Health and Social Security Scrutiny Panel
Quarterly Meeting with the Minister for Health and Social Services

MONDAY, 2nd FEBRUARY 2015

Panel:

Deputy R.J. Renouf of St. Ouen (Chairman)

Deputy G.P. Southern of St. Helier (Vice-Chairman)

Deputy T.A. McDonald of St. Saviour

Witnesses:

The Minister for Health and Social Services

Assistant Ministers for Health and Social Services

Interim Managing Director for Community and Social Services

Director of Finance and Information

Medical Officer of Health

Chief Executive for Health and Social Services

Director of Operations

[9:30]

Deputy R.J. Renouf of St. Ouen (Chairman):

Good morning, everybody and thank you for joining us this morning. I also thank members of the public for attending. This is the first quarterly meeting of the new Health and Social Security Scrutiny Panel and our meeting this morning is with the Minister for Health and Social Services, Senator Green. Can I just remind members of the public that we have a code of behaviour, which is posted on the wall? Members of the press, also thank you for being here and Deputy Southern. First of all, it might be helpful if we went round the table because there are faces I perhaps recognise but I cannot remember all of your names. We will start by introducing ourselves on the panel. I am Deputy Richard Renouf and I am the Chairman of the panel.

The Deputy of St. Ouen:

Right, thank you. You have got a comprehensive team, Minister. Can I begin, perhaps, by asking you very generally about your business plan: where you are with that, what is going into it, when it might be available for us to see what your aims are next?

The Minister for Health and Social Services:

Clearly, the business plan has to lead into the States Strategic Plan, so it is work in progress, but the areas that we are looking at, in no particular order just the order that I remember them in rather than order of importance. Obviously, the new hospital is part of that work in finding the appropriate site, mental health review is part of that work, mental health strategy work going on. Carers' strategy is happening. Work is being carried out on the Children's Service and the strategy for children; that is not just looked after children but, for example, the sort of work that one does around 1,001 Days, those are all areas of work. Primary care; the modelling of primary care in conjunction with our colleagues in the G.P. (general practitioner) and dental services. There is a huge amount of work going on at the moment, but our final business plan - and you can get more details from my team - cannot be drawn up until we have got a final vision of the States Strategic Plan and how we contribute to that.

The Deputy of St. Ouen:

So when do you think it will be available, the final?

The Minister for Health and Social Services:

I am not sure, I do not know if my team have got a better idea.

Director of Finance and Information:

The timetable for production of business plans across the States is set corporately so will more or less, in a sense, be tied in with the preparation of the States Strategic Plan. So there will be a

timetable by which the departments will have to prepare and submit a business plan, but we have not got that deadline yet.

The Deputy of St. Ouen:

Are all departments' business plans then available prior to the debates in the States on the Strategic Plan?

Director of Finance and Information:

I would not have expected them to be available before we needed to prepare for the Strategic Plan debate, no, but as I say, I have not seen the timetable so I could not say definitively.

Deputy G.P. Southern:

Can I come in there? Will your department's business plan be available then because you are central; you are one of the 4 arms of the strategic priorities already set out?

The Minister for Health and Social Services:

Clearly, we have a draft of the areas that we are working in and, in fact, some of that work is already under way and has been under way for some time. But the final written document cannot be published until the States have published their Strategic Plan, because they are in consultation at the moment and that may well change the plan; I doubt that it will change much, but it may change the plan. Furthermore, as you all know, States Members have a right to amend that plan and therefore the final version cannot come in until after that. There are areas of work that are happening: business as usual is going on and, as I said to you, we are working already on the mental health strategy, we are working already on the development of children's services, we are working already on one I have missed, further work going on on C.A.M.H.S. (Child and Adolescent Mental Health Service) so there is a lot of work going on, but the final business plan cannot be produced until we have got a clear steer from the States on the Strategic Plan.

Chief Executive:

Perhaps if I could also help with that. Obviously, I understand that the business plan is helpful to you in terms of looking at your programme for the year. 2015 is, of course, the third year of the phase 1 Medium-Term Financial Plan and we have updated the 2015 year of that in terms of our objectives. So, in fact, if you look at that document, I am sure your officers would be able to find the health extract; it is only a couple of pages. It does set out our key priorities and key objectives, and that might help in the early months while we are waiting for this new business planning process to work its way through.

The Deputy of St. Ouen:

Can I ask how the department does monitor its progress in meeting its objectives for either a year's plan, or ...

The Minister for Health and Social Services:

I will let officers go into the detail, but I get regular briefings, on obviously the R.A.G. (Red Amber Green) system, of the key objectives. That is regularly presented to me and my Assistant Ministers when we meet with the officers to discuss progress and obviously we look at areas then that are at risk.

The Deputy of St. Ouen:

Of falling behind?

The Minister for Health and Social Services:

Yes, if they have got an amber or a green. Usually that is explained in the report, but it gives us an opportunity to discuss it.

Chief Executive:

Obviously there is a lot of monitoring of projects and business as usual at an operation level within the departments and then within the hospital and the community and Social Services and within Public Health. Subsets of that do escalate up to my corporate directors' group and also to the ministerial team, depending on whether they are going astray or not, or whether it is just to reassure that projects are on track. We have been doing a lot of work over the last year to produce a more comprehensive performance management brief that gives us regular information. Jason, I do not know if you wish to say a bit more about that?

Director of Finance and Information:

Yes. We have done a lot work based around what goes on in the N.H.S. (National Health System) and other big, complex organisations about bringing together all our core metrics: so the financial, workforce, activity, outcomes; trying to bring that all together, including some public management information. So we have one comprehensive report to give as an overview of all the key issues that we will be facing and any that are giving cause for concern so that we can ensure that actions are in place to make sure they stay on track. So we are in the midst of trying to finalise that at the moment.

The Deputy of St. Ouen:

Do you monitor against what was set out in P.82? That was the blueprint document initially, was it not? Having read that, there are different dates. 2015 seems to be a key year by which you wish to achieve things. Is monitoring taking place against what was set out in P.82?

Director of Finance and Information:

It is indeed, yes; comprehensive monitoring and reporting against all of the various initiatives within P.82.

The Deputy of St. Ouen:

Are there any areas in which the department, for different reasons, has fallen seriously behind? Is there concern for that?

Chief Executive:

Not in terms of the service developments that we set out for the 3-year period 2013 to 2015. Some of those are fully established now and some of them are still being developed, but they are all in place, they are just developing at different rates, and we would expect all of those services to be in place during this year and operational. In terms of the more strategic projects, the mental health review is one, as we have mentioned, and obviously we can give separate briefs on that if you are interested in going into that in more detail. Similarly, the primary care review. The primary care review has had some difficulty in terms of timeline, but we are working very closely with all of the primary care practitioners: the G.P.s, the dentists, the opticians and the pharmacists, to make sure that we do bring that work to a conclusion during 2015 and go out to consultation on a new way forward for primary care.

Deputy G.P. Southern:

If I may, how close are you to achieving that?

Chief Executive:

We have got quite a lot of good work pulled together now in terms of looking at different models from around the world, looking at a high-level model for Jersey. What we are doing now is starting to drill into the detail of how that might work. Our plan is still to publish a strategy on a White Paper - we are still looking at which is the best option and working with the Ministerial Oversight Group on that - in the late summer for public consultation. Obviously that will then, in terms of any changes that result from that, come through to the States Assembly.

Deputy G.P. Southern:

Are you in a position to reveal what sorts of things you are thinking about there for the delivery of primary care? Because that is central for us of where are we going, is it not?

Chief Executive:

It is. Obviously, we are working very closely with the primary care practitioners. I think it would be wrong for me to be talking about different developments at this point in a public meeting, but we would be very happy to come and give you a briefing in private so you can see where we have got to and what remains to be done.

The Minister for Health and Social Services:

It is essential that this work is done because this will inform such things as the size of the new hospital. If we do not do this work and deliver services differently we will need a bigger hospital than we are planning for. So this is a central part of the modernisation of the health service here in Jersey.

Chief Executive:

The broad thrust is, as we set out in the White Paper, that there is far more that we believe should be done in primary care by primary care practitioners. They agree with us that there is far more that should be done in primary care to release the pressure on the hospital so that people go to the hospital for only the things that should and could be done in a hospital and not for things that can be and should be done in primary care. To get us to that position, obviously, we have to work with practitioners to look at the model of how they are delivering services, how they free up the time to get involved in things like chronic disease management and what options there are for, for example, pharmacists doing more. So we are looking at each and every one of those aspects and looking at the case mix and the skill mix of the work that could potentially go into primary care, and that has to be done in liaison with hospital doctors and nurses as well and then we have to look at the skill sets to see if there are training and development needs. So there are all those different aspects: the workforce planning, the case mix, the development of new services and practices; they all have to be worked up. Of course, how the money flows around the system to facilitate that model rather than the model that we have got currently, is an important factor that we will be doing some work on over the next few weeks and months to make sure that when we say: “We think primary care should look like this going forward”, we can demonstrate how it is funded as well.

Interim Managing Director for Community and Social Services:

Certainly that is the essential bottom line, is it not?

Chief Executive:

Yes, absolutely.

Deputy G.P. Southern:

I suppose we have been picking up hints that that will involve a different structure; are we looking at reducing fees to go and see your doctor, your G.P.?

Chief Executive:

I think we have to look at what incentivises people to go to which part of the system so that we get the right people in the right place. We do hear a lot, and we work very closely with the Consumer Council and use their information. They have done a lot of surveys, as I think the panel will be aware, and they have fed all of that information into the review that we have been doing which has been really helpful. Obviously cost is a factor, so we do have to look at how we make the service accessible, and if cost is one of the issues that is preventing it from being accessible then obviously it has to be part and parcel of the review.

Deputy G.P. Southern:

You say "if it is"; and you have got evidence to suggest that it obviously is.

Chief Executive:

Well, the evidence from the Consumer Council Review says 2 things: it says that people think that there should be a charge and then people also say that they are not sure whether the charge is too high. Some people say it is, some people think it is about right. What we have to look at is how you fund the whole model going forward.

Deputy G.P. Southern:

I thought there was a piece of work commissioned 2 or 3 years back which came to the conclusion that the size of G.P.s' fees was putting off people going to their G.P. rather than ...

[9:45]

Chief Executive:

The reviews that the Consumer Council did, they moved from a survey ... I think you are probably recalling the survey they did; they did a very good survey.

Deputy G.P. Southern:

No, I am thinking about 3 years back.

Chief Executive:

Oh, well, since then they have done a comprehensive survey and they have also had a whole range of focus groups meeting to drill into the issues about what people think about their primary care, not just G.P. fees and access, but also obviously dentists and other aspects of the service.

The Deputy of St. Ouen:

Yes, dental work is another area where people are worried about costs, so are you engaging with the dentists and are they fully engaged?

Chief Executive:

Yes, they are; they are part of this project with us. We are looking at all aspects; it is not just about general practice, it is about dentistry and optometry and pharmacy as well, which is why it is such a complex piece of work. Because most of those things, perhaps less the optometry, but the pharmacies, the dentists and the general practice all interrelate and getting the right model has to make sense to all of those different groups of practitioners as well as to the public, that is the most important element, of course.

The Deputy of St. Ouen:

Yes; complex.

Deputy G.P. Southern:

While we are on dentists, are you working on a replacement, or a better replacement for the dental health fee that we used to have which was, I believe, quite an efficient way of making sure that people got healthy teeth in their formative years?

Chief Executive:

We have been doing a number of pieces of work with the Social Security Department in the last year, one of which is to review the current schemes that are in place to see how we can improve upon them. We have also carried out a comprehensive survey on the state of dental health in children in the Island, and all of that work is being pulled together. I have not yet seen the final report and the proposals from that, but I am told it is imminent and, of course, the product of that will also feed into the full review so that we can make sure that, whatever the charges for dentistry, there are proper services in place to ensure that those who cannot pay still have access to services.

Deputy G.P. Southern:

How is the state of our children's teeth in general?

Chief Executive:

It compares very well, despite the problems. Susan, you may be able to say a bit more about this if you have seen it, but I am told that the review says that we benchmark very well against the U.K. (United Kingdom) and generally the U.K. standard of dental care in children is good, because obviously they have got a comprehensive open service for children's dental health.

Medical Officer of Health:

I think that sums it up very well; I have not got more detail than that, but it surprised me a little bit that it was at the average you would expect in the U.K., where they have free N.H.S. dentistry for children.

Deputy G.P. Southern:

When are we likely to see conclusions of that dental review?

Chief Executive:

I would have to check that and come back to you because the person who is leading that piece of work is not here at the moment, they are on holiday, and I was not able to check it, but it is imminent, I am told.

The Deputy of St. Ouen:

Do we want to know when it is due when you have received it?

Deputy G.P. Southern:

Yes.

The Deputy of St. Ouen:

Could you do that?

Chief Executive:

Yes, certainly.

The Deputy of St. Ouen:

Thank you very much indeed. On financial aspects, we know all departments have to achieve a 2 per cent cut. How is that going to be achieved within the Health Department?

The Minister for Health and Social Services:

Well, again, I will let the team go through it, but I know, because we have discussed it, a lot of work has been going on and is going on, including a 2-day workshop with senior managers to

explain the financial situation and economic situation and how, although Health is top priority with Education, Health is expected to make its contribution in reducing waste and cost to the tune of 2 per cent. But I am sure the team can advise you on the detail.

Director of Finance and Information:

It is obviously a huge challenge; 2 per cent equates to us delivering £5 million, which is obviously a significant sum of money. As Senator Green has referred to, we have pulled together all our senior staff, including clinicians, at the beginning of this month to brief them on the financial situation and engage with them to try and identify how best to deliver some of these savings, because the reality is it is clinicians and frontline staff who will come up with some of the best ideas for delivering savings, not just in the short term, but in a sustainable fashion as well. That is one of the challenges we have got, because obviously we have got to deliver the savings this year, here and now, 2015, for which obviously time is very short, and then also in a sustainable fashion through 2016 and beyond, because they are recurrent, they are not one-off, so we have to deliver them this year and deliver them in subsequent years as well. So we have got a big piece of work going on at the moment to identify exactly how we are going to deliver these savings. In 2015 a lot of the savings will be non-recurrent, one-off in nature, and that will be driven by the timescale we are working towards. Simultaneously, we are working on a programme to ensure that we can deliver them sustainably going into 2016 and beyond. I cannot give you a simple programme at the moment but we are still working it through trying to make sure that we have got a number of schemes and actions to deliver that.

The Deputy of St. Ouen:

Does this involve the loss of any jobs?

Director of Finance and Information:

That is not one of the plans at the moment, but we will be looking at all vacancies as they arise to ensure that they need to be replaced, ensure that we are replacing them with the right level of staff in the right place at the right time. We will be challenging ourselves to push down even further on levels of sickness, and so on, to drive out every last saving we possibly can.

The Deputy of St. Ouen:

We have heard the Minister for Treasury and Resources propose that there be no further recruitments as people retire, but would you follow that policy in the case of nursing staff and frontline staff?

Chief Executive:

No, definitely not.

The Minister for Health and Social Services:

I have made it quite clear to the Minister for Treasury and Resources that, while I understand what he is trying to achieve, we need to look at this on a job-by-job basis because sometimes, and there is plenty of evidence in the public sector to prove this, freezing an essential post not only puts extra strain on the staff but requires then to be covered by overtime, so you do not save money, you pay more; you end up paying double time and time and a half. If you want a local very clear case of that, going back in the past, just look at the way the prison was staffed a few years ago and the huge amounts of overtime that had to be worked there because the target was to keep within a certain number of full-time equivalents. When Mr. Miller came along, he changed that, then you saw more staff being employed but less cost, so it is the bottom line that is important as well as the welfare of the staff.

The Deputy of St. Ouen:

Yes, I can see the rationale behind that. So what sorts of areas might waste be eliminated from or savings made? Give us an indication.

Director of Finance and Information:

Probably a good example of what we have looked at this year is equipment replacement, just as an example. So we have a schedule of minor equipment that will be replaced on an ongoing basis. We will be looking to pull back on that even further and, if possible where we can, keep the equipment going for slightly longer to give us the opportunity to push some of that spending into a subsequent year. When there are vacancies, we will be challenging ourselves on replacing them, bearing in mind Senator Green's comments, which are absolutely right. That does not mean that we will not be looking at vacancies, to ensure that we do really challenge ourselves to make sure that we are only replacing staff when we really need to and that we replace at the right grade. We will be looking at things like overtime and locum cover, and all those issues, to make sure that we are only carrying out spend where we really need to. We will be looking at all our areas of non-staff spending, so we will be trying to make sure that we are as efficient as possible around some of our support services; catering and domestic, those sorts of issues. We are literally challenging ourselves across the whole stretch with everything we do, to say: "Is there any way we can save any further money on this? Is there any way we can eliminate any of the process that will save us money? Do we need to post those vacancies? Do we really need that overtime? Do we really need to do this? Do we really need to do that?" So it really is going through absolutely every line possible.

The Deputy of St. Ouen:

When do you have to conclude that work?

Director of Finance and Information:

We have to conclude it as soon as possible because as every day goes by we need to deliver savings. We are delivering some of those savings at the moment, so we are looking at where can we defer things, where can we re-phase things, where can we squeeze some savings through vacancies, and such like. Some of that is in place and happening today, some of it, more schemes will be worked up as we go forwards. So there are some schemes that we are working through, particularly one example is we are working with T.T.S. (Transport and Technical Services) around how we dispose of our clinical waste to ensure that we get best value for that, both for ourselves and for T.T.S. in the way they process it. Some of those schemes take longer to come online than others, but we have got things we are doing now, things that are imminent and things that take slightly longer to come to fruition.

Deputy G.P. Southern:

That reminds me of a policy that we used to see in the Housing Department where we put off repairs and we put off maintenance for the housing. Is it really a wise move to put off replacement of equipment or to put off recruitment, for example?

Director of Finance and Information:

Not as a permanent solution; no, it is not a permanent solution. That is what I was trying to refer to earlier is that there are some things that we will have to do here and now in 2015 to manage the budget position and then there is the sustainable solution that we need to have in place in the longer term, which ensures that we are not doing those things and not falling into those traps.

Deputy G.P. Southern:

You said that there will be no job losses. Can you guarantee there will not be any job losses in this shakedown that happens in 2015, temporary or permanent?

Director of Finance and Information:

I do not think that is for me to really guarantee job losses, to be honest.

Deputy G.P. Southern:

Can the Minister?

The Minister for Health and Social Services:

No, I cannot. What I can guarantee is that when we look at it, I suspect that we will find that we need different skills sometimes when a vacancy occurs, and therefore all good managers, not just in times of financial difficulty, when a vacancy occurs, the first question to ask is: “Do I need to replace this post? If so, does the person I need to replace it with need the same skills as the one

that left or different skills? Have we got different priorities? Do we need to do things differently?" That will be happening. I cannot guarantee that there will not be some posts that will go; when your budget is significantly staffed then inevitably I think there will be some posts that ... we have not identified an area where we are saying: "That section is going to lose X amount of staff. That section is going to lose that number of staff." We have not done that at all, but I will not guarantee there will be no job losses.

Assistant Minister for Health and Social Services:

It might be fair to add on to that, that with P.82, whenever those initiatives do come to fruition and they were effective, that may well relieve staffing pressures within the hospital. So there are opportunities to do things with staff more sensibly because of P.82, which is why we introduced P.82 in the first place.

Deputy G.P. Southern:

But we are talking here about a mixture of long term, which would be happening anyway, that was amended, and short-term immediate changes now which are one-offs, which otherwise, if you were not under that pressure, you would not be doing.

The Minister for Health and Social Services:

Well, I would query that. I think the department that I know has always reviewed when a vacancy has come up: "Do we need to replace this post? If so, do we need to replace it differently?" as I said before. That is the department I know, and I think that has gone on ... well, ever since I have lived in Jersey, anyway.

Deputy G.P. Southern:

By "differently" do you mean deskilling? Are you reassessing the role and skilling?

The Minister for Health and Social Services:

No, I do not mean deskilling. No, sometimes it is the opposite, but ...

Chief Executive:

If I get this wrong I am sure Michelle will correct me, because she is much more *au fait* with this than I am, but a good example would be that we now employ within the hospital an arrhythmia nurse. She is a very, very experienced, highly-specialised very well-trained nurse who treats all of the patients who come in with arrhythmias, which means that our cardiologist no longer needs to deal with those patients and can see other patients who may need his set of skills. That is not a dumbing-down, that is not a cheapening of the service, that is recognising that this highly-skilled and highly-trained nurse can do that piece of work. I think what we do now with every change is

we always look to see if there is an opportunity with the service as to whether we should be looking at a consultant nurse or a consultant therapist taking on a new type of role, for which they are fully trained and developed. It is not about saying: "Can you just see if you can do that?" It is about making sure that they have the training and the skill sets that they need and the tools that they need, but it is a different type of person doing a service that perhaps 5 or 6 years ago a doctor would have been doing. That doctor may well be bringing work back from the U.K., as indeed our cardiologist is, which he can now successfully do in Jersey, at a better price generally but also at a much more convenient service for local people. So we are always looking for those opportunities as to whether we can do something differently and better but also more cost-effectively. As a department, we were the first department to adopt the Lean methodologies as a service improvement methodology, and that was not about making savings, per se, our focus was always on how can we improve the experience of the patient by using these Lean techniques to look very carefully at: "How does this patient experience their services from us and is there a different and better way of doing that?" Inevitably what you find, if you do find that there are wastes and things that should not be done that are being done, when you take those out the patient gets a better service but the staff are also much happier because they are not wasting their time doing things. Sometimes that does release a savings, sometimes it does not; it just creates more capacity to see more patients.

The Deputy of St. Ouen:

Yes. What you say leads on to a question I wanted to ask about the Oncology Unit, because I understand there is lots more oncology now being carried out in Jersey whereas previously patients were sent to Southampton or London. So has that achieved a saving in financial terms by not having to pay ...?

Chief Executive:

I will defer to my colleague on that one.

Director of Operations:

I do not think it has resulted in a saving as such, but we look at every opportunity to be able to deliver things differently. We know that in oncology over the coming 18 months there will be a retirement of a consultant post and we will use that opportunity, which builds on what Julie has already said, to look at how we deliver that in the future.

[10:00]

We do buy in services still in oncology, so we have visiting consultants who will come over to the Island to look after our patients where they are able to do that, but we inevitably have to send

patients over to the U.K. as well, so we send to Southampton, we send to London for that group of patients. But there is an opportunity moving forward to look at how we deliver things differently from an oncology perspective.

The Minister for Health and Social Services:
You are aware that there is a new department recently opened as well?

The Deputy of St. Ouen:
Yes. So does that mean more people are being treated in the Island than might previously have gone off-Island? Yes, which is good.

The Minister for Health and Social Services:
Yes.

Assistant Minister for Health and Social Services:
I think really the great benefit is to the patients themselves, where they are not having to travel down to Southampton; they are getting the treatment they require here in Jersey and it is far better for families to be together here in Jersey when they are going through that difficult time in their life. It is not just about money, it is also about patient care and giving them the best experience when they come through our hands at the general hospital.

The Deputy of St. Ouen:
Yes, absolutely. I did not want to suggest it was just about money. But is part of it to do with money? Was that part of the rationale behind it?

The Minister for Health and Social Services:
I will say it in principle and then officers can come in. Very often when you make a change in service, it is not always about money, it is about creating capacity within the same money: you provide a better service and you can provide it for more people. That is generally the principle. Health costs are going to increase year-on-year, have done historically, you could almost draw a line. We know where they are going to go, but we want to make sure that we get good value for money. If we create capacity, it allows more people to be treated with the same sums of money. If you want the figures I am sure we could provide them at another time, but we would not have them with us.

Director of Finance and Information:
Senator Maclean used to often talk about productivity across the public sector and the private sector, and this is a good example. Senator Green is right: we historically have always challenged

ourselves around the services that we provide and where they are effective and what we can do in trying to provide them to ensure that we do get the best value for money. That does not always mean cheaper, it might mean doing it in a different place in a different way with a different kind of skill set, and so on. But all these things are constantly looked at and we do drive out productivity gains, which often does not give you any cash, does not free up some money that you can put back in your pocket, but it does mean that you are providing something that is better for the patient or in a better location for the patient or the service is just different and gives a better quality. So it is not always about the cash, but it is about the experience and what is best for the individual at the end of it. Over the years, our programme of changes - and some of those are savings and some are not - are targeted around delivering that improvement in quality and safety as well as value. That is how we measure and prioritise the changes that we make; it is around quality, safety and value, those 3 things have to work together.

The Deputy of St. Ouen:

Okay, thank you.

Deputy G.P. Southern:

Then if I can just return to the theme of this mixture of things you would be doing anyway to improve the productivity and things that you are doing one-off to cater for a £5 million cut: can the Minister guarantee that there will not be any ... not changes in service but reductions in service in what is being delivered to the public?

The Minister for Health and Social Services:

No, I cannot guarantee that. If it is essential that a service is delivered, it will be delivered. Who delivers it might change, but that is part of the primary care review. Things change. Sometimes things that were essential 20 years ago ... if you looked at the health service 20 years ago it is very different to the needs of the health service and the community now, and 20 years hence it will be different again. So I will not guarantee that. What I will guarantee is that people get the appropriate care at the appropriate time in the appropriate place; that is our job.

Deputy G.P. Southern:

The difference between “essential” and “appropriate” is what?

The Minister for Health and Social Services:

I said they will get the appropriate care at the appropriate time.

Deputy G.P. Southern:

If a service is essential, then it will still be delivered, but not otherwise?

The Minister for Health and Social Services:

Well, it depends what you call “essential.”

Deputy G.P. Southern:

No, it depends what you call essential, Minister.

The Minister for Health and Social Services:

No, it depends what you call essential.

Deputy G.P. Southern:

I do not want to get into an argument over who used the word, but you used the word, I was listening carefully, that if a service is essential it will be maintained. So the word was ...

The Minister for Health and Social Services:

Okay, to put it another way: if it is important that we provide that service, it will be maintained.

Deputy G.P. Southern:

But you cannot guarantee that services will not be stopped as one of these one-offs?

The Minister for Health and Social Services:

I will guarantee that we will change the way that we deliver services, absolutely; that is what the primary care review is about for a start. The health service you saw 20 years ago is very different to the one you see today, and that is going to continue to change as new technology comes along and new ideas come along, new understandings and different seasons come along. What I am saying is that people will get appropriate care at the appropriate time in the appropriate way.

Deputy G.P. Southern:

I accept your use of the word “change”; nobody is against change, that is inevitable, but you are saying, are you, that the one-offs that you would not otherwise be doing in response to the 2 per cent cuts, will not produce a reduction in service level delivery?

The Minister for Health and Social Services:

No, I am not saying that.

Deputy G.P. Southern:

What are you saying, then?

The Minister for Health and Social Services:

I am saying we are still going through it and it may bring about a change in service delivery in places if it is possible. We do not know, we are still working our way through it.

Deputy G.P. Southern:

You are avoiding the word "reduction" and you are using the word "change."

The Minister for Health and Social Services:

I know you are looking for me to say there are going to be massive cuts, and I am not going to say it because there are not going to be cuts. What we are going to be doing is looking at our service, developing it where it needs developing, changing it where it needs changing and coming up with a sustainable model for the future. One of the objectives for the Council of Ministers as well as my team around all these service changes and improvements is to have a sustainable funding model, and that is something that we have got to come up with so we do not lurch from difficulty to difficulty. We are working on that.

Deputy G.P. Southern:

Like having to deal with a 2 per cent cut for one year?

The Minister for Health and Social Services:

That is where we are, that is the real world, is it not; that real world that I live in.

Deputy G.P. Southern:

So you are lurching, are you?

The Minister for Health and Social Services:

No, we are not lurching; your words, not mine. We said that we would come up with a sustainable funding model. We are working on that; meanwhile, we have a little hiccup to work to to support our colleagues in the other departments as well, but we are not lurching.

Deputy G.P. Southern:

£5 million is a little hiccup?

The Deputy of St. Ouen:

Okay, well, we have heard all that you can say, Minister. Thank you. I know Deputy McDonald has questions on a slightly different topic, so if I can ask him to lead.

Deputy T.A. McDonald:

Yes, exactly. We will go for, if we may, the long-term care scheme, but if I could ask: has the recently-introduced long-term care scheme freed up some of the department's budget which may have previously been allocated to long-term care?

Director of Finance and Information:

The simple answer, Deputy, is no. I cannot remember the number, but the Social Security proposition to set the long-term care fund up was quite explicit about how the current cost, as it was last year, of long-term care would feed into that fund, and that is that the impact on existing budgets was intended to be neutral as part of the establishment of the scheme. So the money that Health and Social Services spends on long-term care historically is, in reality, all being transferred into the long-term care fund so that the contributions going into the fund come in from individuals and from the money that was already spent from public funds on the long-term care fund. There were 2 ministerial decisions that you will have seen signed off in 2014 - it may have been 2015 - which enacted that, and made 2 transfers to the long-term care fund from the Health Department. They totalled somewhere just over £4 million, I think, but I can send you the numbers, or I am sure your officers can find them.

Deputy T.A. McDonald:

That is fine. If I can continue on from there just to try and find out how the split of that funding is managed between obviously your department and Social Security?

Director of Finance and Information:

There are 2 main elements to it: there are long-term care costs that we are paying to third parties or individuals who were largely in nursing homes or residential homes, so those are individuals who were placed in homes and the Health Department is paying the bill for that. That money is simply being transferred to the long-term care fund to enable those individuals' benefits to be paid directly to the homes. Then the other element of it is provisions made by the department, so our own homes and services for which we now receive the individual's long-term care benefit and pay the equivalent amount back into the fund, so the impact is neutral. So there are 2 elements: services that were provided by the private sector, and that money is now transferred into the long-term care fund, and services that we provide internally for the department.

Deputy T.A. McDonald:

Yes. When you look at the range of these cases, I think we all appreciate just how difficult it is to try and look at the future and so on. If you had a case, for example, which exceeded what I would describe as the top level of the Social Security budget available, who would pick up the excess?

Director of Finance and Information:

Usually the department would pick up the excess account. It is probably worth understanding maybe a bit more about the assessment process.

Deputy T.A. McDonald:

Yes, because obviously it is a very, very complex subject and it is one that I will readily admit I struggle to understand.

Director of Finance and Information:

I will ask Damian to do that.

Interim Managing Director for Community and Social Services:

I can immediately start by empathising with you, Deputy, as somebody who has come on-Island in the middle of this, but what we could have is 4 levels of care that are assessed against, and the group of individuals that you were referring to would be above level 4, where there would be particularly complex care requirements and we as a department would top up the long-term care amount that would be required for those packages. We have an individual placement panel that reviews those particular needs to do that. There are other levels of care, levels 1, 2, 3 and 4, and we would, as a department, conduct the assessments to identify what the resource requirements would be. Those are quite detailed overview assessments, social care assessments, done through an online tool, which is part of our care management system, and that informs the Social Security Department's eligibility criteria for the allocation of long-term care benefit. So we are critically linked into that process and colleagues from Social Security have oversight of the overall end-to-end process, but we oversee the initial assessments.

Deputy T.A. McDonald:

That is fine. It is very, very difficult to work out literally who does what and when and where, but thank you for that.

Interim Managing Director for Community and Social Services:

It is a complex process and my colleagues from Social Security would be able to say what the 36-stage process looks like. We contribute to 2 bits of that.

The Deputy of St. Ouen:

I think we are aware there has been criticism of the online programme in the U.K. Do we accept that criticism and do we try to address it in Jersey? In that, what I am thinking is that it is very easy to see if somebody has not got a leg and therefore has mobility problems and other problems, but if somebody is suffering from a condition such as M.S. (multiple sclerosis) where one day they

may be fatigued and just unable to cope, and another day they might be not as bad, I have understood that in the U.K. the system has not been able to pick up on those sorts of care needs, but how are we doing in Jersey?

Interim Managing Director for Community and Social Services:

I think whichever assessment system you use at scale will have some nuances which do not grade up, if you like. But we do not have automatons conducting the care assessments, we have professional nurses and social workers, and indeed in the agreement we have to prescribe the level of skill that is necessary to conduct those assessments. On top of that, we also have to have a back-up system where those assessments are overseen by an authoriser. The rationale behind that is that we obviously want to ensure that there is a moderation to the application of the care tool. The system that we use has a high degree of reliability and accuracy, but it is only as good as the individual who is conducting the assessment against it, which is why it is important to have those back-ups. What you tend to find is that, after a period of implementation, the consistency of the application of that tool increases in terms of its accuracy. Inevitably, during implementation of any system, you have some teething problems and there will be, and have been, some contentions in terms of challenges back. I think that is healthy in terms of those professions ... particularly if we are looking third-party organisations who are in receipt of resources that are reliant upon these assessment tools. So I think we are in a stage now where it was 1st July, the implementation, so if you look at the massive scale of expectation, we are still at a very early stage. I think the criticisms of the U.K. systems are dependent upon the nature of the tool that you use. I am fairly confident that the tool that we use is as good as the best of breed in the market. But I go back to my earlier point which is it is only as good as the professional capability of the individuals who have been trained up to use it. That is why we have dedicated assessors who have been qualified to do that.

[10:15]

The Deputy of St. Ouen:

Do you know what proportion of the assessments have been challenged?

Interim Managing Director for Community and Social Services:

I do not have that figure to date, I have some anecdotes, because usually I only ever receive those at my level, but I am happy to supply you with the detail.

The Deputy of St. Ouen:

What is the procedure if somebody comes along and says: “I think you have got this wrong”? Who is there to review the assessors?

Interim Managing Director for Community and Social Services:

Well, obviously we have a management and governance process, which is still in the rollout and implementation phase and we have a joint working group with our colleagues from Social Security, and that is one of the routes where we look at the frequency and number of challenges that we have got. We also have bilateral meetings with individuals, so we have had a couple of organisations that have come to us with particular concerns around assessment, and one of the outcomes of that is that we have committed to share transparently those assessments with those colleagues. Because this is a big shift in the system, moving from what was effectively a block grant where everybody just got the money, to where your whole business depends upon the flow. The timing of those assessments is quite critical because when you do them people's care needs are not static and they shift, and we are looking at reviewing the timeliness of the assessments so that we can get as best a fix at the point at which eligibility is applied so that those organisations can have some degree of surety about their cash flow management, et cetera. So there are appeal and referral approaches. What I think we will do is review as we will in June, we have a whole system review, what ongoing procedures will we need to put in place for a business as usual appeal process?

Deputy G.P. Southern:

So you do not have an appeal process set up as yet?

Interim Managing Director for Community and Social Services:

We have a direct appeal process in that those organisations that have a concern will refer through the normal process.

Deputy G.P. Southern:

So it is ad hoc?

Interim Managing Director for Community and Social Services:

It is ad hoc at the moment, but what I am saying is: until we know what the volume is - and I go back to the teething problems - what would the business as usual appeal process be otherwise all we would be doing is tying up resource and constantly having a conflict. I think this flicks back to building in confidence into the system and sharing with the wider system what the issues are. For instance, we do know that the initial demand on staffing capacity to conduct those assessments has been greater than was originally intended. So we are having to sort of work some of those issues through. We also know that the nature of that review later this year will give us a much better fix on what the sort of timeframe ought to be for how long it takes to do an assessment and what the follow-on process should be if individual organisations or individuals themselves want to appeal those decisions. At the moment we are still dealing with a fairly small number but we have

also had to deal with a series of backlogs that were part of that transitional period when we were looking at the funding transfer. I would say we are still in early implementation and until we have done that full review this might be something that the committee wants to review, or we get to the point in June when we have a much better fix on what the implementation issues would be.

The Deputy of St. Ouen:

Okay, I think it is likely we will come back to that at least every quarterly hearing and see how the system is progressing because it affects a lot of people. Can we move on perhaps to consider the hospital, not necessarily the new build for the moment, but staffing levels within the hospital? Minister, are there any particular areas where staffing levels are low and you are having problems with?

The Minister for Health and Social Services:

Again I will have to hand over to the team on that because that is an operational issue. Clearly, at a strategic level we have procedures now for training our own local nurses, something I am really pleased about and very proud of. Clearly as service is modernised and you find older consultants, for example, who retire you end up very often replacing a generalist with a couple of specialists. So I understand those general principles but if you want detail of numbers you will have to talk to the officers on that.

Director of Operations:

In terms of, from a hospital perspective, we have no particular areas that are of concern. We have a number of vacancies. We have 28 qualified nursing vacancies but that is against an establishment of 635 and there will inevitably be a lag time in terms of recruitment if somebody gives a month's notice. But it takes us longer than a month to actually recruit for that post. Probably if I was to pick one area of concern or one area where we are being challenged at the moment in terms of recruitment, it would be in the operating theatre department, but we are working hard to recruit and we are going across to the U.K., to Ireland, and we are also looking at things that have been spoken about earlier in terms of potentially different roles to train staff up to work in different ways within theatre. But we certainly do not have any vacancies that are impacted on being able to deliver the service within the hospital and there is not really any area of significant concern. We do very well compared to the U.K. in terms of recruitment and vacancies.

The Deputy of St. Ouen:

There has been concern expressed in the media about the staffing of the Oncology Unit, I understand, so is that understaffed at the moment?

Director of Operations:

We are currently working with our Lean team to look at the establishment within the Oncology Department. We have seen with the new department, because it has increased the number of chairs that we have, we have been able to treat more patients on-Island but we do not feel that there is a significant shortfall in the workforce within Oncology, no. We may potentially need to look at the way that some of those members of staff are working to work differently. But we do not have concerns about the establishment.

Assistant Minister for Health and Social Services:

Maybe if I can add just a little on it. The ebb and flow of the number of patients coming through the department sometimes did pressure us by sheer volume of numbers but if I just looked at a couple of months. If we look at October last year, there were 20 patients being dealt with in Oncology whereas in January this year there were only 8. So when there is 20 in one month quite clearly the pressure is going to be stronger than when there is only 8, and we do not have flexible staff we can put and take into that speciality. So sometimes they will be under pressure. Other times they will be more relaxed than under pressure.

The Deputy of St. Ouen:

Yes, I understand.

Deputy G.P. Southern:

Looking forward, where do you see, if anywhere, where there will be pressures, going forward on recruitment or on training or particularly on retention?

Chief Executive:

I think we are still working through finding a sustainable way to ensure that we can recruit and retain nurses. We are fortunate at the moment I think the numbers are probably as low as they have been for a while ...

Deputy G.P. Southern:

It is 5 per cent so it is ...

Chief Executive:

Yes, but we do know that we have to pitch it right in terms of both salary and other issues in relation to nurses being able to live and work on the Island. We have done a lot of work with the States Employment Board. They, and the States itself, has ensured additional allocations of resources to increase the number of nurses and to look at how we can change the packages and that work is ongoing. Despite the pressures that we have already alluded to this morning, we are

hopeful that those sums of money, that investment in nursing, will continue. If you look forward into the medium term with the growing demand that we know from the work that we did in the White Paper, the report and proposition that we brought to the States that has led to the investments, the growth in demand is going to be there because of our ageing population. And we will need to have an ability to continue to recruit doctors and nurses and other clinical professionals in order to make sure that we can continue to deal with that workload but then that ties back into the whole issue of who does what, where do they do it and how do they do it in order to make sure that we have the right people in the Island. We have done a lot of work in recent years to establish more abilities for people on-Island already, our local population to train in nursing, and that has been immensely successful and will continue to evolve. We also have a small but very successful scheme to train social workers on-Island, and we will look to do more of that so we can create those opportunities for our local workforce but inevitably we will need to look off-Island as well, so it is important that we remain competitive in terms of the package that we can offer.

Deputy G.P. Southern:

To what extent are pay levels critical to that recruitment process and retention process?

Chief Executive:

I think pay levels are important as the first point. If the salary is not pitched right you are never going to get anybody interested in the first place. But what we find, and again Michelle may add to this, is it is often about whether or not a partner coming to the Island can get employment. It is about whether there is key work and housing available, so all of those issues ... where the childcare is readily available and affordable. So the same issues that people already in the Island living and working suffer from and worry about, are the same issues that somebody coming to the Island will be concerned about. So it is all of those things all need to work together if we are to keep a flow of nursing coming to the Island.

Deputy G.P. Southern:

How much progress have you made with the Hay evaluation, equal pay for jobs of equal value, whatever it ...

Chief Executive:

There is a massive amount of work that has been undertaken. The Health Department is the lead department in working with the Central H.R. (human resources) function to bring this forward. A lot of the work around job evaluations and job matching has either been done or is close to being completed but obviously it is a matter of policy for the States Employment Board to ultimately decide how that will move forward. But workforce modernisation and those issues within it are

critical to the package and to the ability to recruit and retain, which is why the Health Department was very happy to be in the forefront of that because we have to get that right in order to continue to run a sustainable health service and social service, for that matter. But the issues around that, if you wish to know about them, I think we would certainly need to have colleagues from Central States H.R. available to talk through how those projects are going and indeed our expert on that, Tony Riley, who is our Director of H.R., is not with us today but would be very happy to join those States Central H.R. People to come and give you a briefing at a later date.

The Deputy of St. Ouen:

Yes. I suppose a critical concern of the public is that staff shortages are very likely to lead to increased waiting lists. How do we assess our waiting lists? Against what yardstick do we say we are doing well or we are falling behind?

Director of Operations:

That was a large chunk of my role. We monitor our waiting list targets, our waiting list figures, on a monthly basis across all specialities. I am sure you are aware that we publish our average waiting times, and I think have done for the past 5 months on the States website, so that they are easily accessible for people to look at. In terms of wait times as they stand today, compared to this time last year, we have seen a reduction, albeit a small reduction, on the numbers of patients who wait both for surgery and procedures and for outpatient attendances. But we have seen a bigger reduction on the number of patients who were waiting over 12 weeks to be seen, so we have concentrated on that cohort of patients. We know that we have got more work to do and it is given serious consideration on a month-by-month, week-by-week, day-by-day basis, to help to drive down those wait times for patients. We do not work to the same rules as the U.K. but we do aim to see every patient within 12 weeks of referral from the G.P. and then once a decision is made to operate on that patient we aim to operate within 12 weeks as well.

The Deputy of St. Ouen:

Are the waiting lists calculated from the date the G.P. refers to the hospital or from the date the patient first comes to see the consultant?

Director of Operations:

When we get the referral letter into the hospital for an outpatient attendance we count from the day that we receive that letter and then they will wait a period of time to come and see the consultant in clinic. If in that consultation in clinic it is deemed that they need a procedure, and all of the investigations have been done to make that informed decision, they then get added to the inpatient waiting list and we then start counting from that day when the decision is made that they need the procedure. It might be that within that consultation they need to have some further investigations

or some medication may be prescribed, and there might be a review period built in. If that was the case they would probably come back to clinic, be reviewed again and at the point that it is decided they are fit and ready to go on to the inpatient waiting list we start counting from that period in time.

The Deputy of St. Ouen:
So there are 2 counts? From the date you receive the letter from the G.P. to the first appointment.

Director of Operations:
Consultation, yes.

The Deputy of St. Ouen:
Then the clock might be stopped and another clock started.

Director of Operations:
Yes. There is an outpatient ...

The Deputy of St. Ouen:
Why is that?

Director of Operations:
It is the same as in the U.K. There is an outpatient waiting time and an inpatient waiting time.

The Minister for Health and Social Services:
I mean that is part of the diagnostic process, is it not? It is not clear at the first appointment sometimes that the patient needs to undertake surgery. They may need to have surgery or a procedure but medication may be tried first, so you would not expect someone on a waiting list for surgery when surgery may not be the answer. That is the simple reason for that. There are no games played here. The waiting lists are transparently open, not like some of the places I have seen in the N.H.S. (National Health Service) where, for example, you have a number of hours to see a patient coming through A. and E. (Accident and Emergency) and they know they cannot meet it so they leave them in the ambulance until they can.

[10:30]

There are no games like that here. Very transparent. Very open. Doing very well. More work to do but 77 per cent of patients were seen within the 12 weeks.

The Deputy of St. Ouen:

77 per cent of patients within 12 weeks.

Deputy G.P. Southern:

But you are working on it?

The Minister for Health and Social Services:

But we are working on it, yes. We are not hiding anything.

Chief Executive:

I think what was also important to recognise is that is routine wait. If somebody needs to be seen urgently they are seen urgently. That is for the people who their G.P. has said in their referral letter: "We would like you to see this patient but it is not ultra-urgent." Obviously if somebody needs to be in quickly they will come in quickly.

Director of Operations:

When we receive the referral from the G.P. they go to the consultants and the consultants would triage those letters based on the information that is contained within them and will allocate an appointment slot based on what is in that referral letter. They can obviously only make it based on what is in that letter, so the quality of that referral letter is key on occasions.

The Deputy of St. Ouen:

Okay, I understand. Is there any waiting list in a particular area that is cause for concern at the moment?

Director of Operations:

Not significantly. We have some areas where we have patients that were waiting for longer than the 12 weeks but we try to manage and flex our wait, so if I give you an example. In ophthalmology we have a small number of patients who are waiting for surgery but we have a large number of patients who are waiting to be assessed. So as a result of that we flex how we work and we will reduce the number of operating sessions that we will take to allow the clinicians to see more outpatients. We constantly look at how we manage those waiting lists to make sure that they stay safe and to do all that we can to bring them down. But there are none that are of a huge concern. We would absolutely love to see every patient wait less than 12 weeks for both parts of the service and that is our ultimate aim and that is what we are working really hard towards but no serious concerns. We have some who are waiting longer but, as has already been said, where they need to be seen quickly they are.

The Deputy of St. Ouen:

All right, thank you.

Deputy T.A. McDonald:

Could I just ask: what, in your opinion - everybody's opinion - are the other pressures on the hospital? Also do you think we are facing a winter crisis?

The Minister for Health and Social Services:

I will do the hospital bit in a minute but perhaps are we facing a winter crisis, perhaps the Medical Officer of Health could help us with that one.

Medical Officer of Health:

Every winter we have to prepare for an increased number of respiratory illnesses and this winter is no different from others in that sense, although there is an issue with the flu virus. We had the flu pandemic in 2009 and then for the 2 subsequent winters we had a bit of a backlash, if you like, which is often the way after a pandemic, that you get the pandemic flu strain as the predominant strain for the subsequent winters. We use the vaccine that is developed by the international manufacturers to cover the best predicted strains of flu for the coming season and the same thing happened last summer. But it seems that one of the strains has mutated so that the flu vaccine is not as effective for it as it would normally be in a normal flu season. That is one of the factors that has led to there being a lot more flu this winter than other winters. G.P.s are feeling that. It is interesting as well that in a typical winter you do tend to see more deaths occurring through the winter months. It is just a normal phenomenon of colder temperatures, more respiratory illnesses, et cetera. But I sense that ... I have not seen the figures because we review them 3 months in arrears, the death certification system. One of my functions is to authorise cremation. It is one of the Medical Officer of Health's legal function, so when the checks have been done by the 2 doctors involved with the deceased I am presented with the paperwork by funeral directors to make sure that the legal requirements have been complied with. Then finally authorise that the body can be cremated. Since the beginning of the year I have seen I think probably almost double what I would expect to see in a normal week of these forms coming through. The crematorium has been busier and the crematorium is normally closed on Mondays but they are open 5 days a week so yes, we are seeing pressures. In terms of how the hospital is feeling that, we have not had to stop anything or ... I am not as involved with the hospital as my colleagues.

Director of Operations:

We have not seen a significant impact on the hospital yet. We have managed to find side rooms for patients who have needed to have side rooms and we have managed to maintain our elective throughput. No patients have been cancelled as a result of lack of beds because of pressures with

emergency admissions. So very fortunate to date. We manage it quite tightly on a day-by-day basis, a lot of time spent managing beds and trying to safely and quickly discharge appropriate patients. But we have not had any ...

Chief Executive:

I suspect one of the things that will have assisted us with that is we did ... once the States Assembly had given approval to the report and proposition on the service transformation we prioritised a set of initiatives that we felt could release the pressure on the hospital in terms of its capacity because its capacity is very fixed. We know we need more beds going forward and more theatres going forward, and that is part of the new hospital project. But in order for us to survive these next few years while that piece of work is brought to fruition hopefully we did invest in a number of out of hospital services, so we moved to 24/7 nursing. Previously we did not have overnight nursing. We do now have 24/7 nursing services. We have a range of different types of support in the community working through some of the third sector organisations, family nursing home care in particular we have done a lot of work with to ensure there are more options so people can get discharged from hospital. We have also put our relationships with our private sector in terms of nursing and residential care; they are on a new footing in terms of their service agreements. While it is always tight in the winter we do have winter pressures, I do think having those additional services in place, which the States had the foresight to fund and put in place, has meant that we have got the ability ... so long as we do not have a major norovirus outbreak, that is always our worst fear. Sorry, I should not say it really, should I? Touch wood. So long as we do not have that, I think we have got the services in place that have been leeched away in the U.K. because of the disinvestments that are going on. So what you see in the U.K. now is you cannot discharge because a lot of those social care and community care packages are no longer available so people are staying in the beds, which means the people coming through A. and E., which have increased because of all of the respiratory infections and other things, they cannot get admitted because the beds are not free. So you are seeing this horrendous thing going on at the front door and a lot of that is to do with the fact that there is no back door that is open. So we are very careful in terms of ... the big advantage we do have here is we are an integrated department. We run integrated services so the ability for the hospital and community and social services to work with F.N.H.C. (Family Nursing and Home Care) is very close and very well managed. That is not to say we cannot improve on it and we are working on it, but it has given us that extra ability to run the flow though the hospital better.

The Deputy of St. Ouen:

Yes, you would hope on a small Island that we should have the means to organise ourselves well to be able to do that, but that perhaps leads on to Deputy Southern's question about carers.

Deputy G.P. Southern:

We often look at the top end of the skillset when we talk about recruitment retention, et cetera. We also need to make sure that this lower down scale we have people trained and are capable of doing the nitty-gritty of care. How does that tie in to population policy, migration policy and training needs? Where are we with that?

The Minister for Health and Social Services:

Just to be clear: are you talking about the unpaid carer?

Deputy G.P. Southern:

No, I am talking about paid carers.

The Minister for Health and Social Services:

You are talking about a paid carer?

Deputy G.P. Southern:

Yes.

The Minister for Health and Social Services:

Okay, fine. Who wants to answer that one?

Chief Executive:

We have our Health Care Assistants in the hospital. My understanding is virtually to a man and a woman they tend to be locally qualified and employed from the Island. We do not tend to have to recruit in for H.C.A.s (Health Care Assistants) in the hospital. On the community side most of that would sit with F.N.H.C.

Interim Managing Director for Community and Social Services:

It would include domiciliary care as providers, with obviously an expansion of other residential and nursing providers as well. But we are not seeing any sort of employment pressures in terms of recruitment. The other thing, of course, is it does fit in with the earlier discussion around the appropriate skills and what we are seeing is a gradation of trained H.C.A.s who are picking up quite high level skills. That is also essential, I think, in terms of wider sort of deployment of skills further down the job levels.

The Minister for Health and Social Services:

I could add to that a little bit really. First of all, in my 4 years on H.A.W.A.G. (Housing and Work Advisory Group) and I never saw one request come through for that level of staff which would

suggest that they are able to recruit locally. But I also know that our education centre provide training not just for our H.C.A.s but for H.C.A.s throughout the Island up to N.V.Q. (National Vocational Qualifications) level 3, I think.

Interim Managing Director for Community and Social Services:

Just on training, we prioritise statutory and mandatory training for all grades and that would include H.C.A.s so that ... and I have to say in my experience elsewhere I think that prioritisation means that they are job ready and aware of any emerging trends or new techniques. I think there is a major focus on investment in those skills, which of course enhances satisfaction and retention as well.

The Deputy of St. Ouen:

It is just that anecdotally it seems to me that a lot of the residential homes in the Island suggest that they cannot recruit locally the carers they need, so we see carers coming in from different parts of the world, not even E.U. (European Union) citizens, but people from the Philippines or Africa or something like that, to act as carers in residential homes. Is there evidence that that is happening?

The Minister for Health and Social Services:

To do that they would need to have a licence issued by the Population Office and unless it has been done by delegated authority, in the 4 years I sat on the Migration Advisory Group, later H.A.W.A.G., we did not see one.

Deputy G.P. Southern:

But does not the employer now decide who gets that licence, not the politician? We have changed the system have we not?

The Minister for Health and Social Services:

No. Companies or employers that had licences before when we changed the system that was maintained at status quo at that time, and then each one was reviewed as time went past. So if they wanted to change that, they wanted to increase it, they would have to go to the Population Office and get a change to the licence. Now some of that may be done quite clearly by the officer under delegated authority in certain circumstances or it would have to go to the Migration Advisory Group. I am not aware of the issue that you have just raised as being a major one. Certainly I can make inquiries or you could make inquiries with the Migration Advisory Group or H.A.W.A.G, as it is now called.

Deputy G.P. Southern:

I wondered what that was.

Interim Managing Director for Community and Social Services:

Housing and Work Advisory Group.

The Minister for Health and Social Services:

Yes, thank you.

Deputy G.P. Southern:

So nobody knows either.

The Minister for Health and Social Services:

I was much more comfortable with Migration Advisory Group, it was clearer.

Deputy T.A. McDonald:

And easier to say.

The Deputy of St. Ouen:

Terry, over the page.

Deputy T.A. McDonald:

Sorry. I am trying to get over H.A.W.A.G. at the moment.

Deputy G.P. Southern:

Can I just finish on that? You do not see that that is an issue and you do not see that is an issue going forward either? The improvement is fine at those levels and that retention, how easy is it to retain a qualified 19 year-old when they get beyond the ... 16 you train them up, et cetera.

The Minister for Health and Social Services:

Retention in H.C.A.s, the evidence I think, although I am not asked for it, but what I hear and see and the work going on down in the education centre where you see people come in and doing their level 2 and then coming back and doing the level 3, retention is very high, with a few occasionally even moving on then to become general nurses.

Deputy G.P. Southern:

We have the private care providers, those ...

The Minister for Health and Social Services:

They are providing that education for other care providers, so you are seeing the same people working their way through. I think retention is quite good. There will be some movement between one care provider and another but there is not a huge ... there is no loss to the industry. They move around.

Interim Managing Director for Community and Social Services:

I think there is a market clearly and therefore within that market there will be a preference shown as to where H.C.A.s would prefer to work. Obviously I can only speak from my experience in Health and Social Services, and in the time that I have been here I have not heard any issues in terms of recruitment in H.C.A.s compared to maybe nurses. That does not mean that there is not a tail through the rest of the system, in terms of a challenge for recruitment. I have not heard from providers that in particular they have got challenges around H.C.A. recruitment. It may well be something worthy of a further review later but at the moment I do not think it is surfacing.

Chief Executive:

I think the point that Deputy Southern makes is a correct one.

[10:45]

When you project forward into the medium term in terms of the growth and demand we know we have got, we will need to be able to recruit from off-Island, certainly doctors and nurses still and perhaps some therapy staff, radiographers, people like that. That is one of the pressures which thankfully it is not for me to manage because it is something that you, as politicians, must come to a view on, but we will always need to have a channel to bring people like that into the Island otherwise we will find it difficult to sustain the services in the hospital and in the community and social services as well. But obviously we will work with whatever the policy is but a chunk of whatever is agreed as a target for immigration would have to take cognisance of the need to be able to recruit doctors and nurses and other clinical professionals.

Deputy G.P. Southern:

At this stage you do not see that filtering down into the lower levels of some cases?

Chief Executive:

No, I would be surprised. We recruit very well on-Island for those kind of staff.

Deputy G.P. Southern:

Because within the context of population we have to be aware that we will never fill all the vacancies from inside the population at the moment.

The Minister for Health and Social Services:

But if you are going to ... frankly we want to attract your highly skilled specialist not your - very important however - lower end care provider. Very important because they are the ones that have the day-to-day contact with the patients. They are the ones that are going to feed the patient if need be, so it is important. I do not want you to think it is not. But you would never use your licence for that. You would be bringing in a radiologist or whatever, specialist nurse.

The Deputy of St. Ouen:

Moving on to a very different subject. Deputy McDonald has got a question he wants to ask.

Deputy T.A. McDonald:

Indeed, and the subject under review or query here is suicide and self-harming. It has recently been announced that the U.K. Government is calling for a fundamental overhaul of how the N.H.S. tackles suicides. In light of this, what is currently being done to address this, what is now sadly, quite significant issue in Jersey?

The Minister for Health and Social Services:

This is an area that concerns us especially in a small community where people are known to you as well.

The Deputy of St. Ouen:

It is very sensitive.

The Minister for Health and Social Services:

It is very sensitive. Quite a lot of work has already been done, Talking Therapies, for example, at the strategic level. But if you want to drill down into detail, again who is going to handle that?

Medical Officer of Health:

Just to say a little bit of background about where we are at the moment with suicide in the Island. In 2009 we had a particularly bad year with high numbers of suicides.

Deputy T.A. McDonald:

Yes, I remember.

Medical Officer of Health:

Twenty-nine suicides that year. But if you look at the longer run what you see is numbers going up and down and that is the feature of a small population and events that can occur randomly to some extent. At the moment our suicide rate is 8 per 100,000 which is exactly the same as the rest of the U.K. and quite a lot lower than Europe, which is 12.3 per 100,000. It is not to say it is not a problem obviously. Between May 2013 and May 2014 we had 4 young suicides which made us sit back and take a lot of notice, and we have started work on a new refresh of our prevention of suicide strategy alongside the work that is already going on in the big mental health services review. So hand in hand with that, my colleagues have been doing 2 things: looking at strategic actions for the longer term but also looking specifically at the vulnerable group of young people who were around the friendship and social groups of young people who have died. It is coming to a head to some extent last summer just before the school holidays when there had been a number of these tragic young deaths. There was an awareness that with the school holidays coming up people would be away from their school support system, away from the ability ...

Deputy T.A. McDonald:

Much greater risk.

Medical Officer of Health:

... of teachers to notice if somebody was in distress. So the strategic work on the strategy was parked for 2 or 3 months in order to create more of an operational approach to wrap support around a group of vulnerable young Islanders. That has carried on and there have been a number of initiatives of broad-based support right through the schools, lots of things happening alongside the strategy. A group was set up to develop the strategy. It is in its almost final draft form and will appear within the next 2 months.

Deputy T.A. McDonald:

Was that the Suicide Steering Group?

Medical Officer of Health:

Prevention of Suicide Strategy Steering Group.

Deputy T.A. McDonald:

Yes, that is right, back in March 2014.

Medical Officer of Health:

Yes.

Deputy T.A. McDonald:

Could I ask very briefly what are the group's terms of reference, as such?

Medical Officer of Health:

To develop a new strategy for the Island. There was a previous strategy which has been locked in since 2003, which has had a number of different actions by putting a liaison into the A. and E. Department between mental health services and the A. and E. staff. A number of other things were done, such as making multi-storey car parks safer. Another common mode of suicide at that time in 2003 was medication, whether it was Distalgesic or Co-proxamol, and that was withdrawn from availability so that ... because there are other perfectly good, much safer, analgesic painkillers available. So that stopped being available. So a number of things have been happening over the years to work against the risk of suicide and recognising people at risk. Lots has been happening. The other thing that we have done, we had an audit done by researchers from Southampton University looking at all of the suicides between 2000 and 2008 in the Island. They did that by analysing the detailed reports from the Deputy Viscount's Department, which are not publicly available because in a small island people know other people. There are sensitivities so external people had the full trust of the then Deputy Viscount to look through all of his records. They produced a report which had certain findings in it which will inform the current strategy. But then we had 2009, which was our *annus horribilis,* the number of suicides which had no particular common factors between them. It just seems to be now in retrospect the way numbers sometimes behave in a small community. But we had a further audit done of the 2009 suicides, which found exactly the same issues, if you like, common issues that we had found in the review of 2000 to 2008, and that was about appropriate diagnosis of depression in primary care. Perhaps a reluctance to make a diagnosis of depression and to treat somebody as having anxiety rather than depression.

Deputy T.A. McDonald:

And the stigma of ...

Medical Officer of Health:

The stigma of the diagnosis of depression in a small community. Further to that the reluctance sometimes through a person who is a secondary carer because of the stigma of being seen by mental health services, so those were common factors ... and the other thing I have not mentioned is alcohol. Alcohol played a role in almost every single one of them. So it was quite surprising in a way to look at the cluster year of 2009 and see that there was actually nothing very different at play from what had been in the previous 8 years, but it certainly informed some of the work with G.P.s. It has led to a programme being developed, and most of the G.P.s now have it, called STORM Training, which is all about appropriate recognition of people at high risk of suicide. We

have more consultant psychiatrists now and a better secondary mental health service. I am not an expert on that but that is much more functional and probably user friendly than it was at the time when there were greater worries.

Deputy T.A. McDonald:

Hopefully a lot of ... your intervention by somebody to try and prevent it.

Medical Officer of Health:

So it is lots of things. If we tackle it from lots of different approaches and angles at the same time you are more likely to be successful.

Deputy T.A. McDonald:

That is right. Everybody has got something worthwhile.

The Deputy of St. Ouen:

That is sounding positive, so we look forward to the strategy.

Deputy T.A. McDonald:

That is right. Because obviously you address the strategy. Any idea when that would be?

Medical Officer of Health:

I think we are looking at April at the moment.

Deputy T.A. McDonald:

That is fine, thank you.

Deputy G.P. Southern:

And supported in place in schools? Has that been maintained?

Chief Executive:

I think the issue of young suicides needs different approaches and responses. They quite often do not access primary(?) care services, for example. So how we identify young people who are vulnerable and find their way into the services can help them is different. David, I do not know if you want to just add to that?

Interim Managing Director for Community and Social Services:

Picking up from Susan, the disengagement from the drafting of the strategy was to focus in on the operational group. A large amount of that was looking in the wake of the 3 or 4 suicides, and

particularly engaging with young people directly. Obviously I think Jersey has an excellent youth service, which is probably the rival of many, where elsewhere those services have been cut back on. Obviously what that has enabled us to do is to get much greater insight into some of the issues that we have been talking about, not least of which the increasing rates of depression of a 17 year-old, which does lead to that stigma and that willingness to engage with primary care. I think we are dealing with all of that. I also think that from a professional perspective, and this is taking some of the learning from some of the serious case reviews, is understanding how we integrate our response and referrals within the professional realm to high risk individuals, and that has been part of the approach, and adopting a much better needs analysis so that we can be a bit more proactive. The education, communication and engagement with schools is absolutely critical. Through those programmes we are also working with our colleagues in Education to look at what we can do to better inform and some of that is around the management of some of the messages. For instance, we had some recent inquests around how we communicate out there, because if you are not careful you can, with social media, create much more unintended consequences in terms of the reactions from young people. Being alert always to that shift in the sort of channels of communication, that can result in impacts that you would not ordinarily want. Also being clear about where the helplines are and the points of referral. We have communicated that area to young people as well in terms of telephone numbers.

Deputy G.P. Southern:

In terms of in schools did we not have an initiative to place a social worker attached to each secondary school at one stage and has that carried through?

Interim Managing Director for Community and Social Services:

There are counsellors in schools and there is currently a M.A.S.T. review that is taking place at Education we are leading on.

Deputy G.P. Southern:

What was that?

Interim Managing Director for Community and Social Services:

Multi Agencies Support Team, I think it is as opposed to M.A.S.H. which is the Multi Agency Safeguarding Hub. Too many acronyms and not enough understanding, otherwise being reviewed. The purpose of that review is obviously with our colleagues in Education but one of the key requirements for that team is early intervention and prevention. I think any review has to be informed by outcomes as well as needs, so clearly within that remit we will be looking at some of the recent suicides and what more could have been done with those M.A.S.T. teams. Have they got the appropriate skillset? So I do not think it is just a question of: “Do you have a social worker

present?" because they are not always the best professional to the person that you go to if you have got issues within a school setting.

Deputy G.P. Southern:

You have got increased access to Talking Therapies now. Ten appointments have been made, I think it is 10.

Chief Executive:

We do have an increased access now Talking Therapies is now up and running. That is an adult-based service. One of our key proposals that will come through on the M.T.F.P. (Medium-Term Financial Plan) 2 is to extend that service comprehensively for children and young people but because of the need we have out there we are looking at whether we can flex the criteria for our current service so that if there are young adults of 16 or 17, 18 they will get into a service, albeit it is not yet developed fully for young people.

Interim Managing Director for Community and Social Services:

Initially looking at the numbers of referrals into Talking Therapies, in particular age range within the up to 24, we have something like 98 referrals in the period of operation so far. The sorts of issues that we are talking about in late adolescence and the sorts of risks that young people expose themselves to are no different to young adults in 18-plus, particularly when we look at some of the challenges out here, like new psychoactive substances. So what we are doing is seeking to look at what we would take if we were to flex the age range down within the current operation, now say 16, over the period of time before we implement Talking Therapies for children in, I believe, is down to 2016. So that is something we are investigating with colleagues and psychologists because it is critical to have those Tier 2 and 3 services, not just the Tier 4 kind of services.

Deputy G.P. Southern:

It is. Could we have access to those figures that you are talking about?

Interim Managing Director for Community and Social Services:

I am happy to share with you the referrals that we have had into the service so far.

Deputy G.P. Southern:

Can you confirm that the 10 new placements have been filled?

Chief Executive:

Ten?

Deputy G.P. Southern:

I think it was 10.

Interim Managing Director for Community and Social Services:

Sorry, we have got all the psychologists and therapists; they are all filled.

The Deputy of St. Ouen:

Thank you. It is something I think we would like to continue monitoring. It is excellent and much needed work. That brings us to the end of our time.

Deputy G.P. Southern:

Can I have one freebie? **[Laughter]** Is the Minister due to be away immediately? Can he spare 3 minutes?

The Minister for Health and Social Services:

It depends what the question is. **[Laughter]**

Deputy G.P. Southern:

The question is the one on 18; it is about everybody, all politicians in full support of 1,001 critical days. What does that mean for your services? What does that translate to? We are in support of it, what are you doing?

[11:00]

Chief Executive:

The first 1,001 day services in Health and Social Services it was one of the criteria that informed our first wave of developments for our service transformation. So our Children's Services section we did invest heavily in early intervention. The sorts of services you will see there are, for example, the M.E.C.S.H. (Maternal Early Childhood's Sustained Home-Visiting), which has recently been launched by Family Nursing and Home Care which is a sustained home visiting by health visitors. Everybody gets their universal service, so everybody has available to be visited by their health visitor for the set number of times. But where a health visitor finds a family that needs more support they can get enhanced support in the home. They can also signpost them to other organisations like, for example, Brighter Futures. So we have already invested in that, so we are quite happy that that is a strategic direction of travel that we are fully signed up to. What we are also doing as part of the initiative that the Chief Minister launched at a recent conference that was held, we are part of an emerging task force that will bring together people at a senior level from all of the key departments, to put resources together and say: "What we do not do particularly well at

the moment and we need to do better is understand what the full need is and understand what the pattern of everything we do is." So we do a lot more than people think. I mean "we" in the broader sense, not just "we" the Health Department. Across the States and out to the third sector there are a lot of interventions and services available. We have not mapped them yet to say is it comprehensive enough, do people know about it or do they not, do we have gaps we need to plug? So that is what we will be concentrating on, is getting a real grip on what is already there, what might need to be developed and obviously where we see gaps we will need to work together. That will be a challenge because largely we will be looking at can we reorganise our current services and our current funding because, as we know, funding is limited. But it is very much a key priority for the department in terms of young people, particularly those first 1,001 days. Very critical.

Deputy G.P. Southern:
And funding is critical?

Chief Executive:
Funding is always critical.

The Minister for Health and Social Services:
A lot of funding is already there but I have no doubt it will result in moving other funding around.

Interim Managing Director for Community and Social Services:
One of the important points is to map the resource that is already spent within that. I mean what you have to do with the services, a sort of topology, which is sort of mapped around individual age ranges or particular need, then you look at the whole family, you have to look differently. So I think that is part of what the strategic approach will do, is make some recommendations how better to use existing resource and what gaps need to be filled.

The Deputy of St. Ouen:
Again, something we will no doubt speak about in future.

The Minister for Health and Social Services:
Hopefully it will be achieved.

The Deputy of St. Ouen:
Thank you all for coming and assisting us. Very useful.

The Minister for Health and Social Services:

Thank you.

[11:02]