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Health and Social Services Scrutiny Panel

Quarterly Review Hearing

Witness: The Minister for Health and Social Services

Tuesday, 10th February 2026

Panel:

Deputy L.M.C. Doublet of St. Saviour - Chair

Deputy J. Renouf of St. Brelade - Vice Chair

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

Deputy P.M. Bailhache of St. Clement

Witnesses:

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

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

Ms. R. Johnson, Director of Health Policy

Ms. C. Stone, Nursing and Midwifery Change Lead, Health and Care Jersey

Ms. H. Cunningham, Director of Finance

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

Ms. C. Thompson, Chief Operating Officer for Acute Services

[14:03]

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

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

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

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

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

Deputy L.M.C. Doublet:
We have apologies from our fifth panel member, Constable Shenton-Stone, who was not able to be with us today. Minister, if you could introduce yourself, please, and all of your officers.

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

Nursing and Midwifery Change Lead, Health and Care Jersey:
Cathy Stone, Nursing and Midwifery Change Lead, I am presenting for Tabetha Darmon who is the Chief Nurse for the organisation.

Deputy L.M.C. Doublet:
Thank you. Can I just check, is that being picked up with the microphone? It is, okay, thank you.

Director of Health Policy:
Ruth Johnson, Director Health Policy.

Assistant Minister for Health and Social Services:
Andy Howell, Assistant Minister for Health and Social Services.

Director of Mental Health and Adult Social Care:
Andy Weir, Director of Mental Health and Adult Social Care

Deputy L.M.C. Doublet:
We do have 2 officers that you might swap in, and if they could introduce themselves as and when they join the table. Okay, so this is a quarterly hearing for which we have 2 hours and as always a lot of questions to get through, so we may follow up in writing. Minister, there is one section at the beginning or near the beginning of the hearing, which if we had more time left in this term of office would have been a standalone review hearing with you probably on the termination of pregnancy

legislation. But what we have done is we have put it into this quarterly hearing and we are going to handle that slightly differently. Usually we have one or 2 members focusing on one section at a time and we are each going to do some questions on that questionnaire. So you might see a little bit more jumping around than usual on that area. Is that clear? Is everyone happy with that?

The Minister for Health and Social Services:
Absolutely fine.

Deputy L.M.C. Doublet:
Fantastic. Okay, so 2 hours. If anybody needs a comfort break because it is slightly longer than usual, please just let me know and we can have that. Okay, Minister, just one kind of short umbrella question to begin with, because some of the sections at the beginning are to do with various aspects of women's health. The Women's Health Strategy. Further to the panel's amendment to the budget, which you accepted, and we are very, very grateful for that, it was around the Women's Health Strategy to bring that forward in 2026. Please, could you give us an update on the progress of this work?

The Minister for Health and Social Services:
I have to say, as you know, that is work that is being done by Deputy Howell.

Assistant Minister for Health and Social Services:
In conjunction with our policy officer.

Deputy L.M.C. Doublet:
Yes, I am happy for Deputy Howell to answer this one.

Assistant Minister for Health and Social Services:
So definitely it is work in progress and we want to make sure that women in Jersey are empowered for looking after their health, they need to take responsibility for their health themselves but we are going to do all we can or we have been doing for the last 2 years to just carry on doing that work. The policy officers are working on the strategy.

Deputy L.M.C. Doublet:
Okay, thank you. Is it going to be possible for us to see a draft of that before the end of this term, even a confidential draft for the panel?

Director of Health Policy:

We will certainly be able to share with you … I do not know if it will be in the stage where it will be a draft strategy, but we will certainly be able to show you before the end of the term the key areas of focus of the strategy because those are very much taken from the findings of the Jersey Strategic Needs Analysis and also review of key and critical areas of women's health and needs from other jurisdictions as well. So I would not say it was going to be a full strategy with actions but it will certainly give you a really good sense of what we are looking at.

Assistant Minister for Health and Social Services:
So our focus has been for the last few years on taking a whole life approach for women's health before people are born to when they die, and making sure that we listen to the voices of women and make all the improvements that we can.

Deputy L.M.C. Doublet:
Okay, thank you. Yes, so as and when there is something ready to share in confidence with the panel, we would love to have a meeting about that. Okay, if you could keep in contact with our officers to arrange that, that would be great. Thank you. Okay, so I am going to move on to the termination of pregnancy legislation, which has been lodged with a debate date tabled for the 10th of March. Minister, this is a short timeframe for such an important piece of legislation. How are you going to make sure that States Members are fully informed about the legislation, that they understand to have a full debate on it?

The Minister for Health and Social Services:
I assume we are going to have a briefing before the debate takes place and I can hand over to Ruth, have you got a date? I do not know if you have got a date.

Director of Health Policy:
Yes, so I think the date should already be in States Members diaries and, if not, I will chase up on that. But the intention is that there will be a full States Members briefing beforehand, and as with other bits of major legislation we do, such as assisted dying, we will make ourselves available as officers if any States Members have any follow-up questions or want to have any one-to-one meetings to understand the underpinning policy intent.

Deputy L.M.C. Doublet:
Okay, thank you. So if States Members want to do that, would they contact yourself to arrange that?

The Minister for Health and Social Services:
They can do, yes.

Deputy L.M.C. Doublet:
Okay, thank you. In terms of the public understanding the legislation, is there a communications plan? How is that working?

Director of Health Policy:
So we have not organised any public meetings to talk about the termination of pregnancy law, we actually did not organise public meetings during the consultation phase. While we had a public survey and we provided opportunities for people to give us their comments and their thoughts in termination of pregnancy, we did not organise any direct public meetings around it, partly just because it is a very controversial subject on which people are very polarised, in many ways more so than assisted dying, and it felt potentially quite complex to put officers into a public domain of that nature. But what we have done is obviously we have published the law, there is a report and proposition that clearly explains the law and what we are working on now is some clear Q. and A.'s (questions and answers) which will be available on gov.je which will help people understand what the law is doing and also what it is not doing as well.

Deputy L.M.C. Doublet:
Okay, I am going to move over to my Vice Chair in just a second but in terms of Q. and A.'s, Minister, have you had any questions so far along any particular themes from the public, any queries?

The Minister for Health and Social Services:
We have had various questions, I do not think they relate to a particular theme, but you probably can answer that.

Director of Health Policy:
States Members have forwarded to me questions that they have had from their constituents, and the majority of those questions focus on justification of what those particular individuals see as a very liberal approach to termination in Jersey being underpinned by the current law and the general approach I would say, while those people do not disclose their views, is that they are individuals who support a very restrictive approach to termination and the provision of termination in law.

Deputy L.M.C. Doublet:
Okay, and then your Q. and A.'s that you are planning will cover some of these key themes?

Director of Health Policy:

They will do.

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

Deputy J. Renouf:
Minister, one of the key articles I think is Article 12, which is to do with ensuring provision of termination services. It has a clause in it that says that you must take all reasonable steps to ensure that termination services are available with some qualifications. How do you interpret that?

The Minister for Health and Social Services:
Well, it means what it says, all reasonable steps. We cannot force … you are referring to people in the hospital service being prepared to carry out terminations after a certain period, because I think that is the difficulty that we are referring to. At the moment, we do not have a team of people that are prepared to do that and I do not think it is reasonable, but we cannot insist that people undertake that work. If, over the course of time, through the recruitment process, people come on board that are able to, are qualified and prepared to undertake that work, then that is a provision that would be available. But at this point in time, if it is not something that the people that are doing the work are prepared to offer, then that work has to take place off-Island.

Deputy J. Renouf:
What practical actions are you taking to meet that obligation? For example, training expanded to enable the range of services to be expanded?

The Minister for Health and Social Services:
Well, on that particular one, you cannot offer training to somebody who does not want to be trained for the job. Because we do not have extra resources that can afford to have extra people for specific purposes …

Deputy L.M.C. Doublet:
Can I clarify, did you mean training other staff who do not yet have those skills?

The Minister for Health and Social Services:
Yes.

Deputy J. Renouf:
Has any attempt been made to find people who might want to provide services?

The Minister for Health and Social Services:

Well, you would have to have a vacancy in order to do that unless you are going to take on extra staff specifically, and with current restraints that is difficult. I do not know if you have any further comments?

Assistant Minister for Health and Social Services:

Can I just jump in that it is very specialised after a certain period of gestation and so even if you are in England, you would need to travel perhaps to another centre, to a centre of excellence because we just need kind, compassionate service for anyone. But we are trying to encourage any woman who needs a termination to have a termination early because it is much more straightforward then.

Deputy J. Renouf:

But can I just clarify, has any work been done to find out whether there are any clinicians in Jersey who would be prepared to go down a path of trying to ...

The Minister for Health and Social Services:

My understanding is that has been the case. Yes.

Assistant Minister for Health and Social Services:

There has been consultation.

The Minister for Health and Social Services:

There has been quite a lot of consultation.

Assistant Minister for Health and Social Services:

But there is nobody at the moment who would be prepared to do that.

The Minister for Health and Social Services:

But it does not mean that … over the course of time people fall out of this frame and you get new staff and it may well be that that might be something we look to in the recruitment process.

Deputy J. Renouf:

The option therefore will be for people to travel to access those services, which is not going to be paid for, so that will be something that a person has to pay for themselves. What cost analysis or modelling was done to kind of work out how much that would cost were it to fall within a funded service?

[14:15]

The Minister for Health and Social Services:
I cannot recall whether we have … I mean, I do not know specifically whether we have undertaken that work, but I think the numbers from recollection are relatively low in any event, so it would not be vast.

Deputy J. Renouf:
But the justification in the document is that we cannot afford it. So, presumably there is some, some measure of how much it will cost otherwise we would not know whether we could afford it or not.

The Minister for Health and Social Services:
Well, with all these situations … we were in a discussion yesterday about travel policy and on almost every issue you can push the boundaries and say, "Well, why would you not do this and why would you not do that." In the end you end up with a travel policy where everybody gets paid for every element of travel. I think within budget constraints you have got to take a relatively consistent approach to everything that you do and I am afraid travel is one of those areas. One can forward the argument either way but as I say …

Assistant Minister for Health and Social Services:
But we will cover anybody who needs to go medical reasons.

The Minister for Health and Social Services:
A medical situation, yes.

Deputy P.M. Bailhache:
I think I am right in saying, Minister, that in Guernsey, which has changed its law to accommodate a broader timeframe for termination, they send all their patients who are beyond 12 weeks to the U.K. (United Kingdom). Do you know whether that is the case or not?

Assistant Minister for Health and Social Services:
It is the case. I have read that Sir Philip and that is my understanding.

Deputy P.M. Bailhache:
So is that going to be the position in Jersey for the present?

The Minister for Health and Social Services:

At the moment it will be, yes. As I say it is not inconsistent with some general hospitals in the U.K. beyond 12 weeks that would send patients to a specialist.

Deputy P.M. Bailhache:

So what is the justification of increasing the timeframe which is a controversial issue?

Assistant Minister for Health and Social Services:

I think to take away the stigma which perhaps … so it will be lawful whereas at the moment it is not lawful in Jersey and it is to help women in those situations.

The Minister for Health and Social Services:

It is lawful across the U.K. and if I am not wrong it is up to 24 weeks in the U.K., we have been a little bit more constrained in Jersey to the tune of 12½ weeks, is it?

Director of Health Policy:

So the amendments to the law because of the current constraints we have on the service mean that changing the law for most women will not have an immediate benefit. However, if it was in future to be possible to provide an on-Island termination service at later gestation periods, that clearly provides a benefit. Planning for the provision of a termination service at later gestational limits that are not legal is problematic for us. So there is a sequential process that has to be gone through in the first place. We would not in any other areas of healthcare actively recruit for staff to deliver a procedure which was contrary to the law. So amending the law provides for decisions to be made about changes in future workforce in the first instance. Even in the event that we are not able to recruit a workforce that can choose to and safely deliver termination services in Jersey, it is nevertheless the case that amending the gestation limits does help remove some of the stigma that is associated with terminations and particularly with later stage terminations. When we went out to public consultation, for the second round of public consultation, because we understood the dilemma about the air gap between the legislation and the service, we actually asked people if we should bother amending the law given the existence of this air gap and people resoundingly came back in the public consultation and said to us: “Yes, it is important that you do that.”

Deputy L.M.C. Doublet:

Can I ask a follow-up in terms of the current legislation where somebody travels off Island to access a termination, let us say for example at 14 weeks, can they face prosecution in Jersey under our law?

Assistant Minister for Health and Social Services:

I do not believe so because …

Director of Health Policy:
No, they cannot.

Assistant Minister for Health and Social Services:
… you would be having your termination in the U.K. under the U.K. law.

Deputy L.K.F. Stephenson:
Can practitioners locally help to facilitate that or have conversations, recommend where you can go in the U.K. currently under our law?

Assistant Minister for Health and Social Services:
I think at the moment they can produce a list of places where it would be possible to go to have the service and I think that is what they do.

Deputy L.K.F. Stephenson:
But they are limited?

Assistant Minister for Health and Social Services:
But they are limited.

Deputy L.K.F. Stephenson:
If the law changes as it is being proposed to, can they help to facilitate it more?

The Minister for Health and Social Services:
You could have a much more open approach, because technically speaking if somebody goes for a termination in the U.K. now they are sidestepping the local law. Which is, you know …

Director of Health Policy:
That is an important point because the other thing that amending our law does is it provides legal certainty for our clinicians in Jersey when they refer to the U.K. and that is particularly important because at the moment we in our law in Jersey, we have a 24-week limit for termination in the case of serious foetal anomaly. So if a serious foetal anomaly in Jersey was to be found at the moment and the woman was post-24 weeks and the clinician wished to refer the woman to the U.K. where she could, in their law, have a post-24 week termination on the grounds of a serious foetal anonymity. There is an area of complexity for our commissions, amending the law resolves that complexity.

Deputy J. Renouf:

Can I just follow up on the money point? Accepting your point that budgets have to be constrained and you want a reasonably consistent policy, does it trouble you at all that access to pregnancy services is essentially, therefore, financially constrained and that some people will be unable to access pregnancy services because they have to be able to fund it?

Assistant Minister for Health and Social Services:

Can I say I did earlier take off any costs for anyone under 18, anyone in full-time education under 21, anyone on income support and anyone who has been raped or has had incest. But we really need some money in the service because we absolutely need a counsellor whose trauma trained to … because it so the payments are going towards the counsellor.

Deputy J. Renouf:

So there is ring-fenced spending of that money to help within the service in the Island?

Assistant Minister for Health and Social Services:

Yes.

The Minister for Health and Social Services:

I think you can you can describe it as a partial constraint in specific areas, it is not a broad constraint.

Deputy L.M.C. Doublet:

Can I ask a follow-up? Do you have ministerial discretion if there is somebody who … so I understand if you are under 18, if you are accessing income support, some of the other criteria, what about if you do not meet those criteria and yet you cannot afford to access the service, do you have discretion?

Assistant Minister for Health and Social Services:

I think the clinicians have discretion.

Director of Health Policy:

So at the moment the fees associated with termination of pregnancy are non-statutory fees, they are all done as a matter of policy. Under the new law we propose that they are statutory fees. That is really important because it provides full transparency for everybody. In bringing forward the order that provides for the fees, we will ensure that there is a degree of clinical judgment because there are always exceptional cases that arise in relation to matters related to termination. I think the other...

Deputy J. Renouf:
Sorry, can I just clarify the examples that the Assistant Minister gave?

Director of Health Policy:
They will still exist. They will translate …

Deputy J. Renouf:
They will translate into statutory …

Director of Health Policy:
Absolutely, yes, yes.

Deputy J. Renouf:
Thank you.

Director of Health Policy:
I think that the other thing just to always think about when you are talking about the costs associated with termination is in Jersey contraception is a paid for service. If termination was to be made a free service and contraception was a paid for service, you run the risk of creating some kind of perverse incentives to use early stage termination as a form of contraception. So if we were to think about termination being a wholly free service, we would need to think about in the round what also happens with access to contraception as well, from a public policy perspective.

Deputy L.M.C. Doublet:
That is helpful. Deputy Bailhache, I am just going to jump ahead. I am going to leapfrog over one of your questions because this touches on … so there was something in the report that mentioned providing termination services free of charge could result in unintended consequences. Is that what was meant by the unintended consequences?

Director of Health Policy:
Yes, that would be our concern.

Assistant Minister for Health and Social Services:
Yes.

Director of Health Policy:

So there are … and I am not necessarily talking about experience in Jersey but there is quite a lot of information and research that shows that in lots of jurisdictions there are a core group of, very small, women who use termination as a form of contraception, partly because of barriers to accessing contraception. So we would not want to do anything that fed into that. We would want to look at it in the round.

Deputy J. Renouf:
The obvious way would be to make contraception more readily accessible.

Director of Health Policy:
So that is a future policy decision.

Assistant Minister for Health and Social Services:
That is something that is one of things that we need to …

Deputy L.K.F. Stephenson:
Is that workstream still ongoing, the contraception?

Assistant Minister for Health and Social Services:
It is. It is, but we have been … I am ashamed to say that that is the only thing I think that I have fallen down on, that we have not finished that yet because it is quite complex. So it is ongoing, but I really apologise that it is not finished.

Deputy L.M.C. Doublet:
Okay, so just to draw this together, thank you. So there is an understanding that it is not best practice clinically to have free-to-access termination services and alongside paid for contraception services. There is a political will … please, I would like Minister and Assistant Minister to give their views on this. Is the intention, the policy direction, as much as you can given the short time, to provide free-to-access contraception as well as free-to-access termination? Is that the long-term plan?

Assistant Minister for Health and Social Services:
I think we would have to look at that very carefully. At the moment, contraception is free for under 23s, but it is something that we would have to do all the calculations on. Ideally, in an ideal world, you provide everything for free, but we cannot do that.

Deputy L.M.C. Doublet:

Well, we are not talking about everything. In terms of contraception, what does the evidence say about what is best practice in terms of those services being funded or not?

Director of Health Policy:
So, if you look at contraception services, the U.K. provides free contraception to all people of all ages. The U.K. is an outlier in Europe. Most other European countries only provide free contraception to all people below certain age limits. Those age limits vary, but they are usually somewhere between about 21 and 30. Interestingly enough, if you look at the U.K., which does provide free contraception because there are all sorts of pools and drivers around reproductive health, but if you look at the U.K., which does provide free contraception to everybody, the U.K. at the same time has one of the higher rates of termination of pregnancy than some of the other jurisdictions in which contraception is paid for. That is because reproductive decisions are not solely based on contraception. They are based on a whole load of other factors and drivers. So, as I am sure you will recall, in the 1980s, there was a big concern in the U.K. about pregnancy for housing among teenagers. There is nothing straightforward and simple in what is the best public policy around access to these services.

Deputy L.M.C. Doublet:
Okay. So would you expect that whoever is the next Minister is going to be making those decisions quite early on?

The Minister for Health and Social Services:
One would hope they would look at it. I cannot pre-empt what they might decide but one would hope that they would carry on what we are trying to achieve.

Director of Health Policy:
The Women's Health Strategy will have to address this issue for future Ministers to make decisions around.

Deputy L.M.C. Doublet:
Can I just briefly get a view from you, Minister? If you are the next Minister, what is your view around funded contraception and funded termination services?

The Minister for Health and Social Services:
To be honest with you, I have not looked at it in great detail, but in principle I would be in favour of it in targeted areas where it is likely to produce a positive result but not necessarily look at it as a blanket affair. In the same way, I would not look at anything in blanket terms. I think it needs to be looked through very carefully and it needs to be targeted.

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

The Minister for Health and Social Services:
That would just be my overview of the situation.

Deputy L.M.C. Doublet:
Deputy Bailhache, would you like to take question 7 now?

[14:30]

Deputy P.M. Bailhache:
Training. Minister, could you just tell us what is the policy so far as giving counselling to women who are contemplating a termination is?

Assistant Minister for Health and Social Services:
Yes, there will be a counsellor who will be there but it is not going to be mandatory that they have to see the counsellor. They will be offered a counselling service if they would like to have that.

Deputy P.M. Bailhache:
Would this involve trauma-informed counselling?

Assistant Minister for Health and Social Services:
It does and it will. It does. The person we have is excellent and trained in trauma-informed. Because I think it does make a real impact. You know, it is not something to be taken lightly.

Deputy L.M.C. Doublet:
You also have question 9.

Deputy P.M. Bailhache:
Nine. I am sorry, yes, the anti-abortion group Centre for Bioethical Reform were in the Island recently and produced a report for their website. Do you see any risk to healthcare professionals resulting from the activities of this group or others like them?

Assistant Minister for Health and Social Services:
I think it is a very, very sensitive subject. There is a possibility of having a safety zone around the clinic at the hospital. Hopefully … I do not think much will change because we already … I do

understand that the anti-abortion lobby who do not agree with it at all, and I understand that from their point of view, but we are just trying to offer a compassionate, kind, efficient, safe service for Islanders.

The Minister for Health and Social Services:
Could I just check, was your question related to concern about the well-being of the people delivering the service in terms of being attacked?

Deputy P.M. Bailhache:
I think the Assistant Minister has answered the question.

Deputy L.M.C. Doublet:
Did you want to add anything, Minister?

The Minister for Health and Social Services:
No, no, I was just concerned that we had not answered it fully.

Assistant Minister for Health and Social Services:
It is always hard because there is always 2 sides to every story, are there not?

Deputy L.K.F. Stephenson:
Could you give us a bit more information about the safe access zones and how it would work?

Assistant Minister for Health and Social Services:
I think it is just an area around a clinic that is a safe zone and no one can be attacked in any way around it.

Director of Health Policy:
So the draft Termination of Pregnancy Law provides for a regulation making power to introduce safe access zones. So assuming the draft law is adopted, what we will do is we will bring the regulations to the States Assembly and the regulations will enable the States Assembly to determine what actions are not lawful in a safe access zone. So that might be harassment, it might be shouting, it might be obstructing people, a whole range of particular activities that may be unlawful in a safe access zone. There may be some activities that the regulations explicitly say are lawful, for example silent prayer, those are decisions that need to be made as part of the policy development process and decisions to be made by the Assembly. The regulations will then have within them a power for the Minister, by order, to designate the actual area that is a safe access zone. The reason why they would be designated by order is that it may well be that in Jersey in

future we get early termination clinics. Pre-10-week termination services being delivered by providers other than within the hospital. So if, for example, a G.P. (general practitioner) service was to run a termination clinic, we may then use that order-making power to create a safe access zone around the G.P.'s surgery. So we have tried to design it to be as flexible as possible depending on what happens in the future.

Assistant Minister for Health and Social and Social Services:
But up until know, it has just been a very quiet service. This has not had to come into play at all.

Deputy L.K.F. Stephenson:
But will that process automatically happen if this is approved? Or will Ministers wait until there is a need for it or do you intend to have it in place from immediately?

Director of Health Policy:
We will be developing safe access zone regulations under the Assisted Dying Law in any event, if the Assisted Dying Law is adopted. So there will obviously need to be a decision made by the next Minister for Health and Social Services as to whether or not the Minister wishes those regulations to be presented to the States Assembly with regards to termination clinics or not.

Deputy L.K.F. Stephenson:
So that is not a given in this proposal that is currently before the States that that will actually happen?

Director of Health Policy:
Yes. But, of course, any Member of the Assembly could take a proposition asking that the Minister brings forward those regulations.

Deputy L.K.F. Stephenson:
So questions around how they would be monitored will come later?

Director of Health Policy:
Yes.

Assistant Minister for Health and Social and Social Services:
But it is not … we have been running this service … when did we start?

Director of Health Policy:
When the law was amended.

Assistant Minister for Health and Social and Social Services:
Whenever the law was … the Termination Law …

Deputy P.M. Bailhache:
It would be a rather sad state of affairs if we need one.

Director of Health Policy:
I think it would be really … I think Jersey is a kind place.

Deputy L.M.C. Doublet:
In terms of the safe access zones … I believe this is possible, looking at the wording of the law. Is it possible for an order to be made to create a safe access zone around a place that is not necessarily where the service is being delivered? For example, perhaps a girls' school, if protesters target an all girls' school or any other location, will that be able to be covered by the …

The Minister for Health and Social Services:
We need to take advice on that. I do not know what the law does or does not permit.

Director of Health Policy:
May I come back to you on that one?

Deputy L.M.C. Doublet:
It looks like it does but …

The Minister for Health and Social Services:
Formal legal advice on that, just to make sure.

Deputy L.M.C. Doublet:
Does anyone have any further questions on the termination of pregnancy legislation? No. We may follow up certainly on that one and maybe on a couple of the other areas as well. We are going to move on to another area of women's health: I.V.F. (in vitro fertilisation) funding.

Deputy L.K.F. Stephenson:
Perhaps we could start, Ministers, with the underspend from last year. I know we spoke in the Assembly about the request to have it returned and that request was put in. Are you able to provide us an update on that, please?

The Minister for Health and Social Services:

I think it might be useful if Hazel would join us at the table because Hazel has carried out quite a lot of work in recent times.

Director of Finance:
Hazel Cunningham, Director of Finance for H.S.S. (Health and Social Services) Jersey.

Deputy L.K.F. Stephenson:
Welcome, thank you. Yes, just to … on the approximately £280,000 underspend from the I.V.F budget last year, we heard from Ministers in the Assembly that a request had been made to revisit that decision about the underspend. Is there an update on that?

The Minister for Health and Social Services:
My understanding is that we are not in the position to have that money back. But you are in a better position than I am, Hazel, to explain the reasoning for that, if you would.

Director of Finance:
Thank you, Minister. In relation to 2025 financial year, the I.V.F. funding was provided as growth moneys under very clear guidelines, under the Public Finances Manual. Any underspend has to be handed back at the end of the financial year. It is not possible to carry that money over into the next financial year. That is a process that has been conducted through the year end process. The Public Finances Manual sets out how underspends are treated from one year to the next, so there is not a process for carrying forward in annual budgeting processes that carry forward. There is not a process under the Public Finances Manual.

Deputy L.K.F. Stephenson:
But there is a process where Ministers want to make the case to have that money and they have to present a business plan, I understand it, and have that discussion with the Minister for Treasury or whoever assesses it. Has that process happened?

The Minister for Health and Social Services:
We do have an anomaly here and I think it is one that we need to address. I am happy for …

Assistant Minister for Health and Social and Social Services:
Since I met with Deputy Stephenson and the Tiny Seeds, Chloe, last week, we had confirmation that although the reported 2025 underspend was almost £270,000, the 2025 budget did not include H.C.J. (Health and Care Jersey) staff costs. The Minister's amendment for P.20/2024 stated that I.V.F. services costs would be up to £620,000 clinic costs and H.C.J.'s staff costs. But the H.C.J.'s staff costs were not factored into the 2025 Government budget. As we did not know the demand or

staffing impact of 2025, H.C.J. proceeded with known risk re the staffing impact. But failure to include staff in the 2025 budget has resulted in A.R.U. (Assisted Reproduction Unit) staff working to meet the I.V.F. demand. This has had an impact on general gynae, recurrent miscarriage, other services that are carried out there.

The Minister for Health and Social Services:
It might be worth … Hazel, if you have got the estimated number for 2025 for the H.C.J.'s staff costs that relates to I.V.F? This is interesting because what you will find … as I say, Hazel will come up with the figure, … but given that we gave money back to the Treasury, we actually had to take money for the staff cost out of an existing budget for which it was not budgeted. So it actually had a negative impact on our overall budget. I will leave Hazel to provide the detail.

Director of Finance:
So if we are talking retrospectively, we would be looking at something around £200,000 in annual cost, for a full year effect.

Deputy L.K.F. Stephenson:
So the decision of the Assembly was a growth decision to £620,000 growth, how many new staff have been taken on to cope with that work?

Director of Finance:
As the Assistant Minister has already explained, the staff were the A.R.U. staff that supported the I.V.F. service, which meant they were being used by both sets of clinics. Effectively some of the duties for A.R.U. would not have been undertaken while they were doing the I.V.F. clinic.

Deputy L.K.F. Stephenson:
So they were existing staff.

Director of Finance:
In that case, because there was not additional funding provided for the staff. So this is where … when we are looking forward into 2026, we need to take into account that additional staff would be required to make sure this service is fully operational and effective on a full year basis. I think we could learn from this in terms of the 2025 experience, it was setting up a new service. In order to put that service in place, it was a number of months in order to make sure that all of the service requirements and the oversees clinics, et cetera, were in place. Therefore, what they were also doing was using existing staff. But if we want to provide a full service in 2026, we will need to accommodate the additional staff cost within the budget.

Deputy J. Renouf:

I am confused.

The Minister for Health and Social Services:

It is relatively straight forward, I think.

Deputy L.K.F. Stephenson:

I am not confused but I am a little bit worried that money … staff that already existed that were providing a service that are now providing a funded service … so people are paying privately but it has moved to public, there is not new staff costs but there was growth money allocated. Effectively, in my mind, it feels like that department is having its budget that existed before plus its growth funding now eroded.

The Minister for Health and Social Services:

Not at all. There are no staff in the hospital twiddling their thumbs. When we have to redeploy people, it creates a void or a lack of work that can take place, that is the actual work that they would have done.

Deputy L.K.F. Stephenson:

So you have redeployed people to cope with it?

The Minister for Health and Social Services:

No, we have used existing people to do work on I.V.F. that would not have otherwise have been doing it. Without the funding, the I.V.F. would not have increased to the extent that is has. So what we have to do is make sure that we do not carry on putting that work at detriment and not doing other work in order to do this work. So the money will be required to beef up the staff so that we can do the work that we were doing and the additional work. It is relatively straightforward.

Deputy L.M.C. Doublet:

Before this change in policy, if there were the same number of people accessing paid for I.V.F. and you just made it funded, you would not have needed any extra staff, would you? It was my understanding that the funding was simply to stop people having to pay for the service. That it was not necessarily an increase in cycles.

The Minister for Health and Social Services:

It makes I.V.F. available to people who would not otherwise have the money to have I.V.F.

Deputy L.M.C. Doublet:

So has there been an increase in - I do not know what the terminology would be - the number of cycles or the amount of …

The Minister for Health and Social Services:
My understanding is that there has. As there would be, because if people cannot afford I.V.F. … I thought the whole principle behind this was to make I.V.F. available to people who would not otherwise be able to afford it. As a consequence, your numbers go up. As I say, you cannot think about the extra numbers without taking into account the entire costing situation.

Assistant Minister for Health and Social and Social Services:
We have had another 63 I.V.F. cycles this year which the Government provided.

Deputy L.M.C. Doublet:
Over and above what number? What is the standard business as usual?

[14:45]

Director of Health Policy:
We can check that figure and we can get it back to you. There has been an increase in the number of patients as a direct result of funded I.V.F. I do not have those figures available now. We can find them out and give them to you.

Deputy J. Renouf:
I may be missing something very obvious here, apologies, but was the growth bid not designed partly to pay for new people to come in and do that extra work? In a way, by not employing those extra people, you just deferred for a year a decision that was inevitable anyway? Why were people not employed straight away?

The Minister for Health and Social Services:
Because we were not at the stage … I remember making the statement at the Assembly that we were doing this almost on an experimental basis. It did not reflect the work we have to do. We are now able to quantify what that is because we have seen the number of extra I.V.F. treatments that we have got. We have been able to reasonably accurately calculate the amount of staff resource that is required. At the end of year one, we are now in the position to give you a relatively balanced view of what those cost effects are. What we are saying is that we have to address those, because we cannot carry on *ad infinitum* either subsidising it from elsewhere or stopping doing the work that those people would otherwise have been doing. So it does need to be staffed appropriately going forward. We have now got a picture of what that looks like.

Assistant Minister for Health and Social and Social Services:

So we will need £268,000 for staff to run the I.V.F. service for 2026. If the predictions are right, we may run out of money in November. If that is the case, if we go over the £620,000 in November, we may have to stop the service then and get them to wait until January 2027 before they can have their I.V.F. again.

The Minister for Health and Social Services:

The danger here is if we do not take a disciplined approach to this, it will be the same as we are going to get in every other department. We will be back to having a large deficit and everybody will be saying Health is overspending. But I think what we are trying to get into the system now is a more disciplined approach to funding, and a more open approach to it, so we can actually make clear what is going on to people and say this is the effect. If people want more money for I.V.F. on top of that because there is a disappointment factor, so be it. But that has to come from somewhere, and I would suggest it does not come from our base budget because the amount of times our base budget gets eroded almost accidentally by people introducing new things … we need to have clarity on that going forward.

Deputy J. Renouf:

But you consciously chose not to spend all the growth money because you decided that you wanted to work out how much would be required first in terms of how many extra people would be required to meet that service, and then you would start spending up to the limit.

The Minister for Health and Social Services:

As I say, it was not a precise science. So you have got to bear in mind we are almost moving into a vacuum and establishing a service, evaluating what that service looks like in the first year and coming back and giving an open, honest appraisal of what that looks like and saying these are the measures we need to take going forward to make sure that we balance our books to the best extent that we can.

Deputy L.K.F. Stephenson:

While we have got Hazel here, are we able to just drill into that £268,000? What staff does that involve, working at what level?

Director of Finance:

You would have 2 nurse grades. They would be half F.T.E. (full-time equivalent). Two half F.T.E.s, a half admin support. You would have consultant time, a number of consultant P.A.s (programmed activities)) and middle-rank doctor.

Assistant Minister for Health and Social and Social Services:
A counsellor and a middle grade.

Director of Finance:
The middle grade, yes. As the Assistant Minister says, part of that will be counselling as well.

Deputy L.K.F. Stephenson:
So that all added together, ignoring the grades, how many F.T.E.s?

Director of Finance:
I think it is 7 P.A.s from a consultant perspective, and half an F.T.E. of a nurse grade at 6, half of a nurse grade at a 5 and half an admin, which is relatively low, so it is a grade 6, yes

The Minister for Health and Social Services:
As pro-natal policies go, it is probably a pretty good …

Assistant Minister for Health and Social Services:
There is also the I.T. (information technology) as well.

The Minister for Health and Social Services:
A pretty well a sure a bet as you get, is it not?

Assistant Minister for Health and Social Services:
Yes, there is admin and I.T. costs as well thrown in.

Deputy L.K.F. Stephenson:
The A.R.U. budget, aside from the £620,000, do we have the figure for what it was before and what it is going forward?

Director of Finance:
I do not have those figures at hand, so I can …

Deputy L.K.F. Stephenson:
You do not have it, is that something we could have?

Director of Finance:
Yes, so we can share that with you separately.

Deputy L.K.F. Stephenson:
Thank you very much. Do you want to ask these ones?

Deputy L.M.C. Doublet:
Shall I go?

Deputy L.K.F. Stephenson:
Yes, please.

Deputy L.M.C. Doublet:
Okay. Currently single people wanting to start a family cannot access the I.V.F. funding. I think this has been touched on before, Assistant Minister. What are your plans to change this?

Assistant Minister for Health and Social Services:
We are up to looking at the criteria again but we cannot do anything at the moment because we will have to see how this pans out going forward. If by any chance the demand goes right down and we just have 2 couples coming forward, then of course we will look at the criteria. But we will have to just monitor it quarter by quarter.

Deputy L.M.C. Doublet:
What is the rationale for excluding single people?

Assistant Minister for Health and Social Services:
I believe that Deputy Stephenson's original proposition related to couples. That was why…

Deputy L.K.F. Stephenson:
Yes, it did. It did not refer to single people.

Assistant Minister for Health and Social Services:
You have said it was the couples, was it not?

The Minister for Health and Social Services:
Fair to say that with an unlimited budget you could do all manner of good things but I have a long list of other requirements that urgently require money, so it is a difficult one.

Deputy L.M.C. Doublet:

It is just an interesting one, is it not? Say you are a woman who wants to have a baby, that if you do not have a partner that might be a reason why you need I.V.F.

Assistant Minister for Health and Social Services:
Yes, but that was the original proposition that we stuck to.

Deputy L.M.C. Doublet:
Setting that aside …

Assistant Minister for Health and Social Services:
We just have to look at the figures, at the moment we cannot do anything.

Deputy L.M.C. Doublet:
Given the birth rate is so low, have you done any work to establish whether there would be women, for example, that would like to access this service were it funded?

Assistant Minister for Health and Social Services:
I do not think we have done any work on that.

Director of Health Policy:
We have not done any specific work. We can do population projections to try to estimate the numbers of single women in Jersey who are of childbearing age. There are some kind of rough and ready calculations that we can do on a population basis. But obviously that would presume that those single women want to become parents. It is a relatively meaningless figure. There is very mixed evidence from other jurisdictions about the provision of I.V.F. to single women has any real material impact on the birth rate in those jurisdictions. There is conflicting evidence about whether or not if you want to incentivise increases in birth rates investment in I.V.F. is the most cost effective way to do that versus, for example, investment in childcare.

Deputy L.M.C. Doublet:
Okay. Minister, could you reflect on the potential risk to women, particularly exposure to domestic violence, given the fact that women can only access funded I.V.F. if they are in a relationship and in the context of the V.A.W.G. (Violence Against Women and Girls) report? Is that something you could go away and reflect on and think about a policy?

Assistant Minister for Health and Social Services:
Of course, we need to think also about gay men.

Deputy L.M.C. Doublet:

I am going to come on to that in another question but I will let Deputy Stephenson, if she has gathered her thoughts, to come in with …

Deputy L.K.F. Stephenson:

I think probably before I ask the next question … so there is not going to be a review of the criteria?

Assistant Minister for Health and Social Services:

Not at the current time.

Deputy L.K.F. Stephenson:

Not at the current time, fine.

Assistant Minister for Health and Social Services:

Because we changed them at the beginning of October. If there had been an underspend that would have been a very different scenario.

Deputy L.K.F. Stephenson:

Okay, that is fine.

Assistant Minister for Health and Social Services:

But because we now need to put in the staff costs we have to just run for at least 2 quarters, I would have thought, before we can review.

Deputy L.K.F. Stephenson:

The current guidance has that couples earning under a combined income of £82,300, currently qualify for 3 rounds of I.V.F. funding; that threshold is based on 2021 mean earnings and obviously we are a few years on from that and average incomes have risen. Are there any plans to revisit that figure?

Assistant Minister for Health and Social Services:

We will not be doing anything until the figures have come out but then of course we will …

Deputy L.K.F. Stephenson:

Which figures?

Assistant Minister for Health and Social Services:

The £82,000 that you just mentioned. We need the figures for how many couples and what the costs of the service are before we can change anything.

Deputy L.K.F. Stephenson:
When do you expect to have that full picture that you want?

Assistant Minister for Health and Social Services:
Probably thinking to, say, quarter 2.

Director of Health Policy:
We have a commitment to review everything that happens with I.V.F., a root and branch review on a quarterly basis. Next month we will sit down and one of the things that we will look at relates to whether or not those income thresholds should change to track the current averages around earning thresholds or whether or not we need to maintain them as we are because the budget is squeaky tight.

Deputy L.K.F. Stephenson:
Right, so it is on the agenda for the quarterly checks.

Director of Health Policy:
It is on the agenda, it has not been forgotten. But given where we currently stand at the moment with regard to a forecast budget for 2026, assuming we have the same footfall through the service, we end up with a deficit budget at this point in time, recognising that the income thresholds have changed, we are not proposing any changes. But when we do our quarterly review and we look at what activity has happened in January, February or March of this year and whether or not there is any decline in activity, which may suggest we have got some flex in budget; that will be one of the very first things we look at.

Deputy L.K.F. Stephenson:
Okay. Thank you very much.

Deputy L.M.C. Doublet:
Thank you. A question around same-sex female couples and we have had many discussions around this, Assistant Minister, and I am really pleased that you did extend the eligibility criteria in autumn last year to include same-sex female couples. I wanted to ask about the reciprocal I.V.F., again, in response to a written question, you said that: “It was possible to apply the same funding amount to reciprocal I.V.F.”

Assistant Minister for Health and Social Services:

It is but then they would have to make up the deficit.

Deputy L.M.C. Doublet:

Sure, thank you. You mentioned in your response that donor eggs and sperm are not funded.

Assistant Minister for Health and Social Services:

That is correct.

Deputy L.M.C. Doublet:

Are you finding … so not just for same-sex couples but for all couples because they are not funded at all, are they for any of the couples?

Assistant Minister for Health and Social Services:

No, they are not. The reason is that it has to be the choice of the person who is going to be the parent who they choose for their donor.

Deputy L.M.C. Doublet:

Are you finding that any couples, even with the bulk of the funding offered, is still not able to afford to access because of the cost of those elements?

Assistant Minister for Health and Social Services:

I think that is really important that you choose your own because then it is your decision; we cannot provide that.

Deputy L.M.C. Doublet:

No plans to change that element of it. Okay, thank you. In terms of same-sex male couples, are there any plans underway to enable those couples to have access to any of the services?

Assistant Minister for Health and Social Services:

As I keep saying, unfortunately we cannot, obviously we cannot do that at the moment.

Deputy L.M.C. Doublet:

Okay.

The Minister for Health and Social Services:

I think it is safe to say if you broaden the criteria, the more you broaden the criteria the sooner you have to stop providing the service and wait until you get to … say you are building up a waiting list, that is the sad truth of it.

Deputy L.M.C. Doublet:
Yes. Obviously we have asked about several different areas and different ways that the criteria could be expanded, if you could consider those when you have got all the information that you need to have, we would be grateful.

Assistant Minister for Health and Social Services:
I was very grateful for the conversation I had with Tiny Seeds and Deputy Stephenson.

Deputy L.M.C. Doublet:
Sure, okay. Just so that we have covered that.

Deputy L.K.F. Stephenson:
Yes.

Deputy L.M.C. Doublet:
Yes, okay. Thank you for that. We are already nearly halfway through, we might need to get more of a gallop, I think.

The Minister for Health and Social Services:
Might need to get Ms Stone back for the next one.

Deputy L.M.C. Doublet:
Yes, so we are going to ask about home birth next. If you need to do any reshuffling, please do. Thank you, thank you. You are taking this one, are you? Yes. Hello.

Nursing and Midwifery Change Lead, Health and Care Jersey:
Good afternoon.

Deputy J. Renouf:
Hello, if you want to introduce yourself, just …

Nursing and Midwifery Change Lead, Health and Care Jersey:
It is Cathy Stone, Nursing and Midwifery Change Lead for H.C.J. I am acting on behalf of Tabetha Darmon, who is the Chief Nurse, with the responsibility for maternity care.

Deputy J. Renouf:

Okay. Obviously the home birth service was suspended in October 2024 and then it was further announced that there would be a review following incidents in the U.K. Can you update us on what the situation is with regard to that review and the future of home birth services in Jersey?

Nursing and Midwifery Change Lead, Health and Care Jersey:

Very much so. I think it is recognising the under-arching objective of any home birth service is, ultimately, the safety and well-being of both maternal and neonates; that is our overarching objective. In addition, it is that ability to provide a consistent service. We know across the U.K. services that switch on and switch off are, again, detrimental to both the health and well-being and safety of families. Those are 2 key overriding parameters. Within the U.K. in November that Prevention of Future Deaths order that came out, following the tragic maternal and child death in Manchester, was very clear in 6 failings. Those 6 failings have resulted in the U.K. bringing together all midwifery and healthcare professionals to develop clear guidelines against various practice for the provision of a home birth delivery. Jersey has been involved with that, working alongside our colleagues in the U.K. The review of that Prevention of Future Deaths was due to make a report in January; that has now been withheld and did not come out on 6th January, as was required.

[15:00]

Alongside that, Jersey has currently, in line with what I am aware that Ms Ros Bullen-Bell and Tabetha Darmon has brought previously, work relating to competencies, work looking at rostering, work looking towards governance framework and that multidisciplinary working is underway to ensure against our own best practice that those standards are in place before a service could be resumed. We are currently awaiting the benchmarked evidence to come from the U.K. to support those. The work has been ongoing and until we have that benchmark evidence to ensure that what we are doing is in the best interest and safety for all maternity and neonatal women across Jersey; that is what we are waiting for currently.

Deputy J. Renouf:

Can I just probe a little bit on the relevance of the U.K. examples to Jersey? The particular case that happened in Manchester was a catalogue of failings. Why was it determined that Jersey had to act in relation to that? Was there any evidence that any of those failings were in play in Jersey?

Nursing and Midwifery Change Lead, Health and Care Jersey:

I think what was very clear from the 6 areas that were raised within that report and they talked about clear defined national standards, what was the requirement to risk assessment for a home birth

service? It also identified there were not clearly defined staffing models. It also identified there were no competencies available and the lack of robust governance arrangements. If we take ourselves back to November 2024 when the service was paused in Jersey because we knew at that time that we had a lack of staff for those clinical competencies. It is fair to say we have a super team of midwives, very, very much committed to the safety and well-being of our women and our children in Jersey. But that ability to provide that service consistently was not available in November 2024 when we made that decision. Those decisions, if you look, when we made that decision they almost mirror those of the Prevention of Future Deaths order. We were concerned about staffing. We were concerned about risk assessments and we were concerned about protocols. We made that informed decision and that was made informed. It was made against clear evidence. Heaven forbid we should be validated for making that but clearly our Prevention of Future Deaths order and if anybody has read the case it is a very tragic read. A young mum and her baby are not with us; they should be with us here today. I am confident with the service we have in Jersey today that they will still be with us. But we cannot move forward until we are very clear that that evidence base, which is coming to us from the U.K., we are in line with that. I think the question you ask, what was there? There were definite synergies with those there, which is almost, heaven forbid, one should wish validation for an action but clearly there was a validation there.

Deputy L.M.C. Doublet:

Can I pick up on something? You mentioned consistency being something that is important and the reason why the service was paused, can you describe what the inconsistencies were? What did that look like before it was paused?

Nursing and Midwifery Change Lead, Health and Care Jersey:

Inconsistencies, it is generally the inconsistent will be the availability of staffing.

Deputy L.M.C. Doublet:

Right, so the facts that if a home birth goes over a 12-hour shift or whatever, then there might not be another midwife available.

Nursing and Midwifery Change Lead, Health and Care Jersey:

It may be in the beginning of that because if we look at what is happening in the U.K. currently when the services are being cessated, it will be to the use of lack of staff. It may not just be the lack of staff to undertake the home delivery but if your surrounding maternity units are at full capacity and you have all the staff, you do not have enough staff to take them away. For inconsistency, if you are Director of Midwifery or Head of Midwifery you will be looking at, firstly, the deliveries we have going on in the unit; that which we know may come in. Also, always in the background because babies do not always come to order, how many babies have we booked for this month? We know

at certain times of year we have those peaks and troughs if we look at all the evidence and where will that inflict? If I know today, as Director of Midwifery, my maternity unit is full, I have got some sick leave coming on this evening, I will not be up to my minimal staffing levels. At that stage one would be prioritising for the next 12 hours I will not be able to support a home delivery service; that is what I talk about consistency of standard.

Deputy L.M.C. Doublet:

Okay. In terms of understanding what Islanders and what women want, it is my understanding that the home birth services always has an element of not being able to be consistently offered for those reasons and that that was understood and accepted by women who opt into that service. Could you not maintain the safety, the understandably very high safety threshold, by offering that service but with a caveat that it might be inconsistent on the day or night or whenever the birth is happening, that women might be told: "This service is not available tonight" but to have some offering where the staff can fulfil it? Is that not an option? Would that not be better?

Nursing and Midwifery Change Lead, Health and Care Jersey:

I think that we have to go back to that first principle, again, which was outlined in the Prevention of Future Deaths, to be able to offer that … and that is what some services do currently in the U.K., they switch on and switch off the maternity service. To be able to undertake that you need a significant cohort of staff would have those skills. What we know in November 2024 we only had a very small cohort of staff. I am a very old midwife, I was privileged to have trained with a lady called Mary Park; she is one of the most famous independent midwives in the country. I have undertaken a lot of home deliveries. I know what we are talking about. A lot of our newly-qualified midwives do not have that portfolio of experience. When you are working in the community that level of risk assessment and how you deal in autonomy, you need that level of experience and I think that is what is key. It was clear within November 2024 we did not have that cohort of midwives. We did not have that ability to switch on and switch off that service consistently. Because our service should be for all women, not for just those at a certain time.

Deputy J. Renouf:

Can I just wrap it up perhaps by getting some clarity on where we are going with this? You have talked about needing to hear from the U.K., what timetable are you working to? What would be the process? Is there going to be a report? Is there going to be an announcement? If so, who is doing it? What will be the decision-making points and when do you expect to make them?

Nursing and Midwifery Change Lead, Health and Care Jersey:

I am mindful of the wrapping up, however, there are 3 components to this. Irrespective of if the U.K. make a decision, we will then have to assess, have we have that cohort to start? Have they been

appropriately trained? Do we have enough staff and where are our vacancies? That is something our Director of Midwifery is working on currently and you would have heard how we ensure we have the correct training? That will be an answer that has to be taken at that moment in time. As I said, the U.K. was due to make … I think it is 6th January, it did not come out. We have been told it is going to be end of February, it may be March. We have not been given a definitive timeline. Then taking that notice into priority, it will come through our normal decision-making process. But until we have had that evidence of what a good service should look like, what are the standards, what are the competencies against which we can benchmark ourselves, it would not be safe to resume that? I am sorry, I have not given you a date which is X date and I do apologise for that.

Deputy J. Renouf:

No, I understand that, I understand that. My only caveat around all of that was that you are talking about things which have been on the go since November 2024, that review of competencies, all those sorts of things.

Nursing and Midwifery Change Lead, Health and Care Jersey:

I am sorry.

Deputy J. Renouf:

Yes.

Nursing and Midwifery Change Lead, Health and Care Jersey:

I do apologise, I can assure you that we have worked extensively. We now have a very, very good training programme. I know as of today up to 85 per cent of our midwives have that level of skill. We have worked very closely with our ambulance service because, as I outlined in the Prevention of Future Deaths report, the ambulance services were identified. Working well with our ambulance services to ensure we have the correct paramedic support. But in addition to that, we have the correct pathway. I would not like Scrutiny to think we are sat there on our laurels waiting for something to come. This is work that has been ongoing at all times to maintain the safety of our women. I think something I do have to say, which we do have a most amazing midwifery-led unit. It is under 3 years old. It was developed with our women in mind. For any woman who wants a home birth experience I would commend them to talk to Roslyn Bullen-Bell. It is a super unit. We are a small Island and it does give an amazing experience.

Assistant Minister for Health and Social Services:

Yes, and you can take any personal effects in with you and you make it homely. I know it is not at home but it is as close as it possibly could be and it will give you a really … since we have had the

privilege of reviewing our maternity unit, we have come ahead in leaps and bounds. We have gone through all of those criteria that we had to improve.

The Minister for Health and Social Services:
I am probably speaking out of turn but I am a little …

Deputy L.M.C. Doublet:
You are the Minister, you speak.

The Minister for Health and Social Services:
Yes, but I do not like to speak out of turn but I am a little bit concerned that there has been a consistent pressure about this all the way through, pressure for dates, when we will have a date for this and a date for that. I think what has been made very, very clear this afternoon is this has to be and will continue to be driven by safety considerations. I have got to say we are now reasonably close to this, there is an awful lot of work that has gone on over a long period of time. Nobody here is going to move off the mark until people like Cathy are able to sit there and saying 100 per cent certain this can go back out in whatever form it goes back out in and it is safe. I hope you will agree that that really has to be the priority rather than fixed dates. Safety has to be the principal consideration. I am sitting here and I have felt every time this has been mentioned that there has been an underlying pressure in terms to provide dates.

Deputy J. Renouf:
There is never going to be 100 per cent safety around child birth. There are judgments to be made.

The Minister for Health and Social Services:
I understand that.

Deputy J. Renouf:
There is a sense to sometimes come back, I think, to me certainly about a reluctance to do that.

The Minister for Health and Social Services:
No, not at all, I have to say …

Deputy J. Renouf:
That is why those questions are tough but I hope fair.

The Minister for Health and Social Services:

Clarify, no reluctance at all. As I say, I think nothing is going to ever be 100 per cent but I would rather rely on the judgment of people that have a lifetime of experience than us as politicians trying to give you a date just to tick a box. I hope you do not mind, I think it is an important point to make.

Deputy L.K.F. Stephenson:
I think when Jersey is making cautious decisions, whereas other people may be making decisions in a different way as well, it is a very legitimate thing for us to ask those questions, about why we are following that route when other places are continuing with their home birth service.

Assistant Minister for Health and Social Services:
We do not want the headlines that they had in Manchester.

The Minister for Health and Social Services:
We do not want the tragedy, the headlines follow the tragedy and we do not want tragedy, yes.

Assistant Minister for Health and Social Services:
Yes, of course. Yes, we do not want the tragedy.

Deputy L.M.C. Doublet:
Ultimately, we are asking questions of you, Minister, and your officers on behalf of members of the public who tell us …

The Minister for Health and Social Services:
Absolutely, I get that, I get that too, I get that as well. But I am just trying to provide a little bit of balance; that is all.

Deputy L.M.C. Doublet:
I understand. One final one, just for any avoidance of doubt, is the aim to reinstate the home birth service once all of the training reports, et cetera, once all of that is covered, is the aim to reinstate a safe home birth service in Jersey?

Nursing and Midwifery Change Lead, Health and Care Jersey:
I think the reinstatement of a safe home birth service will be a decision-making process and the intention is not to reinstate it.

Deputy L.M.C. Doublet:
Sorry, the intention is or is not to reinstate.

Nursing and Midwifery Change Lead, Health and Care Jersey:
The intention is when we have those facilities, that we have a safe and effective and responsive service, then the decision will be then made whether or not to reinstate that service.

Deputy L.M.C. Doublet:
Okay, and who makes that decision?

Nursing and Midwifery Change Lead, Health and Care Jersey:
Now, in fact, I am unaware of Jersey health-making processes and I do apologise and I do apologise most sincerely to my Chief Officer because I am unaware of that, so I look at the Minister …

Deputy L.M.C. Doublet:
Is it, ultimately, the Minister who makes that decision?

Assistant Minister for Health and Social Services:
No, I think it will be a clinically-led decision.

The Minister for Health and Social Services:
It has to be a clinical decision.

Nursing and Midwifery Change Lead, Health and Care Jersey:
I know what it would be in the U.K. but I would not wish to insult Jersey. I do apologise for my lack of knowledge.

Deputy L.M.C. Doublet:
No, thank you and thank you for the evidence that you have given. You clearly have a lot of expertise in this area, so thank you. Okay. The aim is to clinically have all the facilities and training available …

Nursing and Midwifery Change Lead, Health and Care Jersey:
Most definitely, yes.

Deputy L.M.C. Doublet:
… so that a safe and efficient home birth service can be run where the decision-makers wish that to be.

Nursing and Midwifery Change Lead, Health and Care Jersey:
Most definitely, the answer is yes.

Deputy L.M.C. Doublet:

Okay. Minister, is that your wish to reinstate it?

The Minister for Health and Social Services:

It is but it has to be said that if you came to the end of the process and you had reviewed everything and everything was perfectly safe insofar as the service that you offer but it would need extra resources and extra people to be on standby to have a home birth service, that is the point at which we could come back and say: "It has all been reviewed and on balance we can provide the service that we have got and no more." At that point I should imagine you could then quantify what it would take to introduce a service. But it is a process that has to be undergone and it is at that point in time that we would be able to come back with the decision that either it can be safely reintroduced or in order to safely introduce it, it will require X amount of extra resources.

Deputy L.M.C. Doublet:

Okay.

The Minister for Health and Social Services:

I hope that gives you clarity because I know you have been looking for clarity and we tried our best to provide that.

Deputy L.K.F. Stephenson:

I presume that is where a clinical decision then becomes a political decision, is that …

The Minister for Health and Social Services:

The clinical comes first and the political has to follow as to what then does the public want? How much tax do we charge people and where do we put our priorities? But it may well be that once the analysis is done that it does allow for the service to reopen. But those decisions will be made on a clinical basis.

Nursing and Midwifery Change Lead, Health and Care Jersey:

If I may, the Prevention of Future Deaths review that is currently underway, that very much is looking at resources required and staffing levels. Again, when we are looking at funding it will be staffing resource that will inform and that is one of the clear criteria of this review.

[15:15]

Because currently in the U.K. there is very clear guidance on intrapartum and postnatal care. We do not have that guidance or governance framework for home delivery.

The Minister for Health and Social Services:
There is a desire to get this done as quickly as possible because the good people here have got so much else to get on with once they have done that. Nobody is dragging their heels.

Deputy L.M.C. Doublet:
Yes, a very busy team. Thank you. We are going to move on to the section on endometriosis. Can I just ask that where there are any steps forward or anything is progressed in this area, that you could keep us updated as and when? We would be grateful. Thank you. Deputy Bailhache is going to ask about the endometriosis clinic.

Deputy P.M. Bailhache:
Minister, can I just say that we are delighted to see your Chief Officer here for the first time and we almost got him to speak just now? On endometriosis, we understand the clinic is now established and operational and has begun seeing patients. I wonder if I could ask, how many patients the clinic has supported since its opening?

Assistant Minister for Health and Social Services:
I do not know if we can say. I am afraid I cannot say the number that we have supported.

Nursing and Midwifery Change Lead, Health and Care Jersey:
I do not know if Claire has it.

Chief Operating Officer for Acute Services:
I have not come with that number today but I am happy to provide it, yes.

Nursing and Midwifery Change Lead, Health and Care Jersey:
Okay.

Assistant Minister for Health and Social Services:
We have 2 clinics running, we have got a clinic in the General Hospital and the new clinic, and they are looking after patients.

Deputy P.M. Bailhache:
Can you say what specific services they offer to patients?

Assistant Minister for Health and Social Services:

I think they are specialist clinics for women who have been suffering very badly over a period of years, they are being clinically looked after in those 2 clinics.

Deputy P.M. Bailhache:

Is it possible to say how it is performing in terms of outcomes of treatment?

Assistant Minister for Health and Social Services:

I think the people that have come back to us have said thank you very much. I think it is just a horrible disease and people sometimes suffer for years and years and years without having a diagnosis.

The Minister for Health and Social Services:

It is certainly receiving a lot more attention than it used to. Strangely enough while we are bringing the threads together, it involves our Ministerial team quite a lot. Because I think all 4 of us ended up attending a meeting that was held by somebody that had suffered for a long time with endometriosis. We had a long chat afterwards. We are well underway to establishing a proper working group for endometriosis that takes into account everything from G.P.s to the end of the service. We have got one specialist, as you know, without naming names, who is involved and very keen for this to happen. We have had a number of specific cases that have been ongoing for a long period of time now being fast-tracked to comprehensive treatment and that is …

Assistant Minister for Health and Social Services:

Then we have got a link to specialist U.K. endometriosis clinics, so they can have conversations, M.D.T. (Multidisciplinary Team) conversations, treatment and tertiary referrals.

The Minister for Health and Social Services:

Yes, discussions are underway to make commercial arrangements for that to be a formal process going forward. While they have not reached the end of the process, some successes in getting people with severe endometriosis finally recognised and the complexity of the condition being recognised and being dealt with in a much more comprehensive all-encompassing manner, rather than dealing with single issues one at a time. They have been properly assessed in the overall and being sent for comprehensive treatment. That is something relatively new and something that we are very, very keen to maintain.

Assistant Minister for Health and Social Services:

Yes, we are really delighted to have set this up for the women of Jersey.

The Minister for Health and Social Services:

Yes, important.

Deputy P.M. Bailhache:

Bearing in mind that I think I am right in saying one in 10 women live with this condition, are you satisfied that there is sufficient investment in the department to ensure that the clinic meets future demand?

The Minister for Health and Social Services:

The answer is, no, we are not. But like everything else we have to look at priorities. But this is work ongoing, we are looking to establish a comprehensive service where we can penetrate the population, get people to recognise very quickly, work with G.P.s so that they can recognise it more quickly. This is the first building blocks for something that is going to take some time. As with so many things in medicine, I think once we have got the investment in place to get the network running, the fact that we can then identify and treat people earlier and treat them better will have an overarching positive financial effect. Because I know a number of people who have been off work for a long time, you lose that productivity, you have all the misery that goes with it. You have one appointment after another where the whole process goes nowhere. If you can fast-track the process and make it efficient and get people back to work and having a happy life again, I think this would be self-funding. But we get back to the raw fact that you need that initial investment to get them underway, as you do with so many areas of health. We started to solve that problem by getting a chunk of extra money for preventative work and that is where emphasis is. Whoever sits in this seat going forward is going to have to make sure we really put some focus on putting money into preventative work. Speech over.

Deputy L.K.F. Stephenson:

Has there been any additional resources put into the endometriosis clinic?

The Minister for Health and Social Services:

I think we are having to do everything with the existing resources because we came into the 2026 budget which had been prepared. You can make some fine-tuning decisions but once you are into a prefixed budget you have got very little wiggle room, have you not?

Assistant Minister for Health and Social Services:

But we have now got a full complement of consultants in obs and gynae.

Deputy L.K.F. Stephenson:

Okay. Has there been any of the budget from the Assisted Reproduction Unit that has helped to facilitate this work? Because there is a crossover of consultants, is there not?

Deputy L.M.C. Doublet:
You will need to come to the table if you want to contribute.

Chief Operating Officer for Acute Services:
Thank you. Hi, Claire Thompson, Chief Operating Officer for Acute Services. To help explain, as the Minister was just describing, we are now in a great place in O. and G. (obs and gynae). We have had 3 years of having 3 or more vacancies, which we were able to on-board all of those consultants who brought a range of specialist knowledge and experience within obs and gynae. I think at the last Scrutiny meeting you met Professor Enda McVeigh, who is obviously very experienced in endometriosis and has written extensively on the subject. He has been key in leading the services. As part of our annual job-planning approach, what we are able to do, particularly now we are under less pressure across the whole of obstetrics and gynaecology, is apportion Enda's time to providing this activity. Initial endometriosis clinics were run historically by our other gynaecologist, who obviously now we are able to put to the specialisms within the service, that they more enjoy and have those specialist skills, such as foetal medicine and termination of pregnancy and utilising Enda's expertise in time in formalising these clinics. Deputy Howell was describing how we have managed to have an M.D.T. process. As you know, women often affected with this disease need expertise outside of gynaecology; general surgery, urology. Enda has led putting in those multidisciplinary clinics that allows input from our specialist surgeons and doctors on Island but now with this more regular referral to Southampton for those more complex cases and surgery that we would not be able to perform on Island. We are continuing to look at other tertiary centres to compliment that. Hopefully that is …

Deputy L.K.F. Stephenson:
Thank you very much. Enda is also the specialist consultant for assisted reproduction and I.V.F.

Chief Operating Officer for Acute Services:
Yes.

Deputy L.K.F. Stephenson:
I think what we are trying to get at is the questioning before about the money and the cost, for staff costs.

Chief Operating Officer for Acute Services:
Yes.

The Minister for Health and Social Services:
Is your money being spent elsewhere? No, no.

Deputy L.K.F. Stephenson:
That is the very question, Minister.

The Minister for Health and Social Services:
The answer is no.

Chief Operating Officer for Acute Services:
No.

Deputy L.K.F. Stephenson:
That is absolutely not the case that is happening here.

The Minister for Health and Social Services:
No, that is not the case. We would not be lying to you about how your money is being spent.

Deputy L.K.F. Stephenson:
It is not a suggestion of lying, I am trying to work out how the budgets are working.

The Minister for Health and Social Services:
No, no, no. I think everybody is playing with a straight bat, yes.

Chief Operating Officer for Acute Services:
If I may, most consultant contracts are a minimum of 10 P.A.s, a P.A. being a unit of time, a morning or an afternoon. Obviously we choose then how to deploy consultants' time. In the morning they might be in one clinic, in an afternoon they might be in theatre. Across a consultant's job plan you will see them doing a variety of activities but also they can be a variety of specialisms, for example, A.R.U., plus then some time on endometriosis within those units of times across the week. We would expect to see those dedicated clinics looking at different things. For example, you could have an orthopaedic consultant who was spending time on lower limb in the morning and then other areas of orthopaedic, such as trauma, on the afternoon. It is all around the job planning, so hopefully …

Deputy L.K.F. Stephenson:
Just because I think we have talked in previous hearings it is the challenge in a small place …

Chief Operating Officer for Acute Services:
A single-handed …

Deputy L.K.F. Stephenson:
… about having single consultants responsible for multiple areas. Does someone like Enda doing a lot more work on endometriosis have an impact on waiting times at the Assisted Reproduction Unit, for example?

Chief Operating Officer for Acute Services:
I would have to examine that and look in terms of the time he was spending before. But I do not think we have significantly cut into the time because he was not full time in all of those areas prior.

Deputy L.K.F. Stephenson:
Yes, great, thank you very much.

Deputy L.M.C. Doublet:
Okay, thank you. I think in previous hearings we have talked about this severity levels of this condition and that the clinic is primarily focused on the more severe cases. Deputy Bailhache quoted one in 10 women; that is around 5,000 women that suffer from this condition. What kind of numbers are you treating in the clinic, just to get an idea of where that is?

Chief Operating Officer for Acute Services:
Sorry, I have not come with that data today but I am really happy to get that and share about since we have had the clinics and running, how many would …

Deputy L.M.C. Doublet:
Yes, sorry, you were asked that question already. Yes, could we get that data and could we have alongside it an understanding of the severity and the actual impact of the condition alongside it?

Chief Operating Officer for Acute Services:
Yes.

Deputy L.M.C. Doublet:
Thank you. I also would like to understand that if those services were to be expanded to include some of the middle to lower severity - I am sorry, I do not know the clinical terms for it - how much would that cost? If that work is being looked at, I think we would like to understand whether that is going to be bid for in the next budget or if there is more preparatory work that needs to be done in the longer term.

Chief Operating Officer for Acute Services:
Yes, sure.

Deputy L.M.C. Doublet:
I think the Assistant Minister wants to speak. You will need to come back to the table. Is there anyone that is not … I think perhaps there is … we need to get a bigger table, do we not, a bigger room?

Assistant Minister for Health and Social Services:
No, it was just to say that I think we are hoping that the G.P.s will start the process.

Deputy L.M.C. Doublet:
Right, okay.

Assistant Minister for Health and Social Services:
If you are not getting any response from what your G.P. is able to do for you, then you need to be referred to him and then …

Deputy L.M.C. Doublet:
Is that part of the negotiations around subsidising G.P. fees? Are they required to provide a specific standard of care in return for those subsidies?

Assistant Minister for Health and Social Services:
No. We are just hoping that some G.P.s will become specialists in this area because they will have a special interest in gynaecology and endometriosis.

Deputy L.M.C. Doublet:
Is there a way to be more certain about that or to plan for it?

The Minister for Health and Social Services:
As I say, it is a shame we are coming towards the end of our term because what we are trying to do through the Partnership Board and the subgroups is to have a subgroup for every major speciality and those subgroups then deal with the P.C.B. (Primary Care Body).

Deputy L.M.C. Doublet:
Yes.

The Minister for Health and Social Services:

We then have a network of communication with all G.P.s to try and bring particular areas of focus to people's attention. It is just joining the dots, if you like, and making the flow of information a little bit more effective than it is at the moment.

Deputy L.M.C. Doublet:

Okay.

The Minister for Health and Social Services:

As I say, to raise awareness and get everybody over periods of time to have particular focus on particular areas and trying to find specialists in each of the larger practices who want to … for example, in my own practice one of the doctors is very keen on cancer analysis and he is starting to go through all of the figures within that practice. I have suggested let us go back to the P.C.B. and he then analyses cancer figures across the piece for all G.P.s. It is starting a network of engagement with the G.P.s so that we get more sharing of the data, better use of the data, better analysis from that data and better information going out to them about the things that are needed throughout the system.

Deputy L.M.C. Doublet:

I see.

The Minister for Health and Social Services:

It is all part of this 4-year process, that it is going to take time to build.

Deputy L.M.C. Doublet:

Yes, okay, thank you. I think that will take us nicely into the next section, unless there are any final questions on endometriosis. Okay, so I am going to move to my Vice-Chair.

Deputy J. Renouf:

I am going to jump to A.D.H.D. (Attention Deficit Hyperactivity Disorder), you will be aware of our review that the panel did and our understanding is that there has been recruitment of new staff and I wondered whether you could provide an assessment of where we have got to in terms of the A.D.H.D. service and the waiting lists.

The Minister for Health and Social Services:

Okay, I will hand straight over to Andy who is going to give you much more detail.

Director of Mental Health and Adult Social Care:

Of course. You are right, we recruited a specialist who is a prescriber and that was great news. Unfortunately, almost immediately after he started we were beset by a long-term sickness absence from another member of the team. Our overall capacity has not increased at all since he was taken on. The position then today is that we have got a waiting list of just over 1,100 people. The good …

The Minister for Health and Social Services:
Which has not come down at all though.

Director of Mental Health and Adult Social Care:
Which has not come down and we report this each month in our external reporting and we talk about it obviously in our report. The good news is that the specialist nurse has been doing some work with Children's Services. At one point you may remember we had over 100 young people all waiting to transfer from Children's Services to Adult Services; that figure is now down to 43.

[15:30]

We have done quite a lot of work on transitioning people over; that is a good piece of news I think. We are no further forward with the prescribing of medicines in primary care. It has been back to the advisory group and was rejected again. Consequently, we are almost in the same place in terms of we are having to spend more than half the clinical time prescribing repeat prescriptions.

Deputy L.M.C. Doublet:
What was the basis for rejection?

Director of Mental Health and Adult Social Care:
There was a couple of reasons given, one was the issue about the availability of medicines at that time, where in actual fact that has alleviated significantly; that was really helpful. The second was a view by a number of the G.P.s that this is outside their skill set and that they think it is something that they should not be doing; it should be done within secondary care. There was a concern about the level of demand and about whether or not they would be able to manage that within their current capacity.

Deputy J. Renouf:
It is a bit of a catch-22, is it not?

Director of Mental Health and Adult Social Care:

Simply, I think I have described to you before there comes a tipping point, if we diagnosed about another 250 people and chose to treat them, at the current rate that would mean that all of the clinical time in this area would be spent prescribing. We would be at a point where we could not see anybody else for assessment because we have not the capacity to do so. That is very much an ongoing issue that significantly limits what we can do in terms of the capacity available to us.

Deputy J. Renouf:

Are you taking any actions to deal with this?

Director of Mental Health and Adult Social Care:

There are ongoing discussions. We talk, as you would expect, regularly with primary care colleagues in relation to is there a way that we can move this forward? We have recently had a conversation … we have 2 G.P.s who are interested in coming doing some sessional work; G.P.s with a special interest, essentially, in this service. There are 2 factors that I will need to work through in relation to that. One is in relation to funding and I will come back to that, but the second is having consultant availability to oversee their work and support them and train them and develop them. Because clearly that is what needs to happen. You cannot just deposit a G.P. and then say off you go; it is, essentially, part training, so that is that. I spoke with the Ministerial team, we talked about this only last week, in terms of I think we are now in a pretty steady state. When we have full capacity, I am hoping we will have full capacity for next month in the clinic. We are not going to keep up. We received 301 new referrals last year and we have got capacity to see …

Deputy L.K.F. Stephenson:

How does that compare year on year?

Director of Mental Health and Adult Social Care:

It is slightly less but we have only got capacity to see about 12 new referrals a month. Clearly, we are still in a position where demand really significantly outstrips capacity. I think we are going to have to think about, what can we do? I think the only place that we have now got to is we need to develop a business case for more resource in this service. At one point I was relatively hopeful that we would get on top of it but we are simply not and the demand is not going away. Clearly, there is a question about, do we move? We could move resource now. But the reality of the financial position with the mental health services is we would need to stop doing other things in order to put more resource into this pathway. That is something that certainly would not be supported by the leadership team currently because the other things are things like crisis assessment, acute care; that does not feel like it is a real option. I think we are now in a position where we need to regroup. With the team, the clinical team, such as they are, have still been doing some work about prioritising

waiting lists, for example, because we get very mixed types of referrals. But I think that is where we are.

Deputy J. Renouf:
I was going to ask, what measures have been put in place to ensure that waiting lists reductions are sustainable rather than temporary but since there are not any waiting list reductions I cannot really ask that.

Director of Mental Health and Adult Social Care:
Absolutely.

Deputy J. Renouf:
Is your view that it would be worthwhile looking at triaging more aggressively in that A.D.H.D. waiting list?

Director of Mental Health and Adult Social Care:
We have done that and we have done that twice. In the last 3 years, if you remember, there was one point where we simply introduced gathering some information and asking people to provide a bit more information to allow us to triage and the team do triage out. So, there are referrals that do not get beyond the initial referral because they say: "No, it is not A.D.H.D., it is something else", or: "We want an alternative assessment first", and that is absolutely normal. We, probably 18 months ago, introduced more requirement to complete information in a timely way and provide information to the team for that triage to take place. So we have done that twice. I think in some ways we are now in a place where … and the clinical team would say that is why there is a relatively high conversion rate. People are generally diagnosed once they get through to the clinical assessment because they have already been through a number of sets of eyes that have said: "Could this be something else?" And: "Is this A.D.H.D.?" The other thing that I must say though that I think is important. We, if you recall, started running groups around living with A.D.H.D., managing symptoms, all of that stuff. The feedback that we have had has still been really good. We are on our sixth round of that group now. Unfortunately, the take up is not huge so we have offered 300 people a place on the groups from the waiting list and we have had just under 50 people have taken that up. We are really actively trying to encourage people to go to those groups, not least because the feedback that we are getting from people when they do attend is it is great. It is a succession group that really looks at how do you manage the difficulties that you are experiencing without the use of medicines? But that is a summary of where we are.

Deputy J. Renouf:

You are hinting there at a possible other solution. To what extent do you think A.D.H.D. constitutes a crisis? On the face of it this is a crisis. We have a service that is totally failing to meet demand. You are suggesting there are other treatments that are helping. But where does the answer lie in this?

Director of Mental Health and Adult Social Care:

I think it lies in both. I think it lies in understanding the other things that we can do that are not solely medication related, because people can alleviate difficulties through non-medical intervention. The evidence base is good around that. But I also think in the end we have to think about how do we tackle this problem in terms of waiting for diagnosis? I do think, frankly, we keep bouncing around with this thing, or how do we prioritise the waiting list. We have referrals for people, as I have said before I think, who are 65 and have gone to the G.P. and said: "Oh, I think I might have A.D.H.D.", and the G.P. says: "I will refer you to the A.D.H.D. service." We also have referrals for young people who cannot be in education, for example, because of the symptoms that they experience. So there is something about how do we work through and manage, and I think our clinical preference to date is to think about burden and about impact. But that alone is a huge piece of work that needs to be undertaken clinically which will then remove the clinicians from the front-line work in order to prioritise the waiting list. So, yes.

Deputy L.M.C. Doublet:

In terms of … have you finished?

Deputy J. Renouf:

I am just going to ask the Minister what view he takes about whether this is something he would support trying to get more money for.

Director of Mental Health and Adult Social Care:

It is a real concern we discussed at length last Thursday and we said we have really got to take a new look at this and come up some suggestions as to how we might tackle it. Because it just cannot go on. A number of things have been tried and you can see we are just barely treading water. So it has to be addressed and I would imagine in the next … I do not want to put a timetable on it but you will be coming up with some concrete suggestions …

Deputy J. Renouf:

Quickly.

Director of Mental Health and Adult Social Care:

… in the not too distant future. Yes. Hopefully before we depart from our position, yes.

Deputy L.M.C. Doublet:
Okay, so in the next month or 2 you expect to have a plan of where to go with this?

Director of Mental Health and Adult Social Care:
Which then of course, as we have rehearsed multi times in relation to this, then relies on us being able to find clinicians with relevant expertise to come and do the work because this is a problem everywhere and across the U.K. services are desperately seeking clinicians with expertise in this area in order to tackle exactly the same problems that we are experiencing here. So, I have historically, as you know, gone to agencies for example to look for clinicians and been unable to get them simply because they are not there.

The Minister for Health and Social Services:
But at least we will have a plan, an action plan, that we will try to implement.

Director of Mental Health and Adult Social Care:
Yes, with some quick training, yes.

Deputy L.M.C. Doublet:
In terms of training though, so you mentioned that there were some G.P.s that have a special interest. Minister, I think you mentioned this and they are keen to be part of the solution. I think you said, is it the supervision of those people during the training that is the problem? Could that supervision not be provided remotely?

Director of Mental Health and Adult Social Care:
Potentially. If we had a consultant with relevant expertise who was willing to do that, yes, potentially.

Deputy L.M.C. Doublet:
Is that something you can actively explore?

Director of Mental Health and Adult Social Care:
One of the difficulties that we get into is around prescribing here and the fact that for very good reasons our clinicians are disinclined to prescribe against assessments that have been undertaken by other people unless they are really clear that that assessment is robust. Not least by nature of the medicines that they are prescribing. That makes sense, does it not? But it is certainly something that we could explore. We have done that previously with the autism service. At one point we had some remote support that was coming in. They were not seeing patients but they were supporting staff that were, so, potentially yes.

Deputy L.M.C. Doublet:

Okay, and, Minister, when we have had public hearings with you, I think during the review and you … it was very clear from you that you understood the urgency of this and I think you mentioned having … calling meetings as soon as possible and taking some action. Do you still have that drive to find those solutions?

The Minister for Health and Social Services:

I think more than ever. We are quite desperate that some of the measures we have tried to introduce have not had an effect and it is a big problem so we are very keen. We are keen to get something out in public as to try and get the plan underway before we leave office.

Deputy L.M.C. Doublet:

In terms of the groups that you are holding, have you tried to understand from those that are not attending what they might need to attend? Because I understand you have got the good feedback from those who have attended. For example, are you offering groups that have similar demographics around gender and age that people might feel more comfortable attending?

Director of Mental Health and Adult Social Care:

Sorry, I do not know but I will go away and find out.

Deputy L.M.C. Doublet:

Okay.

Director of Mental Health and Adult Social Care:

Yes, thank you.

Deputy L.M.C. Doublet:

All right, thank you. I think that is everything. Does anybody have any further questions on the A.D.H.D. review follow up? No? Okay. We are going to move on to the cannabis legislation, Vice Chair.

Deputy P.M. Bailhache:

Minister, we note that P.116 has been put off until later in the year and I wondered if you could give us a brief overview of what the next steps will be and what work will continue in the department for handing over to the new Council of Ministers?

Deputy L.M.C. Doublet:

Can I just add something to that before you answer, Minister? So, this is partly a question that has come in from members of the public. You will be aware that there are numbers of Islanders who are keen to understand what is happening in this area and may not be aware of the rationale behind why that proposition was lodged and why it has since been withdrawn.

The Minister for Health and Social Services:

I think the handling by the media of some of this has been a little bit confused. I have had a lot of correspondence from people saying: "Why is the Government going to be opening its own grow your own cannabis farm?" and stuff, and that has never been the intention. So, I think there has been some confusion around it. The intention had been to debate it and I think in the first instance the reason that it was withdrawn is that there were 3 options and one of the options when we had it checked through for a second time, we were not comfortable that that wording was legal, if nothing else, so we had to withdraw it. I think Ruth has probably got a better handle on the points of detail but that is the principal reason that it was withdrawn.

Director of Health Policy:

So we lodged the report in proposition. We received feedback on it as we do quite a lot, including from proofing we did with Scrutiny, and, as the Minister has said, it became clear in the feedback received that option 1 which related to the decriminalisation rather than the legalisation of possession of personal cannabis was not as clearly framed as it should have been to be able to support States Members to fully understand what the option was. So, we were concerned about creating confusion and we were also further concerned that because there was so little time to allow for full consideration by States Members because we were so close to the elections that what we needed to do was to go away and do some more work. That work is being done at the moment and we will have updated proposals, particularly around the first option, option A, to present to the new Council of Ministers post-election for the new Council of Ministers to make the decision to take that piece of work forward.

Deputy L.M.C. Doublet:

Can I just note the time?

Director of Health Policy:

Yes

Deputy L.M.C. Doublet:

We have only got 15 minutes left so if we could pick up the pace slightly?

Deputy P.M. Bailhache:

Can I just ask whether that work is going to include the consideration of what is the appropriate regulation for medicinal cannabis which seems to many people to be something which really ought to be dealt with first of all?

Director of Health Policy:
The work around regulation of medicinal cannabis is a separate workstream that we are working on. We have some draft proposals relating to the regulation of medicinal cannabis which we are meeting next week I think it is, to discuss with the Minister for Health and Social Services before we take those draft proposals out to wider consultation with cannabis subscribers on the Island. So we are absolutely doing that. It is a separate stream of work.

The Minister for Health and Social Services:
Can I just make a comment that, like you, I think we feel that the medicinal cannabis issues need to be resolved but I just ask everybody to bear in mind that the work that we are doing on the other cannabis, recreational cannabis, is as a consequence of a States Member taking a proposition and asking us to go away and do that work. We are not prioritising that in front of the other work. We are responding to the wishes of the Assembly.

[15:45]

What I would say is, as I say, whoever is sitting on the Ministerial team next time around … because this is so complicated and it has got such a lot of arms to it in terms of medicinal and recreational and so on that the public messaging has to be very, very clear. We need to contextualise what is happening because the truth of the matter is in dealing with the illegal market now, or the recreational market, it is fair to say that that market has almost disappeared. It is the medicinal market that, as it strikes me, is supplying the bulk of the market anyway. Like you say, you come back to where our prioritise ought to lie and where our prioritise would be is dealing with the medicinal side.

Director of Health Policy:
Yes. I think we are all agreed that unfortunately the medicinal cannabis came in without the regulation that should have accompanied it at the time.

The Minister for Health and Social Services:
There is a …

Director of Health Policy:
It is really important we get it right.

The Minister for Health and Social Services:

… tribe of enthusiasm over forethought I think, yes.

Deputy J. Renouf:

Can I ask one question about other things that might be being considered at the same time? Which is, once you decriminalise, or legalise cannabis, the smoking of cannabis in public becomes by default also legal. Is any thought being given to how … whether it would be appropriate to bring at the same time as you bring potential State legislation changes forward, a measure that would at least offer the option of criminalising or making illegal in some form the smoking of cannabis in public even after possession was made either legal or decriminalised.

The Minister for Health and Social Services:

That is assuming … it is the Assembly that makes the decision, not us, so it may decide not to decriminalise it. But on the assumption that it was decriminalised that is something that could be looked at but I think there are complexities there as well in terms of the policing of it and the practicality of it. So those are all things that would need to be looked at as a second stage.

Deputy J. Renouf:

So they are not being looked as part of the current stage?

Director of Health Policy:

They are being looked at as part of the current stage.

Deputy J. Renouf:

Could you just give me a very quick … given the time.

Director of Health Policy:

They are being looked at the current stage and we are looking at a range of options which is, can you smoke in public? Can you vape in public? Can you vape in some public areas and not in public areas? We are doing an analysis of what that looks like and we are also looking at how other jurisdictions have responded to that. You might be aware, for example, that Amsterdam has just changed its legislation to prevent the smoking of cannabis in public because Amsterdam stinks.

Deputy J. Renouf:

A bold statement.

Director of Health Policy:

Of cannabis only.

Deputy L.M.C. Doublet:

Are we all done? Anyone? Okay, thank you. Thank you for the answers there. We have some questions on sign language interpreters in the hospital which have come via Constable Shenton-Stone who is not able to be with us today. Minister, could you help us to understand whether there is a sign language interpreter that is available to individuals in the hospital who need it?

The Minister for Health and Social Services:

I have discussed this a number of times with Constable Shenton-Stone and I have met a lady who does a lot of advocacy work for the deaf community twice in recent weeks. That has resulted in a whole new piece of work being undertaken. I do not know if you want to make some comment on. It is in its early stages but I think it is … what became apparent to us is that the deaf community have been a little bit ignored over the course of time so there is a new push. But it is only in recent weeks that we have really upped our game on that and we are now giving full consideration to a number of issues that have been raised to us, particularly by this lady advocate for the deaf community. So, all of the things that she has brought forward have been put forward through to the leadership team and they are all now receiving consideration. I can only apologise that that has been a little bit late in the day but, as you know, we have got a very full agenda but it is now being addressed, but it is in its early stages.

Deputy L.M.C. Doublet:

Okay, thank you. What is the timeline for a fully operational interpreter to be available onsite?

Director of Mental Health and Adult Social Care:

Shall I take that?

The Minister for Health and Social Services:

Yes.

Director of Mental Health and Adult Social Care:

So this has come to me in detail in the last few days. So currently we use sign video. So, this is an app-based interpreting service which is used across the Government for other things as well. But essentially it is a B.S.L. (British Sign Language) app where people can log on and where interpreting occurs through the app. So that is the main way that this is done in the hospital currently. But Tom Walker and I are meeting with representatives of the community within the next 2 weeks to start to understand what are the concerns, what are the issues and what do we need to look at?

Deputy L.M.C. Doublet:

Okay. Is that community advocating for an individual locally to be providing that service rather than an app?

The Minister for Health and Social Services:
As I say, the detail of that is … I had arranged for this lady representative to meet the team and it is running faster than I am because I did not even know that it had been put to you, Andy, to run. That has happened since last week.

Deputy L.M.C. Doublet:
Okay, thank you. There are a number of issues that had been raised with us, for example, around the use of family members for interpreting and how that might interact with consent and coercive control, et cetera, the documentation that might be available, partnerships with those services and how they are accredited. In terms of all of those details and the training, could we be kept updated on that?

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

Deputy L.M.C. Doublet:
Will you be consulting with the deaf community throughout?

Director of Mental Health and Adult Social Care:
Yes, I certainly hope so. I cannot imagine we could do the work without doing that, so, yes.

Deputy L.M.C. Doublet:
Okay, thank you. Thank you for the reassurance on that.

Deputy J. Renouf:
Long term thinking around health spending, the budget has obviously had a big boost but the pressures are still very much there. What long term strategy … what work are you doing to address the long-term funding of health care?

The Minister for Health and Social Services:
Some thinking is going on within the leadership team about that and I have been having discussions, once again in its early stages, with 2 clinicians. One who is retired who had been doing work independently, so I met with them very recently. They would be happy to join a collective approach. Up to this point there is lots of people going off at tangents, particularly experienced people, and coming up with their own workstreams, so the plan is to put them all in the same room together and

have one body of work going on with people that are involved with the service directly, and those that are familiar with it and doing work on the outside. It is early days.

Assistant Minister for Health and Social Services:
Did you want to talk to Hazel?

Deputy J. Renouf:
Well, I am interested in the Minister's take on it first.

The Minister for Health and Social Services:
Yes.

Deputy J. Renouf:
This is not a new problem. It might be slightly concerning for people to hear that it is only early days considering the long term …

The Minister for Health and Social Services:
No, it is early days for making it more collaborative and looking at the more political element to it because there are certain things that can be done internally but then there is the political angle as to how we take that forward, and on what basis we take it forward. I have to say it is going to … we will not be able to get enough done in our own term of office but who knows? We might try and persuade people to let us come back and carry on. If we do … I know the point was made, it was very for us to get money in the first instance, and why did we not think about funding before taking extra money? I made the point that we need the money now to get the service running properly and that the next step would be then to look at getting more money in, more resources. So, I know it might look like a cheap political trick to do it that way around and cast that problem on to someone else but I would be very happy to be in a position to come back and face the music on that. That does not bother me at all.

Deputy L.M.C. Doublet:
We would never suggest such a thing.

The Minister for Health and Social Services:
Very kind of you. You see, what I am saying?

Deputy J. Renouf:
It just sounds … yes, I hear exactly.

The Minister for Health and Social Services:

The political principle here, what was … maybe if we would have been 4 years in the job it would have been slightly different but what we thought was necessary was more money right now to … we have covered a lot of these problems today that just require some funding to get things moving. Which I think we are hopefully, as a collective we are succeeding in doing. We do need to look at health funding. We do.

Deputy J. Renouf:

I note the earlier bid for reappointment but …

The Minister for Health and Social Services:

It is just a commonsense approach to wanting continuity but …

Deputy J. Renouf:

But I think the only take away I would say for that is it does sound very ad hoc to people who have expressed an interest and so on. I mean, what is the structured programme of work that is going to investigate the funding of health services in the future?

The Minister for Health and Social Services:

No, we have got Philip Housden doing work on this. I think it is better at this … I do not want to dig a deeper hole for myself, I will hand over to Hazel.

Director of Finance:

Probably a joint piece from Ruth and myself. So, Ruth and I are working together on this. Both from a policy and financial perspective and we are also working with Treasury colleagues. We have, as officers, we have established a project board. There has been work already, as the Minister has pointed out and I think we have discussed at previous panel hearings, there is work in building a model which will give us that trajectory of what health and care spend across the sector would look like into the future in order for future Government to look at potential policy options. I do not know, Ruth, if you want to add anything to that?

Director of Health Policy:

Just in terms of the work that we are doing on developing a model, the … we also have 2 auditors from the Comptroller and Auditor General, because the Comptroller and Auditor General is particularly interested in this area, who are working alongside us and examining that work on the development of the model as we do it, even though it is a piece of work that is still in flight. That is in terms of the recognition of how important it is. So the plan is that by the time you get a new Council of Ministers we will be able to say to them with authority: “This is what your health care

spending looks like if you continue as you are today. This is what happens if you crunch in different population numbers. This is what happens if you crunch in different efficiency targets." It will be on that basis that the new incoming Council of Ministers can make some very firm proposals about how we afford things as we move forward because there is no doubt that we have to … there is a big funding gap and we have to do 2 things. We have to reduce expenditure at the top, but we also have to think about how money flows into the system at the bottom to close that gap.

Deputy J. Renouf:
When does the public get involved in this? Because these are potentially vast decisions that affect society?

Director of Health Policy:
They are absolutely vast. Obviously, I cannot speak on behalf of a future Council of Ministers but we would like to think that we are in a position to be consulting on options around funding toward the end of this calendar year. So, by quarter 4 next year … by quarter 4 this year, sorry, this year. I am getting my years wrong. In addition to that, as you know, we are doing other pieces of work looking at existing policies and also looking at how we introduce policies that create the right behaviours in terms of use of resources such as the charging people for incorrect use of E.D. (Emergency Department), charging people for "do not attends". This is all part of … these are small bits of work but they are all part of a whole programme of work which is not just focusing on what more do we need but how do we use what we have more effectively and target at those in most need.

The Minister for Health and Social Services:
Just important to say that the charges … I just thought I would get this in, but the charges you are talking about are to drive behavioural change.

Director of Health Policy:
Yes.

The Minister for Health and Social Services:
They are not … those are not revenue raising … they are a means to try and make the system work more efficiently.

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

The Minister for Health and Social Services:

So, I just want to make that plain publicly.

Deputy L.M.C. Doublet:

Can I enquire about the Ministerial group on the wider social determinants of health? Is that group … has it had any output yet and how is that going to feed in?

The Minister for Health and Social Services:

No output as yet but we have had an initial meeting to just discuss between ourselves what we think it should be doing and the approach we would like to take. But I think in the next Government … now that things … there is a certain maturity across the piece here in terms of what is happening and where we are going and that can now be used to feed into that group. The worry about that is if there is no continuity there will be a break in the politics of it working because I know what it felt like, and I am sure Andy would bear me out, being parachuted into this job just over 2 years ago, there is so much to learn if you have not got a background in it. An enormous amount to learn, and until you have got your feet on the ground you cannot take that information up to take through to your other colleagues to join the dots as it were. What we are trying to do is to produce a readable document that can say to somebody: "When you come in this is the structure, this is the work programme", so that if it is not us it is somebody that can say … they can be run through that, the politics of it and know what they are dealing with and that wider determinates of health group will feature as part of that. But, as I say, the worry is … for lay people it is so complex that there will be a hiatus there which is a concern.

Deputy L.M.C. Doublet:

So are you confident then that that group will have some output that can be examined alongside the numbers and the facts to determine what the wider social change might need to happen in order to impact those figures?

The Minister for Health and Social Services:

In principle it can be a very, very useful grouping of people. I genuinely think it can. It is just a shame that our period, from a political side, is not that little bit longer because we are at the stage now where that could have been made to work quite well. But such is politics.

Deputy L.M.C. Doublet:

Okay. Any final questions from anybody? No. Okay, so, Minister, before we close the hearing I wanted to put on record that although we are not launching formal reviews of any of the legislation that you have lodged, we are scrutinising it and we are doing it in this way because of the shorter time period.

The Minister for Health and Social Services:
Yes.

Deputy L.M.C. Doublet:
So members of the public will not see formal reviews being launched but we are scrutinising the Health and Social Care Register and the Termination of Pregnancy Law and will be aiming to publish some comments on those and will keep you up to date with that.

[16:00]

The Minister for Health and Social Services:
Good, excellent.

Deputy L.M.C. Doublet:
Okay. Anything that you would like to add before we close the hearing, or your Assistant Minister?

Assistant Minister for Health and Social Services:
Just to say thank you very much.

The Minister for Health and Social Services:
Hopefully it has been constructive and for anybody listening and I hope they found it constructive as well.

Deputy L.M.C. Doublet:
Yes. Well, thank you very much for your answers, officers as well for your answers and for your time everybody, and I will close the hearing.

The Minister for Health and Social Services:
Thank you again.

[16:00]