States of Jersey
States Assembly

États de Jersey
Assemblée des États

Health and Social Security Scrutiny Panel

Quarterly Review Hearing

Witness: The Minister for Health and Social Services

Thursday, 7th November 2019

Panel:

Deputy M.R. Le Hegarat of St. Helier (Chair)
Deputy K.G. Pamplin of St. Saviour (Vice Chair)
Deputy C.S. Alves of St. Helier
Deputy T. Pointon of St. John

Witnesses:

Deputy R. Renouf of St. Helier, The Minister for Health and Social Services
Senator S.W. Pallett, Assistant Minister for Health and Social Services
Ms. C. Landon, Director General, Health and Community Services:
Mr. R. Sainsbury, Group Managing Director, Department for Health and Community Services

[10:32]

Deputy M.R. Le Hegarat of St. Helier (Chair):

Good morning, everybody, this is a public hearing with the Minister for Health and Social Services, Assistant Minister and officers from their department. Apologies to the public but we changed the time from 10.00 to 10.30 very late yesterday. Apologies for that and hopefully it has not caused you too much disruption. We will firstly go around the panel members and then the members opposite us at the table. I am Deputy Mary Le Hegarat of St. Helier and I am the Chair of the Health and Social Security Panel.

Deputy K.G. Pamplin of St. Saviour (Vice Chair):

Deputy Kevin Pamplin and I am Vice Chair of this panel.

Deputy T. Pointon of St. John:

Hello, I am Trevor Pointon, I am the Deputy of St. John and I am a member of the panel.

Deputy C.S. Alves:

I am Deputy Carina Alves of St. Helier District No. 2 and I am a member of the panel.

The Minister for Health and Social Services:

I am Deputy Richard Renouf and I am the Minister for Health and Social Services.

Assistant Minister for Community Services:

Senator Steve Pallett, Assistant Minister for Health and Social Services.

Group Managing Director, Department of Health and Community Services:

I am Rob Sainsbury, I am the Group Managing Director for the Department of Health and Community Services.

Director General, Health and Community Services:

Caroline Landon, Director General, Health and Community Services.

Deputy M.R. Le Hegarat:

Thank you. Also there may or may not be others who will attend that may have some questions to answer and if that is the case we will ask them to come to the table and to introduce themselves so that the public are fully aware of that fact. Obviously, this is a normal process in relation to the rules of engagement, as in what would normally be in the States Assembly.

Deputy K.G. Pamplin:

Okay, it is me kicking off this morning. We are going to start with a piece of work that we have been looking into over the last few months, staffing levels currently. In response, Minister, to a written question on 10th September, which I lodged, regarding current staffing levels at the hospital, you advised that there were 94 vacancies of which 80 were medicine, nursing and midwifery staff and 22 allied health professionals. You advised that on a very rare occasion or rare occasions activity might need to be reviewed and potentially reduced if staffing levels are not able to support staff care. Following that lodged question and questions in the Assembly and a report in media you provided reassurance that the hospital could continue to run safely. That is a bit of context for everybody

watching and listening. First question: can you provide us now with an updated breakdown of where recruitment has been successful since then and those figures that you shared with us?

The Minister for Health and Social Services:
Yes, I believe I can. I am advised that as of very recently the number of staff vacancies is currently 101 roles within the hospital, not within the whole service.

Deputy K.G. Pamplin:
Just to be clear for everybody, the figures that I am referring to that I have in front of me, as of August 2019 was 194 vacancies, so just to confirm you are now saying there is 101 as of now.

The Minister for Health and Social Services:
Within the hospital, yes.

Deputy K.G. Pamplin:
Yes, this is all within the hospital. Can you just break down where those recruitments have … on the list in front of me the most pressing … well, the highest number in the currently vacant at the end of August 2019 was nursing and midwifery for example which had 74 vacancies. The next one there was allied professional 22, civil servants 50. If you can just provide a bit of a breakdown but particularly the nursing and midwifery vacancies?

The Minister for Health and Social Services:
The number of nursing vacancies at the moment are 55.

Deputy K.G. Pamplin:
What have been the recruitment successes of those employed in the nursing? Is there specific roles? Has it be a mixture of U.K. (United Kingdom) or local, just a bit more detail about the recruitment filling of those nursing roles and what areas they are working in.

The Minister for Health and Social Services:
I do not have that detail. Can I ask our Managing Director?

Deputy K.G. Pamplin:
Yes.

Director General, Health and Community Services:
So it has been a mixture and it is a combination of off-Island recruitment and on-Island recruitment but, I know the Chief Nurse hoped to be here today, we have also got some work ongoing around

growing our own resource so offering educative opportunities to our H.C.A. (Healthcare Assistants) workforce to support them to move into nursing vacancies. So it is a mixture across the board.

Deputy K.G. Pamplin:
Again, sorry for the detail, but the breakdown of off and on, could you provide that information? How many?

Director General, Health and Community Services:
Sorry, I cannot do that now but we can give you that information, unless you have it there?

Group Managing Director, Department of Health and Community Services:
I do not have it; it would be a majority proportion will be off Island for the registered nurse workforce. All of the registrants who train through our connectivity to Chester would come back into our roles but I think that is less than a dozen a year but I would have to get that detail to you.

Deputy K.G. Pamplin:
No problem. Has there been any loss of recruitment since these figures were produced as well to counterbalance the ones that you have been bringing in?

The Minister for Health and Social Services:
In nursing specifically?

Deputy K.G. Pamplin:
In the hospital generally.

The Minister for Health and Social Services:
It would not appear so.

Director General, Health and Community Services:
No.

Deputy K.G. Pamplin:
Would you agree also that part of the challenge, and it is an area we have discussed many times, is the housing of U.K. professionals coming to the Island. We talked about this a great deal in terms of the difficulties, if it is a young family and it is a specialist nurse who is married, has children and there is difficulty housing, so I am curious about the success of the off-Island recruitment and if anything has been done differently to try and house these particular people, and what has worked as opposed to the difficulties we had earlier?

The Minister for Health and Social Services:

Well, housing is now available through the Plaisant Court apartments that have been refurbished and made available to key workers. More housing is coming online. That has perhaps made the offer more attractive. I hope it has, that enticement into good accommodation with room for families.

Deputy K.G. Pamplin:

It would be fair to say it is still a challenge going forward because …

The Minister for Health and Social Services:

Oh, yes.

Deputy K.G. Pamplin:

… how many facilities … are they one, 2-bedroom apartments, and what is the breakdown?

The Minister for Health and Social Services:

There is a mix.

Deputy K.G. Pamplin:

There is a mix?

The Minister for Health and Social Services:

Yes.

Deputy K.G. Pamplin:

Do we know again what the breakdown is of the people coming from off Island, what their requirements are? Are they families? Do we know if they are needing one or 2 bedrooms? Is that something you could also inform us?

Director General, Health and Community Services:

We cannot tell you now but we can give you that information.

Deputy K.G. Pamplin:

Okay. Obviously the knock on effect with staffing levels, as you know, is waiting lists and it is curious on the website and the information provided of waiting lists that I have in front of me, it only goes up to September 2019, it does not have October there yet. But at the bottom it confirms that in July and August a locum doctor was brought to Jersey to see a number of long-waiting patients. This

has inflated the average as a high proportion of long-waiters were admitted in the month. Is that locum doctor still in place as of now?

The Minister for Health and Social Services:
Does it say in what discipline?

Deputy K.G. Pamplin:
It does not, this is all the detail I have from it.

The Minister for Health and Social Services:
Is that orthodontics?

Group Managing Director, Department of Health and Community Services:
So we have multiple locums who we bring in for that reason. In orthodontics we have had to have additional support. In diabetes we have had a locum, had to get additional locum support for some of our cancer services as well. So that additional manpower or womanpower will impact on our waiting list activity and usually helps us to reduce our waiting lists as a result.

Deputy K.G. Pamplin:
I am glad you mentioned that because I am looking at the figures in front of me and they do not seem to have shifted from month to month.

Group Managing Director, Department of Health and Community Services:
We have got a huge amount of work that we need to do on the waiting list validation. We have now finally created what we call a P.T.L. (Patient Tracking List), which we have not had in our department previously and we have been able to interrogate all of our waiting list data. It is showing that we have got a lot of work that we need to do around that, a lot of validation, a lot of patient activity that is listed that is not real. A lot of follow up activity, a lot of watch and wait activity and we need waiting lists managers now to start to work through that. So we are changing the way we are going to be using that P.T.L, and managing our waiting lists.

Deputy K.G. Pamplin:
The evidence then goes forward to the waiting lists and the staffing recruitment, what is the impact, because obviously if you are bringing in locums that tells me that there is an issue there where the people are not getting seen and if you look at the recruitment levels there seems to be impacts there by this, so how much of a pressing issue is this and what can be done … it is great that the work is going on but seemingly now if we carry on this we will always be bringing in locums just to shift things along. So I am just curious about …

The Minister for Health and Social Services:

Yes, okay. Can I just say that this is not an exceptional model, that a locum workforce is an accepted means of delivering healthcare throughout the British Isles, probably in the Continent as well.

Deputy K.G. Pamplin:

Sorry to interrupt, Minister, I agree but I am looking at the data in front of me on the gov website that sees no movement of the waiting list clients and so now I am hearing that there are issues in the data and how this is working. If we continue just to bring in locums, that is an additional cost. Do you know what I am saying? We are seeing waiting lists increase. We are seeing issues growing and we are seeing recruitment drives that just meet the criteria, so can you see the sense of concern that we are …

The Minister for Health and Social Services:

Yes, and it is the sort of question I have asked before and I have been aware of a situation where we were bringing in a locum to deal with a long waiting list of people who are waiting for their first appointments. We reduced that waiting list but what it means is that those people who have come off that list then go on to the list for the surgery or the treatment they need and it looks as if that list has been greatly elevated, but in fact it is people moving along through the system by means of bringing in the locum. It needs a careful consideration sometimes of those waiting lists, just the bare bottom line figures do not always explain the necessary story.

Deputy M.R. Le Hegarat:

Can I just ask something? I visited the orthodontics - I can never say the word right - in recent weeks and there is a notice in the waiting room which says if you are eligible it is a 4-year wait. I do not know whether you can enlighten me as to why that is or not. Because I went into the waiting room and on the wall it says: “If you are eligible to have this treatment, there is a 4-year wait” and I just wondered why that was and whether we are looking at it and what we are going to do about it. It was just … it was not a question I had planned; it was just I visited there myself recently.

The Minister for Health and Social Services:

It is distressing orthodontics, is one of the most, if not the most, difficult of the specialities to recruit into. The department is constantly trying to bring down the waiting list to recruit into it.

Deputy M.R. Le Hegarat:

Is there any other way that … I do not know the ifs, whys and wherefores or exactly what that means but is there any way that there are services that could be provided from other areas within our private sector to be able to alleviate those waiting lists?

[10:45]

The Minister for Health and Social Services:
Shall I just say that we are beginning a conversation with dentists in the private sector to try and take the sort of low grade work off the waiting lists and try and provision it in that way.

Deputy K.G. Pamplin:
That leads me on to my next question because you signed a health agreement with Guernsey a few months back. Is this a conversation you had with Guernsey? Is this something that Guernsey have the same problem with or is there some way we can help each other with that, share resources or staffing?

The Minister for Health and Social Services:
I do not know about Guernsey orthodontics

Director General, Health and Community Services:
I think the caveat has to be, though, and I think we have talked about it before, we have not had a waiting list that is accurate. The information you are looking at, which I think you said was September?

Deputy K.G. Pamplin:
Yes, it goes up to September.

Director General, Health and Community Services:
Yes, it is not accurate and that is a piece of work that we have been doing because we have not had a patient tracking list. The issue with orthodontics is a national issue and on validation of the orthodontics list we took our 1,200 patients …

Group Managing Director, Department of Health and Community Services:
Six hundred.

Director General, Health and Community Services:
Six hundred patients because there were 600 patients on that list that did not need to be on that list. We have got that replicated across all our waiting lists. There is somewhere, forgive me, I recall that we have taken 1,200 off, which is across elective surgical capacities. So patients who should not have been on lists were on there in accurately. So we have committed, because we have absolutely recognised the issue we have around waiting times and it is unacceptable, that we will

have appropriate waiting times and appropriate lists that are publishable by the end of the first quarter of next year. So people will be able to see what date they went on list, how long they have been waiting and who they are going to see and where, and hold us to account. At the moment that information is not accurate. Yes, we have a waiting list issue but I would suggest it is not because of capacity of clinicians and the availability of clinicians it is because we do not manage our waits appropriate and we do not manage our time in theatre appropriately. As I have spoken about before, we mix our public and our private work and we can do dedicated private theatre, we have more than enough capacity for our public work, we just need to manage it accurately. We can commit that we will be able to demonstrate to you at the end of the first quarter of next year that we are doing that but we do need the time to be able to validate the list, which is what we are currently doing. We have a list now but it is not fully validated. I think it will probably take 3 months for us to get to that position.

The Minister for Health and Social Services:
Yes, so in saying that the lists are not accurate, it was me that committed to publishing waiting lists after they had ceased for some time. They are the numbers of on the waiting lists or they have been, so they were accurate in that sense, they reflect the numbers, there is no manipulation of figures, but the lists are being validated to ensure that they are a true reflection of need.

Director General, Health and Community Services:
Clinically validated.

Deputy K.G. Pamplin:
Could I therefore suggest that what you have just said is made clear on this website, on the government website, because to everyday folk looking at it, it looks like this is the information? I think it needs to be clearer that this is not as accurate as you have just described and what the aspirations are to provide it.

The Minister for Health and Social Services:
It is the best information at the moment but we will be able to improve upon it and perhaps we could try and say something on the website that there is a work in progress.

Director General, Health and Community Services:
Absolute assurance for patients who are watching this. We know where patients are, we know what patients are waiting, we just need clinical validation of the lists to ensure that we are bringing patients in appropriately according to their wait.

Deputy K.G. Pamplin:

The other issue, you touched up on it there, is about having the data and the systems in place because looking at the requirements for civil servants and the vacancies at the end of August as well, appointments and letters being sent and how the process is set up at the moment, with texting and the digital framework, this is subject … is this part of the issue as well as to how the appointments are checked in relationship with G.P.s (general practitioners), how the information is received from a G.P. by a letter, then those tech services, is this just an out of date system struggling with the issues that you are talking about? If so, how quickly can that be resolved?

The Minister for Health and Social Services:

There is a lot of work going on to plan the digitisation of so much of our services and that is included I believe. I am not a detailed man in that respect, I do not know exactly where that work stream is or how it will be implemented but …

Director General, Health and Community Services:

We have a lot of work going on internally in H.C.S. (Health and Community Services) with our digital team about linking E.M.I.S. (Emergency Management Information System), which is the G.P. system to the hospital system but I think we have recognised as part of our work around the care model that that work needs to move at a much greater pace and, I think, as we talked about, I think we are probably a year away from being able to have that linked communication but it is absolutely something that we are working to and that our teams are focused on because we realise we cannot deliver our model unless we are digitally enhanced.

Deputy K.G. Pamplin:

Do you have enough staff in place to deal with the demand of writing and contacting patients for their appointments? From my own experience I was taken into an administrator's office on one of the wards and this poor person was in, what I would best describe, as a cubbyhole surrounded by piles of paper trying to dissipate a pile on her desk to move to another pile there. It is not great, we know, that is why we are all looking at the future hospital model and care model. Is there enough resource, procedure and staff in place to deal with this at the moment, or is there room for improvement?

Director General, Health and Community Services:

I think we have enough resource, I just do not think we manage the process well because it has been very organic, it is had developed organically across the organisation as opposed to being a centralised function that delivers that. Similar to many of our public facing functions and that is a piece of work that we are doing. We recognise that we cannot wait for the model and the new hospital and, you are absolutely right, Deputy, we cannot … it is part of our waiting list work because

we can have the best patient list but if we do not have the people to generate the letters it means nothing, so it is part of that work programme.

Deputy K.G. Pamplin:

I am only going by the figures that were given. If there are 50 vacancies in an administrative role, what happens if the person responsible for sending the letters to the patient is suddenly taken ill, who picks up that piece of work? Who does the work that they have just … that is my concern. I am just going by the figures in front of me.

Director General, Health and Community Services:

That is all part of the work stream around this, offering the commitment we will have waiting time management in place by the end of the first quarter. We recognise the work stream around that that we have our modernisation team leading on which is linking the digital agenda to the admin support agenda. But, you are absolutely right, Deputy, it is a challenge and it is a new way of working for us within the organisation but we think we can get there by the end of March.

Deputy K.G. Pamplin:

Final point from me on this. Can you confirm whether there have been any incidents in the last 12 months where activity within the hospital has been reduced to maintain patient safety and, if so, what type of care treatment was affected and how many such incidents have there been, if any?

The Minister for Health and Social Services:

I am not aware of any.

Group Managing Director, Department of Health and Community Services:

Do you mean in terms of capacity?

Deputy K.G. Pamplin:

Yes.

Group Managing Director, Department of Health and Community Services:

No, we have not needed to cancel elected activity because of lack of staffing or bed pressures. Every day is a juggle. Today is quite difficult, we have potentially 2, which will be our first cases this year but we have not had to decommission activity planning at all within the hospital, no.

Director General, Health and Community Services:

If we did, Deputy, that would come to our quality and performance committee which is chaired by our Assistant Minister, Steve Pallett for that to be reviewed and if that has an impact upon any

outcome for patients we go to our board, which is in public. We have a really clear line of escalation around that to ensure that we are delivering that quality of safe care.

Deputy K.G. Pamplin:

Sure. Last year there was a very good … what we call the cold flu season, are you confident as we go into that period again, given the extended rain that never seems to go away and the cold weather here, that you have enough resources in place to oversee not just the day to day but if something extraordinary happened in terms of demand in service between now and over Christmas and New Year?

Group Managing Director, Department of Health and Community Services:

We do. There are challenges this year in terms of some of the patient flow pressures in the acute system. We have seen a reduction in some of the residential care capacity coming online and we have not seen an increase in the domiciliary care environment so that has led to a higher number of patients remaining in our beds than we had at this time last year. So we are fortunate … obviously our care model wants to move towards home focused care but at the moment we have a genuine capacity need. We are fortunate that there are over 20 residential care beds coming online now this month and we have got a further 47 coming online within March. Looking at our activity and where we are, our occupancy still is below 75 per cent overall so we would be able to manage with that kind of capacity within the system, but it is much tighter than it has been previously and we have been managing that on a day-to-day basis.

Deputy C.S. Alves:

Just before you move on, can I just touch on something that you mentioned about being one year away from having this linked digital system with the record keeping? Now, I believe originally we heard that it would be 3 years in a Government Plan hearing, so is that going to put extra financial pressures on you - because we know that with digital there comes extra costs - with you having this sort of one year target now?

Director General, Health and Community Services:

I think the 3 years is for an E.P.R. (Electronic Patient Record), which is the Island-wide E.P.R. I still think that is 3 years. But the linkage between G.P. surgeries and the acute is more or less there with the work we have been doing with digital, but for me to be able to say to you that it is absolutely robust, I think we are a year away from that. So the G.P.s and the hospital are talking to each and many of those issues are only for data sharing not about the technology, probably a year away. E.P.R. I would say …

Deputy K.G. Pamplin:

E.P.R. is?

Director General, Health and Community Services:
Sorry, the electronic patient record that will be Island wide. I would say I think is realistically 3 years. Hopefully with the investment that has been put in and the addition resource that has been brought in it will be quicker but that is the date that we are working to at the moment. That is why we have renewed our Track contract, which is our hospital system, for an additional 3 years not for the 5-year period that they were looking for. So we are optimistic.

Deputy C.S. Alves:
Okay, thank you.

The Deputy of St. John:
Will the new ambulance record system be compatible with the health system?

Director General, Health and Community Services:
Do you want me to take that one?

The Minister for Health and Social Services:
Yes, please, because I have no insight into that.

Director General, Health and Community Services:
I think you asked this at a previous Scrutiny meeting and we committed to go …

The Deputy of St. John:
Yes, I was not allowed to ask the question at a previous Scrutiny meeting.

Director General, Health and Community Services:
… away and have a conversation. We have had that conversation with Justice and Home Affairs and are working with them to ensure that that is the case. I think that that piece of work had already been done as part of the work that was done with Bernie and the linkage between the out of hours custody and the contact with A. and E. (Accident and Emergency). Yes, that work is happening to ensure that they do talk to each other.

The Deputy of St. John:
They can connect with the current system?

Director General, Health and Community Services:

Not now, but that is the intention.

The Deputy of St. John:
How far away are we from that connectivity?

Director General, Health and Community Services:
I will have to come back to you on that.

The Deputy of St. John:
Can I just go back to starting levels because something you said about your health care assistants and upskilling health care assistants or training healthcare assistants, to what level are you training those healthcare assistants?

The Minister for Health and Social Services:
Well, there are different grades of healthcare assistants I understand and then if they want to move into nursing or allied health disciplines that is also available to them. I personally know healthcare assistants who have moved into the nursing profession. That seems a seamless …

The Deputy of St. John:
Have we adopted locally the new qualification that exists in the United Kingdom, which is a level below of that of registered nurse?

The Minister for Health and Social Services:
Yes.

Director General, Health and Community Services:
So similar to the old state enrolled nurse, yes.

The Deputy of St. John:
Exactly, what goes around comes around.

Director General, Health and Community Services:
Exactly. I know that Rose is in conversation … we have not done it but that is the work that I was alluding to. That is the work place that the senior nurses committee is working to in order to be able to address some of the challenges we have around getting nurses and having to get people off-Island is offering that option to our H.C.A.s. I cannot give you the detail of where she is but I know we have a clear work plan around that that we could share post this meeting.

The Deputy of St. John:

Okay, thank you for that. We are going to move on to people being treated off-Island. This is close to my heart. We understand that when patients have to go off Island for treatment, in some cases there are 2 pathways that may be followed. For example, someone with a brain tumour - and you will have to confirm this for us - may be directed by the hospital to Southampton or may be directed by some general practitioners to London, quite independently. In this scenario the local consultant may not know that the patient referred by the G.P. exists. How can the linkup between G.P. and hospital be improved in such cases? In fact, do they happen at all?

The Minister for Health and Social Services:

Yes, that is an interesting question, Deputy. It is highly operational; I am afraid I cannot answer that as Minister but can I ask Mr Sainsbury if he would?

Group Managing Director, Department of Health and Community Services:

Yes, so we do have situations whereby there will be direct referral into off-Island providers from G.P.s independently to us. I think we do get involved if there is some pathway crossover where the returning person will need specialist input but they do not automatically come into our secondary care system via having that referral.

[11:00]

If it is a facilitated referral from us, where our secondary care team are involved, either planned or unplanned, then absolutely our clinicians are involved in the repatriation, the off-Island care co-ordination and everything relating to that, including ongoing interface with the G.P. I think we have a lot more to do around that and I think the way that we manage that activity, we are looking at it at the moment because we think we could probably do a little bit more on-Island activity than we currently are. A lot of patients are going off for outpatient appointments that probably do not need to necessarily travel, might not need to go at all. We are doing that piece of work now.

The Deputy of St. John:

I am beginning to suspect that these people that G.P.s are referring are people paying privately, is that correct?

Group Managing Director, Department of Health and Community Services:

They could be combination of self-funding, insurance funding, it could be private or … yes.

Deputy K.G. Pamplin:

Could I give a bit of background on that because obviously I was the business manager of the Jersey Brain Tumour charity. This was something that we encountered where depending on your diagnosis and where it happened, some people could be a sudden seizure and you are rushed into hospital and that is where you received your diagnosis and then you would be sent to your G.P. It could be picked up by your optician or you go and see your G.P. who will refer you to the consultant at Overdale. So that was where the path was, so depending on what your entry point was what we were seeing was on the way back where is the crossover with consultants because: "I did not know this patient existed because they went via the hospital." I guess it comes back to what we were talking about earlier about the digital network, the communication of it but not just brain tumours, this is obviously the future because we are going to still send people to Oxford for heart and London for specialist treatment, it is just how are we going to improve that connectivity on the way back. I guess this is part of the future care model, if you could give us a bit more insight about that.

Group Managing Director, Department of Health and Community Services:
Absolutely, the electronic patient record is part of that but we have already started making sure that there is connectivity around diagnostics. We have just started to embark on that journey whereby you have got the ability for G.P.s and our secondary care system to join up. We want that to be across all partners. I think you are right about some specialties, so neurology, you know, there is probably a more clunky way of connecting up that activity. With something like cardiology it is much more seamless and there is a real knowledge about all the activity that is going on. It is a very well connected service to primary care so I think we have a bit of a mixed position across the specialties I would say.

Director General, Health and Community Services:
It is a key work stream because that is how we got information for our care model. So we absolutely know as part of our modernisation work, our tracking, where our patients are, how they have been treated and how long they are away for. We are making sure that our patients are not being kept off-Island longer than they should be for not clinical reasons and we are making sure that we get those patients back, we are tracking those patients now.

Deputy K.G. Pamplin:
It is also the pathways because we have had some patients who would be rushed to Southampton for brain draining and then have to go to London to see Mr Kitchen so they have to keep going back and forth at different points. It is how we make those pathways better on-Island and off-Island for the patient.

Director General, Health and Community Services:

That is a key part of the work we doing around the Jersey Care model. We cannot provision the care that we know we can provision now but what we can do is we now track where our patients and own them so that when we are developing the care pathways we understand the current ones and where the blockages are and where the twisty paths are that we do not need to be sending our patients down when they are off Island. We are having a much stronger conversation with external providers around care delivery.

The Deputy of St. John:
Especially in relation to brain tumour, I am glad to see that you have it in mind to, if it is at all financially possible, bring radiotherapy back into the Island.

The Minister for Health and Social Services:
Yes.

Director General, Health and Community Services:
Yes.

The Minister for Health and Social Services:
We would very much like to achieve that.

The Deputy of St. John:
Because radiotherapy is a massive contribution to mitigating brain tumours. I have a question which has been submitted by a member of the public and given that we are some way into our conversation so far I think it is time that I should bring it in rather than it fall off the end if we go over time. This is specifically about the National Health Service deals with the United States. This is really off the ball: "A recent Channel 4 documentary claimed that the price paid by the N.H.S. (National Health Service) for U.S. (United States) medicines will rise steeply with any future trade deals with the United States. Have any discussions taken place regarding future U.S. involvement in the N.H.S. and the potential implications for Jersey?"

The Minister for Health and Social Services:
Well, the key word there is "potential", Deputy. We recognise there could be a risk depending on the outcome of negotiations, if ever the U.K. Government gets to that stage, but I would expect that the U.K. Government would fight and the N.H.S. would fight to keep its pricing as it is at the moment or very close to what it is because I understand that in the U.S. typical drug costs are perhaps 8 times what they might be in the N.H.S. In Jersey we have an excellent agreement with the N.H.S. that we really receive and order drugs on the same basis as they do and at those prices so obviously if there was a dramatic change Jersey would be affected. Because we, as a population of 107,000,

do not really have the capacity to negotiate something ourselves with the big drug providers, although I suppose that could be looked into. It is much better for us to be linked in with the N.H.S. and that scale can produce the efficiencies. So I hope that will continue. The N.H.S. shows no sign of wanting to do anything differently with us and we will rely on them fighting their corner in the interests of patients and give them every assistance in whatever way we can.

The Deputy of St. John:

That, of course, has been the frustrating factor all the way along the line, has it not?

The Minister for Health and Social Services:

Yes.

The Deputy of St. John:

N.H.S. N.I.C.E., (National Institute for Health and Care Excellence) the watchdog deals with standards and drug purchases, what is going to influence our buying for the future in relation to medicines? Are their rules going to remain influential in relation to our purchasing habits?

The Minister for Health and Social Services:

Yes, as a rule we follow N.I.C.E. guidelines in many respects. There is an expertise there. I have not heard of any proposed changes but I will ask my officers …

Director General, Health and Community Services:

Yes, we will continue to follow the N.I.C.E. guidelines, absolutely.

Deputy M.R. Le Hegarat:

The new care model details a list of services that could be commissioned out to the community, including diabetes, renal and heart diseases, chronic lung conditions, paediatrics, et cetera, et cetera. How can the patient be assured that a general practitioner can deliver the appropriate treatment effectively?

The Minister for Health and Social Services:

Can I say first of all that while a general practitioner would be key they would be part of a multi-disciplinary team. General practitioners would work with secondary care, with occupational therapists, other allied health professionals, with community services and perhaps hospice or family nursing sort of thing. So there will be a team wrapped around many of these pathways and we will obviously need to ensure that the G.P.s have the skills to deliver that and some will feel that they are more generalist and cannot specialise in that area. So there will be a validation of G.P. skills before we set up a pathway for patients to be moved into.

Deputy M.R. Le Hegarat:

You talk about the skills of the G.P.s, what will you do in order to ensure that that training is available to them?

Group Managing Director, Department of Health and Community Services:

We will open up our training arrangements to ensure that primary care is part of it. At the moment our secondary care clinicians get quite a good package in terms of ongoing continued professional development and access to courses, information, education. We would have to expand that so we would have primary care as part of that system. We would tie it together and in the meantime our specialist would have to have a process of direct specialist advice and guidance to G.P.s if they are in doubt.

Director General, Health and Community Services:

The care we would commission from G.P.s would be our K.P.I.s (Key Performance Indicators) around outcomes that would be codesigned between secondary care clinicians and G.P.s so that we were able to be assured that the care that was being delivered met the necessary clinical outcomes but would also sit as part of a joint governance structure. So we are already having conversations about how we would share governance to ensure that we were measuring outcomes to ensure safety.

Deputy M.R. Le Hegarat:

Okay. Are there any services identified that will be delivered, other than through G.P. surgeries or at the patient's home? So are there any services identified and what are those sort of services?

The Minister for Health and Social Services:

I know at present there are physiotherapy services being delivered in communities and parish halls or Communicare. That is one example that I think could work well.

Group Managing Director, Department of Health and Community Services:

General frailty. So a high proportion of our activity at the moment is around general frailty, particularly for the older demographic. In supporting those persons, the environment of care will probably be their own home and they do not necessarily need a G.P. to be the person visiting. They might need something else, a bit more care input, a physio, an O.T. (occupational therapist) or a social worker to be more involved. So we would see a change in our model. We would expect that to be more prominent and that would not necessarily be in the G.P. practice, it would be within people's homes.

Deputy M.R. Le Hegarat:

Much has been said about not bringing people into town for hospital appointments. Many people live and work in town and have appointments during the day to attend outpatient appointments currently at the hospital, how would you manage the potential disruption and inconvenience caused by employees having to attend community hubs out of town? How will you manage that because obviously we do have a large percentage of our population who work within St. Helier, so how will you manage that side of it?

The Minister for Health and Social Services:

There will obviously be hubs in town because there are 300,000 plus people here, town is not excluded at all, but we will send one or 2 professionals or a team to work in that hub rather than having 30, 40 people being brought into the hospital for a clinic that afternoon or something.

Deputy M.R. Le Hegarat:

An additional part of that, do you foresee any resourcing issues in relation to the actual moving your hubs out? Can you see any resourcing issues that you may have as a result of that, providing that facility?

Director General, Health and Community Services:

No, we have the resource currently. The resource is just in the wrong place and so we could implement the care model basically, it is not resource constrained. The resource is not where it needs to be in order to be able to deliver care. In St. Helier we would be able to identify need according to commissioning. So you are absolutely right, if there is a demand for a service for people of working age to able to access care we will commission that accordingly. This is absolutely about delivering convenient care for our patients and we have done a lot of work around that. What we would not want is the people in St. Helier then to access E.D. (Emergency Department) or U.T.C. (Urgent Treatment Centre) because that is not good for patients or for staff so it would be through our commissioning framework that we would identify where care is needed to be delivered. If that is emergency access to care during the day at St. Helier practices that is the understanding that we would have with those practices.

Deputy K.G. Pamplin:

If I could just chip in. I just want to go back to our mental health assessment report where - I think this is relevant - there are issues brought up in our report around the continual funding of the length of funding contracts with third parties, the Jersey Alzheimer's Association as we quote in our report says, and I quote: "The service that they run costs considerably more to run than the current grant supporting from Government" and the funding that is received is on a yearly basis. For example, he gave us … in a 6-month period he said he had 5 separate conversations with 5 different civil servants

to discuss ongoing funding arrangements. Is this something that is part of the future care model that will be fixed? Because if we are going to turn around to the charities around, from the very big and well supported like hospice, right down to smaller charities who run the central services, that they are going to have clearer direction on their funding and who they report to … funding particularly.

The Minister for Health and Social Services:

Yes, it will be fixed, Deputy, and we are in discussion with the charities about that and those discussions are not just a pepper pot of civil servants talking to them, there is a dedicated team working with them and we absolutely acknowledge that we want to commission them for a lengthy period of time that would give them security and give their workforce security and provide certainty for the service.

Deputy K.G. Pamplin:

Just to push you further on that. Will we get rid of 12-month rolling contracts which for charities is just not …

The Minister for Health and Social Services:

We do understand that. At the moment I think they are a 12 month contract, or many of them, but that is because we are still working on the Jersey Care model, but after this 12-month contract we will then be in a position to commission them for a much longer period.

Deputy M.R. Le Hegarat:

We will move on to G.P.s.

[11:15]

Deputy C.S. Alves:

Officers have previously advised us that the additional use of G.P.s in providing treatment that is currently delivered in hospital would be funded by the department. Can the public be assured that if a service moves from the hospital to the G.P. that the service will be provided to them free of charge as is currently in the hospital?

The Minister for Health and Social Services:

Yes, because the cost will no longer be in the hospital and therefore I would not want to return it to the Treasury, it can be used to fund the new model of care.

Deputy C.S. Alves:

In the last public hearing the Director General advised that a condition framework was currently being developed. When is this due to be completed?

Director General, Health and Community Services:

So that is an ongoing piece of work. We have our first delivery board meeting on 27th November when we have all providers around the table. There was a codesign meeting yesterday afternoon with some of our third sector partners around codesigning the delivery of care in the community. It is difficult to give a timeframe. I would say probably … we need some contracts for 6 months in order to be able to understand how we spend our money differently. I would think we would be looking to have a working framework probably by the end of quarter 1, or quarter 2. It is difficult for me to give you a date because it is a whole different way of working and it is a cultural change, not just for us but for our partners that we work with. I would hope not longer than 6 months away.

Deputy C.S. Alves:

Thank you. Income support incorporates a contribution based on a certain number of visits to the G.P. per annum, however that may be difficult for recipients to manage if they are having to go to their G.P. more than the assessed number of times. What is being done to address this matter, particularly as the provision of care to be provided by the G.P. increases?

The Minister for Health and Social Services:

Yes, so we have said in the Government Plan that we will address that question and come up with a solution in the course of next year and there is a group working on what may be done about that. Of course, we will be moving to different models of care that are not necessarily payment at the gate before you can see a doctor, it will be that we will commission the G.P.s on a contractual basis to look after their patients without charge to the patients in many respects, particular those with long-term conditions. But for those who perhaps might not have a condition that needs regular monitoring and feel unwell, that immediate need to go to the doctor, for the time being that model will continue. I think that is being reasonable. We are not going to move to a position where all primary care is paid for by the State unless Jersey wants to make a huge change. The way Jersey has grown up is that we do pay for some aspects of healthcare and some of that is going to continue. We have to protect those who are financially vulnerable and that is a work stream that we will complete but it will be in the course of next year that we will come back with firm proposals.

Deputy C.S. Alves:

Obviously I mentioned there income support but there are also many people who are not eligible for income support who are probably slipping through the net and are not being recognised at the minute because they are struggling with the cost of the G.P. and therefore they are just not going at all. Are you undertaking any work to address this, to look into it?

The Minister for Health and Social Services:

Yes, I know work is being addressed to look at the principle outside income support, so we can also look at the group of pensioners who are on the pension plus scheme and then, of course, there are the people who have arrived in the Island in the last 5 years and are not eligible for income support but some of them with young families who would have needs. I think they have been identified as a group through the pupil premium at the moment so they are kind of known to Government in that respect.

Deputy C.S. Alves:

Pupil premium also is disclosed on the agreement by the parents disclosing their income, so there is still a possibility that there is a group of people out there who will not be identified by any of the means that you have mentioned now?

The Minister for Health and Social Services:

That is possible. So we must do this work, we must try and identify that we are reaching all those in need and we have asked community and local services and all other States Departments to help us to reach that part of the population.

Deputy C.S. Alves:

G.P.s are in private practice and, as such, are free to set their fees as they consider appropriate. If money is transferred from H.C.S. to the G.P.s delivering the service, what safeguards will be put in place to control this once G.P.s have an increased demand placed upon them?

The Minister for Health and Social Services:

Well, we will enter into contracts with them and obviously the fees paid to the G.P.s will be fixed and there will be provisions for review of those fees from time to time. So if they are delivering services they are commissioned, they will not be at liberty simply just to say: "I am changing my fees today and we expect you to pay them, Health and Community Services." So it is a contractual basis and their outcomes will be measured as the Director General has said. That is already happening in some respects so the services that G.P.s are involved in such as the clusters now and certain other services such as the cervical screening, for example, a price was fixed for the delivery of that service. I do not know if officers want to add anything?

Director General, Health and Community Services:

I think we have to be really conscious, as I am sure you are, that the way we fund G.P.s joint behaviours …ie I am a G.P. and I only get paid if I do the bleeding, if I put the plaster on. So we have encouraged this really doctor led model of care so G.P.s have not been encouraged to do that

in a holistic practice around practice nurses and physiotherapists and even if they had we have got them all in Gloucester Street. I am conscious we are always saying: "Tomorrow" but the model will address this because the G.P.s are really up for providing holistic care and being able to do much more. Divest themselves of some of the general care that they should not be hands on doing but which if they had the right resource in their surgery their surgery could do. I am really confident that in the conversations we are having with the G.P.s they are up for delivering a completely different model within their practices and utilising their skills in a much more different way. That will allow us to identify the patients who are coming to our E.D. in Gloucester Street, which a majority of those patients are the unidentified need, then we can contract with the G.P.s around that service and what it looks like. I have full confidence in their ability to deliver a holistic service, we just need to commission it and enable them to do that.

Deputy M.R. Le Hegarat:

As Deputy Alves says, there is obviously a differential between the costs of different doctors of different surgeries and so one assumes that you will pay the same fee to all of them for the same job, but will all surgeries come on board with the new care model? Obviously I have a G.P. surgery which I go to and I have a doctor which I go to but accepting that my G.P. may not deliver a particular service, will each of the surgeries that people go to, will they still be able to remain with the same surgery to get their care? Basically, are all surgeries going to come on board?

Group Managing Director, Department of Health and Community Services:

We believe so. I think it is really clear to us that there are some pathways that we think all surgeries will be able to pick up, diabetes, high volume chronic disease management. There may be some specialities whereby some G.P. providers can say: "We are not able to do that at this moment in time." We think that would be very small volume and very specific specialities. We would have to obviously transition any change from secondary to primary care based on capability. That service would still have to be provided by us until we had an alternative for it. But for the majority of activities that could go to all G.P. providers. They are certainly signalling that for the high volume stuff they would all be able to support it.

Director General, Health and Community Services:

If your G.P. did not do a procedure, there probably would be a G.P. on Island that we could commission it but if you would prefer to come into Gloucester Street, because we will be commissioning it by using our expertise, we would still retain expertise within Gloucester Street. We want to get to a system - and it is probably a good 4 or 5 years away - where there is choice for the patients. So they have a choice of care setting as opposed to, at the moment, just the one place.

Deputy K.G. Pamplin:

Just to continue on, I asked an oral question of you, Minister, back in September of this year about this ongoing discussion with G.P.s and I asked a follow up about the ongoing discussions about the night-time doctor service which was reported as early in April, and I quote: "Could be scrapped unless the option of increasing of what is already £150 to £170 or any additional funding of resource for the improvements of this service." Your response at that time is the service is continuing discussions, they are ongoing, it remains the case that discussion is ongoing. We are hearing discussions are ongoing again. Can you provide us an update of what the future will be for the night-time service now and in the future?

The Minister for Health and Social Services:

Yes, it is interesting, is it not, that the only care available at night, if you are at home and do not want to come to A. and E., is from an expensive doctor. We do not have the 24-hour nursing service. I think many of these patients who are forced to call the night-time medical service probably their needs would be met by a nurse being on duty. A team of nurses available to visit these people and that is part of the care model as you have read. But for the moment we have reached an agreement with J.D.O.C. (Jersey Doctors on Call) and that night-time service is secure for a year, is it? A year starting at what date was it? Well, only in recent months.

Director General, Health and Community Services:

Yes.

The Minister for Health and Social Services:

So it is secure for a good few months.

Deputy K.G. Pamplin:

So as of now for another year?

Director General, Health and Community Services:

I think there is like 11 months left. I think we commissioned it in August, end of August. I will need to come back to you with that definitive date, it has been fairly recently.

Deputy K.G. Pamplin:

What is the impact of those negotiations? Was there any increase in terms of funding or will there be any additional costs or will all costing remain the same for the next year?

Director General, Health and Community Services:

We are grateful from our negotiations with J.D.O.C. that the costs have remained the same. Very much a collaborative discussion because it is an onerous service for the G.P.s as well that we need

to do something different next year. Next year we will be provisioning care differently out of hours. For this year we have contracted with J.D.O.C. to continue delivering at the same cost.

Deputy K.G. Pamplin:

So what will the impact for the patients? Will there be any difference?

Director General, Health and Community Services:

Not for the next, I think it is, 10 to 11 months. I need to come back to you on the exact date that we reconfirmed the contract. I am pretty sure it is August.

The Deputy of St. John:

Can I just ask a supplementary in relation to what is provided in the community? You referenced community hubs earlier on. My understanding is that Communicare is the only community hub currently, what are the facilities being provided at Communicare that would meet the general population's medical needs and support needs?

The Minister for Health and Social Services:

I believe that the variety of charitable organisations are attending there, Age Concern, Jersey Alzheimer's Association, Mind Jersey, I believe some of our staff from the hospital are attending also.

The Deputy of St. John:

In what capacity are they in, Minister?

Group Managing Director, Department of Health and Community Services:

We are looking at physio particularly, they think that they can do much more and they could utilise a service or facilities like that. Some of the frailty support that we would envisage, we think that could be really good for socially isolated people. I think we are not at the stage yet in terms of the Communicare offer or similar to be able to say X, Y and Z service will definitely go into it. We are doing that in our feasibilities, we are looking at all community assets, looking at all of the provision arrangements, the parishes and the G.P. surgeries themselves as well but there are lots of services that we could envisage using.

The Deputy of St. John:

Have you identified any further community locations for community hubs in real terms, in firm terms?

Group Managing Director, Department of Health and Community Services:

Not at this stage, no. Not in terms of our Jersey Care model as such. The Communicare and the Closer to Home initiative is really ahead of where we are so it is slightly separate. We have not identified further hubs. What we are thinking about is the Listening Lounge, for example. We think that is probably a really workable offer that we could think beyond just St. Helier and that could be a facility that we would like to see in more than just one place quite quickly. So we are seeing how that goes.

The Deputy of St. John:
It is interesting the more Listening Lounges you open the more staff you require. Are you able to resource that facility in multiple guises?

Group Managing Director, Department of Health and Community Services:
There was pretty successful recruitment to the first facility that was …

[11:30]

Assistant Minister for Health and Community Services:
There was no shortage of peer support, that is for sure. We had a lot of interviews with peer workers and I think 97 people applied and I think they are using about 20 to 25 of them, so there is certainly capacity from that regard. I think from professional support, certainly from LINC and LV there is certainly professional support there to assist. I think if we look at another site then obviously I think we are looking at a tendering process and going out to the market for that.

The Deputy of St. John:
Okay, thank you.

Deputy K.G. Pamplin:
While we have just touched on the Listening Lounge, we just want to issue our congratulations to everybody involved in a successful launch and everybody involved in that side from our panel, from our work and from everybody in the health community. I was there the other day and it is great to see and long may it run and be a success.

Assistant Minister for Health and Community Services:
Can I just thank the panel for their positive comments around it as well, because it works both ways and I know the staff and they appreciate the support that you have given.

Deputy K.G. Pamplin:

Yes, thank you, appreciate that. So we move on to dementia, a subject I have raised previously, again in the Assembly and at previous meetings, in a report in the *Jersey Evening Post* during the Alzheimer's awareness week it was disclosed that the number of people seeking support and advice from the Jersey Alzheimer's Association, another third party charity, has risen by over 235 per cent since 2012. We know this is an issue we have touched on before, we have heard before that again discussions have been going on but how close are we to once and for all having a dementia strategy and what can you update us on that?

The Minister for Health and Social Services:

I do not believe there is a fixed completion date given for the strategy but we are working … I regard it as something critical and important.

Deputy K.G. Pamplin:

What work is going on then currently that you can inform us about with the Alzheimer's Association within Health and Social Services that you have just referred to?

The Minister for Health and Social Services:

Yes, I do not sit on the strategy group.

Assistant Minister for Health and Community Services:

I went to the day itself and spoke to Sean Pontin at that particular meeting. I stressed to him how important that strategy is to the department. It sits under the delegated responsibilities that I have but I need to speak to the Minister and senior officers more closely around what resource could be put in to providing some support to look at how the dementia strategy could be put together. I made it clear to Sean I think it needs to be a priority, we are going to get growing numbers of elderly, growing numbers of people with dementia. It is going to be an issue both for professional staff to support and also in terms of where we support people with dementia so there are a lot of questions that need to be answered. It is a conversation I need to have with the Minister I think.

The Minister for Health and Social Services:

Yes, thank you, Steve. This sits at the heart of the care model, does it not? It is about dementia patients in their own homes, keeping them as independent as possible so that also brings in the technology, the digital programme because there are aids that can help them do that. Where they perhaps cannot stay in their own homes, we do not necessarily want them moving into full residential care. Can we provide this lovely concept of a dementia village that has been talked about or at least some sort of sheltered accommodation that would meet their needs and there will be talks with Andium Homes about that because I believe that is in their programme and planning that they would want to engage with Government to deliver those sort of services.

Deputy K.G. Pamplin:

What that sounds like is a strategy which goes back to what we are alluding to to achieve the future care model and the elements like this there needs to be a strategy in place and this is the strategy that has been talked about for 12 years and still not come down the line.

The Minister for Health and Social Services:

But I think the strategy group will be talking with Andium Homes, for example, about their part in it.

Deputy K.G. Pamplin:

Again, it goes back to what we alluded to in our mental health report, if a charity like this is to sustain the current numbers that it is seeing in terms of support given but only has it funding for 12 months and with the introduction of care regulations that have been introduced recently, there are growing pressures being put on a resource like the Alzheimer's Association which can only rely on its fundraising from Islanders and the relationship it has with Health to meet the demands that are growing all the time. There it sees a future care model which is saying: "We are going to link up more with the charity sector." That is all well and good but we do not know where our support is coming from, the funding, the strategies and also it has to tie in with the mental health services, which is undergoing change as well. Do you see what I am getting at? There is a lot going on but what people are asking for is clear direction, when it is coming and how it is going to work.

The Minister for Health and Social Services:

Yes, so there are all those uncertainties perhaps but we are not going to drop the Alzheimer's Association, they are a vital part of delivering our …

Deputy K.G. Pamplin:

I do not think they feel they are going to be dropped but what I think we are all saying is that this argument for a strategy has been talked about for such a long time.

The Minister for Health and Social Services:

Yes. Yes, and it should have come before. We should have been more ready with a strategy but it has not happened …

Deputy K.G. Pamplin:

But does it surprise you that we are talking about a future care model and we are talking about elderly population, we are talking about getting people out of the hospital into care homes but one of the fundamental big problems we have going forward is the impact of dementia that we are seeing rapidly … and we do not have as strategy in place to work along with the …

The Minister for Health and Social Services:

Yes, well there was … perhaps when people did the mental health strategy they thought that is dementia covered also. There was a part in there dealing with dementia but clearly not enough. But, you know, there was a lot of concentration on the mental health strategy in recent years and that was right, that was severely lacking. We have got that in place now.

Deputy K.G. Pamplin:

With the greatest respect, Minister, we did a review on that strategy, we found a lot of issues within it hence why we had our recommendations …

The Minister for Health and Social Services:

It is still a work in progress.

Assistant Minister for Health and Community Services:

They are 2 separate issues. I agree the mental health strategy also needs a review to be honest and I think we are going to do some work on that, I do not think there is any doubt about that. But the dementia strategy has to deal with a lot of issues not just about care but about prevention, diagnosis, making sure we could maybe get early interventions, trying to prevent people getting it in the first place.

Deputy K.G. Pamplin:

Support for carers as well.

Assistant Minister for Health and Community Services:

Absolutely, so it is a really wide issue and it needs … you are right, it does need to be concentrated on and is it a gap? Absolutely, it is a gap and it is a gap we are going to have to deal with, I think, quickly.

Deputy K.G. Pamplin:

Okay, thank you.

The Deputy of St. John:

The new care model includes an acute hospital offering emergency treatment, elective treatment and so on. The new model creates an emergency department with an urgent treatment centre. What will the urgent treatment centre look like?

The Minister for Health and Social Services:

I will defer to those who have seen one in the U.K. Because that is perhaps the issue that we do not know in Jersey what it looks like, we have not had that experience so this is something new to Jersey but it is certainly not new to people living in the U.K. and it is an accepted model of care there.

Director General, Health and Community Services:

It will be a triaging function. If you are blue lighted in then of course you will go straight to E.D. and you will be taken through to our resus facility, but everyone else who walks through the door will go through a U.T.C. and be triaged as to whether they do require urgent treatment from a secondary care clinician or whether they need to refer back to their G.P., or if they do not have a G.P. a conversation about why they do not have a G.P. but have a G.P. within the U.T.C. who can also service their need. So it is about us being able to streamline need. What we cannot have is what we have currently where we have patients in resus, really ill, and our clinicians having to focus in there and then a whole raft of people outside who need to be seen elsewhere and are diverting our clinicians' attention from our most seriously ill patients. The U.T.C. will allow us to triage care appropriately but we also hope it will be an educative function, and it will also help us around some of the needs identification we need to do with our patients.

The Deputy of St. John:

In some ways the triage process exists already, does it not, in that people are greeted at the door and decisions taken about in which direction they should go. You are saying that the U.T.C. would be staffed by a G.P. or G.P.s, would there be an upfront charge associated with an audience with a G.P. in the Urgent Treatment Centre?

The Minister for Health and Social Services:

Let us not rule it out because if people choose to receive their primary care in an urgent treatment centre, and in Jersey primary care is a service that so far citizens are asked to pay for, then as in Guernsey it could be said that there should be a charge for that. People do talk to me about that and say: "Why do you not do it?"

The Deputy of St. John:

In Guernsey they have an insurance system, private insurance system which people are able to pay into the insurance scheme to enable them to visit their general practitioner. That system has never been available in Jersey, hence you have some 40,000 or so attendances at A. and E. every year. Are you simply going to say: "Well, if you come into A. and E. we are going to charge you anyway so go and see your G.P", is that the intention?

The Minister for Health and Social Services:

No, not at all.

Director General, Health and Community Services:

We are not going to turn away need and we are not going to penalise presentation of need but what we cannot become is, and what we are slowly becoming, an alternate to primary care. There are always going to be people who are not able to access primary care despite out best efforts for a variety of reasons, not just fiscal, and we have to, as a State, be able to scoop those people up and deliver care. But what we are talking about, and it is very early days, is if you are a repeat presenter at E.D. and you are never admitted, and you are presenting for a complaint and you are registered with a G.P. and instead of accessing your G.P. you are coming to the E.D. repeatedly, and we are not admitting you so you do not need secondary, then we need to think about how we deal with that because what we do not want to do is come to a position where we have a facility that is rivalling primary care and turns into the mess that is emergency care in the U.K. That is a piece of work that we need to do and focus on and it is really difficult because we do not want to be in a position of penalising people for presenting for care but we need to understand how we stratify that demand. It is a piece of work that is ongoing with us. If you need care and present at our front door you will be given care.

The Deputy of St. John:

Are there any negotiations going on with insurers to facilitate a health insurance scheme about G.P. consultation?

Group Managing Director, Department of Health and Community Services:

Not at this stage, no.

Director General, Health and Community Services:

No.

The Deputy of St. John:

Is it worth considering that like Guernsey we could ameliorate the difficulties by having such a scheme?

Group Managing Director, Department of Health and Community Services:

We have been really clear on the work we have undertaken on the model and that we have now got a health economic impact assessment that we need to undertake so that will consider the totality of funding, the future forecast of funding, the need, the position and I think it will consider a range of options. The as is, what does insurance make, the private public split, it will look at all of that situation and come up with some recommendations for us.

Director General, Health and Community Services:

What the Island really needs is that needs assessment and we have not got one. It is such a gap because even with our work, you know, we have number crunched and we have looked at stuff and we are fairly confident but you need that needs assessment to determine need. It is a real gap I think we have on the Island because that way you do target care. We do not want to turn away need at all and we hope our commissioning function will provide additional environments of care for need, for need that currently presents at our front door because of fiscal means or because of disorganisation. But we have to have that needs assessment done.

Deputy K.G. Pamplin:

It is not fair to say that where the need is greater is where less resource is available to … for somebody to receive care. Some days, for example, from my own experience, it is a like a doctor's waiting list because where else can somebody go on a Sunday if they need to see a G.P.? As an obvious starting point, how do we challenge that and how do we move forward from that because that Sunday day is extraordinary and the amount of pressure that must put on the staff is extraordinary. How urgently can we move away from that, do you think, in the future?

Director General, Health and Community Services:

That is on the agenda for 27th November, exactly that, because you are absolutely right, out of hours and weekends the only place to go is Gloucester Street and, you are right, is that the most appropriate care? Do we have the appropriate staff on? Probably not. That is one of our first work streams that we are doing that our modernisation team is leading.

Deputy K.G. Pamplin:

Which will be interesting when we look at the figures from the Listening Lounge, which is offering 7 days a week advice and offering, including on a Sunday from a 10 to 10 perspective, how that is picked up and how that is used because if that shows where the obvious problems are it is having that data surely?

Director General, Health and Community Services:

Yes, absolutely. Yes, it would be really valuable.

Deputy C.S. Alves:

So moving on to prescribing medicines. The recent adoption of the Health Care (Registration) (No. 5) (Jersey) Regulations 2019 extends the categories of professionals who can prescribed controlled medicines to include optometrists, pharmacists, radiographers and others. So will there be any controls or limits on what these professionals can prescribe?

[11:45]

The Minister for Health and Social Services:
Yes, there will be. The legislation that was passed in the States Assembly is an enabling legislation but there is also a whole raft of regulatory and governance systems that do make sure that people are prescribing appropriately and have the correct qualifications to do so.

Deputy C.S. Alves:
Following from that, we understand that pharmacists need 12 months of training before they can prescribe. What engagement has there been with the additional categories prior to the introduction of these regulations?

The Minister for Health and Social Services:
I believe there is going to be engagement from now on, not to say that there was not any before, but there is a training system being set up shortly, am I correct in that?

Director General, Health and Community Services:
Absolutely. So we can start to share the full competency framework that has been agreed around how people prescribe and there is a lot of work that is going on with that which our Chief Pharmacist, Paul McCabe, is engaged in.

Deputy C.S. Alves:
Will there be any financial support available for the pharmacists during this 12 month training period if they require it?

The Minister for Health and Social Services:
I do not believe there will be Government funding for that. It is a professional enhancement that pharmacists will choose whether they want to make that progression through their career. It is not something that Government has funded.

Deputy K.G. Pamplin:
Can I interject there then? The success of the future care model is providing more services so under the regulations it means that once trained up pharmacists can prescribe certain medications, however we want this to be a success so if somebody in St. Mary needs to get a prescription they can get that from their pharmacist in St. Mary but if the pharmacist in St. Mary says: “I do not have the funding in my budget to do that to help you out” surely there should be some conversation to say this is part of the future care model that there will be some support.

The Minister for Health and Social Services:

Sorry, I was referring to funding for training when I said that …

Deputy K.G. Pamplin:

Yes, because obviously they might turn around and say: "Right, we want to commit to this but we need help funding the head pharmacist to receive that training because we do not have the budget to spend the money to train that pharmacist up."

Group Managing Director, Department of Health and Community Services:

Yes, exactly the same as the G.P. discussion we had earlier. In the future model, absolutely primary care would be part of our consideration in terms of … I mean, wide primary care including pharmacists in terms of education, training and where we need them to be equipped to deliver pathways of care, which is obviously not in that space at this moment in time.

Director General, Health and Community Services:

That is because we need to have the economic case around the care model, which we quite freely say we have not had done so when we have our partners working alongside us who will stress test the model, both fiscally and operationally, they will be able to say to us what the available envelope is. We think we will have an available envelope given our overhead costs currently to be able to deliver training to do exactly what you say because of course we want to support these people to deliver care. It is much cheaper for a pharmacist to prescribe than for a consultant or a G.P. to prescribe. But what we do not want to make is commitments until we have that absolute economic case around the health economy so that we are not making false promises or putting ourselves into debt around what we can deliver.

Deputy C.S. Alves:

With only one pharmacy currently remaining open until late what additional demand do you envision being placed on the pharmacies? Would there be the possibility of having a 24-hour pharmacy, for example, because I think you mentioned about sometimes people present in A. and E. and they do not necessarily need a G.P., they need a nurse. I found myself in a situation last week where I knew what I needed, I was quite ill and there were no chemists open, happened to go to Roberts Garage, did not have what I needed, so I ended up phoning the G.P. out of hours because I did not know what else to do. But I knew that presenting at A. and E. was not the best option in the current state I was in. What kind of demand do you think will be placed on that and is there the possibility of maybe having something like a 24-hour pharmacy open given now that you are wanting to put that extra training in?

Group Managing Director, Department of Health and Community Services:

I think that is a realistic prospect. We could envisage that happening. I think at the moment we feel that we have a deficit in the system because we only have one provider that is open to extended hours, it is not 24/7, and we know we have got a fallback, which again is the hospital or J.D.O.C. So I think that is a realistic prospect for us. In the same work we do, we have got to work out the volume, how we would meet that, how we get into that contractual framework with the provider to set that up but I think that would be part of the core offer we would envisage in the future.

Director General, Health and Community Services:

We would be able to answer that much more concretely probably April next year, but what we do not want to do is make the mistakes of the past where we are just putting in service and not understanding the economic need, the actual clinical need. I mean your story is such a great example why we need to do things differently. But absolutely, we need to model demand and understand it and see how we can most appropriately meet it. We have got the model, we have got the strategy, we have got the vision, we now need to understand what that implementation looks like and that is the work really of the next 6 months.

Deputy K.G. Pamplin:

Just wrapping this up, it is a bit of a whinge. Well, it is not really a whinge. The regulations we did not see before it was brought to the Assembly and I think we have communicated that. We were not happy about that. We would have liked to have seen … a short-notice period. We usually have very good sight with, and I know there is a lot going on or changing, Government Plan and all that sort of stuff, but just requesting going forward any regulations that are impacting to any change to be brought in the Assembly that, as a request, we have a briefing previously because it meant we had to scramble on our feet to understand at the time of the debate. We did not feel at the time we wanted to bring it in for a Scrutiny Panel but there could have been a concern and it could be in the future that if we have not seen it we might need to. So just in future, as a request from all of us, I believe, that if that happens again we can, even if it is just a briefing from an officer that we have sight of it again in the future.

The Minister for Health and Social Services:

You are absolutely right. I missed that so I can only offer my apologies. It would have been the better course of action. I am sorry.

Deputy M.R. Le Hegarat:

I think sometimes we can think something is straightforward and then in actual fact when you look at it closer and when you talk to the outside agencies that sometimes this may affect, that is when you suddenly think: “Hold up a minute, there is more to this than meets the eye.” I think this was

probably a good case because it was legislation that was introduced and then some of the team, as Deputy Pamplin found out, that it is a 12-months' training programme. So there were all sorts of implications and, yes, it is a good idea to make sure that the law is accepted before maybe putting people on training programmes because you do not want to train people before you have the legislation but it would have given us an opportunity to just at least have some sort of idea, and I think that is where we are coming from.

Deputy K.G. Pamplin:

Because we have had it explained to us asking these questions today. There have been concerns, we have heard from some pharmacists who were not even aware that it was happening so it only works both ways. I know we have got a good working relationship so I only bring it as a constructive criticism.

The Minister for Health and Social Services:

We will take that and you are absolutely right.

Deputy K.G. Pamplin:

Going forward if this is continually raising some concerns in the future, arrange a future briefing on this, I think it is going to be helpful. I think people are realising why I ask so many questions in the Assembly now because another question I asked on 22nd October was about improvement of care for spinal injury patients. You advised me that work to develop an end-to-end care pathway had commenced in quarter 2 this year. So can you just confirm that that is continuing, what an update is, and who has overseeing responsibilities for this?

The Minister for Health and Social Services:

I am sorry, Deputy, I have to confess I was distracted by something else. Could you repeat the first part of your question?

Deputy K.G. Pamplin:

Yes, so basically I asked this question on 22nd October about improvement of care for spinal injury patients. You advised that work to develop an end-to-end care pathway had commenced in quarter 2 this year, so I am asking for an update of that. Can you confirm who is overseeing and who has responsibilities for that and spinal injuries?

The Minister for Health and Social Services:

Work is continuing on that pathway. There is a team lead physiotherapist and a senior occupational therapist who are working on it and are working out the best ways in conjunction with tertiary care providers to deliver the ongoing care to spinal cord injured patients.

Deputy K.G. Pamplin:

I do not want to give you catchphrases and say this but you have said multiple times today "continuing work in progress". Can you just focus in on what that work is? Here is a great example: what has been done since this was commenced? Can you provide any information on what that work is?

The Minister for Health and Social Services:

Let me see what notes I might have. I know there have been discussions with Salisbury Hospital and the specialist unit there. The discussions around how these patients would have a specialist review. It is possible to use teleconferencing facilities and we will arrange for those sessions to be attended by … or the patient to be accompanied by representatives of our rehabilitation team. Then I think there is work around the specific needs as for bowel management that these patients may need that sort of assistance too. That is being discussed with them and better provision made.

Deputy K.G. Pamplin:

There has been a member of the public, who I know has engaged with yourself and other States Members about this, but since looking into this and gathering a bit of research there are a few alarm bells ringing for me here. Maybe, Rob, you could give us some indication. What is available if somebody presents with a spinal cord injury right now and what is happening right now? Because it seems to me that there are a few gaps in service providing.

Group Managing Director, Department of Health and Community Services:

So if they present with a need for intervention then they would have tertiary care. We are not able to provide that acute specialist treatment on-Island. I do not think it would be achievable for us to be able to provide that care, in all honesty. I think we will always need tertiary connectivity for that. Thereafter, dependent on the outcome of the individual, I think there are very few specialist centres who are able to provide such focused rehabilitation. They require significant specialism from physios, from connectivity to spinal experts, neuro experts, psychology services. I do not believe that Jersey has that level of infrastructure to provide such a specialist rehabilitation service. What we can do is expand on the existing offer that we have. That is where we connect our existing physio services, our O.T. services, things like bowel management, general support and psychological support, but I think there will always be the need for specialist connectivity for the acute intervention and rehabilitation within a tertiary pathway. We do not have the numbers in Jersey.

Deputy K.G. Pamplin:

It is very complex. If somebody presented at A. and E. with a multitude of issues that they have a spinal injury, it is a very dedicated specialist area of support so what happens if somebody presented now and needed that, how would you get that person a specialist? How does it work?

Group Managing Director, Department of Health and Community Services:
We would have an urgent tertiary transport for the person. So we have a retrieval service where we would get that person into the right centre.

Deputy K.G. Pamplin:
How many people are skilled up in the A. and E. Department to handle such a complex area?

Group Managing Director, Department of Health and Community Services:
They are all skilled to be able to understand the presenting complaint and whether or not we need to undertake an urgent diagnostic to determine if there is spinal damage. In the event of the diagnostic then, we would obviously plan our tertiary care. Prior to the diagnostics, staff should all be equipped with the knowledge and understanding of how they would maintain the spine and ensure that they are not further damaging the person attending.

Deputy K.G. Pamplin:
So what this is, is more work needed for continual care between the hospital and outside the hospital?

Director General, Health and Community Services:
You are always going to need to go off-Island because even in rehab with complex spinal injury where you have breaks in the vertebrae, you can do teleconferencing but you have to have hands-on assessment. You have to watch mobility. You have to see it with your own eyes as a clinician. So if you have got a spinal injury in Scotland, you have to travel outside Scotland at least twice a year in order to be able to have that spinal assessment in order to be able to maintain that visual about the integrity of the vertebrae and the mobility that arises from that. We have talked long and hard about this because I have interaction with the patient. That end-to-end pathway we absolutely need to keep working on. We have done a lot of work around mobility of the bowel and have we managed that and psychological support. We do need to make sure that we maintain that that is linked up. But you are always going to have to go off-Island. That is for patient safety as well. We do not have the numbers to be able to maintain clinicians' capability around provisioning that kind of complex service. But what we can do is make sure we get the wraparound stuff right.

[12:00]

Deputy K.G. Pamplin:

There is an opportunity there to work with the charity providers. I am thinking of Headway, where I used to work, and Cheshire Home numbers that could step in here and help a bit more. It seems to strike me as an obvious answer.

The Minister for Health and Social Services:

I know physiotherapy and hydrotherapy services are offered by Cheshire Home.

Deputy K.G. Pamplin:

But this is such a niche area. It just seems that there could be somewhere where a charity with support funding, could step in where they are already doing similar work neurologically, like Headway and like Cheshire Home. When do you anticipate appointing an employee in this capacity that was mentioned in your response to my written question back in October?

The Minister for Health and Social Services:

I think the team physiotherapy and the occupational therapists will provide that level of support. I do not think numbers in Jersey will provide a dedicated person who will be solely devoted to working with spinal cord injured patients but it will be part of a wider teamwork.

Group Managing Director, Department of Health and Community Services:

One of our senior physios is leading on this. She is looking at this in conjunction with wider rehabilitation as well and the connectivity to our reablement services. So it might mean that we have some different configuration of the team going forward but we have got an identified lead who is doing this work at the moment for us, working closely with our lead O.T.

Director General, Health and Community Services:

Also signposting. I mean I have had a conversation with a patient and one of their challenges was about signposting. Your life is difficult enough, you do not want to navigate the maze of services and we recognise as part of our modelling work that there is a maze. We do not have a directory of services. So what we are trying to do with our social care team is provide a link person who can do that, negotiate that maze around some of the basic stuff so that you have not got that hassle as well as your mobility issues. It is an ongoing piece of work for us. We recognise it is a niche presentation but we recognise we need to address it. We need to address it because of our geography. Because people are isolated.

Deputy K.G. Pamplin:

You just touched on an issue there that is very interesting, the G.P. patient pathway. G.P.'s have been talking to us about the information that is provided to them on this intranet system that they

have when they are seeing a patient. Previously it was said that this was okay. It does not seem to be working so can you give us any insight on how if that has been worked on as part of all of this, to replace it or help G.P.s so when they can type into, like they do with the system when they are medicating and prescribing, that they can tap in and information comes up of what resource is out there in terms of charity providing stuff because it is pretty dated.

Director General, Health and Community Services:

This is around the advice and guidance work that we want to do around the Communicare models, the G.P.s can access advice electronically or they can be directed to the person they need to speak to. A current piece of work that we have ongoing with the modernisation team is formulating a directory of services so that we are able to have not just the G.P.s but for members of the public a clear roadmap around the services that are available in Jersey. We would like to get to a position where we are able to rate those services and offer recommendations to patients; that is part of the journey we are on, around the D.O.S. (directory of services).

Deputy M.R. Le Hegarat:

I think that is pretty much us done. Thank you all for attending and hopefully we will see you again in a couple of months' time.

The Minister for Health and Social Services:

Thank you, Chair.

[12:03]