Hospital Policy Review Board – Workshop 7

02/10/18 09.30 – 12.30-14:30pm

Attendees:	
Connetable Christopher Taylor (CT) – Project Board Chair	John Howard (JH)
Deputy Richard Renouf (RR)	Rob Sainsbury (RS)
Deputy Trevor Pointon (TP)	Bruce Willing (BW), Jean Lelliot (JL), Andy Howell (AH), Graham Bisson (GB) & David Moon (DM)
Deputy Rowland Huelin (RH)	
Deputy Carina Alves (CA)	
Connetable Richard Buchanan (apologies)	
Ralph Buchholz – SoJ Officer Support (RB)	

Part A – Board members only

Item	Minute	Action
Minutes & Apologies Workshop 5 & 6	Deputy Buchanan sent his apologies Deputy Renouf sent his apologies for not attending the first part of the meeting.	
A1. Survey Update	RB: 629 responses as of 01/10/18, in the experience of 4insight they would normally expect around a 5-10% response rate for this type of survey and we are currently running at around 20%. CT: Reported that a whole department have not completed the survey due to fear of reprisal. CT: Will Contact 4 insight to send a message to respondents from CT to explain staff can gain access to the survey from their personal email. RB: 4 insight can contact the staff and reassure them their response is anonymous RH: Clear that a large group of people do not trust the anonymity.	**RB to liaise with CT & 4Insight about sending out reassurance email to staff about confidentiality.**
Site Visits	RB: Explained the site visit plan to Bristol 09/10 depart, return 10/10 Addenbrook's hospital site visit trip to follow the Bristol trip. RH/CT – to visit Guernsey for States sports day and will include a meeting re Guernsey dual site option.	

Item	1. Introduction	Action
B1. Meet with: **Bruce Willing (BW)** **Andy Howell (AH)** **Graham Bisson (GB)** **David Moon (DM)** **Jean Lelliott (JL)**	The meeting began at 1030 hours with introductions and Connétable Taylor (CT) in the chair. CT: Explained terms of reference BW: Where are you in the review process? CT: We are looking at all of the evidence of decision making and have undertaken a staff survey. GB: The basic problem is that the approved site is too small and the selection process is wrong l – look at the problems with the Les Quennevais school replacement project. GB: Previous CoM manipulated the site selection process, decision, it was a skewed process it to remove the Waterfront, Warwick Farm and St, Saviours hospital for alternative uses such as offices and housing. DM: Attended the planning inquiry and stated that in his opinion the hospital too small and thinks the site selection went wrong as there was no provision for a new hospital by the Island plan "In my opinion we should start with a clean sheet with an amendment to the island plan to include the requirement for a new hospital. Most of the public feel the hospital was put at the end of the line". DM was concerned about the long term financial implications for the island of the hospital project and commented that French hospitals are being built at a fraction of the cost RH: We have heard evidence that the Jersey costs are based upon published RCIS build costs and are location specific with different costs levels across the UK. Does the report talk about different construction costs in France? GB: The Pléric hospital in St Brieuc, Brittany was built for €49million – in 36 months on a clean site with 300 acute beds and 15 operating theatres by a single contractor, but I have no knowledge or experience of the site. You can see the building on Google Earth and it is close to St Brieuc airport. RH: What size was it? GB: Not sure; it is on the web site. CT: Suggested it was around 26,000 Sqm – or around half the size of the current proposal in Jersey. DM: Would be worth going to visit the hospital	BW passed his notes covering political interference in the site selection process to CT for distribution to the other members of the Board

	BW: Expressed concern that the Atkins report (dated 3rd October 2013), which states that an additional 9,000sqm @ £60 million additional cost would be required if P. 82/2012 is not implemented, which he believes has not. Therefore, in his opinion this additional cost and area needs to be added to the project. As the project team's design already over-fills the site, he considers that this is not possible. In his opinion, the Atkins report also dismissed sites such as St. Saviour and Warwick Farm on spurious grounds, such as traffic and electricity connection capacity. The analysis of site suitability should be based on the cost of overcoming these perceived difficulties within the estimated project cost of each site, not used to dismiss them. For example, a mains electrical connection cost is based, as a rule of thumb, on £1K per metre. What we have is a proposal to build a hospital for the next 65 years on a site that has no room for future expansion AH: Spoke of her concerns over the noise, dust and vibrations affecting the delivery of health care in the General hospital during the extended building period, now estimated by the project team as 8 years. As an example of the potential problems of building on a restricted site, the construction of the new catering department is disturbing residents in St Peter's. TP: Have not seen any evidence on developing community care under P.82/2012. We are meeting the team after this - what questions would you ask of them? P82/2012 – is unrealistic. We do not have enough nurses to keep people out of hospital. I believe the hospital is too small. AH/BW: The new hospital needs to have additional facilities, such as cancer radiography, which is currently provided as part of the current £80 million spent annually on off island treatments. DM: it's about getting it right for the next 65 years JL: Attended the neighbourhood forum and asked FHT about where future expansion could take place but they did not know and would get back to her. She is waiting for the figures. AH: There is a reduction from 24 to 12 private beds – why? This is a revenue stream for the new hospital and with a high take-up of private health care, there should be more, not less private beds. Again, this is an example of the size constraints of the proposed new hospital site.	

	BW: Raised the issue of nurses accommodation, pointing out that there is an existing shortage of nurses due to an uncompetitive pay and conditions package that will only get worse due to the requirement for more nurses to staff the increase in bed numbers and the realities of going from open wards to single room patient occupancy in the new hospital. The current plan is for the nursing and junior doctor accommodation to be provided by Andium Homes. However, this is to be done under the yet to be written 'Key Worker Policy'. In the meantime, if planning permission is granted and building starts 91 units of nurses' accommodation will be lost, thus adding to Andium homes declared waiting list of over 200 homes. If St Saviours is used for a different purpose another 30 units of nurse's family accommodation would be lost. AH: Reminded the meeting that junior doctors accommodation had been moved in April 2018 from Westaway House to The Limes, but only for 3 years. CT: Accommodation issue, no point having a hospital if you can't staff it. BW: questions that need to be answered if everything is OK are; • What is the current shortage of nurses? • How much is being paid annually to agency workers? • Why does the proposed design reduce the number of isolation rooms in the renal department from 7 to 2? • Why are the number of toilets in the oncology department being reduced from 4 to 2, thus forcing patients in isolation to use the ward toilets and being at increased infection risk in the new hospital. Everything is being squeezed in the proposed Gloucester Street site. We have to look at the history of the site over the past 68 years, which has gone from a single granite building in 1950, the granite block, to what we have today, which is a full site. Given present Planning building height restrictions, how is it possible to fit a new, larger building on the site, let alone have enough room for further and inevitable expansion? AH: The whole of this project is a risk. BW: The whole project is a disaster and has got to be stopped. Must find a way to build this hospital cheaply and quickly on a greenfield site like St Saviours or Warwick Farm. RH: Stated that if the site was located outside of the town, the Board have not reached any conclusions on two pieces of evidence related to: 1 Blue Lighting – we have a hub and spoke transport network	

	2. Not having an A & E in central St. Helier JL: Can't see it as a problem BW: All ambulance crews are trained paramedics and are trained to stabilise patients in the ambulance before starting their journey to the hospital, if necessary 'blue lighting' to get through traffic on the route to hospital – a 10 minute additional journey time should not be an issue. It is not a problem for the police. AH: Not correct the police are taking twice as long to reach their calls from new site. BW: we are not a big Island – we need a sense of proportion. JL: Said one of her friend's husband is a trained fire fighter driving instructor and that traffic on Queen's road is not a problem. RH: If A&E was not being in middle of town, would that cause problems? AH: There is no bus stop at the current site in St Helier and the public need to walk from the nearest bus stop. If the new hospital is outside St Helier, then a shuttle service can be run from Liberation Station to take the public right to its door. DM: They could also put on minibuses for staff shift changes AH: Public busses could be put on to go straight to the site. GB: Adequate on-site dedicated free parking is an absolute essential for the new hospital. RH: My concern is if the new hospital is built outside of town and one person dies en route to Warwick farm or St Saviours, how can the risk to that patient be minimised? DM: The risks exist on all sites – you cannot limit risks – for example if the Esplanade flooded then all town sites would be at risk. GB: Guernsey's new hospital is outside of St Peter Port therefore maybe a visit to the Queen Elisabeth Hospital in Guernsey would be helpful. JL: I have had treatment in Southampton and the hospital is on the edge of the city, which is not a problem. GB: Your terms of reference talk about supporting patient care, but you are not able to achieve this on Gloucester street as	

	patients will be on a building site. It is also the worse value for money. Not one of the 104 submissions to the planning enquiry supported the site – although I would concede the views of the silent majority are unknown. GB: We do not all agree about alternative sites as we all have our favourites, but we all agree on it must not be built on Gloucester street and it must be under one roof. AH: If we thought we would get a wonderful hospital then we would not object. I am passionate the hospital should not be built on Gloucester street, as we will be shackled to the past and constrained. AH: This is an opportunity to be a training hospital, but there are no plans to include the current lecture theatre and training rooms in the new hospital, particularly the lecture theatre, as the granite building where the administration and training facilities in the new hospital are due to be located is not able to accommodate a lecture theatre. Why are we knocking our existing facilities down? GB: Asked the Chairman, CT, if the States members present could confirm if they are aware of any negotiations, deals, or discussions having taken place between the States and Andium, JDC, Dandara, or in fact anybody else for the acquisition of St Saviours Hospital or Warwick Farm. CT: It is public knowledge that Warwick Farm was earmarked for housing in the last Island Plan, but was removed when the current Plan was written. As a facility St Saviour's needs updating and Andium has been asked to see how the accommodation can be updated. The Waterfront is available. BW: Regarding St Saviour's Hospital, as a matter of record, in August 2016 Dandara visited the site and asked residents of the DHSS nurses accommodation for access to their houses and flats in order to value them as a part of an overall valuation of the site with a view to redevelopment. A nurse resident reported this to me shortly after the valuation visit. JL: Supporting patient care – means during the build and it is an unacceptable risk to the patients, to be on a building site with dust getting into medical equipment, What happens if, as is likely, asbestos is found or drains collapse during the build process? What do you do with the patients if we need to move them? BW: ask of the project team, how did they manage to reduce the Gleeds estimate of a build time of 11 years at a cost £627million in April 2015 to 6 years and £466m by October	

	2017 albeit with 26 fewer acute beds than was originally planned? AH: I do not believe that the States have given approval for the site of the plans submitted in April 2018. P/ 110/2016 gave the States approval for the previous scheme. The 'preferred site' was part of the current General Hospital site, the south east corner of the General Hospital site, rather than the entire site. The Minister of Health, Deputy Richard Renouf, joined the meeting at 1100 hours, just before the meeting closed BW: Whole project has been mismanaged where is the entrance when phases 1A and 1B are completed CT: Chief Minister has indicated to me that we may need to go back to the assembly with a new proposal.	
B2. Primary Care presentation Meet with John Howard & Rob Sainsbury	See attached presentation. RS: Talks through the presentation: RS: We have reviewed the 2012 white paper and it is still sound and fit for purpose. It is also consistent with other strategies we have reviewed elsewhere. We have undertaken a stock review and there are emerging issues, which may change the focus is some parts of the strategy. We undertook some due diligence and asked what schemes needed priority? P82 – is not just for the hospital it is just one part Phase 1 : Achievements 2012 – 2015 – 36 completed projects Phase2: 2016 – 2020 – 29 complete, 12 underway and 20 remaining. Key areas of focus for P82 • Health and care for the future • Development of the Care hub, quite clunky, doesn't connect, our services and the parish system • Primary care, GP clusters to unite • Response and enablement – need more much bigger services that respond to that patient group. • Acute services strategy – bring urgent care to work together There is an issue of fragmentation as some services are not very well connected, there are some GP clusters but they need more work. RH: what are GP clusters? RS: GP practices working together – also sometimes known as federated care systems/partnerships. RH: How do you compensate GPS's?	

	RS: Part of funding strategy review – where monies move from secondary in to primary care to pay for new services. Not happened yet but is planned for Another area of change is in "intermediate care" – more advanced than GP but not at acute care levels. This needs scaling up. Number of older persons coming through the hospital is rapidly increasing and the hospital is not the right place for some of these patients. They would benefit from the intermediate care plans Need to work on the transition/hand-offs Mental health is much more prominent, consider mental and physical health having the same importance. Oncology is an example where new w pathways of treatment, need to be flexible – we will need to adjust future plans as treatments change. The strategy is based upon clear pathways of the future, e.g. increased bowel screening leads to more facilities as we have more success in detection rates and so there will need to be future adjustments and prioritisation in the financial model. Those services with the greater benefits to patients will receive more funding and vice versa. **Challenges** WE have not delivered at a sufficient pace in some areas – such as intermediate care and the mental health strategy. We have a complex health care in Jersey and many of our services are supported or even delivered by the charitable sector, CAG report has highlighted there has been a disconnect between strategy and delivery. Cultural issue to overcome, customer centric view that all people need to be treated in the hospital. TP: Is this culture driven by the cost of going to the GP? RS: We undertook a survey in A&E to understand the issue to see if they went to A&E because it was free. We'll be analysing the results in the Autumn TP: There is a culture for GP's to hang on to patients with no incentive to pass them on. The funding model needs reviewing. WE need a new hospital but p.82 needs to be delivered. RS: In context of the future hospital, we are on the track to deliver. The size has been based upon conservative assumptions using existing and new activity levels with additional bed requirement based upon demographics. We have therefore taken on board future capacity levels, modelled to 2065.

	Any reductions in demand from improvements in community services is a bonus and will further increase capacity of the hospital But there are many variables, recruitment, BREXIT, IT innovation, emerging working with Guernsey – lots of things that we will need to adapt to as constant variables – there are many changes that can impact fixed points but this is normal in healthcare transformation. TP: Have we started on the current staff and future staff to recruit, is there the Staff accommodation available? RS: There are two strands and we are working with the people's bub with some success. There are a number of core pressures, keyworkers recruitment is a State's wide issue, not just related to hospital staff and is an issue that is being dealt with separately through a new strategy supported by the SHU. TP: How is that affecting recruitment RS: We need to improve the offer with help on child care and accommodation. The Welcome to Jersey initiative run by Richard Stevens who is doing this significant piece of work to pull an attractive package together for staff. We are also surveying staff to understand all of the issues. CT: Do you have accurate costs for health services? RS: Yes we are doing work on costings – although similar to the way the NHS does this using broad headings, we can also get some specific patient costs. For example the top 20 high volume patients cost around £4m in expenditure. There is a boundary around the system with lots of transactions recorded within it. The strategy is aiming to reduce the number of transactions to improve it. JH: It is not just a cultural issue but also one about leadership and empowerment. - What is the best way on the island to deliver the care? - Who are the right people to do that? - How do we compensate Doctors for how we want GP services to change in the future? - Law on the medications – change of law is required - Hold people to account - Strategy and thinking is good, the execution and implication is the problem JH: Has enough progress been made and can they be made at pace to make assumptions on the size of hospital required? We should be building a hospital that is right for our strategy – and not build the wrong type and size of hospital to meet a flawed system. CA: Decision can't be made on assumptions, mixture of political and public

	RH: Believes that the proposed hospital is a tight fit, with some areas smaller than currently provided. It needs to be flexible as future changes will require more space. JH: The plans are conservative there is a lot of space, there are enough beds for the island. In fact the proposed size is bigger than is currently predicted or required. The space can be used flexibly, and we have the ability to change the space configurations. RS: You can't always predict what will be needed in the future, i.e. CAMHS (Child and adolescent mental health service). Which is a priority today that could not have been predicted. That's why you need to be flexible with the space, which is what is planned. RS: Hospitals now need staff to work in both the hospital and the community, not just in the hospital TP: can you provide more information on 'shared care'? RS: We need to do more in this area but it is related to improving continuity in care between professionals and services. Initiatives like increasing telecare and sharing of information and processes with the community and key enablers. TP: is this the voluntary sector? RS: Yes, the voluntary sector can also play a part and have and they can have a big impact on services. JH: It is not just about goodwill, it is also about but also about the pathways and funding arrangements. Space requirements can be reduced – e.g. diabetes care. CT: This is positive but would not want to pass on problem to the Parishes as in the past they supported the community but this was taken away from them and centralised which has caused problems and left a 'bad taste' with the constables. RH: The current cost is £466m but it is beyond that – what are the other capital investment required needed to complete p.82? RS: There is an emerging understanding of wider issues, e.g. mental health strategy and other areas for alternative plans related to estates and the digital structural improvements. RH: P.82 identified a budget of £640k for digital improvements but in my experience this will be needed to be of the order of '000's of percent higher. RS: We have an economy of scale issue and we need to ensure our services are productive.. Digital improvements can be a key enabler in addressing this.

	RH: I am struggling location issues related to A & E and Blue lighting – what is RS views on the potential impact of these services if they were located at St. Saviour? RS: We do not have the same experiences as the UK – I would have no real concern regarding any of the potential sites considered from a travel perspective given the Island is so small. RH: With regards to footfall do we need to have A & E in town? RS: The main issue is who attends and there are large numbers of A&E attendees who are presenting with minor illness rather than minor injury or more significant ill-health. This is consistent with most A&E's and is relevant for both in and out of town departments. RH: With regards to mental health, we now have a greater awareness than identified in P.82, and so how important tis it to have psychiatric and acute services accessible to each other? RS: This is an essential part of the mental health strategy – it is a key part of the new model (Core 24) and requires more staff to provide an interface. It should happen in the home in the first instance but A & E needs to be equipped to handle patients coming in. RH: When is the strategy out? RS: It is going to scrutiny in the next few weeks. RH: What progress is there with Digital? Has it been kicked into the long grass? RS: Not at all, but we first need to identify the steps to be taken before investment decisions can be made. TP: 'TrackCare' - is the system any good? JH: Some of the problems can be software related but many are if it is not implemented well – which would be our own issue. The alternative – 'Epic' is incredibly expensive and it would be wrong to simply replace 'TrackCare' with it before we have reviewed all of the issues. It is a very complicated decision that needs to be right. The board thanked RS & JH and the meeting ended