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Health and Social Security Panel

Quarterly Hearing

Witness: The Minister for Health and Social Services

Tuesday, 16th September 2025

Panel:

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

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

Deputy P.M. Bailhache of St. Clement

Deputy L.K.F. Stephenson of St. Mary, St. Ouen and St. Peter

Connétable K. Shenton-Stone of St. Martin

Witnesses:

Deputy T. Binet of St. Saviour, The Minister for Health and Social Services

Deputy A. Howell of St. John, St. Lawrence and Trinity, Assistant Minister for Health and Social Services

Mr. P. Bradley, Director of Public Health

Ms. R. Johnson, Director of Health Policy

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

Ms. R. Bullen-Bell, Director of Midwifery

Mr. S. West, Medical Director

[12:37]

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

Welcome, everybody. We are the Health and Social Security Scrutiny Panel, and this is a quarterly public hearing with the Minister for Health and Social Services. I am Deputy Louise Doublet, the chair of the panel.

Deputy J. Renouf of St. Brelade (Vice-Chair):
I am Deputy Jonathan Renouf, the vice-chair.

Deputy P.M. Bailhache of St. Clement:
Philip Bailhache, member of the panel.

Deputy L.K.F. Stephenson of St. Mary, St. Ouen and St. Peter:
Deputy Lucy Stephenson, member of the panel.

Deputy L.M.C. Doublet:
I am delighted to welcome our new panel member.

Connétable K. Shenton-Stone of St. Martin:
Constable Karen Shenton-Stone of St. Martin.

Deputy L.M.C. Doublet:
Welcome to the panel, Constable. Okay, we have an hour and a half for this hearing. As always, a lot of questions to get through; we may have to follow up in writing at points. We have added an additional section, which I believe has been run by you, Minister. You are happy with that?

The Minister for Health and Social Services:
Yes, that is fine.

Deputy L.M.C. Doublet:
Fantastic. If you could, first of all, introduce yourself and the officers that you have sat at the table with you.

The Minister for Health and Social Services:
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.

Medical Director:
I am Simon West, Medical Director for Health and Care Jersey.

Director of Health Policy:

Ruth Johnson, director of Health Policy.

Director of Public Health:
Peter Bradley, Medical Officer of Health and Director of Public Health.

Deputy L.M.C. Doublet:
Welcome, everybody, and thank you for making time to come to the hearing today. There are some other officers that I believe you will be swapping in and out; and your Assistant Minister, of course. Welcome. If you are swapping in, if you could introduce yourself when you begin answering the question, that would be great, thank you. We are going to start with some follow-up questions around the changes around elective procedures. Of course, there were some questions in the States Assembly recently. Also, we wrote a letter to you; thank you for your response and the details contained within that. You said that there will be an increase in funding, a review of treatments, and some requirement to reduce certain services. My first question on this, Minister, is what specific Jersey-based factors will be used to assess the cost effectiveness in the new T.I.P. (Treatment and Interventions Prioritisation) policy?

The Minister for Health and Social Services:
I am not able to answer that question directly, so I am going to ask Peter. Peter, are you able to ...?

Director of Public Health:
Yes, sure. The T.I.P. policy is meant to achieve some consistency around existing committees. There are a number of committees already that develop clinical policies across the health area. The sorts of things that people will look at are obviously the health needs; so, from the data, we would know how many people were coming forward for a particular treatment; they would look at the research evidence about how effective that treatment would be and what the expected outcomes are. They would also look at the cost-effectiveness, which is not just purely looking at money; it is about what we can see as an investment for future health. As I say, the real intention is to look at that, and then to add to that a number of ethical criteria. We need to look at things like inequity and other issues of that type, to ensure that we have appropriate access to everybody on the Island, but the real purpose is to achieve consistency.

Deputy L.M.C. Doublet:
Okay, thank you. You mentioned committees; which are the committees? If it is not too long to ...

Director of Public Health:
Yes, I am not sure I can give a complete list. We may need to come back to you; there are a number of existing committees at the moment.

Deputy L.M.C. Doublet:

Okay. That would be good if we could have that information, thank you. This is an N.H.S. (National Health Service) policy that we are "Jersey-flying"; is that correct to say?

The Minister for Health and Social Services:

As I understand it, yes. It might be similar.

Director of Public Health:

Yes, so there will be an N.H.S. policy. For example, if we look at some of the N.I.C.E. (National Institute for Health and Care Excellence) guidance, which should be familiar to some people, they look at a particular topic and then they make some recommendations. They are particularly interested in new therapies, but there are factors that are important to Jersey that mean that we cannot always implement those policies in exactly the same way. For example, there may not be a particular specialist on the Island. It is really important that they are adapted so that we do the very best for people on the Island; so, that would certainly be one element of this work. Some of it would be about policies that are already in place in Jersey and then it is just a question, as I say, of achieving more consistency.

Deputy L.M.C. Doublet:

Thank you, that is helpful. You mentioned on-Island specialists and, obviously, there would be a difference there. You also mentioned inequity around health, which I know there have been some reports from Public Health, which the panel have read with interest. What Jersey factors around inequity or inequality do you think need to be taken into account?

Director of Public Health:

I think they are very specific to the clinical area that we are looking at, but Jersey experiences the same types of inequity that you might experience in other places. It is well-known that, for example, people who have mental health conditions often have difficulty accessing. We have recently done the J.S.N.A. (Joint Strategic Needs Assessment) on women's health. But there are many, many reasons and it is quite particular to a particular clinical area. I just think it is one of those things that we need to look at every time we develop a new policy or a new clinical treatment.

Deputy L.M.C. Doublet:

I want to just gently challenge the Minister there. I understand the advice from your officer there, that the inequities will be largely comparable, but Minister, have you consulted with any stakeholders on-Island to try to establish where there might be some differences in the Jersey population that we might need to take account of?

The Minister for Health and Social Services:
No, I have not.

Deputy L.M.C. Doublet:
Is that something that you could do? I am aware that there are groups that make recommendations to Ministers around disabilities; I cannot remember the names of the groups. Could you seek to hear from those groups when you are forming this policy?

The Minister for Health and Social Services:
It is something I am sure, Peter, that we could take into account.

Director of Public Health:
Yes, that is fine.

Deputy L.M.C. Doublet:
Thank you. That leads me on to my next question: what public consultation or stakeholder engagement are you planning?

The Minister for Health and Social Services:
Is there going to be consultation at the end of this, or is this an internal ...

Director of Public Health:
Ruth, can you remember the details? There has been quite a lot of stakeholder consultation already about this. Largely, at the moment, this is about ensuring that there is more consistency of the existing policies. We would think about public consultation if there was an area of interest.

[12:45]

It is hard to have that kind of engagement about something that is a bit more theoretical, but I think that if there were an area of particular interest, that would be the point at ... we would certainly do that in any other area of interest, such as we have shown in the J.S.N.A. But I think it would be better run as a topic-specific consultation.

Director of Health Policy:
I think that is correct. In the development of the T.I.P. policy there ... the way in which to see the T.I.P. policy is that it is not a policy per se; it is a framework in which decisions are made. In the development of that framework in which decisions are made, clinicians and internal stakeholders

have been consulted, and that includes those who are engaged in the existing committees that make decisions, which Peter mentioned earlier. For example, there is a committee that looks at high-cost drugs but just looks at high-cost drugs and does not also look at high-cost surgeries or so on and so forth. All the clinicians who are currently involved in those existing committees have been engaged and consulted in the process to develop TIPP, which is this new decision-making framework. Where TIPP is making or considering the making of decisions, which would need to be ratified by the Minister on the advice of the advisory board ... where that is creating significant change or potential change, we will, on a case-by-case basis, look at what the best form of either general public stakeholder consultation is, or very specific stakeholder consultation, depending on the groups affected.

The Minister for Health and Social Services:
In answer to the question: that has yet to be determined.

Director of Health Policy:
Yes.

The Minister for Health and Social Services:
That will come at the end of the process. When you asked the question: "Is there anything specifically pre-arranged?" then the answer to that would be no.

Deputy L.M.C. Doublet:
Okay.

Deputy J. Renouf:
Minister, in the Assembly on 8th September you were asked about publishing terms of reference for the review of elective surgery, and you said that you would publish any information relating to this review that you could. Do you have any information to publish, and if so, when will it be published?

The Minister for Health and Social Services:
I believe there is some, but I do not think it is a formal terms of reference. Correct me if I am wrong.

Director of Health Policy:
That is correct. There were not formal terms of reference for this review, but what we did do is we have written out and described the process that was stepped through in the development of this policy - how we went about it, who was consulted. I was not aware that that had not been submitted to yourself and the Assembly as of yet. We will chase that up. We have the information.

Deputy J. Renouf:

When would you expect this process of reviewing elective procedures to be finished?

The Minister for Health and Social Services:

I am not doing it, so I would need to be guided by you.

Director of Health Policy:

I cannot answer that, I am afraid. As I understand it - and I think Peter will have more information - it will be an ongoing process. This is where it gets quite complicated; there are 2 pieces of work happening. There is the creation of TIPP, which is this new framework for making decisions; and underneath TIPP, there are a number of sub-policies that exist. The sub-policy that exists, which is the one that you yourself asked the States a question about, is about procedures rather than, for example, medicines and other treatments and interventions. That policy, which has got various different names, but essentially is focused on surgical procedures of low clinical value ... that work has already started. That is primarily and predominantly a desk-based piece of research at this moment looking at the evidence of the clinical value of procedures in other jurisdictions. That will then move into the TIPP framework to be considered by the wider group for determination. I do not know what the end date for that work will be.

Deputy J. Renouf:

Okay. This review was announced in the media in August - this review of elective procedures in particular - in the context of health funding and the fact that the Minister was asking for extra money for Health and he had to justify that. To justify that, he had to show that he was applying value for money in the other parts of the Health expenditure. At some point, there will be an expectation that this is going to save money or not. Is that not the case?

The Minister for Health and Social Services:

I do not think it relates too directly. We are not asking for more money specifically for this, because this is a piece of work that I think would probably have been needed with or without extra money. I think that the extra funding issue is a far, far broader issue than something ...

Deputy J. Renouf:

But when you announced this and made the public statement, you said: “We are asking for more money, therefore, I have to justify to the public that we are spending all the money that we are spending accurately.”

The Minister for Health and Social Services:

That is absolutely correct, but it is a broad statement within which this particular element sits as a part of that process. As I say, in the scheme of things, it is probably a relatively minor part of the process because it is work that needs to be done anyway. The statement about needing to justify extra money, I thought it was an opportune moment, when you are asking for extra money, to assure people that as a team we are looking to do all we can to save money wherever we can. The last thing we want to do is ask for money if we are not comfortable that we are making every effort to spend the money that we are having wisely. I think that was a general statement to try to contextualise the announcement.

Deputy J. Renouf:

I think the hare it sets running is that some treatments that were free are no longer going to be free, and that might be a 2-tier health service in the making where if you can afford to pay for something, you get it. Do you acknowledge that that fear exists?

The Minister for Health and Social Services:

I do. I think we are strolling into the area of health funding and I am very happy to discuss that at length, if you want. Looking at this in the overall, since I have been in office I have tried to change the narrative from this consistent claim of overspend, overspend, overspend to say to people: "Actually, we are not providing the right level of funding to Health to get the job done properly in the first place." That is the background that I come from here; to changing the narrative to say to people: "If you are going to keep living longer and you are going to want more and more treatments, and you are going to want all the up-to-date drugs, all the up-to-date procedures, then you have to realise that either you are going to have to pay more for it in overall terms, in some form of overall taxation ..."

Deputy J. Renouf:

I understand that, Minister, but I was asking about elective procedures which you were reviewing in order to see whether they were all justified. The question is, if some of them are judged to be not justified, that means they will only be available if you are prepared to pay for them.

The Minister for Health and Social Services:

In fairness, you did use the term: "Are we moving to a 2-tier health service?" and, once again, I tried to put some meat on the bone to give further evidence to the direction of travel. You can understand where I am coming from, I hope.

Deputy L.M.C. Doublet:

How much money do you think will be saved after this review?

The Minister for Health and Social Services:

I personally have no idea. As I say, you would have to look at somebody who is more professionally involved than I am.

Deputy L.M.C. Doublet:

Do you have a ballpark?

Medical Director:

I think the answer to that question is that we cannot give you an answer to that question. To answer your question, there was a policy that was in existence before TIPP which was clinical prioritisation policy with respect to individual treatments, which I think we have shared before in relation to some parishioners. This is evidence-based allocation of public funding to ensure the best delivery of care, which is recognised within surgical pathways for the benefit of all patients. If you are going to be put on a waiting list for a procedure, you should really only be put on to a waiting list for a procedure that is clinically validated and shows value for money. There is plenty of work - it does come from the U.K. (United Kingdom) and has been around for about 20 years, so it has had a long track record of working - that shows that this is prioritising the allocation of funding to procedures which deliver the greatest benefit to patients. If we are going to allocate funding to patients for procedures which do not deliver any significant benefit, that is a waste of public funding. In answer to your question, we have a policy already in existence. That policy was here when I arrived 2 years ago. It has been in the process of updating to make sure that it aligns with the most recent data in terms of validated pathways, what delivers the best value for money, what is a good procedure, what is not a good procedure; and it is now back out with a clinical body for consultation. In terms of how long that would take, I would expect it to take at least another 2 months so that we start the new financial year with the pathway embedded.

Deputy L.M.C. Doublet:

Okay, thank you. Minister, just to reflect on what your officer has said, the policy intention behind this review, is it to improve patient outcomes rather than to make savings?

The Minister for Health and Social Services:

The intention is, essentially, to improve patient outcomes. If it does or does not ...

Medical Director:

Yes. And there may be the unintended consequences.

The Minister for Health and Social Services:

Yes. As I say, the focus is on the patient.

Deputy L.M.C. Doublet:

Okay, so it is possible that the same amount of money would be spent but the outcome would be improved health of patients.

The Minister for Health and Social Services:

As I say, I cannot predict the outcome because it is a work in progress, but that could be one of the possible outcomes, I think it is safe to say.

Deputy L.M.C. Doublet:

Okay, so the driving force is not saving money?

The Minister for Health and Social Services:

No, but by the same token, we do have to prove that we are efficient, if that makes sense.

Deputy J. Renouf:

I think my only comeback on that would be that there are disputes around what is considered a cost-effective treatment. Indeed, we have had correspondence from people who have claimed that they are not being able to access treatment which they regard as vital for their health. What transparency will there be around that decision making?

Medical Director:

Within the policy there are, if you like, “get out of jail free” cards where a procedure may be either unfunded or provided with limited funding. There are set criteria by which people can act with the health service to say: “I know it is not funded but, in my case, I think it should be funded because ...” That is the reason why we have those committees which have been alluded to, to hear those cases individually. For example, if somebody wants varicose vein surgery - which is fairly rare these days in terms of the United Kingdom, but more so here - then you would be able to lodge an appeal that would come to one of those committees where an individual case would be heard, and that might result in an individual patient funding request and that person being able to access that surgery.

Deputy L.M.C. Doublet:

Thank you. If you could send us that list of the committees and also information on how that is communicated to patients so that they know that there is a route to appeal or to advocate in that way. Thank you. We are going to move on now to a section on women's health which has a few areas underneath it. Deputy Stephenson is going to open with some questions about I.V.F. (in vitro fertilisation), so if you need to move anybody around, please do so. If the people who just sat at the table could introduce themselves.

Assistant Minister for Health and Social Services:
My name is Andy Howell. I am Assistant Minister for Health and Social Services.

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

Director of Midwifery:
I am Ros Bullen-Bell, Director of Midwifery and Nursing for Women and Children.

Deputy L.K.F. Stephenson:
Thank you. As the chair said, we are going to start with some questions on I.V.F. I think you are well used to some questions on I.V.F. at the moment. Among us, we have asked a few very recently, particularly in light of the figures that showed there was some budget, as it were, left. Only 10 per cent, I think, of the budget was spent to a certain point in the year. We have had some answers around the potential for extending the eligibility criteria, and I think you said you were going to review it at some point. Can you provide an update to us, please?

Assistant Minister for Health and Social Services:
Thank you for asking the question. I do recognise that we are underspent on budget, and for that reason I would like to announce today that we are going to be making changes from 1st October to some of the criteria. I recognise that it is really hard for couples who long to have a child, and the challenges that they face when it is not straightforward. When the first round of changes to I.V.F. funding were announced last year, I committed to keeping these under review in the hope that we would be able to extend the offer and support more couples with I.V.F. funding, with a caveat, so I am delighted that we are now in that position. We are going to make 3 changes. The first is access for couples with children from previous relationships. The current policy says that you are not eligible for funded I.V.F. if either of you or your partner already have children, whether from your current relationship or a previous relationship. This includes adopted children and biological children. The amended policy will say you are eligible for funded I.V.F. if you or your partner already have children from a previous relationship. This, I hope, will allow couples where one of the partners does not currently have a child to access funded I.V.F. and potentially have a child together.

Deputy L.K.F. Stephenson:
So one of them has got to not have a child ...

Assistant Minister for Health and Social Services:
Yes.

Deputy L.K.F. Stephenson:
... to qualify for the new criteria?

Assistant Minister for Health and Social Services:
Correct.

Deputy L.K.F. Stephenson:
Okay.

Assistant Minister for Health and Social Services:
The second is we are going to remove the requirement to be resident in Jersey for one year for certain people. The current policy says that you and your partner must be ordinarily resident in Jersey for at least 12 months immediately before treatment. The amended policy will say: "You and your partner must be eligible for H.C.J.-funded (Health and Care Jersey) healthcare in accordance with H.C.J. policies." This allows long-term Jersey residents who have left Jersey for a few years to return home and to access funded I.V.F. in the same way they can access other H.C.J.-funded services; so they do not have to wait for a year when they have come back.

[13:00]

The third one is something that perhaps Deputy Doublet might like. The current bits are removing infertility requirement for same-sex female couples. The current policy says you must be infertile as a couple to access funded I.V.F. For same-sex female couples, this means you are required to have used artificial insemination and have not become pregnant after 12 cycles, 6 of which used intrauterine insemination. The amended policy will remove the infertility requirement for same-sex female couples; that is, they will not need to undertake artificial insemination to prove infertility. Please note, this does not include the funding of donor sperm or eggs. As per current policy, we will not refund the cost and sourcing of donor eggs or sperm if required.

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

Deputy L.K.F. Stephenson:
Thank you very much for that.

Assistant Minister for Health and Social Services:

I am really pleased that we are bringing this forward early, because I really felt that we have got the funding and we should be using it for as many people who we can help as possible.

Deputy L.K.F. Stephenson:

Do you have any estimates about the number of couples who may now qualify, or what the uptake may be?

Assistant Minister for Health and Social Services:

It is very, very hard. It is like putting a finger up in the wind. It is really hard to predict demand, and that is the trouble with all of this because we are sort of flying blind, but we are hoping we are going to help more couples.

Director of Health Policy:

As the Deputy says, it is very, very difficult because we do not really have data in this area. We are trying to make estimates based on various and different data sources. But if we look at the number of public patients that we have for I.V.F. in Jersey and if we look at the number of private patients that we have in Jersey - who we know about because they are sourcing I.V.F. through the Assisted Reproduction Unit, as opposed to sole private patients that are not coming near the Assisted Reproduction Unit - we estimate that within a full 12 months of the new criteria operating ... that is not the first 12 months, i.e. this year, but 12 months from October to October next year. As you know, we had an available budget of £620,000; we think that this is going to cost around £614,000. Part of the reason why you get that increase in cost is that the more people that we have coming through, the more staffing we need. To date, because numbers have been quite low, staffing has been within the existing contingent. As you get more patients coming through, staffing within the unit is going to increase. The other thing it might be helpful to understand is that because there is a time lag in the financial data that we provide, when a question about I.V.F. funding was recently answered in the States Assembly, we said that - I think it was £64,000 - about 10 per cent of the budget had been spent. That information was correct at the time based on the data that we had at the time, but what we have done is we have gone back to our financial data and we have looked not just at the spend that has gone out of our budget, but the committed spend through the people that we know are coming through because their I.V.F. has already been agreed and it simply waiting to happen. From January this year to August this year - so, before we implement these new changes - it is not £64,000, it is actually £211,000. That £64,000 figure I think has created some concern about it being very low; the spend is actually higher and ...

Deputy L.K.F. Stephenson:

Okay, but still on the same number of people? Or is it more people?

Director of Health Policy:

It is more people; so, a combination of some more people but also the actual invoicing and costs associated with committed people coming through the system. Does that make sense?

Deputy L.K.F. Stephenson:

Sure. Would it be possible to ask to have those more rounded figures?

Director of Health Policy:

We can certainly provide those more rounded figures to you.

Deputy L.K.F. Stephenson:

Thank you.

Director of Health Policy:

Based on the fact that current spend is higher than we previously indicated it was - we have actually spent about one-third of the budget, not 10 per cent of the budget - and based on these changes, we are expecting around £614,000 of the £620,000 will be spent. But as the Assistant Minister has indicated, we will continue to keep that under review because our predictions may be incorrect. They may be higher or they may be lower, and we need to address those as we go along.

Deputy L.M.C. Doublet:

Thank you. I have got 2 questions, and just to echo Deputy Stephenson's thoughts on the ... thank you. I am delighted, not just for the L.G.B.T.Q. (lesbian, gay, bisexual, transgender and queer) community but for families across the board who need to access this. But a question about the access for same-sex couples. Do you know how much of a saving that will be, not having to self-fund those 12 cycles? Just roughly. If you do not, it can follow in writing; that is fine. Also, communication on this. In terms of the same-sex parental rights, I think large portions of the community have been left very confused because they have not recently been very well communicated with. Now, this is a really big change and will be a really big moment for that community. How are you planning to get the message out there?

Assistant Minister for Health and Social Services:

I will go to the press, and I am sure that I will work with our policy officers and others in Public Health to get the message out.

Director of Health Policy:

This afternoon, after the Assistant Minister has told the panel this, we are going to put out an initial press announcement explaining that to people. The Government of Jersey website will be updated

from 2 o'clock today saying that these changes are coming into force on 1st October. We have moved at pace to do this. We recognise that we now need to do some proactive communications around it.

Deputy L.M.C. Doublet:
Yes, okay. If we were to make some suggestions, is that something you would be open to?

Assistant Minister for Health and Social Services:
Yes, I am very happy to listen to suggestions.

Deputy L.M.C. Doublet:
Great, thank you. The other question; you mentioned the criteria may be further reviewed. One of the criteria that I would like to ask you about is for single parents. People who obviously could not prove infertility if they were single, how would they ... could they be covered with this as well?

Assistant Minister for Health and Social Services:
At the moment, we are just looking after couples because I think that Deputy Stephenson in her proposition was very clear that it was for couples. That is what we are dealing with at the moment and we just have to see how this moves forward. Because it is also unfair on gay men as well, is it not?

Deputy L.M.C. Doublet:
Have you done any financial modelling? Say, if you were to extend it to single parents in the first instance, what that might cost?

Director of Health Policy:
We have tried but, as I say, our datasets are very sparse and they have got big holes in them. When we initially started the work over a year ago we looked at different options and it is quite clear from the fact that we have spent £200,000 out of the £600,000 budget that our initial forecasting was not as accurate as it could have been, which therefore casts a light on the rest of our forecasting, which we always recognised might be incorrect because of the gaps in our data. But I think that if, within the next 12 months, we do spend £614,000 clearly there would not be sufficient budget within that 260 to open the doors for single women as well.

Deputy L.M.C. Doublet:
Can I ask the Assistant Minister then, if the money is not spent what would be your next criteria? Would it be single parents or would it be ... I think maybe Deputy Stephenson might have supplementary to that in terms of other criteria.

Assistant Minister for Health and Social Services:
I think I would need to come back to Tiny Seeds and Deputy Stephenson and work with them to see which area, if we are under spent, we should look at next.

Deputy L.K.F. Stephenson:
I think a practical question, because there will be people out there today who will take this as real good news and they will be ringing up A.R.U. (Assisted Reproduction Unit) tomorrow. If they have self-funded in the past 6, 7, 8 months, there is a potential that that counts them out of this funding if they now come into it. Where does that fit? Have you considered that at all?

Assistant Minister for Health and Social Services:
Something in my heart. I really would like to support them but I think it is really hard, whether we …

Director of Health Policy:
The current criteria for access say that it is up to 3 rounds of I.V.F. and any previously self-funded rounds count towards those 3 and we … within the modelling we have done we are assuming that that criteria is maintained, i.e. if you have self-funded that counts towards your 3. I do recognise, however, that when we first introduced this policy we created mere space for people who had just funded I.V.F., and that is something that we will think about and we will have done that before 1st October.

Deputy L.M.C. Doublet:
Minister, do you have some discretion in that area as well?

Assistant Minister for Health and Social Services:
I would like to think I have.

The Connétable of St. Martin:
As I am new to this panel but also somebody who has campaigned for infertility treatment for over 30 years I am thrilled with this announcement this afternoon. I know that the budget will be severely impacted by this announcement but I still would like to ask, because we have been asked: since treatment occurs off-Island will the department consider funding travel or accommodation assistance, given that this remains a significant barrier to many couples?

Assistant Minister for Health and Social Services:

Yes, I am really sorry about that but we recognise that we should be helping more couples have the actual treatment than the travel and the accommodation costs. With regret, but we just cannot … we have not got a big enough …

The Connétable of St. Martin:
I know. But this is a massive step forward today, so thank you.

Assistant Minister for Health and Social Services:
Thank you.

Deputy L.K.F. Stephenson:
I would just add off the back of that it, am I right in saying it is still the only healthcare where we send people off-Island for paid treatment but do not cover their travel though?

Assistant Minister for Health and Social Services:
Well, I think it is something we are going to have to look at as well in the overall.

The Minister for Health and Social Services:
Does everyone else cover travel?

Director of Health Policy:
No, I think what Deputy Stephenson was saying, that when we send people off-Island for any other form of healthcare we currently pay for their travel. Not that we are the only jurisdiction that does ...

Assistant Minister for Health and Social Services:
I recognise that but I would rather that we were helping more people have the treatment.

Deputy L.M.C. Doublet:
Do you have any further …?

Deputy L.K.F. Stephenson:
No, thank you. Thank you very much for your answers.

Deputy L.M.C. Doublet:
Thank you for sharing that news with us today, thank you for your work. So, still on women's health we would like to ask some questions around maternity and the home birth. We have obviously asked lots of questions on this subject in the past and there have been some communications from

yourselves that we have noted with your website and the media and we understand that there was a course - the Baby Lifeline course - that was being delivered in July. There was a slight delay. It was due to be delivered in April or May and that was delivered in July. Please, could you update us as to the status of the training and the review in this area?

Director of Midwifery:

Obviously, the training did take place in July and that was, obviously, we could not do every single midwife, but that was joint training between ourselves and the Ambulance Service. We have got our next training day in 2 weeks' time and then we have got a full programme of training throughout 2026. That is not just with maternity, that is also with the Ambulance Service as well. As part of our review we did a whole mapping exercise in relation to where we were with our home birth service and that was our guidelines, policies, pathways, et cetera. The second part of that then, obviously, the Ambulance Service has come into H.C.J. so we did some work with them. We did a big mapping exercise with them and that became evident to us that they have got new staff within their thing so they had to have the training as well. We had to make sure that they have got that child bearers emergencies as well. We became aware of the Ambulance Service data with their response times. So, we are working through all of that data in relation to the response times and also when they have got periods of time where there might not be ambulances available. We need to make sure that we have looked at pathways, policies and procedures that align with our maternity as well as our Ambulance Services as well, to make sure that we are aware of times and that women are fully informed of the availability of the emergency services if required, because obviously we have got a very strict criteria within our guideline but we need to now strengthen that with the Ambulance Service. That is the piece of work at the moment that we are doing, is working with them to make sure that we have got these policies, procedures and guidelines are all in place. But, obviously, paramount to all of it is safety. So, at the moment we have not got a home birth service and there is no timeline for when that will become active again, but at the moment we are working very closely with the Ambulance Service.

Deputy L.M.C. Doublet:

The training, you said some of your staff and some of the ambulance staff have been trained. When will both of those services, everybody, be trained? When will that happen?

Director of Midwifery:

We have got our next training session is in 2 weeks' time and that is when the maternity service will be almost up to capacity but it is the Ambulance Service where we started on that.

[13:15]

That might not be until into 2026 because they have got new individuals come and they have also got agency within the Ambulance Service, so we have got to take that all into account. It had to be something for them to answer on behalf of when they believe that all of their ambulance crew will be fully trained.

Deputy L.M.C. Doublet:

Minister, is there anybody here who can answer that because, obviously, the public interest in this is very high and I think it would be helpful to understand that target date, or, Minister, can you set a target date whereby you would like all of your staff to be trained?

The Minister for Health and Social Services:

No, I cannot and I will not be forced into doing that. This is a public safety issue. I think the team are working as quickly as they can. I think it would be wrong of me to put them under extra pressure to do that. I think we have to put the patient first, and that is exactly what is being done.

Deputy L.M.C. Doublet:

Have you communicated though that politically it is a priority and are there sufficient resources for that training to be carried out at the earliest opportunity?

The Minister for Health and Social Services:

Resources are there and I do not think anybody this side of the table needs to be reminded of the public importance of this. I think it is very plain to everybody the last time that we met that it is an issue of great concern to people. But I think it would be wrong to fast-track it in such a way that somebody's life or a child's life might be put at risk.

Deputy L.M.C. Doublet:

I think it is prioritising is what I am asking, rather than fast-tracking.

The Minister for Health and Social Services:

No, I am happy with the level of prioritisation that it has at the moment.

Deputy J. Renouf:

Can I ask a follow-up question regarding your … you have mentioned the Ambulance Services as being a significant extra thing. When did it become apparent that the Ambulance Services were needing to be trained up as well?

Director of Midwifery:

I think it has always been something that we have done, but looking at it as a whole to get the data about what percentage of training they have got and obviously with the turnover of staff, making sure that everybody who is new within it have been trained as well. It became part of our clinical effect in this work alongside the ambulance crew and as part of that training. So, they are very much… it is training together, that the midwives and the paramedic crews are training together. It is through doing all that review and doing the mapping exercise and the quality improvement that we saw that we needed to make sure that they have all got that training as well, and that they have got that child birth emergencies training ... all of them have got it and not just one or 2, that we made sure. It was all part of that mapping exercise that we did.

Deputy J. Renouf:
Given that you have identified the need and the work is underway, why is it not possible to say when that training will be complete? Because there is a risk here of an ever-receding horizon.

Director of Midwifery:
No, you are right. It is about making sure that we have worked very closely with the Ambulance Service and it would have to be the Ambulance Service that we could ask them for an update on that.

The Minister for Health and Social Services:
I think, if you do not mind me saying, we have got to trust individuals who are clearly competent and doing their best. I am very, very comfortable with the team that I have got here and I know that nobody wastes any time. I think we have got to stick with the position that we have got here. It will happen when it happens, in a timely fashion, and I do not think there is any chance of drift. That the people we have got this side of the table are on to it and that sort of thing.

Deputy L.M.C. Doublet:
Sure. I think what we are asking for is drift from where? I think we will follow up in writing, if you could seek that information for us, so that we could make sure that the public are aware of that so that people know when to expect that. In terms of the review then, aside from the training, what other objectives and recommendations are you currently working on?

Director of Midwifery:
Our criteria is down. We are making sure that our policy guidelines, and obviously our policy and guideline for maternity was one specific, but we now need to work alongside our ambulance crew and that is ... we are absolutely not slipping. We are working with the ambulance crew to make sure that our pathways align with them and that our response times, et cetera, are all within it. That is

where we are working at the moment. Our guideline policy is in maternity but we need to make sure that they align with the Ambulance Service as well, within it.

Deputy L.K.F. Stephenson:
Sorry, if I am not understanding it, have paramedics not been trained in the past in this?

Director of Midwifery:
Some have been trained in the past in it but not all of the paramedics. Obviously, you have got new staff that might have come in and we have very much now taken it that we will be having a paramedics training with our midwives to make sure that they are all getting the same training, yes.

Deputy L.K.F. Stephenson:
Forgive me for pushing the point somewhat but we are coming up for a year formally without a home birth service. I think other people would say informally it has been months before that. Perhaps a question for the Minister, is that good enough for Islanders ...

The Minister for Health and Social Services:
Yes, it is.

Deputy L.K.F. Stephenson:
I believe there is some new principles from the Nursing and Midwifery Council about supporting person centred care for women and babies and it is very specific that it talks about women's views and choices and preferences being put at the heart of maternity care. It talks particularly about the options for where a woman can give birth and talks about home birth specifically. I just cannot square the circle here that we are a year on from that. Is there a sense of urgency about trying to work towards this in the best interests of everybody?

The Minister for Health and Social Services:
I have said it before and I have said it again. Yes, there is an urgency. We appreciate it. We appreciated it the last time. But I think you might find it extraordinary, I do not. The job is being done properly. It is being done comprehensively. That is what needs to be done. It will be done in a timely fashion by good people and I will not be pressed any further on it, I am afraid. We are where we are, it will be ready when it is ready and you have got good people taking care of it. There is nothing more that I can say.

Deputy L.K.F. Stephenson:
When everybody is trained is the button ready to be pressed to switch back on the service?

Director of Midwifery:

I do get the principles have come out but I think paramount to that it is all about safety and I think that is where my role is, is I have got to make sure it is a safe service and it is a sustainable service, and that is for every single woman on Jersey. I think that is what I just keep saying is that the safety, and we will make sure that we are ready, but it needs to be very much in line with our Ambulance Service as well as ourselves, to make sure that everybody is on the same page and that the criteria is … because at one given time, as I have said before, it will never be able to give it 100 per cent because we have to look at what is the activity within the maternity service and with our Ambulance Service at any one given time, and we all know that sometimes that can be compromised because of different things that are going on.

Deputy L.M.C. Doublet:

That has always been the case, has not it?

Director of Midwifery:

Yes, always been the case. It is not a new thing. But it is about safety, making sure that I can provide that absolute assurance to you all.

Deputy L.M.C. Doublet:

Just to be clear, when we are asking questions in this area we are always asking it with the underlying assumption that the service delivered would be a safe one, and we agree with that principle.

The Minister for Health and Social Services:

I stand to be corrected but I think we have had problems here before, have we not, in maternity some time ago? That there was an incident that …

Deputy L.M.C. Doublet:

Minister, my next question to you would be: is it your aim to reinstate the home birth service as a funded service?

The Minister for Health and Social Services:

To the extent that that is possible within the budget, yes.

Assistant Minister for Health and Social Services:

As long as it is safe for the mother and the baby, and we have to make sure that we have got enough ambulances also to be able to do the service.

Deputy J. Renouf:

Clearly safety is vital, but safety can never be 100 per cent, so there has to be a point reached at which it is acceptable. There is a risk that the focus on safety becomes, as I say, a receding horizon where you are never completely sure. Do you have, in your own mind, a clear point where you will be able to say: "Yes, I am comfortable"?

Director of Midwifery:

I absolutely have got that and that is when I will be going to the Ministers and our chief officer at the hospital as well to give them that assurance with it.

Deputy J. Renouf:

You do not see that as 10 years in the future?

Director of Midwifery:

No.

Deputy L.M.C. Doublet:

What does it look like, that point?

Director of Midwifery:

To me it is about that we have got … everybody is safely trained, that I know when a woman phones up that I am able to give her that evidence about that, yes, we can provide the midwives within the care for them and also that our Ambulance Service is able to provide if they require to be transferred in for any reason but that everybody is trained to this high standard. That is what I want to make sure.

Deputy L.M.C. Doublet:

Thank you for your answers there. The next section that we are going to ask some questions, which is semi-women's health. We appreciate this might be an issue across any gender, but we want to ask around the assessment and treatment of anaemia and I think Connétable Shenton-Stone is going to open.

The Connétable of St. Martin:

The panel has been made aware that there may be inconsistencies in how anaemia is assessed and treated in the Island. Does the General Hospital's pathology laboratory follow UK standard haematinic investigation protocols e.g. ferrous and vitamin B12, folate, reticulocyte counts when anaemia is suspected, and are their local protocols or guidelines that outline these investigations?

The Minister for Health and Social Services:

I certainly cannot answer that question, I am sure you will not be surprised.

Director of Midwifery:

Shall I answer as much as I can? So, obviously, in relation to … it is women's health, I do not know about the specific area, but in relation to pregnancy, we absolutely follow U.K. guidelines, and N.I.C.E. guidelines, and we do offer the different ones depending on what their level is. We do the normal testing of all women at booking and at 28 weeks. If they require further testing they get that done, if they are anaemic. But we do follow the guidelines in relation to medications as well. We absolutely do follow them within our guidelines. It is N.I.C.E. guidelines that we follow, which is exactly what the UK follow as well.

The Connétable of St. Martin:

The question I was asking, it was not actually for pregnant women, it was for other; especially young women that it has come to our attention that I think the criteria in Jersey for … the threshold for being diagnosed as anaemic is far higher than it is in the UK. That has been brought to our attention, so maybe if nobody can … we could follow these up, could we not?

Director of Midwifery:

I am very happy to do that.

The Minister for Health and Social Services:

I am sure we can find the appropriate person.

Director of Midwifery:

I am very happy to, if you put that question in, we can answer that because it is not something we could answer today.

The Connétable of St. Martin:

Thank you very much, thank you.

Deputy L.M.C. Doublet:

Do you want to ask any of the other ones on that section or shall we follow …?

The Connétable of St. Martin:

I think I will have to follow up because I think it is unfair if you cannot really answer them today.

Deputy L.M.C. Doublet:

Thank you for your efforts anyway. The next section we are going to move on to is around eating disorder support services provision. We might have another swap in and out. Would you like to introduce yourself, or you already did? You have already done that bit.

Deputy P.M. Bailhache

The first question is whether current referral treatment waiting times for eating disorder clinic services and J.T.T.'s (Jersey Talking Therapies) services for disordered eating can be stated?

Director of Mental Health, Social Care and Community Services:

Yes, so for the eating disorder service the average wait is 21 days from referral to assessment. It is important to describe the eating disorder service. It is a pathway that has got 33 people in it and it is one clinical nurse specialist, part of a psychiatrist and part of a dietician. That is the specialist service. Lots of people with eating disorders will receive care from that team but also will receive care from other people like Jersey Talking Therapies, for example. So, if people need psychological support it is not dedicated within the eating disorder service, it comes from our normal psychological services.

Deputy P.M. Bailhache

Twenty-one days from referral to treatment?

Director of Mental Health, Social Care and Community Services:

Referral to assessment, yes. There were only 2 patients currently waiting.

Deputy L.M.C. Doublet:

Did you say from referral to assessment rather than treatment?

Director of Mental Health, Social Care and Community Services:

Assessment, that is right.

Deputy P.M. Bailhache

Right, okay. There is no waiting time for referral?

Director of Mental Health, Social Care and Community Services:

It is 21 days. If someone needs to be seen more urgently, so if it is a mental health crisis, for example, they will be seen routinely by the crisis team first. The way that mental health services works is that referrals come in through a central team, they are triaged by that team. They may see the patient, they may not need to. It may be very clear where the patient needs to go, and then they

get referred into the specialist part of the service. But people are seen currently within 21 days for a routine eating disorders referral.

Deputy L.M.C. Doublet:
Can I ask, just as a follow up to your question, the time from the assessment to the treatment?

Director of Mental Health, Social Care and Community Services:
It will then just start straightaway.

Deputy L.M.C. Doublet:
Is it immediate?

Director of Mental Health, Social Care and Community Services:
It absolutely is. It is not that we just do an assessment and then you wait. That is not true for psychological therapies. For psychological therapies there is a clear differential and we report differently between referral to assessment and referral to treatment.

Deputy P.M. Bailhache
Are there any capacity limitations which lead us to need off-Island treatment?

Director of Mental Health, Social Care and Community Services:
Only for in-patient care. The only time that we would send someone off-Island for care for eating disorders is if they need care in a specialist in-patient mental health provision. They are highly specialised services. They are regional in the N.H.S. so lots of towns and cities will not have one. They may be shared between a number of different places and we would never be able to provide that here. That requires a whole clinical multi-disciplinary team of people to look after someone in a hospital setting. There is currently one person off-Island. Generally there is one or 2.

Deputy P.M. Bailhache
Can we talk about A.R.F.I.D. (Avoidant Restrictive Food Intake Disorder), which is something which I learnt about today?

Deputy L.M.C. Doublet:
Should I state what it stands for? It is Avoidant Restrictive Food Intake Disorder, we have been informed.

Deputy P.M. Bailhache
Is this a major problem in Jersey?

Director of Mental Health, Social Care and Community Services:
It is a problem and certainly my C.A.M.H.S. (Child and Adolescent Mental Health Service) colleagues tell me that it is a problem that they are thinking about currently. Our criteria for adult eating disorder services would generally not include A.R.F.I.D. currently. Because of the size of the service they tend to focus on the people with the most need. But we are currently talking with the Children's Service about an all-age eating disorder pathway.

[13:30]

Because that would make sense in terms of pooling and resources but it would also potentially allow us to start to think about widening our breadth. It is an issue. It is an issue that we are thinking about. Certainly, as I say, it is an issue that is talked about more in Children's Services than Adult Services but in the overall thinking about what do eating disorder services look like, we need to consider what we are going to do moving forward around A.R.F.I.D.

Deputy P.M. Bailhache
But how do you distinguish between a child who simply does not like spinach and someone who has a problem?

Director of Mental Health, Social Care and Community Services:
It is a clinical assessment. As with anything else the diagnosis would be applied following a full clinical assessment and not just based on the child will not eat spinach, I hope.

Deputy L.M.C. Doublet:
Can I just ask a quick one on that? In terms of that pathway being expanded, will there need to be additional budget?

Director of Mental Health, Social Care and Community Services:
There will. One of the things that we have started to do now is think about budget allocation for next year. As you would expect, we have a variety of potential pressures on budgets. We have a variety of areas where we would like to, perhaps, put some more resource in one place but more resource in one place means less resource in another, so we are starting to think through at the moment how will we do that for next year.

Deputy L.M.C. Doublet:

Okay, and final one. Are there any interim measures? As you have told us you have done with other things like the A.D.H.D. (Attention Deficit Hyperactivity Disorder) pathway, is there anything in the interim that you could put in place?

Director of Mental Health, Social Care and Community Services:
I think one of the things that we do well, and increasingly around eating disorders, is working with a third sector. We have a good relationship with a number of charities, the eating disorder service works well with us around this area. They, for example, have some counselling capacity which we can ask people to think about using if they are waiting for our psychological assessment services. Yes, I think there is some stuff that we can do but fundamentally we just need to work out what is the breadth of the service going to be moving forward?

Deputy L.M.C. Doublet:
Please, would you keep us updated on that service? Thank you. We are going to move on now to some questions about the Rheumatology Department.

Deputy J. Renouf:
I think it was back in May, Minister, you announced that there was not going to be a group compensation scheme for rheumatology patients. Can you outline what objective criteria were used to make that decision?

The Minister for Health and Social Services:
I will hand over to Simon.

Medical Director:
It is difficult to give a solid answer on that from my perspective. From the perspective of Health and Care Jersey we welcome any applications for compensation from previous patients and/or, relatives that have been caught up in the rheumatology affair. The decisions with respect to compensation back when the Minister made his announcements were the decisions at that time but negotiations are still ongoing with respect to the possibility of a scheme or not. Those negotiations are being carried out by various legal entities and bodies involved, both within the Island but also as representatives of those concerned. I do not think it is a hard no at the moment but the Minister, I think, was being honest at the time in terms of where negotiations were at that stage.

Deputy J. Renouf:
Just to clarify, although there was announcement in May that there was not going to be a group compensation scheme, there might be?

Medical Director:

I cannot say that there would be and I cannot say that there definitely will be, but I can say that certainly discussions with respect to any possibility for that are ongoing.

The Minister for Health and Social Services:

It is a very complicated area as a layman, when you get into the complexities of medical law. You get a lot of uncertainty from my point of view, so I have to really look to the best advice that I can be given.

Deputy J. Renouf:

In terms of the current situation. If a patient is trying to seek some redress, is their only option to take legal action or can they engage in a process short of legal action to try and gain compensation?

Medical Director:

There is no other process other than engaging in legal action at this point in time.

Deputy J. Renouf:

Does the Minister recognise that that places an onerous expectation on people who might be suffering quite considerable health implications?

The Minister for Health and Social Services:

It does, and as I say, it is a very complicated area and it is under discussion all the time. We have not reached a particular concrete position as yet.

Deputy P.M. Bailhache

Can I ask where this is being dealt with? Is it being dealt with in a department? Is it being dealt with by insurers? Is it being dealt with by lawyers?

Medical Director:

I think you have covered all 3. It is a combination of all 3.

Deputy P.M. Bailhache

Who is in the lead in terms of the scheme which Deputy Renouf is talking about? What are the criteria of whether there should be a scheme or should not be a scheme?

Medical Director:

With respect to the criteria as to whether there should be a scheme or not a scheme, I think it is reasonable to say that negotiations are continuing between the legal people on the Island and the

insurers that represent the individuals and also those people with a specific interest in relation to the possibility of a scheme. I am not party to those so I am speculating, and it would be unfair to the public to speculate in a public forum like this.

Deputy J. Renouf:
The Minister made an announcement; was that your decision, Minister?

The Minister for Health and Social Services:
A decision based on advice.

Deputy J. Renouf:
Does the buck stop with you in terms of whether there will be a scheme or not?

The Minister for Health and Social Services:
Ultimately, I assume that it will and, as I say, I have to be guided in this because this is not an area of specialisation for me at all. It is an immensely complicated business.

Deputy J. Renouf:
But the decision that was announced has, to a certain extent, been rowed back on in the sense that it is now …

The Minister for Health and Social Services:
That was the decision at that point in time. As I say, this is ongoing. I appreciate that that does not give complete certainty and hopefully we can get to a more certain position in the not-too-distant future.

Deputy L.K.F. Stephenson:
Can I ask what has changed since that announcement to make you reflect on that?

The Minister for Health and Social Services:
To be honest, I cannot answer that directly other than the fact that discussions are carrying on within all the departments that were mentioned. As I say, it is an evolving piece of work.

Deputy L.M.C. Doublet:
You mentioned your officer advice; is it that you have reflected on officer advice?

The Minister for Health and Social Services:

As I say, I have to be guided in all of this. I do not know as to whether we can put a timetable together as to when we can have a …

Medical Director:

I do not think we can put a timetable on that and it would be unfair to label a point in time where this would be concluded. I think it is reasonable to say that, with respect to the possibility, people are still exploring the possibility. I think the Minister was being honest at the time in terms of the advice that he was given and I think he was not trying to raise expectations of the public as a whole, but that does not mean that people are not continuing to try to do what is felt to be the right thing to do for Islanders.

Deputy J. Renouf:

Can you update more generally on the mortality learning reviews that have been going on? Where are we with that? We have heard that 5 cases have been referred for the police, I believe. Is the process of assessing complete?

Medical Director:

In terms of Operation Crocus, which was set up to review rheumatology, the process is near conclusion. It concludes at the end of this year and, yes, in terms of those people who had deceased, those have all been reviewed, and the previously reported number of cases that were referred to the Viscount has not increased. In terms of the number of cases that the Viscount is looking at, those have been reported in the media over the course of the last few weeks, I believe.

Deputy P.M. Bailhache:

Just following up Deputy Renouf; there are 2 issues, are there not? There is the issue of liability and then there is the issue of compensation if there is liability, and whether or not a scheme is established depends to a large extent, I suppose, on the question of numbers of those people falling within each category. But I think one of the concerns of the panel relates to people who do not have enough money to employ a lawyer and to pursue legal proceedings, unless of course they join up with other people to do that. But on the assumption that one is talking about an individual, is there any action which is being taken in the department in order to assist such people to obtain their entitlement?

Medical Director:

I think it is very difficult for the department to actually put in place. We are very much open to working with people who feel that they require a degree of compensation, but we are not equipped in a legal entity to assist those people. That is why we encourage people to work with members of the law

community within Jersey. But I fully appreciate that that leaves people at the behest of those people in terms of how they would be able to fund such an entity.

The Minister for Health and Social Services:
Do you want to move on?

Deputy L.M.C. Doublet:
You can add a brief comment.

The Minister for Health and Social Services:
I have just been thinking, while these questions are being asked, I am very happy to bring all the threads together and put some focus on this and try and write to you at some point in the future with a fully up-to-date position, if you like, which I think might be helpful. It might take a few weeks to bring those threads together because, as you can imagine, everybody has got a full agenda but I think it would be probably quite timely to get all the relevant heads together and come up with something that gives a bit more clarity for everybody that might be out there. I think it would be helpful.

Deputy L.M.C. Doublet:
I think, given the gravity of the issues around this with the public, that would be very helpful, thank you. Okay, we are going to move on to a different section now, and we are following up to our recent review into A.D.H.D. prescription of medication. Deputy Stephenson is going to lead this one.

Deputy L.K.F. Stephenson:
At the end of February this year I think the waiting list for assessment and diagnosis was at 932 individuals, with the waiting time approaching 5 years. Can you please provide an update on the current status?

Director of Mental Health, Social Care and Community Services:
The current waiting list as of today is 1,026 people. The service receives an average of 25 referrals a month and has capacity to undertake 4 new assessments a week. As we have rehearsed previously here on numerous occasions, some of that is because a vast amount of medical time is taken up with prescribing. There are over 300 people currently on the prescribing list. They are not all being prescribed for. The dilemma is that the more people we assess and the more people that we seek to treat, the less capacity there is to see new people. That is simply the dilemma. The prescribing nurse that we recruited started yesterday, so that is good news. I am hoping that that will have an impact around some of this. Unfortunately, the service has had a significant amount of sickness absence medically. That has further impacted in the last few weeks on the capacity of the

clinic to see people. We are kind of holding a relatively steady state in terms of assessments. The work is ongoing in relation to prioritisation. The team have met twice, I think, to look at that. They are meeting again on Thursday. That will then require someone to go through the 1,000 people and prioritise them based upon any criteria that they decide. They are thinking about is that a good use of their time frankly, as opposed to seeing patients. That is a dilemma that is ongoing for them. This is clearly one of the areas where we need to think about do we need to put more resource into the service, but if we do, where are we going to take the money from.

Deputy L.K.F. Stephenson:
Thank you for that update and for the figures as well. I think the one that I missed was waiting times then to get through that; is it still at 5 years?

Director of Mental Health, Social Care and Community Services:
It is, it is approximately the same.

Deputy L.K.F. Stephenson:
I think previously you talked about G.P.s (general practitioners) and could there be shared care pathways - I think G.P.s have rejected that idea in the past - are those discussions still ongoing?

Director of Mental Health, Social Care and Community Services:
They are ongoing. We have not got any further forward. Certainly since the last time that we were here, it has gone back on one occasion to the committee that makes a decision about whether drugs can or cannot be prescribed in the community and was not supported by primary care. We remain in the same position that we were in. We have had a helpful conversation with a G.P. who has a potential alternative model around G.P.s working into the hospital. We need to explore that further. That may be a potential solution to increasing medical capacity.

Deputy L.K.F. Stephenson:
Is there anything that G.P.s are feeling that would help change that decision for them? What are the barriers for them?

Director of Mental Health, Social Care and Community Services:
I think it is interesting, it is one of the things that we have started to see now in other jurisdictions. I think I have said here previously, I came from a place where lots of G.P.s did shared care prescribing; that was very much the routine. The specialist A.D.H.D. service did diagnosis and annual review and that was that really, unless there was a concern. Everything else was done in primary care. That is starting to change in England at the moment, so we are starting to see G.P.s saying: “We do not want to do this shared care, we are concerned about the A.D.H.D. medication”

and starting to withdraw from some of the shared-care arrangements. It does not seem that there is an easy answer. The G.P.s are saying, very consistently, this is about confidence, it is about skill and knowledge, it is a concern about the potential risks around some of these medicines, and it is also about capacity. We know what the issues are, we know why people are saying they do not want to do it, but fundamentally we will ... if we carry on, on the current trajectory, we will reach a point where we cannot see anybody new because all the service is doing is prescribing medication.

[13:45]

The Connétable of St. Martin:
Can you advise on the uptake and attendance at the new Living with A.D.H.D. group and what feedback you have received from attendees, and how the outcomes of this group are being assessed?

Director of Mental Health, Social Care and Community Services:
I have not got figures but I can get those for you easily. Feedback has been really positive. We have had some really good feedback from people who have said: "Actually, I now realise this is not just about waiting for medication, there are some things that we can do." It is not a formal psychological therapy group, it is very much an information-giving psychosocial education-type group. But generally the feedback is positive and we have got more people signing up to the next round, so we are just going to keep on rolling this out. I think it is an initiative that helps people that are on the waiting list, and it is a different lens to the answer to all of the problems that you have with A.D.H.D. is medication because we know that is not the case.

The Connétable of St. Martin:
Okay, thank you; that is positive.

Deputy L.K.F. Stephenson:
Just before we move on to the next section, where is that tipping point? You say about when there will be no new patients. Have you got a number that you work to?

Director of Mental Health, Social Care and Community Services:
It is one of the things that we are talking about on Thursday, about we need to model it. I think we do need to say at what point can we see no one new because all we are doing is prescribing.

Deputy L.M.C. Doublet:
So the next section, and I am just noting the time, we are quite short on time, so if we could have the answers as brief as possible.

Deputy J. Renouf:

Minister, you are bringing a proposition to the Assembly to renew the Advisory Board and to set up a new partnership board to co-ordinate and advise you in health matters. There is a slight disparity between what you have said in a previous hearing about the selection of community partners who will sit on the Partnership Board - focusing on that - in terms of them being elected and being representative of their groups or not. Can you clarify, is the intention that the community partners who sit on the Partnership Board will represent their sector? And if so, how?

The Minister for Health and Social Services:

They have 2 roles, as I see it. They are there as representatives. They bring the knowledge from their sector. The intention is not that they necessarily come as a lobbyist for the sector, they come with the experience and knowledge of the sector, with a view to contributing to the overall well-being of decision-making. Does that make some sense to you?

Deputy J. Renouf:

Do they have a mandate to try and find out what their sector is thinking?

The Minister for Health and Social Services:

Yes, we have done some work. I had a meeting about 10 days ago with the primary care body, and we had discussions around tightening up some of the ways that they operate so that every practice on the Island is encouraged. Not forced, but put under pressure to make sure that they all participate. Similarly, I had a meeting with the chairpeople of the various health charities yesterday about tightening the framework of engagement so that information can flow back down and back up from those entities. That is work underway. As I say, we cannot put too much in place without knowing whether we are going to have this passed in the Assembly, but as soon as the Assembly ... I am assuming that the Assembly hopefully will pass this, then we go back and we build on the work that we have done to strengthen those various organisations.

Deputy J. Renouf:

Can I just explore the area of policy that the board will advise you on? The expectation is that the Partnership Board will advise you in specific areas of health policy, is that correct?

The Minister for Health and Social Services:

It is as much an operational mechanism as an advisory. The advice that I take in the main comes from the Health Advisory Board that sits above the whole enterprise.

Deputy J. Renouf:

So you do not expect the Partnership Board to advise you on matters of health policy?

The Minister for Health and Social Services:
Yes, it will do ... of course it will because it is actually doing the operational stuff. As I say, the top guidance will come from an overall policy from the top, the operational guidance will come from the Partnership Board.

Deputy J. Renouf:
The reason I am asking this is it does not appear particularly clear in the proposition, as it currently is. There seems to be some dividing line that you are articulating, that some stuff is to do with the Advisory Board, some stuff is to do with the Partnership Board. Do you have a clear sense in your mind of where that is?

The Minister for Health and Social Services:
Perhaps I do not articulate it properly, but I see the Advisory Board as people who take a completely external view of the entire enterprise and advise on that and advise on best practice with their experience from having worked elsewhere, and the Partnership Boarrd advising on more immediate issues because they are an operational board.

Deputy J. Renouf:
Then final questions around resourcing. I am just mindful of time. We might have to follow up with some more written questions on this. But in terms of resourcing, I think £70,000 has been put aside for it. I think that is right. I stand to be corrected. That is essentially to pay for the attendance and the people who are on the board. Is it correct to say that there is no secretariat support, so say research back-up, commissioning of research that they might want to do in order to support their work?

Deputy L.M.C. Doublet:
Or research officer.

Deputy J. Renouf:
Or research officers.

The Minister for Health and Social Services:
There is no funding for that, is there?

Director of Health Policy:

So £70,000 in the budget and, as you say, that is for attendance and participation and also for training for community partners to do things to upskill them to go out into their sectors and to gather information and views and bring those back. With regard to secretariat functions, research functions, that will be performed within H.C.J's existing resources. It will be from a combination of people within my policy team but also, depending on the subject that they are looking at, it will be from within other areas of H.C.J. The secretariat function will be provided by the same secretariat function that supports the existing Advisory Board.

Deputy J. Renouf:

Is there a risk here though of overload in that there are many potentially weighty issues for the Partnership Board to consider? Where will the authority sit for saying yes or no, you can or cannot have that level of support, given the existing commitments of staff within H.C.J., for example?

The Minister for Health and Social Services:

As I say, I do not think we can predetermine the complete direction of travel. I think we are going to have to run this for 12 months and see how it goes. It might require some more resourcing, but I do not see that it will require levels that go beyond the resourcing that is available in-house at the moment. The idea is to keep this operational and as lean as we can.

Deputy P.M. Bailhache:

The concern which I have, Minister, about your Partnership Board, I think, is the extent to which it is going to tie up the time of your senior people, like the medical director and the director of health policy. You have got an advisory board, you have got a partnership board, you have got provision for committees and subcommittees of a partnership board. When are your people going to have time to do any work?

The Minister for Health and Social Services:

That is a very good question. I would argue that this will be an advantage rather than a disadvantage. The only decisions that will be being made by the new Partnership Board are decisions that are currently being made at the moment. People spend an awful lot of time making decisions in what I would consider being an operationally slightly discordant way. I think this is going to bring, over the course of time when it pans out, a degree of clarity. The right thing is happening in the right place with the right people. I think there is a degree of confusion because the system has evolved in what appears to me, as an outsider that has worked in the commercial sector, to be quite a hectic sort of approach to things. As I say, it is not ideal. I have asked the question ... we did 14 consultations and I asked every one of those consultations from all the various sectors: "If you were designing a health service from scratch, would you end up with the one that we have got?" On 14 occasions, I was told a very resounding no. So this might not be right, but I feel it is. When

we asked the 14 different sections whether they wanted to proceed with it, as it was explained, they all said yes. So I am hopeful. As I say, Health is a big and complicated enterprise and it needs to be very well-structured from a human point of view, so the right people are talking to the right people to make the right decisions, and it needs to be backed up digitally. As you all know, it is no secret now our digitisation levels are appalling. I think we have got to get the human side right. We have got to get the digitisation right as well to map the 2 things through together.

Deputy L.M.C. Doublet:

To follow that up, Minister. You mentioned decisions made by those boards, but can you confirm that the ultimate decision-making responsibility will still lie with the Minister?

The Minister for Health and Social Services:

I think from a public perception point of view that has to be the case, the way Jersey works, yes.

Deputy L.M.C. Doublet:

But it is not just perception is it in terms of ...

The Minister for Health and Social Services:

The reality is it is the right professional people coming up with the right, yes.

Deputy L.M.C. Doublet:

The ultimate responsibility will still lie with whoever is the Minister.

The Minister for Health and Social Services:

That is correct.

Deputy J. Renouf:

Which means that a Minister could reject a recommendation from the Partnership Board?

The Minister for Health and Social Services:

Yes, in theory.

Director of Health Policy:

Yes, and the terms of reference set out that where the Partnership Board makes a recommendation to the Minister and the Minister rejects it, the Minister must in writing provide their reasons for rejection of that, so there is full transparency.

The Minister for Health and Social Services:

I think the safeguard to that is if the Assembly ever thought that there was a Minister in place that was taking weird decisions then it would be the responsibility of the Assembly to remove that Minister and replace him with somebody else. So there is a fallback safeguard.

Deputy J. Renouf:
We may follow up with some more detailed questions around that.

The Minister for Health and Social Services:
Yes, of course. Very happy to answer them.

Deputy L.M.C. Doublet:
I am going to try and fit some questions into the last 5 minutes. Thank you for your answers there, Minister. There was a report published by the C. and A.G. (Comptroller and Auditor General) in July around the financial management and internal control of your department. Some of the findings cover budget overruns, weak financial controls, forecasting gaps; many of which you have spoken about yourself to us in previous hearings. Can you identify what specific measures are being taken to prevent the department from exceeding its budget again in 2025?

The Minister for Health and Social Services:
We have not got our finance director with us, who would be the best person to give the detail of that. Would you be able to, Andy?

Director of Mental Health, Social Care and Community Services:
I think there are a series of very regular reviews where we look both as an executive team and within services at budget and forecasting. In fact we spent the whole of yesterday afternoon doing precisely that in order to understand where we are forecasting the position. In relation to the C. and A.G. review, the response to that is currently being finalised. It has not yet been lodged with the C. and A.G., so clearly we cannot go into the detail of that here yet, but that will be published..

Deputy L.M.C. Doublet:
When is that due?

Director of Mental Health, Social Care and Community Services:
I do not know the date. We can check that for you.

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

Deputy J. Renouf:

I guess the central point you are making really has been all along that the reason you go over budget is because you are underinvested. I guess the question is: what will you do after the Budget is published, you have got extra money, what assurance have we got that you will not again, overspend? What has been put in place to ...

The Minister for Health and Social Services:

As I say, I do not deal with the day-to-day budgeting, but I certainly will, if we can achieve the extra money that we are asking for, be putting a great deal of pressure on everybody to make sure that this time next year we come in within budget. That is as much as I can actually do, from a layman's perspective. But I think everybody on this side of the table understands the gravity of the situation. I think they would be very grateful if the narrative can change and that they have got a chance, they have got enough money to have a chance of coming in with budget. Because I think that people here have felt sort of vilified to try and deliver a service when always they have been short of money, and that is a difficult place to be. I think you have possibly lost good people as a result or the pressure that that imposes upon people.

Deputy L.M.C. Doublet:

I am sorry to hear that. I think we will have to follow that up with some questions in writing, as we do have several more. We have got a couple of sections which we are not going to cover, but we might be able to squeeze in, if Constable Shenton-Stone wants to squeeze in, a question on mental health services. Do you want to ask maybe the first question on that?

The Connétable of St. Martin:

So the Jersey Recovery College, which provided recovery education and community mental health courses closed in August 2024 because of unsustainable finances, removing a valuable layer of support. So how does H.C.J. plan to reduce the backlog in psychological therapy, given the current average wait of 184 days?

Director of Mental Health, Social Care and Community Services:

There is no relationship at all between the Jersey Recovery College and the backlog for psychotherapies. They are 2 very, very different things. We have replaced the Jersey Recovery College with a recovery hub, which is now up and running with a whole series of different groups. We can provide more information in relation to that, if that is helpful. But that does not relate to the waiting list for psychological therapies at all. Psychological therapies are delivered at tier. The first tier is around counselling and support. We commissioned that through the Listening Lounge and we have changed the contract in relation to that to provide more capacity. The second tier is Jersey Talking Therapies, which is essentially manualised treatment. That is a place where we have had

quite a difficulty around waiting for treatment. Not waiting for assessment but waiting for treatment. We have increased the staffing number within the service, and there is a review being led currently by the service manager thinking about is there something else that we can do to manage that. It has dropped and so we have seen some recovery in the last couple of months.

[14:00]

Unfortunately it has gone up slightly in the last month, but it will fluctuate. The biggest challenge is around specialised psychological therapies, so psychologists, clinical psychologists who do particular trauma-type work, for example. That is where the real weight is. We are increasing the number of posts that we have in the psychology service and we are about to advertise 3 consultant psychology posts and a number of other middle grade psychology posts. We are reviewing how we then structure psychology, because psychology is structured in a number of different ways, and I do not think it always gets people to the place that they need to be as quickly as possible.

Deputy L.M.C. Doublet:
Thank you for your answers. We are just going to ask a brief one.

Deputy J. Renouf:
I just want to ask one question about P.F.A.S. (per- and poly-fluoroalkyl substances), Minister. Obviously the expert panel has produced its third report and the Government has responded to that third report and it involves some treatments and pathways being offered for members of the public who have been affected ... giving Professor Bradley a chance to take his position. Although it is partly a Ministerial question, I think, because the question is that is going to ... obviously, that is a service that will be provided to the public. I think £700,000 has been mentioned in relation to that. Is that money covered within the budget? If it goes beyond that, what is the expectation in terms of funding for that service?

The Minister for Health and Social Services:
In terms of the treatment, Peter, is that included in the sum of money that we are looking for?

Director of Public Health:
Yes.

The Minister for Health and Social Services:
Or is it within the sum of money that we have?

Director of Public Health:

So the sum that is quoted is over several years and all the costs are included in that sum.

Deputy J. Renouf:
At the moment we have a treatment pathway, a set of pathways and all of the money that will be needed to cover that is within a budget?

The Minister for Health and Social Services:
That is my understanding.

Deputy L.M.C. Doublet:
I think we are going to have to stop there.

Deputy J. Renouf:
Sorry to put you there but I think I just wanted to get clarity for that.

Deputy L.M.C. Doublet:
Thank you. We do have a few other questions on that topic area and, as always, we will send our follow-up letter. Thank you very much for your time today. Minister, did you want to add anything final before we close the hearing?

The Minister for Health and Social Services:
No, I cannot think of anything offhand.

Deputy J. Renouf:
Apart from more money.

The Minister for Health and Social Services:
I can make a plea but politically, if you can vote for all the money that we are looking for, I think we can do great things with it.

Deputy J. Renouf:
We may have separate debates about that.

The Minister for Health and Social Services:
Finish on that note, that is fine.

Deputy L.M.C. Doublet:
Thank you for your time today, everybody who has attended, and I will close the hearing.

[14:02]