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Health and Social Security Scrutiny Panel

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

Witness: The Minister for Health and Social Services

Wednesday, 16th 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 R. Binet of Grouville and St. Martin, the Minister for Health and Social Services

Mr. A. Weir, Director of Mental Health, Social Care, and Community Services

Mr. K. Smith, Acting Director of Pharmacy Services, Jersey General Hospital

[15:04]

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

Good afternoon, everybody. We are the Health and Social Security Scrutiny Panel and this is a public hearing for our review into A.D.H.D. (Attention Deficit Hyperactivity Disorder) prescription medication and our hearing today is with the Minister for Health and Social Services and his officers. Thank you very much for attending the hearing and welcome to those who are watching online because I am aware that there are some watching online today. I would like to thank those in the public and stakeholders who have made submissions to us. We have used a significant amount of that material to help form our questions today for you, Minister, so we thank those who have taken the time to send their information on to us. We will be running the hearing from 3.00 p.m. until 4.30

p.m., we do have a lot of questions to get through so we will try to get through all of those, but we may need to send some in writing. My name is Deputy Louise Doublet, I am the Chair of the panel. I will let the rest of my panel introduce themselves.

Deputy J. Renouf of St. Brelade (Vice Chair):
Deputy Jonathan Renouf. I am 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:
Minister, if you could introduce yourself and your officers?

The Minister for Health and Social Services:
Deputy Tom Binet, Minister for Health and Social Services.

Director of Mental Health, Social Care, and Community Services:
Andy Weir, Director of Mental Health, Social Care, and Community Services.

Acting Director of Pharmacy Services, Jersey General Hospital:
Kevin Smith, Acting Director of Pharmacy Services for the hospital.

Deputy L.M.C. Doublet:
Welcome. Do you have any apologies today from your side?

The Minister for Health and Social Services:
No.

Deputy L.M.C. Doublet:
We were expecting the Chief Pharmacist today.

The Minister for Health and Social Services:
I was not aware of that.

Deputy L.M.C. Doublet:
We do have apologies from one of our panel members, Deputy Lucy Stephenson is not able to be with us today. So, to open the hearing, Mr. Weir, I wonder if you would be able to just give us a very

brief definition of what A.D.H.D. is just for everyone's mutual understanding, and our review is focusing on adults, so if you could inform us how it presents in adults?

Director of Mental Health, Social Care, and Community Services:
Yes. So A.D.H.D. is neurodiverse condition where essentially people will present with attention deficit or hyperactivity, so they may experience difficulties in concentration and they may experience difficulties in flight of ideas and sometimes they will have other neurodiverse symptoms, so they may experience difficulties, for example, in engagement with other people. But essentially it is a condition where people experience a hyperactivity and overthinking of that way.

Deputy L.M.C. Doublet:
Thank you. It is A.D.H.D. awareness month this month and we have seen some activity from Government and indeed we had a hearing with the Minister for Social Security on Monday of this week and we found that there was a very good understanding of the condition and a good shared understanding of some of the issues around the prescribing of medication. Some of the difficulties that the public are experiencing in that area, and also indeed some of the positive stories from people who have been able to access these services that the Health Service is providing and the medication provided to those who have obtained a diagnosis with your service. You mentioned that it was a neurodevelopmental condition, so it is not a mental health problem. Could you elaborate on that further please?

Director of Mental Health, Social Care, and Community Services:
So it has historically been classified as a mental health problem and is frequently treated in Mental Health Services but there is a lot of debate now about a number of conditions that historically were treated as psychiatric conditions. Dementia is another really good example where there is a debate about whether or not it is a psychiatric disorder, a mental health disorder, or it is a neurological disorder that also has some behavioural presentation. Certainly there are some psychiatric symptoms that can present and there is clearly a relationship between A.D.H.D. and some other mental health needs. But at the moment, within our system, we treat A.D.H.D. as part of our Mental Health Services. That is where it sits.

Deputy L.M.C. Doublet:
Okay. Thank you. We spoke to some stakeholders and one of the charities in particular raised that as something that comes up that they said there was this misconception that it is a mental health disorder. Do you feel that is something that across the Health Service that professionals are aware that it is not a mental health disorder, but it is a condition?

Director of Mental Health, Social Care, and Community Services:

I think it varies in all honesty, I think the information that we are getting back in the work that we are doing around the neurodiverse strategy is that people's experiences of different health professionals are quite different. So, some people absolutely recognise the condition and recognise the need to make adaptation and perhaps to do things differently. Some people do not. I think there is often a lot of stigma around anything that has the label of mental health illness, mental illness stuck to it. There is not always a great understanding, but I think you were right earlier, it is getting better. It is a condition certainly that people are much more aware of now than we were say 10 years ago. These are relatively new services, but I think there is a significant increase in awareness.

Deputy L.M.C. Doublet:

Yes. Thank you. Minister, what has Government been doing to raise awareness of A.D.H.D. during October, which is the awareness month?

The Minister for Health and Social Services:

We were just discussing this a little bit earlier and what you will have seen is there has been a limited approach to it simply because I think that our common view is that we really need to get things resolved before we raise too much more awareness of the condition. I am hoping that by this time next year we are able to make more of it by virtue of the fact that we have made some advances in some of the problems that I am sure we are going to discuss during the course of the next hour and a half.

Deputy L.M.C. Doublet:

Could you tell us about the conference that was held, I think it was last week?

The Minister for Health and Social Services:

I am afraid I was not able to go there because of other commitments. I would have to hand on to Andy.

Director of Mental Health, Social Care, and Community Services:

So it was a conference that was set up by the Education Department within H.C.S. (Health and Community Services) and it was really successful, the feedback has been excellent. We had a range of speakers, we had speakers from on Island and people from off Island that are considered to be expert in this area. We had a presentation from one of the charities here, for example. So it was primarily aimed at raising awareness among professionals, so that was the primary aim of the conference. But it was not just professionals that attended and, from all of the feedback that we have had to date, people found it very useful. There was a lot of discussion, people felt able to engage and perhaps even create some new networks which will help with that awareness raising.

Deputy L.M.C. Doublet:

Thank you. So the current focus of this review is on the prescribing of A.D.H.D. medication to adults. Was that discussed at the conference and were any new ideas or was there any movement forwards in thinking around that?

Director of Mental Health, Social Care, and Community Services:

So it was certainly discussed at the conference and I do not know whether there was anything specific that came out of that in terms of moving it forward, but I know certainly from conversations that I have had, it was one of the things that people talked about.

Deputy L.M.C. Doublet:

Okay. Will there be some reflection on the content of the conference so that it can be fed into practice and what are the outcomes of the conference?

Director of Mental Health, Social Care, and Community Services:

Yes, I think that is a really good idea. I think we can certainly ask. There has been a piece in the *J.E.P.* (*Jersey Evening Post*), because one of the journalists from the *J.E.P.* was in attendance. But certainly for us, yes, it would be useful to hear what has come from that.

Deputy L.M.C. Doublet:

Minister, would it be possible for the panel to receive an analysis of that reflection as it pertains to the terms of reference for this review?

The Minister for Health and Social Services:

Very happy to provide that.

Deputy L.M.C. Doublet:

Thank you very much. Jonathan.

Deputy J. Renouf:

Yes. Some questions we have had from the public have been quite interesting on this and one of them drew attention to the idea that A.D.H.D. is not just a condition that is relevant to the Health Department. If you are looking at the prison population and all of these, there is a lot of extra costs that potentially arise out of the prevalence of A.D.H.D., possibly undiagnosed and so on. So I guess what I am asking, Minister, is do you think that that is sufficiently understood and reflected on in Government?

The Minister for Health and Social Services:

Perhaps not to the extent that it should be, because it is an evolving situation, is it not? When I was a child, A.D.H.D. had never been heard of and I think it is now coming to public attention. There are more people realising that they have the condition and I think there is a growing awareness of it and it is something that is going to take time for it to be fully understood by everybody. As I say, there is this dilemma at the moment of making sure that we get the treatment right before we make too much noise about the awareness of it. So it is a fine balance that we are dealing with at the moment.

Director of Mental Health, Social Care, and Community Services:

It is the absolute premise of the neurodiverse strategy work that we are not just concentrating at all on just health diagnosis and medication. So, for example, there has been a focus group held in the prison to talk about how does A.D.H.D. interact with the prison, and if you have got A.D.H.D. and you are in prison, what are the issues? So I think the strategy will be a whole system strategy. It will not be a health and social care strategy. It will be much wider than that.

Deputy J. Renouf:

I think what that gets at is the need to consider, when you talk about the costs of, say, providing medication and so on, that is a cost, but it might also be helping prevent costs elsewhere in the system. Is that adequately reflected in in the way that we approach that at the moment?

The Minister for Health and Social Services:

I like to think it is adequately understood, if nothing else, and that reflection has to be portrayed over the course of time.

Deputy J. Renouf:

It still has to be driven through.

The Minister for Health and Social Services:

It does, yes, it does indeed.

Deputy J. Renouf:

One of the other people we heard from talked about the impact on their job, losing a job, not being able to see any progress because they had lost their job and the reports were then disappeared into the ether. They could not follow through to see whether the company were acting and so on. What processes do you have in place to monitor the way that A.D.H.D. is being experienced in the community in that way?

Director of Mental Health, Social Care, and Community Services:

I do not think we have any formal processes now, but I think that, to be repetitious, I think that is one of the key focuses of the strategy work. So we have asked people about their experiences in a range of domains and employment is one of those and so I am hoping, because I will hear at the end of next week all of the feedback. We had great uptake with the questionnaire, we have had 450 people respond to the questionnaire and we have had people going to the parish hall events. So I am hoping that we will hear some really insightful information about, for example, what can we do to help employers make adjustments to make sure that people with A.D.H.D. are not disenfranchised and are not disadvantaged in the workplace.

[15:15]

Deputy P.M. Bailhache:
I have been reflecting on something that Mr. Weir told us on a previous occasion, which was that there had been speculation that up to 40 per cent of the population was suffering from A.D.H.D. That seems to me to be an impossible situation, not that it does not exist, but impossible in the sense that there are not enough people in the Island to treat 40% of the population. Am I right in thinking that there is a spectrum of affected?

Director of Mental Health, Social Care, and Community Services:
There is a spectrum of neurodiverse conditions, without a doubt. There is a lot of conversation at the moment about the relationship between A.D.H.D. and autism, for example, and increasingly some services are looking to move towards doing the 2 assessments at once because it does not really make sense to do them entirely separately. I do not think 40 per cent is the assumed figure. I think it is lower than that and I will confirm that figure for you. I was looking at something last week that I think it is not 40 per cent definitely. We will get you the most up-to-date figure.

Deputy P.M. Bailhache:
The purpose of that introduction was really to ask whether any work is being done in the Department to think about how one can concentrate on those people who are more severely in need of treatment and help and distinguishing them, differentiating them from those who might have a problem but it is not too serious.

Director of Mental Health, Social Care, and Community Services:
Continuously. It is one of the things that we have been really thinking about in terms of how we manage the waiting list moving forward. So I think I have spoken previously to the panel about in some places, so by coincidence only yesterday the organisation that I came from, the N.H.S. (National Health Service) Trust that I came from in Leeds have closed their A.D.H.D. waiting list because they have now got 4,500 people on the waiting list, waiting for an assessment, and they

have said: “We cannot continue with a waiting list of that volume.” The exception is that they are still accepting urgent referrals and you then get into a constitution about what constitutes urgent. We have talked, we know on our waiting list, and we are doing a piece of work at the moment looking at the waiting list in detail, we know that we have people who are significantly, immediately, adversely affected. For example, someone who is not able to engage in education because they need to be treated. We also know that we have some people who are in the 60s and 70s who have been to their G.P. (general practitioner) and said: “I think I may have A.D.H.D. and I would like to be assessed for it.” Those 2 positions are quite different. So we are continuously working through in discussion how do we prioritise, do we prioritise based on urgency, do we prioritise based on how people are impeded, those are conversations that we are still working through.

Deputy P.M. Bailhache:
Obviously it affects waiting lists.

Director of Mental Health, Social Care, and Community Services:
It certainly does and it affects how you manage waiting lists. The thing I would really want to say, of course, is that there are always other services available. So if someone has A.D.H.D. and is on a waiting list to be seen, if they are in mental health crisis, for example, there is a mental health crisis service that can assess them and meet their needs, it does not mean that you just wait, but we do have to work out how we prioritise.

Deputy L.M.C. Doublet:
Could you advise us what the current numbers are on the waiting list?

Director of Mental Health, Social Care, and Community Services:
So the current waiting list for adults as at today is 873 people waiting for an assessment.

Deputy L.M.C. Doublet:
So there has been an increase quite recently, possibly because of the awareness raising.

Director of Mental Health, Social Care, and Community Services:
So we are still receiving an average of 40 referrals a month. That has gone up slightly in the last 2 months. There are also 590 young people in C.A.M.H.S. (Child and Adolescent Mental Health Service) today awaiting an assessment. So that means there is a total of 1,463 people currently waiting.

Deputy J. Renouf:

What are the implications of that in terms of how long people would expect to wait before they get seen?

Director of Mental Health, Social Care, and Community Services:
Currently, and I cannot speak for the C.A.M.H.S., I do not know the detail of that, but in the adult service, if you are referred today, it is going to be 3 and a half years at the current run rate before you are seen. The longest waiting list in the U.K. (United Kingdom) currently is 10 years.

Deputy L.M.C. Doublet:
So we understand from previous hearings and information from stakeholders that there is one psychiatrist within the funded Health Service who is managing all of these.

Director of Mental Health, Social Care, and Community Services:
One consultant psychiatrist and there is a junior doctor who works, so there are 2 psychiatrists within there. The A.D.H.D. consultant is not full time in A.D.H.D. He also works in autism, and so he has a split role. But he is the specialist consultant and then we have a junior doctor who works alongside him under his supervision.

Deputy L.M.C. Doublet:
Okay. Is the junior doctor full time?

Director of Mental Health, Social Care, and Community Services:
She is full time. She is not currently funded, but this is a post that we put in some while ago to try to manage the pressure essentially.

Deputy L.M.C. Doublet:
Previously there was mention of a nurse who was seconded. Was that for assessments or prescribing?

Director of Mental Health, Social Care, and Community Services:
She has been seconded to help initially with the waiting list work, so to help manage the waiting list, she is not doing any assessments yet. She can do. She is able to. We are about to review her secondment and think about how do we use her moving forward. Because she is a specialist in this area. Her substantive employment is in the education centre. She is one of the lecturers in nursing. But she is currently spending some time with us helping with this service.

Deputy L.M.C. Doublet:
Okay. That review, what are the potential outcomes from that?

Director of Mental Health, Social Care, and Community Services:
Clearly, whichever way we dice it, we need more capacity to manage the waiting list. We are in the process of budget setting currently and one of the things that I am having to do is juggle demand and think about where might we put additional resource next year. Clearly, she has done an excellent piece of work triaging the waiting list. She has helped introduce a new screening tool which has been really helpful. So I am hoping that we will continue with that, but I cannot guarantee that.

Deputy L.M.C. Doublet:
The screening tool, at what stage in the pathway is that used?

Director of Mental Health, Social Care, and Community Services:
Right at the beginning.

Deputy L.M.C. Doublet:
By the G.P.s?

Director of Mental Health, Social Care, and Community Services:
No, it goes to the person, the referral. You can self-refer into our services, you do not have to be referred by a G.P. So what we are now doing is, when people are initially referred, we are sending them a screening tool for completion and that means there is more clinical information available, it helps us potentially sift out people who may not correctly be placed on the waiting list, but also it means that, when we come to do the assessment, we have got a lot of clinical information available to us already.

Deputy J. Renouf:
You say that has been rolled out already and it has been very helpfully, but you have seen an increase in the numbers of people coming through. Are you saying it would have been even greater if she had not been working there?

Director of Mental Health, Social Care, and Community Services:
I do not think it is stopping people coming in, the referrals will still come in. It is when the referral comes in, how do we best get people ready for assessment and really particularly how do we make sure that people are not inappropriately waiting. Because occasionally people get referred into the wrong thing and you might look at the referral and think this person needs a mental health assessment before they come into this waiting list, so you might move them over there first.

Deputy L.M.C. Doublet:
So, is there already some triaging of that waiting list?

Director of Mental Health, Social Care, and Community Services:
That is exactly what we are now doing. So the nurse that we seconded in was brought in specifically to help us review the waiting list, review who was on it, and to do that piece of work.

Deputy L.M.C. Doublet:
So, is it possible that some people who have been waiting quite a while already, who perhaps as a result of this process were deemed to be not as urgent, may have to wait a little longer.

Director of Mental Health, Social Care, and Community Services:
We are not seeing that yet. Once we have completed the work and, if we do decide to prioritise the waiting list by need, that may be the case. Up until now, we have pretty much done it with the odd exception just on chronology, so people are seen in the order in which they were referred. That may change in due course.

Deputy L.M.C. Doublet:
In terms of managing the staffing of this service, Minister, are you actively recruiting for more staff in this area?

The Minister for Health and Social Services:
Once again, this has been under discussion. My understanding is it is extremely difficult because, as you know, there is a dire shortage of specialists in all areas, as you just heard. Is it Leeds that have just closed their waiting list? It is very, very rare indeed that you can get your hands on people to do that work.

Deputy L.M.C. Doublet:
But are you actually looking? I think it is good that there is that shared understanding, but is there an active search for staff?

Director of Mental Health, Social Care, and Community Services:
We do not have any additional funded post currently, that is the piece of work that we are doing as part of budget setting to ascertain is that the right thing. We have already put in the second junior doctor, because we needed to do that. We have historically been to agencies, for example, to look for nurse prescribers because that is one of the things that we have explored in terms of that would help reduce the pressure on the psychiatrist, to no avail. We have some nurse prescribers in our system currently, but any conversation about would they wish to come and work in this area has not

borne fruit. So the key to this will be the budget setting and determining what the future configuration of the service looks like.

Deputy L.M.C. Doublet:
In the meantime, Minister, would you or are you considering using a locum psychiatrist in this area?

The Minister for Health and Social Services:
No, I am always guided by the specialists in this area, it is not something I would intervene with.

Deputy L.M.C. Doublet:
What has your advice to the Minister been?

Director of Mental Health, Social Care, and Community Services:
We cannot get them. We are struggling to get routine locum psychiatrists currently and we have been in a position in the last month where we have had 2 posts that we have not been able to fill with locums, even though we have gone out searching wide. So we would not get an additional locum and we are balancing priorities again. So, for example, one of the posts where we have not been able to fill the locum post is the crisis service recently. So we have had to fill that by moving other psychiatrists around to accommodate that. In terms of, if tomorrow a locum appeared, that is the first place I would want to put them. But you are also ...

Deputy L.M.C. Doublet:
So the crisis service, could you just describe that?

Director of Mental Health, Social Care, and Community Services:
So that is the service where people ring up because they are in crisis and we see them within 4 hours in terms of immediate mental health emergency. So there is a good news story in that we have recruited more substantive psychiatrists than we have had in the time that I have been here and we have got another 2 coming. So that is good. But you do need to be a specialist in this area and not just any old psychiatrist can come and work in the A.D.H.D. service. Because it is such a new and evolving thing, those people are very limited.

Deputy L.M.C. Doublet:
Yes, yes. Okay. So, in terms of the long-term plans for staffing this service, Mr Weir, you mentioned that the funding was not in place. Minister, what will you do to ensure that the funding is put in place for this post should a professional in that area become available?

The Minister for Health and Social Services:

As I say, we are going through the process of working out how the budget is going to be spent in the next 12 months and there are lots and lots of compelling areas for funding. So, unfortunately, this is but one of a number of very, very compelling areas. As you probably know, we have got a fixed budget position, all things being equal, and we are having a great deal of trouble to stay within those parameters already.

Deputy L.M.C. Doublet:
Did you consider bidding for additional funding?

The Minister for Health and Social Services:
Believe me, I had to go quite a long way to get the funding that we have hopefully got agreed at this point in time. So I think we have pushed the boat out as far as we can and there comes a point where you have to have some very, very difficult discussions about what you prioritise and what you do not and we are in that territory at the moment. As you know, going into next year, we are going to be doing a piece of work about what funding looks like in the future and having a conversation with the general public about what sort of Health Service they want and the extent to which they are prepared to pay for it. Because in an Island with 20 per cent tax, and continually growing expectations of the quality of healthcare, the 2 things do not match up terribly well. So that is a discussion that we will be having in the new year.

Deputy L.M.C. Doublet:
Given the numbers of people on the waiting list, I think you mentioned 873 plus the numbers of Islanders already diagnosed, plus the numbers of Islanders who are not yet on the waiting list who may have the condition and not be aware, would you agree that this is an area that would need to be prioritised?

The Minister for Health and Social Services:
Extremely, extremely compelling to be prioritised, absolutely.

Deputy L.M.C. Doublet:
Okay, would you like to move on?

Deputy P.M. Bailhache:
So there are not enough psychiatrists at the moment to carry out the necessary prescriptions, is the long and short of it?

Director of Mental Health, Social Care, and Community Services:

So we prescribed for 300 in adult services. We are currently prescribing for 300 patients a month. Now, routinely, we would not be prescribing every month for people, but that is one of the things that we have put in place in order to manage the lack of medication. So, rather than giving people large amounts of 3 months' worth of medication, for example, and then some people not being able to have any, we have limited supply down to one month at a time, which means that we need to prescribe every month, therefore the current psychiatrists in the service are prescribing for 300 people each month.

Deputy L.M.C. Doublet:
Can I just clarify those numbers? Does that mean that there are 3,600 individuals, is this just with A.D.H.D.?

Director of Mental Health, Social Care, and Community Services:
No, so there is 326 people on the adult caseload and we are currently prescribing for approximately 300 of those. There is not more people, there is a couple of people who we cannot prescribe for because they require a specific drug that is not available because of their clinical need. Not all A.D.H.D. drugs are the same.

Deputy L.M.C. Doublet:
It has to be every month, is that what you are saying?

Director of Mental Health, Social Care, and Community Services:
At the moment, because of the medication supply issue, yes, it is every month.

Deputy L.M.C. Doublet:
Understood. Thank you.

Deputy P.M. Bailhache:
Is any consideration being given to the appointment of a specialist pharmacist prescriber who could prescribe for repeat prescriptions?

Director of Mental Health, Social Care, and Community Services:
We advertised and recruited to a specialist mental health pharmacist who is a prescriber. It took us the best part of a year and a half from advertising the post to get someone into that post. We have a second mental health pharmacist post that is unfilled that we have covered by locums over a period of time. This is an area where specialist mental health prescribing pharmacists are like hen's teeth. They are very rare. Kevin may wish to elaborate.

Acting Director of Pharmacy Services, Jersey General Hospital:
Well, only just to confirm, yes, it is extremely difficult to get locums with the kind of skills that you want to take on those roles.

[15:30]

Deputy P.M. Bailhache:
Has any thought been given to having nurse prescribers to help alleviate the pressure?

Director of Mental Health, Social Care, and Community Services:
Certainly has. So we have tried on a couple of occasions with agencies to obtain a nurse prescriber to come and prescribe. Again, nurses cannot just prescribe anything. Prescribing in this area is a specialist skill. You have to prescribe within your scope of knowledge and practice, so you need a nurse who has a good understanding of A.D.H.D. and treatment of A.D.H.D. They are quite rare. But then on top of that, the job, the feedback that we have had when we have spoken to people is the job is not particularly attractive. If a qualified nurse has spent their time specialising in an area and training to be a prescriber, to ask them to come and write 300 prescriptions a month is probably not something that they are going to be jumping at. So we have never had anyone take up that opportunity when we have offered it. We have been talking more recently about, if we put an additional post into this service, whether, if we could not get a nurse prescriber, for example, but we could get a nurse, we could train them to prescribe. So it may be an area where we need to grow people's skill set.

Deputy L.M.C. Doublet:
What do you need to do that though, in terms of resources, what needs to happen?

Director of Mental Health, Social Care, and Community Services:
So that is back to the budget setting. We need to make a decision about if we are going to fund an additional post here, does that post come from somewhere else. It is not unusual for us to support people to undertake prescribing training here. We have got a couple of folk that have done that and we have got someone else who has just started that. So that is eminently doable if you can get a nurse that wants to come and do it.

Deputy P.M. Bailhache:
Minister, we understand that there have been some discussions recently, with the Minister for Social Security in relation to a shared care pathway with the general practitioners, and I wonder if you could give us any information about how that is going?

The Minister for Health and Social Services:

I read the transcript of the scrutiny session with the Minister for Social Security with interest. She is quite correct, there are ongoing discussions about that and I think the hope is that agreement can eventually be reached and that issue can be resolved. I think that it is fair to say that would make a significant difference, would it not? What I am contemplating is seeing if some sort of political intervention into that process may help. As I say, I do not want to clear the pitch either, but I think that we have to make every effort to try to see if that can be progressed. Because, as I see it, as a layperson, that is one area that I think could prove very beneficial if we can get that resolved. I do not know if you want to make further comment on that, Andy, as to the appropriateness of that, or the effect that it might have.

Director of Mental Health, Social Care, and Community Services:

I think that is absolutely right. It is a system that works well elsewhere and it alleviates pressure, the prescribing pressure particularly, on the specialists. Shared care is always initiated in secondary care, so it always starts with the specialists, you hand over at the point at which the person is adequately settled for the G.P. to take on prescribing. But of course G.P.s have to be able to get specialist advice when they need it under those circumstances. G.P.s are not specialists in A.D.H.D., so you do not want the G.P. to be left feeling: "I am prescribing something that I do not feel confident in and I cannot get special advice." So the key to the shared care protocols is making sure that specialist advice is available when it is needed.

Deputy J. Renouf:

I just think for the members of the public it would be useful to know what schedule you are working to, to develop these shared pathways. When might that bear fruit?

The Minister for Health and Social Services:

I do not know if you want to comment on that. It is fair to say there is not a set timetable, we just need to work through those issues and the issues that ...

Deputy L.M.C. Doublet:

When would you like to see that resolved?

Director of Mental Health, Social Care, and Community Services:

As soon as possible. Yes, there is 2. There are 2 outstanding issues. So the first issue is that we need to agree the protocol with primary care. We have been working on that jointly with C.A.M.H.S., so that is a tripartite arrangement essentially. Then it needs to be agreed that A.D.H.D. medicines can be prescribed from the H.I.F., so can be prescribed in primary care. That has been agreed by the group that support that, notionally it has been agreed. But there were 2 conditions, one was that

the G.P.s needed to be happy with the shared care arrangement, and secondly this issue of the drug availability. So, no one wants to sign up to a shared care arrangement and make prescribing potentially more complicated on the Island at the point at which there is a limitation in the amount of drugs that are available. But, once that settles, I am hoping that we will be in a position where we can move forward. I do not think every G.P. practice is keen to do it, I think we have had that feedback really clearly. But we have also heard really clearly from some G.P. practices that they are really keen to do it and would be happy to take that on. So, yes, as soon as possible.

Deputy L.M.C. Doublet:

What were the reasons of the G.P.s that did not want to do it? What were their reasons?

Director of Mental Health, Social Care, and Community Services:

So I think some of that was about being concerned about we are not specialists in this area and we are being asked to take on prescribing of specialist drugs, controlled drugs. But the answer to that I think, where it works well elsewhere, is making sure that people have access to the specialist advice when they need it.

Deputy P.M. Bailhache:

Presumably not every G.P. will be obliged to take part in this process.

Director of Mental Health, Social Care, and Community Services:

We cannot oblige G.P.s to prescribe anything. You cannot oblige a prescriber to prescribe something that they do not feel competent to prescribe.

Deputy P.M. Bailhache:

But I mean, apart from that sort of general problem of finding individuals who are prepared to get involved in the shared pathway, are there any other substantive issues which stand in the way of reaching an agreement?

Director of Mental Health, Social Care, and Community Services:

I do not think so. There is a concern that because people then will have to pay to see their G.P. in order to get their prescription, some people have expressed a concern about that. But that is our health system, is it not, that is the system that we work in. So I have certainly, from conversations that I have had with individuals, lots of individuals would be very happy as patients to be looked after under a shared care arrangement, it will be more convenient for them, certainly, and particularly in terms of where they pick up their medicines. We hear often from people that they experience having to come to the hospital and to go to the hospital pharmacy to pick up their medicines to be a bit tricky. So if you can go to the chemist at the end of your road and do it ...

Deputy P.M. Bailhache:
It sounds as if you are pretty close to agreement.

Director of Mental Health, Social Care, and Community Services:
I hope so. I really hope so.

Deputy P.M. Bailhache:
Because this is one of the things that stands in the way of changing the arrangements for the H.I.F.

Director of Mental Health, Social Care, and Community Services:
It alleviates the pressure on the prescribing psychiatrist. To have a consultant psychiatrist who is highly specialised spending a large amount of his time just repeatedly prescribing for people is not efficient best use of his skill.

Deputy L.M.C. Doublet:
Could I quote from the letter, your response to us, Minister, that the draft shared care protocols have been developed and the Pharmaceutical Benefit Advisory Committee have met to consider the inclusion of A.D.H.D. medication on the prescribed list. However, while they were supportive of this in principle, they were unable to recommend this until the international shortages of these medicines is resolved. So that is one other issue, is it not? Secondly, agreement has been reached on the shared care protocols or A.D.H.D. pathway. Could you initially give some more detail about the shared care protocols, whose responsibility is it to finalise those so that an agreement can be reached?

Director of Mental Health, Social Care, and Community Services:
It is a joint piece of work between H.C.S. and currently the primary care board. So we met 2 weeks ago and we are having exactly this conversation about how do we know . But also, because it is a tripartite arrangement, C.A.M.H.S. are also involved in that.

Deputy L.M.C. Doublet:
Right, those are the talks that you mentioned. Okay.

Director of Mental Health, Social Care, and Community Services:
Absolutely, and it is and it is drafted. So the A.D.H.D. consultant and the child and adolescent consultant have driven the work. They have produced the protocols and they have been seen by primary care. They have been part of an ongoing discussion and I do not think there is much debate left in terms of the protocols, frankly. I think that the real issue now is the availability of the medicines.

Deputy L.M.C. Doublet:

Okay, that is good news.

Deputy P.M. Bailhache:

There is no evidence at the moment of this shortage of drugs leading to any kind of black market emerging in the island?

The Minister for Health and Social Services:

I do not want to speak out of turn, but is there not recent evidence that the drug shortage may be alleviating to an extent?

Deputy L.M.C. Doublet:

The Minister for Social Security did inform us that it was an improving situation and indeed Mr. McManus, who was present ...

The Minister for Health and Social Services:

I am reluctant to make the point, but I think it has to be accepted that slowly but surely that does seem to be ...

Director of Mental Health, Social Care, and Community Services:

Can you give us more ...

The Minister for Health and Social Services:

Yes, sorry. I hope that is not out of order, but I just think, if we need to be up to date with things, we need to be clear about what is happening.

Acting Director of Pharmacy Services, Jersey General Hospital:

So, for a number of the drugs that are used for A.D.H.D., the situation has improved to the point where people can now start initiating new patients on them. But there is still a range of products where that is not the case, where the shortage is so severe that we are struggling to maintain the treatment of people who are already prescribed those medications. But it is definitely improving and it is very difficult to put a timescale on it because, when the issue first arose last year, it was expected to be resolved within a couple of months at that point, and it has continually been pushed back. So, at the moment, we are not absolutely certain.

Deputy P.M. Bailhache:

What in practice happens if a particular patient is on particular medication which is in short supply and cannot be found? I mean, do they simply have to go without it?

Acting Director of Pharmacy Services, Jersey General Hospital:
We have not had that situation in Jersey so far. I know it has happened in other jurisdictions, but we have been able to utilise other products with the same characteristics to treat those patients by working with the prescribers to make sure that they are prescribing things that we can obtain.

Deputy L.M.C. Doublet:
Some of our submissions have mentioned that even the substitutes though, like changing to the slightly different drugs, has caused them some severe difficulties. So is that fair to say that that is something that is a problem still?

Acting Director of Pharmacy Services, Jersey General Hospital:
I am sorry, I do not have the detail of what you are talking about, but it is certainly possible that, even where the medication is otherwise identical, but is a different brand, that some people will not necessarily respond to it in the same way as they responded to the original brand. It is unusual, but it is not unheard of.

Deputy L.M.C. Doublet:
Okay. So, in terms of the shortages, from the hearing that we had with the Minister for Social Security, we were informed that there was a website that informs practitioners about the availability of certain drugs and that it is updated every week. Is that something that you are aware of and checking?

Acting Director of Pharmacy Services, Jersey General Hospital:
Yes. So that is something we use on a regular basis. The data behind it comes from the Department of Health and Social Care in the U.K., so it is the most up-to-date data they have got. It does not always reflect exactly what is available on the ground, and sometimes events overtake it very rapidly. But it is a very useful resource and it is something that we use and we refer to continually.

Deputy L.M.C. Doublet:
Do you have any other sources of information to tell you what the long-term outlook is for these medications?

Acting Director of Pharmacy Services, Jersey General Hospital:
Not really at the moment. So I mean obviously, because it is a global issue, it is not even just a U.K. issue, it is dependent on decisions made by manufacturers, in some cases by the Drug Enforcement

Agency in the U.S.A. (United States of America) sometimes. So at the moment it is very difficult to predict and clearly it has been difficult to predict just from what we know of the timelines that have been suggested and then passed.

Deputy L.M.C. Doublet:
In terms of the root causes, is it just that the demand has got so big that production cannot keep up?

Acting Director of Pharmacy Services, Jersey General Hospital:
That is a major part of it. Yes, that is a major part of it, yes. It is also affected by some odd things, like, as I said, the Drug Enforcement Agency in America restricts the supply to manufacturers of certain raw materials and so that can have an impact on what they can produce. It also, in the U.S.A., they restrict supplies to community pharmacies there, which perhaps has an impact then on the way that people access the medication by using online services, which have a more global impact.

Deputy L.M.C. Doublet:
Is there anything among those factors or any other factors that our Government can influence that supply issue?

Acting Director of Pharmacy Services, Jersey General Hospital:
Not that I am aware of. I guess it is possible that you could talk to the U.S. Government about what they are doing with the ...

Deputy P.M. Bailhache:
Do you realise we are very, very small?

Deputy L.M.C. Doublet:
No, I was asking for a wildcard idea, there we go, got one. That is what scrutiny is all about. I am sure the Minister will consider that. Thank you. In terms of medication, so we have talked about the waiting list for assessments and we have been informed by some of the submissions that there is another waiting list after a person receives a diagnosis, there is another waiting list to receive medication. Is that the case?

Director of Mental Health, Social Care, and Community Services:
I do not understand that. I think that (a) it might be this very small group of people that we cannot prescribe for who are now waiting for the drug that they require to be available, I think. Certainly one of the things that has been most challenging is when people go and receive their diagnosis privately elsewhere, we still require them to have an assessment here.

[15:45]

So people do not just automatically pitch up with their A.D.H.D. diagnosis and we will prescribe for them. The psychiatrist that leads the service is very keen that he assesses and understands who he is prescribing for, given the nature of the medicines particularly. So I wonder if it is that. I wonder if people's experience is that they have had an assessment, perhaps not with us, but are now having to wait in order to be seen again in order to be prescribed for.

Deputy L.M.C. Doublet:
I wonder if it is people waiting for medication that there is a shortage of.

Director of Mental Health, Social Care, and Community Services:
Potentially. I mean we have not had that here. We have managed really successfully with pharmacy to pretty much continue to treat almost everybody. There is a tiny handful of people who, just by nature of the fact that they require a specific medicine and we cannot get it. But the indication is that we have 326 people on the caseload and we are treating 300 of them. So a small number of those are not yet ready to be treated. We have not made that decision. For the other whatever it is, and I think the last time we looked it was about 10, we just could not treat.

Deputy J. Renouf:
It is just a question in terms of the maths of this. If you are currently treating 300, you have got 800, nearly 900 on the waiting list, what are the cost implications in terms of the drug supply for that? You are going to be well over trebling the number of prescriptions for what are relatively expensive drugs.

Deputy L.M.C. Doublet:
I think the estimate was £800,000.

Director of Mental Health, Social Care, and Community Services:
So there was an estimate, given what the cost to the H.I.F. would be, for the people that we are already prescribing for, the cost is coming from the hospital pharmacy, so the cost is already in our runway, it is there. Of course, you are absolutely right, if by magic next week we could assess everyone and everyone requires treatment that is currently on the waiting list, then the number of people that are being treated would treble almost.

Deputy L.M.C. Doublet:
Do you have an idea of what the costs are?

Director of Mental Health, Social Care, and Community Services:
I do not know what the average cost of an A.D.H.D. medicine is.

Acting Director of Pharmacy Services, Jersey General Hospital:
It does vary a lot. I think of the people we are currently treating within the hospital, we are spending roughly £250,000 a year. But obviously that is at the hospital prices. It would be more if it was being dispensed through community pharmacies.

Deputy J. Renouf:
As Deputy Doublet says, the Minister for Social Security said it would be an £800,000 hit on H.I.F (Health Insurance Fund) were they all to go through the shared pathway. But there would also be ones who would not necessarily be going through that pathway. So that is why I am trying to get a global picture of the total cost.

Director of Mental Health, Social Care, and Community Services:
That seems to work, does it not, if you are saying £250,000 a year for 300 people approximately, yes, okay.

Deputy L.M.C. Doublet:
That is fine. In terms of the waiting list and people waiting for assessment, what kind of communication is there with those people who are waiting for assessment, diagnosis, and treatment?

Director of Mental Health, Social Care, and Community Services:
So people are written to periodically and I think this is one of the things that we absolutely have not got right so far. I think it is been quite erratic. So I think some people have been written to more frequently, some people have not been written to at all. But people are ...

Deputy L.M.C. Doublet:
What is the reason for that?

Director of Mental Health, Social Care, and Community Services:
It has just been due to the workload on the service, I think. So I think one of the things that we need to do is put a system in place where we are more routinely advising people where they are in terms of waiting, and I think one of the things that you suggested the other day was publishing waiting times. I think we kind of do that because we seem to be very regularly having to state publicly what

the waiting times are and the waiting lists are. But we could proactively do that and make sure that people do understand what the current waiting time is.

Deputy L.M.C. Doublet:
Yes. So we did ask the Minister for Social Security to have a conversation --

Deputy L.M.C. Doublet:
Yes. We did ask the Minister for Social Security to have a conversation with yourself, Minister, about a centralised information source on the Government website that where people could find out what the waiting times are, what the processes and pathways are and what the different implications are for if they either wait to use your health service or if they go private and what the costs are. Because we have become aware that many individuals are not aware that even if they go and get a private assessment and then receive a diagnosis they cannot just receive their prescriptions for free then in the health service. In terms of those costs or the costs for the assessment and then the cost for their medication, if you are looking at different practitioners, which some of the questions focused on before, nurse prescribers, could separating those functions out and allowing people to perhaps pay for a private assessment but then come in to see a separate practitioner without taking the time away from your consultant, is that a possible solution to that?

Director of Mental Health and Adult Social Care:
The problem with that is that people are then being asked to prescribe against an assessment and diagnosis that they have had no role in and that is slightly unusual.

Deputy L.M.C. Doublet:
Would that not be the case if it was a nurse prescriber?

Director of Mental Health and Adult Social Care:
Still the nurses prescribing, they are legally responsible for what they are prescribing and they have to be satisfied that they are prescribing the right drug to the right person for the right reason. One of the conversations that we have had a lot during the last year when we have been thinking about this service is whether we do or do not go to external providers to do assessments and there are such mixed views about that. You will know because it has been very public, there has been some scandals in England particularly around A.D.H.D. diagnoses where people have pitched up and been given a diagnosis within 15 minutes, for example. There were television programmes about it, so I think that has been unhelpful. We have to find a place where we're confident that the person that is making the diagnosis is robust, that it is a diagnosis that the prescribers are willing to accept and are willing to prescribe against. It is not something that we have entirely said we would not ever do but we have not got there yet. The other balancing issue in this is let us imagine by magic we

could have 800 assessments done tomorrow. We are not thinking I have the capacity to do the prescribing, so all we are going to do is move the problem from here to here. Ideally, we need to find a solution where we are able to get both capacity in terms of assessment and capacity in terms of prescribing. Those 2 things must go hand in hand because otherwise we will simply have a group of people that we have approved their diagnosis for but we are not able to treat and that would be even worse.

Deputy L.M.C. Doublet:

Minister, given that there are some private practitioners offering services on Island and many of our submissions have described how they are stretching themselves financially and further stretching themselves accessing the medication because of course there is a cost to those appointments as well and some people in really kind of crisis situations, would you consider using your ministerial discretion to provide subsidies to bring in some of the private services to ease that burden?

The Minister for Health and Social Services:

I think there is a grave danger of setting a precedent there that you would not be able to keep up with, to be honest with you. What I am really hoping is that we can reach a successful agreement on the shared-care arrangements and that that can start to ease the situation. I think that would probably be a preferable route to pursue. I do not know if you want to comment on that, Andy, as being a suitable preference.

Director of Mental Health and Adult Social Care:

I think that is right. We have never entirely excluded the use of private provision but it needs to be a provision that is sustainable. What we do not want to do is diagnose a load of people and not be able to treat them because the private provider walks away and that is able to get that balance for us between assessment, diagnosis and prescribing. We have been having a conversation with a private provider who, potentially, could come and do some of that work here, both assessment and then prescribing, which would be ideal frankly. But it leads us right back to the question of budget-setting for next year. What would be the best addition to put into this service to help us meet demand?

Deputy P.M. Bailhache:

Can I just follow up the Chair's question on this waiting list? Can I understand a little bit more about the practicalities involved? How do you get on to the waiting list? Do you fill in a form of some kind?

Director of Mental Health and Adult Social Care:

It is a referral, so on the whole we get referrals from primary care, from G.P.s or from other health services. But people can also self-refer into mental health services. You would then be asked to

provide some basic information as to why you believe that you have A.D.H.D. and why you feel that you need an assessment from this service; that is then screened. The team look at the initial referral, often we have to go back even to primary care to say: "Can you send us some more information, please, because we are not sure that this is the right place for the referral to come to?" Then once there is enough information received by the service to say, yes, this person needs an assessment for A.D.H.D., they go on to a waiting list. As I said earlier, what we are now doing, which is a new addition to that process, is we are also sending people a screening tool and asking them to fill that in. That gives us a much better idea about what people's needs are and what the issues are before they get seen by us.

Deputy P.M. Bailhache:
When the screening process has taken place the person is put on the waiting list.

Director of Mental Health and Adult Social Care:
That is right.

Deputy P.M. Bailhache:
Are they put on a number 456 or can they go in at 200 if they are ...

Director of Mental Health and Adult Social Care:
Pretty much up until now it is just done chronologically. You are put on the waiting list in the order in which you are referred.

Deputy P.M. Bailhache:
You are going to be put at the bottom of the list.

Director of Mental Health and Adult Social Care:
Absolutely. However, as I said earlier, one of the things that we are talking about is, should we not manage that waiting list based on need?

Deputy P.M. Bailhache:
It sounds as if you have got some kind of information which would enable you to prioritise some ...

Director of Mental Health and Adult Social Care:
Totally, totally that. Of course that has a downside for some people. Some people will hear that and will then worry and think, goodness, I have been waiting for 2 years and now there is a risk that I am not going to be seen as a priority and I am going to keep getting knocked down the list. That is the dilemma of managing based upon need in that way. It is a very fair way up until now in terms

of you get seen in the order in which you are referred but it is not necessarily clinically the most sensible way of managing the list.

Deputy P.M. Bailhache:
I suppose you could have a rule that people could not be on the list for longer than a specific period of time, so that if they were continually knocked back eventually they would ...

Director of Mental Health and Adult Social Care:
That is when it all starts to get a bit challenging, is it? Yes.

Deputy L.M.C. Doublet:
It is probably very difficult to actually triage that, is it not, without spending a lot more time contacting people?

Director of Mental Health and Adult Social Care:
It is one of the reasons that we are really clear that if people have other presentations or are in crisis, that they must access those other services because this is not a crisis service. This is not a service that is going to respond to immediate need by any stretch of the imagination. If it was fully resourced it is not a service that is going to respond to immediate need; that is not what it is there for. This is a diagnostic and treatment service that is specific ...

Deputy L.M.C. Doublet:
Sure, yes. Could I pick up on something, Minister, that was in your letter of 3rd September where you wrote to the panel: "Planned implementation of A.D.H.D. training for staff across mental health services to support with initial mental health screening and, potentially, reduce unnecessary referral for A.D.H.D. assessment."? Could you outline what you mean by an unnecessary referral?

The Minister for Health and Social Services:
Once again it is a more specialist matter and ...

Deputy L.M.C. Doublet:
Yes.

Director of Mental Health and Adult Social Care:
This is when someone is referred. Occasionally we get quite blanket referrals in mental health services, so people are referred to a number of services. One of the things that you need to do early doors is work out which is the right service to see someone, particularly when there is such a long waiting list for some services. There are occasions when people are referred and the right thing to

do first is not to refer to the A.D.H.D. service. You might want someone seen by the Community Mental Health Team, for example, for a routine mental health assessment because there are other things going on. It is not clear that it is A.D.H.D. or there are other priority issues that you want to attend to. Occasionally we get referrals that are rejected, so people refer in and we say: "No, this is not an appropriate referral here." Ideally, particularly because there can be a relationship between A.D.H.D. and other mental health presentations, we want to make sure that generically mental health staff have a good understanding of A.D.H.D. and are able to pick up, when is the right time to do something else, as opposed to just make a referral to the A.D.H.D. service?

Deputy L.M.C. Doublet:
Do you suspect that some of the people who are on the waiting list may have different conditions that are not A.D.H.D.?

Director of Mental Health and Adult Social Care:
They may. The work that is being done on the waiting list today has not pulled out lots of people, based on the information that is available. But of course that may happen and that would be awful for someone to wait on a waiting list for a long time only for them to pitch up and us to say: "No, sorry, wrong service, you need to go somewhere else."

Deputy L.M.C. Doublet:
Sure, okay, thank you. You also mentioned in your letter, Minister, that: "There was a planned implementation of a programme of psychological support and interventions for people on the waiting list that would be in place by the end of November." How is this progressing, please?

Director of Mental Health and Adult Social Care:
We are due to run the first of the groups in the first week of November. This is a response to feedback that we have had from people who use the service and people that are waiting. The focus is primarily always on medication. There are lots of other things that we can be doing to help people with A.D.H.D. There are lots of things that we could be doing to help people with A.D.H.D. while they are on the waiting list and some of that is about psychological management of the condition. We have developed through our psychological service and mental health services a Living with Neurodiversity group and that group is going to be up and running from November. We are hoping to run it twice a month. Clearly, we are not going to get everybody seen quickly but I am hoping that this will be an intervention that will help signpost people to other places but also provide people with some skills and support while they are waiting to be seen.

Deputy L.M.C. Doublet:
What format does that group take?

[16:00]

Director of Mental Health and Adult Social Care:
It is a group of between 10 and 12 people. It is led by an Assistant Psychologist who is supervised. It is a closed group, so it is a group that people will come to. I think it is 2 sessions I think but it may be 3. People are given information but also have the opportunity to talk about their own experiences, how that relates to them and given some tools around managing some of the presentation.

Deputy L.M.C. Doublet:
So, 10 to 12 people per group for one to 2 sessions, did you say?

Director of Mental Health and Adult Social Care:
I think it is 2 sessions.

Deputy L.M.C. Doublet:
2 sessions.

Director of Mental Health and Adult Social Care:
I think it is 2 sessions per person. I could check that for you but I think it is.

Deputy L.M.C. Doublet:
Okay.

Director of Mental Health and Adult Social Care:
We are hoping to run it twice a month.

Deputy L.M.C. Doublet:
Okay. It will be quite a while before everybody on the waiting list can access it. Is there potential for you to expand the staffing of that to enable more people to access it?

Director of Mental Health and Adult Social Care:
It is not really a staffing issue. We are running a number of psychological groups in this way that are new and this is one of a package. But, potentially, we will have a look at what the uptake is like and we might have to team local our resource but it may be that there is some stuff that we do more of and some stuff that we do less of. Yes, we will see how we go.

Deputy L.M.C. Doublet:

Okay, thank you. We spoke about social prescribing quite a bit in the previous hearing with the Minister for Social Security, so this leads nicely into that. We are aware that there is a scheme that Government have launched. It is something that those who have made submissions to us and also people who have come in and spoken to us about their experiences, have spoken quite passionately about having alternative options, for alternatives to medication in terms of treating their A.D.H.D. What kind of relationship do you have with charities? Are there any funded charities or commissioned services that are providing things like this outside of the health service?

The Minister for Health and Social Services:

Once again, a lot of these are very specialist questions. I hope you do not mind I am much safer having somebody who knows the detail a bit to respond properly.

Director of Mental Health and Adult Social Care:

We are clearly really tied into the social prescribing projects; that is across a whole raft of our services, including this one. That is something that we are actively supporting and involved in. The steering group that is developing the strategy has charity representation on it. One of the things that I have no doubt the strategy will do will be indicating where there are more things that can be done but do not need to be done by H.C.S., can be done by other partners. I anticipate that is something that will fall out of the strategy.

Deputy L.M.C. Doublet:

Will the strategy recommend a result in additional funding for those kind of services? I think, Minister, that is a question for you. Are you prepared to commit to additional funding if the strategy indicates it?

The Minister for Health and Social Services:

No, I cannot because we have got a number of strategies, many of which will indicate things that we would like to do that we cannot afford. As you probably know, since I have been in office we have made a commitment to producing strategies with action lists, cost of action lists, which show where we would like to be in an ideal world and what we can afford to do with the funds that are available to us. At this point in time it is very, very difficult to make extra commitments to anything.

Deputy L.M.C. Doublet:

It is something that you would consider and that you consider a priority.

The Minister for Health and Social Services:

There are a lot of things that are a priority and, as I have said, it is a major priority because just by virtue of the fact that we have got a very long waiting list. As I say, there are a number of things that

we are hoping to bring into play that can change that but I think we can have a reasonably substantial problem for a fairly long period of time.

Deputy L.M.C. Doublet:
Are there any waiting lists longer than this one, the longest waiting list?

Director of Mental Health and Adult Social Care:
No, this is the longest one, certainly in mental health and social care services this is the longest waiting list.

Deputy L.M.C. Doublet:
Okay. Did you want to ask anything?

Deputy J. Renouf:
Yes. It is a point that came up from one of the contributors to us. They made the point - and you have brought this out very clearly in your answers - there are many different things available to people. There is many different specialist services. There is many different pathways. There is many different resources. Some of them may be directly A.D.H.D., some of them may be from other things. Is there a case for a one-stop shop where people could come to a single point and access the information they need, not necessarily the services because obviously the services may be dispersed for various reasons? But certainly somewhere where the people could come and just find out the latest information.

Deputy L.M.C. Doublet:
This is something that was raised by one of the stakeholders and it has occurred across the submissions as a potential solution that would be very popular.

The Minister for Health and Social Services:
I am making a political statement and saying that in an ideal world that would be fantastic but then I have got to hand that back to the people that have got the difficult job of organising that and funding it.

Director of Mental Health and Adult Social Care:
I think this has got to be one of the things that the neurodiversity strategy looks at. I think we have done a piece but we had a waiting list concern around autism 18 months ago. We have done a piece of work with Autism Jersey in the interim period where we have commissioned - and it is small beer - a support service for people who were waiting to be seen and people who were newly diagnosed. There is also Graham, he has done a really good piece of work and we are maintaining

that. That is because, exactly as you describe, people have been able to go to a place and say: "These are the problems that I am facing, where do I go?" There is a load of stuff around but often people do not know, they do not know how to access it and sometimes things come and go, do they not, as well, so that is problematic? But I think the idea of having a place that someone can go to and say: "What is available to me and how do I get to it?" It makes eminent sense really.

Deputy L.M.C. Doublet:

Can I expand on that and go back to the shared care discussion? One of the other suggestions that we had from a stakeholder, at least one stakeholder, was to have a G.P. clinic or similar whereby those G.P.s who did feel that they were confident in managing this condition and prescribing, could perhaps have a central clinic where the services would be available. Is that something that is being explored?

Director of Mental Health and Adult Social Care:

One of the other things that we have been talking about recently with primary care is G.P.s undertaking special interest sessions in some of our services and this is one of them. If we have a G.P. who is particularly interested in this area and wants to develop some expertise, receive supervision from the specialist but also increase capacity and help with the service, that would make really good sense. Only last week, I think, we were talking with the primary care leads about we want to do that in some of our other services. The Alcohol and Drug Service, for example, we have had a really good history of having a G.P. working in there for a couple of sessions and not just prescribing for people with alcohol and drug-related issues but prescribing physical health checks, all of that, that kind of stuff. We would like to replicate that across a few of our services, this is one of them. If we had a G.P. that came forward and said: "I would really like to spend some time in the A.D.H.D. service and run a joint model", of course that would be superb.

Deputy L.M.C. Doublet:

What would that look like to the patients? What would the costs be? Would it be the same as a G.P. consultation?

Director of Mental Health and Adult Social Care:

That is the thing we would have to work out. In the past where we have used G.P. sessions in some of our services, that has been an H.C.S. service, so it just happens to be a G.P. that is receiving it. I guess one of the things that we are really keen to do is to make it as simple and as seamless for people that use the services. We do not want people to have to pick, I do not want to go there because I would have to pay that there; we want to make it as easy as we can.

Deputy L.M.C. Doublet:

The Health Department pay the G.P. for their time.

Director of Mental Health and Adult Social Care:
Yes, that is exactly right, yes.

Deputy L.M.C. Doublet:
Okay, so that is a model that is being considered and you think could work.

Director of Mental Health and Adult Social Care:
Yes, yes.

Deputy L.M.C. Doublet:
That sounds promising.

Director of Mental Health and Adult Social Care:
If we had a G.P. that came forward I would have that conversation urgently.

Deputy L.M.C. Doublet:
Minister, you mentioned that you were considering some political intervention and I am supposing that would take the form of discussion with the G.P.s. Could you take this idea to the ...

The Minister for Health and Social Services:
I am very happy to take anything away. We are very keen to resolve all of these problems. As you know, behind the scenes is a little bit more complicated than the front scene. I would hope that anybody that is listening and does not think I am reluctant to support sorting this out, it is just that it is very difficult to make public commitments to things without first discussing some of these things behind the scenes as to what they are going to cost and what we have got available in terms of human resources to work out a timeline to implement it. As I say, a lot of people under a lot of pressure in this area and very happy to go away from this, have a discussion about it and come back to you again with ...

Deputy L.M.C. Doublet:
That is a commitment itself, is it not?

The Minister for Health and Social Services:
I am very, very committed to trying to do that. Just in case everybody thinks I am reluctant or think that none of us are bothered about it, it is just difficult to make public commitments. It is easy and I do not want these 2 guys cringing thinking, what has he committed to now, knowing that their

workload will not allow them to do it for a couple of months? That is the slight reluctance on my part, knowing the pressures that these people are under.

Deputy L.M.C. Doublet:
Sure. We would be really grateful if you could update us on your conversations with the G.P.s and keep us informed.

The Minister for Health and Social Services:
Very, very happy to do that. I intend to meet the Minister for Social Security as soon as we can get a date in the diary and see what I can try and do to ...

Deputy L.M.C. Doublet:
Great. When do you think that would be that you would meet the Minister?

The Minister for Health and Social Services:
We have got the States sitting next week and a number of other things but as soon as we can, as soon as we have got some sensible time and to get the right people in with us.

Deputy L.M.C. Doublet:
Okay, so within the next 2 to 3 weeks you would say.

The Minister for Health and Social Services:
Yes, absolutely, yes, yes.

Deputy L.M.C. Doublet:
Great, thank you.

Deputy J. Renouf:
There has been an issue raised with us about the Hospital Pharmacy, both in terms of its opening hours and in terms of the environment before with these kind of neurodiverse conditions. There is a stress in terms of having to get there via a particular window, people who may not live and work in town. There is also a stress around the fact that the environment itself is not necessarily conducive to people with that kind of condition. Have you reflected on this at all and is it a problem you recognise?

Acting Director of Pharmacy Services, Jersey General Hospital:
There are 2 things there, are there not?

Deputy J. Renouf:

There are.

Acting Director of Pharmacy Services, Jersey General Hospital:

In terms of the opening hours, certainly we have looked at what is possible in the current circumstances. To progress that really we need to change the way the contracts work for people who work within the Pharmacy Department. That is not a short-term thing to do, that would take a significant amount of time and energy to progress that so we can start the conversations. That is not something that is going to happen in the near future. The other issue about the environment for the pharmacy, I agree, it is an old building; it is not an ideal circumstance for people who arrive at the pharmacy. What we have done is worked really hard to make sure that we manage the queues that were in the pharmacy. Certainly when I started there were sometimes 20, 30 people in the ...

Deputy L.M.C. Doublet:

We have had some positive feedback that that is for ...

Acting Director of Pharmacy Services, Jersey General Hospital:

I think that clearly is an improvement for people because they are not having the frustration of waiting in a queue of other people. I am not saying that it is always a short queue because Friday afternoons it can be still a long queue. But it has certainly improved and we have had some positive comments this week about the experience of going to the pharmacy. Obviously it assists the staff who work there as well because it is a pressure for them seeing this queue of people they know want to be served. The way that we had been working and that they were not being seen and maybe people get frustrated and sometimes expressing that frustration in unpleasant ways. We have certainly improved that and that environment has helped. There may be other things that we can do around the ...

Deputy J. Renouf:

With reference to the poor lighting, the lack of seating, loud Tannoy announcements, I am sure you have looked at this but is there no way that you could create a space that is sort of separate for people queuing for this sort of thing?

Acting Director of Pharmacy Services, Jersey General Hospital:

Not within the current structure of the Hospital Department there. Obviously when we are thinking about the new hospital plans then that is something that should be part of that planning. But where it is currently at the moment and I am always open to ideas but we have not got a space that we could utilise in the way you have described.

Deputy L.M.C. Doublet:

I think it is positive that you are open to ideas, would you consider having some discussions with perhaps some of the stakeholders that have made representations to us if we could connect you with them? Because I think they probably would have some suggestions that may be easy to achieve and I understand you cannot move the pharmacy at the moment. But is that something you would consider doing?

Acting Director of Pharmacy Services, Jersey General Hospital:

Absolutely. We have utilised suggestions from people before, that have assisted us in making progress, from the experience people have had at the pharmacy, so, yes.

Deputy L.M.C. Doublet:

Okay, we will make that connection outside of the hearing. One of the submissions or stakeholders, I cannot remember which, told us about where there has been some improvement that they do not have to go in and necessarily queue but they get a phone call, is that right? But then sometimes that is becoming more of a problem that they have to make several phone calls. Is there some way that you are keeping these new systems under review to get that feedback and to reflect on how it is going so you can make further improvements?

Acting Director of Pharmacy Services, Jersey General Hospital:

The workload that comes through the Hospital Pharmacy Department is significant and the staffing has remained an issue for our capacity to do that. We are aware that it is not always the best experience in the sense that people have ... it is not always easy to get through on the telephone line. We have introduced an additional person taking calls, so obviously removes them from doing something else. But that has helped in terms of making sure we get the phones answered. But I am still aware that the phone is ringing absolutely constantly. Until we can remove some of the workload from the Hospital Pharmacy out into G.P. services, that is going to remain an issue, I suspect, because the Hospital Pharmacy does probably 10 per cent of all prescriptions on the Island, which is really unusual for a typical D.G.H. (District General Hospital) Hospital Pharmacy.

[16:15]

Deputy L.M.C. Doublet:

Yes. When you say move some of the workload, are you talking just A.D.H.D prescribing?

Acting Director of Pharmacy Services, Jersey General Hospital:

No, not just A.D.H.D. We do dispense quite a lot of repeat prescriptions, which normally in the U.K. ... and obviously it is a different system, I get it. But normally you would expect that to be something

that goes back to the G.P., the G.P. prescribes on it and it gets dispensed to the community pharmacies. That is where we would like to get to alleviate some of those pressures and make it a better experience for those people who do need to go to the Hospital Pharmacy and for the in-patients who ...

Deputy L.M.C. Doublet:

Yes. I understand that your staff must be under a lot of pressure and it sounds like they are working really hard to try and offer a really good service.

Acting Director of Pharmacy Services, Jersey General Hospital:

Yes, that is right, yes.

Deputy L.M.C. Doublet:

Are more members of staff needed in that area?

Acting Director of Pharmacy Services, Jersey General Hospital:

Ideally that would be the case but we have to be realistic about what is going to be affordable for that. One alternative is, as I say, to providing more staff is to reduce the workload. Ideally we do both but certainly within our current budget we are at the point where we have either agency staff or fully-established staff working in all the posts we would expect to have.

Deputy J. Renouf:

Can I clarify one thing? Are you fully staffed, in other words, are you carrying vacancies and when those vacancies would fill you might be more at capacity or are you at fully staffed?

Acting Director of Pharmacy Services, Jersey General Hospital:

If you take into account locums, then we are fully staffed, there is turnover, so there are vacancies ...

Deputy J. Renouf:

Roughly, give or take.

Acting Director of Pharmacy Services, Jersey General Hospital:

Yes, yes, that is right.

Deputy L.M.C. Doublet:

Sorry, I did not catch the answer, there are not any vacancies, is that right?

Acting Director of Pharmacy Services, Jersey General Hospital:
There are vacancies, yes.

Deputy L.M.C. Doublet:
How many are there?

Acting Director of Pharmacy Services, Jersey General Hospital:
We have a vacancy in a couple of our pharmacy technician posts, in particular because they are very difficult to get on Island.

Acting Director of Pharmacy Services, Jersey General Hospital:
2 pharmacy technicians.

Acting Director of Pharmacy Services, Jersey General Hospital:
Yes, there is 2 pharmacy technicians, one of whom will be working with our Aseptic Unit and one working on our procurement. We have got vacancies filled by agency staff and obviously that comes with the pharmacy, I will not include those because we understand that they are covered by agency ...

The Minister for Health and Social Services:
Yes, those 2 positions are always covered.

Acting Director of Pharmacy Services, Jersey General Hospital:
That is correct, yes. We are looking for agency staff to cover those in the short term and obviously a lot of substantive ...

Deputy L.M.C. Doublet:
Those 2 posts, Minister, are they subject to the recruitment freeze that is across Government with the vacant posts at the moment?

Acting Director of Pharmacy Services, Jersey General Hospital:
No, they have been approved, so we have been given approval to go in and recruit those.

Deputy L.M.C. Doublet:
That is good to hear, thank you. Okay. Do you want to follow up with anything else there?

Deputy J. Renouf:
I have a final question but it is my final question, so ...

Deputy L.M.C. Doublet:

It is your final, final one. It is not my final question I think.

Deputy J. Renouf:

No. Yes, I guess it has been very interesting to hear the work going on and there is clearly a lot of thought being given to this. If I summarise correctly, I think this is one for the Minister, you are pinning an awful lot of hope on the shared treatment pathways as the solution. Would you say that that is for you the kind of the golden key?

The Minister for Health and Social Services:

As I say, I am not a specialist in this area but it seems to me logically the easiest win to ease the pressure. As I say, I am happy to take comment from these gents who have a much clearer view of it. But on the face of it that would seem to me if those arrangements can be made that would ease the situation. But, like I say, I am only looking at this from almost the same perspective as you would for the evidence that is in front of me. I would be very happy to see if that view is shared by the 2 people that are more ...

Director of Mental Health and Adult Social Care:

By all means I have got one follow-up. It is going to be a significant improvement. Even with that the figures, the capacity and demand equation is really significantly challenging, is it not? I think that is the other reason why we need to think about, what else can we put into the service to help, acknowledging that that is competing with a whole range of other pressures where people will equally make compelling arguments about needing additional services, additional resources? That is routinely part of my job, that is budget-setting, that is what we do every year. It is obvious that even if everybody moved to shared care tomorrow and we would still be seeing those patients at least annually, we still need more capacity to catch up. We are not going to suddenly solve this waiting list problem just by shared care. But shared care would be extremely helpful in focusing the right resource in the right place.

The Minister for Health and Social Services:

What I hope comes out from this afternoon is you can see that there has been a very comprehensive approach to this and I cannot think of any stone that has been left unturned in terms of trying to resolve the issue. That has not come from me; that has come from ...

Deputy J. Renouf:

The Minister for Social Security made clear that there was a considerable cost implication for the H.I.F., £800,000 of the order of for the shared-care pathway. I guess is that the main barrier now,

given that the drug shortages seem to be alleviated and given that you are saying that the shared-care pathway is not too far off agreement? Is it money that would stand in the way?

The Minister for Health and Social Services:

That is not a barrier insofar as the Health Insurance Fund has got some money in and presumably some of the cost that is being borne by the State at the moment in the H.C.S. budget would transfer over to the H.I.F. Some of that is left pocket, right pocket but insofar as reducing the waiting list, as you reduce that waiting list then those are net additional costs. You rightfully make the point that the broader economy might benefit from that, to the tune of possibly more than the cost of the treatment. But that does not help us from a direct budgetary point of view and it all comes back down to, once again, looking at the overall cost of providing a health service and where we come to in increasing the number of services and the complexity of the services that are offered. We come back to this business that health inflation is running considerably higher than standard inflation. That conversation has to come back in whether we are going to accept that or not because I think it is a fact that it is inescapable to me. How are we going to deal with it? Because it is something we cannot turn our back on. There are some difficult conversations coming up and they have to be had.

Deputy J. Renouf:

Just a very practical thing, you have talked a lot about the need to budget and that is your job; you produce budgets. When will you have clarity on what money you are allocating to this?

Director of Mental Health and Adult Social Care:

We are working through budget-setting now in detail, so service by service, with the intention of having that completed by mid-November.

Deputy J. Renouf:

If we were to ask a question in the Assembly in November you would be able to tell us what had been allocated, whether all of these things had been ... what decisions had been taken basically, what was being funded and what was not out of that shopping list that we have been talking about.

Director of Mental Health and Adult Social Care:

The normal process is that we do that within services and then of course in H.C.S. we have to bring that together and look at the net position. Invariably people are wanting more than there is money and so we then go through a process of having to negotiate what it is that we are going to prioritise with the available resource.

Deputy L.M.C. Doublet:

This is the budget that we are about to debate.

Director of Mental Health and Adult Social Care:

Yes, for next year, yes.

Deputy L.M.C. Doublet:

Yes, okay. So you are still deciding where that money is going to go in your services.

Director of Mental Health and Adult Social Care:

Absolutely right, yes.

The Minister for Health and Social Services:

Got the timetable.

Director of Mental Health and Adult Social Care:

Yes. Certainly by the end of November you would anticipate that to be complete; that is the timetable that we are working on. It often takes a little bit longer than that, yes.

Deputy L.M.C. Doublet:

Sure, okay, thank you. Thank you for all the information that you have imparted to us today. I wanted to read a quote from one of the submissions that I found particularly striking and representative of some of the experiences of those who are going through this. It is from a member of the public who had accessed a private assessment and been diagnosed and was prescribed medication but then could no longer afford the ongoing costs, so had to stop taking that medication. This person said: "The drastic change when medicated was noticed by everyone in my life. It was like half of me had been asleep for my whole life and then to realise that finances meant I now was going to lose it again was devastating. Since diagnosis I have realised how A.D.H.D. touches every part of my life and how it truly is a disability. I cannot focus for more than 2 minutes on a task and no level of trying changes it. But on the medication I was able to focus as needed. It affects my sleeping habits, productivity, eating habits, social relationships, the state of my home, my ability to talk to others and I am constantly in a state of felling overwhelmed." Minister, just finally, are you able to give your response and your reaction to that and what would you say to members of the public that are going through those experiences?

The Minister for Health and Social Services:

I would say it is an extremely compelling statement. You cannot fail to but be moved by it. But the sad reality is we have gone through this afternoon over the course of the last hour and a half all of the many difficulties that we confront in trying to alleviate that situation. I think what you do see is a team of people who are very, very committed to doing exactly that. Can we go out from this? For

my own part I shall not intervene but play whatever part I can in trying to bring that forward. It is an unacceptable situation but it is a very real world situation and it is not exclusive to us, it has to be said. There is no excuse, I get that but there is no absolute quick fix, which is a great shame.

Deputy L.M.C. Doublet:
Thank you. We hear your commitment to resolving this issue and we would be very grateful for any updates on any of the issues that we have explored today.

The Minister for Health and Social Services:
Very happy to do that.

Deputy L.M.C. Doublet:
Is there anything final? Would you like any final questions there? Is there anything that you would like to add, Minister, or either of your officers?

The Minister for Health and Social Services:
No, I do not think so, it has been very comprehensive.

Director of Mental Health and Adult Social Care:
I do not think so. I think we have taken steps, we have made tweaks and we have done some work over the last year particularly. For example, we had really clear feedback from people about repeat prescriptions and that was a problematic process. Working jointly between the service and the pharmacy we have totally changed that. You asked a question earlier about, are we reviewing those processes? We absolutely are and we are making change in process. We keep coming and saying, is it working? How do we know whether it is working or not? But I think exactly there is a sense sometimes that we do not appreciate the significance on individuals of not having an assessment and not being treated and that is not true. There is absolutely no doubt, as you have alluded to earlier, the burden that that places on individuals but also on the health system, on the social care system, on the prison system, is really significant. This is a very significant international crisis; that is how it is described in literature, for example, by the Royal College of Psychiatrists. Really I just want people to know we are working as hard as we can to try and alleviate it.

Deputy L.M.C. Doublet:
Thank you very much for that.

Deputy J. Renouf:
Thank you.

The Minister for Health and Social Services:

Thank you very much. Thank you.

Deputy L.M.C. Doublet:

Thank you for your time today. I will close the hearing. Thanks, everyone.

[16:27]