time and I do not think any of us expected to live through the transformation that we have seen because of the pandemic.

We do want, as we have been saying, to be able to offer opportunities for the local community in a whole host of disciplines, not just nursing. So, I think that broader education piece for me is a positive.

The Chair: Did you have any more questions?

Dr Fleming: I do have other questions actually, thank you.

I just really wanted to have an update on, there has been a lot of discussion around the recruitment of the Chief Nurse vacancy, so if we could have an update on that that would be really helpful.

***Deputy Brouard*:** Yes, we have decided not to go at the moment for a Chief Nurse, but a partnership, an alliance sort of partnership working across, because we are different from some of the UK places where you have trusts which are just a particular hospital or a particular area.

We have a much wider piste, right across from care in the home through to mental health so we need a Chief Nurse position that encapsulates everything; and I probably would ask Matt Jones, if

he is behind me somewhere, who was instigator and has come forward with this pilot we are running at the moment and we have had some very positive feedback so far.

***Mr Jones*:** So Dermot will help with the latest information on this because I am obviously focusing on the transformation piece, but we have done without a Chief Nurse since I think March 2020 all throughout the pandemic and what we have seen is exceptional support in the operation of a strategic space from all our senior staff – so the people who are reporting to Dermot, Peter, to myself in my previous role.

The concept of a professional alliance which is all those skillsets coming together to deliver what the community needs overall is the one favoured by HSC. It seems to fit the Bailiwick context. In the UK and on the mainland obviously you have got the NHS trusts, you have got what local government does, you have got mental health trusts, and chief nurses can be exceptional in that space. So, what we are doing, we are asking the senior team to work together as an alliance. They have a whole host of off-Island attachments, Dr Fleming, which means that someone like Elaine is reaching out to someone on the mainland to really get that challenge to push forward her practice and her support for the organisation.

So just to echo what Deputy Brouard said there, we feel as though we have magnified the nursing voice because you have Karen Leach in the community space, you have got Elaine in the acute space, you have got Fiona in the mental health space and you have got an Associate Director to my right, Nicky, in the children's space, and so on. So that professional alliance, I think, is something that we favour, and we continue to pilot, and it has been very useful for HSC.

Dermot, in terms of the latest on that one?

***Mr Mullin*:** Yes, so I think that is right, because you were involved in the sales structure, you will understand that distributed leadership and the ability to draw on a wide range of knowledge, skills and expertise across a number of disciplines.

The professional alliance is not unique to Guernsey, it is something that is quite global and so it operates in New Zealand, operates in Ireland. I think it is back to Matt's point that, yes, we are Health *and* Social Care, so we are not that traditional UK model of trusts and local authorities. So, we have been meeting and it has been hard work because it is a new approach. We were very glad of the Committee's support to pilot it. We have come up with ten key objectives to deliver over the next year, so looking at workforce plans, looking at, 'well what next after the Care Values Framework?' which you will be aware of, our appraisal process, SCIP audits. It is about that distributed leadership and much more connections across Health & Social Care and out into the wider sectors because the practice nurses in the care homes that I know can lead it.

We have real benefits from it, it's been hard work, and I think even if the decision was made in a few years' time to go back to a chief nurse model, I am fairly confident the foundations we will have put in place through the alliance framework will support anyone in the future. But as it is, it is working productively for us, obviously the previous Chief Nurse laid the foundations for that.

Dr Fleming: When it was actually commenced, the issue of an evaluation was discussed. (***Mr Mullin:*** Yes.) Has that actually taken place?

Mr Mullin: So, we have provided Committee with a progress report in terms of formal evaluations too soon because we only commenced in April.

What has been agreed is the objectives that have been agreed. The other thing we have looked at is CQC standards and also a document that the Associate Director for Maternity and Paediatrics provided us with from the midwifery ward. We have combined those under – because we have got an acronym now, which we work to, called CARE. It is about compassion, accountability, respect and excellence in what we do. We would use that framework from CQC and the maternity ward then to devise a survey so that we understand from ward to board level how it feels for the staff. And obviously out in the other sectors as well because there are some people who do not like the idea

that we are trying to be different, but I think as I said earlier the level of transformation that the pandemic has brought on has shown us that we can think and work differently.

Deputy Bury: Just to add to that, if that is okay.

We are very aware that it is running as a testbed at the moment and that we will be expecting that full evaluation and that we have asked, as Dermot just alluded to or specifically I asked, that we want to hear all voices as well from those that do not necessarily favour the model and why, and those that do to ensure that we are moving forward in the right way.

Dr Fleming: Okay. When do you anticipate that that evaluation will take place?

Mr Mullin: In 2022.

Dr Fleming: Okay.

Deputy Fairclough: Could I just come in on the back of a question that Dr Fleming has asked there and picking up on one of the answers?

I accept that you are not, HSC is not, a traditional UK model by any stretch of the imagination, but do the nurses themselves feel that their voice has been heard and has been magnified as a result of this new process?

***Deputy Brouard*:** Certainly, the evaluations that we have had so far and the reporting back to the Board has been that way, but I think Dermot would be probably better to add to that.

Mr Mullin: Yes, to be honest, it is still new, it is still in its infancy. And it is more than nurses. I think if I looked at social care colleagues ... Interestingly, we have a new Chief Pharmacist on the Island. They have said in terms of their experience of being welcomed into an organisation they are, an integral part of the professional alliance now, and so they are able to make that connection with colleagues in social care space as well as in health care space, so we are seeing the benefits.

As I say, there are a small number of sceptics, but we have an open door with them. We liaise very closely with the Royal College of Nursing. In fact, we have a meeting with them coming up in the beginning of November to discuss where we are at. We shared the papers with the Committee, the committee on the alliance model, with that union because they have a particular interest on the behalf of nurses.

Deputy Fairclough: Yes, that was going to be my final supplementary question; to what extent are you working with the unions on this?

***Mr Mullin*:** Really closely. In fact, one of the benefits, going back to earlier comments about this narrative there is around mental health services, we have engaged with their practiced development section within the RCN and actually two representatives from the RCN joined the Committee – two weeks ago? (Deputy Bury: Yes.) – to provide our Deputies with the assurance that they needed in respect of how we are working in partnership with them in a much more collegiate manner.

***Deputy Brouard*:** I think they are also interested in what is going to happen here, because it may have ramifications for them in the UK. There may some things that they could take forward from it so they are quite interested in what we are doing.

Deputy Bury: I think just a really important point to highlight that, Dermot, you did make there, is that as well as magnifying the nurses' voices it is about all those other roles that we have within our unique-ish structure and making sure that those are heard and represented too.

Deputy Fairclough: I appreciate that, thank you.

The Chair: Okay, now would be a good time to take a 10-minute break –

Deputy Dyke: Could I just ask a few supplementary questions (**The Chair:** Oh, yes.) on the points we have been discussing earlier?

In terms of the orthopaedic backlog, are you still outsourcing, for example, knee replacements and hip replacements to Southampton, and have you considered or talked to any of the private health care providers in London, for example ACA health care, whether they can make competitive bids to do this sort of thing which might help you lower the backlog?

***Deputy Brouard*:** I know we have been in touch across the country as to where we could go, but it was not successful. But I think Dr Rabey can probably tell us more and I think as far as I am aware, I do not think we are passing much to Southampton at the moment unless it is an absolute emergency that we cannot handle.

***Dr Rabey*:** Southampton take a lot of our emergency work and we have a contract with the Wrightington Hospital for complex orthopaedics but at the moment we are not sending Islanders for routine surgery off-Island at any private providers or UK providers for things that we should be doing on-Island ourselves – total hips and total knees are the big issues.

The NHS is fully backlogged, and the NHS is struggling to help us. We did a big off-Island … I cannot think of my next word. We sent a lot of patients off-Island in 2019 to get the orthopaedic waiting list down and we got it down to 360. It was a huge piece of work.

We found that the off-Island providers that were willing to do this prefer to cherry-pick the fit and well patients who will have a short length of stay and come back – understandably. We found that a lot of Islanders were reluctant to go off-Island even if offered a place sooner, they would rather wait and be treated on-Island. We are not doing it now, but it does not mean we will not do it: it may form part of an in-the-round plan to tackle waiting lists in future, but at the moment, no, we are not sending people off-Island just now.

Deputy Dyke: Right, thank you.

We were talking about screening earlier. PSA screening is something on my mind. Are we doing it? I mean, in my view once you get above 55 you should start PSA screening for prostate cancer and I know there are now some newer tests that are more accurate with fewer false positives. Is the Health Department contacting men regularly to go for regular screenings once they get past the age of 55 or something like that? Is that how many? It seems to me a bit of a Cinderella of the screening business.

***Dr Rabey*:** Yes. I know that Public Health will want to comment on this. I do not think the evidence is fully worked through about screening for PSA. Certainly on its own, a blood test on its own, I do not think is the best way to do it; although I do not want to speak out of scope because I am not an expert on this. But I know that it is important to take things like a family history, do an examination, that sort of thing, and my understanding is that doing just a simple blood test when you reach 55 might not be the most productive way of doing it.

I am not saying you do not find cancers, but what I am saying is you do not prolong lives. And I am going to pass over to Nicky before I dig any holes for myself! (*Laughter*)

***Dr Brink*:** So, something that we are looking at as we hopefully move out of the pandemic is a review of all our screening programmes.

So not only the population-based ones, but also the targeted ones as well because a lot of these had been introduced in the UK and other areas on quite an *ad hoc* basis without a sound evidence base. So again, you have got to look at the basic principles of a screening programme which is that

you do more good than harm. So that is really important. On a population base you have got to look at what the value of their programme is.

So, we are going to be looking not only at the non-selective screening programmes so things like all women get cervical screening, breast screening, bowel screening, but also some of the more targeted screening programmes. For example, like abdominal aortic aneurysm screening, PSA, all of those individual ones. We are also looking … the programme that we are looking at at the moment, is our diabetic retinopathy, the most important preventable cause of sight loss, and we have had a programme, but it needs to perform far better. So we are looking at having the diabetic retinopathy screening, but then what Deputy Burford said earlier is look at the prevention and early intervention, so we are looking at linking that with a health screen of diabetics and those who need to watch their weight and so on, so you have that holistic approach. So, we want to approach it in that way.

To summarise, we are looking at the screening programmes but we want to look at them in a very thorough, evidence-based way, making sure that first of all they are of value to Islanders from a clinical health and wellbeing, but also they made financial sense across the Island.

Deputy Dyke: In terms of prostate cancer, are you looking at the new tests which I believe are now being introduced in the UK that are rather better than PSA tests with fewer false positives?

***Dr Brink*:** We have not as yet, but when we look at that programme, we will look at all of the evidence. At the moment we are looking at the diabetic retinopathy programme, so we have to work through these programmes in an ordered way and make sure that we implement it and it is functioning well. But when we look at it, we will look at all of the technology.

Deputy Dyke: Right, thank you.

***Deputy Brouard*:** If I can add on there, I think we are always talking about priorities and value for money and making sure we do the most important thing first. Public Health, for the last two years, COVID has literally been the priority and so it will be inevitable that some programmes will not be as closely looked at. We have not got two or three Dr Brinks – probably a good thing! (*Laughter*). No, it is not. It would be great.

Deputy Dyke: You can never have too many!

Deputy Brouard: But in a small community, we do have to prioritise and our priority has been getting through the pandemic and that area, and as soon as we can get back to business as usual then all these programmes and the research that needs to go with them can come in. But you make a very good point.

Deputy Dyke: Thank you.

One last very quick question. On the bed blocking issue, are you still accommodating the patients from Les Bourgs Hospice?

***Deputy Brouard*:** We are, and we are monitoring their repair of their hospice.

Deputy Dyke: It is going very slowly, I walk past it every day, that was the point I was making.

Deputy Bury: It is on track.

***Deputy Brouard*:** It is on track.

Deputy Dyke: It is?

***Deputy Brouard*:** We have been advised that it is still on track, I think, for early part of next year that those patients can –

Deputy Dyke: I am not seeing any builders on-site, for your information.

***Deputy Bury*:** Well, we have checked in on that. We asked that question actually not too long ago and to keep abreast of it, and also there are, as far as I am aware, sanctions for any delay that there might be. But at the moment we have got no indication that that is going to be the case.

Deputy Dyke: Thank you.

The Chair: Thank you, John.

We are taking a short comfort break now. If we come back at 10 past, so if anybody needs facilities it is out the door and to the right.

Thank you, everybody.

The Committee adjourned at 11 a.m.
and resumed its hearing at 11.10 a.m.

The Chair: Thank you everybody, we will kick off with part two.

My next question area relates more to the social care part of your mandate. To start off more broadly, do you believe that all major HSC service areas should be routinely inspected on a regular basis to ensure that the care provided is of an adequate standard?

***Deputy Brouard*:** Yes, I think that would be a reasonably good premise to start from, yes.

The Chair: And on that basis, do you know when Children's Services was last independently inspected by an appropriate external agency?

***Deputy Brouard*:** Not off the top of my head, but behind me is Nicky Gallienne who will be able to tell you hopefully far closer than me.

***Mrs Gallienne*:** So, 2015 was the point at which we last at the equivalent of an Ofsted inspection and a visit on-Island.

However, since that time we have had a variety of other individual inspections and reviews of certain areas of the service. We had a review undertaken in 2016 or 2017 of our Children's Disability Services on-Island and in relation to our residential care on-Island we already have independent UK scrutiny of our residential provision that takes place and has been to Ofsted standard for a number of years.

The Chair: Okay, and are those reviews published?

***Mrs Gallienne*:** In relation to the inspections (**The Chair:** Yes.) of our residential care?

No, those are not.

The Chair: Right. And also, sorry this might not then fall into yours, when was the Mental Health Service last independently inspected?

***Mr Mullin*:** We had Dr O'Sullivan here in 2017 and 2018 who did an immediate review of services and then subsequently to that we involved David Getz who came in and did a bespoke piece of work around the structure of mental health services and what structure we would require if we were going to go for future accreditation of the service.

The Chair: Okay, and is that something you are going to follow up?

***Deputy Brouard*:** Yes, following Deputy Lester Queripel's questions, the highlights of Mr Getz's report will be released shortly. We saw part of it at the Board meeting yesterday. But that is in train to come out, and also with his recommendations and the follow-up work that we have done on each of those recommendations. We were actually even considering perhaps bringing him back at some stage to do a follow up … was a suggestion.

Deputy Bury: A suggestion that was made yesterday was possibly consideration for us to see whether that would be of merit to the service, and also out of that conversation came the fact that Mr Getz did stay following the review in order to start the Department on the right track addressing the recommendations.

Deputy Fairclough: Could I just come in on that?

The Chair: Yes, sure.

Deputy Fairclough: Yes, I mean because there was some talk politically about whether a further review of mental health services was needed.

I think it was felt by some that one was. Others felt that there might be more of a need for, say, a gap analysis in some of the services that were perhaps falling short, if that is the right term. What is your position on that?

Deputy Brouard: I think our position is at the moment we have had some very good reports of our secondary mental health services *per se*. What we would like to do is to progress to pilot the crisis centre and we will use that as our feedback for the next iteration of where we go to next.

So I think we would like to do some actual work rather than another survey to actually put that in place and that will then inform where the temperature is hot, where it is cold, what we may then need to do as a board to take us forward to the next level. I do not know if anybody has anything else to add?

***Mr Mullin*:** Yes, I think as Deputy Brouard says, secondary mental health services are specialist in dealing with mental illness. They have had several reviews. If there was to be another review what we would welcome is a broader review of all mental health because it is not just about the specialist services HSC provides. There is primary care, there are third-sector organisations who can partner with us, and it will be about what a model of mental health and wellbeing would look like across the Bailiwick.

Deputy Fairclough: Would you also welcome the publication of such a report?

***Mr Mullin*:** Yes, I am sure, if it was commissioned.

***Deputy Brouard*:** It would have to be commissioned with that in mind; that should not be a problem. I think Dr Brink would like to add something on the gap analysis that was already done previously.

***Dr Brink*:** In 2018, Public Health did do a gap analysis of services. We do service mapping quite frequently as part of our public health function and what we did is we looked from prevention and early intervention right up to complex off-Island care. We mapped every single service provided both by Health & Social Care, by individuals, by third sector, charitable organisations across the piece.

What we saw is that we had quite a lot in the prevention and early interventions, there was quite a bit of work going on there. We had Healthy Minds working in the primary care sphere, we had obviously GP practices as well. We had secondary care services and pathways to off-Island referral for complex, tertiary care, but we had this gap in the middle for people with moderate amounts of stress and distress that did not fulfil the criteria for secondary care mental health services but needed something other than primary care services. So hence, the idea of providing something like a crisis cafe which was proposed.

But also, in the future perhaps something broader linking up, for example, to things like social prescribing. I think the view was if there was going to be a review of mental health and wellbeing services that to give the most, we would need to follow from prevention and early intervention all the way to complex off-Island care. So, across the piece.

Deputy Fairclough: Just my final supplementary on this.

Do you feel as a board that there is a growing reliance now on the third sector for the provision of mental health services locally?

***Dr Rabey*:** I do not think it is a reliance, I think it is just how things should be. So most mental health, what goes on in primary care, I think people really value the input of the third sector in this area – and they should do because, it is not just in Guernsey but across the UK, the role played by organisations such as Mind is incredibly helpful for people who need those services. They run things like crisis cafes in numerous cities and with great benefit to people.

So that sort of service is exactly, I would say, how it should be. People who need specialist secondary care, mental health services in Guernsey I think get actually a good service and I know that many people who use those services would rather not have to use those services and I know that there are a lot of people who will always feel that more could be done.

But actually, I think in any straight, fair comparison of secondary health care services, I think Guernsey is providing good quality services.

***Deputy Brouard*:** I think part of that will come out – I know it is a few years out of date but – in Mr Getz's report, when it comes, they will see it. He is very complementary of our secondary mental health services for those who have got mental health illnesses.

Deputy Fairclough: Thank you.

The Chair: Now just skipping back slightly to the first question I asked on things such as Children's Services, when you have a full external review done, is that full report then presented to the board? Sorry, dragging you forward again.

Mrs Gallienne: Yes, it was presented to the Board. It was also published online.

The Chair: Right okay, that is fine. Thank you very much.

I think the final question I have got in this particular area is: how are complaints, either from staff or service users, dealt with in areas such as Children's Services?

***Deputy Brouard*:** Well, I think they start off with our Customer Care Team, and then they move from there.

Mrs Gallienne: They come in through our Customer Care Team and are cascaded down through the organisation to a senior representative in the Children, Family and Community Services and they are investigated and responded to.

We often meet with complainants so that we can fully understand the nature of their concerns, and then the level of scrutiny that goes back to the Customer Care Team is fully signed off by Dr Rabey.

The Chair: Okay, thank you very much.

Deputy Bury: As a board, we receive regular updates and reports of the nature of, and obviously … (***Deputy Brouard*:** Anonymised.) anonymised, thank you – etc. to keep an eye on themes and areas and we keep a regular eye on that.

The Chair: Okay, thank you.

Does anyone have any supplementary questions on that?

Dr Fleming: Yes, if I could just ask about secondary mental health services.

My understanding is you have a duty team who are almost, in effect, like your A&E for your general services, they are your A&E for psychiatric services – and absolutely crucial team of people. Are you confident that you have adequate people to work in that team to do that first response for secondary services?

***Deputy Bury*:** Duty and intervention team, is that the one?

***Deputy Brouard*:** The response to the Board when we have asked those questions is, 'yes', but I cannot go into the detail more than that.

***Mr Mullin*:** So, there is an on-call system for associate psychiatrists. They are the first on-call but they are always backed up consultant psychiatrists so that is 24/7, 365 days a year. They are supported then by a crew of social workers because if someone needs to be detained under the Mental Health Law, as you know, it needs appropriate professionals to make that assessment. There is a challenge in terms of the number of approved social workers; we have talked about recruitment challenges across a number of areas but we have liaised with the Law Officers locally and actually we brought a paper to Committee a few weeks ago to say that we would like to look at other practitioners within mental health which merged a lot to the UK. So, APs can also participate in that, following the appropriate training, just to broaden the resource output there.

There is 24/7 access to mental health services for those with acute mental illness. Very often, they will turn up in the Emergency Department and then the on-call psychiatrist will be called out to carry out an assessment. We have also been working closely with the Police and sometimes if it is appropriate, we will allow access to the Oberlands building because it is quiet, it is not like a busy emergency department so someone can have time in there. If someone is safe to go home, there are slots kept for the first outpatient clinics every morning so that someone who then wants to see somebody maybe the next day, that is available to them first thing.

Dr Fleming: Thank you.

And if I could just ask about psychological therapies within secondary services, are you confident again that you have enough appropriate qualified people to deal with the full range of specialist conditions that present? So, for example, perinatal mental health, psychoses, all those areas – do we have enough psychological therapy and secondary care to help those people?

***Mr Mullin*:** As Deputy Brouard says, we could always have additional resources. The psychological therapies team used to have a two-year waiting list, that is now down to three months.

But if Dr Bishop was here, he would say sometimes it is good for people to explore where they have low-level anxiety, whatever or depression some of these online self-help approaches before going into formal psychology services.

In terms of the perinatal care question, it is something that the Associate Director for Maternity and Paediatrics has looked at, and we are looking at a practitioner that can work more closely with that service. I think, and I may be wrong, there are midwives who specialise in that area.

Dr Fleming: And psychoses and eating disorders, again, we have enough?

***Mr Mullin*:** Yes, and with eating disorders we have Vincent Square. So, there is a consultant who visits from there, I think it is every three months. Whilst they are here, they also provide supervision for the practitioners who obviously are supporting individuals with eating disorders on a day-to-day basis.

Dr Fleming: And just a final question around service user complaints. Obviously sometimes people are in the service against their wishes. How do you deal with the challenges of people raising complaints? We have obviously heard from Nicky in terms of what happens in the Children's Services, but for people with mental health do you involve more external people (***Mr Mullin:*** Yes.) because of the circumstances?

***Mr Mullin*:** So, someone who is detained because of their mental illness, there is a tribunal system which is part of the mental health laws introduced. So, service users do access that if they disagree with their detention. That involves off-Island professionals, so we are not governing ourselves. Similar to what Nicky has said, other complaints go through the customer service team and they will obviously involve the appropriate professionals to get a response. As Nicky also said, we will very often meet with individuals who maybe are not able to get across their particular concerns so it is easier to meet with them and have a conversation and see if we can resolve it.

Dr Fleming: Thank you very much.

The Chair: Can I just follow up on that complaints issue?

So, there is no mechanism for people independent of HSC to deal with complaints then, if staff or service users have complaints?

***Mr Mullin*:** If service users are unsatisfied with the response they have had, there is an appeals process which, I think …

***Dr Rabey*:** So, if I make a complaint and I do not agree with the response, I can ask for an appeal panel to review that process. A complaint might well be sent off-Island for review at that early stage if it looks like the sort of thing that we should have an off-Island input to. But sometimes the complaints can be investigated and answered locally – and most of them are. But then I could go to an appeals panel who will review the process, and the appeals panel can uphold my complaint and if they do, they can send it off-Island for review for further investigation or they can ask for it to be reinvestigated locally if that is appropriate. Or if sometimes the appeal is not upheld. (**The Chair:** Okay.)

And of course, anybody who has been through the States of Guernsey complaints process has access to the States of Guernsey Complaints Panel which is a separate and slightly independent organisation.

The Chair: Just as a ballpark figure, how often are complaints sent off-Island to review?

Dr Rabey: I would say regularly. Off the top of my head I would say –

The Chair: One or two a year, or …?

Dr Rabey: Oh no, I would say we frequently have 10, 15 complaints and things being looked at off-Island.

The Chair: Each year?

Dr Rabey: Yes, oh yes.

And I might be underestimating that actually. When you add the incidents in, the incidents here, we always have things off-Island being reviewed.

The Chair: Okay, thank you.

Deputy Dyke, do you want to come in with some questions?

Deputy Dyke: Yes, a supplemental on that.

How do you monitor the quality of the surgeons practising here – that they are doing the best possible job competently? How do you monitor that going forward?

***Dr Rabey*:** It is a really key question and in my role as Responsible Officer, I need to be able to give you a good answer to that.

Surgeons are all registered with the GMC and have to undergo revalidation every five years through the GMC process, and as part of that they have to provide evidence at their appraisal every year on their entire scope of practice including any private work that they do and that is reviewed in terms of auditing their practice every year with an appraiser.

Most surgeons also submit data to specialist societies. So, for example, the National Joint Registry take data on all our hips, knees, shoulder replacements, that sort of thing and we get an annual report that plots people for their rates of needing re-do surgery and things, and our surgeons get individualised reports as to whether they are in the funnel plots for that.

Similarly, our ENT surgeon send their data to the Registry for ear, nose and throat surgeries. So for example, we had a very good presentation by one of our ENT surgeons at the academic half-day just last week, presenting his outcomes for his thyroid surgery and showing that damage to key nerves is lower in Guernsey than in the UK and has been for the last nine years. So, surgeons are interested in getting the best possible outcomes and demonstrating that they are good surgeons and they are highly motivated to do that, there are lots of national registries that they take part in. And of course, there are other things that are fed into me as concerns. People can approach me, and often do, with concerns about their individual outcomes or a complaint about the way that they had a problem after their surgeries. So, we look at complaints, we look at incidents, we look at concerns that are raised and we investigate.

Finally, and then I will shut up, the College of Surgeons are coming over to review our surgical specialties, I hope still at the end of this year, but it may slip into early next year and they will be reviewing our general surgery, vascular surgery, breast surgery and whatever. We had the Getting It Right First Time team over to review our orthopaedic surgery just in 2019. So, there is external review of surgery here as well.

Deputy Dyke: That is good to hear.

One more question, how many times over, say, the last five years have you had cause to say to a surgeon, 'Perhaps you had better give up and do something else'?

Dr Rabey: When numbers are small, we have to be very protective of people's confidentiality. So I can think of two people from surgical specialties who are no longer operating in Guernsey and where I had concerns about their practice, and I am going to say they were not necessarily related to poor outcomes in surgery but, yes, I am going to say two.

Deputy Dyke: So, there are a few cases from time to time.
Thank you.

The Chair: Okay, Deputy Dyke, did you have any questions you wanted to ask on finances?

Deputy Dyke: Yes, back in the COVID days, money was advanced to the private medical centres – about £200,000, £250,000 each – for COVID services. One of them received an extra £½million. What was that for exactly?

***Deputy Brouard*:** That was before my time as President of Health & Social Care, and it was money advanced through P&R. I am now racking my brains as to the exact details as to why one – I think one practice was more involved than the others, but I will defer to my colleagues here. If anybody was around at the time, can you remember?

***Dr Rabey*:** One of the practices put their entire workforce entirely at the disposal of the States in the lead up to the first lockdown period and there were different conditions attached to that. In effect, I am going to say, in my mind, the States bought insurance it did not need in the end from that particular practice and that is how it was.

Deputy Dyke: Okay, thank you.
Following up from some Rule 14 questions from Deputy St Pier, which are probably on your mind because they were quite recent, concerning cannabis licensing. It is now becoming quite a lot of cases: September 2021 – 500 licences …

***Deputy Brouard*:** I think we are over 3,000 now.

Deputy Dyke: Over 3,000 in total with 2.5 or 3.5 staff handling it.
And the number is going up at an average cost of around £55. So, this is just for licensing, it is not the prescription? It is licensing –?

***Deputy Brouard*:** It is licensing to import the prescriptions from the UK.
It is something we are very much aware of. I do not think anyone from Health at the time when they allowed the importation for personal use with regard to medical conditions realised how much demand would be and how it would grow. It has grown exponentially and there was no provision at the time when it was originally set up with regard to funding. So, it was basically a free service.
We have been very much reviewing that. We are meeting, in fact, tomorrow with the local cannabis users' group and we have been hoping that a local provider would come into the marketplace and dispense locally which would then … many patients may well prefer going through a local route. I think there may well be two pharmacies, or two clinics, who will be offering local positions, in which case the requirements for licensing, we hope to a large extent, will fall away. And then we can review and recoup.
For those who may well require to still use the particular clinic that they have got a particular relationship within the UK, we will be thinking of a charge for our services to help to mitigate any costs. So, we are hoping that the local clinics will take over and therefore this particular issue will hopefully, from our point of view, fall substantially away. And if it does not, we will be looking to recoup some of the funds that we are spending in providing that particular service.

Deputy Dyke: Right, thank you. That is very good to hear.
Some more general questions. I have looked – I do not know whether you have looked at it – I looked at the BDO report, August 2015, and it made suggestions – obviously you were not there, but – to the then Committee regarding what they might do to save money. Their findings were broadly that the cost of health and social care in Guernsey was roughly 17% more expensive than

the peer group and they made various suggestions as to how money might be saved which, depending on which list you look at, could be between £7 million and £20 million a year.

They identified three problematic areas for Guernsey. One was in respect of children: greater use of residential care as opposed to foster care. Much longer lengths of stay in hospital. Poor utilisation of expensive assets such as theatres. And then in the sense of social care, using medical staff where perhaps non-medical staff could be used, which apparently is more the case in the UK. And also, delivering more services in Health rather than outsourcing to the private sector.

I do not know whether you can comment on that. Have you been working to this BDO report? Although obviously we are five years on, I guess the general principles and points are still current.

***Deputy Brouard*:** Yes, I think also we do have to accept that, like most things on a small island in the middle of the sea, some of our services will be more expensive than they will be ... If you just look at building costs for concrete and whatever else, it is all going to be slightly more expensive here. And there are some trade-offs as well. Residential care may well be cheaper but isn't it better for a child to have a home life with a foster family? So, although we can make it cheaper, we may not make it better and I think some of those issues come through as well. We have our secondary services through the MSG. We have consultants, we do not have junior doctors. So, when you go to see your doctor, you are seeing a specialist at the top of his game in that field as opposed to someone who is perhaps just starting out. There is a cost for that.

So, I think these are some of the inevitable costs and there are some trade-offs on the quality of care. Probably those who have been here longer than me, perhaps Dr Rabey or Dermot, would like to pick up on some of those BDO findings? I know Deputy Soulsby spent a long time anguishing over them and was not able to square those circles.

***Dr Rabey*:** Firstly, I would comment that the report was done before I arrived – just – but it was very topical when I arrived and the themes will be the same.

If you look at Guernsey's health and social care services, I think they probably will cost 17% more than the UK because there are absolutely no economies in scale in Guernsey and we have to be able to provide for somebody who needs brain surgery and needs transporting off-Island in a way that would not be required if you pop them into an ambulance and drive them 20 miles in the UK.

So, there are no economies of scale, but the points you make are still points that we should be able to answer. I am going to pick up particularly on the ones that I can remember. Theatre usage –

Deputy Dyke: Theatre usage was one, yes.

Dr Rabey: We felt that was a hard report on our theatre usage because we have been told by the Royal College of Obstetricians to keep a theatre empty in case we have to take an emergency caesarean section to theatre, day and night.

So, although we have four operating tables, we have to have access to one of them any time at the drop of a hat to get a baby out in a hurry if there is a crash section. So of course, our theatre utilisation looks poor when you factor that in, but it is an essential safety mechanism that drops it.

We have the Getting It Right First Time team with Professor Briggs over to look at our theatre utilisation in 2019 and then our theatres in all. They made recommendations about how we might be able to use that fourth theatre safely in future, and of course I think part of that will link to bringing maternity services down closer to theatre so that we can get rid of some of that delay in getting a woman down to theatre when we get that new maternity service open.

Deputy Brouard: I think we have also asked that question as a board as to whether or not we could just use it and then if someone happens to be in there, the chances are that one of the other theatres may well be free at the same … it is that sort of utilisation. But there are risks.

***Dr Rabey*:** So that one fully sides to … and I think the BDO also mentioned our rates of day surgery which had improved.

The length of stay was another one that caught my eye, and length of stays were long. If you look at our overall lengths of stay at the moment, they will be shocking because we have got these 25 to 35 patients who really do not need to be there and have been there for weeks and months. But in surgical procedures where you should be able to say the average length of stay for this procedure is five days, we are right on the money or better, and our orthopaedic times are actually improving above UK rates because the surgeons are so keen to get orthopaedic cases through. So, we have done a lot of work on those areas.

And I am sorry, I have gone blank on the others and some of them were not in my patch.

Deputy Dyke: Right, okay, thank you.

***Deputy Brouard*:** I think Dr Brink would just like to add something on outsourcing.

Dr Brink: I think the point about outsourcing that they made was very valuable. So for example, things that we have done in relation to outsourcing over the last years since the publication of that report are: establishment of the under-21 contraception service, which has been outsourced to the various primary care practices or to Choices, so the service follows the service user but is not primarily provided by Health & Social Care. That has brought our teenage conception rates down to the best in the UK. So that has been successful.

Other forms of outsourcing are the cervical screening programme which we outsourced to Primary Care and Choices. An example is also the Health Improvement Commission where we have outsourced a lot of the operational part of the drug and alcohol, tobacco, healthy weight. Not the policy strategic part but the operational part, has been outsourced to the Health Improvement Commission.

So, I think that flexible partnership working is of absolute key importance in a small island because you have got to use all the expertise we have got. So, I thought that was a valuable comment and I certainly took note on that as we move forward, and we have been integrating it into our practice.

Deputy Dyke: Right, okay.

Deputy Bury: And I think an important part of that in terms of their commissioning and outsourcing is that that is all in line with the Partnership of Purpose. It is also about the service user and patient experience when things are removed from hospital and from government clinical setting, there is possibility for more engagement from service users.

Deputy Dyke: Right, thank you.

I suppose the one other main point – it is a 100-odd page report – they have in their summary was the use of medical staff for social care provision in cases where it might not be necessary to use medical staff, is a point they made.

Dr Rabey: I am going to suggest that it probably refers to mental health services, but I am sorry I –

***Mr Mullin*:** I cannot remember the context.

Dr Rabey: I would need to look up … I will look up the context, but I am sorry it is not ringing a bell in my mind.

Deputy Dyke: Okay, thank you very much.

I will leave it all with you, but you are still looking at this as you go along (***A witness***: Definitely.) Because it is full of good ideas. Thank you.

***Mr Mullin*:** I think it is probably –

The Chair: I would like to – oh sorry.

***Mr Mullin*:** Sorry.

It is probably worth adding one of the areas they looked at in the social care context was the number of individuals we had in off-Island placements, and that is right across from Children and Families into the adult space. So, we have got a group who look at requests for off-Island and look at whether it is feasible to provide those packages of care on-Island because obviously individuals … this is their home.

So since probably 2014, we have repatriated quite a few individuals with complex needs where it is appropriate, and we can provide and deliver good outcomes for them locally. So again, that is reduction in expenditure that is going outside the Island.

The Chair: Thank you.

Deputy Dyke: Thank you.

The Chair: Right.

So, some of you might be surprised that we have not really focused very much at all on COVID, except (*Laughter*) as it has impacted other things like waiting lists etc. But I do want to get one question in on it, so I suppose I am aiming it at you, Dr Brink. I think everyone would agree on the Island that this has been managed extremely well since day one and obviously a lot of credit is due. But how concerned are you now, because in the last week obviously cases have ticked up from hovering around 80 to yesterday's figure, I think at just over 200; and perhaps, more importantly, five people in hospital? Given the shortage of hospital beds and the issue you have there, how concerned are you about this increase, and more to the point, at what point, and particularly looking at hospitalised cases, will there be a need to do something to prevent the Hospital filling up with COVID cases?

***Deputy Brouard*:** Dr Brink, this is your moment! (*Laughter*)

***Dr Brink*:** So, the answer is, yes, we are concerned – so much that we think we have reached some of the triggers that we need to put extra interventions in place. So, this morning's tally is that we have 219 active cases –

The Chair: Sorry, two one nine?

***Dr Brink*:** – Two one nine – (**The Chair:** Okay) in the Island this morning, those are this morning's figures.

Now I think it is always looking at the preventative measures as a matrix rather than in a singular fashion. So last week when we saw the cases going up, one of the things we have done which has been enormously successful is ramped up the testing programme. So, the lateral flows are performing very well, and we are very pleased with the new generation of lateral flows and their performance in the community, so performance and angle, so to speak – so in real time, real life experience.

The testing programme now consists of the symptomatic testing for which we have retained PCR testing. That gives us the ability to look for other respiratory viruses in the event of those becoming prominent on the Island, but we have got our surveillance testing. Our surveillance

testing consists of our lateral flow testing, so the free kits which we started distributing on the 18th means that people can get tested twice a week. We are also encouraging people to think about how they use these kits. So, for example, if you are going to an enclosed space where you cannot wear a mask – and I will come to masks in a moment – you should consider doing a lateral flow test before you attend that event. This is all about prevention of transmission. If you are visiting a vulnerable relative in a care home, do a lateral flow test before you visit them. So, think about those and think about how you use the lateral flow testing.

So that is the lateral flow component. We have then looked at the vaccination component, and vaccination obviously forms the main protector against hospitalisation currently. But what we are doing is we are accelerating the booster programme to deliver that as quickly as we can. Now the reason for that, the scientific reason, is you now have some people coming up to six months after their previous – or over six months – after their second dose of the vaccine. So, we are looking at accelerating the booster programme and of course we have got the vaccination of the 12- to 15-year-olds.

So, we have testing and vaccination. The next thing that comes in is non-pharmaceutical interventions. Now one of the messages that we have to get across is that Delta is predominantly transmitted through aerosol transmission. So, we have to think about space, about ventilation, and that becomes really important as we move towards the winter months and people become more crowded. But we also have to think about what the role of masks are under those circumstances, and we are going to produce very shortly – tomorrow – some guidance on the use of masks.

So then if you think about our matrix of risk protection, you have got the ramping up of the testing programme, you have got the accelerations of the booster programme and you have got considering what else you can do in the form of non-pharmaceutical interventions. Now the reason why I am keen to see this happen now is that we will increase our risk over the half-term period. So, what I want to do is look at what mitigations we can have in place so that we have those available after the half-term period. So, it is looking at it in a complex way rather than saying, 'Well let us do one thing' or 'let us do the other'.

The Chair: And the non-pharmaceutical interventions are still going to be relying on goodwill rather than actually bringing in any restrictions?

Dr Brink: So, our intention, as with the lateral flow testing, is to work with Islanders. I think to date Islanders have worked really well with us, and the support we have had from the population has been absolutely phenomenal and we owe an enormous debt of gratitude to Islanders. When I speak to colleagues around the world, I just realise how fortunate we are to live in a community that wants to work together.

I think the other thing that has been important in our COVID response is that no one has looked on it as a Public Health problem type of thing, it is *our* problem. So, our workers speak regularly to Dr Rabey. We consider the medical hospital side in a singular fashion together with Dermot. We have had huge support from our political board. So, we have got the politicians, the Hospital, Public Health and the community working together. We have had a lot of support from Primary Care, from the care homes. Sue has chaired our care homes cell. So, that working across the community has been so important, and so that is why we prefer to engage with the community and make interventions recommended should things change in a way that we become concerned, we can always ramp up further if that is required.

But I think that incremental step, again sharing the data … and we will as usual put the data out. We used to publish on social media, then we stopped publishing on social media because it was part of our 'living responsibly'. Some people thought that was a good idea, some people thought it was not a good idea and it is very difficult to find the right balance between giving people enough information, making it available and people saying, 'Stop putting it down our throat'. So, it has been a difficult tightrope to walk.

The Chair: Yes, I can appreciate that. So, can we expect a public briefing shortly, is this what you are leading to?

Dr Brink: Yes.

The Chair: Yes, okay. Thank you.

I have some further questions, but I am very mindful that some of the other panellists might as well and we are working rapidly through the time. So, Deputy Fairclough, do you have anything – (**Deputy Fairclough:** No, no –) specifically you want to –?

Deputy Fairclough: Nothing specifically, Yvonne.

The Chair: On any other questions? There is nothing.

Right, so I just wanted to touch actually on one of the things that we skirted around a little bit before but not in any great detail – the Medical Specialist Group. Are you content with the performance of the MSG?

***Deputy Brouard*:** Yes, I think we are very impressed with the services that they provide. We have the opportunity to see specialists when in need. They are very keen to work with us, they have even offered some extra staffing to try and help us with our backlogs, and I think it has moved from a 'them and us' to a partnership position and I look to my staff if they will support me on that?

***Dr Rabey*:** I agree. We work well with the MSG. There are always things we would like to improve or change. We monitor a whole series of key performance indicators for the contract that are regularly monitored by Stephanie Barnes at the contract review meetings. Stephanie does the day-to-day contract management with them. But there are no issues that we do not feel we can get in a room and thrash out.

The Chair: Do you feel that you get value for money?

Deputy Brouard: I think so, yes. I think so. For specialists to come to an island in the middle of nowhere its quite a challenge. If you are one of the leading heart surgeons, you would maybe want to be in one of the leading heart places in London. So, we are very lucky with the quality of service that we have. There is a cost to it, and we have gone for the model of having specialists rather than having a hospital … (**The Chair:** Junior doctors.) junior doctors' system.

So, I think there is a premium for it. I do not think it is excessive. I probably would not have said that a few years ago but I now meet them, I am starting to know them, and I can understand the pressures that they are under and we have to be an attractive place to come and work for many years for them. That is not always easy and the marketplace they are in they are in demand worldwide.

Deputy Bury*:** And I think when you take into consideration the amount of on-call work that they have to do (Deputy Brouard:*** It is possible.) that if they were working in a different jurisdiction they would not have to do nearly as much (**The Chair:** Right.) and I think that is a really important factor to take into account.

The Chair: And finally on that one then, thinking of the services provided in the Hospital by specialists from the MSG, are you happy with the very wide time differential that exists in some cases between the private services they offer and the services they offer on contract?

***Deputy Brouard*:** That is always a bone of contention.

We would not be able to attract the quality of specialists if we do not allow private work. The Hospital also relies on private work – about £20 million of our budget comes in from private work in Victoria Wing. It is one of those balances and the financial help that we get from that supports our budget and the specialisms that they bring with it and the ability for them to do private work in their own time out of our contract is something which helps them.

***Dr Rabey*:** All I would add to that is that the MSG doctors provide a full-time role for the States of Guernsey patients, and in addition to that many of them do private practice.

Those who do private practice do more hours above a full-time job and that needs to be remembered. If they went out and cut other people's grass for money in the evenings nobody would bat an eyelid but they do not, they do private medicine and they do it during the daytime, but their overall job plans, which I see every year, are in excess of a full-time job, those who do private practice.

The Chair: Okay.

Any other questions from any other Members?

Deputy Dyke: Well I have loads of questions, but I will stick to one. (*Laughter*)

We have just bought a new MRI machine, so presumably that is state of the art and we have the latest thing, but what is the waiting list now for public health patients to have an MRI scan when they need one, and is one machine enough? And my other question was in terms of reading the scans, are those done on-Island or are they beamed up to London and read in London?

***Deputy Brouard*:** If I can start off, and then when I get into trouble I will look to my colleagues.

I think one thing that I have certainly learnt in the short time I have been on Health is that getting a good diagnosis at the beginning is absolutely crucial. (**Deputy Dyke:** Yes.) You waste so much time going back to the doctor and GP about your leg or your arm or whatever it is and if you do not get a diagnosis on day one that is absolutely accurate, the rest of it just becomes really annoying. I think we are seeing that the use of MRI scans is becoming more and more important because it gives you that accuracy right off at day one.

I think we will be looking for a second MRI scanner. It is in our thinking. We are now trying to extend the hours that it is working, and I have not got the exact hours, but it is now going well into the evening, so we are really sweating that particular asset. We were able to use the magnets from the previous MRI scanner across to the new Siemens machine which also then saved a few pounds along the way.

But I think at that point I am out of my pay grade.

***Dr Rabey*:** We are running it six days a week and we need to run it seven days, and I feel sorry for the poor staff who … there are disadvantages to working in Guernsey; there are lots of advantages, but one of the disadvantages is that they will be asked routinely to work Sundays as well as Monday to Saturday, as they are now, to get those patients through. Waiting times are longer than we would choose for routine patients; we prioritise the high-risk work.

In terms of reporting, I believe we need a sixth radiologist to report not just MRIs but across the board because the amount of imaging work going through is huge. But at the moment we have got the five, they work up to capacity and if there is still reporting to be done, we have to send that off-Island to be reported, and we do. We use a high-quality organisation to do that, but we prefer to report on-Island. The clinicians prefer to know the person who has reported the film and the scan and there is a business case in for additional capacity in MRI and additional radiographer and radiologist time to work the scanner and do the reporting.

The Chair: Okay, thank you very much. (**Deputy Dyke:** Thank you.)

So, we are at 12 o'clock now, I think you have suffered enough! (*Laughter*) Thank you to all of the witnesses for coming along today and helping increase public awareness of what the Committee for Health & Social Care does. And thank you, as always, to the members of the public and the media who have come along. Our next hearing will be on 19th November. It is here in the Castel Douzaine Room and it will be with the Committee for Economic Development should anyone wish to attend that.

The meeting has now closed, thank you very much.

The Committee adjourned its sitting at 12 p.m.