STATES OF JERSEY

Health, Social Security & Housing
Health White Paper Review

FRIDAY, 27th JULY 2012

Panel:
Deputy J.A. Hilton of St. Helier (Vice Chairman)
Deputy J.G. Reed of St. Ouen
Mr. M. Gleeson (Panel Adviser)

Witnesses:
Ms. R. Naylor (Chief Nurse)
Ms. M. Leeming (Head of Nursing, Adult Mental Health Services)
Ms. E. Torrance (Head of Midwifery and Divisional Lead for Women's and Children's Services)
Ms. J. Mesny (Head of Nurse Education)
Ms. H. Blain (Senior Manager, Workforce Planning)

Also present:
Ms. K. Boydens (Scrutiny Officer)

[12:00]

Deputy J.A. Hilton of St. Helier (Vice Chairman):

We have 2 members of the public here this morning who are well aware of the rules regarding telephones off and not speaking or eating during the hearing, so I will not repeat that. Welcome. We will start by introducing ourselves for the tape, so I am going to start. I am Deputy Jacqui Hilton, I am the Vice Chair of this Panel.

Deputy J.G. Reed of St. Ouen:

I'm Deputy James Reed, Panel Member.

Panel Adviser:

Mike Gleeson, Adviser to the Panel.

Scrutiny Officer:

Kelly Boydens, Scrutiny Officer.

Ms. R. Naylor:

Rose Naylor, Chief Nurse.

Ms. M. Leeming:

Marie Leeming, Head of Nursing for mental health,

Ms. E. Torrance:

Elaine Torrance, Head of Midwifery and Divisional Lead for Women's and Children's Services.

Ms. J. Mesny:

I'm Julie Mesny, Head of Nurse Education.

Ms. H. Blain:

I'm Honor Blain, Senior Manager Workforce Planning.

Deputy J.A. Hilton:

Thank you very much indeed. Again, thank you very much for coming here this morning and giving us this opportunity to ask you some questions around the Health White Paper. Can I just start by asking each one of you, if possible, what level of involvement have you been able to secure in the process leading up to the publication of the White Paper and the preparation of the outline business cases? So, if we could start with you, Rose.

Ms. R. Naylor:

I have been involved in the development of the White Paper since the beginning with the U collaborate event that was held up at Trinity, which was the multi-stakeholder event, which was around about 2010. Following that event, I was involved in the development and the work-up of the Green Paper; I am part of the Health and Social Services Steering Group, which is also joined by members from Treasury and also Social Security as well as G.P.s (general practitioners) from primary care. Then, following the publication of the Green Paper and the feedback on the consultation, as a member of the

senior management team at Health and Social Services, I have been involved in the identification of the outline business cases and then I am also the senior responsible officer for the End of Life Pathway. But I have also had involvement with the other S.R.O.s (senior responsible officers) in relation to the outline business cases they have developed.

Deputy J.A. Hilton:
Can I just stop you, S.R.O.s?

Ms. R. Naylor:
Sorry, senior responsible officers.

Deputy J.A. Hilton:
All right.

Ms. R. Naylor:
So each outline business case has an executive lead who is part of Health and Social Services, corporate management team, so Richard Jouault is a lead, Susan Turnbull as Medical Officer for Health is a lead, Andrew Mc Laughlin and myself, and then some of the others lead on the cross-cutting workstreams as well. So I was directly responsible in relation to the End of Life Pathway. Then, in relation to the White Paper, as well as being to all the public events, which I also saw Deputy Reed at them as well, I have also been involved in leading on elements of the consultation, particularly with individual particular groups of staff and most recently we held a management day with all our ward sisters, charge nurses, and deputy ward sisters, which was about 70 people, gave them a presentation and an opportunity to discuss some of the elements in that. In addition to that, in the Green Paper consultation, I was asked to lead on some of the consultation processes, so I cannot remember the name of the group, but the group; I cannot remember the name of the group, but it was the Standing Womens Conference.

Deputy J.A. Hilton:
Whiteley Group.

Ms. R. Naylor:

Is that what it is called? Yes. So I led on the consultation with that group as well.

Deputy J.A. Hilton:

All right. Thank you very much indeed.

The Deputy of St. Ouen:

Can I ask, Rose's experience, is that reflected across the board or is it somewhat different?

Ms. M. Leeming:

Rose probably had more involvement on a wider scale, but I also attended the u collaborate session in 2010 and post that session we had lots of opportunities to feed back, to discuss, to offer our views and opinions, and additionally, from my own area of mental health, we spent some time with our senior colleagues talking about the White Paper, the Green Paper initially and then the White Paper. So we have had quite a bit of involvement and opportunity to comment and to offer views and opinions.

Deputy J.A. Hilton:

Thank you. Elaine?

Ms. E. Torrance:

Mine is the same as Marie's experience. I attended the event as well and I was quite a vocal member of the group looking at pre-birth to 3 years old.

Deputy J.A. Hilton:

So just to confirm, you were both heavily involved in the outline business cases for your own particular departments, which is mental health and children.

Ms. M. Leeming:

Yes, I participated for I.A.P.T. (improving access to psychological therapies), which is the psychological interventions, early interventions, and drug and alcohol strategy.

The Deputy of St. Ouen:

Can I just ask, Rose, you spoke about the identification of business cases, and the White Paper sort of identifies a sort of a phased approach and it is almost a prioritisation, how was that decided? Who decided this should happen first; this should happen second, and so on and so forth?

Ms. R. Naylor:

Yes, it was decided by the steering group in relation to the identification of the priority areas, and it was based particularly on relieving some of the pressures on the capacity issues in the General Hospital. So, for example, with the End of Life Pathway, we know that over a third of people who currently die in Jersey, die in a General Hospital bed. That was the same for some of the issues around chronic disease management. So there was 2 sort of strands to the identification, one was around relieving some of the capacity and the other was around getting upstream in the preventative measures in relation to the I.A.P.T. and the early years intervention. So that was how the discussion was led in relation to the priorities and, without directing you too much, I know Julie Mesny was at that meeting in particular where the priorities were decided.

Ms. J. Mesny:

Yes, they had an afternoon meeting, Rose could not attend, so I attended on Rose's behalf, and there was an open discussion and there are minutes from that as well, which Rachel Williams was chairing that meeting, Julie Garbutt and other senior managers were there as well.

Deputy J.A. Hilton:

Were you involved in any of the outline business cases?

Ms. J. Mesny:

No. My role is in nurse education. I was there at the Ucollaborate event and I was involved in looking at some of the themes as well. I recognise a stick diagram on page 23, because I remember drawing that at the event, and that looks nicer than my stick diagram.

Deputy J.A. Hilton:
Honor, would you like to tell us what your involvement has been?

Ms. H. Blain:
My involvement with the White Paper is that I was the author of the outline business case for End of Life and that process was multi-sector stakeholder involvement and from that collaborative piece of work then the pathway emerged based on best practice. So the pathway in the diagram is earlier on, you can see it in the White Paper but you can see it in the business cases themselves that was the pathway that was developed by the collaborative group.

Deputy J.A. Hilton:
All right.

The Deputy of St. Ouen:
Do you support the priorities and the timing of the different businesses identified in the plan?

Ms. R. Naylor:
Yes, I think it is fair to say we would all like things to happen quicker, and I think that is because we are focused on patients and families in relation to the priorities, and we would all like to do more than we can currently do. But we also recognise that we have to have a phased-in approach because we are talking about a significant workforce challenge in relation to attracting people to the posts, getting those services set up and established. In relation to one of the O.B.C.s (outline business cases), for example the intermediate care O.B.C., that will have a significant impact on the hospital in relation to changing the way services are currently provided. So, in terms of the phased-

in approach, I think we all recognise that it has to be phased in from a manageability point of view, but I think it is probably fair to say we would all like things to happen quicker, but that is just because of the way we are.

Ms. M. Leeming:

I would also say, having it phased and having a lot of consideration for the journey we are about to go on, which is really a radical change in terms of community-based services, we need the investment up front, we need to ensure that these are sustainable changes, because the end user, the service users, who could be any one of us, they need to feel like it is not going to chop and change. I think for quality reasons and in order to gain public support, people will need to feel that they can trust the next phases and the next stages, and they will buy into it because the model is very much based on a collaborative approach. In order for it to succeed, we need that collaboration with colleagues across the board, primary care, and also with service users. So I think that is another part of why phasing it and staging it is going to be more successful.

Deputy J.A. Hilton:

Thank you. What difference do you think the White Paper is designed to make to your role and that of your profession?

Ms. R. Naylor:

Who wants to start? I am happy to start. But, all of you, feel free.

Ms. M. Leeming:

I think it is very exciting. I think from a professional point of view there is a great opportunity for extended roles, for people's knowledge and skills to grow. I think in terms of attracting a workforce, this is the kind of work that certainly nurses in mental health want to be involved in and I think that will support us in terms of attracting highly skilled people, people who have that vision and have shared this vision are excited by that sort of change in more institutional care and certainly person-centred care and community-based services.

Ms. J. Mesny:

Can I add to that with clarity in relation to nurse training. We have been working on our nurse training programme for over 10 years, so having a clear vision of where we are going for the future and the type of training and education we need to provide, so as managing the vocational training centre, it means that we can grow the population to work within different roles. We can look at the staff who are in roles now and think about how we work with them in the future, and that takes time as well to develop those skills. So for us it is great to have that clear vision for the future of what is going to be happening within the education department.

Ms. E. Torrance:

Nurses and midwives like to give care that they were trained to give and the way that care is being described in the future within the White Paper mirrors that. We really should be giving care where it is required by the right person at the right time and the White Paper fully supports that. So that is why you have received such good buy-in from nurses and midwives, because they can see that their professional role is going to be enhanced.

Panel Adviser:

With regards to I.A.P.T., there is going to be high-intensity workers, low-intensity workers. What sort of people are you expecting to recruit for that service?

Ms. M. Leeming:

I suspect they will come from a variety of backgrounds, it might be counselling, psychologists, nurses who have trained specifically in C.B.T. (cognitive behavioural therapy) work, D.B.T. (didactic behaviour therapy) work, and so it will be a combination. There may be some that we know we have existing staff with those skills who will find these posts very attractive, and there will be a combination I think of some new people and some existing people that will form the teams for the low-intensity and high-intensity workforce.

The Deputy of St. Ouen:

I would just like to touch on sort of what I call workforce challenges, because we hear, not only do we have consultants getting older, but there are also challenges within the nursing profession, and indeed we already have, or I believe we have, quite considerable vacancies still exist within the current system, without allowing for the quite large numbers of extra people we are looking to recruit to deliver the services. I suppose my question to you is, do you believe we are being realistic in believing that we can recruit the numbers involved within the timeframe?

Ms. R. Naylor:

I think there are 2 things: one is, if we stand still, then we are not going to be able to sustain the services anyway, so we have to change something. In relation to nurse recruitment and retention, as a department we have done a huge amount of work, certainly over the past 6 years, in relation to doing more about growing our own, and we are currently out to tender at the moment with the U.K. (United Kingdom) universities to see if we can change the way we run our current programme on-Island so there is more places more readily available for local people. We are doing the Back to Nursing training programme as well at the moment and I think we have, is it 14 nurses on that, Julie?

Ms. J. Mesny:

Yes, we have, and we have also had over 120 nurses through the degree programme. So we have grown over the last 10 years, we started running our degree programme modules in the year 2000. So we do run modules and are already getting nurses additional skills and knowledge, like Marie has already alluded to, in care of the older person and long-term conditions, so that work is going on as well.

Ms. R. Naylor:

So we are doing a lot about growing our own, and also we have done quite a lot of work in relation to relocation allowances. Honor does a lot of work to do

with on-boarding of nurses to the Island. We have worked with the Population Office. Our nurses carry J-cats now. We have started to do some work last year around childcare provision, just to see what the demand is out there, across our workforce. We have also recently been working with Staff Side, for a piece of work that was agreed with the States Employment Board, which is around doing a review of equal work for pay of equal value, and we took that paper back to the States Employment Board on Monday.

[12:15]

But I think there is a recognition that we do need to fix the issue around nurse recruitment and retention, for which we have been asked to work up a plan following our meeting with the States Employment Board this week. We are continuing to recruit nurses, but we seem to be sort of stuck at this position where we generally have about 40 registered nurse vacancies across the board, with an additional sort of 20 that we are always sort of waiting for them to come into the service, which gives us an overall position of about 60 unfilled posts. That has stayed static probably for about 2 to 3 years. But the issue, I have been going to the States Employment Board since 2009 about the issue around nurse recruitment and retention, and the issue is quite complex in the sense that it is not one thing that is going to fix the problem in that there are different issues relating to the cost of rentals in Jersey, which are further compounded by the fact that nurses coming over now generally come with families, partners, the partners are increasingly finding it more difficult to find work in Jersey because we do have an unemployment problem, which puts the nurse then in the position of being the breadwinner for a family, which makes it very difficult for them to afford to live here, particularly if they have a property in the U.K. that they cannot sell or rent out because the market is saturated over there. So it is not a simple fix, but I am confident that we are working on it to find a solution with States Employment Board and Staff Side. We have done everything we can to source within our own department.

Deputy J.A. Hilton:

Can I just take you back to the training of nurses, what training do you offer? Nurses do degrees now, do they not?

Ms. J. Mesny:

We offer a variety of training.

Deputy J.A. Hilton:

So can somebody go from the start to the end in training here in Jersey and qualify in Jersey?

Ms. J. Mesny:

Absolutely, yes, and we can start with our cadets, so we have a cadet scheme, we are now working with Social Security on the long-term unemployed scheme possibly as well for the staff to access our qualification, and then they can work as a healthcare assistant for a while, then they can become a specialist in an area within healthcare, and eventually they could come on to the nursing programme. The plan is to run the nursing programme every year from next year for adult nursing, and we will do the same then for mental health every couple of years.

Deputy J.A. Hilton:

I think our concern, because of what you have just said, 60 vacancies at the current time and that position has remained quite static, which surprises me a little bit because of the employment situation, the economic situation in the U.K., I thought maybe you would have received more response from the U.K., so we are concerned how realistically are we going to be able to deliver these outline business cases with the numbers involved for full-time employees, and that is why we asked that question.

Ms. R. Naylor:

Yes, I mean, as I said in relation to that, I am more confident after our meeting with the States Employment Board on Monday in relation to the work that we have just done that we have been tasked to go away and develop some

solutions around that from within our existing budget that we have been allocated for next year.

The Deputy of St. Ouen:

Can I just ask, you speak about growing our own, great, but I would just like to know how many new nurses are required annually for us just to stand still, because obviously we have nurses that retire and we need to replace, what is the average sort of number?

Ms. H. Blain:

Usually, I try to facilitate the return of about 4 or 5 local residents who have undertaken the nurse training in the U.K. Due to skill-mix requirements, we cannot have huge numbers of newly-qualified nurses across the clinical areas at any one time. We need a real mix of that experienced staff; we need people to mentor them in practice and support them in that transition from student to registered nurse. So at any one time we have about 4 or 5 newly-qualified nurses in the organisation that are undergoing 12-month preceptorship for a 12-month period of post-qualifying, it is similar to a probationary period, just to support them over that transition. I have just today emailed out a number of nurses who are due to qualify and get their N.M.C. (Nursing and Midwifery Council) pin around September/October. I have just emailed about 14 or 15 of them this morning because we are going to release another 4 posts now as the last preceptorships are coming to an end, we are going to release another 4 posts for newly-qualified nurses to apply in the organisation. So it probably is about 4 or 5 at the moment. Part of the reason being is, because of the vacancy factor, the supervision and support that they do need when they are new registrants, we need to make sure that we do fill some of those vacancies before we start taking on larger numbers of newly-qualified nurses. But we know that is something we need to do. But in relation to the O.B.C., from the workforce planning perspective, there is a significant proportion of those posts are going to be for a non-registered workforce, which we are going to recruit from local residents. They will not be from outside in the U.K. They are mostly specialist posts, the registered nurse posts, in the O.B.C.s., in the White Paper, and that will give nurses who

are already here the opportunity, as Marie has already said, to get promotions and develop their skills and move into those posts, as well as perhaps a mix of some from the U.K., and those post-holders will be backfilled by, maybe experienced nurses, who are wanting to come at senior staff nurse level to the Island. So I do not envisage having any challenges fulfilling the vacancies of the specialist posts in the outline business cases that make up the White Paper. It is going to be the generic backfill, and also it is the generic community posts that, they are going to be in larger numbers.

Ms. R. Naylor:

Honor, I think in relation to the standing-still question, what is our percentage turnover? Does it sit around 9 per cent?

Ms. H. Blain:

Our annual percentage turnover over the past periods has been 10.66 per cent, but it dropped last year to about 3 per cent, because there were no jobs for the staff to go back to in the U.K. if they resigned, so they stayed.

The Deputy of St. Ouen:

So, number-wise, because percentages are different, number-wise ...

Ms. H. Blain:

The posts unfilled, including the people who are waiting to start, and the vacancies, were sitting at about 9%.

Ms. R. Naylor:

But numbers, Honor, not percentages.

Ms. H. Blain:

As rose said earlier, it is about 40 vacancies and about 20 staff who are waiting to start.

The Deputy of St. Ouen:

So every year there is about between 40 and 60 natural, that leave, so just to stand still we need 40 to 60.

Deputy J.A. Hilton:

Just to clarify, you are saying that the more specialist posts in the outline business cases, you do not see a problem in filling those, so you are confident that can be achieved?

Ms. R. Naylor:

What we have seen, certainly in recent times, on the back of what has happened in the U.K., is, while we are still not swamped with volumes of people wanting to come to Jersey to work, because people are frightened to leave their jobs and change their jobs for a whole variety of reasons, we have seen an increased calibre of individual applying for jobs, which I think is where Honor is coming from for the specialist posts. We might get small numbers of applicants for those jobs, but they are of good quality. Where we struggle, and have struggled for a number of years, are your jobbing staff nurse, so these are the nurses that you see in numbers across the medical floors, the surgical floors, and that is why we are trying to do more around supporting newly-qualified nurses who, in the U.K., are struggling to find work.

Deputy J.A. Hilton:

Can I ask you a question with regard to a consultant nurse, can you explain what a consultant nurse is and what qualifications that post would have?

Ms. R. Naylor:

Yes, Marie has one consultant nurse in her service. I do not know if you want to explain what he does.

Ms. M. Leeming:

That person would be trained to Masters level and generally consultant nurses tend to want to go on and do PhDs. Our consultant nurse is considering that right now. He has been with us a while. They are highly skilled in their particular area. They work clinically as well as supporting us in

terms of developments, new directions. They tend to see complex cases, so would work with other professions in the complex case area.

Deputy J.A. Hilton:
All right, thank you for that.

Panel Adviser:
On the role of nurses, can you give us an idea what you think the practice nurse is going to be doing? What is the role of the practice nurse going to be in primary care? How do you see this as a nursing role?

Ms. R. Naylor:
I think it is fair to say the role of practice nurse in primary care is very new here and the way in which practice nurses are currently operating, because of the way in which the money flows around the system currently, means that they are operating below their skill-set. So they are working at a level that we would recognise in the U.K. as a treatment room nurse. So we are not, at the moment, exploiting the skills that nurses have in relation to working in practices. That is not to say that there is not an opportunity to develop that, and we have had a couple of meetings with a primary care body, myself and Julie from the education point of view, to see what we can do to support them to develop the skill-sets of their nurses. But because of this issue of the fact that the G.P. has to see the patient in order to access the payment, it means those nurses are not able to practice autonomously at the moment.

Panel Adviser:
Do you see that being a solvable situation? Do you think the primary care teams, the G.P.s, are going to agree to changing the funding of practice nurses?

Ms. R. Naylor:
Yes, we have some examples within midwifery, but also just to say that, in terms of working with the G.P.s, they do recognise that there is scope there to use their nurses to a greater potential, so I do not think that is a situation that

is going to remain, is what I am going to say, but they are at the beginning of a journey on that. But Elaine has some examples where midwives have been working in G.P. practices.

Ms. E. Torrance:

Yes, we have Cleveland Road, a big poly-practice, and we worked very closely with the G.P.s: one, we wanted to get midwives into G.P.s practices because we did not want the women in the hospital that did not need to be there; but we always came up against this wall of: "I need to see the woman because that is how I get my remuneration." They have worked closely with us, they have developed a package where women pay £110 for the whole of their pregnancy care at the G.P., including their flu vaccine. They see the G.P. at least twice, but more if they need to, and if they need to see the G.P. more for a pregnancy-related complication they do not pay any more than the £110. The midwife sees the woman for the rest of the time in the practice, it includes a flu vaccine as well, which is really good news for us, and the midwife sees them for the rest of the time and we have literally just moved midwifery from the hospital into the G.P.s' practice. There is no financial gain for me or the G.P.s in that aspect, but what they are seeing, if you use the business model, a loss leader, because the women then stay at that G.P.s' practice for their childhood vaccinations, their gynaecology, because they have had such a great experience of seeing a midwife and a G.P. in partnership throughout their care. It is working for them.

Deputy J.A. Hilton:

So at the moment it is only Cleveland Clinic?

Ms. E. Torrance:

No, we have midwives in Lister House and in Indigo House. But the model I feel that is working the best is the one at Cleveland Road, and we really explored that in the outline business case to try and offer that as a model for other poly-practices within the Island.

Panel Adviser:

Can you explain why, working between the maternity services and the G.P.s, leaves a better outcome at birth and lower-weight babies than current antenatal care?

Ms. E. Torrance:

The idea of having a co-ordinated service between G.P.s, midwives, health visitors, the consultant in charge of the case, it is a cliché, but it is like using the woman, where she is, and we are all her skirts, we fit around her rather than her fitting us. These cases where you would see those absolute benefits are usually with vulnerable families, families that have co-morbidities, so if the mother has mental health issues, drug and alcohol problems, or is in a violent relationship, there is evidence to show that, if we put her firmly at the centre of her care, we move around her, she will have a much better experience, she will be more likely to comply with services. If she does comply with services and have a better experience, she is more likely to have a better outcome. But it is not just the birth weight, it is about parenting, going on into early years, and that is where the Mesh(?) programme fits in. Does that answer your question?

Panel Adviser:

I think so, yes.

Deputy J.A. Hilton:

Can I ask you a question about the Mesh programme now you have come on to that. I am aware that we have N.S.P.C.C. (National Society for the Prevention of Cruelty to Children) Pathways here and Brighter Futures offering very similar programmes. How much are the third sector, organisations like those, going to be involved in that type of work. Because I understand, certainly with Brighter Futures, that they are offering programmes that do centre around the whole family. It is no good just addressing the child who is having difficulties or the mother, because quite often it flows through. So how much are the third sector going to be involved in delivering these services?

Ms. E. Torrance:

They are vital to be part of that team, absolutely vital. If they want to come, we have to make sure that they are pushing on an open door. The thing with programmes that are currently in place, you have to want to go to them. Mesh is quite a targeted programme. So if you have a certain set of criteria, as I have just described around the vulnerable family, it is not so much as, "Would you like us to do this for you", it is, "We know this is the best way to deliver your care so that is how we will deliver it".

[12:30]

Some of the stuff that is already going on at the moment is opt-in, whereas we would have to opt the third sector in to be part of that programme; that skirt that goes around the woman and her family.

Deputy J.A. Hilton:

So, for instance, if you have a family who have a woman who is about to give birth, who is obviously vulnerable, and does so, are you saying that you are going to be creating a new service?

Ms. E. Torrance:

It is co-ordination really; it is more about co-ordination, us all working together, avoiding duplication, and it is about avoiding duplication for us, but also for the person that is receiving those services, and giving it to them at the right time that they need that. It is not just about when they are having the baby, ideally, as these services develop and we go into different phases with our new way or working, we would ideally like to be starting this as soon as the woman even thinks about becoming pregnant. So, if there is somebody in Marie's service who has disclosed to her team that she wants to start a family, we will start having a conversation and we will get to know that woman and enable her to get pregnant healthily.

Deputy J.A. Hilton:

Yes, thank you for that.

Panel Adviser:

We have just been to Guernsey and had an interesting day there and we talked about their I.A.P.T. service. Their I.A.P.T. service is headed up by a consultant psychiatrist. There is no mention of a consultant psychiatrist involved in the projected I.A.P.T. service in the White Paper.

Ms. M. Leeming:

I.A.P.T. services can be run by any professional, generally it is psychologists. It was driven by, developed by, psychology services, because it is early interventions. But in all sorts of places you will find the team lead could be from any background, it just depends on the model that has developed. I mean, I.A.P.T. to work well would mean that we would all have to work together, so it will be a partnership anyway.

Panel Adviser:

We just have concerns, and I am sure you will know far better than I do, about the rapidity with which, what appears to be a very mild depressive illness, can develop to suicidal thoughts and then to suicide. How on the toes are I.A.P.T. going to be to make sure that sort of tragedy is not a possibility.

Ms. M. Leeming:

It will be about partnership working, so, for anyone who poses a risk, they will go into secondary mental health services. So, if you are working with somebody who starts off and as they are being seen sessionally, more complex issues develop, risks seem to get higher, then they will be able to be responded to through our liaison service rapidly.

Panel Adviser:

Is there going to be one psychiatrist who you will sort of refer them to?

Ms. M. Leeming:

We only have one door into psychiatry, so we have one access route into psychiatry. Although it is adult psychiatry it is made up of, there are currently

3 consultant psychiatrists, 5 staff grade doctors, and then nurse therapists and others. The access route into psychiatry is through our acute service, so all referrals come through the acute service. Additionally, we have what we call our liaison service, which is our rapid response and crisis intervention service. Just for numbers, so far this year the liaison service has seen in excess of 300 people between January and June who presented in crisis, and the response time is a 30-minute response time, so within 30 minutes of that person being referred, normally through G.P.s, but it could be through other agencies, A. and E. (accident and emergency), inpatient services at the General, are seen within 30 minutes. So that is part of the service.

The Deputy of St. Ouen:

But if we are offering and providing this sort of co-ordinated service and we are working in partnership with organisations now, what real benefits do we get from the business plan then?

Ms. M. Leeming:

I.A.P.T. is early interventions for psychological distress, and the whole process of I.A.P.T. is to get people who might have gone off sick through stress, minor depressions, reactive depressions. Currently, for example, in these economic times, people are stressed, they are more stressed than they previously were. People find themselves in different situations and early intervention to psychological treatments has proven everywhere to increase the likelihood that you will increase wellbeing and you will reduce clinicity(?). So the stages of your illness do not develop into that more chronic type of illness, you get back to work sooner, so from a well-being perspective your resilience is increased in terms of being able to deal with the situations you are in. It has proven to be very, very effective. It is preventative; we do not want to wait until people get into crisis, so it is that preventative element, where people are going to their G.P.s and they are being signed off for one week, 2 weeks, suddenly it develops into 12 weeks or 14 weeks, and what we all know is, the longer you are out of work, the harder it is to go back and get back into it. So, if you have these brief interventions, so low-level for low-level stressors and concerns, and higher-level impact for more complicated care.

But, within that process, there is a third pathway, and if your risks increase you would be referred to secondary mental health.

The Deputy of St. Ouen:

I think no one would argue with you that early intervention is the best way forward. I suppose my question to you is that, I mean obviously you are clearly aware of the benefit, why are we not doing it? What has been the barrier?

Ms. M. Leeming:

The resources.

The Deputy of St. Ouen:

What has stopped us from working in partnership?

Ms. M. Leeming:

No, we are working in partnership.

The Deputy of St. Ouen:

Sorry, and dealing with then people who we know exist.

Ms. M. Leeming:

We are working in partnership, but it is the resources, there is a wait time for psychology at the moment, so you could wait for up to 6 weeks for a screening and then there is potentially a 12-week wait or longer. So it is about that. It is capacity and it is resources.

The Deputy of St. Ouen:

So it is funding. We know what needs to be done, it is just that we do not have the money to do it.

Deputy J.A. Hilton:

It is a long time, 18 weeks, for somebody to wait who is ...

Ms. M. Leeming:

Yes, it is.

Deputy J.A. Hilton:

So you are confident that the adoption of the Health White Paper and the necessary resources, that situation will be solved?

Ms. M. Leeming:

Yes, I would say it would go certainly a long way. If we can fulfil what is in the White Paper, then yes.

Deputy J.A. Hilton:

We have touched briefly on what we have just been talking about now, in Mesh, are there any other services that you feel would need to change as far as primary care goes to improve outcomes for people in Jersey?

Ms. R. Naylor:

Other than what is in the White Paper, or those included in the White Paper?

Deputy J.A. Hilton:

The ones in the White Paper, yes.

Ms. R. Naylor:

I think it is fair to say that all of them will improve outcomes for people in Jersey in relation to offering them choice, a better quality of service. So, for example, if you take end-of-life care, while we know people work very hard to support people at the end of their life, dying in a busy hospital ward when there are not enough side rooms and the environment is not necessarily appropriate, is not the best place to care for people and their families at that time. So the End of Life Pathway gives people from any age, it is not just for older people, it is for all age groups, an opportunity to express their preference in relation to end-of-life care. So, in terms of preparing families, supporting families and individuals through that process, the End of Life Pathway really talks about getting upstream of that, using the gold standards

framework, which is recognised in the U.K., training all clinical staff to use the triggers, so they recognise when somebody is perhaps approaching the last 12 months of their life, so that people can be better supported and we have a position where people have a good death and the family are left with a legacy of a good death as well. That legacy is carried through people's lives in relation to how their loved one dies. So that is just one example, because that is close to my heart obviously, but I think all of the outline business cases will improve outcomes for people, because they will give people choice, they will provide care in the most appropriate place.

Deputy J.A. Hilton:

Can I just ask you a question with regard to that, I think we are talking about adults when we are talking about end-of-life care. When we completed our first review into respite services for children and young people, it became apparent to us that there is no hospice facility for children, and I cannot recall any mention of how children are going to be helped and the families of children facing end of life.

Ms. R. Naylor:

What we have put in the first sort of phase of the outline business case, which is the first 3 years, because obviously they are all in 3-year tranches to fit with the medium term financial planning process, in the first 3 years we have put additional resource for a paediatric palliative and supportive care nurse that will be working across services, so our vision for services around end of life is not that, if you go into hospital you get a different nurse that is in that specialty, and you go into the community and get a different nurse; our vision is that the nurses work without walls, so to speak, so they follow families. So this nurse will be the sort of beginning of our support for children with life-limiting conditions. In addition to that, in our next 3 years in our transition plan going beyond the O.B.C., we have work in there to scope out respite facilities in relation to end-of-life care. Because, like you, we recognise ... I have been to the Isle of Man and their hospice facilities for children are fantastic, and we recognise here, while Hospice have built that fabulous new facility, and we have been working in partnership with Hospice, it is not necessarily built from

a child's perspective either, so that is work that we have recognised needs to be done and we have put some measures in place upstream of that to start that work.

The Deputy of St. Ouen:

Just picking up on the outcomes as identified in the White Paper, I would like to try and understand or ask you what changes are needed within the organisation and the role of primary care to ensure the outcomes described are delivered?

Ms. R. Naylor:

I think some of it relates to the development of the quality improvement framework that they are working towards so that we can link some of our outcome measures that we have identified in the outline business cases to the performance of the G.P.s, so there is a direct link there. That work has been going on for quite some time and is ongoing, so while there may not be everything that is included in the outline business cases included in that at the moment, I understand there is an opportunity to further develop that over time. I think there are further changes required around the technology so that we can share information, and again, just as an example, if you take the End of Life Pathway, sorry to keep labouring the same one, within that we would like to develop a sort of "co-ordinate my care" approach, which is in essence having a register and thereby, when we recognise people are approaching that phase of their life, they are put in this "co-ordinate my care" approach on this register, and that makes sure that all the services, whether it is primary care or whether it is family nursing, hospice, or Health and Social Services, are able to integrate and share information across the services, and that also would extend to the paramedics as well, so if a paramedic was called to a house where there was a patient there who had expressed their preference in relation to their own end of life care, they would have access to that information so they would not go in and necessarily start to perhaps resuscitate somebody who had chosen the way in which they wanted to be managed at the end of their life. So I think there are issues around information technology and how that flows around our system, and also in

relation to, as everybody says, the way the money flows around primary care at the moment, which does put a perverse incentive into the system and makes things quite difficult to change because of the way the business model is currently configured.

The Deputy of St. Ouen:

What you say is imminently sensible, but I am still struggling to understand why we do not have this information, why have we not been able to have the sharing that you just described, because we are a small Island, we are not a huge country. We are dealing with people that we see almost on a daily basis. What do you think the barriers have been to achieving what I would call basic good practice?

Ms. R. Naylor:

I do not think it is lack of motivation or will, I think some of it is around legislation, so some of it is around the legal framework in which primary care is currently operating, and I think undoubtedly it is down to resource because the work around the information and the informatics required will take some additional funding, and they have started the sort of first phase of doing this project in relation to that, but there is much more work to do on that to make sure that all of the work that we have set out in the outline business cases can be enabled and supported through that process. So I do not think it is a lack of will or motivation on anybody's part, because I certainly can say, from our interaction with G.P.s, it has been very positive, and we all go into the profession to do what is right for the patients, so we are all on the same page there. But it is the legislation around it and resource.

The Deputy of St. Ouen:

Does anybody else want to add anything? I see these people nodding in agreement.

Ms. M. Leeming:

I would say, traditionally, obviously, the way primary care worked was that you had whatever the number was, 70 G.P.s, some working in small practices,

some working in bigger practices, running very much as businesses, and independent almost of each other.

[12:45]

I think now there is a cultural shift. I think part of that is about their own governance and coming into the 21st Century I think the primary care practitioners feel this is a really enhancing time for everybody to share care and share that kind of responsibility and in fact collaborate in the best interests of the user. It is exciting and certainly, from mental health's point of view, we run a training programme called Store(?), which is all about supporting people, paramedics, G.P.s, to recognise risk and how to communicate risk. The uptake on that has been really good, they have come in the evenings to the training sessions, because I think everybody is beginning to recognise that we can do the best for service users if we collaborate, work together, learn from each other, work to each other's strengths as well. Because all the multi-professional groups have special skills and strengths and we avoid that duplication that often wears people out, where they have to go and tell their story to several different people. So again that kind of access to information, but feeling like you are doing it in a safe way, because clearly people's confidential information is really important to them, so for all of us to recognise what those limitations are and in what we share and how we share it, and are supported to do that; I think will just free people up.

The Deputy of St. Ouen:

Just moving outside of the G.P. area, to sort of looking at the other providers, how do you see that relationship? What changes do you envisage in that sort of relationship to enable everybody to have the confidence that they will step up to the mark and play their part in helping to provide this wraparound care that we are all looking for.

Ms. H. Blain:

I think it is not the will and the competence of the workforce; I think it is the infrastructure and specifically the I.T. (information technology) infrastructure. It is the public sector departments that really plays a key part in this and enabling other public sector departments to maybe agree to have third sector access with very specific permission so that our third-sector partners can access vital information about that patient. I think it is about breaking down the boundaries as well between the third sector ... from our perspective, certainly again with the end of life, my vision is that it is not where the staff particularly work or work out of, or who pays them, whether they are based in a third-sector environment or the hospital or another community-based environment or not, it does not matter where they are based or wherever that funding stream is, as long as the work is done, But we need the infrastructure to support the staff to deliver. The staff will deliver; they need the infrastructure to support them to do that.

Panel Adviser:

So we ask then, the question is, how far away are we from producing an integrated I.T. records system, which integrates with hospital, general practice ...

Ms. R. Naylor:

I think we are some way away from that, I think it is fair to say. Our finance director has that, he is the senior responsible officer for the cross-cutting work stream on informatics, and I could not give you a timeframe on that because it is still in development in relation to what the informatics dependence for all of the outline business case is, but ...

Panel Adviser:

What do you think of the state of the hospital records, are they tidy, up to date, are people getting out discharge summaries and so on? Are they managing that well?

Ms. R. Naylor:

It is probably best to ask Elaine from a hospital point of view in relation to Trak and the paper record system.

Ms. E. Torrance:

Yes, we have had the TrakCare system implemented into the hospital and there are 3 areas that we use it as an electronic patient record: maternity; theatres; and our E.D. (emergency department). There are other electronic patient records within the hospital. Marie's service uses one. The diabetic service uses Diamond. We are on a journey with electronic patient records; they have huge advantages, you can read everything that is put in, if it is typed in, but there is little annoying things, the way we have some, what we call "canned text", it is a bold prefix for a vaginal examination, and when you print it out or you put it on a screen, the bold bit goes ... there are silly little things, and we meet with the company director from InterSystems and our I.T. team and we are getting them fixed. So I could not say to you it is absolutely brilliant, but it is getting better, every week it gets better.

Deputy J.A. Hilton:

I am just curious, how are services going to be delivered in the community if the I.T. system just is not ...

Ms. E. Torrance:

We are already doing that in maternity. The girls that are at Cleveland Road, they do not have access, so they are going to the G.P.s' surgery, because what I did not want them doing was writing everything in E.M.I.S. (Egton Medical Information Systems) and then writing it in the hospital record. So they are going into TrakCare remotely from the G.P.s' surgery, so we had that all checked out that it was safe to do that, and they can put all the woman's record in. We have not tried it yet, but we have the ability for them to do that from their home P.C. (personal computer) if they are doing a home birth, they could go and enter the record. We have not moved and confidently done that yet. The next bit we need is it to be able to be blue-toothed into E.M.I.S. or cut and pasted into E.M.I.S., and that is the link that is missing. But if I can go back to talking about how infrastructure ... we put midwives into the Bridge

years ago and straight away the fact that midwives were sitting in an office next to health, next to housing, next to Jersey Youth Service, and having a pop-up shop(?) for finances, you know, a woman who is vulnerable, who perhaps needs a loan or health visitors, whether you all work from the same record or not, you could see that co-ordinated communication and action was taking place. Some of the testimonies that have come from women who had babies and had their midwifery care at the Bridge, and they might have had toddlers that required extra support from the parenting service, it is just all there. That has happened because of the Bridge and the third-sector services that were in there. So without us all having access to the same record, you could see straight away that the will is there, we have good models.

Ms. J. Mesny:

So we have good models and we want more of those good models all over the Island.

Ms. E. Torrance:

It is just the little bits that have been taken account of in the White Paper that should just finish that jigsaw off.

Ms. J. Mesny:

Just, there is lots of will.

Deputy J.A. Hilton:

Can I just ask you a question with regard to Guernsey and how much communication you have with Guernsey and what potential there could possibly be with sharing services and whether you have looked at that?

Ms. R. Naylor:

Yes, we have a group from the point of view of CSR work that is a joint working group with Guernsey, I know that is a separate issue, but that is just one example. From a Chief Nurse level, we have regular contact, I have contact with all the chief nurses in all the islands, so Gibraltar, Isle of Man and Guernsey. So we do look at joint schemes where we can.

Ms. J. Mesny:
And share good practices as well.

Ms. R. Naylor:
And share good practice. I know Elaine particularly works with ...

Ms. E. Torrance:
I was in Guernsey last week; I am going again next week, helping them recruit to a senior midwifery position. So we do the recruitment in the morning and then we do business in the afternoon, and we are looking to find neonatal services.

Ms. R. Naylor:
In relation to Marie's service, in terms of joint working, I do not know if you have done any with Guernsey recently?

Ms. M. Leeming:
Not recently, but we will work with each other when we might invite them to come and view our services, or we will go and see their services. They are going through quite a change in terms of how they are delivering mental health services now, so over the next period of time, I did go with Ian Dyer recently to look at their older people services, so we do work together. We also have an Island conference ... what do we call it?

Ms. R. Naylor:
Our small communities conference, because Germany comes now as well.

Ms. M. Leeming:
Yes, so they join us for that.

Panel Adviser:
Just on the point of recruitment, there is going to be a huge number of recruiting jobs to do on so many new staff. Will you be looking for

independent external assessors, especially for more senior posts, on your appointments? You apparently go to Guernsey to help with recruitment there. It is important, because there is going to be a lot of local applicants, and there is the sort of potential for disappointment and recriminate, “Because I did not get the job and it is cronyism”, and this sort of thing. How are you going to make sure that you have truly independent recruitment committees?

Ms. R. Naylor:
I think it is fair to say that we all, on behalf of everybody here, we always would go for the most suitable person for the job. So that is first and foremost.

Panel Adviser:
I have no doubt you do.

Ms. R. Naylor:
It would not be usual for us to bring in an independent source to recruiting for the lower grade of nursing post, I think that is fair to say. In terms of senior posts, I would sit on those panels, I do not regularly recruit jobbing nurses so to speak, so the more senior the post, the more ... like, for example, I would be on the panels for the levels of nurses that you see here and other people would be brought into those panels as well. We would not routinely bring in somebody independent.

Ms. E. Torrance:
I think it is when we do not have the expertise. We are going to be advertising soon for an oncology paediatric post, and we have enlisted the help of a specialist in Southampton to come and be part of that panel.

Panel Adviser:
Is that a clinician post?

Ms. E. Torrance:
She is a senior nurse.

Panel Adviser:

Because the clinicians have done it for years and, it did not used to happen, but we get independent assessors from the Royal College in, and so on, so that there is a sort of guaranteed totally independent neutral sort of component in the employment process. It is just that so many posts are going, it might be difficult at times, in a small Island, making your mind up between ...

Ms. E. Torrance:

I think our employment processes are so robust that, if somebody was disgruntled that they did not get the job, we have such a good system in place we can give them really constructive feedback.

Ms. J. Mesny:

Everything is recorded regarding the interview, is it not?

Ms. E. Torrance:

Often we can then help them to amend what was missing, because we do want people to come and work from the local community in those jobs, so we are very proactive at giving people feedback and ...

Ms. J. Mesny:

Before they go for interviews as well, they can go and speak to ...

Ms. E. Torrance:

Yes, they can come and get coaching.

The Deputy of St. Ouen:

Can I ask, do you expect the third sector to take on far more responsibility than they are now as we develop the community services and that care within the community?

Ms. R. Naylor:

We have made it quite clear in the public consultation events and other events that we have held that this is not about Health and Social Services taking over the world; this is about outlining the services that need to change and, again, in relation to the business case I have worked on, I do not think it would be right and appropriate for Health and Social Services to deliver that care. We have very good providers in the Island that would be able to deliver that care better, and who could step up to the plate, given the resource to do it. I think that goes for the other business cases as well. I think that, as long as the third sector does have the resource to follow, they have all been involved in the development of the business cases in the first instance, so it is not that we have developed them and then we have said: "This is what we are going to do to you", so to speak, they have been inherent in the process. So we had Hospice, family nursing, primary care, as well as some members from the chaplaincy, on the development of our business case, when we first drafted it. As we develop the full business case, that will be extended even further in terms of the membership of that group. In addition to that, we have other layers of things that are going on and I am sure mine is not different to other people's. So I have an Island-wide palliative and supportive care steering group that has representatives from all the organisations where we talk about how we move end-of-life services more into the community, closer to home. In addition to that, we have a Partners in Cancer Care Forum, which involves charities. So they have been kept absolutely up to date with what is happening in the development of the outline business cases and have been very supportive in that approach.

The Deputy of St. Ouen:

So just one final question on this matter: are we saying that, apart from the additional significant extra staff that are required and identified in the White Paper to help deliver the first phase, something like 200-plus I believe, there could equally be a further requirement of manpower from the third sector?

Ms. R. Naylor:

No, in relation to the way the business case has been developed, because they have been in the room with us and the conversations with us, the manpower that is in the business cases is the manpower that is needed.

The Deputy of St. Ouen:
Overall?

Ms. R. Naylor:
Yes, overall. What you do not see in the business cases though, I have to say, is the manpower that will be funded through the long-term care fund. So these are the healthcare assistant workforce that Julie and Honor mentioned before, and this links into the work that we have been doing with Social Security and Highlands, and the schools board, in terms of bringing in more local people into the caring industry.

[13:00]

So we are working with them to develop a workforce fit for employment anywhere in Jersey in the care industry, because we know that those jobs are going to be there. So when the long-term care fund does come in, and we have these wraparound packages, we need to make sure we have people ready and competent to do the job. They are not in the business cases, so they are additional, you are quite right, they are additional. But they are, in relation to your question about saying: "You have these and then does the third sector need more?" In terms of the specialist level posts, that is all it is that is in the business cases, there is not more on top of that. But there is this non-registered healthcare and supportive workforce that would follow the money.

The Deputy of St. Ouen:
If one was to drill down into, for argument's sake, alcohol, which is one of the areas, I would be able to identify the number of staff that would be anticipated to be recruited by Health and Social Services alongside any staff that may be

required, additional staff or resources, that may be required for a third-sector type of provider?

Ms. R. Naylor:

Yes, with the alcohol one, which is quite different, if you take an example, say intermediate care, which is predominantly a nursing care one, what you would see in the outline business case is the absolute figures in relation to the qualified level of staff. I am not saying that our healthcare assistants are not qualified, but in terms of the different layers of staff within that. What you will not see is, when the long-term care fund comes in and we develop care packages around these individuals if they are eligible for the long-term care fund, they will be predominantly provided by healthcare assistants or support workers. They are not in there in absolute numbers because you might need 4 healthcare assistants to care for you, Deputy Hilton might need 2, so that is the workforce that is not in there at the moment that we will be using the long-term care fund to support that.

The Deputy of St. Ouen:

Are we saying that the funding that has been identified to help deliver the areas; that is accounted for?

Ms. R. Naylor:

Yes.

The Deputy of St. Ouen:

But we are also saying that the long-term care proposals, or funding, when it is introduced, will help and add to the funds that have already been identified to support these services?

Ms. R. Naylor:

Yes.

The Deputy of St. Ouen:

All right. Thank you.

Deputy J.A. Hilton:

Thank you very much indeed. It is 1.03 p.m., so thank you very much for coming, it has been very useful to us.

Ms. R. Naylor:

Thank you for inviting us.

Deputy J.A. Hilton:

Yes, thank you for your time. You are all obviously very enthusiastic; it is good to hear your thoughts on it. Thank you.

[13:03]