STATES OF JERSEY

Health, Social Services and Housing
Coordination of Services for Vulnerable Children
Clarifications provided by the witnesses subsequent to the hearing are highlighted in blue

FRIDAY, 15th MAY 2009

Panel:
Senator A. Breckon (Chairman)
Deputy G.P. Southern of St. Helier
Deputy T.M. Pitman of St. Helier
Mr. S. Le Quesne (Scrutiny Officer)

Witnesses:
Ms. J. Gafoor (Lead, Child and Family Services, Family Nursing and Home Care)
Ms. J. Querns (Health Visitor)
Ms. B. Bell (Divisional Manager of Governance, Family Nursing and Home Care)

Senator A. Breckon (Chairman):
Okay. I will just give you the sort of process. We are recording this mostly for our own benefit really, it is just to get things on the record and then you will get a copy of this when it is transcribed and if you say 60 when it should be 16 or something like that, it is not an entrapment, it is just so that we know and then following at the end there will be an opportunity if you want to say anything to us that we might have missed or that we have not touched upon and it is ... although it is a formal process it is fairly informal in that sense and the reason that you are here is so that you can share your professional experience and the services that you provide with us so that we get it first-hand from you and not from somebody else. Okay, so my name is Alan Breckon and I am chairing this sub-panel which is looking at the coordination of services for vulnerable children and it is a very wide area and as we are looking at it it is getting wider, but we need to produce a report in the next sort of 3 weeks or so, so we are under some pressure to do that anyway. The Vice-Chairman is Deputy Trevor Pitman and another member is Deputy Geoff Southern and we have apologies from Deputy Roy Le Hérissier. Sam is our officer, he has probably been in touch with you by email and Linda is doing the recording in the corner there. For the benefit of the tape can I ask you to say who you are and just a little bit about the role of your job.

Ms. J. Gafoor (Lead, Child and Family Services, Family Nursing and Home Care):
My name is Julie Gafoor and I am the Lead for Child and Family Services at Family Nursing and Home Care.

Ms. J. Querns (Health Visitor):
My name is Jenny Querns and I am a health visitor working in the St. Helier area.

Ms. B. Bell (Divisional Manager of Governance, Family Nursing and Home Care):
I am Barbara Bell and I am the Divisional Manager for Governance at Family Nursing and Home Care

but I also have a more general role as Island designated or named nurse for child protection.

Senator A. Breckon:
Okay. All right, thanks for that. What we would like to do, we have a number of questions but as I say at the end there is an opportunity to tell us anything else that you may wish to, but when we ask the questions they are not aimed at anybody in particular so please feel free if you want to say anything or add something to what a colleague says, then do so. Can I start by asking if you can just give us the background really in reference to children and the services that are provided by Family Nursing and Home Care?

Ms. J. Gafoor:
Right. Well, what we have done is split the questions, so my job is to do the first bit, so really we looked at the terms of reference of the *Williamson Report* too and realised that Family Nursing really were not incorporated into the terms of reference and thought there was a huge gap, because there were services that we provide that no other service on Jersey provides, so without that information we just thought it would leave you not knowing certain things. So Family Nursing and Home Care provide specifically for vulnerable children. We have a health visiting service and school nursing service, so that provides universal services for children 0 to 18 and the health visiting service is a universal service that visits people in their home when they have a baby. We are one of the few people to be able to do that, to offer a universal service that is non-stigmatising, so we are not like a social worker or have a statutory duty. So we go in and see people after they have had their baby and we are one of the key agency that identifies vulnerable children, because other services do lots of ... provide services for vulnerable children but we are one of the key services that identify them. That is really important. So the health visitor will visit people at home, assess the home situation, assess the parenting and do follow-up visits at home because that is only a window of opportunity, do an assessment and decide whether that person should and that family should just be offered the universal contacts for a family, which would be 2 home visits, a 6-week developmental check, immunisation contacts, weaning contacts and routine developmental contacts at 9 months and 2 years. But if they are assessed to be a family in need they would have a more intensive programme of home visiting and other support services such as nursery nurses who will do behaviour management, toilet managing, those sort of things, and sleep management. Or we would refer them to a number of groups that we have that are specifically for vulnerable families such as Pop In and Play, or Tiddlers which is a special needs group. So the health visitors will assess families and from that will refer them and signpost them into the most appropriate place. So we are one of the key referrers for children's services for the under 5s. It is different for school nursing, they often offer the same type of service but they also have other responsibilities and there are other people who are monitoring families and children, vulnerable children, such as Education. The other thing that we refer people to are obviously other providers, such as The Bridge and Pathways, and this is the reason that they have those referrals, is through our assessment. (Clarification provided 01.06.09 approximately 70% of Bridge referrals come from the Health Visiting Service). All the health visitors have post-graduate qualifications in public health as do the school nursing so they are highly qualified staff. We have 11 whole time equivalent and we have got a handout for you to see what the school nurse and health visitor role is so that you understand it, because it is quite an unknown role, I think, and how we work, so you might find that useful afterwards. Is there anything else?

Senator A. Breckon:
Can I just ask you to clarify something there? Some of the services you said, such as is mum okay with the baby and that sort of thing, then if there is more support needed do you provide those through Family Nursing and Health Care?

Ms. J. Gafoor:
Yes, we will do more intensive home visiting through the health visitors and then we have the support of

nursery nurses who work under the supervision of the health visitors who will again visit people at home. Because the most vulnerable people with children do not go to groups, they will not come into centres, so the health visitors are doing that work in the home, and that is hidden, that is often hidden, but yes, we do offer that.

Senator A. Breckon:
Do you keep records of the number of cases and referrals and programmes; have you got general statistics on that?

Ms. J. Gafoor:
Yes, we do. We have a profile, we do a profile of the case loads and we know how many children that each case load has, children in need, and Barbara is going to give you information later about the number of hours that we specifically undertake that work.

Deputy G.P. Southern of St. Helier:
Presumably you know some of your families quite well?

Ms. J. Gafoor:
Very well.

Ms. J. Querns:
You can follow families up for years, because as long as they have a child under the age of 5 then they will have a health visitor, so we have got families ...

Ms. J. Gafoor:
And beyond.

Ms. J. Querns:
Yes, well beyond into school nursing. So, yes, we know families very well.

Deputy G.P. Southern:
Do you have contact with families pre-birth?

Ms. J. Gafoor:
Yes, we do. We work very closely with the midwives and we have a maternity liaison meeting and they will highlight mothers who have booked who they have assessed as at risk, for various reasons, all sorts of reasons, either the mother's health or addiction problems or the child's development, and they will liaise with us and it works especially well at The Bridge where they have got a team based there and there is a health visitor team as well. Obviously if it is a really vulnerable child then they will do a 20-week planning meeting where Social Services will be involved as well as the midwife, the G.P. (General Practitioner), the health visitor and the paediatrician.

Ms. J. Querns:
Can I just add there as well that there is a uniqueness to the home visiting, because although it is quite easy to identify some need it is only when you are visiting people's homes that you can identify other needs.

Deputy G.P. Southern:
So in terms of any initiative which was preventative, so early prevention, you would see yourselves as a vital cog in that support?

Ms. J. Gafoor:

Definitely, I think that is important...

Deputy G.P. Southern:
You are the point of contact?

Ms. J. Querns:
That is our key role.

Ms. J. Gafoor:
I think so. In areas where they have withdrawn health visiting services, because we are quite an expensive service because we are highly qualified professionals, that is the problem. They do not know then who is a vulnerable child.

Deputy G.P. Southern:
Areas where it has been withdrawn from?

Ms. J. Gafoor:
In Cambridge, in Cambridge. [**Laughter]**

Ms. B. Bell:
When they withdrew them in Cambridge I think it lasted between 6 and 9 months without them and then they realised they could not function as an authority without their help.

Senator A. Breckon:
Can I just ask you to comment on something there? Part of our remit is to look at coordination. Does that work with the other agencies and if you want referrals and support with whoever, is everybody working together here?

Ms. J. Gafoor:
When it is good it is very good and when it is not it is not. I mean we all work very hard at liaising with other services, with children's services and maternity services. It can work for certain families very well but it can break down. It does sometimes depend on certain practitioners' skills in communication. It does not happen naturally sometimes, is that fair to say?

Ms. B. Bell:
We all have to work at communication.

Senator A. Breckon:
How would it work then if a little one starts school, does that translate through your service so there would be a case record which perhaps the school nurse would see or ...?

Ms. J. Gafoor:
Well, because we are all employed by Family Nursing, all the community nurses, they have a handover to the school nurse of any child that they think is particularly vulnerable and they will have a health assessment when they start school so they then start the process. It is a gap that we have very few school nurses and obviously a large school age population, 13,000 children, and we only have one qualified school nurse and another 2 and two-thirds full-time staff, (Clarification 01.06.09 Registered Nursing, Staff Nurses) so we are really short, so we cannot offer, as much as we would like to, the same service as we can for the under 5s.

Deputy G.P. Southern:
I think you mentioned while you were talking that you are not seen in the same way as a social worker

per se?

Ms. J. Gafoor:
By the families?

Deputy G.P. Southern:
Yes.

Ms. J. Gafoor:
I think so, and that is because we visit every family. Everybody knows that when they have a baby they have a health visitor and our remit, obviously when we identify a child in need, it is child protection, but it is not just that at all. So it is supporting people not to reach that level.

Deputy T.M. Pitman of St. Helier:
So it has been a really difficult time to be a social worker in the last 18 months. Has that affected you guys in the same way, because a lot of what you hear there is ...

Ms. J. Gafoor:
I think, you know, with the Baby P inquiry it was not just the social worker who was criticised. In most of these cases there are shortfalls in all services, it is not just social workers themselves. I mean I think it just makes us focus more, and especially around the sharing communication and keeping everybody updated on the status, and to keep referring and to keep highlighting that: "I am still concerned about that child."

Deputy T.M. Pitman:
Can I just ask the other thing about the relationships and the interagencies, often we hear that it works really well at the coalface but sometimes not at the top. How do you feel? I am not saying it is true.

Ms. J. Gafoor:
I am not sure where the top is - Barbara is probably nearer the top than me - but at my level I work with the senior managers in Children's Services, and I meet them regularly for each area, the assessment team and the long term team and with the acute services and very well with maternity, but we have to all work at it.

Ms. J. Querns:
So I think we have a staff goal and we have to ...

Ms. J. Gafoor:
That is the thing.

Ms. J. Querns:
Staff turnover can have an impact and then we have to re-establish relationships.

Ms. B. Bell:
Yes, that can be quite destructive.

Ms. J. Querns:
There is quite a high staff turnover.

Ms. B. Bell:
When staff change over, because you do get used to working with certain people and those sort of communications can be very good when you know the person you are working with and you have

worked with them for quite a while and I think that particularly the health visitors and social workers have probably suffered from the turnover in both services really. Not so much health visiting at the moment but in the past that has happened and it certainly has been the case with the social workers, so it is difficult when you are dealing with a lot of difficult families and difficult problems if you do not have that good relationship.

Deputy G.P. Southern:
Is that also about stress levels and caseloads?

Ms. J. Gafoor:
Yes, and how able they are to respond, yes.

Ms. B. Bell:
But you asked about further up the tree, I personally do not have a problem. I think we have worked ... Family Nursing and the other agencies have worked quite closely with senior managers in Social Services, the police, probation. Head teachers, well we do not see them that often, but we see them at case conferences if there is anything in particular or particular meetings. So from my point of view I think we have a reasonably good relationship with all of them I believe, unless they tell me differently, but it has been really important as being part of the J.C.P.C. (Jersey Child Protection Committee) to get all these people on board. I think sometimes it is difficult for people who do not work in the area to comprehend some of the stresses and strains that go with it and some of the issues that people have to deal with, how long it takes to do these things, because none of this stuff is quick fix. I think sometimes the timeframe for dealing with these families can be underestimated, the amount of work that a health visitor or social worker has to do is a lot really for these families.

Senator A. Breckon:
Have you any idea about the number of families and vulnerable children you are dealing with, is it on the increase?

Ms. J. Gafoor:
Well, what we did is reconfigure our health visiting teams, so we only have 3 health visitors for all the rural parishes, so we have 11 full-time equivalent and we have 3 doing all the rural parishes and we have concentrated on the health visiting teams into St. Helier, St. Clement and St. Saviour, because obviously they are the areas of deprivation. So with our criteria of children in need what we feel that we have is about 231 children who are identified as children in need, that is 5.2 per cent of the under 5s population. Obviously that is the population as a whole.

Deputy G.P. Southern:
When you say: "in need" what sort of ... it depends on who you are talking to for in need.

Ms. J. Gafoor:
That is using the critiera that ... the threshold of criteria which is from the Health and Social Services and Family Nursing *Child Protection Policy and Procedure*, so it is fairly clear. So it is: "All families with children, health and developmental needs who may be compromised unless multi-agency services are provided. Any intervention in the life of a child should be purposeful and the effect of the intervention must be judged as more beneficial than not intervening. Any child with disability ..." and it goes on and on.

Deputy G.P. Southern:
So it is a developmental test or is it health?

Ms. J. Gafoor:

Mental health as well as physical health, and that is of the child and then of the parents as well, so their capacity as well. So any of the addiction problems where parents are struggling.

Deputy G.P. Southern:
Okay, so it is not necessarily at risk but it is ...

Ms. J. Gafoor:
Not necessarily.

Deputy G.P. Southern:
But it may be.

Ms. J. Gafoor:
It is people who require extra support to be able to parent in a good enough way.

Ms. J. Querns:
We felt that our remit was slightly wider than the children in need context within Children's Services where they have an allocated social worker.

Ms. J. Gafoor:
Yes, we help them.

Ms. J. Querns:
So they have a category for children in need but our category of children in need is much wider.

Deputy G.P. Southern:
So if a social worker is involved it is already serious, I would have thought?

Ms. J. Gafoor:
Well, they still call them children in need, and they are for us as well, but theirs is a high tier. Underneath this there (Clarification 01.06.09 - is a tier) of parents who are having post-natal depression, or are struggling to interact with their child with attachment, and we would call them a child in need and put extra support there ...

Deputy G.P. Southern:
There are all sorts of reasons and they might be quite low level.

Ms. J. Gafoor:
They might be but if you do not support them they will go into that. It is that triangle, (Clarification 01.06.09 - common assessment framework) yes, you know of children's needs.

Deputy G. P. Southern:
I mean the level in terms of the scale of being boiled?? to significance that is important.

Ms. J. Gafoor:
It is significant.

Ms. J. Gafoor
Because some families need some intervention when they are going through a particular crisis in their life and it might only be once and it is over and done with and everything is absolutely fine. That would not constitute the same criteria as perhaps social services would put. But it would actually mean quite a lot of extra visiting for the health visitor to do and that is --

Ms. J. Querns:
I think the thing that is important is that we hold the responsibility for that so it is difficult situations and complex situations that we will assess and decided whether that needs to be referred on or decided whether that can stay within our remit, so they are quite complicated situations that we are assessing and that changes. It is fluid.

Deputy G. P. Southern:
That sort of decision is not taken in isolation I would have thought, it is --

Ms. J. Querns:
No, we use the common assessment framework tool that the social workers use as well to assess whether the child is in need.

Senator A. Breckon:
You have mentioned before certain things, obviously preschool and from mother and baby, do you get any referrals of older children where you are asked to get involved?

Ms. J. Gafoor:
Yes, we do, and the school nursing service would be involved in that. Often there has to be a health focus for that specifically so behaviour difficulties, so tier one - not when they are ready to go to CAMHs but some intervention before that - any continence issues, risk taking behaviour, advice on sexual health and emotional health, so about tier one level.

Ms. B. Bell:
Health visitors and school nurses work very closely together and sometimes they are both visiting, very involved with one family because of the age range.

Ms. J. Gafoor:
They also visit all the children in the homes, at La Preference they do drop-ins and Heathfield and also D'Hautree House they go to visit.

Senator A. Breckon:
You would get referrals from where? G.P.s and schools and anywhere really?

Ms. J. Gafoor:
No, well because we visit every family they are always on our case load, so we do get referrals from occasionally G.P.s and other services who come across children, for instance recently A. and E. (accident and emergency) referred 2 children to Children's Services but Children's Services referred them to me because they were not at their level, so we get other things but otherwise it is us assessing the need or the family. The families refer to us themselves.

Ms. B. Bell:
One of the areas we do have a gap in and it is not really a gap in services, it is a gap in knowledge, if a family comes to the Island and they have children and they do not necessarily register with a doctor or register to have immunisations or they do not go to A. and E. or something of that nature which would highlight that the child was there, if they are too young to go to school, those children we would not know about and neither would anybody else. That is a bit of a gap and it is a worry because it is in the area where I know several years ago a child was on the Island and nobody knew about them and there were major problems with this particular child.

Deputy G.P. Southern:
Pre-school and no obvious risk, and no contact with G.P.

Ms. B. Bell:
Unless the families that have come here with children have gone to seek help from an agency for whatever reason we would not hear about them because there is not any way of checking and that is quite a concern.

Deputy G.P. Southern:
It must be hard to get numbers because whatever it is, 12,000 people who sweep in and sweep out.

Deputy T.M. Pitman:
It must be hard to give numbers, I suppose?

Ms. B. Bell:
I think it would be and it one of those things that is a concern but you do not know quite how you are going to deal with it, because it is not about anything we as Health Visitors can do to deal with that, it is more of a .

Deputy G.P. Southern:
You mentioned that everybody was pretty highly trained. Would you like to talk a bit more about training?

Ms. J Gafoor:
Yes, we are all registered nurses and then we have done another post-graduate year at university to become public health specialist nurses.

Deputy G.P. Southern:
Ongoing on-Island training?

Ms. B. Bell:
Well, yes.

Ms. J. Querns:
There is means. I trained through distance learning through Robert Gordon University in Aberdeen and another 2 health visitors, one who has trained and one who is training at the minute, but at the minute that is self-funded, so you have to have the drive to want to do it yourself.

Ms. J. Gafoor:
I mean they have all professional development training but it is quite a struggle on a small Island, I am sure lots of other professionals have that. problem

Senator A. Breckon:
We touched on generally Children's Services and police and probation. Would you generally say you have a good working relationship with States departments and other agencies? Does everybody know what you do?

Ms. J. Gafoor:
I would say yes, I would say that strongly. I would say we do have. We sometimes have to keep on having to highlight we are here. But generally I think so, yes.

Senator A. Breckon:

Would you say there are any weaknesses or areas where we could do things better, we being the Island?

Ms. J. Gafoor:
I think there is scope for having a commissioner for all children's services, so at the moment we have an S.L.A. (Service Level Agreement) with Health and Social Services, so they are a provider and a commissioner and I think it would be really useful to have an independent commissioner who … they decided where all the budgets went, because I think allocating certain budgets makes everyone quite protectionist about their area, so it does not make for such a sharing, joined-up working, is my feeling because people think: "Oh no, that is my area so I do all that." Well, it is a lot of people's areas and we all try and do it together well.

Senator A. Breckon:
Do you get involved with reporting, say for the courts or anything like that?

Ms. J. Gafoor:
We do. Not in a huge way.

Ms. B. Bell:
It is one of the things that we need to be (Clarification 01.06.09 - more involved in) we are trying to look at it at the moment but we are asked for court reports. Occasionally, not enough I would say. I think the reports that health visitors could give would be very supportive of the other services because we are all seeing the same children that end up in court or families that end up in court, so I think there are benefits in the U.K. (United Kingdom) court reports from health visitors is a very common thing. It does not happen so much here and that is work that we need to do to try and see why that happens, whether it is the way the legal system works, I do not really think it is. It is either that we have not practised it, we have not done it very recently and so they do not think about it.

Deputy G.P. Southern:
Not the way we do things.

Ms. B. Bell:
There is an element, I have to say there is definitely an element of that but I think it is a lack of understanding really of the true nature of what health visiting is and how much information we do hold on these families, which 90 per cent of the time would back up what the other professionals and certainly Social Services ... it might not always, we are independent practitioners, as it were, and they may see things in a different light than we do, but it is certainly an area that we would be seen to be supportive in most of the cases.

Senator A. Breckon:
Can I just ask you a question, do we have it right on issues like data protection? Are there protocols there that allow you to get the information you need without encroaching?

Ms. J. Gafoor:
I think with child protection it is quite clear that that overrides the data protection and we all seem to be ... I mean I have not been here a huge length of time but when I first came that was more difficult and people's understanding has improved, so that we do share information in a better way, do you think? Generally.

Ms. B. Bell:
Yes, we do. The J.C.P.C. is working on a document for chief officers within the States to peruse and decide whether they will sign that, about information sharing but it certainly is something that we have to do if we are to adhere to the best practice standards everywhere else to do with safeguarding children,

basically.

Deputy G.P. Southern:
You have mentioned J.C.P.C. twice now. Would you like to expand, seeing as you will be involved in it, on how it has gone for you and what you think its strong points, weak points are?

Ms. B. Bell:
I think that we have made great strides in recent years with the J.C.P.C. When I first came here I think it was fairly new in conception and it did not really function quite the way it does now and over the last 3 or 4 years we have ... 4 years, I would say, we have developed sub-group working so that we have (Clarification provided 01.06.09 - developed various areas) to try and improve practice across the board, and when we talk about practice its about all the agencies, because there are representatives on the J.C.P.C. from all the agencies that are dealing with children, so it is about improving practice, having a better understanding of what we all do, developing protocols and policies that are universal. We also try and do quality and audit and resource management within that arena now. Obviously if there is an issue to do with serious case reviews and that sort of thing, if something has not gone quite right, it is the arena for trying to look at that and to do it in a non-blame way, because we do not need to be blaming people. What we need to be doing is finding out where things have gone wrong, if they have gone wrong, and address that and learn from that. But we also need to be able to celebrate the good practice and there is a lot of good practice and you would not necessarily know that from the press, across the board not just in Jersey but in the U.K. as well. But in actual fact there is a lot of good practice goes on but it gets lost in all the media hype.

Senator A. Breckon:
Do you think there is any way that can be done without sort of revealing anybody's identity because that has also been said to us, that it is the success stories that perhaps do not get publicity, it is only when ... it is like the hospital, if somebody has waited 2 years for an operation then that is news but if 500 people have been through there today it is not an issue when nobody has complained at all. So is there anything you think that you could do?

Ms. B. Bell:
I think we have to be careful to get the whole thing right. If there is a problem with the way in which people have been working together, because that is usually the issue, that is one thing and we have to strive to try and get that right and I do not think there is any point in naming and shaming people. I mean if a member of staff has done something that is unprofessional or brings into question their practice then they have to be dealt with within their own agency under their own disciplinary procedures and to have people's names splashed across the papers does not serve any purpose.

Deputy G.P. Southern:
But then you are into best practice and that decision, at whatever level, should not be taken individually, in isolation, you should be able to reflect that through to whoever your supervisor is or your colleagues and say: "Right, my feeling is we should go this way, what do you think?" You kind of share responsibility and have been checked on, not checked on …

Ms. B. Bell:
Things have to be monitored and supported. The health visitors have supervision, practitioners within Family and nursing to do with child protection have a lot of supervision, so that they are not carrying the can for what they are doing on their own, it is a shared responsibility.

Deputy G.P. Southern:
As you say most of the work is not child protection that is the minority. There is an assessment but most of the work is far more ...

Ms. J. Querns:
You say that in numbers but in time …

Ms. B. Bell:
I can tell you about time.

Deputy G.P. Southern:
You did say you were going to.

Ms. B. Bell:
I can tell you that we had a significant increase in the amount of time that health visitors have spent, and school nurses, dealing with vulnerable children in families and also the number of activities that they have undertaken, although the activities have not varied hugely. So in 2006 they spent about 1,981 hours. Now that is not visiting, that is attending case conferences, core group meetings, making referrals, liaising with other services, writing court reports, case conference reports and dealing with issues maybe to do with domestic violence, and that is a huge amount of time out of those 11 staff's hours. In 2008 we spent 2,621 hours. So that is an increase of 640 hours' work specifically related to the mechanics of protecting and safeguarding children, not the going out there and visiting them which is an additional thing, but that is the mechanics of the logistics of the work that has to be done. So I think somewhere along the line we have to, all of us, understand that if you have a family that is in crisis for whatever reason it is not just about visiting them. The time that you have to spend is not just about spending time talking with mum and dad and all the rest of it. There is a lot of other work, it is essential work and it is the work that helps them in the long run, but it is time consuming, very time consuming.

Deputy G.P. Southern:
What would you put the increase down to?

Deputy T.M. Pitman:
That is what I was going to ask.

Ms. B. Bell:
I think to be honest the increase has come about because there is better working together, so if you work together better you are talking together more and you are identifying things and that is the big issue. I think overall in general everybody to do with ... every agency to do with child protection is much ... getting much better at identifying what the problems are, identifying that there are problems in the family, because once you identify something you have to do something about it. But I would also say there probably has been a slight rise in what is going on.

Deputy G.P. Southern:
Awareness.

Ms. B. Bell:
Yes, there is a bigger rise in awareness that is the issue. I think the more people talk ... it is like anything, is it not, once you have identified it you raise the profile.

Ms. J. Gafoor:
But what we have put is more health visiting time into deprived areas so that we are able to assess the need and respond, you see.

Senator A. Breckon:
That is in that period that change of …

Ms. J. Querns:
These areas are mainly in St Helier, St. Saviour and St. Clement, , the health visitors that work in the rural parishes, work very, very hard, but the work would be different.

Ms. J. Gafoor:
They have quite big numbers (Clarification provided 01.06.09 in their caseloads.)

Ms J. Querns:
That is quite significant.

Senator or Deputy:
I would say so, it is difficult when you have no statistics.

Ms. J. Querns:
I would say that the health visitors of St Helier, St. Clement and St. Saviour would work a lot more with children in need.

Deputy G.P. Southern:
Interesting that you made that distinction between urban and the country parishes. Is that based on any evidence that it is spread more thinly?

Ms. J. Gafoor:
Well, there is evidence from the public health report, the last public health report, in their deprivation index it is very clearly St. Helier and St. Clements.

Deputy G.P. Southern:
The association with deprivation is a strong one presumably.

Ms. J. Gafoor:
Yes, that is right.

Ms. B. Bell:
Also a higher population in those areas as well.

Ms. J. Gafoor:
A dense population of mobile newcomers, yes.

Ms. J. Querns:
It is not that there is no need, because there is the country parishes.

Deputy G.P. Southern:
I remember a particular constable saying, and I will not say what the issue was but: "There is none of that in my parish."

Ms. B Bell:
I would say there is some of that in every parish but some parishes have unfortunately got more.

Ms. J Gafoor:
There is a hot spot in St. Lawrence, in the middle of St. Lawrence, which we are not quite sure about but on the public health report there is that, yes.

Senator A. Breckon:

Do you think the general public and the community at large are aware of the work that you do?

Ms. J. Gafoor:
No, I do not and I think that the majority of people will only have universal services from a health visitor when things are going well, so the majority of people will not realise the breadth of the work that goes on when you have got a family in need and that is our problem, that is our marketing problem.

Ms. J. Querns:
(Clarification provided 01.06.09 - Unfortunately our service can and is often judged by people who have only required the universal service provision so they have no experience of the breadth of intersine work we do.)
The majority of them are professional people, they are rely on …

Deputy T.M. Pitman:
You said earlier that one of the issues was you had to keep telling people you were here. Is that what you were getting at?

Ms. J. Gafoor:
Absolutely, because I know professionals who just think health visitors go in and weigh babies and drink coffee, because maybe that was their experience. They did not need the health visitor for any more but there are a range of people for whatever reasons who will use you more and they are the ones who make ... who appreciate the role more but, of course, in the scheme of things very few families will have the whole breadth of the service.

Deputy T.M. Pitman:
It could be worse. People think politicians just drink and sleep in the States benches. **[Laughter].**

Ms. J. Gafoor:
It is a bit of a hidden role and that is a difficult thing for us and we need to shout about it, which is why we are here, we need to tell people.

Ms. B. Bell:
It is quite a difficult role to quantify and I think to provide outcomes, to give positive outcomes and it is extremely difficult and that is not an excuse, it just is, because it takes years to have an outcome. I think we would be really happy if we were seeing the children of the families that we are visiting now not getting into difficulties when they have got children. That is what our outcome submission would be.

Deputy G.P. Southern:
That is long term.

Ms. B. Bell:
But that takes many years and people do not have time to wait. When we are planning resources and all the rest of it you do not have time to wait 15 years down the line to see whether that service worked.

Deputy G.P. Southern:
Occasionally a bureaucrat wants something measurable.

Ms. J. Gafoor:
Yes, and there are lots of variables that do influence families, are there not, it is not just us and that is fine but it is very difficult to prove outcomes specifically for health visiting, I am afraid.

Ms. B. Bell:

The only evidence we can say is that in Cambridge they removed all the health visitors, said they did not need them and 9 months later they were in such a pickle they had to go and employ them all again. Now, that sounds very crass really but that is quite telling that people think they could get rid of a service, it did not matter.

Deputy G.P. Southern:
Remind me not to go and live in Cambridge if they can have that mindset.

Senator A. Breckon:
You said at the start you are a qualified social worker?

Ms. J. Querns:
I am a health visitor.

Senator A. Breckon:
Do you have any social workers on the team?

Ms. J. Querns:
No.

Senator A. Breckon:
You do not? So you use the agency?

Ms. J. Querns:
No, we work with the agency.

Senator A. Breckon:
Where would the line be then from say a health visitor, you are at the sharp end, so when would you sort of say: "We need some extra support here."

Ms. J. Querns:
Well, that is where our skills really come in in an assessment. It can be a difficult shout and it can be quite hard, that is the hardest part of the job really, but we have the tiers that we would use and we have criteria within. Sometimes it is just intrinsic, sometimes it is just something that you know, so there is not really a full model that fully fits but there are models that we use, the common assessment framework to sort of guide our way through our assessment and sometimes you just know that this is a family that needs to be referred, and there are telling issues there. I think the easy thing is if there is an incident, if there is a bruise or if there is sort of definite neglect within a home or a disclosure, that is easy. The more difficult things are the sort of long term chronology maybe of incidents and perhaps a feeling that there is something more going on here for this child, because of their behaviour or because of their parents' demeanours. Domestic violence, as you know, has been high on the agenda and that is hidden and we have to search for that, and we will search for that in most families that we go and visit across the board, because we know that it is across the board that that is a big issue for children.

Senator A. Breckon:
Is there a general age group where you are encountering problems or is that not the case? Is it under 11s or is it above that?

Ms. J. Querns:
We focus on 0 to 5 year-olds but then the school nurses are involved with the older children**.**

Ms. B. Bell:

If you were to look at a snapshot of the Child Protection Register you would probably find there are more children over the age of 5 that are within school that are classed as being at risk and therefore on the register. So there is a quite a lot of incidents I think with the older child but it is the younger child, the 0 to 5, that cannot speak for itself that needs a great deal of support and we need to be very vigilant with those. I am not saying that we should not be vigilant with the others, because they have major issues that need to be dealt with, huge issues that if they are not dealt with when they are babies become major problems when they are older. But the vulnerability, in terms of physical vulnerability of a baby that cannot speak for itself is much higher. You may have less of them but you have ... you could have bigger problems.

Ms. J. Querns:
That is really where we want to stop it.

Deputy G.P. Southern:
Are we getting better at it? I am just thinking in particular about coordination, I mean obviously J.C.P.C. is ...

Ms. B. Bell:
We still have quite a lot to do.

Ms. J. Gafoor:
I think what happens is child protection, you cannot plan for the year the resources because demands vary so much, so if there is a rise in demand and there is no staff, the thresholds go down. That is the problem, you cannot respond because you do not have the staff. So I think at times we do it really well and at times we do not and I think what is disheartening is when you are seeing the children of people you have health visited and the same issues are coming again with that family.

Senator A. Breckon:
With the second generation.

Ms. J. Gafoor:
It is a huge problem.

Deputy G.P. Southern:
I am just trying to get my head around this. Is it a bit like policing and crime, if you have put some more police out there you find more crime? You could say more police equals more crime.

Ms. J. Gafoor:
I think so. We assess more need.

Ms. B. Bell:
But that is not to say it has not always been there. It probably has always been there but when you identify it you (Clarification provided 01.06.09 - have to act. identification of need and problem areas is improving all the time)

Deputy G.P. Southern:
The outcome then is that you ... when I am thinking about are we getting better at it, is when you need it what resource is there that you can ...

Ms. J. Querns:
The family centres are very good, The Bridge and Pathways are good. Lifesavers for us, we really use them well, we work with them and we have worked from the very start when Pathways first set up, I

worked down there with Pathways and then moved up to The Bridge when The Bridge ... because I really believe in this way of working. Unfortunately it does not ... we are still not managing to get our most vulnerable families into the centres and that is something that I think we will just still have to keep on working with and that is because of the nature of those families and how they perhaps have had bad experiences and lack trust in what they would class as authority or professionals so it is something that you continually work on and we still work with those families and still try to encourage them in. So they are very good but we also ... we still need centres such as Grand Vaux that are run by the Social Work Department and are specifically focused and there are specialists within those to work with the most vulnerable families. I think we need social workers within all the children's centres and that then becomes part of normal society within those areas, so that it is accepted by the community.

Deputy T.M. Pitman:
Sorry, I have to make my apologies; I have to be at another meeting at 5.00 p.m. I have to leave you, thank you.

Deputy G.P. Southern:
But what you are talking about there is how they are resourced so that you can be flexible and have the appropriate response as you do …

Ms. J. Gafoor:
I think an example of that was the M.A.s (Multi-Agency) teams, the multi-agency teams in schools and the senior schools that were started in the Le Roquier and Haute Valley. When they had a social worker presence I think that was really good, because they were nipping lots of stuff in the bud and they knew the families, they were in the schools but I think, I believe, that they have had difficulty staffing those posts.

Deputy G.P. Southern:
Coming back on to that, just in general terms, you mentioned that you had similar problems some years back and you set down ...

Ms. B. Bell:
The problem is it is okay as long as you have got health visitors that stay put but people move, their own personal circumstances change and they move on and the strange thing is it tends to be in batches, does it not, when that happens. You might go for a long time with no change in your staffing, they are all settled, and then all of a sudden different things happen and ... or people retire and you have to recruit new folks. Now our problem with that is that we have to recruit for the most part in the U.K. because we do not have a lot of people at that ... I suppose we could count on probably not even half a hand how many highly qualified health visitors are out in the Island who are not working for us. So that means that we have to go to the U.K. and the U.K. has a shortage of health visitors. So we have to be able to (Clarification provided 01.06.09 - offer favourable incentives. Nursing wages are almost on a par with the UK now but the cost of living in Jersey is considerably higher.)

Deputy G.P. Southern:
So the problem that applies, that we know that applies to social workers is that they are only running on one-third of the strength … are you facing identical problems attracting people here ...

Ms. J. Querns:
I do not think we do as much.

Ms. B. Bell:
As I say I think it goes in peaks and troughs. We have not for quite some time but I think you are going to find that we will in the future, so it is peaks and troughs.

Deputy G.P. Southern:
But as you say it is a shortage area and with the current publicity nationally let alone locally, it is not going to be easy.

Ms. J. Gafoor:
It does not help. We have not advertised for nearly 2 years, appointed anyone new for nearly 2 years so it will be interesting to see what happens when we do have a vacancy now.

Senator A. Breckon:
Is there any tension with your funding from Health and Social Services? You are finding obviously more work to do and how does the funding flow with that, if you were to identify something?

Ms. B. Bell:
I would say there is difficulty with funding across the board, is there not? Finance and economics, it is not a happy place to be at the moment. I think we are all facing the same difficulties. What is really important is that we have got, on this Island, an elderly population that we know is going to increase and we have to deal with that but we have also got quite a lot of children and they are, for a cliché, they are the future and if we do not look after them and we do not give them the supportive services that they need and we do not support parents in those areas we will have problems later on. I am not saying that you necessarily have to give equal money but I do think that has to be very much a part of the debate when it comes to resources, because the services for children in Jersey do lack ... they are lacking because there are not huge numbers of children. and ... we do not have a huge number of children compared to the U.K. of children with special needs, either physical or learning difficulties, but we do have them you need the resources money to give the right level of support (Clarification provided 01.06.09 - to those children and their families) There is not sufficient respite for parents of children with complex needs for example

Ms. J. Gafoor:
I think there is a tension because primarily Health and Social Services have got a very acute focus and I think that money flowing into ...

Deputy G.P. Southern:
A very acute ...?

Ms. J. Gafoor:
Acute service focus and I feel that community services everywhere are the Cinderella and that is an issue of having them as the commissioner for our services.

Deputy G.P. Southern:
I can see you moving, as you spoke then, towards a document called *New Directions* which is about promoting long term goals rather than acute services and that applies in social areas as well. It is all very well to be able to get in there ...

Ms. B. Bell:
Well, acute services they are sexy, are they not, that people (Clarification provided 01.06.09 - are treated – expensive and new technology and results .are easier to define as outcomes), to coin a phrase. But a community service is the nitty gritty of everything that happens in people's lives and it is not always pleasant so, you know ...

Senator A. Breckon:
Others have said to us in evidence that perhaps, like you mentioned there, the interventions are at a critical level and there is not the scope when you are under that sort of pressure to get a quality

intervention at a lower level that is a preventative measure rather than wait until you get to crisis level. Is that some of your experience as well?

Ms. J. Querns:
We tend to get sucked into the more crisis level, health visitors, when there is less staff I would say, so the balance changes, so we are not able to do as much of the proactive stuff and we have to work reactively with the family who have gone into crisis. So we want to be working on the, the proactive side, of the continuum of need as such.

Senator A. Breckon:
Just another question I have, that was a referral on the medical side, what you might find with the co-operation of G.P.s are you maybe getting cases that you are referring children to G.P.s or to the Robin Ward, is that happening?

Ms. J. Gafoor:
We refer to all agencies; we refer directly to G.P.s, paediatricians, speech and language, physio, audiology, all of those. We are one of those ... we signpost people and refer them to the right agency.

Senator A. Breckon:
So if somebody comes to your attention and you have ...

Ms. J. Gafoor:
We decide who the most appropriate person to refer is and then refer it on. If we cannot deal with the situation ourselves.

Ms. J. Querns:
On an initial health assessment I might refer to the Children's Services, to E.N.T. (Ear, Nose and Throat), to speech and language, to the paediatrician all from one visit, so there is ... from one home visit you can have a lot of referrals that you then have to go and do ... or just meeting the family, sometimes by chance.

Ms. B. Bell:
There is good access to those services generally.

Ms. J. Querns:
Yes, there is good access and all referrals are well accepted.

Senator A. Breckon:
I think something that will be useful to us is ... because what we do is evidence-based, some of the things that I think you mentioned there I think you mentioned a Service Level Agreement and also the statistics, I mean would be useful. Then obviously as we progress the report in the final stages you would see ... obviously it does not identify anybody so it would be anonymised in that way but if you had any problem with any of that if you let us know. So if you share information with us, obviously it does not identify people and if it did it would be confidential in nature, and if you did not want it in the public domain then if you said that as well.

Ms. J. Gafoor:
Yes, we just have to check with the agency, would we not?

Senator A. Breckon:
Yes, and someone we will get in touch. If we could say for example we have got some figures there which look like about a 30 per cent increase year-on-year, if we said that and somebody said: "How do

you know it has gone up by 30 per cent?" well, we know because that is what you told us and that is the proof of it.

Ms. B. Bell:
Yes, I mean in actual fact it has gone up most between 2007, 2008 that was the greatest, I think there was about 500-odd hours involved in that. More than it had before and it is quite significant. When I looked back over the figures before going back to 2003 you can see that it was fairly stable then and it has jumped and I am sure the reason is not because we have suddenly grown a lot of problem families although I think there are more than there was. I suspect it is going to get a little bit worse as the economic climate worsens but it is also, as we have said, about identifying and working together and spending time, knowing that we need to spend time with these families to try and prevent it from getting any worse.

Senator A. Breckon:
Well, thank you for your time and coming to see us. It is probably not the place you would rather most be on a Friday afternoon but just before we close is there anything that we have not touched on that you would like to say to us?

Ms. B. Bell:
No, thank you very much.

Senator A. Breckon:
Thank you very much for your time.

Ms J Gafoor:
I will leave that with you.

Senator A. Breckon:
Okay, that is fine. Thank you.

(Clarification provided 01.06.09 - Statistical Data

Annual figures in relation to Health Visitor Activity and hours spent in relation to Children in Need/Safeguarding Children.

Year	Activities	Hours
2006	2,501	1,981
2007	2,231	2,048
2008	2,631	2,621

The activities and hours represent a snapshot of the management time spent on attendance at the Case Conferences and Core Group meetings. The report writing associated with these meetings, referrals,

liaison with other agencies and no access visits etc **(they do not include the actual client visits that are made).**

The figures show that there has been an:

Increase of 130 activities since 2006 and an increase of 640 hours since 2006.

That is 3.4% rise between 2006 and 2007

28% rise between 2007 and 2008

This indicates a significant rise in time spent dealing with needy families, but in no way does this demonstrate the full services and packages of care offered to families in need. Universal services to all families are not included in these figures.)