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Health and Social Security Scrutiny Panel

Quarterly Review Hearing

Witness: The Minister for Health and Social Services

Thursday, 6th June 2024

Panel:

Deputy J. Renouf of St. Brelade (Vice-Chair)

Deputy L.K.F. Stephenson of St. Mary, St. Ouen and St. Peter

Deputy P.M. Bailhache of St Clement

Witnesses:

Deputy T. Binet of St. Saviour, Minister for Health and Social Services

Deputy A. Howell of St. John, St. Lawrence and Trinity, Assistant Minister for Health and Social Services

Ms. R. Johnson, Director of Health Policy

Mr. C. Bown, Chief Officer, Health and Community Services

Mr. A. Weir, Director, Mental Health and Adult Social Services, Health and Community Services

Ms. C. Thompson , Chief Operating Officer, Acute Services, Health and Community Services

Mr. S. West, Deputy Medical Director, Health and Community Services

[14:02]

Deputy J. Renouf of St. Brelade (Vice-Chair):

Well, if everybody is ready then, action, as we used to say in my previous career. Welcome, Minister, Assistant Ministers and officers. Welcome to those members of the public and members of the Fourth Estate who I am sure are joining us online. First, let me explain that Deputy Doublet, who is Chair of the Scrutiny Panel, is currently off sick, so I am afraid you have got an understudy today, I will be chairing the meeting. My name is Deputy Jonathan Renouf and I am the Vice-Chair of the

panel. Just to help everyone, if we go around and everybody introduces themselves first and I will start at the end of the table.

Committee and Panel Officer:
Sammy McKee, Committee and Panel Officer.

Deputy L.K.F. Stephenson of St. Mary, St. Ouen and St. Peter:
Deputy Lucy Stephenson, panel member.

Deputy P.M. Bailhache of St Clement:
Philip Bailhache, panel member.

The Minister for Health and Social Services:
Tom Binet, Minister for Health and Social Services.

Assistant Minister for Health and Social Services:
Andy Howell, Assistant Minister for Health and Social Services.

Director of Health Policy:
Ruth Johson, Director of Health Policy.

Chief Officer, Health and Community Services:
Chris Bowen, Chief Officer, H.C.S. (Health and Community Services).

Deputy J. Renouf:
Thank you very much for attending. If I could kick off with a question, first of all. Minister, you have been in post for about 4 months now, what would you say are the things that have gone well?

The Minister for Health and Social Services:
That is an interesting question. I think that we have actually, as a ministerial team, settled down with the management team quite well. As I say, it was a slightly turbulent introduction with the changeover but I think that has settled down well and we have got to grips with the key issues reasonably well over the course of that time.

Deputy J. Renouf:
Any particular achievements?

The Minister for Health and Social Services:

No, I think it is too early to be talking about achievements other than the fact that I think hopefully we have a grasp of the key issues by this stage.

Deputy J. Renouf:

If we talk about a health strategy first. The panel understands that you are creating a health strategy which will encompass a large number of strategies and work programmes that have otherwise fallen away. What are the main objectives of the strategy?

The Minister for Health and Social Services:

At this stage of the game, the way things are evolving, the thing that I have observed for myself is I think that with the various elements that you have, you have H.C.S., public health, the G.P.s (general practitioners) and the third sector and I really think that we need to improve the interaction of all of those elements together. So I think the new strategy might involve a slight restructuring to make sure that there is particular focus on each of those individual elements and a particular focus on the integration of those elements, which I think would be beneficial.

Deputy J. Renouf:

So is work on the strategy underway at the moment?

The Minister for Health and Social Services:

It is, yes.

Deputy J. Renouf:

So people are actually working on it?

The Minister for Health and Social Services:

Well, we are collectively formulating that as we go, yes.

Deputy J. Renouf:

Okay, so what timeline are you working to?

The Minister for Health and Social Services:

Do not have a specific timeline at this stage, I have to be honest with you. That is one of the things that we are working through now.

Deputy J. Renouf:

Okay, I think it is one of those things that, since the Jersey Care Model was dropped, we have been operating in a bit of a vacuum and it keeps being referred to and keeps being something that appears

to be something is going on but we cannot quite get a handle on it. It feels like a really crucial piece of work. I wonder, if you cannot tell us what the timeline is now, when you might be able to tell us what the timeline is?

The Minister for Health and Social Services:

If I said as soon as possible, you would probably start laughing. But I think we are all very conscious of the fact that the political cycle only has 2 years to run and we are all very, very determined that something meaningful happens that means that when we get to the end of that period, that things are established and underway, and hopefully unchangeable from that point forward. That is the overall aim.

Deputy J. Renouf:

Is that you saying that the health strategy will be in place by the end of that 2 years?

The Minister for Health and Social Services:

Hopefully in place and in the process of being implemented.

Deputy J. Renouf:

Okay, so we might expect to see something within the next year that would ...

The Minister for Health and Social Services:

Yes, yes. I hope that things will emerge … ideas towards that will emerge as we go so it does not all just come out in one. So the thinking progresses.

Deputy P.M. Bailhache:

The advisory board will be part of that strategy, will it not?

The Minister for Health and Social Services:

Indeed, yes. I think everybody has to play a contribution to this.

Deputy J. Renouf:

Has any consultation been done yet? Has any work been put out to consult on it, either with officers or with public or anything like that?

The Minister for Health and Social Services:

Not formally. We have a group that has been meeting … that has only actually had a couple of meetings, because obviously getting your head around everything that is happening, there was a bit more just to be looking at strategy when you do not understand the actual apparatus that you are

dealing with. So strategy development really has to come after the point at which you have got the bones what you need to know before you start the process.

Deputy J. Renouf:

So there is a group, a ministerial group or ministerial officer group that is going to be working on the health strategy?

The Minister for Health and Social Services:

Yes. That is the ministerial team, Social Security and Treasury effectively, but with extensions from that as required.

Deputy J. Renouf:

Okay, good.

Deputy L.K.F. Stephenson:

We know that one of the areas that now would come under the all-encompassing strategy is the women's health strategy. You have stated that that is not going to be a separate strategy but will come under that piece of work. I just want to know what feedback you have had from the public following that announcement that there will not be a separate women's health strategy.

The Minister for Health and Social Services:

Before I hand over to Deputy Howell, who has been working on this specifically, the situation of the women's health strategy was we inherited what I understood to have been a decision taken already not to actually develop one and we carried on with that decision. That was what I believe we had inherited, simply down to funding. I will hand over to Deputy Howell.

Assistant Minister for Health and Social Services:

I have been really lucky that I have taken over responsibility for women's and girls' health and am part of the Women's Health Political Advisory Group, which I think, Deputy Stephenson, you were on recently. So I think we inherited the fact that there was not enough policy provision for us to have a standalone policy but it does not mean that we are not caring about or wanting to care for the women and girls on this Island. We have launched the survey, I think it went live in February and finished on 21st May, for the women's health and well-being. That has been really good. We have had a fantastic 1,650 valid responses from a good demographic spread in terms of age and ethnicity. The vast majority of responses have come from females, I think 97 per cent, which was responding based on their own experiences as a woman and girl in Jersey. We are confident that we are going to get quite a lot of insight. When we have had the replies and we have analysed them, then we will be working to see what we should prioritise. But we are still working hard and we met yesterday,

there is a group of the advisory group, and we have been working on your I.V.F. (invitro fertilisation) proposals and we are very much … there are lots of good things that we are doing for women at the moment. We have also …

Deputy L.K.F. Stephenson:

Just to go back to the survey launch in February. Now you have both told us that it was a decision taken previously. Why was the survey then launched as billing a women's health strategy in February if a decision had already been taken it was not going ahead?

Assistant Minister for Health and Social Services:

Because I think the previous Minister for Health and Social Services had set things in motion and so the everything was ready to go.

Deputy L.K.F. Stephenson:

So it had been stopped or it had not been stopped, I am unclear?

Assistant Minister for Health and Social Services:

The previous Minister of Health and Social Services decided not to have a standalone women's strategy but she still continued with the women's health strategy that she was sending out.

The Minister for Health and Social Services:

I think it remained important to know what women and girls actually wanted so that can actually feed into the overall health strategy in general. So it will not be wasted work.

Assistant Minister for Health and Social Services:

I think we need to listen to the voices of Islanders because unless we listen to what they are experiencing, we do not know. Like it was very helpful today that you sent us an email about something that has not happened for one patient because if we did not know that we would not be able to put it right.

Deputy L.K.F. Stephenson:

Absolutely. Obviously the previous Minister for Health and Social Services is not here to have that discussion so I think it is inappropriate to probably go further on there …

The Minister for Health and Social Services:

Just establishing the history of …

Deputy L.K.F. Stephenson:

… but I think there may well be a conversation that needs to be had there.

Assistant Minister for Health and Social Services:

Yes, and I think it was confirmed by the Director of Health Policy that that was the case when we met.

Director of Health Policy:

There was a commitment in the ministerial plan that was produced in 2023 to do a number of pieces of work in the women's health space. The first of those was to produce an overarching women's health strategy and the other 3 pieces of work related to bespoke work and research around I.V.F., around contraception services and around termination of pregnancy services. Throughout 2023, we started work on the development of the women's health survey, because in order to produce a strategy you need a basis of understanding of the priorities for women and girls in Jersey. So we launched the women's health survey. The women's health survey stands in its own right as a valuable source of information and data, regardless of whether or not there is or is not a standalone women's health strategy. The women's health survey will form part of the Jersey strategic needs analysis which has been developed by our public health team, which is a collection of data that supports both policy makers and Islanders to understand the needs of the Island. The women's chapter of the Jersey strategic needs analysis will include the findings from the survey that we have undertaken and we will also include data about usage of women's health services and data about what we know about health outcomes and health issues for women. So this survey was never intended just to underpin a strategy, it always had a broader context of us understanding issues relating to women and girls and their health and well-being in the round. So the work on the survey went ahead even though the previous Minister for Health and Social Services had acknowledged that there was not sufficient resources to undertake a standalone strategy as well as to do the other priority work that had been identified around I.V.F., termination of pregnancy and contraception services. That was discussed and agreed at the Women's Health Political Advisory Group prior to the change of Government. It was not publicly announced, but it was a decision that had been discussed at that group.

Deputy L.K.F. Stephenson:

Thank you. To get to the really important bit in all of this, all those, I think you said, 1,650 women, what are some of the key themes that came out in those responses?

Assistant Minister for Health and Social Services:

They are only just slightly coming out now but it did show that if you were living in a comfortable home, had a good work-life balance, in a financially reasonable position that it tended to be positive

towards your health. I think that is about all they have found so far in this survey, but they are working on it as we speak. As soon as we have more, I will let you know as a scrutiny panel.

[14:15]

Deputy L.K.F. Stephenson:

The, I think, 3 workstreams from that that I think you have all spoken about, the termination of pregnancy, I.V.F. treatment and contraception workstreams, can you give us an update on the timeline and where we are going with those pieces of work?

Assistant Minister for Health and Social Services:

The I.V.F. work has been done because we have to apply for the Government Plan. So I think I have shared it with you, what we were proposing.

Deputy L.K.F. Stephenson:

Yes. If there is any possible details you can put on public record for those listening and about the timescale for that work, it would be useful.

Assistant Minister for Health and Social Services:

They have worked … the officers, I cannot praise them highly enough because they have had to work at pace to get this timeframe.

The Minister for Health and Social Services:

It is worth talking about the timeline and how we are going to go about that, if you would not mind?

Director of Health Policy:

Yes, so in response to your proposition, we did some policy work and we did some financial analysis to look at the costs associated with an extended access to I.V.F. services in Jersey. We developed some draft access criteria which we have consulted on. Because the timeframe is ahead of us, it was a short consultation but we consulted with the members of the Political Advisory Group, with yourself and with Tiny Seeds as the lead campaigning organisation in this area. That consultation on the access criteria has informed the business case that has been submitted to the 2025 Government Plan. C.O.M. (Council of Ministers) are in the process of making final decisions on the funding allocations through the 2025 Government Plan and as soon as that has been sorted in the Government Plan and has been published, we will be publishing - putting into the public domain - the access criteria which will come into effect from January 2025 on the assumption that the Assembly approve that allocation within the Government Plan.

Deputy L.K.F. Stephenson:

Great. Thank you very much. Termination of pregnancy work and the contraception work?

Assistant Minister for Health and Social Services:

The contraception work, I am really sorry we are just losing an officer at the end of this week to go to Social Security who was working on this. So we met yesterday as a group, as the Women's Political Oversight Group, and it was a very difficult decision but in view of the complexity of the Termination of Pregnancy Law and the number of hours that would be entailed we decided that it was a joint decision that we would not pursue it at this time. But we are hoping to make one amendment because we are just worried at the moment about access for workers who are coming over on licenses and at the moment they are in not a very good position from this point of view.

Deputy L.K.F. Stephenson:

Sorry, it is the contraception workstream that is being delayed or the termination of pregnancy?

Assistant Minister for Health and Social Services:

Yes, the contraception work is ongoing but it cannot start until the summer when we may have a person who might be able to come and help to analyse the results of the survey.

Deputy L.K.F. Stephenson:

The termination of pregnancy one is progressing or is that the one that is …

Assistant Minister for Health and Social Services:

That has unfortunately ceased.

Deputy L.K.F. Stephenson:

Completely?

Assistant Minister for Health and Social Services:

Well, we have all the details … it is on hold at the moment.

Director of Health Policy:

Perhaps I could help just with some of the timeframe because I have it close to the top of my head. With regard to the termination of pregnancy work, we have done an initial survey to test public attitudes and professional attitudes towards challenges and potential changes to the Termination of Pregnancy Law. We have analysed the results of that and we have published a feedback report. That feedback report, I think, was published in March, off the top of my head, and is in the public domain. On the back of that feedback report, we have established a professional officers working

group, so with the professionals in Jersey who provide termination of pregnancy services or have an interest in women's sexual health and family planning matters. That working group is actively working through the responses to that survey and developing proposals for reform. We had been anticipating that there would be a debate before the end of the term of this Assembly on changes to the Termination of Pregnancy Law. The Women's Health Advisory Group made the decision yesterday that that should be delayed until post-purdah, i.e. until when the next Assembly is in place, because of resourcing challenges that we have within health policy. The exception to that is that, as Deputy Howell has mentioned, we are looking at bringing forward in short term one key change to the Termination of Pregnancy Law, which addresses the challenges imposed on women in Jersey who are on work permits, who are currently not able under our legislation to have a termination of pregnancy in Jersey. That puts a cohort of women who are potentially quite vulnerable into a very difficult position. We are looking at bringing forward an interim change, which we will hopefully do before the end of this year and then we will bring forward wholesale change toward the end of 2026 in the Termination of Pregnancy Law. With regard to the work that we are doing on contraception services, alongside the women's health survey, we did a standalone contraception survey. The reason it was standalone is because contraception is an issue for men as well as for women, albeit we redirected women who went to the women's health survey to that survey as well. We have had just over 700 responses to that survey and the data that we have got from that contraception survey is going to be crunched and analysed over the summer months. We will be comparing the data to that survey with data … so the findings from that survey data with data we have about uptake in use of contraception services in Jersey and trends towards use in contraception services, in order that towards the end of this year we can start to develop some proposals for potential change or reform - if it is determined that that is required - in order that the Women's Health Political Advisory Group can bring forward recommendations and a funding bid into the 2026 Government Plan, if they determine that is required.

Deputy L.K.F. Stephenson:

Thank you, that is helpful. We started with a comment that people should be reassured that we are still prioritising women's health, yet of the 3 workstreams that remain from the shelved strategy we have heard that one is on hold, one is progressing and one is going to start in a few months. How can you reassure the public that women's health will be treated as a priority? Will it be treated as a priority going forward?

Assistant Minister for Health and Social Services:

Well, I think we have also done other things. The maternity services have really improved of late. If you want me to go through that, what we have done for those?

Deputy L.K.F. Stephenson:

I think we have a separate question section on that shortly.

Assistant Minister for Health and Social Services:

Okay. So breastfeeding has improved, we have listened to the Violence Against Women and Girls Taskforce and we are implementing all the recommendations of that report in regard to health so that the G.P.s have to do compulsory training called I.R.I.S. (Identification and Referral to Increase Safety) training. It is mandatory and every time any woman goes for any health consultation, that is something that they need to be asked about: "Are you okay?" Although it is not us, but the rest of the Government have made period products … they have tried to stop period poverty and they have also made G.P. appointments and home visits less expensive for all men and women, with 3 and up for children, and it is cheaper for everyone, including those on Pension Plus. We are just … what else have we done? We are just always learning and we will be continuing. When we get the results back from this survey, then we will know what we want to prioritise because it is women and girls from the age of zero to 100. We have lots to do.

The Minister for Health and Social Services:

I would just make a point, and I know we are going to come to funding, but there is a lot of pressure, as you can imagine, for us to prioritise in an awful lot of areas and the finances only go so far. I know we are going to come to that, I am sure we will, but I think we have to bear that in mind when we say that we are running short of resources here or there, then that has to be taken seriously because that is just a fact.

Deputy J. Renouf:

I think it what is revealing, though, is obviously when money is tight and decisions are taken, that that does reflect priorities. So we draw up …

The Minister for Health and Social Services:

Very, very tough decisions to be made going forward, yes.

Assistant Minister for Health and Social Services:

But we will be carrying on doing our screening programme, we will be carrying on with the vaccinations, we will be carrying on doing all the things that we do. I think over the last few years, we have really done a lot for women and girls, in my opinion.

Deputy L.K.F. Stephenson:

I am just conscious of time, I will just sum up with one final question. There was a recent thread on social media, and I do not know if any of your team would have picked up on it, in which a number of local women cited quite negative experiences with the department, and A. and E. (Accident and

Emergency) particularly, around early pregnancy bleeding, miscarriage and ectopic pregnancies. Obviously, ectopic pregnancies can be fatal and obviously lead to health complications as well. First of all, are you aware of those concerns? I believe there is a petition that is coming from it as well.

Assistant Minister for Health and Social Services:
Shall I pass that over to our …

The Minister for Health and Social Services:
I think it might be worth Chris …

Deputy L.K.F. Stephenson:
I would just like to know what is being done to improve those experiences, in the context actually of what we have just discussed as well.

Chief Officer, Health and Community Services:
Yes, first thing we are aware of it and it was brought … not that I watch social media a lot, but it gets brought to my attention. So the Chief Nurse is actually now investigating those issues that were raised in social media about E.D. (Emergency Department) and maternity around ectopic pregnancy and the experience that women are having. So that is something that is alive and being investigated to make sure that we can improve that experience that those women had that was articulated through the social media.

Deputy L.K.F. Stephenson:
That is really good to hear.

Assistant Minister for Health and Social Services:
I will just come back and say I hope that we might be able to work together to make something better, because we did lose our gynaecology ward, which was somewhere they could go. But I think it is a discussion we need to have together with the Executive of how we could improve things for women, because it is not really acceptable, I would say.

Deputy J. Renouf:
The maternity strategy, can you update on the timeline for presenting the maternity strategy to the Assembly?

The Minister for Health and Social Services:
I will hand over to Chris on that.

Chief Officer, Health and Community Services:

Scrutiny, I think you had a private briefing on the Maternity Improvement Plan. As regards to the strategy, it is due to be presented to the H.C.S. senior leadership team at the end this month. We probably need to take it to the board as well, because it is an important strategy, and that would be on 24th July. In effect, it will be in the public domain on 24th July but, subject to any amendments that the board makes, it will be published directly after that date.

Deputy J. Renouf:

We have heard from the Minister about funding issues. Will the maternity strategy be funded, Minister?

Chief Officer, Health and Community Services:

It can all be funded within existing resources. By improving the service, it does not require additional resources for maternity. The team have confirmed that to me.

Assistant Minister for Health and Social Services:

There were 127 recommendations. They have now done 103, so they have done a huge amount work.

Chief Officer, Health and Community Services:

Much of this is about patient-woman experience, so the improvement plan, which I think you had the briefing for … of course there are 3 things that sometimes get conflated. One is the previous recommendations from Scrutiny, then there are the multiple recommendations from the Royal College of Obstetricians and Gynaecologists that were in 2 reports. Those combined make the Maternity Improvement Plan. Once the strategy is finally approved, then the actions from that strategy will also go in. We will have a single maternity improvement plan that will cover all 3 aspects. As the Assistant Minister said, we are making very good progress on those that the Royal College put forward in the previous scrutiny, some of which were the same - or many, in fact were the same. From the point of view of the additional resources needed for the strategy, we do not believe that that is required. It is all possible to improve within our existing resource.

Assistant Minister for Health and Social Services:

I think it is now almost business as usual but in a much better way. The facilities are so improved. They spent £6.4 million but they have really improved them because before poor ladies in labour had to walk down a corridor to go to the loo and now they have all got their own ensuite facilities.

Chief Officer, Health and Community Services:

Of course the strategy is up to a 3-year timeframe so these are the immediate things that we are doing to improve but the strategy be over 3 years with different aspects over those 3 years.

[14:30]

Deputy J. Renouf:
So in terms of where we are at, if you like, clearly there was a significant improvement needed in maternity services. Would you say we are on the steep upward part of the curve or are we levelling off towards the top?

Assistant Minister for Health and Social Services:
No, I think we are levelling off towards the top, we are plateauing, I would say. We are just gradually doing the last few bits, but we are carrying on. It has made such a huge difference.

Chief Officer, Health and Community Services:
There are a number of things that still need to be done. Cultural issues that colleagues in maternity will tell us that still exist - and they do - and we are doing some targeted cultural interventions in maternity to make sure that gets better. But other than that, actually, many of what I call the technical recommendations around the clinical quality and the clinical aspects of care have all been addressed.

Deputy J. Renouf:
Those cultural issues, are you able to elaborate on what those cultural issues are?

Chief Officer, Health and Community Services:
This is something that you do see in maternity units elsewhere, in other jurisdictions, and this is the relationship between colleagues and between midwives and obstetricians, and indeed between obstetricians and obstetricians and midwives and midwives. So something that has been quite historical, it is a legacy issue that we have got to rid ourselves of. Work has been taking place with those staff groups to address that.

The Minister for Health and Social Services:
It is safe to say that there has been quite a vast improvement.

Chief Officer, Health and Community Services:
Yes, there has been an improvement. Yes.

The Minister for Health and Social Services:

Well, I have to say the unit itself is extremely impressive and I do not know if you have had a chance to visit it. If you do not mind me saying, genuinely you might find it a useful experience to see what that investment is.

Chief Officer, Health and Community Services:
The environment is so much better.

Assistant Minister for Health and Social Services:
I think, Deputy Stephenson, you will be pleasantly surprised.

Deputy L.K.F. Stephenson:
I can compare it to my previous experience.

Assistant Minister for Health and Social Services:
Yes, exactly.

Deputy J. Renouf:
Are you happy for me to move on?

Deputy L.K.F. Stephenson:
Yes.

Deputy J. Renouf:
Moving on to health funding reform. Sorry, yes.

Deputy P.M. Bailhache:
May I put a question to the Minister?

Deputy J. Renouf:
Yes, please do.

Deputy P.M. Bailhache:
In the informal discussions that we had with some of your officials on maternity issues, we discussed the Amelia Clyde-Smith case. It is customary for people to say that lessons have been learned, but can the Minister be a little bit more specific and tell us what lessons have been learned from what was a catastrophic event?

The Minister for Health and Social Services:

You are probably closer, given your background, to the absolute detail of that than I am but what I can say is that with the change in the facilities and the change in general approach to governance, I think people can rest assured that there has been a dramatic improvement. I think for more detail than that, it is probably worth Chris coming in.

Chief Officer, Health and Community Services:

Sir Phillip, of course this tragic case happened some years ago, so over the course of time a number of the issues that led to that sad event have been addressed and through the Maternity Improvement Plan that we have already, we are addressing those issues. There are still on-going things that we need to address with regard to the individuals involved. That is a separate investigation that is taking place, which I will not talk about here. Our relationship with the U.K. (United Kingdom) and Southampton, the transport arrangements, the whole issue that led to that tragic event has been taken very seriously. I do not know if our Deputy Medical Director, Simon, had anything to add to that.

Deputy Medical Director, Health and Community Services:

I think you have covered the fact that we have what is called a maternity improvement programme.

Deputy J. Renouf:

I think we will need you to come to the table, sorry, otherwise you are not going to be on camera and not going to be heard, I beg your pardon. If you just introduce yourself.

Deputy Medical Director, Health and Community Services:

I am Simon West. I am the Deputy Medical Director. Chris has already alluded to the fact that we have a maternity improvement programme which has been in place now for over 9 months. From that, we have taken actions that have been generated from various college reviews and independent reviews conducted by specialist obstetricians into that specific case. The programme is RAG (red, amber, green) rated. We have now closed all of the red recommendations and we are working through the amber recommendations. We have taken the feedback from the inquest itself, incorporated that into the programme, and are working with the Maternity Department to ensure that that is carried through. It is not something that would stop, it is something that we would continue to do for as long as we need to do. Some of the amber recommendations that are there on the workflow are some things which will stay in progress for a long period of time. An example of that being what Chris just alluded to, the cultural aspects. Cultural aspects will take a long period of time to clear and that is work that we are actively doing with the department.

Deputy P.M. Bailhache:

Are you reasonably confident that an event like that would not take place again today?

Deputy Medical Director, Health and Community Services:

I am reasonably confident that an event like that would not take place again today. I think a lot of learning has been undertaken over the period of years since that event occurred. Obstetrics is a high-risk field. It is difficult to attract obstetricians to come to work in an isolated jurisdiction such as Jersey. We have a substantive workforce that has been here for quite some time, but being a high-risk field there is always going to be the possibility that something will happen with any obstetric delivery.

Assistant Minister for Health and Social Services:

Can I just say that, on behalf of all the ministerial team, we are so sorry and send our sincere condolences to her family, as everybody does?

Deputy J. Renouf:

That is shared on this side of the table too. Thank you. I beg your pardon, Phillip, I forgot that you had a question. Minister, you recently reported that you plan to double the amount of money received from private patients over the next 5 years with a strategy that commits to expanding the choice of service provision back to Islanders by enhancing the private health care offer, attracting skilled professionals to Jersey and increasing income to the benefit of all others. Can you provide the panel with more detail about the private health strategy?

The Minister for Health and Social Services:

Well, that is the hope. Nobody is guaranteeing that we can actually achieve that, but it certainly makes a great deal of sense to all of us to try and get more money from private health insurance because obviously every pound that comes in from that has a pound that comes off the taxpayer and that saving can then be reinvested for people that get their health funding from the state. But we have to bear in mind that we have got a new hospital coming online and I think that gives us a great deal of opportunity to extend into that area as well. So that is the hope that we can combine those 2 things.

Chief Officer, Health and Community Services:

Would you like me to add to that?

The Minister for Health and Social Services:

I would like you to, certainly, if you can, yes.

Chief Officer, Health and Community Services:

Of course, when we looked at the development of that strategy, we recognised that Jersey is different to the U.K. We are seeing 30 per cent of residents of Jersey have health insurance, it is 12 or 16 per cent in the U.K. something like that, so there is a significant difference. We believe that there are opportunities - and there are opportunities, because we have seen it already - where we can generate income through private practice that then supports public services. As the Minister said, with taxpayers' money being limited, we need to find alternative sources of that income. A good example that we have seen is that during the course of end of last year we had waiting lists for routine M.R.I.s (Magnetic Resonance Imaging) at some 52 weeks a year. We agreed with the Radiology Department that we would put some risk funding to staff up more sessions in the MRI and 50 per cent of those would be for public patients and about 50 per cent for private. It was the 50 per cent of private patients that we saw that funded the staffing for both, which we could not have afforded without that private income. That saw waiting lists go from 52 weeks to 6 weeks. They have gone up slightly at the moment because we have had a drop in staffing, but we are working to bring that back in. So I suppose it is a small example of how you can use private practice, and it happens in the National Health Service as well, to fund public services. Of course, many people who have sat on our waiting lists or received care are holders of private insurance and are just not using it. We have a number that self-pay, of course, like everywhere else. We - and our experts in private healthcare - believe that there is a significant opportunity to strengthen private healthcare on the Island, but that, in turn, is a win-win for public patients. We would not see a deterioration but in fact a strengthening of public services through that income.

Deputy P.M. Bailhache:

Is it fair to say that there was an initial reluctance to engage in this enhancement of private health in relation to the M.R.I. thing and has that hiccup been overcome?

Chief Officer, Health and Community Services:

Yes, I think, as I say, different leadership teams have different views on private practice like individuals do, I guess. I always saw the potential when I worked in the N.H.S. (National Health Service) as a chief executive for the benefit of public and the taxpayer to generate that income. It is important to attract consultants, certainly in some specialties. As Simon said earlier, it is difficult to recruit people onto the Island. Private practice is an incentive in some specialties, not everyone, but to some. It is an important aspect of consultant recruitment. I personally, certainly the leadership team, the senior leadership team, and the board are supportive of that strategy in the direction that we are taking, which we believe can only benefit the people of Jersey.

Deputy J. Renouf:

Can I probe in a little bit more? What guarantees can you offer that there would not be a perverse incentive to maintain waiting lists in order to generate income, because people can then have the

incentive to jump the queue? If there is no queue, it is a bit like when you pay for fast access at the airport, you are not going to pay for that if there is no queue.

Chief Officer, Health and Community Services:

No. That is where the good governance comes in. If we recall the Professor Hugo Mascie-Taylor report around governance, private practice was mentioned there. Part of the deal is that we ensure that clinicians abide by good governance, that it is transparent, that we, through the Chief Operating Officer of Acute Services, and good officers, ensure that we do not see that happening. There is a private patients committee that will monitor waiting lists and the balance. I guess the assurance that I am providing to the Committee is that you cannot have good private practice and fair and equitable services without good governance. It is the good governance that will ensure that that does not happen.

Deputy J. Renouf:

We would not get into a situation where you might not recruit a specialist because that would help reduce waiting lists, which might reduce your private income?

Chief Officer, Health and Community Services:

No. The thing for anyone, certainly for the leadership team, is that the patient comes first. There should be no perverse incentives in relation to private practice. Individuals will have particular views about private practice and that is to be expected but, no, we would not want to not appoint a technologist, a second one, just because we wanted to keep the waiting list long and generate private practice. That would not be something that the board would tolerate or I would tolerate.

Deputy J. Renouf:

Minister, can you summarise what you think the offer is to the private patients? What are they getting in the sense that we might have fears of a 2-tier health service, people on private healthcare are going to get a better service? What is it that they are going to get for their money?

The Minister for Health and Social Services:

I think that going forward, as things continue to improve, there probably has to remain some slight difference between private care and public care because otherwise people will not have that incentive. In terms of the new facilities, there is a private ward which will offer that little bit more privacy and so on, but I think when we look at what the public boards are going to offer, that is going to be state-of-the-art in any event. So that differential is probably going to be squeezed up, which is going to make the private health funding that little bit more difficult to achieve because as the standards rise generally people would be less tempted. You still have to maintain some sort of differential to make private health that little bit … it is a very delicate one and that is why lots of

people have got different views on the morality of it and otherwise, but the fact of the matter is if it is delicately handled and everybody is open and honest about how it is being done, then I think you can maintain that necessary tension to balance off getting in the extra money to offset the money that is required from the public purse. I accept fully that it is a difficult one.

Deputy P.M. Bailhache:
The key issue must be that if somebody is seriously ill and needs some urgent treatment it does not matter whether he or she is a private patient or public.

The Minister for Health and Social Services:
Unquestionably, that is not an area for consideration at all. If somebody needs urgent treatment, that is urgent treatment and money does not come into it.

Deputy P.M. Bailhache:
You have to improve the quality of the accommodation which is available to private patients.

Chief Officer, Health and Community Services:
Which we have done.

The Minister for Health and Social Services:
Indeed, yes.

Assistant Minister for Health and Social Services:
Perhaps give them nice food.

Chief Officer, Health and Community Services:
We have refurbished Sorel Ward, many of you might remember it used to be the private ward pre-COVID. We have smartened that up. It has not been an expensive effort but we have given it a lick of paint, it certainly looks a lot nicer, and branded it appropriately so people wishing to use their insurance or self-pay will have the sort of facility that you would expect. As the Minister said, the new hospital is going to be excellent, but we have provided that improved environment. Of course, with private practice, you can choose which consultant. There is a time differential. You are buying quicker access - that is true the world over - but we have to ensure is by using the income that we generate from private practice, we reinvest that in public service to ensure that we also reduce the waiting times for, as we have done with MRI, public patients.

[14:45]

At the moment, as I said, many of the patients who have been receiving private care since we started the strategy are patients who would otherwise have sat on the public waiting list. They come off the public waiting list, which shortens the public waiting list as well. We are not in the position, because that is year 3 of the strategy, where we are generating an increase in the numbers of people we are treating. It is the funding source for the existing patients, by and large, that would otherwise sit on the public list.

Deputy P.M. Bailhache:

Is there any resistance within H.C.S. itself to enhancing the private health aspect?

Chief Officer, Health and Community Services:

I think the resistance is what you might expect. Anywhere where I have worked in the last 30 years, there are some people that are opposed to private healthcare for all sorts of reasons, political reasons, ideological reasons and that is fine. What you do not therefore tend to use is … if you have a nurse that is opposed to private practice, do not put them on the private ward because that is not appropriate for them or anyone else. From a clinical point of view, we have engaged with clinicians over the past year to develop this strategy and there was a great deal of support for it. As I said, there are benefits to recruitment, but some people will approve and some people will not. That is the case the world over.

The Minister for Health and Social Services:

I think the important thing is to be transparent about what we are doing and continuously articulate the benefits that accrue from doing it. If you are honest with people about the way you are going about it, you are honest about what those benefits are, then most people will be able to take a judgment for that and judge for themselves that it is the right thing to do. I think it is incumbent upon everybody involved on this side of the table to make sure that that is done properly.

Chief Officer, Health and Community Services:

I know the board will insist … what I have been used to is that at the end of the year we are reporting as to how much we have made in private practice and what we have actually done with it, how we have reinvested it in state services, so it is very transparent about how that money has been … that income has been used.

The Minister for Health and Social Services:

The better our digital processes are, the more information we can put out to the public domain, the more confidence we can buy on that front.

Deputy L.K.F. Stephenson:

Just for absolute clarity, because I do not think we have quite got there and I think it is important for the public record, can you just clarify that there is no clinical difference between what a patient would receive in private or public?

Chief Officer, Health and Community Services:

No, absolutely. The clinical outcome is exactly the same.

Assistant Minister for Health and Social Services:

The clinicians would always have exactly the same standard for public and private.

Chief Officer, Health and Community Services:

Yes, the clinical outcomes.

The Minister for Health and Social Services:

It would all fall apart very quickly if that were to change.

Assistant Minister for Health and Social Services:

You could not do anything but that.

Deputy L.K.F. Stephenson:

The same access to drugs and things like that.

Chief Officer, Health and Community Services:

Yes. If there are drugs which are not approved by N.I.C.E. (National Institute for Health and Care Excellence) for example, which is the guidelines that we use, then there could be an option for a patient to have discussions with the consultant if they wish to try those drugs but the States would not pay for them. It would be a private purchase.

Deputy J. Renouf:

The other thing that might play into this is the fear that the top consultants, if you like, do all the private work and the more junior people do the state sector work. Can you offer any reassurance about that?

The Minister for Health and Social Services:

Those are clinical matters.

Chief Officer, Health and Community Services:

Yes, those are things that, if that were to be the case, we would soon hear about it and it is something that we would address with the teams involved because of course that is not conducive to good team working either.

Deputy P.M. Bailhache:

It is a governance issue.

Chief Officer, Health and Community Services:

It is a governance issue, yes.

Deputy J. Renouf:

My final question on this is you have talked about a doubling of income. I think that is 12 to 24 or something. I cannot quite remember the figures over a 5-year period.

Deputy L.K.F. Stephenson:

Yes, over a 5-year period, yes.

Deputy J. Renouf:

How realistic is that given that there have been documented problems with some of the services in the hospital? Is it not more likely that people will choose to take their money to the U.K.? What can you do in practice to deliver that kind of increase?

Chief Officer, Health and Community Services:

We have to improve the quality of service that we are providing. It is a stretch target. We wanted to be ambitious about it but improving services for everyone of course is an important part of that strategy. You are right, Chair, if we provide poor quality services, no one is going to pay for them and, indeed, it would let the people of Jersey down. The way we can achieve that is making sure that services are better for everybody.

Deputy L.K.F. Stephenson:

I have sensed a recurring theme in a lot of the discussions we have had today about you wanting to hear from people if things are not going right. You very kindly, as you say, responded to me today very quickly about the case. Is that the message to people? You want to hear if things are not working.

The Minister for Health and Social Services:

I will just say we are not inviting to hear from more people than we do already. We hear an awful lot. What we are hoping to do is, as the system increases, hear from less people because we are hoping that there are less people that have something to say.

Assistant Minister for Health and Social Services:
We hope that one of our ambitions as a ministerial team and working with the executive is that things are going to get better.

The Minister for Health and Social Services:
We have an empty inbox.

Assistant Minister for Health and Social Services:
You will not have to email us.

Chief Officer, Health and Community Services:
We do have the Patient Advice and Liaison Service.

Assistant Minister for Health and Social Services:
Yes, that has improved.

Chief Officer, Health and Community Services:
I think we have been trying to raise the profile of that service so if patients have concerns, they can raise them quickly. What we want to do is resolve issues before they become a formal complaint. We would encourage people to deal with the issues there and then and then we can deal with them there and then rather than wait for a formal complaint to be managed.

The Minister for Health and Social Services:
As a layperson, I would like to just mention the P.A.L.S. (Patient Advice and Liaison Service) team. We went and had a session with them and they are an impressive bunch of people who are very, very committed to doing their job properly.

Assistant Minister for Health and Social Services:
Hopefully, a lot of these things will be addressed on the ward level, so if something is not working on the ward level, perhaps it could be sorted out then before it becomes a bigger issue.

Deputy L.K.F. Stephenson:
Thank you. On Health funding reform - to go from the very localised into the wider discussion - can you, Minister, tell us how the work on that is progressing?

The Minister for Health and Social Services:

I will make a few comments before I hand it on. I think funding has been one of the critical issues that we have had to address. I know these good people have been addressing that for a very long time. Is it fair to say for the first time proper throughout the process we now have a very full picture of where we are?

Chief Officer, Health and Community Services:

Yes.

The Minister for Health and Social Services:

I think we know pretty much - and I am going to be struck down at some point - in reasonably absolute terms where we are with the finances. Discussions are going forward. Obviously, we have to have something in the Government Plan for the following 2 years and I think we know roughly where we are and why we are where we are. There is an interesting drivers of the deficit document that I think, if you have time, is worth a read because it casts a great deal of light on why we are in the financial position that we are in. The reason I am going on about the historic finances is because you have to have a baseline to work from and have some certainty. If you do not know where you are, you cannot start working on where you are going to bring money in and how much money you need until you have that baseline. I hope I am not talking out of turn but certainly from the parts that I have been involved with, I think we have reached a point where we realise what is now needed and we realise why we need it. That does not just have to appear in the Government Plan. That is going to have to be properly articulated and we are going to pass that on to you in the first instance and then I think perhaps have a briefing with the Assembly. I think everybody needs to know why we are where we are. I have to say, having not been involved in this in the past, I think the common view was that there is a huge amount of money being wasted and everything is completely out of control. There are a huge amount of different things that have come into the equation in recent years for various reasons, not least of which is that the Assembly have a series of good ideas to vote for something, happily think it is a good idea and there is another £1 million there and another £500,000 here. These poor folks then are on the receiving end of having to fit all of that into an existing budget. As I say, it is not worth me trying to list the numerous things that have given rise to where we are but I think once we have recognised those, we will work to try and put that into a single document that you can put up on the wall. It is to create a simple description of where we are. It is quite a difficult task but once we have done that, we will seek to articulate that to everybody so that we can say: “Here is the baseline, this is what we will need going forward and these are the projections going forward.” Then we can start to work out to what extent the Treasury can muster up the money that we require as a baseline, how much we need and where we are going to get it from. That will tie in with a degree of restructuring around the Health Service and the possibility of

centralising things and possibly centralising funding. These are things that are all up for discussion but these are relatively early days because, as I say, without a baseline to work from, I think it is very difficult to work out where you go from there. I think we are making definite progress but it is early days. I do not know whether you want to speak further on that.

Deputy L.K.F. Stephenson:

Before we move on, just for clarity, is part of the Government Plan that we will expect to see a long-term forward look about the finances or is it going to remain short-term at this stage?

The Minister for Health and Social Services:

We can both make comments but I think it is important that we bottom this one out because it is one of the biggest problems that we confront.

Chief Officer, Health and Community Services:

I think from the point of view of the immediate, i.e. what this year-end is going to look like and what we need next year, there has been quite a lot of discussion around the Government Plan - and you have been involved in it, Minister - as regards to the future and that is something where there is further work to be done. I think from the Government Plan point of view, there is a need to be clear about what the next 2 years might look like but, thereafter, that is when it kicks into the health funding reform and the issues that Ruth has been leading on about what we do in Jersey, as is debated across the globe and what jurisdictions do, to afford health care going forward.

Deputy J. Renouf:

Can I interrupt for a moment? I thought there was a tantalising moment there when the Minister said: “We finally have our hands on the data and we knew what was coming” and so on but now it seems to be slipping away from you.

The Minister for Health and Social Services:

To add a tiny bit more context to it, one of the things is health costs have increased more quickly than everything else. I think the onward trajectory is going to be quite sharp and not because you have a baseline for where we are for the next 2 years that that solves the problems. All it does is it gives you a better platform to work from than that which we have had already. Perhaps I have been a bit too optimistic in the way I have articulated it.

Deputy P.M. Bailhache:

The Minister was putting his head on the block, I must confess.

Deputy J. Renouf:

“Clarity” he said. Clarity.

The Minister for Health and Social Services:

One thing I can say is I think there is greater clarity now than there has been at any point in the past.

Chief Officer, Health and Community Services:

I think with regards to why the Minister mentioned drivers to the deficit - and I think our Finance Director for the previous Scrutiny gave a detailed briefing as we do for this Scrutiny - understanding what has got us to where we are has been an important part of the work that we have been doing. Getting through the issues of reconciling information and data, both financial and workforce, has not been the easiest of tasks to be quite honest. We are, as the Minister said, pretty clear now about what we are spending and where we are at as regards to why we are where we are and that has allowed us to give a clear view about what we think we need this year and next year. We know that those costs are going to rise and the big debate then is how the Government and Jersey can afford to bridge what will be a constantly rising cost pressure.

Deputy P.M. Bailhache:

Yes, but one of the alarming things that we were told not so long ago was that health spending was out of control and what the Minister I think is saying is that it is no longer out of control in the sense that you know what the baseline is.

The Minister for Health and Social Services:

I really do need to think more carefully about phrasing that. He is trying to speak so that I do not.

Chief Officer, Health and Community Services:

I think just to be clear, what we are saying does not mean there are not savings to be made because there are as we know that we are spending too much on locum and agency staff. However, the projections that are likely to happen over the coming years into the future efficiencies alone will not be enough to bridge the gap between costs and income.

The Minister for Health and Social Services:

The point I was trying to make, perhaps rather badly, is that the position that we found ourselves in, contrary to popular belief in some parts, is not all down to mismanagement.

Chief Officer, Health and Community Services:

No, it is not.

The Minister for Health and Social Services:

There are a number of different factors that have driven what is quite a considerable deficit. The point I was trying to make is that having an understanding of the various factors that have been pulled forward perhaps under enormous circumstance would have been known about on an ongoing basis. This poor team have had to dredge all of that information through to make sense of it. Maybe I am wrong.

Chief Officer, Health and Community Services:
No.

The Minister for Health and Social Services:
I am led to believe that we have the best view so far of where we are.

Chief Officer, Health and Community Services:
We know why we are where we are.

The Minister for Health and Social Services:
Indeed, and if you do not know that, then you are in trouble.

Deputy L.K.F. Stephenson:
The previous panel was told in November 2023 that those financial forecasts had been developed and the next stage was it was going to the Council of Ministers which would happen the following week and Scrutiny would be made aware. There was a timeline and a commitment in place I think in the current Government Plan that this issue will be addressed and brought to the Assembly in 2024. Is that all still the case?

[15:00]

The Minister for Health and Social Services:
Absolutely.

Chief Officer, Health and Community Services:
That is where Ruth's work kicks in.

Director of Health Policy:
The piece of work that that is referring to is the piece of work that we call health funding reform so that is about future health and care costs. It is not about today's health and care costs which have just been the subject of conversation. Yes, we briefed the previous Scrutiny Panel on some work and that we intend to produce a set of what are called national health accounts. It is a standard

O.E.C.D. (Organisation for Economic Co-operation and Development) methodology for counting health spend across jurisdictions. What the national health accounts do is it does not just count government spend. It also looks at spend that comes in from private insurance and, very importantly, out of pocket spend by Islanders as well. We have produced some national health accounts. That has given us some insights into where Jersey is today and some of the things that we need to think about addressing as we move forward. For example, the national health accounts that we have produced tell us that our overall spend on health and care in the Island is broadly comparable as a percentage of G.D.P. (Gross Domestic Product) as other O.E.C.D. jurisdictions. It also makes it very clear that, out of that comparable total spend, we spend really quite significantly more on hospital based care than we do on primary care and prevention care, which is a very valuable insight into where the flow of the money is and one of the things that we might address as we move forward. It also shines a light on the complexity of our funding system. Most other jurisdictions have a predominant form of funding so it is predominately social insurance or predominantly taxation-based funding. Jersey is notably almost unique from the other countries of the O.E.C.D. in that we have a very mixed funding model so it is part taxation, part hypothecated tax, part contributions and part out of pocket spend. That complexity of how we raise the funding also creates some potential challenges about how we govern that funding and how we make decisions about how we spend that funding across the whole of the health and care system. We have done that initial work. We have also, on the basis of those national health accounts, flung forward potential costs over 20 years factoring in health inflation, which is the general cost of the increases of medications and treatments, and also looking at changes in our population. What is clear from that is what we already knew anyway which is that, as the years progress as a jurisdiction as with all other jurisdictions, we are going to have to invest increasingly more money in our health and care services if we are to continue to deliver the healthcare services that we have today. Now we can push down some of those increased costs through efficiencies but we will not achieve a no increase position though efficiencies alone. We have the ministerial group that the Minister mentioned earlier and what we are going to be doing with that ministerial group is we are going to be looking at options for how we address the need to increase the monies that are spent on our health and care services as we move forward.

Deputy L.K.F. Stephenson:

That ministerial group includes who and is it working together already?

The Minister for Health and Social Services:

Yes, and once again, it is early days. There have been only a couple of meetings for various reasons because it is not worth having meetings in the first weeks when you do not know what you are doing but it includes Treasury and Social Security because those are the ones that are most directly affected and obviously the ministerial team.

Deputy J. Renouf:

Does that work include looking at funding options and not just what the funding demand is going to be? Does it look at how we might fund health in terms of whether we might increase the insurance model or whether we might increase the taxation funding? You are nodding at me so I can carry on with the supplementary which is how are you going to engage with the public to find out what the public might want in terms of the way that they are going to pay for their future healthcare?

Director of Health Policy:

Absolutely. In terms of where the work is at the moment, as I said, we have looked at what the forecasts might look like and we have also done, as policy officers, background desk research on models of healthcare funding in other jurisdictions. We have looked at Germany and France's social insurance models, private insurance only models, tax funded models and pay as you go models. We have done some basic background and research and what we will be doing is we will be working with the ministerial group and the Minister to frame some options which we will then need to take out to public consultation.

Deputy J. Renouf:

Minister, do you have in your mind a preferred formula?

The Minister for Health and Social Services:

Not at this stage, no. It would be wrong to say I do. Nothing is ruled in and nothing is ruled out. We have to approach this with an open mind.

Deputy L.K.F. Stephenson:

Minister, are you able to confidently say that, by the end of your term of office, we will have an answer to this question about how we are going to fund healthcare going forward in a sustainable way?

The Minister for Health and Social Services:

We should be careful about being too confident about anything. Yes, we are working as hard as we can. We have just under 2 years to run and, yes, I am very, very hopeful.

Deputy L.K.F. Stephenson:

Thank you.

Deputy J. Renouf:

If we return just for a moment back to the narrower 2-year window, you have been quoted several times, Minister, of saying you wanted an extra £18 million for health. Is that the figure that you have arrived at now as a result of the servicing of information that you talked about in your first answer to the subject?

The Minister for Health and Social Services:
I am obliged to be entirely honest in these situations and it is more than that.

Deputy L.K.F. Stephenson:
How much more?

The Minister for Health and Social Services:
I am here to tell the truth. It is £24 million.

Deputy J. Renouf:
£24 million is what you expect for the ongoing yearly additional cost?

The Minister for Health and Social Services:
For this year and next year.

Deputy J. Renouf:
For this year and next year so £24 million this year.

The Minister for Health and Social Services:
Yes, we will say for 2025/26. No, 2024/25.

Chief Officer, Health and Community Services:
Yes. This year and next, yes.

The Minister for Health and Social Services:
Yes, 2024/25, sorry, because that is where we are dealing with the scrolled up deficit. That is why, as I say, it is very important for people to understand why that number exists.

Deputy L.K.F. Stephenson:
That is per year?

The Minister for Health and Social Services:
Yes.

Assistant Minister for Health and Social Services:
Yes, additional.

Deputy J. Renouf:
Does it account for savings that you might have made through the efficiency programmes?

The Minister for Health and Social Services:
During that period, yes, it does. Yes, it does.

Chief Officer, Health and Community Services:
Yes, so when we look at what we call the F.R.P. (Financial Recovery Plan), those savings, last year, in just the second half of the year because we only started in the first, we made £3.5 million. We are still on target to deliver more savings this year so that £24 million relies on us making further savings through the F.R.P. and indeed in future years. What we have done is rather than being over-optimistic about the savings is just to spread them a little further into the future because there is some significant recruitment et cetera that is taking longer than we would all want. That £24 million includes savings, yes.

The Minister for Health and Social Services:
I think we have to be honest about it. If H.C.S. would have been required to come down to the budget number that we had, the list of surplus cuts that would have had to have been made would have been quite savage. It is a route that somebody could go down if they wanted to but I think it would be deemed to be entirely unacceptable from every point of view.

Deputy J. Renouf:
I guess the argument from the financial controlling point of view is that health always seems to need more money. Is this a result of the increased demand for health services that is continuous and health inflation, as we know, goes up all the time or is it a result of underfunding over many years?

Chief Officer, Health and Community Services:
I think it is a third thing and that is cost as well. If you look at the costs of our tertiary care social care packages and mental health packages, the costs are rising significantly. One provider that deals with cardiology tertiary work in the U.K. has looked for an increase in what we pay them by an additional £1 million. What we are seeing is significant inflationary costs that are over and above the standard 2 per cent to 3 per cent that we would get as a department or other departments get. The increase is in the costs of medication and certainly specialist medication very recently we have had to pay for. Simon, how much was it per month for the C.F. (cystic fibrosis)?

Deputy Medical Director, Health and Community Services:

No, it was more than that. It was £100,000 per individual per year for 3 individuals.

Chief Officer, Health and Community Services:

Yes, so 3 individuals is £300,000 that we were not expecting to spend that we did. You are seeing an increase in demand but not dramatic so it is not a direct correlation. The big issues have been cost and the rising costs of healthcare and that is the same all over the world. The work that is being done by the economists that Ruth has employed, the work that has been done by the internal teams, the work that indeed was done by the Jersey Care Model showed a significant and exponential rise in the costs of healthcare that only certain actions could suppress but not resolve. That is why I think the health funding reform is just so important. The cost of healthcare has increased significantly and continues to do so.

The Minister for Health and Social Services:

We have come back to this baseline requirement. What I feel we are obliged to do on this side is if we are saying to the Government that is £24 million for this year and £24 million for next year, the obligation is on us to explain that in simple terms as to why that is and that is what we are committing to do in the not too distant future.

Assistant Minister for Health and Social Services:

Things like oncology drugs have become so expensive and then for diabetes, now people can have special pumps for those so they do not have to prick their fingers every day but that all comes at a cost every month per diabetic.

Chief Officer, Health and Community Services:

In the U.K. as a trust chief executive, in my budget as regards those high cost drugs, there was a cancer care fund that was a national fund so with certain high cost drugs, rather than it impact on my operational budgets for running the hospitals, it would be funded centrally so I would not see that hit my bottom line, for example, whereas we do not have this in Jersey at all. There is no reserve from that.

Assistant Minister for Health and Social Services:

Yes, because I think in the U.K. they do have to have something like our strategic reserve so that you have some give in the system.

Chief Officer, Health and Community Services:

It becomes very obvious in our operational budget, the bottom line, those costs.

Deputy J. Renouf:

Are you sufficiently confident in your figures to say that it will not go up from £24 million?

Chief Officer, Health and Community Services:

I think we are to a point but if we see some more patients, for example, like the ones we have just described that we do not know about yet, another 4 or 5 people are going to cost us another £500,000, £1 million. We will not know about that so there may be some exceptional and extraordinary costs that are not yet known to us.

The Minister for Health and Social Services:

What we can do in establishing the clear baseline over 2 years is clearly identify any exceptional items and deal with them as such so everybody has clarity on saying: "Here is an honest picture." If everything goes completely wrong tomorrow and there is some great disaster, I think everybody will understand that that has to be treated differently. If the operational baseline is there, everybody has clarity on what the starting point is. For example, if something comes to the Assembly that required £500,000 or £1 million, the Assembly will then have to be mindful that that cannot come out of the H.C.S. budget. It will have to be accompanied by us saying if it is £500,000 required: "Here are the cuts that we are going to have to make" to introduce whatever thing you want to bring in unless the person bringing the proposition has a proposition to fund it as well. There has to be total clarity on both sides, we are drawing the line on this side as to what is required to run the health service that people expect at this point in time but if somebody wants something else, they have to inform us as to how it is going to be done.

Chief Officer, Health and Community Services:

I think we have seen the exceptional costs of the rheumatology situation where additional funding was provided to manage the costs of rheumatology both last year and indeed this year. What we cannot predict - and we are not expecting anything - is if anything like that happens again or there is a major incident. From the point of view of our general operating costs, as long as there is not an extraordinary increase in demand that we have not predicted or do not know about, then we are expecting to live within the £24 million.

The Minister for Health and Social Services:

Exceptional items will be identified and taken to the Assembly and dealt with as such.

Deputy J. Renouf:

That is going to be in the Government Plan so your discussions with the Treasury have begun on this or, presumably, you are expecting it.

The Minister for Health and Social Services:
Yes. Quite advanced I might say, yes.

Deputy J. Renouf:
The expectation is this will be paid for out of general taxation.

The Minister for Health and Social Services:
That is a discussion we will have with Treasury but Treasury are aware of where we are.

[15:15]

Deputy P.M. Bailhache:
Can we turn, Minister, to primary care? Since 2021, I think it has been fair to say that there has been a commitment to what was called a sustainable funding plan which would have seen the Health Insurance Fund re-purposed which some people interpreted I think as a move towards a system of free access to primary care. Is that the policy of this Government?

The Minister for Health and Social Services:
To make any changes to that?

Deputy P.M. Bailhache:
We have a system at the moment whereby primary care is paid for in part by the patient, in part by a contribution from the Health Insurance Fund and I am asking whether there is any plan to change that.

Assistant Minister for Health and Social Services:
Can I just butt in here? Can I say that I think that that is down to the Minister for Social Security but I think she is of the opinion that it will carry on as it is. Although she would like to make it free, she realises that we cannot afford to do that or she cannot afford it out of her budget.

The Minister for Health and Social Services:
That question would not strictly fall under our remit. Are you asking are there intentions for us to attempt to raid the Health Insurance Fund? Is that what the question is?

Deputy P.M. Bailhache:
I am sure you would not dare to do that.

Assistant Minister for Health and Social Services:

No, we definitely would not. There would be a lot of opposition from 2 of your Ministers.

Deputy P.M. Bailhache:

Yes, this is really a matter for the Minister for Social Security. So far as the Health Department is concerned, there is no plan, as it were, to raid the Health Insurance Fund to bring that money into the Health Department.

Assistant Minister for Health and Social Services:

I think if you listen to 2 of the Assistant Ministers who joined you on the Scrutiny Panel, I think you will know our point of view.

The Minister for Health and Social Services:

I think all 4 of us have been very plain in our approach to how it was dealt with before. Though I do have to say that, going forward, if we are going to look to restructure health, I would like to think that, while things may remain as they are, nothing should be off the table in terms of how we look to restructure to make things more efficient, which might be a combination of factors. It might be a combination of funding to simplify things and that would be subject to there being cast iron guarantees. Any collective fund would have to be handled appropriately and deal with all of the things that it is required to deal with at the moment. That is a more complicated one I think for another day and that is thinking very much in its early stages, but it would not be with a view to undermining the key intentions of whatever funds we are dealing with were set out to do.

Deputy P.M. Bailhache:

Do you feel that there is a better relationship with the primary care body?

The Minister for Health and Social Services:

I do, yes, I do. Very much so, yes.

Deputy P.M. Bailhache:

Why?

The Minister for Health and Social Services:

I am happy to answer the first question; I do not know if I can answer that one. I can only speak for the atmosphere at the moment. There is a much more relaxed atmosphere than I witnessed at any meetings that I happened to attend in the past or that I was aware of, so I think it is safe to say that the relationship with G.P.s has improved.

Chief Officer, Health and Community Services:

Certainly, Sir Philip, when I arrived we sort of refreshed the joint meeting between the primary care board and H.C.S., and I chair - or it should be jointly chairing but it seems I chair it all the time at the moment so that is not right - but a joint meeting with primary care and H.C.S. executives and doctors where we talk about increasingly clinical issues around pathways and services. We do not always agree on things, you would not expect that, but I think that dialogue there is a regular dialogue. I obviously cannot speak for primary care but I think that has enabled us to address some of the issues that they have as regards referrals and governance, and equally we can with them. So that is something that we are doing. You will be aware that one of the non-executive directors on our board, Dame Clare Gerada, who is a G.P. and was the President of the Royal College of General Practice, she attended the last meeting, is keen to attend future meetings and I think that is helping as well. There is a long way to go, of course, and there are issues and stressors on both sides, but there is certainly a dialogue from my point of view.

Assistant Minister for Health and Social Services:

Can I just say that I do think they were very, very grateful for the increase in the rebate, which had not been increased for over 10 years? They have been not very well treated for that time because they have been just put on the backburner. I think that has helped.

The Minister for Health and Social Services:

A massive contributary factor has been that easing of that situation because I think for a long period of time they felt increasingly frozen out of the frame. In conjunction with a number of other things that has ...

Chief Officer, Health and Community Services:

Money helps.

The Minister for Health and Social Services:

Yes, and it is a situation that should not really have been allowed to occur.

Assistant Minister for Health and Social Services:

It has also helped with recruitment as well and it has eased ...

The Minister for Health and Social Services:

It has eased a whole lot of trouble.

Assistant Minister for Health and Social Services:

It has made a lot of difference.

Deputy L.K.F. Stephenson:

That is something that started, you said, since you have been in post. How long have you been in post?

Chief Officer, Health and Community Services:

April last year.

Deputy L.K.F. Stephenson:

So there has been 2 increases, have there not, to the payment?

The Minister for Health and Social Services:

There have been operational factors, political factors, yes, it is a combination of things.

Assistant Minister for Health and Social Services:

Yes, I think they have really helped, and also the fact that patients now have much better access I think.

Chief Officer, Health and Community Services:

Sorry, I had nothing to do with the rebate so ...

The Minister for Health and Social Services:

No, but as I say, it is fair to say there is a combination of different approaches from areas ...

Deputy L.K.F. Stephenson:

Over the past 18 months or so, yes.

The Minister for Health and Social Services:

... that in combination have led to there being a much better connectivity between the 2.

Deputy J. Renouf:

My reading of that then is that then is that essentially the H.I.F. (Health Insurance Fund) will continue in its present form until such time as work on future funding may suggest something else, but essentially if things happen within the H.I.F. it will be tinkering rather than ...

The Minister for Health and Social Services:

Yes, and as I say, it is not our fund essentially, is it, so subsequent to ...

Assistant Minister for Health and Social Services:

It belongs to each and every one of us who are contributing.

The Minister for Health and Social Services:

Yes, there is no clandestine sort of ...

Deputy L.K.F. Stephenson:

I would like to move on to the hospital pharmacy now, really as a follow on from the last quarterly hearing where we talked about plans for a bigger piece of work, and I think, Minister, you said that you were going to have a briefing around some of the complications and obstacles that there were there. Obviously at the time we know there were long queues and there were complaints from members of the public. Can you give us a brief update on all of that, please?

The Minister for Health and Social Services:

As much as I have been briefed you are going to get a much more comprehensive answer to that from either Chris or from Simon.

Chief Officer, Health and Community Services:

I suppose there are sort of 2 aspects to the debate of queuing. One is the operational things that we have been doing and can do - and Simon will talk about some of the things that we have put in place - the second of course is a much bigger debate and again with our colleague, the Minister for Social Services, about how drugs are funded and indeed whether at the moment ... the hospital pharmacy dispenses about 4 times as many prescriptions as you would see in a hospital in the U.K. of our size. About 50 per cent of the drugs that are prescribed and dispensed in the hospital are drugs that are available on the G.P. list and could be provided by community pharmacists, so you do not need to queue up at the hospital. It is a significant number. Over the years the numbers have increased. That is obviously a bigger political debate about the funding source but we have been making some operational changes that we believe are making improvements. Simon, are you happy to talk about those?

Deputy Medical Director, Health and Community Services:

Yes, certainly. We have changed the format in terms of the outpatient prescribing, so a lot of the prescriptions that come through the hospital pharmacy throughout the week are as a consequence of outpatient prescribing, both for public and private patients. So we have moved to an electronic prescribing mechanism which has been tested initially through 3 clinics last year, then rolled out for the inauguration of the Enid Quenault and then has now been rolled out completely, so all of our outpatient prescribing goes through what is called E.P.M.A. (Electronic Prescribing and Medicines Administration). That means that particularly for Enid Quenault, for example, your prescription will

literally be out of Enid Quenault before you are, and has the likelihood of being ready for you when you come to pick it up from the main hospital. Other mechanisms that have been put in place have been texting and a telephone service, which has required resource, as has the E.P.M.A. which has required additional resource, so moving from a paper based system to a digital system had the unintended consequence of taking up some additional resource in terms of people sitting looking at the computer screen and actioning the requests. One of the disadvantages of prescribing in any mechanism, whether it is paper or electronic, is the fact that doctors do not always get things right, do not necessarily know a dose or that sometimes a drug might not be available. We have seen an increasing level of drugs not being available, not just here but worldwide, and so the pharmacist has to contact the doctor to say: "We do not have this drug, we do have this drug, are you happy to use a biosimilar?" Sometimes when they get it wrong: "You have written this dose; did you mean this dose because that is 3 times the normal dose?" and they can correct the dose. Again, with Enid Quenault there is a big advantage to that because before what used to happen is the patient used to come all the way down to the outpatient pharmacy in the main hospital for that then to be discovered, for them then to have to make the call and the patient have an additional wait. So by making it digital that prescription can be reviewed far more expediently and a telephone call made back to the doctor. Yes, there is still going to be a little delay getting hold of the doctor, but that can be corrected even before the patients get down to Enid Quenault, particularly if it is 4.30 p.m. on a Friday.

Deputy L.K.F. Stephenson:

That is great to hear and I have to say I did go past yesterday and it was much better than my experience of a couple of months or so ago. Do you have times of where we are at now with how long people are waiting ... because obviously I appreciate the electronic prescribing means you do not have to queue to put your prescription in, but there is still a natural queue to go and pick it up. Has that improved?

Deputy Medical Director, Health and Community Services:

The baseline data, and it is relatively raw in terms of we have gone completely live in terms of the whole of outpatients, suggests that there has been an improvement but I think it is too early to be able to say we have reduced it by 75 per cent, 50 per cent, 40 per cent, whatever. But that is certainly a piece of work that needs to be done to show that we have had a quality improvement and an overall decrease in the length of time. I am very aware from social media, I have seen comments that have been made, particularly after the article in the *J.E.P. (Jersey Evening Post)* which said that the texting and the telephone service is not as robust as we might want it to be. I think what is important to recognise is that all of these things have been put in place and will need to be tested through time more than anything else. The other mechanisms that have been alluded to in trying to improve the service is that we are having a wholesale review of pharmacy, which is being conducted

at this time. It has been running for 2 days. It is an external team that has come in to review our processes and to look at pharmacy as a whole, so it is not just to look at dispensing outpatients, it is to look at inpatients, wards how we interact with the community, and equally to look at the cultural aspects as well, so it is literally a wholesale review. Now, they will provide us with a report hopefully by the end of June. I met with them yesterday and we discussed timescales for a report to come back to Health and it would normally - as we do with all the reports that come through from external reviews - look at taking that back through the senior leadership team and ultimately through the board.

Deputy L.K.F. Stephenson:
It would be public at that stage?

Deputy Medical Director, Health and Community Services:
It would be public, yes.

Deputy L.K.F. Stephenson:
Sorry, who is carrying out that review? Is it an organisation that we can …

Deputy Medical Director, Health and Community Services:
No, it is 2 chief pharmacists who currently work in London, who I will admit that I had connection to from my previous employment in West Hertfordshire. The advantage to them was time in terms of getting a review at pace because we did not have a facility to get a review at pace and I think the situation demanded a review at pace. The other advantage is that one of those pharmacists has a strong management background, is part chief pharmacist and part senior management team within that establishment so has a working knowledge of how the management structure works and the challenges that would face any senior manager, of which our chief pharmacist would be counted as one.

Chief Officer, Health and Community Services:
I wonder, Chair, if I could also add that I have agreed to an additional 7 posts in pharmacy. Of course that is half the battle because of course recruiting is the issue, and with those 7 vacancies our vacancy rate - and of course we are having to cover by locums which again are high cost - is around 30 per cent. But we have checked what the U.K. position is on vacancies in pharmacies in hospitals in the U.K. and it ranges anything from 30 to 50 per cent. So our vacancy rate is not out of line of what you might see in the United Kingdom, and I suppose demonstrates a challenge in hospital pharmacies. Here, and in the U.K., working in a community pharmacy or in a chemist can be more attractive, it sometimes can be paid better and of course the hours of work and the stress is probably less. So we face challenges in recruitment so agreeing 7 posts, because those 7 posts

would clearly help if we can recruit them, is the challenge around recruitment. We have got some of those posts covered by locums but even trying to find locum pharmacists is very difficult because it is an increasingly competitive market.

Deputy L.K.F. Stephenson:
Staffing and culture and things is all part of the review, is it?

Chief Officer, Health and Community Services:
Yes.

Assistant Minister for Health and Social Services:
Can I say that - which is rather unfortunate - we have lost quite a few pharmacists, so that is all part of the review I think.

Chief Officer, Health and Community Services:
Yes.

Deputy Medical Director, Health and Community Services:
We have included previous staff and recently departed staff so we can understand the reasons for people leaving the department. We are being open and transparent; we would like to understand why previous colleagues have wanted to leave H.C.S. and why they felt it might be more beneficial to go to work in other centres on the Island, and whether that related to pay, whether that related to culture, whether it related to lifestyle, whatever it might have been. We want to understand that because that way we can improve the service.

[15:30]

Deputy J. Renouf:
Moving on to waiting lists more generally, are you able to provide a general update on waiting lists in terms of where we are at in the hospital?

The Minister for Health and Social Services:
I think you require a full, accurate, up to the minute update.

Chief Operating Officer, Acute Services, Health and Community Services:
Hi, I am Claire Thompson, I am the Chief Operating Officer for Acute Services. So in general I think it is a really positive position in terms of our waiting lists. The public will have been able to see the recent reports that were available online due to the public board last week, and we can really see

that not only the volume of the waiting lists both for inpatient and outpatient activity is reducing, but particularly important to patients is how long they have to wait. So we have set ourselves some really significant targets around reducing the amount of people that we know that have waited a long time, and particularly we can see how we have really obliterated the number of people who are waiting a long time for outpatient activity. As of course we have caught up with our outpatient activity some of that has then knocked over into people needing to come in for elective care. While that did increase slightly over winter we can see that is now really plummeting since the start of this year, and we have opened more beds within the hospital to allow us to do that. So in keeping with the conversations earlier about access, we have also set ourselves some new targets around how we are assured that people are being seen in line with their clinical triage. So unfortunately patients who are being referred under a routine process, and that is obviously the clinical criteria set by a clinician, so a G.P. will refer and it is ultimately the consultant that confirms whether that is an urgent or a soon or a routine. But we are really assured that people who are sitting within that urgent criteria, as you were enquiring, Deputy, and particularly those who may have a suspected cancer, we are really confident - and I review on a weekly basis - that those patients have got appointments within 2 weeks and are being seen.

Deputy J. Renouf:

I think at the last hearing it was suggested that we could have quantifiable information regarding wait times. I do not think we have had it yet; will that be forthcoming?

Chief Operating Officer, Acute Services, Health and Community Services:

Absolutely. On the quality performance review it obviously describes our performance against key targets about reducing patients who are waiting the longest, so that is all ...

Chief Officer, Health and Community Services:

Just to say, this is all in the public domain, it is all part of the board process, it is also on the Government website, so there is a lot of information.

Deputy J. Renouf:

The panel is aware of instances where one patient might have multiple health issues and is, therefore, on various waiting lists. They get to the top of one, get referred because they have a complication in the other, and then they go to the back of another queue kind of thing. Is there work being done to address those sort of complex needs cases with multiple things where people do not feel like they are being bounced from one queue to another?

Chief Operating Officer, Acute Services, Health and Community Services:

Absolutely. So some of those specialities, the timing may be important. Other scenarios may be obviously that the referrals could be completely independent. For example, I have been helping a patient this week who needed to be seen in one speciality and a procedure that he needed doing in another was obviously going to help his management in another. So through how we are reforming our patient access centre and working with our appointment clerks, and the new system that we have got, we have got much more visibility on that. I know it is frustrating for patients; they might have one appointment land on a letter for one thing and then another, but we are trying to obviously co-ordinate that better. Particularly with those crucial appointments that are you describing that are integral to a patient pathway - and you will see described in the board papers - the changes that we are making to our access policy, we want to hold ourselves to account for patients getting care within 18 weeks. You may have heard that described in the N.H.S. Obviously what that is ensuring is from referral to treatment happens within that 18 weeks, so that could include being seen in outpatients, having the right diagnostic test to allow the consultants to diagnose and set a treatment plan. So as we start to measure ourselves to 18 weeks, rather than historically what we have done is just counted how many people we have waiting, and obviously demonstrating that we are getting the long waits down and that urgent people are being seen very quickly. Being able to describe our performance in an 18-week pathway will very much reassure patients I think in that scenario you are describing, Chair, that we are getting things sequentially right and people are getting good access to treatment in an 18-week period. So that is the next stages for us.

Deputy P.M. Bailhache:

One of the decisions made I think by your predecessor, Mr. Bown, was a very strict and clear division between private waiting lists and public waiting lists, which has been very much criticised by a number of clinicians. Has that been resolved now?

Chief Officer, Health and Community Services:

It has. It is a difficult issue and it was debated greatly but we have decided that because there was an impact - or certainly people have said there was an impact - on efficiency, that we have gone back to what was known as blended lists. Some clinicians want blended lists because they cannot fill full lists and some do not, however, it all goes back to the point made earlier to the panel that this is all about good governance. One of the issues that I believe existed around why blended lists were stopped, because it was not working in a way that was fair. Ensuring that is appropriate ... so we are seeing an improvement in efficiency but the Private Patients Committee at the end of June or July have committed to go back and look to make sure that is working effectively.

Deputy J. Renouf:

That is quite important because you are slightly gliding over something there; the blended lists were criticised because they were the method by which some consultants were cherry picking the best and most expensive ...

Chief Officer, Health and Community Services:
Indeed, so we have got systems in place now that will ensure that does not happen and, to be honest, I have made it very clear if people do not abide by the rules then we will go back to not having blended lists. So I am expecting people to abide by the rules, but you are right. The other thing to say of course is an important part - and a bit of good news - is about how well we utilise our operating theatres. We have seen now for the fourth month in a row an improvement in the utilisation, which of course is good news for patients. The other sort of mix of good or bad news is our "did not attend" rate for outpatients is coming down, but still over 10 per cent of patients do not turn up for their appointments. Now, of course that is 10 per cent of wasted capacity. We have set a target to get to 8 per cent because we understand that you are never going to get to zero because people have good reason, but it is still a number that we have seen come down but we want to see that coming down more. That is also not just about patients deciding not to come, it is about us internally ensuring our administrative processes are effective and that if people do cancel early that we know. It is another indicator; ensuring that we have got freed up capacity in outpatients through people not attending, and improving our theatre utilisation. Both those things are improving.

Deputy P.M. Bailhache:
Can you do what the airlines do and overbook?

Chief Officer, Health and Community Services:
What do you think, Claire?

Chief Operating Officer, Acute Services, Health and Community Services:
Unfortunately we do have some people for a variety of reasons are not able to attend, we do anticipate that we will have that or we do have an element of that in some specialities and of course we also still hold some outpatient capacity back on a daily basis to ensure that we have got the space for on the day referrals that might be urgent, so we do that. But I suppose just to reassure finally on that point, it would be ultimately us demonstrating our performance in terms of public access; both compliance to our access policy that will demonstrate good access for public patients across urgent, routine and soon, and how we continue to improve our waiting lists that will provide that reassurance to the public that that impact of the private/public blend is not to the detriment of public patients.

Deputy P.M. Bailhache:

Thank you. Minister, from a previous briefing the panel understood that the Capacity and Self-Determination Law amendment were to have been lodged in June, is that still on track?

Director, Mental Health and Adult Social Services, Health and Community Services:
I am Andy Weir, I am the Executive Director of Mental Health and Adult Social Care. So we are thinking July now. The work is near to completion and the first tranche of the proposed amendments are in final drafting currently.

Deputy P.M. Bailhache:
So far as the mental health strategy is concerned, is that developing satisfactorily?

Director, Mental Health and Adult Social Services, Health and Community Services:
The work is coming along. We are prioritising currently the publishing of the dementia strategy and the finalisation of the suicide prevention strategy. We anticipate that both of those things will be done within the next 4 to 6 weeks. We have started already the work on the wider mental health strategy and we anticipate again that that will be completed by the end of the year. We have been engaging with service users, staff and all of this is being done under the umbrella of the multiagency Mental Health Strategic Partnership Board that is steering that work.

Deputy P.M. Bailhache:
Has that included public engagement at all?

Director, Mental Health and Adult Social Services, Health and Community Services:
Some; particular with groups of people who use mental health services and their carers. There is a wider piece of public engagement to be done which we anticipate will happen during the summer.

Deputy P.M. Bailhache:
Recent correspondence has alerted the panel to the fact that Clinique Pinel has not yet opened. Can you tell us the reason for that delay?

Director, Mental Health and Adult Social Services, Health and Community Services:
I can. There was unfortunately a delay with the fire doors. The fire doors that were purchased were the incorrect doors, which resulted in a significant ligature risk in the building so we could not safely open it to patients. That work has now been completed. The building has been handed back in its entirety to us and I currently anticipate that we will move Orchard House into Clinique Pinel in the last week of this month.

Deputy P.M. Bailhache:

The last week of June?

Director, Mental Health and Adult Social Services, Health and Community Services:
Yes.

Deputy P.M. Bailhache:
Thank you. Following the recruitment of 2 carer support workers in H.C.S. has the introduction of a carer assessment, that you spoke of at our last hearing, been ...

Director, Mental Health and Adult Social Services, Health and Community Services:
They are piloting currently. I met with the workers yesterday and they have developed a carer's assistant tool and they are piloting that tool to see if it works. The purpose of the tool is twofold; firstly it is to identify carers' needs and make sure that carers are then able to access the type of support that they need. But, secondly, really importantly for us, it will allow us to identify unmet need. We think that there are some carer support needs at the moment that we do not have anything for and we think there are a group of carers who are particularly unsupported, so young carers for example. So as the carer support workers do their assessments we will start to understand much more clearly what the range of carer needs are across the Island, but also how can we best meet them. I think that will tie in quite nicely and be incorporated into the mental health strategy because that should be part of our overarching mental health plan.

Deputy L.K.F. Stephenson:
How long is the pilot?

Director, Mental Health and Adult Social Services, Health and Community Services:
It is only a few weeks. They drafted an initial document, there were some changes that they wanted to make to that, so what will happen is they will pilot the one they have got now for probably a couple of weeks and then we will get it uploaded on to the system and it will be tool that we use moving forward. In parallel, the other thing that they are doing as well as identifying the individual carers' needs, they are asking people a series of questions about their experience of the service and their experience to date of carer support, so that we can start to gather some information around that as well. That will help us shape future provision I think.

Deputy P.M. Bailhache:
Can you tell us anything about the A.D.H.D. (Attention Deficit Hyperactivity Disorder) waiting list? Is that closed, not closed?

Director, Mental Health and Adult Social Services, Health and Community Services:

We have not yet made a decision to close and we may not make a decision to close. What we have said is that we are going to keep reviewing it. It has increased, so it is now at 817 adults as at the end of last week. There is an additional 140 approximately young people in children's services that are waiting to transition into adult services. We are nearing to 1,000 people now that are on the waiting list. In good news, we have appointed a very senior and experienced nurse 2 days a week and we are borrowing her from elsewhere. She will be doing 2 things; she is going to review that waiting list for us, so she is going to look at everyone that is on the waiting list and understand what we might want to do in terms of triaging that, but also she is going to help build up diagnostic capacity, so she is going to be doing some training with other professionals. But the core issue is still exactly the same issue; we have one consultant psychiatrist and this is part of his work, and we have a very good junior doctor currently supporting. But the level of demand so vastly exceeds the amount of capacity that we have. The list will just continue to grow currently unless we do something else.

Deputy P.M. Bailhache:
Then the diagnostic capacity is concentrated on one or 2 people?

[15:45]

Director, Mental Health and Adult Social Services, Health and Community Services:
Yes, and the additional issue, which I think we have rehearsed previously here, is that because of the prescribing arrangements currently the only people that are able to prescribe these medicines are the specialist psychiatrist and, therefore, the psychiatrists are spending more than half of their time now just issuing repeat prescriptions over and over and over again. The more people that we bring on to the list of people receiving care, the worse that problem will become because people will need to be regularly prescribed for. Now, our solution to that is that we are still working with primary care towards a potential shared care policy. That is what happens in other jurisdictions; your treatment is initiated by a specialist, so you would still be seen by the psychiatrist to start your A.D.H.D. treatment, but thereafter your routine prescribing is undertaken by your G.P. in primary care, with an annual review by the specialist. That is a very standard model in other jurisdictions for care of A.D.H.D., but unfortunately we do not have that here and I think that is an immense frustration clearly to all of us and not least to the clinicians involved who are just spending vast amounts of time represcribing.

Deputy J. Renouf:
What is the barrier?

Director, Mental Health and Adult Social Services, Health and Community Services:

It is predominantly around funding and the H.I.F. So at the moment the funding for these drugs comes from H.C.S., not from the H.I.F. Understandably, some of the G.P.s also have a reticence in terms of taking on specialised prescribing for something that they do not feel that they are experts in, and some G.P.s are concerned that it may just further increase their workload. But the fundamental barrier is that even if the G.P. was desperate to do it today they could not because our policies do not allow that because of the way that the drugs are funded.

The Minister for Health and Social Services:

Which is one of the anomalies that we are going to try and address because you can see that these things that have evolved over the course of time that were fit for purpose originally are no longer fit for purpose and are now causing some real issues. That is why when we talk about having everything on the table for discussion I think that has articulated it very well.

Director, Mental Health and Adult Social Services, Health and Community Services:

The other thing that is really important to say, because I think we tend to only focus on the diagnostic and prescribing element of this care, but we have now commenced the work on the neurodiversity strategy and that is a piece of work that is jointly chaired by myself and Helen Miles as the Chair of Autism Jersey, and is a multiagency group. One of the things that we have started to talk about there already is the other things that we can do for people that are beyond medication and psychiatry, and frankly there are some and that is a bit of a gap. One of the things we have started to talk about very recently, this week, in mental health services is what type of offer could we make that might support other people while they are waiting. So there are some psychological interventions for example around things like sleep management, anxiety management, et cetera, that if we could make those available it will not get people further up the prescribing list any more quickly but would certainly potentially help manage some of the presentation that people struggle with. So that is something that we are going to look at in the immediacy.

Deputy J. Renouf:

Minister, recently the clinical lead from the Change Team resigned. Can you say what you are planning to do to address that situation?

The Minister for Health and Social Services:

We went through that yesterday, Chris and I, but I will leave it to Chris to give the full detail. I am happy to answer ...

Deputy J. Renouf:

I would quite like to hear from you what you want to achieve there. We are going to ask some questions about the Change Team.

The Minister for Health and Social Services:

Well, I am very happy to say that I want to achieve a continuation of the work that was going on. I am happy to say that quite clearly. My understanding - and I stand to be corrected - is that the individual concerned at the end of this month was going to go down to very short time in any event. Somebody has been brought in to do a slightly different job with part of the funding for that individual, and we are now looking to recruit someone to replace the job that was going to be done had that particular individual stayed on. If you want to elaborate on that?

Chief Officer, Health and Community Services:

That is right, that Professor Mackenzie was due to reduce his hours. We had already planned to fill those hours with a medical consultant to help us with the Acute Medicine Improvement Plan which we have. That individual has started; he has a reputation in improvement patient flow, as we call it, through the hospital, so we are focusing on acute medicine. So the hours that Professor Mackenzie was reducing have already been filled. There are discussions currently being undertaken with another individual who would undertake the other part of Professor Mackenzie's role which would be focusing on specifics such as job planning and consultant appraisal, on strengthening clinical governance, working with the Chief Nurse of the Change Team. So we are actively discussing with an individual whether they would come and work with us.

Deputy J. Renouf:

That is another individual from outside?

Chief Officer, Health and Community Services:

Yes.

Deputy J. Renouf:

So a new member of the Change Team?

Chief Officer, Health and Community Services:

Yes, a doctor.

Deputy J. Renouf:

Where does that leave the Change Team in your mind now? Are they up to strength and doing what you feel they need to do? Do you feel that the work is almost done? Where do you think we are with the Change Team?

The Minister for Health and Social Services:

Well, if the replacement happens as anticipated we are in exactly the same position as we would have been, give or take. My understanding is that the Change Team have an extended contract.

Chief Officer, Health and Community Services:

The H.R. (human resources) and O.D. (organisation development) specialist finished; she wanted to go back to the U.K. That is not a major issue for us, we now have our own workforce director so that is good news. I wanted to have workforce director that was accountable through to me as Chief Officer; that has happened. It is an interim at the moment but we will be going out for a permanent recruitment, so that has really dealt with that part of that Change Team portfolio. But the Chief Nurse and the finance and the doctor, if we fill this, will continue to the end of this ... the funding lasts until the end of this calendar year and then it stops.

Deputy J. Renouf:

Is your sense of it that the work that the Change Team was brought in to do will have reached its end by the end of this year or do you think it will need to continue?

The Minister for Health and Social Services:

That really is more a clinical matter and I think it is much safer for Chris to make that call rather than me.

Chief Officer, Health and Community Services:

I have not discussed it internally with people but the financial challenges are going to continue, they are not going to disappear after Christmas, and the need to continue to strengthen our clinical governance will also continue. We have also of course got the Jersey Care Commission inspection due at the tail end of 2025 we believe. The law and the regulations are going through at the moment as a preparation for that. We may need to adjust the roles and the types of people but capacity to address ... and I think I can remember Sir Philip at a States Employment Board where I took a paper around management capacity. But we are in a major turnaround and having the ... no organisation has the sort of leadership and management capacity on standby to do a major turnaround; it is designed to run the business on an operational basis. I think we will continue to need to change using the jargon "change management support" whether it is doctors, nurses or others, past this calendar year. The permanent chief officer, my replacement, and I think the intention is to go out and start the search this month because it will take some time, and in some ways the new chief officer will also have to take a view on what they believe that they want and discuss that with Ministers.

The Minister for Health and Social Services:

There has to be a blending. When you are going through a process of change - like these people have been through and are still going through - you then have to look at some point in time introducing people who are going to be doing the long term day job, and tapering out the change that is required. To an extent it is fair to say that is something that is an ongoing discussion that has to be monitored from time to time. I do not think it is possible to look forward to say: "Here is a complete end date."

Chief Officer, Health and Community Services:
Not at the moment, but I think - and I am looking at my colleagues here - the amount of change that is needed in H.C.S. is significant ...

Deputy J. Renouf:
Still?

Chief Officer, Health and Community Services:
... and that change will not have been completed by 31st December 2024, so we will need something.

Deputy P.M. Bailhache:
But change is perennial, is it not? Change is part of the process of governance.

The Minister for Health and Social Services:
I think it is fair to say that what the team here have been dealing with is not the change of the day and sort of getting from today to tomorrow with the change that is required in that time; it is a lot of historic change that was not done. It is a backlog. I have got to be careful about how I describe it but I think it is fair to say that Health possibly was not properly funded over the course of time and perhaps not as well managed as it might have been in terms of keeping pace with what should have been done.

Deputy P.M. Bailhache:
I do not want to go back to finance, we have covered that. Have you been successful in persuading the centre, if I can put it that way, to repatriate the financial controls and the H.R. controls which used to form part of the Health Department and were taken away?

Chief Officer, Health and Community Services:
Only in part and there is still a lot more.

The Minister for Health and Social Services:

It is a work in progress but it has been very much recognised, and I think the trick there is going to be … a complete repatriation with the current central system is going to be difficult and what I think we are going to have to do is have a separation within an overall system, but much greater control of what comes and goes into the central system.

Chief Officer, Health and Community Services:
I think that having our own workforce director is a step in the right direction, but there are things that should be done centrally - we are a small jurisdiction - and things that would make sense with more local control. That is true of H.R. and it is true of finance, it is true of digital ...

Deputy P.M. Bailhache:
Taking 9 months to complete a recruitment - if that is not an apocryphal story - is too long, is it not?

Chief Officer, Health and Community Services:
Yes, it is too long.

The Minister for Health and Social Services:
The job that has to be done is not simply saying we are going to separate it, it is how do you do that, what are the component parts that you need and what are the effects on the 2 different systems as you do that. But I think ...

Chief Officer, Health and Community Services:
And the funding.

The Minister for Health and Social Services:
... there is an acceptance that it is needed to be done and certainly that has got my support anyway in terms of trying to make sure that that happens. I think finance is another critical one as well ...

Chief Officer, Health and Community Services:
It is procurement, so there are a number of functions that we would be keen, I would be keen, the Change Team finance lead would be keen to see that we have more control over, and procurement is a good example. We work very well with the Treasury, very well with the procurement team. They struggle with capacity for the level of input that we need, and I think that is probably true of H.R. as well. It is not that our relationships are poor by any means, and they have been incredibly helpful, but the reality is we are a priority but if there is not the resource or the people to make that priority a reality then we move forward not an inch.

The Minister for Health and Social Services:

There is a separate issue with digital and I.T. (information technology), another key area that needs particular progress.

Chief Officer, Health and Community Services:
We are making progress but, as you say, it is slow.

Deputy J. Renouf:
Can I ask one question which has cropped up in the last few days? It was reported a couple days ago that there is an investigation going on into potential deaths in the Rheumatology Department. Can I ask if that was triggered by particular concerns or is that a routine process that would have been undergone?

Chief Officer, Health and Community Services:
I think Simon can answer that.

Deputy Medical Director, Health and Community Services:
The review of the deaths that was reported last week over the board and then in subsequent newspapers is part of the Operation Crocus that has been undertaken to review the whole of rheumatology. The reason for that is that it is right and proper for a doctor, if he or she thinks something untoward has come to a patient as a consequence of treatment received, to make that report to the G.M.C. (General Medical Council) but also to the Coroner. Here that would be the Viscount. There is a tranche of patients, who are called tranche 5, who are the deceased patients that have been through the rheumatology service over the period of the last 3 years, which equates to the number that was reported in the press. The process for reviewing is to conduct a standard M.L.R. (Mortality Learning Review). That comprises of a review by an independent rheumatologist, an independent physician, and then a panel meeting with 2 other senior doctors. If those doctors all felt collectively, having heard the review independently at the meeting, there was a concern that needed to be raised to the Viscount then that would occur. If they were not sure then they might say: "Well, we are not certain about this one, this might be one that we might refer to the Viscount" and that is for the Viscount then to determine whether or not anything needs to be undertaken. If they were completely convinced that there was nothing wrong with the treatment then they would say: "Well, okay, we do not need to do anything with that and we will park that one." That process has arisen because of the responsibilities of the doctor; it is written within the G.M.C. code of good medical practice that if you see harm coming to patients you are supposed to speak up. It is right and proper that that occurs. It is a large number of deaths. The process is quite detailed, as you can see. So far we have reviewed I think 90 records and out of that a very small proportion of patients have come to the need to make notification to the Viscount. That process will continue until

all the records have been seen and then we will have to meet with the Viscount to determine what the Viscount might wish us to do.

Deputy J. Renouf:
Can I just clarify, when you say they have been sent to the Viscount is that because the assessment of all the professionals involved was that it is possible or likely in fact that deaths were caused as a result of the treatment?

Deputy Medical Director, Health and Community Services:
That is correct.

Deputy L.K.F. Stephenson:
You say a number; can you be any more specific at this stage?

[16:00]

Deputy Medical Director, Health and Community Services:
I can be honest and say I cannot recall the exact number that we feel need to be referred to the Viscount. In the first cohort of patients there were 30 patients reviewed. That distilled down to 11 patients that we wished to undertake further review of, that were reviewed down to a small number, in the order of ones, that we felt might need to be looked at by the Viscount. But, as I say, we have to review all of those before we then make any further recommendation.

Chief Officer, Health and Community Services:
I think the plan was to do an update for the board in July but we will not have completed ...

Deputy Medical Director, Health and Community Services:
We will not have completed 182.

Chief Officer, Health and Community Services:
... all 182 patients by July, but we felt it was important that the board received an update, and that would be a public update.

Deputy J. Renouf:
We are looking at likely deaths as a result of that?

Deputy Medical Director, Health and Community Services:
It is for the Viscount to make that determination as the Coroner on the Island.

Deputy L.K.F. Stephenson:
At what stage are families informed?

Deputy Medical Director, Health and Community Services:
As part of Operation Crocus there is a duty of candour process. That process is currently being undertaken for the patients that have been going through the rheumatology clinics as part of tranche 1, tranche 2 and tranche 3, et cetera. I think with tranche 5 that process will still need to occur but it would only really occur when it gets to the point where the Viscount feels there is anything to answer on. That is a very long process so there is making recommendations to the Viscount, there is then the Viscount reviewing, and then there is the duty of candour process. The determination is not within the medical workforce; the determination within the medical workforce is we feel something needs to be looked at here, that is our responsibility to raise and elevate to the Viscount, it is for the Viscount to determine whether or not there is an issue.

Deputy L.K.F. Stephenson:
So none of the families of the 183 have been told?

Deputy Medical Director, Health and Community Services:
The families are aware that Operation Crocus has been undertaken but none of those families have been notified or would be notified until the Viscount makes a determination, because it would only be when the Viscount makes a determination that we would do that.

Deputy L.K.F. Stephenson:
It is probably a question for the Minister; are you happy with that approach that families are not aware that their loved ones cases are being reviewed to that extent, even then being referred to the Viscount, they are not notified at that stage?

The Minister for Health and Social Services:
My understanding would be that that would be custom and practice, would it not? Is that how you would normally expect in any scenario for that to be handled?

Deputy Medical Director, Health and Community Services:
That would be the normal practice in terms of review, decision whether something needs to be taken forward with the family, and then speaking to the family, yes. Because otherwise we would be speculating and we are not the determiners in this, it is the Viscount.

Deputy P.M. Bailhache:

It is possible that at the end of the day the Viscount might decide there are no cases worth ...

Deputy Medical Director, Health and Community Services:
Yes, of course, and that is why it would be unfair to speak to families and give them undue concern and raise anxieties.

The Minister for Health and Social Services:
Yes, I have to say that there must be no suppositions from here. It is a matter for the Viscount and I think one has to wait until we find out what the Viscount has to say. I think that is fair enough.

Deputy J. Renouf:
We are at time, in fact a few minutes over, so thank you. I am sorry to end on a slightly sombre note but thank you very much indeed for your time everyone who has come and contributed, and we will look forward to seeing you again in 3 months' time when you will be very happy to have the proper Chair back.

Assistant Minister for Health and Social Services:
Can I just say that you are very welcome to have a viewing of the new facilities for Orchard House before patients go there?

The Minister for Health and Social Services:
It has to be done before it is brought into use.

Assistant Minister for Health and Social Services:
It has to be done before.

Deputy J. Renouf:
Okay, thank you again and we can go off camera if we could, please. We are off camera, thank you.

[16:04]