STATES OF JERSEY

Health, Social Security & Housing
Health White Paper Review

FRIDAY, 20th JULY 2012

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

Witnesses:
Mr. J. Le Feuvre (Executive Director, Mind Jersey)

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

[12:00]

Deputy K.L. Moore of St. Peter (Chairman):

I am sure the members of the public are quite aware of our code of behaviour and so I shall not go through it all again for the second time, but we will start by introducing ourselves formally for the record. So I am Deputy Kristina Moore, Chairman of the Panel.

Deputy J.G. Reed of St. Ouen:

I am Deputy James Reed, Panel Member.

Panel Adviser:

Mike Gleeson, adviser.

Deputy J.A. Hilton of St. Helier:

Deputy Jacqui Hilton, Vice Chair of this Panel.

Scrutiny Officer:

Kelly Boydens, Scrutiny Officer.

Mr. J. Le Feuvre:

I am James Le Feuvre, Executive Director from Mind Jersey.

The Deputy of St. Peter:

Thank you, and thank you very much for coming in today. Our first question is slightly unusual in that you have had prior engagement in your former life as part of the Ministerial Oversight Group and so you would have had, I am sure, some insight into the White Paper and the Green Paper and the developments that have followed. But really we wanted to start by asking about Mind's involvement in the White Paper and how that has been a part of the process.

Mr. J. Le Feuvre:

Yes, I had involvement in the Green Paper to be precise, not in the formation of the White Paper, because that was the only time when I was not involved. But colleagues that I work with were involved in helping on the planned business cases, the O.B.C.s (Outline Business Case), so they were particularly involved around the dementia strategy, which would be my carer support manager perhaps had input in there, and our independent mental health advocate was also involved in other workstreams as well. So the charity has been pleased to be involved. I obviously came into my role in January and picked up on some of the work and prepared a submission, which is the same one that I have shared with the Minister because I thought it was appropriate. It is the same content in every respect. It is our observations around some of the key things that need to be attended to.

The Deputy of St. Peter:

Would you briefly outline those again for us?

Mr. J. Le Feuvre:

Yes.

The Deputy of St. Peter:

Generally, the tone was very positive.

Mr. J. Le Feuvre:

Yes, well I think it is a once in a decade opportunity for there to be hopefully some investment in health and social care; it has been sadly lacking in the previous decades I would have to say, with quite a strength of feeling in fact. I know that is a challenge because we live in times when resources are going to be very tight, but

there is everything to say that we need to invest in ensuring that we have a community that is healthy and with a strong sense of social wellbeing as well, so the context I come from, it is a good opportunity for there to be a very strong debate about the priorities the community has and the sort of things that need to happen in terms of health and social care going forward. Mind is very pleased to see that, out of the Green Paper, 90-something per cent of the population thought that your sense of mental health was as important as your physical health, and that was a big step forward, because hitherto mental health has been rather a Cinderella service. People do not like to talk about it too much; there is a lot of stigma associated with it, and we would suggest very strongly that your sense of mental health and wellbeing is as important as your physical wellbeing. So, in a small community where we need to have a productive workforce, it is absolutely important that people are fit and healthy and encouraged to be working and involved and engaged in society, for economic reasons, but also for their own sense of wellbeing. So we take that as a positive assessment from the population that it is important. We think that there are a number of areas, and we went into some specific ones, but we need to make sure that mental health services are given a proper share of the resources as well. I say that quite pointedly, as someone who worked in the acute sector for 20 years and more, we need to recognise that, if we are talking about care in the community, then there has to be investment in ensuring the right infrastructure is in place, and that applies equally to people with mental health problems and people with physical disabilities as well. So there is something about what is termed long-term conditions, which can be asthma, it can be diabetes, it can be chronic obstructive pulmonary disease, it can certainly be mental health issues, and people with those conditions need to be supported and managing them in the community if they can, with the appropriate support and access to specialists only when they really need it. So I am jumping about a bit, but that leads very much to say that the White Paper has touched upon the need to review and revise how primary care is organised and that is important. There is merit in the current system in many senses. I think the system of co-payments is probably right; it is something I think that other jurisdictions would like to be able to reintroduce if they could. By that I mean that for many people, having to pay an element to go and see your G.P. (general practitioner) is not necessarily a bad thing, because people will think about it, reflect about whether they should be accessing the G,P, then or not. Where it becomes a real impediment, and when you have one of those long-term conditions, the asthma, diabetes, when you should be in regular contact with your G.P. so he is keeping tabs on you, making sure that you are being properly managed and looked after, those people will find it

very difficult, because to go and see your G.P. once a fortnight, once a month, is expensive. The very people with long-term conditions maybe are not enjoying as much prosperity as other people, are the ones that are not necessarily being seen as often as they should be. We would suggest it is exactly the same for people with mental health illness. If they can be maintained by their G.P.s and other practitioners in primary care, perhaps some nurse practitioners, community psychiatric nurses, and others that could be involved in primary care, then that is a very important step forward.

The Deputy of St. Peter:

You have acknowledged approval of I.A.P.T.s (Improving Access to Psychological Therapies) and their development here. What evidence is there that they have been trialled sufficiently in the U.K. (United Kingdom) and they work?

Mr. J. Le Feuvre:

There is lots of evidence from the U.K.; Mind U.K. has some examples where our sister charities are involved in delivering those services. Now, I am not sure that is something we would absolutely want to do, but it is absolutely evident that easier early access to someone to talk to is a preventative measure; it is a really sound investment to be made, because you can avoid all of the other things that will come along in some instances. Not always, people might still need to be referred through, but if people are feeling low or not feeling very well, if there is someone they can get to talk to quickly and easily, in confidence, then that has to be a plus. For a certain percentage of individuals that will be all that will be required; they will not then have to go through the more prolonged route of having a referral into the secondary service.

The Deputy of St. Peter:

But having somebody to talk to, you would see it as a G.P. in the first instance?

Mr. J. Le Feuvre:

No, I think it can be someone else. As I understand it, psychological therapies mean that it would be a counsellor, someone who is trained properly, who would be there and available to see people really very quickly. I would not be sure what the precise mechanism is, whether it is after a G.P. referral or as a prelude to a G.P. referral; that sort of protocol would have to be worked through.

The Deputy of St. Peter:

In the O.B.C.s it outlines evidence that says that self-referrals often see the quickest recovery rates, and we were quite puzzled as to whether that was the person going to their G.P. as a self-referral or going directly to ...

Mr. J. Le Feuvre:

No, I think it is direct, I hope. That is the point about giving people control over how they manage their own condition and, if there is access that they can have, it could be that a single intervention is going to be all that it takes; there is somebody outside of the family who they will talk to, give them advice, and on they go. That has to be the cleanest and the neatest and the cheapest intervention you can have.

Deputy J.A. Hilton:

I agree with you. It all sounds very good in theory. But most people, when they are unwell, will go to their G.P. obviously for help and advice and I was just wondering how the general public would know how to access these services.

Mr. J. Le Feuvre:

Depending on how they were organised, it could very well be that G.P.s would be interested in tendering to run the service and that perhaps would be an ideal arrangement, if you thought about it. Some of the larger practices we now have on the Island physically, in rather better conditions, do lend themselves to having a variety of different professionals working in those services. Perhaps nurses is the obvious one, but you could have midwives, you could have psychiatric nurses, you could have the counsellors, people by appointment are available in certain sessions during the week, it could work very well.

Deputy J.A. Hilton:

Is it a service that your organisation would consider?

Mr. J. Le Feuvre:

I would not be certain that we would. We would certainly look at it, but, if it is going to be of the size that is required, it could have a disproportionate impact on our existing team, because we are a very tight and very small team, so we would have to consider whether we wanted that extra burden. Certainly we think it is an excellent service and it should be supported, whoever does eventually provide it. I think it is

not something that is thought should be provided in the hospital setting; it is absolutely something that should be outwith the hospital.

Panel Adviser:
Could I ask, the recruitment of I.A.P.T. therapy workers, high intensity, low intensity workers and so on, what sort of qualifications are you looking for when you are going to recruit these people? Are they going to have a background of psychology or health?

Mr. J. Le Feuvre:
I am not certain of that, Mike, to be frank, but I would think it will build upon the work the Highlands College are doing at the moment, some counselling courses that they run, but there would have to be a good deal of certainty about what would be the preferred qualification and there would have to be some quality assurance that people had the right qualifications. I think we would have to look to psychology to help ensure that we had the right level, the right individuals.

Panel Adviser:
The White Paper does not seem to make clear who is going to lead this group of I.A.P.T. workers, and I am not too sure that .., there is no mention of a consultant psychiatrist involved, so ...

Mr. J. Le Feuvre:
No, I think it is definitely a step away from the secondary services, so it would either be the psychology services quite possibly, or there would be an expectation that it is provided somewhere else in the community by others. It might be a charity; it could be G.P. practices; that is yet to be resolved I am sure. There are many different ways it can be done. Some in the U.K. are provided by the statutory services. In Solent, for instance, we know that Mind in Solent do deliver the service. Obviously I can talk to them about how has it been and what are the implications. The difficulty is, if you start running services in relative isolation out in the community, who does the professional supervision and there are lots of governance issues now about where they get professional guidance from. So I think one has to be very careful about how that is organised.

Panel Adviser:

The impression is it is a variable feast, it can start off with very minor sort of symptoms and then rapidly progress to suicidal thoughts and suicide.

Mr. J. Le Feuvre:

Which is why you need to have really strong links with the G.P.s and I think the G.P.s are fundamental to a lot of the delivery of the White Paper. They are the people that know the patients, the clients, the best. They know their family; they have known them over many years, and they must not be marginalised in any of the process.

Panel Adviser:

That just makes me concerned about self-referral and will these workers then, the high-intensity workers, be really on their toes and recognise a rapidly-deteriorating situation?

Mr. J. Le Feuvre:

I do not know, Mike. I hope they would, which is why I would hope that they probably would be collocated in G.P. practices. That would be the preferred arrangement.

Panel Adviser:

Do you have any data on outcomes of this service?

Mr. J. Le Feuvre:

Not immediately to hand, but it is written up in lots of different reports and ... I will just get the guy's name ...

Panel Adviser:

My understanding is it is a relatively new service; it has been going since 2008?

Mr. J. Le Feuvre:

That is about ... the last four to five years, but Professor Layard, who has done a very important piece of work from the London School of Economics, writes it up very, very strongly in the report that he has done. I do not know whether you have access to that report or not.

Panel Adviser:

I think we have references in ...

Mr. J. Le Feuvre:

I certainly referred to it, because it was very timely. It was arguing very strongly there was a very sound economic argument for doing this in terms of early interventions with the preventative agenda, and I would be pretty confident that it has been properly reviewed, because it is so widespread and so frequently spoken of nationally; I think it is pretty robust. It is Jersey's task to find out how is it organised and how might we best deliver it.

The Deputy of St. Peter:

I presume that there would be a need for the I.T. (information technology) systems to be working properly so that I.A.P.T., the therapists, were able to inform G.P.s perhaps.

Mr. J. Le Feuvre:

I would have thought so, yes.

The Deputy of St. Peter:

There are, I presume, data protection issues, but you would expect that they would advise of the treatment that was ongoing and do we have the right I.T. in place yet for that to happen?

Mr. J. Le Feuvre:

I am not certain that we do, to be honest with you. No, I do not think we do. I think the G.P. practices have probably bought much better I.T. systems than they had. There is a big question about how they interface with the health and social services systems. That was always, as I understood it, the idea that there would be a shared single patient profile, which would be held. But you are asking the wrong person that question.

The Deputy of St. Ouen:

How would you describe the current relationship between Mind and the Health and Social Services Department?

[12:15]

Mr. J. Le Feuvre:

Generally good. Our task is to be a critical friend, is what we would like to say that we are. We have a degree of independence, even though we are part-funded by Health and Social Services. It enables us to identify where we think there are improvements that could be made and services could be adapted and changed and we are perfectly happy to do that. We do it in a discreet way, because we think that is more effective, and we do have good relations generally with the providers, and I think that is important.

The Deputy of St. Ouen:

As the third sector and organisations like yours are key to the delivery of the approved services proposed in the Green and the following White Paper, what improvements would you like to see in the relationship between yourselves and Health and Social Services in order that you are confident that you would be able to help to support it to provide services that eventuate?

Mr. J. Le Feuvre:

Our role is around some very specific services, so we have the independent advocate who advises clients who maybe will need support because they are not always fully functioning in any number of ways, so it could be about elements of the treatment they are receiving or it could be with Housing or Social Security, it could be with employers around things that have not gone well at work because of their diagnosis. The carer support manager also has an important role in that he supports the carers rather than the individuals, and again he has the capacity to identify with the community teams where things could be changed or done better and we will do that on an individual case-by-case basis. More generally, we are pushing hard for a partnership project with Adult Mental Health Services and that is around encouraging more service user involvement in how they review their own services, so we are in a position to be able to identify and forward consenting individuals who are happy to become involved in reviews, reviewing protocols. So Orchard House there are some going on now around elements of treatment so we are able to help suggest that X or Y, who has previous experience as a service user, could help them shape the service. The intention is to be able to provide people to sit on interview panels as well, so if they are interviewing for a charge nurse, we think it is important that someone who has experience as a client can be on the panel as well. Again, that is something we are working hard, we want to take that all the way through to consultant appointments when it becomes appropriate. I would suggest that could be equally relevant to diabetes and other services. There is rarely anyone better than

the patient themselves, as the expert patient, to advise the panel, and to advise others, about how it feels to have this condition. That is a general aspiration that I think everyone should aspire to.

The Deputy of St. Ouen:

I understand the aspirations you talk about. I suppose what I am trying to get to grips with is whether or not Mind has had any meaningful consultation with Health and Social Services about, first of all, what Mind is able to provide within the services proposed, and what additional work you may or may not be able to undertake. Have those discussions taken place?

Mr. J. Le Feuvre:

Yes, they do. They tend to be around single issues, so we have recently been doing a review of our own residential accommodation and the facilities we offer and we have done that hand in hand with the Adult Services, because, and I do not know if this is confidential or not so this is difficult potentially, they definitely have plans to relocate off the St. Saviour site, and there is a particular unit there that they want to relocate into the community, and I will not go further by identifying it, but we are working with them around some capacity we have within some of the units we offer, and we will be talking to individuals about whether they are best placed where they are. So there is a give and take and there is a lot of co-operation done with the individuals about whether their needs are being met best by ourselves or whether they are met best by Adult Services in one of the group homes they have. I cannot be more specific because it will begin to identify individuals, so that is an example where we do work with them and we know who the client group is and we know where they are located and it is a matter of where they will be best placed, be it with us or be it in a group home that is run by the States.

The Deputy of St. Ouen:

So what do you expect to happen once the White Paper consultation is over? What would Mind want to do, or how would Mind want to approach the improvements in services that are identified?

Mr. J. Le Feuvre:

We hope there is going to be some investment first of all, and whenever the financial plan is debated in late-October/early-November, we hope that States Members will approve the proposals, and then the detail of these discussions will start. We have

identified a need around the dementia strategy, we know that there are going to be many more people who are going to be older and many of them, sadly, are going to have dementia. It is a consequence of our success in keeping alive is that they have complications further down the road. Our independent advocate, for instance, is currently experiencing a lot of extra demand from older clients where there are issues about some of the advice they need as they negotiate their way into residential care or changes in their own circumstances. We will be making a case for investment there, which we hope will come from the White Paper. As an example, we have worked with Jersey Alzheimer's around that, because dementia is their bag really, but they do not have an independent advocate, so, in conjunction with them, we are saying we have the capacity, given the resources, we would have a team of two rather than a single-handed individual, we would serve people experiencing difficulties within age. It is that sort of level of co-operation between the charities and with the statutory services. The other important area is our manager who works with the carers and I think that is hugely undervalued. Again, across the board, the community does not recognise the net benefit that carers put into looking after their loved ones, and it is absolutely the case with people with mental health. Again, our carer support manager has the capacity, given extra resources, to have a colleague, and they could do very much more than they are currently doing in supporting families in ensuring that people remain in the community much longer than would otherwise be the case. There is an absolutely sound economic argument for supporting people at home if we can do that.

The Deputy of St. Ouen:

Have you received any quality of indication from Health and Social Services that fully supports the development of services as you are proposing?

Mr. J. Le Feuvre:

Yes. Julie Garbutt has come and met my committee and they have approved the presentation I have made for you. We had a good discussion where we fleshed a lot of these things. We are up to the challenge; we just hope the States support the capacity to secure the resources.

The Deputy of St. Ouen:

Do you have current service level agreement with Health and Social Services?

Mr. J. Le Feuvre:

We have a funding arrangement with them; it is not a very formal service level agreement, we do not ...

The Deputy of St. Ouen:

There is no service level agreement at all at the moment?

Mr. J. Le Feuvre:

There is a very loose one, I would not say it is a particularly tight one.

The Deputy of St. Ouen:

Would it be your expectation that, in order to get greater certainty of funding, which enables Mind to deliver the services, that a far more robust service level agreement would be entered into as part of the process?

Mr. J. Le Feuvre:

Probably. There would be some hesitation if it was unduly complex, I would have to say, and that is something I would wish to say to scrutiny, I think there is every reason to expect that the States must get value for money from the arrangements that they devise, but I would be very anxious if they were over-complex. The example I think is around the procurement system that was set up about 4 years ago, which has been so complex that lots of small operators have just walked away and have not felt able to become involved. This is a long way away from this topic, but if we ended up with a very, very sophisticated commissioning process, I think charities that are very small and without infrastructure will simply not engage because it will be too complex, too difficult, and charities, and I will speak for my own with a degree of confidence, have always wanted to invest in frontline services, in the people who are working with clients, and there is a hesitation about investing in financial, HR, commissioning expertise, within the charities. There are very few charities who will have the capacity to get stuck in if it is a really, really complicated process.

The Deputy of St. Peter:

While we are on this topic, we will briefly touch on the chief executive officer of the Third Sector Forum and I am under the impression that the job description for that role will largely assist the smaller charities in doing just what you have explained. Would you agree that it is ...

Mr. J. Le Feuvre:

I have not seen the job description but I hope that might be the case. But, anyway, I am sure it will be fine, but just my caution tells me that there is evidence from the U.K. that it can be a very complicated process and this is Jersey after all and, yes, of course there must be transparency and there must be value for money, but it must not be so onerous that it just ... I mean the issue would be that there are some charities who do not even bother to express interest because they will be so concerned about the process. I am not saying that is our response but I think with some of the smaller charities that might be.

The Deputy of St. Peter:

This is currently a 3-year process obviously and the presumption is that the reform of the health service will move on to another area and continue making changes in that area. What happens to the mental health aspect after the 3-year process? Does it achieve what is set out to be achieved in the White Paper or is there any ability to continue developing services? Because earlier you mentioned the important role of carers and the lack of recognition perhaps for carers, which strikes me that there is perhaps a need for enhancing respite services, et cetera, et cetera. But that is not in the White Paper as it stands; that is perhaps worth ...

Mr. J. Le Feuvre:

It is not in the first phase. We were pleased that Adult Mental Health Services was mentioned as well, in the 4 priorities, so that was good news as far as we are concerned. There are things further down the road in phase 2 and phase 3, and quite properly they have to prioritise what must be done, and you cannot do everything to start with, and I am going to not be able to find the examples of the things that come next, in the next phases, but our approach is to work positively around the things that we know could be fixed fairly soon. I have intimated that around expanding the role of the carer support manager and we think the independent advocacy work that we do could be developed for older people. I think charities have to get on and do things themselves as well, so if there is something that we know needs to happen, some work we can do because there needs to be a stronger focus on campaigning and education, and there is beginning to be a shift. There was someone on T.V. (television) this morning talking about mental health and employment, and slowly but surely people are coming out and talking about their experiences, be it sports individuals or personalities, and we think there is a big task for the charities to be campaigning very hard to get people to recognise that one in 4 individuals will at some stage have experience of mental health issues and we need

to be open and talk about that as a society. We are getting there. It is one of the great past taboos that I think there are. The example I give is that men did not talk about prostate cancer 7 years ago; they talk about it a bit more. We are looking for the same sort of shift in how people acknowledge that it is all right to have a mental health problem and you can talk about it.

The Deputy of St. Peter:
I hope I have not taken us too far ...

Panel Adviser:
Mind seem to have a very clear-cut and strict confidentiality concept. Looking at the broader sweep of the White Paper and the section of multidisciplinary teams, do you have any reservations about patient confidentiality when you have multiple health workers having access to case notes on patients?

Mr. J. Le Feuvre:
Not if it is properly managed, which is where I think I go back again to how things are going to be delivered in primary care. So I think that has to be the focus. I think the charities can supplement and add into what is there, but if you have a system with perhaps 4 or 5 practices, which is where I think we are heading, where there is firstly a great array of talent among the teams, there will be individuals with interests in obstetrics of maternity or paediatrics of mental health. If there is a proper system and it is properly managed then individuals working there would surely have to abide by the requirement for patient confidentiality. I think, if things became dissipated too widely across too many locations, then there is a high risk that there might be some leakage. The charity has a very, very strong policy on that. We are monitored by the U.K. on that basis and we comply in every respect with their requirements. But there is that danger in an Island community that things can leak.

Panel Adviser:
Yes. You mention Mind U.K., with which you are obviously linked.

Mr. J. Le Feuvre:
Yes.

Panel Adviser:
Have Mind U.K. members been exposed to the I.A.P.T. therapy and so on?

Mr. J. Le Feuvre:
Yes.

Panel Adviser:
Have you had feedback from those members in a positive manner?

Mr. J. Le Feuvre:
As I mentioned before, in the Solent region they are delivering the service on behalf of the statutory services, so I am in touch with a colleague who I have not been to see yet, but that would be an early priority to go and see how they organise it, how does it work.

Panel Adviser:
Solent is ...

Mr. J. Le Feuvre:
Hampshire. It is quite a big ...

Panel Adviser:
So that would constitute what has been the early experience of I.A.P.T.?

Mr. J. Le Feuvre:
No, that is just a relatively local one that we are aware of; that Mind have been involved in. I think a lot of the other services are statutory, provided on a statutory basis. But it just so happens, in that region, they have chosen to do it with Solent Mind. So I do not know enough yet to say how it works.

Panel Adviser:
So the management of that service, the leadership of that service, is ...

[12:30]

Mr. J. Le Feuvre:
Is with the charity, as I understand it, yes.

Panel Adviser:

Is with the charity?

Mr. J. Le Feuvre:
I believe so, but I have not seen the detail.

Deputy J.A. Hilton:
Could I ask you what your vision of mental health services, across all the age groups, in Jersey would be for the next 5, 10, 15 years? I know that, through Mind, you deal with the over-18s.

Mr. J. Le Feuvre:
Mostly, yes.

Deputy J.A. Hilton:
But are there any concerns that you are aware of for the under-18s that you feel maybe have not been answered in the White Paper or ...

Mr. J. Le Feuvre:
I do not think so. I think there are issues at those points of transition between being in Children's Services and Adult Services, and again being Adult's Services and Older People's Services. It is sometimes described as the cliff face. So everything is there within the service when you are up to 18, and then suddenly it is very different because you are appropriately referred into Adult Services. The same thing can happen with Adult Services when you become Older Person Services at 65. I think perhaps the points of transition should be much more carefully managed, because there can be a 62-year-old who is very young in their approach and there can be an 80-year-old who is quite young in their approach, and there can be a 47-year-old who has complications and issues that are more akin to someone in their 80s, So you have to have defining points, and I accept that, and the way that the service is structured with Children Services, Adult Services and Older People Services is better, because that is more inclusive, but I think we do need to be aware that the people need support at those moments of transition. Maybe they are used to being seen by a particular specialist and then suddenly it changes, and then it changes again further down the road. My vision would be that the services are much more inclusive; that we accept that most of us are going to have a number of pathologies later on, so we could have diabetes, we could have heart problems, and maybe we are a bit depressed as well, and I think we need to somehow take the stigma out. It

is just part and parcel of how you feel about yourself and the need that you have to have proper and appropriate care delivered to deal with all of those different things. So, when you see your G.P., he could well be talking to you about your diabetes, but he could also be talking to you about, "How do you feel in yourself? Are you a bit flat? Are you a bit low?" It should just be normalised and it should be part and parcel of the regular service; it should stop being a separate standalone different service. So inclusivity is really important to remove the stigma that there is and the isolation that there can be.

Deputy J.A. Hilton:

From the information that I have read in the Outline Business Case, there is quite a considerable wait for people to access psychological therapies, and I was just wondering, as a charity, if you are involved with those individuals, how can you assist them when we just appear to be so hopelessly under-resourced?

Mr. J. Le Feuvre:

You push for the early interventions we have been talking about before, because prevention has to be better than cure. In the interim, we are not there yet, so we advise them to stick with their G.P. and be in regular contact with their G.P. and ask for the referral. The G.P.s do have the capacity to navigate and get their patients seen, because the providers understand that, if the G.P.s are making a strong appeal, a strong recommendation, for an early referral then that usually follows, because there is trust between the providers and the G.P.s generally. But it is not ideal.

Deputy J.A. Hilton:

No.

The Deputy of St. Peter:

You briefly outlined your vision. Do you think that the White Paper properly allows that to be implemented?

Mr. J. Le Feuvre:

I think so. It is a 10-year thing as far as I see it, and, as I said, the stage 1 is the one we are concentrating on. What will be interesting is to see how the other elements pan out, how the Island as a whole adjusts to the notion that they are going to have to spend more on health and social care, and that is a big challenge, because when

people are well generally they are not certain that there should be the investment, but my goodness when they have had family or personal experience with a condition, they definitely think there should be resources. There is a bit of an education programme really around people understanding this is going to have to be funded in one way or another, and that is going to be a tough set of debates for the States and for the public as well. I have to be optimistic. I think this is the best opportunity we have had for quite a while and at least there is a discussion and a debate about what might need to happen. But people really do need to understand the way in which the population is changing and, with an ageing population and less people working and economically active, that is a huge challenge, because the very people who are going to require additional support and care are doubling in numbers, so, not to be too gloomy about it, but it is a serious challenge.

Deputy J.A. Hilton:

At one of the public meetings we attended, a member of the public made some comments about the provision for the medical health ward that was in the general hospital and then moved out to St. Saviour. She very strongly believed that provision should be in the general hospital; the delivery of care for those patients who need to be ...

Mr. J. Le Feuvre:

I would suggest that it would be better if Health were able to consolidate on to 2 sites, which would be the general hospital and Overdale, which is the preferred option I think, and entirely dispense with St. Saviour. The investment probably would be more appropriate at Overdale, which is mainly rehabilitation and Older People Services, and I think that is where you would have a better opportunity to have an integrated model. The general hospital is not really where anyone should be for very long.

Deputy J.A. Hilton:

That was my personal view, but she was quite firm in her views on that, and I was just interested to know what you thought.

Mr. J. Le Feuvre:

I think there is the potential to have a better environment at Overdale. Some people will require institutional care in the inpatient area for months. I do not think anyone should be at the general hospital for months unless they absolutely have to be. I

think Overdale has much better potential, particularly if the States succeed in selling St. Saviour for the right sort of amount of money and then reinvest that resource, and there would be advantages in having 2 sites rather than 3, I would have thought, just in terms of economics.

The Deputy of St. Peter:
In terms of mental health issues, I presume you, given what you just said, support the step-up/step-down approach?

Mr. J. Le Feuvre:
Yes, and having things together on sites, the stigma is less, so you could be going there to have your diabetes checked, you could be going there to see a geriatrician, or, all right, you might be going there to see someone about a mental health problem. I think what we do not want is isolated areas with labels over the door saying, "Mental health". I think it is just generally generalising it and making it just one of a number of different services that are collocated on one site.

The Deputy of St. Peter:
That is very helpful, thank you.

The Deputy of St. Ouen:
Do you have any concerns over the way services have been prioritised over the 10-year period of the plan?

Mr. J. Le Feuvre:
Yes, we would always want everything to come first, as the first priority, but I think we have to be realistic. Adult Mental Health Services; that is important. The introduction of the talking therapies is a very early and very obvious priority. Supporting the carers and supporting the independent advocate, we think that fits and that feels about right.

The Deputy of St. Ouen:
So the first phase, you are content that the highest-priority issues are going to be dealt with?

Mr. J. Le Feuvre:
Yes.

The Deputy of St. Ouen:

What would fall slightly outside? What would be the next priority? Is it again highlighted in the second phase?

Mr. J. Le Feuvre:

I think it is, James. I am going to have to ... I mean I think it is a huge priority that the capital programme is sorted and that there is investment at Overdale, if it is going to be Overdale, and that we get off the facilities at St. Saviour.

The Deputy of St. Ouen:

All right, so it is basically around capital ...

Mr. J. Le Feuvre:

That would be one, but that is a separate programme for capital, I think. I am going to struggle to tell you what I think the priorities are in the second one, because our focus has been around the first one really. So early intervention is there by 2015, and that does fit ...

The Deputy of St. Ouen:

Where would support for individuals who find themselves perhaps even considering taking their life come in to this?

Mr. J. Le Feuvre:

Sorry, could I have that again?

The Deputy of St. Ouen:

How would services that support people who get to the point of maybe considering their own lives, how would you view that? Do you think that has been given enough attention in this first stage?

Mr. J. Le Feuvre:

I think so. I mean that would be something that the psychiatric medical team would be charged with leading on. That is a very serious area that you are talking about and one would hope those people are in regular contact, not just with their G.P.s, but also with the social services.

The Deputy of St. Ouen:

Let me try and rephrase it because maybe I was not very clear. What experience does Mind have perhaps with regard in that area and what influence can you have on the Health Department to meet those needs?

Mr. J. Le Feuvre:

We would have very little direct involvement, because, if someone is that ill, we are not going to be based ... we are there as a charity, we help signpost people and encourage them to accept help from the professionals, which is what they must do. So their G.P. is the first point of contact, or it can be A. and E. (Accident and Emergency) if it is that serious, and that is the advice we give to individuals, "You go and see your G.P. or you get yourself to A. and E. because you need to be seen", and that is where the professional specialist services will kick in. We would support people and families subsequently, but we would be very much encouraging them to access the professionals.

The Deputy of St. Ouen:

I appreciate that, but you spoke about early intervention, and obviously the aim is to help these people before they get to a position where they feel that they need to take their own lives. I suppose I am trying to understand how the work that you undertake as an organisation, and the support that you will provide, fits in with the overall picture that is designed to support the individual so that they do not get to a position where they feel that they ...

Mr. J. Le Feuvre:

If they are in that position, I would hope that we might have seen them sometime back and have had them into the G.P. and on. We are the front-facing early stuff and we are there afterwards to help people when they are getting better as well, but we are not clinically based. We are there to identify how people can access services, to advocate on their behalf, to support them and their carers if we can, but we do not begin to presume to deliver frontline services ourselves. We identify the pathways and we encourage people very strongly to access the proper professional support.

Panel Adviser:

Do you have contact Portuguese and Polish population? Is their mental health a concern for you?

Mr. J. Le Feuvre:

It can be. They do not tend to come forward and identify their problems as readily as would be the case. We try ...

Panel Adviser:
As we saw fatally last August when the untreated Polish person murdered 6 others.

Mr. J. Le Feuvre:
I think there is an issue. I do not know the detail there but I suspect that it is harder for those individuals to access our services because they do not know the networks and the routes that we do. There is literature that can be translates, but that is fairly tokenistic I think. It is a question ...

Panel Adviser:
Should we be making more effort to reach out to that population?

Mr. J. Le Feuvre:
Yes, I think so. I think everyone should be doing that. There are all sorts of thoughts about how those communities access services in any case and whether they access A. and E. more readily than would otherwise be the case, because that is certainly the case of the Portuguese community as I understand it. There is not a tradition of accessing primary care immediately. It is not something I am very strong on. I would suggest that as a community they do not tend to access services as readily.

The Deputy of St. Peter:
I think I should just state for the record that particular case has not gone through the court process.

Mr. J. Le Feuvre:
No, I think it should not be commented on.

The Deputy of St. Peter:
It is still in the court process and pending conclusion, so just for the record. But it is a valid point for accessing different sectors of our community, and indeed the sheer numbers of volunteers and professionals that are needed to make this plan work is quite a high level, and given your experience to date in treating and finding people, do you think that we are able to do this, to provide adequate numbers of people to provide the therapy and the professional input that is necessary to do it?

Mr. J. Le Feuvre:

I am not sure I am quite with you.

The Deputy of St. Peter:

Well, say for example, I think the figures, is it we need to go from 6 to 15 psychologists, according to the O.B.C., and also to staff up the community support facilities in the form of the I.A.P.T.s, do we have enough people out there and the ability to encourage them perhaps to Jersey or to skill-up people who are already here?

Mr. J. Le Feuvre:

It would be a mix. The preference would be there would be locally based people who had an interest, and maybe some of those with counselling, they had done the right course and if they had the proper accreditation. But implicit in the whole of the White Paper is there are going to be ... if you invest in a service that is 80 per cent staff cost then you are going to have to recruit more people, and that is another conundrum for the Island that is very anxious about immigration, and I would make that observation about older people who are going to need some very basic physical care; that is going to always be delivered by other human beings, it is not something that is just going to be done. I think that is a whole different debate that we are yet to have about who is going to provide that physical personal care for the burgeoning number of older people.

[12:45]

The Deputy of St. Ouen:

I would like to maybe start that off with you, because I would like to know, in your opinion, can voluntary and retired people provide that stable sort of 24/7 type of ...

Mr. J. Le Feuvre:

No, I do not know that they can. They can do lots of different things. I think there is a huge potential in an older population, they are hugely experienced, they are locally based generally, and there is a very strong sense of community spirit in Jersey and we need to somehow capitalise on that and galvanise it. But we cannot expect perhaps people who are going to be doing rudimentary personal care necessarily, but they certainly could be involved in the charities supporting them. We have

examples; meals on wheels is the absolute classic of all time. But you cannot go on just presuming that is going to cover everything, because it certainly is not. So it is the balance between encouraging people to be active in their old age, because that is good for them intrinsically, and to be involved and to be doing something during the week around a charitable commitment, working at a charity shop of driving patients or doing any number of different things; that is absolutely crucial. But, beyond that, there is going to be a need to have more individuals, presumably paid, who are going to do some of these other tasks that need to be covered.

The Deputy of St. Ouen:

Then I suppose that does question what services, organisations like yours, provide. Because, if your view is that there is a requirement for professionals to deal with more important matters, there must come a point where one makes a decision, "We do not need to fund this organisation; it is better to fund the individuals and provide the manpower to offer the complete range of services that we choose to provide". How would you answer that sort of question?

Mr. J. Le Feuvre:

I do not quite understand what you just said.

The Deputy of St. Ouen:

From what you just said, you said that it would be unrealistic to believe that voluntary people and other individuals could provide these sort of services, 24/7 type services that are provided.

Mr. J. Le Feuvre:

The direct ...

The Deputy of St. Ouen:

Then it follows presumably that paid people would have to undertake that role. I suppose you could argue, it is either paid in the public or private sector, so just follow the train of thought and the situation that has arisen currently is that generally it is the public sector that has met that increased demand by taking on more staff. The question I am trying to get to is, how do you balance the inability for the third sector to meet certain needs and the requirement that that service needs to be provided, and then the funding issues that go alongside with it?

Mr. J. Le Feuvre:

For instance, the extra capacity the volunteers bring in their old age is around fundraising and around raising the profile of charities, running charity shops, and doing all sorts of other things. That might give the charities the capacity themselves to employ more people to deliver some of the other services. But I think what we cannot suggest is that retired people are just going to start doing some of the basic care tasks. That requires a degree of professionalism and there are all sorts of reasons why that would not be appropriate. People will do it with their own loved ones as carers, because that is hopefully how people respond to those that they love. But it is a stretch to think that they can go and do it with other people necessarily. So the charities can provide some of those basic services if the funding is there, and the funding can come from the States, and some of it must come from fundraising. There is a good tradition in Jersey in successful fundraising campaigns. It is not easy just at the moment. But that must never be taken away because that I think is one of the differences about living in Jersey; there is a feeling that the community does get stuck in and can sort some of this out themselves. So again I would say, charities must not just assume that everything is going to fly with the White Paper; we know that we have to do something around campaigning and education, for instance, so we are going to get on and do that ourselves in any case. But we are looking to work with the States and others. It is a long answer, James, I think there are difficulties. My anxiety is that the net result is there will be more individuals employed providing health and social care into the future and that flies in the face of the immigration policy, and those people have to be paid for.

The Deputy of St. Ouen:

Do you see the third sector employing more people to help provide the services they are responsible for?

Mr. J. Le Feuvre:

They could do.

The Deputy of St. Ouen:

Or do you see a continuation of the ...

Mr. J. Le Feuvre:

It is going to be a mixed approach. I think there are sound arguments to do both things. I think one of the dangers of the third sector doing lots of things is you could

splinter up individuals into so many little corners that there would be a lack of co-ordination and there would perhaps be the potential for duplication. So there is a counter-argument saying sometimes in a small Island with limited resources maybe people should be managed, certainly professionally, they should have leadership from one of the statutory services. That is the difference and that is how you could devise the relationship, because it could perversely, counter-intuitively, be more expensive to have little pockets of money all over the place, whereas maybe having them co-ordinated somewhere, which is why I come back again to the central importance of how is primary care going to look in seven years' time, and that is an absolute fundamental question behind the White Paper. That is how the secondary services are going to survive if there is more provision in the primary care sector and how are individuals going to access primary care. Those questions are not answered fully yet and they are very important ones I think to tease out.

The Deputy of St. Ouen:
Thank you.

Mr. J. Le Feuvre:
Thank you for your time.

The Deputy of St. Peter:
Thank you for your time.

[12:51]