Hospital Policy Review Board – Workshop 8

12/10/18 09.30 – 14.00 – 16:30pm

Attendees:	
Connetable Christopher Taylor (CT) – Project Board Chair	Richard Downes (RD)
Deputy Richard Renouf (RR)	David Ig (DN)
Deputy Trevor Pointon (TP)	
Deputy Rowland Huelin (RH)	
Deputy Carina Alves	
Connetable Richard Buchanan (apologies)	
Ralph Buchholz – SoJ Officer Support (RB)	

Item	Minute
A1. Richard Downes (RD) – Director of Mental Health	CT Welcomed RD introduced the Board and outlined their work and terms of reference. RD explained that he felt he was in a unique position as he has seen developments from both sides; initially up to 2016 he was a consultant in the Ophthalmology Department and clinical director for Surgery involved in the FH discussions from the outset, latterly as clinical director for mental health services. RD described the process undertaken to date on the site selection process and he was very familiar with it, but mental health was not considered as part of these plans at that time. Mental health in his opinion has been a Cinderella service compared to acute services and the acute mental health ward was taken out of the hospital over 10 years ago and moved off site to Orchard House at St. Saviours RH asked what acute services were available. RD stated at there are 5 wards for adult and older adult services. Orchard House is an acute M.H facility for adults from 17/18 up to 65 years. Clinic Pinel comprises 2 wards; 1 for functional M.H problems such as depression/bi=polar, etc. and 1 for structural M.H problems i.e. .dementia. There are a further 2 long stay wards for dementia and more elderly patients with long term mental health issues who are unable to live independently at home or in a residential care environment. Children with mental health conditions are managed in Robin ward, but there are only two allocated beds available and he believes that this is not sufficient as evidenced by a recent surge in admissions for children with acute and serious MH problems. Activity across the board will increase as a result of three main pressure areas;

	• **Younger/teenagers** - In the UK there is evidence of up to a five-fold increase in mental health issues over the last 5 years • **Young Adults** – greater pressures on them from social media, illegal highs and work • **Elderly** – Changing demographics with ageing population leading to more demand with at least 35% of patients having co-morbidities i.e. combined physical and mental illnesses. Not all will require hospital as some can be managed in the community, but some will require hospital treatment and therefore a facility adjacent to the new hospital would be the safest and most efficient option. RD considers that these could be accommodated in the current plans but not sure about the longer term as there are many unknowns. There are plans for a new mental health facility at Overdale but believes that this should be provided very close or adjacent to the new hospital site. Given the scale the current site RD considers it is therefore not likely to be appropriate as it would also need to be more flexible over its lifetime and able to adapt and expand as necessary. RD knows of many UK sites that have mental health on the same site. It is a given this will be the biggest investment that the Island has seen and will affect everybody including visitors - it's a long-term decision for the next 30, 40 or 50 years and will need to be flexible and be modular to allow for future changes. We should get the site decision right and there should be adjacency with primary care next to mental health facilities. TP: Will the Robin ward facilities for the young with mental health issues come under increasing pressure? RD: Until relatively recently we appeared to have sufficient capacity within the existing services as many of the issues are around eating disorders (30-40%) and other less acute matters, but we are now seeing far more complex cases which I believe will continue to be the norm . TP: What happens to long-term patients with regards hospitalization and particularly the Young? RD: There are stark choices, you either manage them on island; or off island which is less than ideal. The majority can be managed here, but if beds are under pressure this creates increases in the relapse rate so these vulnerable patients need to kept in hospital as long as necessary to reduce this. RR: Is Robin ward sufficient to manage the demand for younger persons? RD: if we had a facility or 4-5 beds and not two then these would likely be occupied and avoid in some cases of having to transfer to Orchard House. Some treatment of mental health can be dealt with more flexibly; it does not require a lot of specialist care as some can be based on good “old fashioned basic nursing and humanitarian support The need for a nurses to have degrees

	is not required in all cases, they just need to be passionate and be caring with training in practical skills /less emphasis on educational achievements. RR: With the concept of a joint facility is there a best practice guidance? RD: The best is a separate facility but adjacent to existing acute facilities for greater efficiencies of practice. RB: Can you define how close an adjacency would be? RR: Is Overdale adjacent? RD: In my opinion Westaway Court would be would be my definition of adjacent - not Overdale. CT: How much stress does travelling to an acute facilities for those long-term patients? RD: It stressful for anyone with mental health issues to go to hospital and this is compounded by going into A&E which is often a noisy environment. RR: Even if it was co-located – would this still be a problem? RD: The problems would be far less with a co-located facility since travel would not be needed in many of the cases nor admission to ED. In cases necessitating the latter the transfer would be less traumatic simply because of potential adjacencies. RH: How many require an ambulance to get to hospital? RD: I don't know the exact figures but would guess that anywhere up to 5 to 10 per month from Clinic Pinel; for Orchard House it is less mainly because of a younger patient profile with less comorbidity. CT: How big is the proposed new mental health site at Overdale? RD I do not know the figures but the site could easily accommodate all of the current services there. Overdale is potential an extremely large site CT: I believe that the budget is 46 million for the mental health strategy, how much would a psychiatric intensive care unit cost? RD: At a guess about 5 million pounds. TP: I know of patients who have to go to the UK and this is stressful, could this be reduced with better facilities? RD: The NHS has its own pressures. New capacity and the new service could minimise that situation of stress of people having to go to the UK. RD: Was not sure who had agreed the Overdale option and it appears to be a

	'fait a compli ', including the decision to not include an acute mental health facility in the new General Hospital. He considers that this is not the right thing to do. RH: Asked about staff recruitment - could we do better? RD: We have the highest requirements around locum staff within HCS, and currently employ more locums than permanent staff. 3 separate national adverts have had no success to date. The reasons for this include; 1. Regarding doctors we are competing with the private sector as well as the NHS; agency wages average £95-100 per hour and £2250 for a complete weekend, compared to a lower salaries for permanent staff. 2. Lack of flexibility with regard to relocation packages and other incentives such as subsidised accommodation and childcare. For the nursing staff/ Allied health professionals this becomes a retention issue even if we have been able to attract staff in the first place. 3. For admin support we can only make appointments for 12 months so we have to use agency temps since staff are not prepared to move from their permanent posts nor can applicants be attracted to these short term fixed appointments TP: Why only 12 month appointments? RD: part of the restrictions imposed by the workforce modernisation programme which was extended to health care admin who are regarded as non-frontline We have some good locums who hopefully will apply for the current vacant medical posts. The Board thanked RD for his time and comments.
A2: Mr David Ng (DN) – Endoscopy Consultant	CT: welcomed DN and explained the board's terms of reference DN: Described his background and experience and said that his motives are centred on what is best for patients and the Island. When the new hospital is completed he will in any event be at that time retired and not see the benefits of running the new service. DN fundamentally believes that the new hospital will not be big enough. He has funding for a third endoscopy consultant but he has been told he will only be provided with two endoscopy theatres. Bowel screening is around 1200 per annum and with an ageing population this is increasing. In the UK it is estimated there will be a 14% increase in endoscopy use by 2020. There will then have to be repeat monitoring which will also increase over time.

	The FH team are not listening to him just as they have also not listened to Mr Kumar who has also told them that his and other areas will also experience increased service demand such as oncology and the chemotherapy unit. He believes the future hospital plans are not future proofed and needs rewriting. If we build on the current site how will they expand based on the projections there is no room to expand? If a greenfield is chosen then there would be room to expand. In addition if it is built on the current site there will be significant disruption which will impact on the care and recovery of patients. DN then played two audio recordings to the Board of construction and traffic noise outside the endoscopy unit staircase area which overlooks Kensington Place. *Note: the recordings were of jack hammers and general traffic noise.* DN explained that in the summer when it is hot -as we have had this year - the windows are open but there is no air conditioning. He believes that this is not safe as during demolition that fungi spores and dust always gets in whatever measures the builders do. He believes the builders will not prevent that happening which therefore will impact on patients. TP: Asked where the demand for increase in services is coming from. For example the Board recently visited Bristol and they estimated that service increases are running at 9% per annum. DN: Stated that the demand is coming from the increasing elderly population. TP: Asked about private care and whether that increased business would be beneficial to supporting the hospital business model? DN: Stated that he is restricted to having 30% private patients and also there is only one private patients Ward open at the moment as Rozel ward has been closed for the last few years and Sorrel has often to be used as an isolation Ward because there are no isolation beds in general wards. CT: Asked why is Rozel closed? DN: Explained that it was a staffing issue. Staff retention is an issue and that accommodation is very expensive – we are losing very good staff after only 2 years to the NHS as they cannot afford to live in Jersey. CT: Is all about disposable income then? DN: Agreed. CA: We have heard that improvements to care in the community will make a

	difference to improving the efficiency of the service, but is this relevant to endoscopy? DN: For more elderly in-patients there are discharge issues that can lead to some bed blocking - in the NHS there are penalties for this but this is not appropriate in Jersey. RH: What would be the benefits of a cottage hospital being adjacent to the current site, I imagine this would help? DN: Overdale acts as the rehabilitation hospital and patients use their own GP to support them. The development of a patient hotel would support care in the community initiatives but would need primary care to be fully joined up. RB: Ask DN what capacity level of the current endoscopy unit was running at. DN responded that it is running at 100% capacity, we have high quality staff but are one FTE consultant short. RR: Asked about preventing cancers and asked about policies that would reduce future cancer patients needing endoscopy procedures. DN: Agreed that in the longer term this would be the case but we still have lots of Legacy issues. RR: Asked if we chose a new site are you worried about the ongoing potential issues of in house maintenance - as you have provided in your audio recordings - whilst a new one is being built? DN: Said that the future benefits will outweigh the short-term problems. It is also not easy to predict what would future developments would be available, for example in endoscopy we could end up having a motorised pill with a camera in it and I could do 5 cases simultaneously but this is the longer term - 10 plus years away. RH: My understanding of current screening is it is generally directed at bowel, breast, cervical and prostate – is this at the expense of other less known well cancers? DN: Explained that it is related to the budget and so the affordability of only being able to concentrate on the most common diseases as the primary monitoring services. DN: also offered views about gagging of staff and stated that this has occurred in the past and at consultant level. He mentioned specific names to the Board that he was of the opinion they had been gagged. RH: Believes that the current management team is more open although we have seen with the survey there has been some reluctance to fill it in - perhaps this is still a legacy issue?

	DN: Believed that this was probably the case RH: if you ask consultants what they want, won't they always just ask for more than they actually need - what are your views? DN: Believes most consultants are not empire builders they have patients and the health services as their primary objective. RR: At the public enquiry there were five consultants who all said that had been no gagging - there never had been. DN: This is contrary to what I witnessed at the MCS meeting RH: Are the MCS minutes available - who takes them? DN: Believes they should be available. CT: The Board thanked DN for his comments and time