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Health and Social Security Scrutiny Panel

Prescription of Medication for A.D.H.D.

Witness: The Minister for Social Security

Monday, 14th October 2024

Panel:

Deputy L.M.C. Doublet of St. Saviour (Chair)

Deputy J. Renouf of St. Brelade (Vice Chair)

Deputy P.M. Bailhache of St Clement

Witnesses:

Deputy L.V. Feltham of St. Helier Central, the Minister for Social Security

Ms. S. Duhamel, Associate Director - Public Policy

Mr. P. McManus, Prescribing Advisor

[12:32]

Deputy L.M.C. Doublet of St. Saviour (Chair):

Welcome, everybody. We are the Health and Social Services Scrutiny Panel and this is a public hearing for our review into A.D.H.D. (Attention Deficit Hyperactivity Disorder) prescriptions and we are questioning the Minister for Social Security today. Welcome, Minister, and welcome to your team. My name is Deputy Louise Doublet. I am the Chair of the Panel and I will let the rest of my Panel introduce themselves.

Deputy J. Renouf of St. Brelade (Vice Chair):

Deputy Jonathan Renouf, the Vice Chair of the Panel.

Deputy P.M. Bailhache of St Clement:

Deputy Philip Bailhache, member of the Panel.

Deputy L.M.C. Doublet:
If you could introduce yourself and your officers please?

The Minister for Social Security:
I am Deputy Lyndsay Feltham and I am the Minister for Social Security.

Prescribing Advisor:
Paul McManus, I am a pharmacist, I provide professional advice to the Minister.

Associate Director - Public Policy:
Sue Duhamel, I am Associate Director in the Cabinet Office.

Deputy L.M.C. Doublet:
Lovely. Thank you for coming today and we have apologies from Deputy Lucy Stephenson, who could not be with us today. Okay, so, just to give some background on the review, Minister, we have exchanged some letters with you and we are grateful for your engagement thus far. The review was undertaken by the Panel following concerns that have been raised by members of the public and evidence that came out at previous quarterly public hearings about the medication shortages and various issues around that. We are aware that there are various issues around the medications that some people have raised in our submissions, so we are hoping maybe to question you about some of those issues and to see what your perspective is on those. Mr. McManus, I wonder if you could just give us a bit of an introduction yourself in more detail as to what your role is and what you do and who you represent, before we get into the questions.

Prescribing Advisor:
Yes, certainly. I am registered pharmacist. I am contracted to provide professional advice and support to the Minister for Social Security, particularly around the use of medicines in the community, funded through the Health Insurance Fund. That involves a range of activities around analysis of prescription data for primary care, working with community pharmacists around dispensing medicines and quality frameworks. There is a whole range of support and information that goes on around prescribing in primary care.

Deputy L.M.C. Doublet:
Okay, thank you. So you are contracted to advise the Minister and how long have you been in this role for?

Prescribing Advisor:
About 12 years, on and off.

Deputy L.M.C. Doublet:
Okay. Does anyone want to ask Paul any general questions about his role? Okay. Thank you. So we are going to start with some questions about the Pharmaceutical Benefits Advisory Committee. We note, Minister, from your letter dated 3rd September that A.D.H.D. medication is not included at this time within the prescribed list of pharmaceutical preparations, which I think means that G.P.s (general practitioners) cannot prescribe it, but it has to be a hospital consultant. Is that correct?

The Minister for Social Security:
It means that it is not funded via the Health Insurance Fund and not on the prescribed list for G.P.s to prescribe, yes.

Deputy L.M.C. Doublet:
Okay. Thank you for confirming that. We are aware that A.D.H.D. medication has been considered for inclusion in the past; is that correct?

Prescribing Advisor:
Yes, we have got application both from the adult psychiatrist, Dr. Müller-Sedgwick, and the Children's and Adolescent Mental Health specialist, Dr. Catherine Keep. They are currently in process.

Deputy L.M.C. Doublet:
Thank you. The reasons for those medications not currently being on the approved list, was it because of the shortages, is that the main reason that they are not?

Prescribing Advisor:
At the last meeting of the P.B.A.C. (Pharmaceutical Benefit Advisory Committee), the medicines were considered and generally the committee was supportive of the medicines going on to the prescribed list, but, yes, there were concerns expressed at this time around the shortages of a number of medicines that are used in the treatment of A.D.H.D. and it was felt that, because of those shortages, it would put the arrangements, what we call shared care arrangements, it would make them difficult to enact because, if patients had to chop and change medicines because of those shortages, it would mean them having to go back to the specialist if there was a change in the medicine needed.

Deputy L.M.C. Doublet:

Okay. Could you list all of the reasons as to why those medications are not on the list, so shortages being one of them, and are there any others?

Prescribing Advisor:

At the moment in time, the shortages was the main concern. I think, in general, there was concern, not concern, but a need to understand the whole pathway around it. It is not simply a case of asking G.P.s to write on the bottom of a prescription, to sign these, it is about how do we make primary care part of the overall management of patients with A.D.H.D., not simply about who is going to sign the prescription, so there was some uncertainty in P.B.A.C. around how that would all work and how that would all fit together in the pathway for patients.

Deputy L.M.C. Doublet:

Yes, that was mentioned, I think.

Deputy P.M. Bailhache:

Can the Health Insurance Fund afford to cope with A.D.H.D. prescriptions?

Prescribing Advisor:

I am not sure I am the right person to say whether it could afford it. Certainly it would be quite a substantial additional cost We estimate, based on the estimated number of patients, about 1,500 patients, and the average cost per year for each treatment, which is about £550 a year. So we are talking in excess of £800,000. To put that in context, we currently spend just over £17 million a year on prescription medicines in the community under the H.I.F. (Health Insurance Fund). To put that £800,000 in context, that is more than we spend on treating infections, on antibiotics and things. So it is quite a substantial chunk of money.

Deputy J. Renouf:

Can I ask, Minister, what view, if any, you have about the desirability or otherwise of having A.D.H.D. medications covered?

The Minister for Social Security:

Of course I, like many other people, have been following this story before I was in this particular role, and I remember reading about it in the media and thinking to myself that would surely be the most simple, straightforward answer to a lot of the issues that we know people in the community are facing. So I was of the view, surely that is what appears to be an easy fix. However, then coming into this role and speaking with Paul and the Chair of the Pharmaceutical Advisory Board, it became clear that there were multifaceted layers of complexity around taking that decision. I was quite keen to ensure, and I asked in fact for the Board to provide detailed reasons, because I knew that this is

a matter of great public concern and interest. When I did receive the advice last time around, not putting these drugs on the prescribed list, I was satisfied that the Board had given due consideration to all of those complexities. Because, of course, we all want to be in a place where we can resolve the issues. I find that this particular scrutiny review is incredibly helpful because it does draw out, from other perspectives as well, the issues that we are dealing with and also how we need to work together right the way across Government, because we have 3 Ministers involved here, and I think that we are all committed to finding a way that we can resolve the issues. It was just that there are other things that are currently outside of our control, which means that it is not appropriate at this point in time to add it to the list.

Deputy L.M.C. Doublet:

What do you see as the main things that are outside of your control?

The Minister for Social Security:

So, of course, the availability of the drugs themselves is the main thing that is outside of us as an Island and outside of the control of us within our community. Obviously, then we need to look at the shared care arrangements as well. I know that my team and the Health team are working incredibly hard to look at how shared care arrangements may be put into place. Also opportunities for others that are not necessarily G.P.s, so prescribing pharmacists, for example. So there is all sorts of different cogs going on with within different wheels, I think, at the moment. It is around getting everybody to work together. I think people do want to resolve this issue. We know how critical it is for a number of Islanders.

Deputy L.M.C. Doublet:

Yes. That is exactly why we have picked it up as an issue. I think we definitely agree in terms of your observation that it is not a simple and straightforward matter. So that is something I think bears out in the submissions that we have received and the evidence we have examined. In terms of the shortages, what you have said is that it is something globally that we do not have any control over. In terms of monitoring it, how is that being monitored and what kind of information do you get about where the drugs are coming from and how much of each drug you can access and are there different places that we can go to get the drugs, et cetera, how does that work?

The Minister for Social Security:

That is quite a technical question. I am not sure whether Paul would be the right person to answer that, or whether it would be a colleague in Health.

Prescribing Advisor:

I can answer it in terms of from the community perspective. All of the community pharmacists in Jersey obtain their medicines through U.K. (United Kingdom) based wholesalers and manufacturers. They face the same challenges in obtaining supplies as they do in the U.K. and are affected by shortages. It is an improving picture and at the minute most medicines for A.D.H.D. are now back in adequate supply. There is a handful that still there are some problems with. We monitor that weekly. There are specialist sources of information in the U.K., particularly the Specialist Pharmacy Service *[1] based in the U.K., which publishes updated information every week around medicines' availability.

Deputy L.M.C. Doublet:
Is that publicly available information?

Prescribing Advisor:
Yes.

Deputy L.M.C. Doublet:
Could you send that to the Panel?

Prescribing Advisor:
Yes, certainly. There are other subscription-based trackers that G.P.s have access to, but also we take soft intelligence from local community pharmacists about what their experience is because what we find is that different pharmacies have different sources of supplies and some are able to obtain limited supplies for their patients and word spreads then that such and such a pharmacist has got supplies in. But they have enough for their patients, but would not be able to accept any other patients.

Deputy J. Renouf:
I am just interested, Minister, Mr. McManus has said that there is an improving situation. At what point, just coming back to my original question, would you feel comfortable with this as being a potential solution to add them to the list, or do you think there are other factors other than availability that mean you will not feel like you want to go down this route of adding A.D.H.D. medicines to the prescribed list?

[12:45]

[1] Chief Pharmacist provided the further additional information following the hearing "this requires [free of charge] registration but is for health professionals only"

The Minister for Social Security:

What would make me feel confident is the advice of the Prescribing Advisory Board. I get good advice from that board. As Paul said, there are current applications in and the board themselves did say in the last advice to me that in principle they are supportive, so I do not see them as being a blocker. I see it that I will look to the advice that I am being given by experts in that area. It would be foolhardy for me as a Minister to think that I could make that decision without the expert advice.

Deputy J. Renouf:

But it would not be, for example, to Deputy Bailhache's point, compromised about the cost, because clearly it is a significant cost, you would not regard that as a blocker were the other issues to be resolved?

The Minister for Social Security:

I would not regard that as a blocker per se. We get other advice all of the time, which is saving us money around different drugs to use and things like that as well. But the cost was not something that came through within the advice. Of course, we always need to be cognisant of the H.I.F. I need to work together with the Minister for Health and Social Services to make sure that we have a Health Service that functions as one and delivers the right care and the right pharmaceuticals as well to the community as a whole.

Deputy L.M.C. Doublet:

Yes. In terms of the cost, from some of the evidence that we have gathered, it is our understanding that there has already been an increase of people being diagnosed with this condition and there is likely to be further increases. What kind of costs could the H.I.F. absorb in terms of medications for this condition?

The Minister for Social Security:

I would need to go back to ...

Associate Director - Public Policy:

There is a point about this is a medicine that is currently prescribed in the hospital, and Paul is really better to do this than I can, but I will introduce the subject, which is that hospitals will buy drugs at a lower cost than community pharmacies and, although the shortage situation is getting better now, if you are in a shortage situation, you are better going through one central provider rather than having 30 separate people around the Island doing it. But, Paul, perhaps if you could just say a little bit about the cost differential, in terms of how much does it cost Jersey to have A.D.H.D. medication, which costs a certain amount of money going to the hospital, costs a different amount of money when it is available in the community. It is not to say you should not put in community pharmacy,

absolutely, but that needs to be one of the things to take into account when you are making that decision.

Prescribing Advisor:
There perhaps is about a 30 per cent cost difference between the price of medicines in the community and what on average you would you would spend on A.D.H.D. medicines in the hospital, because of the kind of contract pricing that the hospital is able to use.

Deputy L.M.C. Doublet:
So, in terms of if that was the route that Government decided to go down, increasing capacity within the hospital for seeing patients, and I know that has already happened with nurse prescribers, I know it is slightly outside of your ministerial responsibilities, but in terms of nurse prescribers being offered training to issue repeat prescriptions within the hospital, can you give your views on that and whether that would help?

The Minister for Social Security:
I think that would be a question for the Minister for Health and Social Services and his team, but I think that goes to the point as well around us having a single functioning kind of Health Service, both out in the community and then within the hospital. Because the points that Sue made about balancing the costs as well and where we are getting the pharmaceuticals from, we need to see that as a whole and also check that people have got the right pathways in place, so the right care pathways. This is an incredibly complex piece of work.

Deputy L.M.C. Doublet:
So would that not be part of that care pathway that nurse prescribers could be part of that? Would that not be part of that solution and changing the care pathway?

Associate Director - Public Policy:
Nurse prescribers is just one of your options, so you could have nurse prescribers today, they can prescribe against the H.I.F. in an appropriate clinical setting, so that may or may not be appropriate because we talked about shared care groups need to be firmly in place, so you would not do that with nurses before you had done it with the G.P.s, for example. You could also have the nurse prescriber in the hospital, again within an appropriate clinical setting. So you can have it in either situation. It is an extra string to your bow, if you like, in a health service these days that there are more types of people who can prescribe, and this was mentioned before about pharmacies, both pharmacists and nurses are able to get qualifications to do prescribing within a specific kind of area of practice.

Deputy L.M.C. Doublet:

Okay. Thank you. Is that something that the Advisory Committee would give a view on, that kind of thing?

Prescribing Advisor:

Not necessarily. The P.B.A.C. tends to look at an application in the terms of Is this medicine safe, effective, is it cost-effective, is it good use of public money, how does it sit within primary care and what we would expect G.P.s to do and to prescribe and do we consider primary care as the best place for these medicines to be prescribed? There are examples of medicines, like medicines for A.D.H.D., where, with support, G.P.s can undertake that long-term prescribing. But it is making sure that G.P.s are well supported in doing that.

Deputy L.M.C. Doublet:

Yes So, in terms of the G.P.s, Minister, your letter stated that, even if a final version of a protocol with G.P.s is confirmed, that some G.P.s may not feel comfortable to prescribe and have stated that they will decline requests for shared care. You went on to say that G.P.s are responsible for the prescriptions they issue and the Government cannot require G.P.s to prescribe a specific medicine or agree to participate in a shared care protocol. So, again, I can see why you are saying it is not a straightforward, simple solution. Can you elaborate, whoever wants to answer this one, why do you think that some G.P.s would decline requests for shared care?

The Minister for Social Security:

Do you feel confident to answer that?

Prescribing Advisor:

I can make a start. I think largely, and certainly views that we have had expressed back to the P.B.A.C. from some G.P.s, particularly those who are in the small practice, do not feel that they will see enough patients and gain enough experience day-to-day to feel comfortable in prescribing and dealing with queries around medicines for A.D.H.D. and they have suggested perhaps in larger practices where they have got more patients, it may be appropriate to have maybe one or two clinicians in those larger practices who have more experience and have done more training to oversee prescribing for A.D.H.D.

Deputy L.M.C. Doublet:

Can you reflect on that, Minister, given what we have just heard about the numbers of Islanders with A.D.H.D. and the figures comparable to antibiotics, I think you said, so it seems like a fairly common condition. Can you reflect on that?

The Minister for Social Security:

It is difficult to reflect on, I suppose, what private entities, which are the G.P. surgeries, may well be thinking or feeling. If we do get to a place where we have got shared care arrangements, it is around ensuring that there is clear pathways in place and people know where to go for what help and when. But also that communication is absolutely clear as well. Again, I think that is part of the value of having a specific scrutiny review, because I know you also are getting submissions from G.P.s, so those submissions and the information that you are gathering will be highly valuable as well in enabling us to assess where there may well be other issues or concerns that perhaps are not coming through to us through our ongoing dialogue. But I will say the dialogue around this is ongoing and it is a continuing piece of work. It is certainly not something that is being left alone. It is understood as something that needs to be resolved.

Deputy L.M.C. Doublet:

Yes. What could Government do, given that reluctance, which I think is understandable, that G.P.s have some reluctance around taking on the shared care, what could Government do to perhaps incentivise that or make it easier? Is there training that could be funded or could there be a funding for perhaps a specialist clinic so that some G.P.s could have that additional expertise? What could be done to make that a more attractive thing for the G.P.s to do?

The Minister for Social Security:

I think there is probably all sorts and a mix of all of those things that you have just suggested. But, at the end of the day, it is that ongoing piece of work around coming to an agreed shared care pathway that everybody feels comfortable with and then, as part of that agreement, I am sure that between the G.P.s and the Health Service, there will be ongoing work to help make people feel more confident going forward. If indeed, as Sue said, that is the best pathway to be prescribing those medications.

Deputy L.M.C. Doublet:

Yes. Which of those kind of supportive solutions would you be minded to prioritise?

The Minister for Social Security:

I would need to refer to experts to advise me on that. It is not something that I think would be a political decision.

Deputy L.M.C. Doublet:

Would Mr. McManus be one of the experts that you would ask? Do you want to give a view on that?

Prescribing Advisor:

Yes. Certainly we would expect, as part of any shared care arrangement, for the initiating specialists to be the one to provide the education and support and training for G.P.s. I know Dr. Müller-Sedgwick has already offered that and I think has provided some limited training already. So we know, within the specialists on Island, that there is a willingness to support G.P.s in doing this and to take part in education and training.

Deputy L.M.C. Doublet:
Okay, that is good to hear. Does anyone have any comment on what perhaps the blockers are then if there is support being offered, where are the blockers to that support being taken up?

Associate Director - Public Policy:
It is not quite ready yet, is it? The shared care is not quite sorted out yet.

Prescribing Advisor:
Yes, the shared care arrangements are still in development and there is a collaboration between the specialists and the G.P.s and P.B.A.C., so then they have not been agreed and signed off yet. In terms of blockers, I think with G.P.s, it is not just about the education and training, it is about G.P.s feeling that there is adequate support in general for them to undertake the prescribing and not just being seen as somebody signing the bottom of a prescription.

Deputy L.M.C. Doublet:
Okay, thank you. Did you have ...

Deputy P.M. Bailhache:
Can I just pursue a little further that question from Deputy Renouf about the costs to community prescribers of issuing? You were saying that there is a 30 per cent differential between costs as done by the hospital as opposed to community prescribers. Do the community prescribers act *en bloc* in placing their orders or do they all do it individually?

Prescribing Advisor:
They all do it individually.

Deputy P.M. Bailhache:
Could this problem be ameliorated if they were to act as a collective and having the benefit of bulk buying?

Prescribing Advisor:

We are tied in, in terms of remuneration for community pharmacists, we link into a reimbursement scheme for England and Wales and a pricing system that is operated through England and Wales. So we would have to effectively set up our own remuneration process, which is quite an undertaking.

Associate Director - Public Policy:

Do you want to perhaps just explain how our prescriptions get priced, because that might be helpful for the panel to understand that, because it is a very technical issue, which we cannot do in Jersey ourselves.

Prescribing Advisor:

Yes. So, each year there is about 2.2 million prescription items that are dispensed in Jersey, and each month those prescriptions are sent off-Island to Newcastle to be processed by the N.H.S. (National Health Service) Business Services Authority and they have an operation that deals with all prescriptions from across the U.K., to process them to capture information about who the prescriber is, who has dispensed it, what the medicine is, what the value of that medicine is, with the end result being how much to reimburse community pharmacists for the products that they dispense and the fees that are associated with that dispensing. That is the service that Jersey has bought into for many years, and it is only because of the specialism N.H.S. Business Services that we can use that.

Deputy P.M. Bailhache:

I am sorry, I am probably being slow, but I have not quite understood. So the community pharmacists do not buy or acquire from some central source the drugs that they dispense?

Prescribing Advisor:

No, they will purchase either directly from manufacturers or through wholesalers, who are U.K. based wholesalers, so that they will all have different wholesalers that they will purchase through. They will purchase at one price, we will reimburse them at another price, and the difference is their profit margin. The system that we use to determine the reimbursement price is based on the system for England and Wales.

Deputy P.M. Bailhache:

So it would not make any difference then to a pharmacist, or would it make any difference?

Associate Director - Public Policy:

That is correct. Yes. There is basically a fixed price per item, which is set by the U.K. rather than by Jersey, because we do not have the facility or resources to set our own prices. So we have to use a bigger country to do that, so we are using the U.K. system. Yes, the chemist will take

commercial decisions as to how and when they buy drugs, at what price, and the Government will always pay a set amount for that drug, however much it has cost, or how little it has cost to the chemist to get it.

[13:00]

Deputy P.M. Bailhache:
So the community pharmacists have an incentive to go to some wholesaler.

Associate Director - Public Policy:
Exactly, if they can get it at ...

Deputy P.M. Bailhache:
Who is selling it at a lower price.

Associate Director - Public Policy:
Yes, not so much nowadays, but there used to be arrangements around the discount that pharmacists were able to achieve themselves So now, currently, I think the pharmacist just collects anything that they can buy at a better price, they will they keep that difference as part of their overall profit margin. So the whole system is based on the pharmacists being able to do that.

Deputy P.M. Bailhache:
I mean, the pharmacist could lose money.

Associate Director - Public Policy:
They could lose, yes, and they will lose money on some special items. They will buy something in and it will go out of date, all sorts of things will happen, yes. Yes.

Deputy J. Renouf:
What you are really saying is that everybody buys, the hospital and the pharmacies, all buy at the same price, roughly speaking, and the difference in price for the pharmacies is their profit margin.

Associate Director - Public Policy:
No, so the hospital buys at a cheaper price.

Deputy J. Renouf:
The hospital does get a cheaper price, bulk buying?

Associate Director - Public Policy:

Again, Paul can explain that, it is the way the pharmacies ...

Prescribing Advisor:

Yes, they have access to U.K. contracts that community pharmacists do not have access to.

Deputy J. Renouf:

Okay, so there is still a price differential there, but most of the differential is attributed to the fact that you then have to reimburse more than the price to the pharmacies. Yes, okay. Thank you.

Deputy L.M.C. Doublet:

I am not sure I have understood why a prescription from a G.P. could not be filled in the hospital and access the cheaper ...

The Minister for Social Security:

So that is to do with the legislation.

Associate Director - Public Policy:

No, a prescription from a G.P. can be filled in the hospital. That is up to the hospital. The hospital would not want to take that cost. There are currently 2 completely separate systems in Jersey. The hospital pharmacy provides the outlet, if you like, for things which are prescribed in the hospital, and the community pharmacists are paid by the Health Insurance Fund to prescribe H.I.F items. The community pharmacies will also prescribe private items at a cost to the patient. They will just agree what the price is, and I think you could take a hospital prescription to a community pharmacy as a private prescription if you wanted to. It is a legal prescription, if you like. There is a difference between a prescription that is legal and a prescription that the cost of it is going to be reimbursed by the person you give it to.

The Minister for Social Security:

I am just trying to get to the nub of the question.

Deputy L.M.C. Doublet:

I am trying to understand what is the cheapest route in terms of where you should expand the provision.

The Minister for Social Security:

Even if that was the case and that was done, you would still then have to have the shared care arrangement in place with the G.P.s., so that would not, in and of itself, resolve an issue that ...

Deputy L.M.C. Doublet:

No. So as the issues are there is the shortages, there is the care pathways, which involves the G.P.s., and then there is the costs of where you access it. So I guess we are talking about costs at the moment, are we not?

The Minister for Social Security:

Then you also have the funding. So you have the prescriptions being filled out and completed by the hospitals coming from outside of the H.I.F. and then prescriptions that are then filled out by G.P.s and going to community pharmacies, being funded via the H.I.F. So that is why I have to work quite closely with the Minister for Health and Social Services as well and also ensure that we have also got the Minister for Children and Families in the loop as well.

Deputy L.M.C. Doublet:

Yes. So it would be a greater cost to Government, would it, if there was shared care with G.P.s, would that increase Government's costs?

Associate Director - Public Policy:

The overall cost to Jersey, yes, if you moved prescribing out of the hospital into the community, there will be different costs, you would reduce the cost on the clinics, you would increase the cost of the drugs, and you would bear some of the costs of the patient visiting the G.P.s, so you have a variety of different things to take account of. But, can I just ask Paul to just clarify whether, because we said that the hospital are able to buy drugs cheaper than the community pharmacy, but I am assuming that if all G.P.s, if you could manage it physically, if all G.P.s sent their prescriptions into the hospital pharmacy, the hospital pharmacy would very quickly be excluded from the contract. You cannot use the hospital as a place to get cheap medicines from, can you?

Prescribing Advisor:

No, no, we cannot. Probably the most important reason why, we would then lose the fantastic resource that we have of high street pharmacies. The whole mechanism of dispensing is about supporting community pharmacists as the most accessible healthcare professionals. So they are an important part of that supply of medicines and we would not want to have a system where everything went into the hospital.

Deputy P.M. Bailhache:

Just supporting the pharmacists is a kind of mutual benefit.

Deputy L.M.C. Doublet:

As in, if the pharmacies close, then that is not available for people to go and get health advice, okay, I understand. It really is very complex, is it not? I think what we will need to do is compile a grid, almost comparing the different options, and who would bear more of the costs and what the impact would be. So we might come to you for something in writing to help us compile that for clarity.

Associate Director - Public Policy:
Just to give you a little bit more background about the hospital pharmacy is tiny as compared to community pharmacy, community pharmacy is, what, 2 million prescriptions a year?

Prescribing Advisor:
Yes, 2.2 million items.

Associate Director - Public Policy:
And the hospital pharmacy will be a few hundred thousand. It is a different scale. So, if you tried to put an awful lot more business into the hospital pharmacy, that would cause enormous problems with the hospital. So basically you have got what you have got today.

The Minister for Social Security:
I should make a suggestion that perhaps the panel might want to go and have a look at the hospital pharmacy as well because it is very tight space, small facility at the moment as well. So there is a practicality, I think, around what is possible.

Prescribing Advisor:
There is the issue around operating hours as well and access for patients and the high street pharmacies are open on Saturday, they are open early in the morning, late in the afternoon and evening, so it is more accessible for patients. It is closer to where they live.

Deputy L.M.C. Doublet:
So, ultimately then, I think what I am gathering is that the shared care, is it inevitable? Is it really the only feasible solution given all of these limitations of the hospital and care at the hospital?

The Minister for Social Security:
That is what we are working towards is having that clear shared care pathway that people know where they need to go to access the right help and when. But we need that for all sorts of things and those interactions between primary care and secondary care, it is crucial in a number of areas.

Deputy P.M. Bailhache:

Shared care only works then really if you devise some method for prescribing the drugs which does not involve the hospital. The cost either has to be paid by the patient himself or herself, or it has to be paid by the H.I.F.

Associate Director - Public Policy:

Should we just describe what a shared care agreement is? It will be a treatment which cannot be done wholly by G.P. A G.P. does not have enough expertise or clinical knowledge to do it on their own, so it is always initiated in secondary care. So you are always going to go to a specialist first of all, you are going to go to secondary care. The secondary care clinician is going to set you up for what you need to do, and if they are happy that you are stable on that treatment, they are then going to share the care with a G.P. The G.P. is going to take over the monitoring of that patient and going to continue to prescribe the same drug at the same dose and the same frequency. If the G.P., who has got the clinical knowledge to monitor the condition, sees any change in the condition and thinks something might need to be changed in terms of medication, they have to move the patient back into secondary care because it is the secondary care clinician who has to initiate each full treatment. So it is shared between the two, but the G.P., we talked before about training or whatever, so the G.P. needs to have the training to be able to monitor the condition, but is not going to be making a change. So it should always be shared between the 2, so it is sharing it out. So if somebody is very stable, the G.P. can carry on with it. But, if there is a change or something is not quite right or whatever, has to go back. Just while I am talking, just very quickly on shared care, so we talked about G.P.s and small practices, you have to also remember that, for the shared care, unless all the G.P.s feel confident to do it, there will be some patients who will not be able to access a shared care agreement and some patients who will be able to access it, and the last thing to remember in Jersey is if you have a shared care agreement, when you go to your G.P. you are going to pay for that, if you are going to a hospital clinic it is free. So there are lots and lots of complexities to doing that. When we get past the technical issue as to how to do it and how to create the right training and support for the G.P.s, there are other things to think about as well. It is just quite a complicated situation unfortunately. That is probably why we are not quite there yet because there is lots and lots of things to think about.

Deputy L.M.C. Doublet:

Yes, we had reflected on that and the cost of G.P. visits, we had reflected on that. Did that answer your question?

Deputy J. Renouf:

Have you been involved in discussions with the Minister for Health and Social Services specifically about this issue, about the shared pathways and the potential resistance among some G.P.s to being involved in it?

The Minister for Social Security:

Yes, I have had conversations with the Minister for Health and Social Services. I continue to have conversations with the Minister for Health and Social Services. We do have regular meetings that are set up to discuss issues such as this, which cross over both of our portfolios. So we are keen to be able to resolve issues and, again, must not forget, within this mix we have also got the Minister for Children and Families because that is where CAMHS (Child and Adolescent Mental Health Service) resides as well. There is definitely the will to want to resolve this. It is known that this is having an effect on a number of people and their quality of life and I can absolutely understand the frustrations of people who are having difficulty firstly in getting their diagnosis and then secondly in then being able to get the prescriptions and the medications that they are prescribed. So this issue has not been put away in a drawer and I want to give people the confidence that it is an ongoing piece of work that is being taken seriously.

Deputy J. Renouf:

Can you give any indication about when you might reach decisions around this?

The Minister for Social Security:

It is difficult because of the complexities around this. There are complex conversations that are ongoing at officer level at all times and it is something that I regularly ask for updates on. But, due to the complexities, I think it would be ill advised for me to try to commit to timeframes at this point in time.

Deputy J. Renouf:

But not this year, maybe next year, just sort of a rough sense? I mean, at the moment it is beginning to sound a bit open-ended. Is there a sense of that there is a decision point going to come at some point?

The Minister for Social Security:

I would hope so. We are rapidly approaching the end of this year, so I do not think we will see a conclusion this year. I would hope that we will see some movement next year, but perhaps I can provide the panel with ongoing updates at future hearings as well with regard to this. This topic is a priority. It is something that we know we need to get resolved and it is something that Ministers and departments are committed to working together on.

Deputy J. Renouf:

You state within your letter that the proposal to move repeat prescribing from secondary care into primary care has not been accompanied by a costed patient pathway which considers financial and behavioural impact. Is that something that is underway?

The Minister for Social Security:
I will refer to the officers around the practical work that is being done.

Deputy L.M.C. Doublet:
Could we start with whose responsibility is it to do that first of all?

Deputy J. Renouf:
Costed patient pathways, which consider the financial and behavioural impact, which is what was mentioned in the letter.

Prescribing Advisor:
We have done some provisional work around that pathway and the costings of the pathway as part of the submission to P.B.A.C. That would then need to be worked at, once we got the support from P.B.A.C., we know that the shortages have been the issue, shortages have been removed and medicines are in good supply, then P.B.A.C. I think would then feel confident to support the inclusion of the medicines on the list. The next step would then be about building on the provisional work around the costings and working that up in terms of costs of the pathway. Because that is the kind of wider issue, putting the medicines on to the list is only one part of the whole jigsaw.

Deputy J. Renouf:
The behavioural impact, to what were you referring when you referred to behavioural impact? Is that behaviour in terms of patients, more patients seeking treatment?

Deputy L.M.C. Doublet:
I think it was the Minister referred to that in her letter, so it was the Minister's words.

Deputy J. Renouf:
Yes, the reference in the letter towards considering behavioural impact of putting things on to the patient pathway. So what sort of behaviour are we talking about?

The Minister for Social Security:
That is what Sue was talking about earlier, about being able to see the right clinician at the right time and thinking that it would be the G.P., and perhaps people going to a G.P. when they would need to go to the specialist instead.

[13:15]

So, if people think: “I can go to my G.P.”, and they will not be able to get their diagnosis there and they will not be able to get a change in medication there. So it is about understanding as well and people knowing the right place to go throughout that care pathway. I think Sue actually gave a really good explanation about what that shared care pathway would look like and it is really important that people understand that so that behaviours do not change and that people go to the specialist when they need to see the specialist.

Deputy L.M.C. Doublet:
Could you clarify whose responsibility is it to create that costed patient pathway?

The Minister for Social Security:
I think there is multiple responsibilities, we have already discussed around how we have got 3 Ministers involved here. We have got at least 3 departments involved here. So I think really there is a collective responsibility across the whole piece for ensuring that what we do into the future is sustainable and provide the right level of care for the community in a sustainable and efficient and effective manner. I do not think that one person can hold the responsibility on this piece.

Deputy L.M.C. Doublet:
Understood. Yes. I think given that the responsibility is shared and would you agree that this issue perhaps needs a champion among those Ministers to lead and gather all of those views, given the responsibilities are spread out, and could you be that champion?

The Minister for Social Security:
I am happy to champion this particular issue, but I think the other Ministers involved as well are also acutely aware of the issues as well. Thanks to the scrutiny panel’s request, we have a specialist on A.D.H.D. now also added to the Disability Strategy Advisory Group. So that group had an update on this situation at its last meeting. So, again, in that group this issue and other issues related to it are visible as well. So there is all sorts of multifaceted approaches to try to keep this on the ...

Deputy L.M.C. Doublet:
So a champion is emerging is what you are saying. We will keep looking out. Thank you. Some further questions on the H.I.F., in fact I am just going to reflect on my question plan because we have jumped around quite a bit. Okay, I want to ask a question then about the hospital pharmacy, which we have touched on. The majority of patients in Jersey who are diagnosed with A.D.H.D. are under the hospital consultant and accessing their medication via the hospital pharmacy. Some of

our submissions, in fact many of the submissions we have had, have noted that the conditions waiting in the corridor and the opening hours, et cetera, are not ideal for those who are neurodivergent. Could a discussion be had regarding making accommodations in terms of has anything been considered about that?

The Minister for Social Security:

I am not responsible for the hospital pharmacy, although I have had ongoing conversations with the Minister for Health and Social Services about what I can do where possible to help alleviate some of the issues at the hospital pharmacy. I think those submissions, that is useful from the Disability Strategy perspective around the area. So, if I can, I will take back those observations and obviously that would be something for the Minister for Health and Social Services as well. But, with my Chair of the Disability Advisory Group hat on, I will also take that to that group as well and also to my team that work on disability and inclusion, so they can feedback to the relevant department.

Deputy L.M.C. Doublet:

Thank you. Yes, and we can send the submissions to you, we may need to seek some permissions around confidential ones. We could send those to you to send on to that group for consideration as well. Okay, anything else?

Deputy J. Renouf:

I am interested in the situation, we have had a lot of reports back from people who have saved up a lot of money to go for a private diagnosis and then received the sort of sticker shock afterwards that that did not mean, just because they got a diagnosis, that they were going to get free care. So they had gone down a private route and I think we were informed that the purpose of the Health Insurance Fund was for a particular set of purposes and it would be corrupting of that purpose if it was to be used to subsidise private patients or patients who had chosen a private pathway. In fact, offering a subsidy to individuals who have sufficient means to pay for private consultants will add to Jersey's health inequalities, was the kind of summary of the statement. Do you recognise though that in this case these are people who are not necessarily well off choosing to go for a private pathway, they are doing so out of desperation, they spend all their money on that and then end up in a very difficult position when they realise they have to pay for the medicines or go back into the system to pay for the medicines?

The Minister for Social Security:

I think this comes down as well to clear communication so that people understand what they should be expecting when going for those private consultations. So I would hope that whoever is providing those private consultations is telling people at the outset, before they pay for that, what the outcome

is going to be. I would be concerned if people are going and paying for that type of consultation without that information at hand.

Deputy L.M.C. Doublet:
Is there anything that obligates those providers to provide that information?

Associate Director - Public Policy:
Can I just make a point about the Health Insurance Fund, because I think you are asking these questions outside our remit. So the Health Insurance Fund is set up to support the costs of people visiting general practice and the Health Insurance Law very specifically says that it has to be a general practice service that is provided. It cannot be something that is a specialist service. So an A.D.H.D. specialist would absolutely not be G.P. That is what we are talking about, it is about shared care. The G.P.s may be like a junior partner in some kind of relationship, but their clinical practice does not extend to A.D.H.D. diagnosis to start with, so you could not use the Health Insurance Fund to fund somebody visiting a specialist in A.D.H.D. or anything else. Then we are also saying that at the minute we do not have the A.D.H.D. drugs on the health insurance prescribed list, so there is not really any legal way in which you could use the Health Insurance Fund money to support people seeking an initial diagnosis or getting their initial set of drugs. So I think that is more a question for the Minister for Health and Social Services in terms of what could be done there. The Health Department do contract out some other things in some other areas so it is not unknown, the Health Department do use external providers for all sorts of things at different times.

Deputy P.M. Bailhache:
Do you have any information as to the scale of the number of G.P.s who might be unwilling to help in a shared pathway?

Associate Director - Public Policy:
I think the point was made before about some larger practices may be better suited to support it, because they could have one or two partners within the practice who would deal with it and they would have enough patients to maintain their clinical practice. I think that is a really important point. We talked about 1,500 people in Jersey altogether, so spread that out across 100 doctors, that is not very many people per person. So you probably would need a bigger cohort of patients to look after for it to be worthwhile.

Deputy J. Renouf:
Can I just pick up on one thing there, that 1,500 figure, that is the number of people you currently ...

Prescribing Advisor:

That figure has come as estimates both from Dr. Catherine Keep and Dr. Müller-Sedgwick, based on the current number of patients they have in their service, how many of those are receiving prescriptions, and what proportion they think would be both eligible for shared care and willing to take it up. I think they both estimate that something like between 50 and 70 per cent of people who are eligible for shared care would want to take that up. Not everyone will because of the costs involved, et cetera. But that 1,500 figure is very roughly based on those estimates.

Deputy L.M.C. Doublet:
Does anybody at a ministerial level have oversight of private providers? I am not sure whether this is your remit or the Minister for Health and Social Services.

The Minister for Social Security:
Of private providers in what sense, like the specialists?

Deputy L.M.C. Doublet:
So private prescribers, I guess, like what is the oversight and who are those people accountable to?

The Minister for Social Security:
So my area would be the G.P.s in the primary care. But I think in this context we are talking about the specialist private providers, which that is more the Minister for Health and Social Services.

Associate Director - Public Policy:
The Minister for Health and Social Services holds the performance list and the Minister for Health and Social Services is responsible with Medicines Law. So you are talking about people who are allowed to be doctors in Jersey, that is the Minister for Health and Social Services, and drugs that are allowed to be prescribed in Jersey, and that is the Minister for Health and Social Services as well. So the Minister for Social Security has a kind of subset of those things, if you like.

Deputy L.M.C. Doublet:
It is this diffusion of responsibility again. What is the solution to this?

Deputy J. Renouf:
Well, I think the Minister for Health and Social Services presented us with his solution last week.

Deputy L.M.C. Doublet:
Yes. What do you think the solution is?

The Minister for Social Security:

I am actively obviously working with the Minister for Health and Social Services to look at how we can unify the Health Service across primary and secondary care. We do need a service that is able to work proactively all together. I am happy to work as a Minister with the Minister for Health and Social Services and I am not somebody that would be putting blockers in the way of us improving services and making them more efficient into the future.

Deputy P.M. Bailhache:
That is not really answering the question, if I may say so. The question was, what is your solution?

The Minister for Social Security:
I think we do need a single unified Health Service. I am supportive of the proposals that the Minister for Health and Social Services is bringing forward.

Deputy L.M.C. Doublet:
Would that entail a single Minister?

The Minister for Social Security:
A single Minister is not something that I would be opposed to.

Deputy L.M.C. Doublet:
Is that part of the plan?

The Minister for Social Security:
It may well be, I think that at that point we get into the politics of things. I think what we need to get right first is the structure and the basics and then we will look at how that then flows up for political oversight as part of that. That is probably outside the remit of this hearing.

Deputy J. Renouf:
She says very hopefully.

Deputy L.M.C. Doublet:
Interesting though. Okay, thank you. I am going to ask about social prescribing because many of our submissions have noted that they would prefer a non-pharmacological prescribing, so rather than medication they would like to have access to perhaps support groups or talking therapies or online courses and some of the charities that are established already spoke to us about how they are providing some of those, and some of it is funded, some of it is not currently funded. We are also aware of the Connect Me social prescribing project, thank you for providing a briefing on that, it was very interesting. On the Connect Me first of all, there is a budget of £325,000 being proposed.

Is that funding adequate for the Connect Me generally and will it assist people with A.D.H.D. to access some of these social solutions that they are asking for?

The Minister for Social Security:

Firstly, I would hope that it will enable people with A.D.H.D. to access some of those solutions. I have been impressed by what I have seen. I think I have had a very similar briefing to what was given to the panel just last week. It has not been suggested to me that there is a funding pressure, but of course this is a new pathway as well. Everything seems positive so far and I look forward to getting the first reports on some outcomes from the Connect Me programme with the social prescribing. But it is very new, literally just launched, and I think a really positive thing.

Deputy L.M.C. Doublet:

Yes, and the social prescribing, it is not just the Connect Me projects, is that right, there is other things?

The Minister for Social Security:

No, no. From what I have seen, and it probably would be best to have the officer who runs this, but it is a wide and broad database of opportunities that are available. So I am really keen to see how this works in an ongoing practical way as we go forward.

Deputy L.M.C. Doublet:

Yes. Does your Department currently fund or commission any services from any of the third-sector organisations for people with A.D.H.D.?

The Minister for Social Security:

I probably need to come back to you with details on that because I am just trying to think about the organisations that we fund and some of them probably do provide services for people with A.D.H.D., but I would like to go back and check on that.

Deputy L.M.C. Doublet:

Okay. Is that something that you could look at alongside the care pathway, well as part of the care pathway if we are thinking about pharmaceutical solutions, could you ensure that the social prescribing is considered as part of that, so it is not just a drug-based solution being offered?

The Minister for Social Security:

I would certainly be open to looking at that, but of course I think as well, when it is about providing care, any type of medical care, politicians are probably not the people that should be making those decisions. We should be looking to specialists.

[13:30]

Deputy L.M.C. Doublet:
No, but the money will be from your Department.

The Minister for Social Security:
But I take your point about supporting non-pharmaceutical interventions as well.

Deputy L.M.C. Doublet:
Yes. So, do you believe that it is important that those third-sector organisations are sufficiently funded so that they can provide those services to individuals suffering with A.D.H.D.?

The Minister for Social Security:
I do, yes. How we fund and support the third sector is something that I am currently looking at as well.

Deputy L.M.C. Doublet:
Yes. Do you agree that any funding solutions should go beyond just a kind of one-year cycle, but there should be multiyear funding supplied?

The Minister for Social Security:
Yes, that is something that I would be prepared to talk with the panel about in more detail and maybe we could have a private briefing based on some of the work that I have asked officers to do in relation to the third sector as well.

Deputy J. Renouf:
I am just going to backtrack, so if you have got more on that, I have just got one final question.

Deputy L.M.C. Doublet:
Okay. We will come back to that one. In terms of the pathways then, what would it look like? So, if a care pathway did involve social prescribing, what would that look like to a patient?

The Minister for Social Security:
I think that is quite a technical question that I do not feel qualified to answer. But I do not know if ...

Prescribing Advisor:
It is certainly outside my remit. I do the medicines bit.

Associate Director - Public Policy:

The G.P.s are going to get, either have or are about to get access to the social prescribing network that exists. So, if a patient went to G.P., the G.P. would be able to show them, I am not quite sure whether it is directly or indirectly, but certainly give them a good route through to a social prescribing solution. I am guessing that will mean, and again I am talking out of turn, but I am guessing the hospital would also be involved in that and have similar kind of routes through.

Deputy L.M.C. Doublet:

Yes. So it is another area with that shared responsibility.

The Minister for Social Security:

It is, yes. But it is very new and very fresh and I would say it is probably going to take people a while to get into the swing of how to use it on a very practical level as well.

Deputy L.M.C. Doublet:

Are you referring to G.P.s.?

The Minister for Social Security:

I am referring to any referrer that is going to be using that particular model because it is a new thing that is available and it is around ensuring that it is used and people know that it is there and that it can be used as well.

Deputy L.M.C. Doublet:

Sure, okay, all right. Thank you. We might follow up in writing some of those questions.

Deputy J. Renouf:

I guess, listening to this conversation, which has been very, very interesting and very helpful, it is clear that your primary involvement in this is through the H.I.F. obviously. That is where your primary responsibility lies. There has been a lot of talk about the long-term stability of the H.I.F and obviously what we are talking about here is potentially close to £1 million being added to it. What are you thinking about the long-term stability of the H.I.F and these kind of additional demands on it? Does it worry you? Do you sort of want to examine this a bit further or what?

The Minister for Social Security:

Yes, of course I think that I should look at the H.I.F very, very seriously and the sustainability of it. I think that it also needs to be looked at within the context of the broader health system and broader health funding as well, because of course the H.I.F deals with that primary care element of things,

but everything all works together. So I do think that we do need to look at the H.I.F in the context of the ecology of whole health system.

Deputy P.M. Bailhache:
Does that mean you are going to run the H.I.F down to zero?

The Minister for Social Security:
No, that does not mean I am going to run the H.I.F down to zero.

Deputy P.M. Bailhache:
The H.I.F is going to be quite severely affected if there is some kind of shared care pathway, is it not? The additional £1 million is not something that is sustainable by the H.I.F at the moment.

The Minister for Social Security:
I think, as Sue explained, even with the shared care pathway, it may not be the G.P.s that are always prescribing. But what I do not want to happen as a result of this hearing is people to be concerned or worried that they would not be getting the care that they need. I think what we need to do is look at what the most sustainable solutions are to ensure that people get the care that they need. Obviously, the H.I.F has its role to play, but, like I said, it needs to work in conjunction with the rest of the health offering that we have. But what I do not want is people worrying, because what we will find is a sustainable pathway to provide the care.

Deputy J. Renouf:
Is that a ministerial commitment to fund whatever outcome comes out of this review of the shared pathways?

The Minister for Social Security:
I think we all need to work together to ensure that people get the medications that they require no matter what their condition is, so at the moment I am committed to ensure that people get the medication that they need.

Deputy J. Renouf:
Thank you. I do not have any other questions.

Deputy L.M.C. Doublet:
I want to go back to something that you mentioned about communication and we were talking about the private providers and I am not clear whether there is an obligation on the private providers, but we will ask, I think you mentioned the Minister for Health and Social Services, we will ask the Minister

for Health and Social Services that. In terms of what Government could do to communicate what the current situation is with perhaps what the waiting times are for an assessment and what would happen if people go down the private route, is that something that Government could help with and have a page on their website that explains that? Because that is something that has come across in the submissions as well.

The Minister for Social Security:

I think if that is something that has come across in the submissions, that communication needs to be clearer, then I would be working with the Minister for Health and Social Services to have a look at what information is there to ensure that we have useful and relevant information so that people know exactly what their options are and exactly what the effect of making choices to go private or otherwise might be. So I think, again, this review is a really useful review in terms of the complexity of these issues, and I think that is one of the roles of scrutiny to pick complex issues such as this and do the type of deep dive that Ministers cannot always do.

Deputy L.M.C. Doublet:

Yes. Could you possibly have those conversations before Wednesday, even on a surface level, because we would like to have some kind of conclusion between the 2 Ministers when we question the Minister for Health and Social Services on Wednesday?

The Minister for Social Security:

Yes, I am sure I will see the Minister for Health and Social Services before you see him on Wednesday.

Deputy L.M.C. Doublet:

That would be great. Thank you. Any final questions, is there anything that anyone would like to add on A.D.H.D. prescriptions before we close the hearing? No, okay. Well, thank you very much, all of you, for attending. It has been great to have you and thank you for your expertise. It has been very helpful and we will keep you posted on the progress of the review. I will close the hearing now. Thank you.

[13:37]