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Health and Social Security Scrutiny Panel

Follow-up Review of Mental Health Services

Witness: The Minister for Health and Social Services

Monday, 28th February 2022

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

Senator S.W. Pallett

Witnesses:

Deputy R.J. Renouf of St. Ouen, The Minister for Health and Social Services

Deputy T. Pointon of St. John, Assistant Minister for Health and Social Services

Mr. A. Weir, Director for Mental Health and Adult Social Care

Ms. R. Naylor, Chief Nurse, Health and Community Services

Mr. P. Armstrong, Medical Director, Health and Community Services

[10:35]

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

Good morning, everybody. This is the public hearing of the Health and Social Security Scrutiny Panel with the Minister for Health but we are meeting today in relation to our review of the situation in relation to mental health following the review we did, which was released in 2019, so basically this is a follow-up. Normal rules apply as if we were in the States Assembly. We apologise for being slightly late but we are using both tech and a number of us are within the States building this morning. What we will ask is that if people are going to speak that they put their camera on in order that the public can see them and while not speaking ensure that cameras are off and that any microphones

are off. I will start off by introducing myself and then I will ask all members who are likely to speak today to introduce themselves. If by any chance somebody ends up speaking that has not introduced themselves, I would be grateful if they could do that. I am Deputy Mary Le Hegarat, District 3 and 4 of St. Helier and I am the Chair of the panel.

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

Good morning, everybody. Deputy Kevin Pamplin of St. Saviour District 1 and I am the Vice-Chair of this panel.

Deputy C.S. Alves of St. Helier:

Good morning, everyone. I am Deputy Carina Alves of St. Helier District 2 and I am a member of the panel.

Senator S.W. Pallett:

Good morning. Senator Steve Pallett, another panel member.

The Minister for Health and Social Services:

Good morning. I am Deputy Richard Renouf, Minister for Health and Social Services.

Assistant Minister for Health and Social Services:

Good morning. I am the Deputy of St. John, Trevor Pointon, and I am the Assistant Minister for Health with responsibility for mental health.

Director for Mental Health and Adult Social Care:

Hello. I am Andy Weir. I am the Director for Mental Health and Adult Social Care at H.C.S. (Health and Community Services).

Chief Nurse, Health and Community Services:

Good morning. I am Rose Naylor and I am Chief Nurse at H.C.S.

Deputy M.R. Le Hegarat:

Okay, perfect. I think a lot of the questions this morning will obviously be directed to the Assistant Minister, Deputy Pointon, but we are going to start this morning with Deputy Alves who is going to ask questions in relation to the impact of the COVID-19 pandemic.

Deputy C.S. Alves:

To start, please can you provide the panel with some details about how mental health services adapted and were impacted during the COVID-19 lockdowns in 2020 and 2021?

Assistant Minister for Health and Social Services:

Yes, thank you for the question. Certainly we were not able to provide all of the services that we would have liked to during that period, for obvious reasons, but out of the ashes rose a phoenix because we were able to increase our community support network and move staff into the community to make the lives of people with mental illness much steadier. For absolute detail, I will ask Andy Weir to come into the conversation.

Director for Mental Health and Adult Social Care:

Thank you. I think it is really important to remember that at the start of COVID every health service everywhere was operating in an entirely new situation and without a manual. No one really knew exactly what to do, so anything that any service did I would contextualise by saying people were doing their absolute best at the time to maintain safety. There were lots and lots of concerns about particularly physical contact with people. So the mental health services really quickly did a R.A.G. (red, amber, green) rating assessment of the services that they provided, what they needed to carry on providing as an absolute priority, and that included the inpatient services, 24 hours services and access services, the points at which people would come into the service, and community services. Some other services were reduced or for periods of time temporarily stopped in order to facilitate that and that was predominantly a staffing issue. There was a need to move staff around in order to maintain those services in a safe way. That is entirely normal. That was the case in any health system anywhere in their initial response to COVID. I think the consequence of that was that there were a group of people who had less direct face-to-face contact than they would have had ordinarily. A lot of staff did not work. They were working remotely for a period of time and consequently some of the contact, the mental health contact, was done virtually and that was new. That was something that had not happened before, so it took a bit of time for the service to adapt to that but they did that well, I think, is my assessment of it. Subsequent to that, things have then built up over time. I think there were really quite significant changes that they had to make to the delivery of some of the core services. So in the inpatient setting, for example, the first person to die of COVID on the Island was in the mental health service, so mental health nurses, who normally look after people with psychiatric illness were suddenly nursing folk with infection prevention measures in place, physical health issues that they might not have otherwise dealt with. The way that the service adapted to manage that I think again is exemplary, frankly, and they have managed infection prevention well subsequently. There has certainly been an impact. As with any service, where things are shut down temporarily then you end up with a bit of a backlog. So we know that in some of our services we have got a backlog around particularly psychological therapies and again in line with any health system anywhere we are having to develop recovery plans to say how will we now deal with that backlog and make sure that people get seen in a way that is appropriate and as quickly as possible within the limitations of the resource that we have got. But the other thing that Deputy Pointon said,

which is absolutely right, is that in the middle of all of this ... one of the recommendations from the original Scrutiny report was the development of a crisis model, a home treatment and crisis team. In the midst of all of this stuff, the service managed to pull together quickly and implement a crisis and home treatment team, which is remarkable, frankly, from my perspective and really should be applauded. So there was a step in the middle of the crisis pandemic that led to the development of a more coherent model for people in crisis and in the community. So, per se, the summary is there was certainly quite a lot of significant impact on service delivery, on models and some service reduction in the community but plans were put in place and are being implemented now to make sure that we recover from that in a sensible and appropriate way within the limitations of the resource, so there are some things that we will not be able to do as quickly as we might have been able to if we had more resource and that is about people. It is not about money. It is about having the skilled professionals in the Island to do the work. That is a summary, I think.

Senator S.W. Pallett:

Can you be clear about which services stopped, which services temporarily were suspended and what you did to support people that had their service or their treatment curtailed at very short notice?

Director for Mental Health and Adult Social Care:

I do, of course, have to caveat this by saying I was not here, so I am relying on the information that has been provided to me. I understand that some of the direct face-to-face community services were temporarily suspended, particularly the Jersey Talking Therapies, the Listening Lounge and there was a reduction or change in the way that, for example, the Memory Assessment Service worked. I will use that as an example because it is a good example, that because of the frailty of the population that will be worked with by the Memory Assessment Service there was a significant reduction in face-to-face contact. The service continued to provide some support to people virtually and there was some direct contact but they were not able to do diagnostic work as part of their normal routine work because you have to do that in a face-to-face way. But I would say again this is absolutely consistent with any mental health system that I am aware of.

Senator S.W. Pallett:

Can you explain why Jersey Talking Therapies was suspended considering it is a service that is provided over the phone? What service was put in place to support people at the time?

Director for Mental Health and Adult Social Care:

I cannot, I am afraid, because I do not have that detail. Jersey Talking Therapies is also face-to-face contact. It is not just a service over the telephone.

Senator S.W. Pallett:

No, I accept that but a lot of it is done over the phone initially. Why was that suspended?

Director for Mental Health and Adult Social Care:

What I do know, and one of my colleagues may have more detail, is that a percentage of therapists from Jersey Talking Therapies were seconded very quickly in COVID into the wellbeing support offer. That reduces the impact, that reduces your capacity within the service, but other than that I cannot give you a factual answer as to why that was reduced other than to say again that is very, very common with all mental health systems that I know. There was an absolute requirement to redeploy staff and resource into front line and 24-hour services to maintain the safety of those services.

Senator S.W. Pallett:

How long before there was re-engagement with clients after the service was suspended?

Director for Mental Health and Adult Social Care:

My understanding of all of the services is that service people were R.A.G. rated. There was an assessment undertaken by the service of the level of input and intervention that the service user would need. Some people maintained contact over the telephone, some people did not have direct therapy, formal therapy, but they had a contact offer and a support offer, and some people, I understand, waited. What I do not have is the detail of which numbers of people were in those brackets but there was always maintained through the COVID period direct access to services available. So if people were waiting, for example, for counselling but their position changed or deteriorated there was absolutely and always the opportunity for people to be seen, reassessed and to receive a higher level of input if that was required at the time.

[10:45]

Deputy C.S. Alves:

Thank you. You mentioned there the establishment of the crisis and home treatment team. Are you able to give us a bit more of an overview, including plans for it in the future as well?

Director for Mental Health and Adult Social Care:

Yes, certainly. If we separate out the 2 components, the crisis team provides a quick response for anyone that is in crisis and at the moment that is predominantly people who are either referred into the community services, people who are referred by the police, particularly around things like Article 36 but also other folk that the police are concerned about; anyone where there is a crisis and it is felt that we need to undertake an assessment quickly to work out what is happening. That team is available 24 hours a day, 7 days a week for adults and our plan at the moment ... we are having

conversations with C.A.M.H.S. (Child and Adolescent Mental Health Service) as to how we start to develop in the C.A.M.H.S. arena and possibly work the 2 services together in some way. The other component part of the service model is home treatment and that is really important for a couple of reasons, firstly because we know that lots of people who historically were admitted to hospital did not need to come into hospital and do not want to come into hospital. They can be treated at home and I will give an example. Historically people were admitted because they needed to receive medication twice a day but now the home treatment team can go out and administer medication twice a day if required, so you can maintain people at home if it is clinically safe to do so and that is terribly important because, of course, we do not want to take people to hospital unless we absolutely have to. That is part of the whole community model. It works closely with the liaison service where people are in hospital and have mental health needs and that has developed in the last couple of years but also with the generic community mental health team, so the mainstream mental health services in the community. We are currently in the process of reviewing that community model because one of the things that has happened, I think inevitably, is that as services have developed particularly quickly they have not necessarily tied in well together. We have the services but we do not have a service that works in a coherent way all together as one system. I described it the other day as it is a bit like having a jigsaw where the pieces just do not quite fit together. We have started a piece of work, which we started 2 weeks ago and will complete at the end of March, redesigning our community model so that we are much clearer about what crisis does, what home treatment does and how we make sure that wherever possible we maintain people in the community unless they need to come into hospital and then of course they will come to hospital.

Deputy C.S. Alves:

Thank you. To focus on the start of the pandemic, can you give us a brief overview of the action plan for mental health services? When the pandemic was declared in March 2020 what was the priority in respect of the mental health services?

Director for Mental Health and Adult Social Care:

The COVID action plan?

Deputy C.S. Alves:

Yes.

Assistant Minister for Health and Social Services:

Deputy, I think Rose might be able to answer because she was around at the time, if you like. Andy was not, but it was very much an operational arrangement.

Chief Nurse, Health and Community Services:

Thank you. So just in relation to the outset of COVID and when it first hit Jersey, our main priority at that time was to make sure, first of all, that we were prioritising service provision, so those in most need of services still had access to services, but also that we were very clear in relation to our workforce numbers and our overall bed base. If you remember at the time, the forecasting for COVID impact in Jersey overall was predicted that potentially we would need to increase our inpatient bed base across our whole environment and that included mental health beds as well. So our initial focus was very much on working with mental health services to make sure those in most need of services still had access to services and where possible face-to-face appointments could be held as well. In terms of the specific detail, I would need to go back and refresh that. We would need to provide something in writing to the panel.

Deputy C.S. Alves:

That is fine. Thank you. With reference to the Emergency COVID-19 Mental Health (Jersey) Regulations that were approved by the Assembly in April 2020, please can you outline what communication was provided to front line staff about the new powers and any guidance or training they received in case these powers were ever required?

Assistant Minister for Health and Social Services:

Deputy, I personally am not aware of what training was given but again we have not got people who worked in the system at this meeting at that time and it would be appropriate, I think, for us to provide you with that information in writing.

Deputy C.S. Alves:

That is fine. Thank you. Okay, so in respect of the governance arrangements that were in place in 2020, was there an existing pandemic or epidemic plan as part of a risk register or business continuity plan that sought to ensure the continued operation of services?

Assistant Minister for Health and Social Services:

I think the answer to that is that our Chief Nurse, Rose Naylor, has just given you an answer which would apply to all of the services, because at the time we were really very concerned that we protected our population from COVID. Again, I do not know whether you have anything to add to that, Rose?

Chief Nurse, Health and Community Services:

Yes, if I may. It is just to say that services worked really hard to develop their business continuity plans in the backdrop of the previous work we had done around pandemic preparedness. When COVID hit us, despite the best plans that we had made, everybody across the world was learning things as the time unfolded so those business continuity plans did require refreshment and

realignment as new information came to light. In terms of the governance arrangements and oversight, we quickly moved to a governance arrangement of managing operational delivery through a variety of groups to a bronze, silver and gold command structure. In addition to that, that was not just within H.C.S., we also had that replicated across the Jersey community as a whole as well, of which Mental Health and Adult Social Care were very much part of that.

Deputy C.S. Alves:

Okay. Where does the responsibility for the business and continuity planning sit in the structure of H.C.S.? Is it at board level or within individual service management?

Chief Nurse, Health and Community Services:

It sits at service level. So within individual service management they were responsible for developing those plans but as the executive and the board, we would have to have oversight of those plans to ensure that they were appropriate.

Deputy C.S. Alves:

Okay. Thank you. What data is available to review the prevalence of mental health illness and mental health problems? Is there any evidence of particular areas being especially impacted by the pandemic, for example levels of diagnosis or an increase or decrease in the treatment of certain conditions?

Director for Mental Health and Adult Social Care:

The place that appears to have been most impacted by COVID is low level mental disorder, so anxiety and people feeling socially isolated, those types of things. I think that we have seen that in the level of activity in what I would describe as primary mental health type work, so things like the Listening Lounge, for example. We were talking last week with one of the clinical leads in the service and one the consultant colleagues was telling us that there does not appear to have been much significant impact on things like rates of schizophrenia or bipolar affective disorder. That does not appear to have been an issue here, but certainly what is an issue is that a number of people that are under the care of mental health services lost their social networks, very quickly became isolated, had reduced contact, et cetera. So their experience of the quality of life was reduced in some way or another and that is something certainly that the services say is having to be an ongoing dialogue with some of the folk who use our services in the longer term. We have seen an increase in low level mental health presentation, certainly an increase in things, as I say, like anxiety, but in terms of the direct impact on the rates of schizophrenia, et cetera, we have not seen that at all.

Deputy C.S. Alves:

In relation to the Drug and Alcohol Service, for example, are you able to provide any data relating to the referrals to that service? Can you advise whether there is any evidence that this has been impacted by the pandemic?

Director for Mental Health and Adult Social Care:

I have not got that to hand, apologies. We can get that. I do know that the Drug and Alcohol Service maintained direct provision throughout the COVID pandemic. They formed a view that because of the reasons that we have just described, a lot of people who use drugs and alcohol and are known to that service were likely to be significantly socially impacted and were likely to experience other issues which in turn may result in an increase in their drug and alcohol use. They adapted the way that they delivered their service during COVID. They did not have clinics in the clinic, for example. They were doing a lot more community work, they were doing some virtual work, et cetera. So they have maintained, but we can get for you the data around referrals and caseloads into the service over the period.

Deputy C.S. Alves:

That is great. Thank you very much. The panel has noted that the budget funding in the Government Plan for mental health services has not changed since 2019. However, we know that because of the pandemic and significant changes, for example the swift establishment of the crisis resolution and home treatment team, will have changed the focus of the work undertaken in the service in 2020 and 2021 and possibly seen funding reprioritised. Please could you comment on that assessment and advise what projects or work have been delayed or changed as a result?

Director for Mental Health and Adult Social Care:

I think this is going to be the Assistant Minister or the Minister.

The Minister for Health and Social Services:

I can say that there are significant COVID recovery moneys that are being applied towards mental health projects. We managed to continue with the vote that was in the Government Plan. Perhaps my Assistant Minister or Mr. Weir could detail exactly how and if there are any current pressures, but I do not believe so necessarily.

Director for Mental Health and Adult Social Care:

One of the things that I would say, and I do not think it is a financial answer, is that inevitably there were things that were delayed or there were pieces of work that started as a consequence of the previous Scrutiny Panel review but then either stopped or were much slower in terms of their delivery. I think that was the reality in terms of prioritisation of use of resource. I think a good example of that is the piece of work on outcome measures started but is yet to complete. It needs

to be readjusted and restarted because it was one of the things that fell by the wayside. In terms of money, my understanding is that we have allocated growth money and I think you ask about that later for this year. So we certainly know that there are some pressures on the service, of course there are, particularly in terms of psychological therapies, talking therapies, low level primary mental health. The things I described earlier we are just seeing more of and of course that creates a pressure.

Deputy C.S. Alves:

Following an amendment from this panel, the most recently approved Government Plan included an additional £500,000 of funding for the mental health services. What do you plan to prioritise this funding for in 2022?

Assistant Minister for Health and Social Services:

Certainly from a political point of view we perceive a gap in the service to people who are autistic. We are working on that service to try and increase its efficiency and to decide whether or not putting some of that £500,000 into that service might improve that service. But there are other elements of the provision elsewhere that Andy will have a handle on.

Director for Mental Health and Adult Social Care:

If I explain to the panel the process that we are using to determine this. It links the piece around recovery plans, the formal recovery plans. There are 2 parts where we have decided already we need to allocate some of the money. The first is to the leadership structure of mental health services because I think everybody here has said that that needs to be reinforced, and I think that is absolutely right. The second is we have agreed that we are going to implement a consultant pharmacy role, because one of the big gaps is pharmacy and medicines management and management of long-term illness and particularly the relationship between medicines management and physical health issues, for example, in our population. So we have agreed that we have a business case that we have supported for a consultant pharmacist in mental health, so a pharmacist with very specific expertise in mental health to work alongside the medics particularly. The remaining money will be allocated based on the formal recovery plans, so it will go into psychological therapies, but we need a realistic assessment. I could say today we need to employ 10 consultant psychologists, for example, but that will not happen. It certainly will not happen overnight and it certainly will not happen in a way that will get us what we want to get in a timely way. So we are working through detail with the services currently as to what needs to be prioritised around those recovery plans and we will allocate the money against that, so it is highly likely it will be psychological therapies, autism, A.D.H.D. (attention deficit hyperactivity disorder) which we call neurodevelopmental disorders, those areas. But it is about what can we get, what can we best

spend the money on and how can we most quickly impact our waiting lists, where there is a waiting list.

Senator S.W. Pallett:
You mentioned leadership structure. When you talk about putting funding to leadership structure, are you talking about front line services or management?

[11:00]

Director for Mental Health and Adult Social Care:
I think probably a bit of both.

Senator S.W. Pallett:
If it is a bit of both, what is the percentage of a bit of both?

Director for Mental Health and Adult Social Care:
We have not worked out the exact detail of that yet but fundamentally services need to be led. So you have an external review of mental health services from last year that says the leadership structure is not working and the services need to be led and managed, hence the creation of my post, for example. So if we do not do that, if we do not put leadership capacity and management capacity into services where that does not exist, things will not get better. There is a really clear evidence base around leadership in health services and management in health services about the impact of that. So, simply, if we do not do that, if we do not in some way make sure we have an interim management structure in place that we put in almost immediately when I arrived to make it clear and safe and understand people's roles and responsibilities ... as you know, we have previously talked about, there is lots and lots and lots of developmental work to be done in the mental health services. It is not going to do itself. The people who are providing direct care are not going to be leading significant system change, for example, because they are providing direct care. That is their job. So you have to have the infrastructure to get us to where we want to get to.

Senator S.W. Pallett:
In terms of system change, are you talking about people who are going to come in and work for a short period of time to change the system or be longer-term appointments?

Director for Mental Health and Adult Social Care:
I think it depends on what we want to do. So if we want to do a very specific piece of work, for example, around redesigning something then the logical things to do would be to bring in someone with expert skills and experience in that something, get them to do that piece of work and then off

they go. If the conclusion is that we need a stronger, longer-term management structure then bringing someone in temporarily is not the right thing to do for that. It is about getting someone in to work with the services over a period of time.

Senator S.W. Pallett:

Okay, and what is the timeframe so we can understand what the management structure might look like?

Director for Mental Health and Adult Social Care:

I think that we will be really clear within the next 2 weeks where we want to allocate the growth moneys and the rationale for that, and we should be able to articulate both of those things.

Deputy C.S. Alves:

Thank you. I will hand over now to Deputy Pamplin.

Deputy K.G. Pamplin:

Thank you. Just to wrap up the COVID response, I think the obvious thing to say at this stage, and we will be doing this quite a lot, is drawing a distinction between mental health and mental illness and what impacts are there. Andy has done a great job of outlining that but I just wanted really to highlight it. The pandemic showed, as crises do, good things and bad things. The service is obviously going through a major change, prompted by a review, and other work is going on. There are good things that came out of it like the Connect Me service. We heard a little bit about the decrease of work on that, which we will get to later. My Jersey did a wonderful piece of work capturing people's view on the pandemic and we also heard the great lengths that H.C.S. staff went to. Obviously the concern that we shared in our mental health strategy with the Minister and Assistant Minister was the concerns we had with the crisis and that could destabilise the service. We did not expect what we would expect. Just very distinctly, Ministers, in reality where is the service now and what is the challenge for the next few years?

Assistant Minister for Health and Social Services:

The immediate challenge, of course, Deputy, is that we need to bring the service into good order and ensure that we have the groups of individuals to bring the service back to a place in which it can be depended upon, and we are busy doing that in putting together the systems to create stability within mental health services. Of course, Andy will let us know exactly what is going on at this point in time and give us some idea of how long it is likely to take. You have just heard we are not talking about months, we are talking about weeks to get things moving, which is an absolute good way to proceed. Andy, if you could ...

Director for Mental Health and Adult Social Care:

Okay. If I describe what we have done in the last 2 months, I think that helps set the scene for what next. We have immediately refreshed the leadership structure and management structure to make that clearer and to set clearer expectation and some outcome measures around what services will do moving forward. We have done a piece of work looking at our overarching governance structure, so we now have a new system of meetings, information sharing, performance review, which is much more robust. Essentially all of this leads back to the findings from the external review of last year. We have started a staff engagement piece of work, because that is essential to moving all of this forward. I have to say everything that I say about anything that we are doing differently or needs to change is caveated by there is some really good direct care in mental health services. People work very hard every day, often in a challenging context, and because we are saying we need to improve and strengthen things, it is not to say it is all rubbish, because it is not at all. As I say, there is some stuff that I would be very proud for my relatives to receive care in some of our services. We are introducing a model of co-ordination of care, which is equivalent to the care programme approach that is used in the U.K. (United Kingdom). That is important because people with complex mental health needs often have multiple interventions from multiple people across the system and they have to be co-ordinated, they need to be part of the planning of that care and they need to make sure that they know where they can go in a crisis and there is a really clear plan around that. So we are in the process of introducing that currently. We have been going through a piece of recent work around our community services. We are particularly focusing on physical health of people with exactly as you described, serious mental illness. People with serious physical health needs, long-term physical health needs, are likely to die 15 to 20 years more quickly than the average member of the population for a variety of reasons. So we are making sure that we are doing some interventions around that from a physical health perspective to monitor and support people's physical health needs. As I described earlier, we are redesigning the community mental health services to make sure that they are clearer. People consistently, since I took up post, have talked to me about challenges with access, that people feel that they often get passed around the system and that they are not quite sure where to get into it or how quickly they are going to get a response, how to get their needs met quickly. So we are redesigning our access points into the service so that that is much clearer and everyone, whether it is someone in their home, whether it is the police, whether it is someone in the general office, knows exactly how to get a referral in, how to get seen. We are putting some measures around that in terms of timescales and expectations, so I am hoping that within 3 months' time anyone that is referred in a crisis will be seen for a face-to-face assessment within 4 hours, because that should be our standard. There are some good measures that we can utilise in relation to that. Then, as I say, the last priority for us at the moment is a piece of work around looking at recovery plans and how we manage issues where we have got waiting lists and backlog in our services. Underpinning that there is a couple of pieces of work that will not be done quickly but will have really significant impact. One is around recruitment and retention, so

that is about looking at how we recruit, the roles that we are recruiting to, how we retain staff once we get them, and that is particularly around training and career development, having opportunities to develop new skills, et cetera. The other is just a general cultural piece around how people are engaged, how they are able to put ideas into the system and how people react or behave between teams with each other. This happens in systems, people end up working in silos and you have lots of debate about: "It is not us, it is you; it is not you, it is someone else." We need to iron all of that out of the system as quickly as possible. So we are doing that in the process of planning for quarters, so this is our quarter 1 plan, they are the things we are working on now. As soon as we finish those, we will move on to quarter 2, and that is really deliberate because one of the things that has inevitably happened over COVID is that things get started but they do not get finished. People then get fed up, they feel that what they have engaged their energy in does not get delivered, and we need to make sure that we we are on a path where we are taking actions and doing the things that we say that we are going to do and then moving on to the next thing once that is completed. That is overall where I think the services are today.

Deputy K.G. Pamplin:

Great, thanks, Andy. I will let you have a little breather. You have touched on the Independent Review of Mental Health Services, which was published on 19th November 2021. As we are hearing, and obviously we welcomed that review and the brief that we received, that immediate action was being taken across the board. There was obviously previously the Adult Mental Health Services Improvement Plan. A lot of the things you are talking about were slippages already in that. We have heard the structural detail. How can you reassure that these things in 4 years' time will not be the same issues that were in the previous mental health strategy? It is a difficult question to answer but considering the response of the Independent Review of Adult Mental Health Services, they firmly made ... in terms of the management structure, at the clinical management delivery. So I guess where you will start; could you summarise that?

Director for Mental Health and Adult Social Care:

Certainly. I think it is a really good question because I think it is part of the culture that we are seeking to introduce. I think the first thing to say is that from my view - and of course I am going to say this - the action that was taken immediately by the H.C.S. leadership team was absolutely right, to create an executive direct job with responsibility for mental health and social care puts it really firmly at the executive table. The system here is a very hospital-centric system and inevitably it is the only system I have ever worked in where it is all managed under one umbrella but the acute hospital dominates that. That is inevitable, I think. But having that voice and having a different sort of discussion sometimes, because mental health is represented, but also taking immediate action to change the management structure, put in new roles and develop an action plan was dead right. What we need to do now is we need to put the infrastructure in to make sure that this is very publicly

seen so that people can see as we go along the things that we do, whether we are doing what we say we are going to do or not. I think that the vehicle, the mechanism for that is going to be the new mental health partnership board, which is going to be chaired by the Director of Public Health but will be a system partnership board. We will particularly have our third sector partners around the table. I am used to working in a system where our partners hold each other to account, so it is not just everyone pointing the finger and blaming each other. There is a collective conversation about are we doing, as a system, what we should be doing and, if not, what can we do to make that work differently.

Deputy K.G. Pamplin:

Sorry to interject, Andy. For reference, that has replaced the Mental Health Improvement Board that featured heavily in our original review. So that is a like a newer version of that, an improved version of that because one thing that will come across through this is communication. In the Mental Health Improvement Plan it talks a lot about pathways, communication. There was not anything in place to work with third parties and obviously the Listening Lounge is partnered by an outside source. Then the pandemic happened and then quickly things got ... I just wanted to add that context because that featured heavily in our review. Could you just explain again the structure of that? But what will be done differently because obviously sometimes when something was not working it could be given a new name but the same things probably still happened? How are we going to see the outcomes of that?

Director for Mental Health and Adult Social Care:

Okay. So my understanding of the Mental Health Improvement Board and the plan that was developed is that the focus of the board was about checking that what had been said in the plan was happening. That is a very transactional: “Is this happening or not? Yes or no” and then we move on to the next thing. That is not where I hope we get to. I hope the Mental Health Partnership Board is a place where people around the table collectively hold responsibility for the mental health system so there is an ability for people to challenge are we doing the right thing, are we developing the right models, are we spending our money in the right way, but also really thinking about how do all of the bits of the jigsaw fit together. How do we make sure, for example, that health and clinical staff particularly are doing the right tasks that clinical staff should be doing and that where other parts of the system, particularly third sector and voluntary agencies but also increasingly people who use services, can provide work and support and help the system move along that they are doing that? So a good example of that is around the Memory Assessment Service where at the moment we have clinical staff doing a lot of work that I would describe as support work that could be done by third sector partners and others. That then allows the clinical staff to focus. My experience of working in a system where there was a good strong partnership board is that if you can do that and you can get people used to that open honest dialogue then the system develops. The system

evolves and grows together and you start to see much stronger partnerships, much better challenge but also a much more coherent explanation for how the whole things works together. In the end where I would really like to get to if we were having a conversation about growth money, for example, we would not just be having that in Health. We would be having that around the table with the system partners and saying: "Where do we think this money should best be spent?" and people would have different ideas about that. How do we make sure it is different? Well, I think it needs to be a public thing. I am very clear, my approach is that we say really clearly and publicly: "These are the things that we are going to do" and then people can hold us to account for them. We should be able to say: "This is what we have done, this is the impact it has had and these are the measures that we are using." We are refreshing the measures that we use in the performance report that sits at the H.C.S. board for mental health services currently. There are only a couple. There are some others that we want to put in that I think are really important.

Deputy K.G. Pamplin:

That is reassuring to hear because our recommendation 14 ... sorry, key finding 17 was about this, so that is reassuring and to go back to our recommendation 5, it literally says: "The terms of reference, membership and reporting lines of the Mental Health Improvement Board should be made public." Are these the sort of things you are talking about that will be all public?

Director for Mental Health and Adult Social Care:

Precisely. I understand that the terms of reference for the improvement board were made public. They were put on the website, I am told. I think what then happened was that the Mental Health Improvement Board ceased to meet as COVID came in and that has been the problem there.

[11:15]

Senator S.W. Pallett:

Can I just come in here? Whether I agree or disagree with your comments around the Mental Health Improvement Board, I certainly do not think it was set up just to sign things off. It very much was around co-producing services. So I think that is underestimating what that board was doing. What is going to happen to the Health Improvement Plan? There were a lot of good things in that. I presume it has not just been thrown in the bin and we start from scratch again.

Director for Mental Health and Adult Social Care:

No, not in the slightest. Apologies if I have misunderstood. My feedback around the Mental Health Improvement Board is from people who have talked to me about it and were there or were part of it and their view was that it was a process: "Has this been done or not?"

Senator S.W. Pallett:

I was there and I do not think it was process-driven board.

Director for Mental Health and Adult Social Care:

Of course it has not been thrown in the bin. We have already looked at and updated and have been regularly updating all of the 80 actions in the Mental Health Improvement Plan. So we have looked at where we are against all of those and they will form some of the priority work. Some of them are things that I have already talked about, so developing the community system, for example, is in there. It is worded slightly differently but it is there. So, no, we are not going to throw it away. I think we need to go back and look at ... one of the biggest issues for me is prioritisation and I have said this repeatedly publicly before. I can now list over 200 actions that have been attributed to mental health services for this year, ranging from very minutiae pieces of action to wholescale system review and developing new services. This system does not have the capacity to do that and, therefore, we have to be really clear about prioritisation and how we prioritise the things that we do. Again, publicly we should account for that. We should be able to say: "This is why we have chosen this rather than this" but the actions from the original Mental Health Improvement Board are very much about ...

Deputy K.G. Pamplin:

Going back to our original review, recommendation 5, which I was just starting to refer to, we were also concerned about the original chair of that board, the former Director General of the Department of Justice and Home Affairs. That was based on feedback anonymous and publicly. That obviously is not the same person overseeing this. You mentioned it is the Director of Public Health. Do you think, given the weight of responsibility he has in developing the new Public Health Law and the whole range of responsibilities he has, that that is going to be focused enough? Would it not be better - and I throw this out - as we recommended in our original review, somebody with more of a direct responsibility or expertise, shall we say, in mental health and mental illness delivery? That could be a political question, so obviously if the Ministers want to ...

Director for Mental Health and Adult Social Care:

I can only say from my conversations with the Director of Public Health that he is happy to do that. It is very normal so my experience from elsewhere is that system partnership boards are very much led by public health because we need to think about mental health as a public health issue.

Senator S.W. Pallett:

Thank you, Andy. I just want to delve into the plan regarding the integration of adult mental health and adult social care. Obviously in the previous structure before you came along the roles were

split, so can you just update us on who is responsible now for adult social care? Is it you or how is that structure going to work?

Director for Mental Health and Adult Social Care:
So currently it is me, is the answer. I am the Director of Mental Health and Adult Social Care and currently the services operate as 2 care groups. There is some interface in the middle, there is some overlap and essentially they have 2 different management structures that sit separately and there was some previous integration that was then separated back out. We are reviewing that. We are not reviewing that quickly, so we are going to continue for the next couple of months to have them as 2 separate care groups, but we are going to strengthen the interface and the overlap and there is certainly some more work that could be done there. I think probably in about 6 months we will then take a collective view as to whether moving back to integration is the right thing to do or not, but for the time being it makes sense just to leave them as they are and settle them down.

Deputy K.G. Pamplin:
Give us an update on the new staff engagement programme that we heard about at the last quarterly hearing?

Director for Mental Health and Adult Social Care:
We had the first meeting. We had a good staff attendance. Essentially, deliberately the meetings will be done in 2 ways. We will present information and provide people with an update and then we will have an open session for staff to do, kind of questions and answers and talk to us about the stuff that is important. I have written out to all staff inviting them to participate in the process because I think that is really important and also told people that if they cannot come to the forums, which is only one of the vehicles, then there is an opportunity for them to come directly to me or to my leadership team to raise concerns and issues, ideas, et cetera. As well as people telling us what does not work, very often staff in services have got really good ideas about things that could be new or different, so we want to encourage that. The next forum is either next week or the week after, but it is not just that. We are looking at an electronic platform currently to have a staff dialogue, an open staff dialogue for people to be able to talk about themes and issues and share ideas because otherwise what you get is often one-way communication and then we wait a bit and then we go back out. I would like it to be much more live than that, frankly. Lastly, the way that we make change has to be really key to this. So when we held the workshop to look at how we redesign our community services, we had over 60 staff and that included a range of front line staff, support workers, qualified staff, et cetera, but we also had stakeholders. So we had C.A.M.H.S. there, we had Social Care there, because we need to be much more inclusive and engaging in the way that we do this type of work really. So this will become our norm, I hope.

Deputy K.G. Pamplin:

Sure. We will get to staff reactions a little bit later but one of the things also mentioned in our last quarterly hearing was about the mental health services being realistic about what was practically achievable within the plethora of actions that had been taken or not being done. I guess the question ... and I know we talked a lot of detail, there was a lot to absorb. Again, how we set aside what is realistic, what is ambitious but being honest of how everybody's contribution is critical to that instead of a headlong run in there.

Director for Mental Health and Adult Social Care:

I am hoping that the approach that I have articulated, which is the 4 lots of 3-month plans, is the way that we do that. We need to engage people in the conversations about what we prioritise and how we prioritise things. That can be tricky sometimes because people will have their own favourite ideas or things that they most want to do and sometimes we will be saying: "No, we are not doing that initially, we are doing something else." Clearly sometimes that might annoy some folk but we have to be able to be clear and honest about our rationale for that. I think that we, as I say, have started by setting out the things that are an absolute priority , which is about the overarching structure of the service and making sure that we operate in the way that we should be operating moving forward. Now the next steps are ... and obviously, as I say, prioritising particularly direct access so that people can get into the system and know what they are going to get. Once we have done that we will then move on to the next group of things. But you are absolutely right, there is a real issue about capacity and needing to be honest about capacity is finite. That is not just true of here, that is anywhere, frankly, but here it is a particular issue.

Deputy K.G. Pamplin:

One of the recommendations from the independent review was: "The importance of the development of adult mental health services must be considered within the context of the Jersey Care Model." The first question is: could there have been a better job at the outset - it is in tranche 2 this year - and how do improve that to ensure that that recommendation is met as the care model continues?

Director for Mental Health and Adult Social Care:

I think the direction of the mental health services fits nicely with the care model, which is about community-based care, about making sure that where possible people are supported at home, that they receive the range of services that they need to receive from the system and that when you come into hospital you get a good experience that lasts for as short a time as possible and provides you with the treatment you need. I think that is consistent. I think we are already thinking about, for example, direct access points, how does that work with the Jersey Care Model in terms of single point of access. I think there is a lot of water to go under the bridge in terms of the detail but there is nothing in terms of the direction of mental health services that is not consistent with the model

that is set out. I think that the point that is made about the Jersey context is terribly important. We are not going to replicate all of the specialised services that you would have in the U.K. here because we have not got the capacity to do it, we have not got the resource to do it. That is a challenge but it is also a real opportunity because I think there is some stuff that we could do really well and differently here. When we talked about care co-ordination earlier and the care programme approach we are not just lifting the English system and applying it here, because that will not work, but we can have a really good system here that would be, frankly, a step ahead of the review that is happening in the U.K. at the moment around the care programme approach because the system in Jersey lends itself really nicely to that. So we have to keep checking: are we using best practice? Where there is an evidence base, are we using it? The evidence base is no different in Jersey or anywhere else, frankly, but are we then making sure that our systems and processes around care delivery fit with Jersey and the needs of Jersey. I think that is going to be an ongoing bit of work.

The Minister for Health and Social Services:

Can I just add that I see it as key that we involve our community providers: Mind Jersey, Youthful Minds, the Recovery College focus. All of those have got excellent work to do and contribute and want to, and they are keen to be involved in that redesign.

Deputy K.G. Pamplin:

I guess that comes back to the original point of co-ordination. These things need to work. They just are not working. The report is now the ... I have forgotten the name of it, it has just dropped out of my head, these things that have been talked about since 2008. I guess the point is people are tired, the pandemic has exacerbated that, pathways are not where they should be and communication is still an issue. So I guess it is a challenge going ahead. The other issue is obviously staffing, which is my last section. We have heard about the excellent work of staff across the board in mental health services is a challenge and they are going above and beyond and then some, working still in conditions that are just frankly not good enough. But we have also heard about their continued issues, some again through this review, about the challenges of recruitment and retention of staff related to cost of living and also within the service about being appreciated and valued and the turnover of staff still. So, Minister, why has not this moved as fast as everything else as this is a key issue and have you considered any plan to assist with these problems with the money available as we have talked about?

Assistant Minister for Health and Social Services:

Yes, we, along with all of the other essential organisations within Government, are having a problem with recruitment, not just with the recruitment but retention, as you say, and there are specific problems in the Island that are not even unique to the Island but they do need to be addressed in the wider sense for education, for health, for mental health, for the civil service to bring in the people

that they need and to keep them here given the cost of living and the price of housing. But we have been doing some work on this and Rose has been involved in looking at this problem and perhaps she can let us know what work is being done to try to ameliorate this problem.

Chief Nurse, Health and Community Services:

Thank you, Deputy. Yes, there are 2 elements there. One is around training and one you mentioned around housing. In relation to training, thanks to some Government funding we started our mental health nurse training on-Island last September. We have a cohort of 6 students on the programme at the moment with a view that we will next have an intake in 2023. We had more students than we had places apply and we do have a waiting list of Islanders who want to come on to various programmes, not just the mental health one. We hope to grow that in the future further now we have got a small team of lecturers within the department who all come from a mental health background. That is working really well and that will start to feed our supply going forward. In relation to housing and cost of housing, it is a perennial problem for which there is not any straightforward solution and I say that with some years of exasperation. I have sat in front of this panel and we have talked about it many times before. There is a renewed focus on it across Government at the moment and I am involved in a piece of work looking at key worker accommodation. Again we are not the only department that struggles. C.Y.P.E.S. (Children, Young People, Education and Skills) are also struggling with housing for the children social workers and more recently we have heard about uniformed services that are now also starting to struggle as well. Tom Walker is heading up that piece of work, so it sits within S.P.P.P. (Strategic Policy, Performance and Population) as a department. There are 2 sort of elements to it at the moment. One is trying to address an immediate issue that we have got more demand than we have supply, and that is with combined issues within our department and also within children's services. Then the other is looking at a longer-term solution, all building on the work that Altel(?) did previously independently for the Government of Jersey. So I have not actually got an answer. We will all have a party when we have an answer, but it continues to be a difficult problem. In relation to relocation, the Government does now provide that relocation service who want to access it. There is 2 companies that support new staff coming to the Island and the feedback that we get from staff is that that is very well received. Of course there is relocation costs included within that. Then overall in terms of the figures, I do not think we have got the overall figures but certainly when we were at the Our People and Organisation Development Committee last week we saw some data which covered our leavers and our starters over the last 12 months and we have had more people start in the department then we have lost, which is a really positive change in direction. But we are very mindful of the challenges and we have some specific hotspots across all services.

[11:30]

Deputy K.G. Pamplin:

You have read my mind. My question was what is the actual number of turnover of staff. Is that something you could send to us for this review and also the average number of applicants per job for a range of mental health services would be helpful.

Deputy M.R. Le Hegarat:

Can I just follow up with something? You said before that you had more applicants than jobs available.

Chief Nurse, Health and Community Services:

More people interested in the student nurse programme than we had places that we could support them.

Deputy M.R. Le Hegarat:

That is a shame.

Chief Nurse, Health and Community Services:

Yes.

Deputy M.R. Le Hegarat:

Can I ask what you have done as a department in relation to those individuals who have shown an interest? Have you given them a different pathway? What I am trying to say is, in order that we do not lose those individuals, what have we done to maybe encourage them to do something else in the interim? Does that make sense?

Chief Nurse, Health and Community Services:

Absolutely, yes, and we do it with all our programmes. If anybody applies for a programme and they cannot get on it in the first year, sometimes it is a case of they need to do some additional study, they need an additional qualification, but we also encourage them to join our service on the bank and start to get some experience. Quite a few of the people that do apply already work as carers out in the system somewhere but some do not, so it is new to them. We keep in contact with them as well over the course of the time.

Deputy M.R. Le Hegarat:

That is good. Thank you.

Deputy K.G. Pamplin:

The final question from me is obviously again as the review is still ongoing some of the issues that we are also hearing away from the issues of cost of living and housing is some members of staff burnt out and obviously that is a concern of the mental health services when people are leaving the service because they do not feel valued and appreciated and are tired. We understand there has been a lot of changes and turnover and that happens, but are you doing exit interviews? What are you seeing and how can we stop that sort of culture from happening that people just do not want to work, not just because of the cost of living and housing - those things are there to one side - but as we are going through this again we are hearing this similar sort of thing from members of staff who feel that way.

Director for Mental Health and Adult Social Care:

Factually, last year the turnover rate was 7 per cent. There were 19 leavers. The overarching position was an increase of 2 people, so headcount increased by 2 overall. In 2021 we lost 19 and increased by 2. You are correct in that it is not just about accommodation and cost of living, is it? It is also about that people are tired, people have worked differently for quite some time. I think we need to do a number of things and I think we are doing them. Firstly, it comes back to the communication and engagement piece of work because people need to feel engaged, they need a sense of direction and they need to know what we are doing and why we are doing it and how they can contribute and be part of that. The feedback that I have had to date has been generally very positive, that people feel that that is a move in the right direction and people feel a bit enthused by an open conversation about what we are doing. Training in most places has dropped off over COVID. One of the things that we agreed last week in our leadership team is that we want to really push the training agenda this year and find time for people to do training, because that is one of the ways that people will start to feel really enthused and it also gives them time to concentrate on something other than direct care delivery. So training needs to be a priority for us. Jobs that we are advertising and our skill mix are very traditional and I think that there is a lot of things that we can do differently in terms of new roles, different roles. I was talking to some support workers recently who would really like to do a lot more and clearly have got ability to do a lot more. At the moment we do not have roles for them in our structure. In other mental health systems those roles do exist, so we are going to do a piece of strategic workforce planning relatively quickly that says let us think about different roles and bring in different opportunities for our own people who are currently working in the services. It is not all about advertising jobs and bringing people in. It is also about saying to people who are currently working here: “How can you work differently? What would you like to do?” Of course one of the things that is really going to underpin that this year is appraisal and that one is a conversation about: “Where are you at? How is it going? What could be better, worse or stay the same but also what is your aspiration?” I think part of the overall agenda from the review, as well as putting systems and structures in place, is about creating vision and hope, is it not? I think that part of our job is going to have to be to keep working with staff continuously because you cannot

communicate enough, can you? I am sure there are people today who would say: "Well, I still do not know enough about what we have done in the last 2 months." You just have to keep going, keep communicating and trying to get people onboard but recognise that people are pressured.

The Minister for Health and Social Services:

Can I just put in a plea, if I may, just from understanding of what has happened over the last 2 years? We asked staff in the health service to stand into the breach really when the whole of our community just faced imminent danger and we did not know what to expect. We asked these people to work differently and we told them to work differently. We pulled them out of what they were comfortable doing and most of them had to work in a very different way. It has created pressure, which most people have to take for a few weeks or months but this has gone on for 2 years. Alongside that we have put in place some excellent measures to address their wellbeing and that is continuing and that is really good to see. But of course staff, they will still be feeling anxious and is disturbed by what has happened. It is not surprising that some will want to leave, some will feel dispirited. We are doing what we can but I think there has to be that understanding that it is different from the rest of us, who, even as politicians with oversight of all that is happening or people in other industries, the health service, the staff working in it had something extra difficult to do on behalf of us all and it has affected them. We need to get back to that position where they are back to normal.

Deputy M.R. Le Hegarat:

No, there was something I was going to pick up on in relation to your comments and that was to do with your leavers and the exit interviews. The question I was going to ask and it was interesting for you to say about developing people because I think that is significant and I think the training. This is what always disappoints me, when we cut budgets we cut training and to me that is totally the wrong thing to do because that has a serious impact on people's whole wellbeing and value because it is not all about money it is about a variety of things. Obviously this would have to be before the person jumped ship maybe but what I was going to ask was, of the people that leave do we keep data so that we know where they have gone? I can fully understand in the pandemic a lot of people may have felt that they wanted to go home back to families, particularly if they had elderly relatives, et cetera living in the U.K. or vulnerable relatives. But what I was going to say was you might have somebody who is doing a particular role but may decide not to develop that role but there might be opportunities somewhere within the States as a whole. For example, if you have somebody who is working in mental health and may wish to side line out of mental health, there may be other opportunities, I do not know, mental health policy or whatever. What I am saying is is do you know - and this may be more of a generic question for S.E.B. (States Employment Board) - what work is done to keep employees but maybe allowing them to diversify from where they are? I do not know if anybody can answer that question.

Director for Mental Health and Adult Social Care:

We certainly get the data.

Deputy M.R. Le Hegarat:

Patrick Armstrong is going to give an answer to this question, he is not coming (audio cuts out).

Medical Director, Health and Community Services:

Patrick Armstrong, Medical Director for H.C.S. I think you raise a really, really good point and Rose and I have had numerous conversations about the education and development offering that we need to provide to our staff. But I think we need to be even more flexible than that. We need to have roles where people may want to come to the Island for shorter periods of time, come and get a qualification, move back to the U.K. It helps them with funds around housing and moving families here and we need to develop much more closer links with more educational establishments in the U.K. and soon we will already have a lot but we need to exploit that and use that. But I think you are absolutely right, people who come to Jersey if they believe that they will be developed and maybe get a qualification, get experience and then see elsewhere and then move back and, hopefully, some of those people will stay more permanently.

Deputy M.R. Le Hegarat:

Thank you, thank you. Now over to Senator Pallett.

Senator S.W. Pallett:

Thank you. Minister, we are going to move on to buildings and estate. First of all, can I thank you for allowing us to visit many of the sites, it was good to go on that to look around? We saw there had been some significant improvements in a physical environment, Orchard House, for example. The addition of skylights, I think the decoration and some of the furniture and make it so much more welcoming. Briefly, what feedback have you received from patients and staff around changes to that physical environment, both formally and informally?

The Minister for Health and Social Services:

Yes, perhaps the Assistant Minister is in a better position to answer.

Assistant Minister for Health and Social Services:

Yes, we heard when we went around Orchard House about the development of activities, therapeutic activities and diversional activities, the creation of a weekly community meeting and the views of residents in Orchard House being taken into account in developing the service. Of course, co-production is very much on the agenda of the Scrutiny Panel and we want to see co-production

expanded in order to improve the service further. Andy of course has a view on this and is day-to-day involved with the feelings of the residents in Orchard House.

Director for Mental Health and Adult Social Care:
I have heard directly from both staff and people who use the services that the physical changes in Orchard House have been really, really important and really positive. I met with a group of service users recently to remind who we are talking about, how awful their physical environment was prior to some of the changes. Certainly heard directly from some of the staff, the fact that they feel that the ward is far, far better now than it was before. I personally like the way and I think we saw on the tour, did we not, how they were adapting the environment? They have got a wall where they have service users writing their hopes and aspirations and thoughts on, they are utilising the environment as part of the care delivery now, which is great; that is exactly how it should be. Overall, the feedback has been really positive.

Senator S.W. Pallett:
What has been the outcome of any … presumably there have been any recent health and safety reports for Orchard House. Have there been any updates or anything recently?

Director for Mental Health and Adult Social Care:
I have not seen anything myself but, no, do not know, I will check.

Senator S.W. Pallett:
Just a question I am going to add, there was a recovery plan for Orchard House, was that completed?

Director for Mental Health and Adult Social Care:
Yes, it was. What happened was that it got moved into J.N.A.S.S. assessment, the Jersey ... Rose, help, nursing …

Chief Nurse, Health and Community Services:
Jersey Nursing Assessment and Accreditation System.

Director for Mental Health and Adult Social Care:
Thank you. Orchard House had been part of that and they had a J.N.A.S.S. assessment and they have developed a subsequent plan. Some of the things that they have set out to do were done and the J.N.A.S.S. assessment showed that, they said where the system has been agreed for some of those things. Some of those things there is still some work to do, so they are doing some more work, for example, around ancillary working and how that works, et cetera. But they have done a

lot of work in Orchard House, again, through the pandemic, they have not just delivered to the care, they have also done quite a lot of developmental stuff in terms of how they work differently, which is great. It is the reason why Orchard House is not one of their major priorities in terms of a piece of work for us to do because they are moving along to a plan currently.

Senator S.W. Pallett:

What ongoing assessment is there within Orchard House to make sure we have full backing to sever the old ways?

Director for Mental Health and Adult Social Care:

One of the things that they do now, which I think is really helpful, is they have a regular, I think, weekly meeting of people that are on the ward and they talk about what is working, what is not working, what the issues are. That is recorded, there is a minute kept and that gets talked about in the leadership meeting, so we get to hear what people are saying directly. Obviously one of the other thing that I am hoping will impact on that is the Staff Engagement Board, so I would expect us to be hearing directly from staff if things are starting to slide, frankly. Then there will be ongoing assessment, so the J.N.A.S.S. process is an ongoing process. I know that they will be assessed again at some point against standards and in the end of course you will get to the formal J.C.C. (Jersey Care Commission) assessment of the service, which will include a lot of the same standards that is in J.N.A.S.S. There should be an ongoing process for knowing where things are.

Senator S.W. Pallett:

At the end of the day you do not want to be there, you want to be in a new building.

Director for Mental Health and Adult Social Care:

Yes.

Senator S.W. Pallett:

Clinique Pinel, when we visited we learned that the handover from the contractors has been yet again pushed back to September 2022 and, therefore, there are unlikely to be operations for 6 to 8 weeks after that date. Really one for the Minister and the Assistant Minister, that is obviously disappointing. What oversight or actions have you taken to try to mitigate against that delay with the contractor and with Jersey Property Holdings because it seems to be a never-ending delay?

The Minister for Health and Social Services:

Yes, I can say not just disappointing, it is so frustrating because this has taken so long. I have not personally received any reports from Jersey Property Holdings because it is a Jersey Property Holdings project. I do not know whether the date we have been given, September is still under

challenge or whether there is any mitigation measures to try and bring it forward. I am in a position where, as far as I am aware, that is the date that has been given.

[11:45]

Senator S.W. Pallett:
Knowing how important it is, where is the pressure coming on to finish this building? We all know how important it is.

The Minister for Health and Social Services:
Yes.

Senator S.W. Pallett:
It is a critical building and we know how poor the reports have been on Orchard House in the past. Where is that pressure coming from?

The Minister for Health and Social Services:
The pressure that creates the delays, yes, I am sorry.

Senator S.W. Pallett:
No, sorry, the pressure to ensure that this building is completed in the shortest possible timeframe.

The Minister for Health and Social Services:
Yes, we have an operational team that is working with Jersey Property Holdings and with the contractor, which is headed by the gentleman we met, I forget now the name of the person. Please, forgive me, I have forgotten. I am sure that that person is doing all they can to try and hold the timetable that we would have wanted to achieve. It appears because of labour shortages and weather has played its part that the contractors saying they cannot complete before September. If Deputy Pointon has anything more to add …

Assistant Minister for Health and Social Services:
I was going to say, Minister, that we were informed late last year that delays would be until March time and those delays were about the internal structure of the building that is being altered. Things like firebreaks and so on and so forth, which are part of any residential building, needed additional work. I believe they found some asbestos, I may be wrong there. But certainly they had to put extra work into that building, coupled with the fact that the building industry in the Island is quite severely overheated with a number of large projects underway. Getting hold of tradesmen, as I know personally, is particularly difficult. Builders are not just running one project, they are running other

projects as well. I know you would say that they need to be forced to prioritise this project but that is down to Jersey Property Holdings, it is not to do with Health unfortunately.

Senator S.W. Pallett:

Okay. The contract attender and whether there is financial penalties is probably not an issue that you can answer, so I am about really to pick up with the Minister for Infrastructure. But it is very disappointing and we do need to ask some questions around that. I will move on …

Assistant Minister for Health and Social Services:

It is, I agree, extremely disappointing because this new building is required and we cannot go forward, we are stuck, marking time. I fully agree with you that it is not acceptable.

Senator S.W. Pallett:

Okay. We see for older adult care on the first floor of Clinique Pinel is still operating through the adjacent construction work and we saw that. We also saw one patient room used as a last resort that was significantly overlooked by the building works. Do you consider that is acceptable circumstances for both patients and staff? I can probably guess what your answer is going to be.

Assistant Minister for Health and Social Services:

No, it is not.

Senator S.W. Pallett:

Okay. Another issue, I suppose, is how is the health and safety of the site, including noise levels being monitored to ensure it is being limited in terms of patients?

Director for Mental Health and Adult Social Care:

The lead nurse on site is very much involved in all of this, she meets with them weekly, I understand, with builders to make sure that if there is anything that is causing any impact and occurs and that gets dealt with really quickly. I will give an example, I know that the room that you have identified is the room that is only used if it absolutely has to be used because the staff have identified it is overlooked and it is far from ideal. They have also had a conversation about putting on the windows film; that means that people can see out but cannot see in. They are doing quite a lot. I think the ward are doing well to adapt to having a building site next door to them. I have asked on a number of occasions about noise, for example, but I have been told it has not been obviously a significant issue to date. But they are absolutely on top of this in terms of meeting on a very regular basis with the senior nurse there and talking about what you are doing next and how is that, potentially, going to impact on the kind of care that we are delivering?

Senator S.W. Pallett:

Is that impacting our service delivering capacity?

Director for Mental Health and Adult Social Care:

Not at the moment, no. We have not yet been in a place where we have been fully occupied at 100 per cent occupancy, no.

Senator S.W. Pallett:

Okay. I wonder if you could advise us how routine maintenance jobs for the mental health services are dealt with, how do you track how long it takes for issues to be actioned, for example?

Director for Mental Health and Adult Social Care:

I am afraid I cannot, I have absolutely no idea at all how the routine maintenance system works here, so …

Senator S.W. Pallett:

No, I understand, to make sure that it gets done on time.

Director for Mental Health and Adult Social Care:

Yes, yes, yes.

Senator S.W. Pallett:

Yes, okay. One of the aspects that was explained as partially beneficial for patients was access to outside space. We saw Rosewood House and Orchard House and their gardens and patios and safe balconies. If any of these services are co-located within the proposed mental health unit either at Clinique Pinel or at the general in the future, is suitable outside space part of that specification?

Director for Mental Health and Adult Social Care:

Yes, it would have to be. In order for it to be an appropriate physical environment for the delivery of in-patient mental health care, particularly where people are restricted and cannot leave the ward, for example, you have to have access to outside space and that outside space can be really important in terms of therapeutic delivery of care, so, yes.

Senator S.W. Pallett:

In the short term Clinique Pinel will have that necessary space, okay. I want to move on to transfer of care, unless you have got any questions anybody?

Deputy K.G. Pamplin:

Yes, just very quickly on the hospital plans, I had a meeting over the weekend because the new hospital, if we get there, where the mental health facility is, it is quite close to where the rose gardens are, the crematorium, that raises a little concern for me. People with outdoor environments are seeing an area that probably would be best … you have just guessed, I just chucked that out there, that is my aspiration; I am happy to be proven wrong about that. But when will we be able to get on board and get on top of and look at these future hospital plans and say, hang on second?

Director for Mental Health and Adult Social Care:

We have a meeting in the diary to look at exactly the plans for what the mental health provision is in the new hospital. This is history repeating itself and we have recently built a new children's service in Leeds, the city that I work in, and, unfortunately, it partially looked over a graveyard, so we then had to environmentally put a wall up and some trees and to make sure that that was not going to be a particular issue. There are ways that you can mitigate against that type of stuff, using your environment. But per se, do you know, I think we need to have a look at the whole of the plan for mental health services? Co-location is absolutely the right thing, it is superb co-locating the mental health service with the General Hospital but we just need to make sure the environment works best, do we not?

Deputy K.G. Pamplin:

Yes.

The Minister for Health and Social Services:

Can I just say I do not think there is a direct overlooking because there is a car parking area and then a road before the rose garden? There is planting around for the car parking area.

Deputy K.G. Pamplin:

Just the way I looked it at the weekend it just needs a little look and, again, I can be proved wrong but some of the location at Orchard House looked a bit strange but I could be wrong, it is just what I looked at over the weekend, I am just throwing that out there.

The Minister for Health and Social Services:

Okay, okay. Of course that rose garden is remaining and that is on the site, well that is adjacent to the site.

Deputy K.G. Pamplin:

Yes. I am just throwing that out there, it is just because the plan had originally changed and we are seeing 2 tiers now. Again, I just chucked it out there.

The Minister for Health and Social Services:

Yes, one tier.

Senator S.W. Pallett:

Okay. I am going to move on to transition between children's mental health and adult mental health services, how many patients transition between the 2 services each year?

Assistant Minister for Health and Social Services:

What I can say, Senator, is that currently there are some 25 people who are in the process of transitioning. We anticipate people becoming 18 and becoming adults and moving from C.A.M.H.S to adult mental health. But in actual fact it does not happen that way, it happens very slowly. People reach 17½ and there is an assessment done in C.A.M.H.S. and with adult mental health about the appropriate way forward for these people. Currently there are 25 people who have remained with C.A.M.H.S. over the age of 18 simply because it is in their best interests to be shepherded into adult mental health by their current clinicians and for therapeutic interventions to continue unbroken. Those people will very slowly move into mental health. There are now dedicated staff in adult mental health who will assist with that process as well. Perhaps Andy could tell us a bit about them.

Director for Mental Health and Adult Social Care:

That is right. There is a nurse within C.M.H.T. (Community Mental Health Team), her specific job is to do the transitions work. I think you are absolutely right, just it is artifice, is it not, to say at 17 and 360 days you need this and suddenly 3 or 4 days later it is something different? It is nonsense. The key to this is about the assessment of someone's needs and where their needs of their health is best met. We may take some people slightly earlier than 18, frankly, but, equally, there may be some people who can stay longer with C.A.M.H.S. because finishing their treatment you have to stay with C.A.M.H.S. is the right thing to do with them. This has got to be done on an individualised basis. We have got a transitions post come out between the 2 services and the feedback that I have had is that generally it works well, not all of the time of course, there will be glitches but on the whole it is described as working better. Certainly the communication seems to be okay between the 2 services at the point of handover currently.

Senator S.W. Pallett:

Is that a written protocol?

Director for Mental Health and Adult Social Care:

There is a written protocol, yes.

Senator S.W. Pallett:

Could we see that?

Director for Mental Health and Adult Social Care:
Yes, of course you can, yes.

Senator S.W. Pallett:
Brilliant, thank you. You have gone through much of that transition process, which is good. Do you have any delays, do you know, in terms of patient transfers, if there is any insufficient capacity within adult mental health services?

Director for Mental Health and Adult Social Care:
There has. There is a particular issue around neuro developmental disorders, so autism and A.D.H.D. where the demand has shot up in adult services and, consequently, there are some folk who are still sitting with C.A.M.H.S. while they are waiting to move into the adult service. We are looking at that currently. That is all wrapped up in part of the recovery plan around the neuro developmental disorder services, so to understand what the demand coming through is, as well as what we have got in adult services currently.

Senator S.W. Pallett:
Is that down to staffing issues?

Director for Mental Health and Adult Social Care:
It is capacity, so that it is about the capacity of the service, particularly for A.D.H.D. is prescribing particularly. The nature of the medication that is prescribed for A.D.H.D., there is a limitation currently on the Island as to who can prescribe. Consequently, it is psychiatry and of course they are overloaded currently in terms of prescribing need …

Senator S.W. Pallett:
We need to see whether we can change that …

Director for Mental Health and Adult Social Care:
Totally by it, so you could, potentially, make it so that primary care G.P.s (general practitioners) can prescribe for A.D.H.D. within an annual review, which is what happens elsewhere, yes.

Senator S.W. Pallett:
I see. Is there a formal oversight and audit of the transition process so that it is clearly written down about how that structure works?

Director for Mental Health and Adult Social Care:

How the process works is written down. I do not know if there has ever been an audit of it, frankly. I think I said earlier we are currently having conversations about how we work between adult mental health services and C.A.M.H.S. to kind of strengthen the governance around some of that. The relationships are good and certainly I have met with a C.A.M.H.S. consultant on a couple of occasions and we have had conversations about some stuff we could do differently. I think there is an opportunity for us to do some of that in a different way moving forward. But at the moment what I am told is it is generally working well.

Senator S.W. Pallett:

Okay. I did have a section on oversight which really was around the Mental Health Improvement Board but I think we have pretty well covered that. I have just got one question, I think it is one for the Minister really, you believe the Mental Health Improvement Board has been unsuccessful, is that the reason for the change?

Assistant Minister for Health and Social Services:

The reason the Improvement Board has not been successful is that it had to cease functioning and its replacement in the new board will be very much more flexible and will put decisions into the hands of people who are providing services, both the mental health service itself and those people in the community; Mind, Recovery College and other providers. They will be able to work together to provide better services for people with mental ill health. If Andy would like to expand on that.

Director for Mental Health and Adult Social Care:

If you look at the Improvement Board plan and the actions there is some stuff that was absolutely done and completed and there is some stuff that was started and has not got to full fruition and there is some stuff that did not really start. From my perspective as someone coming into the system, was it an abject failure? No, of course it was not. It clearly delivered some stuff, really important stuff. I have talked about the crisis team earlier, there has been real progress around co-production, for example, so you referenced that earlier. There is now a regular meeting between the mental health services and I am going to say experts, quite experienced and probably get it wrong, they use a slightly different language here but people who use services and their carers and it was superb. I was so impressed by the peer support workers in Mind, for example, who were saying: "We really want to be more involved in stuff. There is a real opportunity for us to do more jointly with services." Steps have been made, good steps have been made; there is just more to do. We need to have more aspiration to do more, I think.

[12:00]

Senator S.W. Pallett:

The new group, is that purely going to cover adult mental health services?

Director for Mental Health and Adult Social Care:

At the moment we have described it as Adult Mental Health Services Board but I am meeting tomorrow with the Director of Public Health's Deputy to go back through the terms of reference. That is one of things I want to have a little think about, because my preference would be it would be a whole system mental health partnership board, yes.

Senator S.W. Pallett:

That is where Mental Health Improvement will want it to go.

Director for Mental Health and Adult Social Care:

Yes, yes. In the context of the conversation tomorrow I would really support that. I think a whole system board would be far more effective. The problem is if it is not a whole system board, you inevitably get to that ping-pong about us and them, all of that stuff. The more you design a thing as a system the better but obviously there has to be some boundary around it.

Senator S.W. Pallett:

Okay, one very final quick question from me. Is there anything in the pipeline around regulation or law updates in regards to mental health and thinking about the Mental Health Law, for example? Is there anything in process?

Director for Mental Health and Adult Social Care:

There is. There is the Mental Health Law Group that has been meeting and they have identified some things that we think probably we need to tweak in terms of the kind of legislation. From next month we are introducing a formal Mental Health Legislation Oversight Group, which will be the assurance group. It is not the working group that will do it, it is the assurance group that will give us all assurance as to how legislation is being used. But that will also be the group that will then report direct to the Minister in terms of proposals around legislative change. There are a couple of areas in the current legislation that probably do require a bit of adaptation.

Senator S.W. Pallett:

Okay, so that is a review rather than a total revamp, they are just looking at how the tweaks can be made.

Director for Mental Health and Adult Social Care:

Yes, and the basis of the current legislation is sound and there is just a couple of bits where it just needs a bit of tweaking.

Senator S.W. Pallett:

Okay. Chair.

Deputy M.R. Le Hegarat:

Right. We are at 2 minutes past 12.00 p.m. and you will be very surprised you have not heard from me yet. However, we still have a significant amount of questions left to answer. I am minded that it is 12.00 p.m. and I do not know whether there is any capacity for us to extend this hearing at all in relation to other people's commitments, Minister. My apologies, in actual fact I think some of these questions will have been answered due to our visits but obviously we would like to get these on the public record. In relation to place of safety and the role of the States of Jersey Police, can you clarify all of the locations that are used as a place of safety for adults in mental health crisis, please?

Assistant Minister for Health and Social Services:

Currently, Chair, a total inappropriate police cell would be one venue and provision in E.D. (Emergency Department) another venue. But it is part of the development at Clinique Pinel to provide a place of safety and that is the plan, both for adults and for children. Of course for children Robin Ward is still a place of safety for young children. But, Andy, perhaps you would like to …

Director for Mental Health and Adult Social Care:

I think that is right, that is exactly what I was going to say.

Deputy K.G. Pamplin:

Can I just refer back to our review, key finding 14: "Jersey does not have an appropriate place of safety for children or adults in a mental health crisis, people in crisis are often detained in inappropriate environments such as police cells." Do you think it is inappropriate for young people to be detained on Robin Ward because of the pressures of that ward for obvious reasons and Orchard House? We did present a recommendation which was accepted: "An appropriate place of safety should be created within the existing hospital until an alternative arrangement can be found at the new hospital. Children and adults in mental health crisis should be separated where possible." Obviously that changed, there was a place that was designated in the hospital, we heard that was stopped and then was talked about, Orchard House, the pandemic happened. But, again, one of the things that the pandemic chucked up was this was still an issue and the inappropriateness of Robin Ward for young people who were suffering because of eating disorders and self-harm with young children who have got leukaemia or cancer, pressures of staffing. While we still do not have this place and we are hearing about the delays in Orchard House and that place of safety continues,

which is why we are stressing the issue about that delay at Clinique Pinel. But, equally, the pressure on the hospital staff as well, this is all still continuing and yet the ultimate goal of the hospital. I just wanted to highlight all the context around that. There has been pressure on staff dealing with things that is challenging and, equally, on young people and adults who are in environments that they should be in. That is the context behind the question, I just wanted to …

Assistant Minister for Health and Social Services:

Yes. You mentioned people with eating disorders, Deputy, the fact of the matter is that we are not tied to utilising the place of safety in E.D. But in recent times it has been the case that single rooms on the private wing have been utilised and staffed by C.A.M.H.S. nurses or C.A.M.H.S. professionals. They have been able to manage individuals in that way when the need is demonstrated. There are other venues within the hospital that are used as a place of safety and very appropriately so.

Deputy M.R. Le Hegarat:

Okay, thank you. I will move on to a question in relation to how the introduction of the community triage team impacted on front line mental health services. How is this introduction now impacting?

Assistant Minister for Health and Social Services:

Andy.

Director for Mental Health and Adult Social Care:

The community triage team is the team I have described earlier as the crisis team. It is impacted in that people can get a crisis assessment much more quickly. The feedback from the police has been positive in terms of they feel that they have had some less activity as a result of the triage team, although not anywhere near yet where we would want to get to. But certainly and where the police have got concerns about some on the triage team are able to respond quickly and undertake an assessment. The team also, I think during COVID, was offered as part of the offer to the prison. One of the things, of course, that was problematic in the initial part of COVID was people going in and out of the prison and how all of that was going to work. I know that certainly the mental health services said that if the prison needed an urgent assessment of someone the triage team would be able to do that assessment. I think some of that work was done remotely, rather than people going there. But moving forward crisis access and getting an assessment within a timely manner from the crisis team is absolutely essential as part of our services. People must know that they are going to be seen face-to-face for an assessment within 4 hours of the referral being made if a crisis assessment is indicated.

Deputy M.R. Le Hegarat:

How do you co-ordinate and communicate in relation to these call-outs with the police?

Director for Mental Health and Adult Social Care:
There is a small team of people, so they are a discrete team. There is a number that people can ring and they go and get someone from the crisis team. If the crisis team are out doing an assessment, then there will be someone else that will take that call. They are also able to get hold of the liaison staff during the day in the hospital. If it is in the hospital, for example, they need someone to go there, the liaison staff might do that. This is one of the things that we are trying to tidy up around the piece of work that we are doing currently around access and redesign of the community services. Essentially, there is one way in, so it does not matter where you are, who you are, you will get one way in and we will then deal with it thereafter.

Deputy M.R. Le Hegarat:
Will that be 24/7?

Director for Mental Health and Adult Social Care:
Yes.

Deputy M.R. Le Hegarat:
Okay. Do you envisage that the community triage service could be developed and further resourced in future, for example, so that the police and/or paramedics would not need to be called out to those mental health incidences?

Director for Mental Health and Adult Social Care:
This is really interesting, I am going to separate them out. There are other models in the U.K. where exactly this happens, how this is called the triage in the U.K. and how that works jointly with the police really varies from one organisation to another. The best model I have seen is where there is a designated police officer and a mental health nurse and they do together to determine really quickly. My concern about let us send the triage team rather than the police is you could get back into that ping-pong thing again about it is not us, it is you, it is not you, it is us and particularly when the police have been called, for example, there is potential safety issues there, is there not? My preference would be, I am not aware we have 2 people going out together and doing that assessment and then deciding really quickly if it is not the police then of course likely the police should back away. Often the police are the last people you want in a mental health crisis. That is through no fault of the police, that is the just the uniform and the police presence can make things worse, frankly. But, equally, there are times when that is the absolute thing that you want in terms of safety. Nothing to be determined but could we do that in a different way? Yes, we could. Paramedics and ambulance, absolutely. There are some really good models elsewhere, where

people who routinely use mental health services who call an ambulance, unless they are calling with an immediate physical health risk, say, for example, if they say: “I have taken a significant overdose” but they are just calling because they need mental health support, that can be diverted to the mental health service and the paramedics do not need to be involved in the first instance.

Senator S.W. Pallett:

Okay. Could I just ask, is there a protocol in place for something like a domestic violence incident, for example, where there is a risk of violence, the police have been called, could be armed unit or even Taser? Is there a protocol with the mental health service to have somebody there to talk to that individual? Obviously we have got a debate coming up around Taser use and I am just interested in how that might work.

Director for Mental Health and Adult Social Care:

I do not know in immediacy as to how whether that would happen immediately at the point in which the police arrived in the house. What I do know is that there is a morning briefing every morning that someone from mental health goes to where the police go through, for example, instance of domestic violence or concerns about domestic violence and there is a conversation about, is anyone known to the mental health services, is there anything that the mental health services need to do? I have never seen that before, that is something that seems to be very specific here and I think it is great. It feels like it is a really good system. I will find out for you whether there is ever a point at which the police could say: “Come now, mental health nurse, this instant”, I do not know if that is true or not. But there is a system by which domestic violence cases are thought about jointly between the police and mental health and I think it is good practice.

Senator S.W. Pallett:

I think it is good practice and there is an opportunity here, I think, to lean on some good practice in terms of, potentially, engaging with people from a mental health point before we end up injure them in other ways through Taser or whatever.

Director for Mental Health and Adult Social Care:

There is so much debate these days, is there not, about where the lines are? It is what you described earlier, between mental illness and mental health and there are people behaving in a strange way in the street, is that public disorder? Is it mental illness? Is it a matter for the police? The lines are blurry a lot of the time. I think one of the things that we have to do and it comes back to the finite resource issue, we have to make sure that we are making best use of the resources that we have got. If we implemented a proposed model and then we found that mental health nurses are just spending their time going round in cars with police and very little contact that happens with secondary care services, we should not be doing it, frankly. But that is about trialling and evaluating

stuff, is it not? Yes, and is a good example, I think, of how we could do something different here because of volume and demand that might not work in other places.

Deputy M.R. Le Hegarat:

Okay. We will move on to the sort of other front line mental health support. Minister, in your response to the panel's previous review it was stated that: "Support of primary care colleagues is central to your plans for improving access in early intervention and providing assistance to develop their knowledge and information about good mental health care in the Island. We have already started an initiative that allows G.P.s to gain instant telephone advice from a psychiatrist." Please, could you provide us with an update on what support the Government has provided to G.P.s to assist with early interventions?

Assistant Minister for Health and Social Services:

I think we really need to go to Patrick Armstrong here. He is clearly involved with the G.P. process and the support that G.P.s can obtain through the G.P. supervision. Patrick, you are muted.

Medical Director, Health and Community Services:

I think I could say …

Deputy M.R. Le Hegarat:

No, I think the answer is is that Patrick Armstrong does not have the answer to that question and I believe the Minister might want to contribute here.

[12:15]

The Minister for Health and Social Services:

I think it is just say that if we had not had the pandemic we would be further along this route but the pandemic has affected the development of this piece of work and the G.P.s have had other duties that we have asked them to do. But as the Jersey Care Model develops we will be engaging with G.P.s about enlarging their practices and taking on primary care work in mental health for which they are well suited.

Deputy M.R. Le Hegarat:

What you are saying is basically that in the future there is an anticipation that we will be providing the training for G.P.s to be able to provide that first line opportunity.

The Minister for Health and Social Services:

Yes. It may well be, I am sure, there would have been some discussion with G.P.s around it but I am not aware of any huge initiative at the moment. But this year we will see progress being made with the various work streams and the Jersey Care Model, G.P.s are involved in that. This is definitely one of the areas where we believe G.P.s can help and can address primary needs, rather than bringing people into secondary care services.

Deputy M.R. Le Hegarat:

Okay, thank you. Minister, we understand that the involvement of the community in charity sectors and some commercial relationships, for example, the Listening Lounge, are integral to the planning future service delivery. Please, can you provide us with some details about the commissioning framework for those services?

Assistant Minister for Health and Social Services:

The third sector are absolutely essential to providing support to people with low-level mental ill health and also for people with mental illness. But the fact is there has to be co-ordination and that is what the new board will be all about, is getting people to work together and providing services in a targeted fashion, rather than everybody providing a similar thing. Andy, of course, will know more about this.

Director for Mental Health and Adult Social Care:

At the moment it is a basic commissioning framework, so services commissioned against specification which may or may not say exactly what the outcomes are, for example. Some of the commissioning frameworks currently are based on activity, so they are on headcount of contact and some of those are even broader than that. There are terms of provision of some support service, for example. That is not unusual in a new system where partners are being integrated into the system, I think you would expect to see that. There is 2 things going on, the first is that there is a piece of work going on at the moment in H.C.S. which is about developing and strengthening the commissioning framework per se. An example that I would give is I think it is really important where we can with that set of departments that we still ask them to articulate outcomes. It cannot just be about contact and how many people come through the door. It has got to be about, so what is the outcome of what you are doing really? That is the first piece of work and that is well in train. Then the second issue, as you rightly say, is the partnership or this is the whole business of Partnership Board really. The Partnership Board should be saying, we need to provide X, who is best placed to provide it? I come from a system where we do that, using a commissioning framework, so there is a group of people on the framework and we will give the framework a piece of work and say this is what needs to be done and they will work it out among themselves who does it and does not do it. Sometimes they vie for it and sometimes they jointly work together. That then creates different partnerships, it creates a different type of collaborative approach to this stuff. Those 2 things together are strengthening the commissioning framework, plus the Partnership Board thinking about

how this stuff moves forward should get us to a stronger place, I think, around commissioning and recognising this has got to be the model. The model has to be utilising those sets of partners and other agencies but also people who have used our services to deliver our services in the future because it is the right thing to do; it impacts service delivery.

Deputy M.R. Le Hegarat:
How far in advance do you commit to budgets or contracts with other parties? If you are going to contract somebody, how much in advance do you do that in relation to your budgets and contracts? How far in advance are you doing that?

Director for Mental Health and Adult Social Care:
I think currently that is reviewed on an annualised basis and I know I can certainly think of an example where we have contracted something and we have just centred it because it is the right thing to do to keep it going. In the end of course that may change again because it creates an instability issue, does it not, for the first sector providers? There is a sustainability issue if they are only going for year on year on year on Mondays. In the end I would hope we can move towards a different contracting mechanism that provides them with more stability.

Deputy M.R. Le Hegarat:
More stability.

Director for Mental Health and Adult Social Care:
Absolutely.

Deputy M.R. Le Hegarat:
Okay, thank you.

Senator S.W. Pallett:
No, I was just going to say, with the commissioning framework obviously this amounts to a commercial enterprise run by a commercial group, how do you operate that up to the service level agreement space, key measurables? You have not got 3 or 4 Listening Lounge groups in the Island, how does that work to make sure that the public get best value for money?

Director for Mental Health and Adult Social Care:
At the moment it is measured on activity but I think it is …

Senator S.W. Pallett:
(several inaudible words)

Director for Mental Health and Adult Social Care:

No, I think it is a good example. Of course you need to measure activity but, frankly, headcount of contacts tells you almost nothing, does it not? This is an argument that has been going on for donkey's years in mental health services. I remember as a community nurse having to fill in forms of how many people I would see and thinking every week, this means nothing, I could be going in and saying hello, how are you, and coming out again? Or even I could be doing a really good piece of work if we are not counting it as one. It cannot just be about contacts, it has got to be about the quality of those contacts, service-user feedback, so that is important, although experience of service user is not always the same thing as outcomes; they are different and then outcomes where we can get them. When we are looking at things like the Listening Lounge contract we are starting to think about things like, how many people come back? If you are regularly seeing someone for 6 sessions of counselling and you are doing that over and over again, it is probably not working and you might want to do something different. How many people get referred into other services, so Step Up, Step Down? That type of stuff is the stuff that we will start to integrate into that contract …

Senator S.W. Pallett:

That is being prepared now.

Director for Mental Health and Adult Social Care:

We are starting now. That is part of the development of the commissioning framework, we are absolutely talking about, how do we measure some of this stuff differently? But we also must not create an industry, this is my personal view, one of the errors of the N.H.S. (National Health Service) system was creating an absolute industry around commissioning where you ended up with hundreds and hundreds of people counting a load of stuff that never really made much difference. Commissioning is important but we must not overegg the pudding I think.

Deputy M.R. Le Hegarat:

Okay, thank you. Are there any plans to establish a dementia strategy for Jersey?

Assistant Minister for Health and Social Services:

Quite definitely, Chair. But, again, I will let Andy describe this service to you.

Director for Mental Health and Adult Social Care:

There are indeed. We have started conversations with a number of stakeholders, including the first sector stakeholders who have got a really clear voice in all of this, charities particularly. What is important though about a dementia strategy is it is not a strategy that is owned and held by mental health services. A dementia strategy has to be a whole system strategy that thinks not just about

mental health services but also about people's physical healthcare, about their social care needs, things like housing and also carers and how we support people to look after their relatives with dementia where that is the appropriate thing to do. Mental health will be a core part of that and we have started those conversations and later this week I am meeting the Chief Executive of Dementia Jersey to have exactly this conversation. But we cannot own it, it has got to be a strategy that is owned in its entirety and it is not just a health issue, even a wider health issue, it needs to be a whole system strategy of which health and mental health should be a component part.

Deputy M.R. Le Hegarat:

Okay, that is perfect, thank you. The previous mental health strategy ran from 2016 to 2020, are there plans to publish a new strategy to clarify the new strategic direction of the services?

Director for Mental Health and Adult Social Care:

Yes, we need to review, we need to refresh and review the previous strategy, which of course would have happened. It was in the improvement plan previously but was parked as a result of COVID. I think one of the things that we would want to do by the end of this calendar year is to have absolutely refreshed the mental health strategy and published another one for the next few years. That ties back in answer to the question I was asked earlier about, how do we know in 3 or 4 years' time that we have done what we have said we were going to do, when it was set out in our strategy with measurables and milestones? We have done it.

Deputy M.R. Le Hegarat:

That is what we do, is it not, Minister, we do a review and then we follow you back 3 or 4 years' later? Please, can you provide an update on the Government's work in relation to pathways for the transgender people, please?

Director for Mental Health and Adult Social Care:

There has been a number of meetings between members of H.C.S., the third sector and voluntary agencies that are involved in this work. There is currently a provision that is a small provision, that is part of the community service, that is overseen. We have got a contractual relationship the Tavistock and Portman Clinic in London who provide gender services. I understand the lead clinician there provides significant support to the Commission on Islanders doing that work. But we are meeting this afternoon to look at a business case that has been developed, a draft business case to expand the pathway for people with gender issues and we are looking to talk about that this afternoon to see about where is that going, what are the next steps and understanding how we might implement the next stage with them?

Deputy M.R. Le Hegarat:

Can I just clarify that you or your officers met with Liberate?

Director for Mental Health and Adult Social Care:

Yes, indeed. I understand there has been a number of meetings between health officers and Liberate.

Deputy M.R. Le Hegarat:

Okay. Minister, as part of the Government Plan, the final couple of questions here, there was funding approved for a paternal mental health service as part of the children's health recovery and run by C.A.M.H.S. Please, can you describe how adults who need access to this service will be signposted to it, please?

Assistant Minister for Health and Social Services:

Of course this is about women and families who come into the service because they are having children and those people who need assistance will be identified via maternity services or via house Health-visiting services or may well be known to mental health services from the outset. Yes, we are putting a significant amount of money into H.C.S. to cater for those needs and to develop outcomes. But, Andy, perhaps you could take this and expand.

Director for Mental Health and Adult Social Care:

This is currently managed under what is called the perinatal pathway. Perinatal mental health services are for women who have either developed a mental illness during pregnancy or child birth or subsequent to that or have got a history of mental illness and then get to be pregnant, for example, and need some specific advice around how to manage their medication during that time, et cetera. There is currently a meeting on a regular basis of key stakeholders in the perinatal pathway where they look at all of those in and they determine who is the right person to go out and do the work; that sits across C.A.M.H.S., women's and children's maternity and adult mental health and social care, so there is a little system there. But because of the business case and the work around development of these services, we have a meeting on Thursday and we have got a workshop on Thursday afternoon to map out in detail how the perinatal pathway will work moving forward. We are putting quite a lot of resource in and we need to make sure that it is seamless, we need to make sure people are not overlapping and we need to make sure that people are using their best skills and experience in that pathway to deliver the best care. Paternal support around perinatal mental health services is a good example of something that can be really well done by non-clinicians. It needs to be overseen by someone with a clinical eye but people who have experience of that ... for example, I certainly have had experience of managing a perinatal service where a lot of the paternal support was done by peer workers and volunteers, by people who had been through the experience and understood. That is one of the things we will be looking to develop as part of the new model.

Deputy M.R. Le Hegarat:

Thank you. My final question: how do the various mental health services collect patient feedback?

Assistant Minister for Health and Social Services:

I will leave this one with you, Andy.

Director for Mental Health and Adult Social Care:

There is a number of ways currently. Obviously the formal complaints concerns staff, that is one way of doing it and understanding the thematics of those and also understanding what can be done, what is in place. That is where we do not want to be, is it not really? There needs to be a lot more staff before we get to there. In our inpatient services, as I described earlier, there are regular ward meetings. There is a name for them that I cannot recall, apologies, where the staff sit down with the people on the ward at that time and talk about care and they minute those and actions are taken. Then they go back and talk the next week about what have we done and what have we not done. That is one way of doing it. In the community, and in fact across the whole sector, we get feedback through, for example, the regular experts by experience group, or whatever that is called here, managers from the mental health system meeting with people who are using the system and that is facilitated by charities. I think that Focus and Mind are the two charities that currently facilitate that regular meeting. So that is another way of doing it. We are going to create a board to strengthen that arrangement. Rather than what we have got at the moment is generally service users come along, they say that this is the problem, we go away and think about it and then we go back the next time and say that this is what we have and not done ... we need more of that. We want them to be involved. For example when we are thinking about changing the systems in community mental health access we need to be talking to service users about that now and getting their collective ideas about what we could be doing differently. So you engage them. Proactively engaging them is another way of doing it. Then I guess you get a lot of informal stuff. One of the things we have been doing in the last few weeks is encouraging people to come forward and say: “These are the doors that are open to you” up to and including my role. I have had a couple of families directly contact me in the last few weeks about concerns or where they think things could have been done differently. That is important. It is important that people know that they can get the right feedback from somewhere.

[12:30]

At the moment it is done. There is clear evidence in the system where particular services have said things and changes have been made, so that is what I would always look for. I would look for what has happened. It is no good just saying: “Yes, we collect people’s views.” It is about what you do

with them, but there is evidence that that does happen. What we are going to do moving forward is make that a bit more systematic. We are also going to replicate ... in other places there is an annual community survey so anybody who is on the books of the community mental health services gets the survey sent to them and they are also told where they can get support, not from workers in the system but from, for example, their sector partners to help fill it in if they need that. We are going to do that this year and particularly we need to make sure that we do that in multiple languages and that we make it as accessible as possible to people. Some people do not have internet access, for example, so how are going to make sure that they are able to fill in the form and get it back to us. We are really thinking at the minute about how we make that accessible. That is the sort of stuff that we will keep on doing. There will be routine processes but people get a bit turned off by surveys, do they not? I think you have to have lots and lots of ways of people giving us their feedback and their experience.

Deputy M.R. Le Hegarat:

Perfect, and that is .... no, you cannot ask another question. One day I will do that.

Deputy K.G.Pamplin:

I know you will. I just want to refer to recommendation 17 of our report. We did touch on G.P.s: "The Government should review the fees charged by the G.P.s in relation to mental health and explore in close consultation with G.P.s whether a different funding method could be used if a patient presents to a G.P. with mental health issues seeking referral." It has come up again in this review, people's access to the service via G.P.s. The barriers are still there culturally and Island-wide about the structure of paying for referrals. Your quick thoughts on how does that piece of work continue and how do we think outside the box with it?

The Minister for Health and Social Services:

Can I begin this one unless Trevor ...

Assistant Minister for Health and Social Services:

Yes, I think so, Minister.

The Minister for Health and Social Services:

Since your review, Deputy, there have been changes in that easier access to G.P.s is available to families where there is somebody on Income Support in the household and to pensioners who are on Pension Plus and of course for children. Children now have free consultations and adults at a very much reduced rate of £12. My understanding is that - I will be answering a question on that tomorrow - that has been well received and there is evidence that people are responding and have been attending to a greater extent. I am very pleased we were able to introduce that. My camera

has just died - sorry about that - after 2 hours. It may be that the next Government will want to investigate what further steps might be taken, but it is not just a question of fees and payment. It is a question of how G.P.s fit into the overall system really. Insofar as we have to fund that this year we are beginning a review of sustainable funding for health across the board, across the whole Island, and not just in Government.

Deputy K.G. Pamplin:

You covered everything, Minister, so we have got that. My final question is, Andy, you have talked a lot about hearing things, all the good things. You talk about the central part of this is going to be hearing the things that are not so good and obviously that is going to help change. So how are you going to establish that people, that is staff, can finally ... because that was in the Independent Mental Health Review said that they see a lot of changes. You are going to hear the stuff that needs to be heard, not just being told everything is great, everything is good. It is a cultural phenomenon on this Island. How are we going to change that?

Director for Mental Health and Adult Social Care:

I have already said that some of this is about personal style, is it not? I will not ever fluff stuff up and make it sound like it is good if I do not think it is and if the evidence is that it is not good then we need to know that. We have been really honest about that. In all of the work that we have done around staff engagement work until now, we have talked about the things that, the external review says has not been very good. Moving forward, we need to keep making sure that the staff are able to receive less positive feedback. It needs to be evidenced. There is a lot of things that I think are unsubstantiated or people's generic views about things and then when you unpick them that is not actually true, that is not what really happened or the decision that was really made. So we need to evidence the things that are not working, but we need to be honest about them and own them and then we need to say: "These are the things that we are going to do about them", notwithstanding that we need to recognise finite resource, need to prioritise and the significant challenge in staff being tired. So in that context, though, I think we have to just be honest. I think that people have been honest about the mental health review and the concerns that were within that and we have subsequently been very honest with staff about that. There is no point hiding behind it otherwise all we are doing is talking about what other people are doing behind their backs. That is no good at all, is it? To date my experience has been that there has not been much difference of view among most of the people that I have spoken to in the 7 weeks that I have been here about what the key challenges and issues are. There are differences of view about who is to blame, there are differences of view about what the solution might be, but pretty much people are saying and naming the same things as being a challenge. What we must not do ... this is all about balance. We have to make sure that we can talk about the stuff that is tricky but we also acknowledge and talk about the stuff that is good and the hard work that people have put in and the fact that people still get up

every day and come to work and provide care for people, often in very challenging circumstances. If we get that balance wrong then all we do is just demoralise people further and that is the last thing that we want to do, is it not?

Deputy M.R. Le Hegarat:
And we lose more staff that we cannot afford to lose.

Director for Mental Health and Adult Social Care:
Yes, exactly that.

Senator S.W. Pallett:
I have a very quick one. It goes all the way back to the start with governance arrangements back in early 2020. Was there ever a point where mental health services in terms of the risk capacities were included on the risk register? If so, do they remain on the risk register? Clearly there has been a need for services and there is a risk that we cannot provide those services. Is it on the risk register and should it be on the risk register?

The Minister for Health and Social Services:
I believe it was. In your experience, Rose?

Chief Nurse, Health and Community Services:
Yes. Trevor, I do not know if you want to answer first as the Chair of the Quality Committee?

Assistant Minister for Health and Social Services:
Yes. It did appear on the risk register but there were several things in association with mental health services that did not. We pulled that into line and, of course, the actions taken last year and the resulting appointment of Andy were directly responding to the level of risk identified.

Senator S.W. Pallett:
Could you provide us some details around that, when it went on to the risk register and subsequent actions that came off the back of that, please?

Assistant Minister for Health and Social Services:
Would you like to add to that, Rose?

Chief Nurse, Health and Community Services:
Yes, we can provide that.

Senator S.W. Pallett:

Thank you. I am done.

Deputy M.R. Le Hegarat:

Okay, I think that us is done then. Thank you all very much and I should have welcomed Andy to his first public hearing with us. Thank you for all the answers, Minister, Assistant Minister, and Andy, Rose and Patrick as well. Thank you to the panel as always and the panel officers and have a good day.

[12:37]